**Supplementary Appendix to:**

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**A. Protocol**

*Title:* Psychological interventions for Complex PTSD: systematic review and meta-analysis.

*Reviewers:* Thanos Karatzias, Mick Fleming, Susan Roberts, Aoife Bradley, Claire Fyvie, Jonathan Bisson, Neil Roberts, Philip Hyland, Marylene Cloitre, Tobias Hecker, Andreas Maercker, Paul Hutton

*Review question(s)*

What psychological interventions are effective for complex post traumatic stress disorder, and how effective are they? What is the safety and acceptability of psychological interventions for complex post traumatic stress disorder?

*Searches*

Searches of MEDLINE, PsycINFO, EMBASE and PILOTS will be conducted using the search terms listed below. Unpublished trials will be identified through contacting investigators and through searching clinical trial registries such as Clinicaltrials.gov. Language will be restricted to English. There will be no time period restrictions. #1. PTSD or posttrauma\* or psychological stress\* or combat or post-trauma\* or gross stress reaction or stress disorder\* or trauma\* or psychological trauma. #2. randomised or randomized or randomised controlled trial or RCT or randomized controlled trial. #3.therapy or psychological therapy or psychological intervention or intervention or treatment).mp. [mp=ti, ab, ot, nm, hw, kf, px, rx, ui, an, eu, pm, sy, tn, dm, mf, dv, kw, fs].

*Types of study to be included*

Randomised controlled trials with or without rater masking will be included. Uncontrolled, non-randomised and crossover trials, qualitative studies and case studies will be excluded.

*Condition or domain being studied*

Complex post traumatic stress disorder (CPTSD) as described in ICD-11 proposals. According to ICD-11 individuals meet diagnostic criteria for complex PTSD if they meet existing criteria for post traumatic stress disorder (PTSD) (re-experiencing of the trauma, avoidance of reminders of the trauma, enhanced sense of threat indicated by hypervigilance and hyperarousal) and have clinically significant difficulties in affect dysregulation, a pervasive negative self-concept and experience interpersonal disturbances (Cloitre et al. 2013). Individuals meet diagnostic criteria for complex PTSD if they meet existing criteria for post traumatic stress disorder (PTSD) (re-experiencing of the trauma, avoidance of reminders of the trauma, enhanced sense of threat indicated by hypervigilance and hyperarousal) and have clinically significant difficulties in affect dysregulation, a negative self-concept and experience interpersonal disturbances (Cloitre et al. 2013).

*Participants/population*

We are interested in the effect of psychological interventions on adults who meet criteria for CPTSD. However, since CPTSD is a new diagnostic category, we anticipate that few studies have explicitly included this group. For this reason we will only include trials of interventions where participants meet ICD and DSM – III and IV criteria for PTSD and present with clinically significant symptoms of re-experience, avoidance hyperarousal and score within the clinically significant range on at least one of the additional CPTSD criteria, namely emotion dysregulation, negative self-concept and interpersonal disturbance. We will only include trials where the mean or median age of participants is at least 16, and we will only include trials where participants with developmental or intellectual disability, neurodegenerative disorders and acquired or traumatic brain injury are excluded. We will include studies where participants have comorbid substance misuse difficulties, but we will exclude trials where participants have a primary diagnosis of substance misuse disorder.

*Intervention(s), exposure(s)*

We will include trials where participants in at least one arm receive 'bona fide' psychological interventions (defined according to criteria developed by Benish et al (2008),\* delivered in group or individual format, including but not limited to CBT, interpersonal therapy, psychodynamic therapy, EMDR or psychoeducation. \*The bona fide definition (Benish, Imel and Wampold, 2008) requires that treatments had to be delivered by a trained therapist who adapted the treatment to patients on the basis of a therapeutic relationship (i.e., no delivery of a non-modifiable standard protocol, e.g., progressive muscle relaxation); treatments also needed to be conducted personally and face-to-face (i.e., no online treatments or treatments conducted with, e.g., audio material). Moreover, at least two of the following four criteria had to be fulfilled with regards to their descriptions in the studies: (a) a citation to an established school or approach to psychotherapy; (b) a description of the therapy that contained a reference to a psychological process (e.g., operant conditioning); (c) a reference to a treatment manual that was used to guide the delivery of the treatment; (d) the identification of active ingredients of the treatment and citations for these ingredients.

\*Benish SG, Imel ZE, Wampold BE. The relative efficacy of bona fide psychotherapies for treating posttraumatic stress disorder: A meta-analysis of direct comparisons. Clin Psychol Rev. 2008;28:746–58. doi:10.1016/j.cpr.2007.10.005.

*Comparator(s)/control*

Psychological interventions will be compared against one another and also against no additional treatment (i.e., 'treatment as usual' and 'waiting list control') and non-active interventions, such as befriending.

*Context*

All settings to be included.

*Primary outcome(s)*

The primary outcome will be twofold: 1. The between group difference, at end of treatment and 12-months post-randomisation, in severity of (a) PTSD symptoms as per ICD-11 and DSM III and IV and (b) emotion dysregulation, negative self-concept and/or interpersonal disturbance. To compute this composite outcome, we will calculate the average standardised mean difference across these outcomes taking into account the correlation between these variables where / if possible. 2. The between group difference at end of treatment and at 12-months post randomisation, in the relative and absolute risk of not achieving a clinically significant response in PTSD symptoms, defined using Jacobson criteria.

*Timing and effect measures*

End of treatment and 12-months post randomisation (or nearest time-point within a 3-month range).

*Secondary outcome(s)*

1. Safety, as measured by the between group difference, at end of treatment and at 12-months postrandomisation, in the relative risk of serious adverse events (death, suicide, attempted suicide, significant deterioration in symptoms, admission to hospital). 2. The acceptability of the interventions, as measured by the between group difference in the relative risk of dropping out early from either the treatment or the trial (where the comparator is treatment as usual).

*Timing and effect measures*

End of treatment and 12-months post randomisation (or nearest time-point within a 3-month range) for safety, and end of treatment for acceptability.

*Data extraction (selection and coding)*

We will extract group means and associated standard deviations (and N contributing to those means) for continuous outcomes, and number of events (denominator = number randomised to arm) for dichotomous outcomes, using a spreadsheet. We will use the total number randomised if reported. For all outcomes except acceptability, we will assume those not including in the reported analyses are either missing completely at random (for continuous outcomes) or had no change from randomisation (dichotomous outcomes). Two researchers will double-extract data for all outcomes, and a third rater will be consulted in relation to any discrepancies and / or disagreements. If means and standard deviations are not reported, then we will estimate the between group difference from other statistical parameters, such as confidence intervals, standard errors, p-values, t-values or F-values, following procedures in the Cochrane Handbook, and using the Campbell Effect Size Calculator, if possible. If we need to combine data from 2 groups before entry into the meta-analysis, we will do so following the formulae specified in the Cochrane Handbook.

*Risk of bias (quality) assessment*

At the study level the risk of bias will be assessed using the Cochrane collection Risk of Bias Tool (Higgins et al 2011). This involves categorising studies as having a low, high or unclear risk of bias in the areas of selection and allocation of participants, intervention concealment, attrition and reporting. The results of this assessment will be used to inform interpretation of reported effect sizes and overall conclusions. The quality of overall outcomes will be assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) (Guyatt et al 2011).

*Strategy for data synthesis*

For continuous outcomes, we will perform random-effects meta-analyses to compute an overall standardised mean difference and associated 95% confidence intervals, with Hedges's g adjustment. For dichotomous outcomes, we will also perform random-effects meta-analyses to compute an overall relative risk, an overall difference in absolute risk, and the number needed to treat for one to experience benefit / harm (computed as the inverse of the absolute risk).

*Analysis of subgroups or subsets*

We will examine whether the results are moderated by the degree to which the sample population meet CPTSD criteria (whether the sample score within the clinical range on 1, 2 or 3 CPTD criteria at baseline). We will also examine the potential moderating role of quality parameters including rater blinding, attrition, random sequence generation description. We will also examine whether the effectiveness of psychological treatment for CPTSD is moderated by the following: - individual vs. group format - adult onset trauma vs.. childhood onset trauma vs. both - phased / staged interventions vs. non-phased / non-staged interventions.

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None known

*Language*

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Review\_Ongoing

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*Subject index terms*

Humans; Psychotherapy; Stress Disorders, Post-Traumatic

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*Date of publication of this version*

10 February 2017

 *Details of any existing review of the same topic by the same authors*

*Stage of review at time of this submission*

|  |  |  |
| --- | --- | --- |
| *Stage* | *Started* | *Completed* |
| Preliminary searches  | Yes | No |
| Piloting of the study selection process  | No | No |
| Formal screening of search results against eligibility criteria  | No | No |
| Data extraction  | No | No |
| Risk of bias (quality) assessment  | No | No |
| Data analysis  | No | No |

Available from:

<http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42017055305>

**B. Changes from Protocol**

A subsequent change was our inclusion of some psychological interventions (e.g., mindfulness, yoga) which were not strictly ‘bona fide’ psychological interventions (Benish, Imel, & Wampold, 2008). We made this decision in the interests of completeness.

While we had planned to take into account the correlation between variables when computing the composite outcome, this was not possible due the range of measures used to assess the variables; instead we had to assume the correlation was zero.

Additional changes included abandoning our pre-specified moderator analysis of phased vs non-phased interventions due to insufficient data.

We were also unable to determine rates of clinically significant response according to our pre-specified method (Jacobsen’s criteria). We instead converted the SMDs to NNTs using the Furukawa approach, under 3 assumptions of the control event rate (10%, 50% and 22%, which is half the control event rate observed for PTSD). Secondary outcomes (safety, drop-out) and follow-up data will be reported separately.

**C. Excluded Studies**

The following table (**Table C.1)** details studies or reports excluded after inspection of the full-text report, or via correspondence with authors. Studies or reports excluded on basis of title or abstract alone are not detailed as these are too numerous and the vast majority were of different conditions or were otherwise unrelated to the review question.

| **Study reference** | **Reason for exclusion** |
| --- | --- |
| Acarturk 2016 | No useable CPTSD index |
| Acierno 2017 | No relevant comparator |
| Akbarian 2015 | No useable CPTSD index |
| Alghamdi 2015 | Sample not suitable |
| Arntz 2007 | Baseline CPTSD index/indices not clinically significant |
| Asukai 2010 | No useable CPTSD index |
| Badura-Brack 2018 | No relevant psychological intervention |
| Bass 2016 | Sample not suitable |
| Beidel 2017 | Not RCT |
| Belleau 2017 | No useable CPTSD index |
| Betancourt 2014 | Sample not suitable |
| Bichescu 2007 | No useable CPTSD index |
| Blanchard 2003 | Baseline CPTSD index/indices not clinically significant |
| Boden 2012 | No useable CPTSD index |
| Bohus 2013 | No useable CPTSD index |
| Bormann 2013 | No useable CPTSD index |
| Bormann 2014 | No useable CPTSD index |
| Bradley 2003 | Sample not suitable |
| Bremner 2017 | Baseline CPTSD index/indices not clinically significant |
| Brom 1989 | Baseline CPTSD index/indices not clinically significant |
| Brunet 2013 | Sample not suitable |
| Bryan 2016 | No useable CPTSD index |
| Bryant 2003 | No useable CPTSD index |
| Bryant 2008 | No useable CPTSD index |
| Buhmann 2016 | Baseline CPTSD index/indices not clinically significant |
| Carlson 1998 | No useable CPTSD index |
| Castillo 2016 | No useable CPTSD index |
| Catani 2009 | Sample not suitable |
| Chard 2005 | No useable CPTSD index |
| Classen 2001 | Sample not suitable |
| Cloitre 2010 | Baseline CPTSD index/indices not clinically significant |
| Cloitre 2012 | Study has overlapping sample with another study |
| Coffey 2016 | No useable CPTSD index |
| Cook 2010 | No useable CPTSD index |
| Cooper 1989 | No useable CPTSD index |
| Cooper 2017 | No relevant comparator |
| Cottraux 2008 | No useable CPTSD index |
| de Bont 2016 | No useable CPTSD index |
| Devilly 1998 | No useable CPTSD index |
| Devilly 1999 | No useable CPTSD index |
| Echeburua 1997 | No useable CPTSD index |
| Edmond 1999 | Sample not suitable |
| Edmond 2004 | Study has overlapping sample with another study |
| Ertl 2011 | Baseline CPTSD index/indices not clinically significant |
| Fecteau 1999 | No useable CPTSD index |
| Feeny 2002 | Study has overlapping sample with another study |
| Feske 2008 | Unable to obtain relevant norms |
| Foa 1991 | No useable CPTSD index |
| Foa 2004 | Study has overlapping sample with another study |
| Foa 2013 | No useable CPTSD index |
| Foa 2017 | No useable CPTSD index |
| Fredman 2016 | No relevant psychological intervention |
| Gamito 2010 | No useable CPTSD index |
| Gersons 2000 | No useable CPTSD index |
| Gilboa-Schechtman 2010 | Sample not suitable |
| Glynn 1999 | No useable CPTSD index |
| Goldstein 2018 | No relevant psychological intervention |
| Gutner 2016 | Study has overlapping sample with another study |
| Hien 2004 | No useable CPTSD index |
| Hien 2009 | No useable CPTSD index |
| Hien 2017 | Baseline CPTSD index/indices not clinically significant |
| Hien 2017 (b) | Study has overlapping sample with another study |
| Hinton 2005 | No useable CPTSD index |
| Holliday 2014 | Study has overlapping sample with another study |
| Holliday 2015 | Study has overlapping sample with another study |
| Ironson 2002 | No useable CPTSD index |
| Jacob 2014 | No useable CPTSD index |
| Jensen 1994 | No useable CPTSD index |
| Jindani 2015 | Baseline CPTSD index/indices not clinically significant |
| Johnson 2011 | No useable CPTSD index |
| Johnson 2016 | Not RCT |
| Kearney 2013 | Baseline CPTSD index/indices not clinically significant |
| Kearney 2016 | Baseline CPTSD index/indices not clinically significant |
| Kip 2014 | Study has overlapping sample with another study |
| Konig 2016 | Study has overlapping sample with another study |
| Kruse 2009 | Not RCT |
| Lange 2003 | No relevant psychological intervention |
| Lee 2002 | No useable CPTSD index |
| Levi 2016 | Not RCT |
| Liedl 2011 | Retracted |
| Litz 2007 | No relevant psychological intervention |
| Lovell 2011 | Study has overlapping sample with another study |
| Macdonald 2016 | No relevant psychological intervention |
| Marcus 1997 | No useable CPTSD index |
| Markowitz 2015 | Baseline CPTSD index/indices not clinically significant |
| Markowitz 2017 | Study has overlapping sample with another study |
| Maxwell 2016 | No useable CPTSD index |
| McGovern 2015 | No useable CPTSD index |
| McLay 2017 | No useable CPTSD index |
| McLean 2014 | No useable CPTSD index |
| Meier 2015 | No useable CPTSD index |
| Mills 2012 | No useable CPTSD index |
| Monson 2012 | No relevant psychological intervention |
| Moradi 2014 | No useable CPTSD index |
| Morath 2014 | No useable CPTSD index |
| Morland 2014 | No relevant psychological intervention |
| Moser 2010 | Study has overlapping sample with another study |
| Nacasch 2011 | No useable CPTSD index |
| Nacasch 2015 | No relevant comparator |
| Neuner 2004 | No useable CPTSD index |
| Neuner 2008 | No useable CPTSD index |
| Neuner 2010 | No useable CPTSD index |
| Nijdam 2018 | No useable CPTSD index |
| Nosen 2014 | No useable CPTSD index |
| Oktedalen 2015 | Baseline CPTSD index/indices not clinically significant |
| Pabst 2014 | No useable CPTSD index |
| Paivio 2010 | No relevant comparator |
| Paunovic 2001 | No useable CPTSD index |
| Peniston 1991 | No useable CPTSD index |
| Polusny 2015 | Baseline CPTSD index/indices not clinically significant |
| Possemato 2016 | Sample not suitable |
| Pruiksma 2016 | Study has overlapping sample with another study |
| Reger 2016 | No useable CPTSD index |
| Resick 2003 | Study has overlapping sample with another study |
| Resick 2008 | No relevant comparator |
| Resick 2015 | No useable CPTSD index |
| Resick 2017 | No relevant comparator |
| Roberts 2016 | Not RCT |
| Rothbaum 1997 | No useable CPTSD index |
| Rothbaum 2005 | No useable CPTSD index |
| Rothbaum 2006 | No useable CPTSD index |
| Rothbaum 2014 | No relevant psychological intervention |
| Ruglass 2017 | No useable CPTSD index |
| Sack 2016 | No relevant comparator |
| Sannibale 2013 | No useable CPTSD index |
| Sautter 2015 | No relevant psychological intervention |
| Schaal 2009 | Baseline CPTSD index/indices not clinically significant |
| Schneier 2012 | No relevant psychological intervention |
| Schnurr 2003 | No useable CPTSD index |
| Schnurr 2007 | No useable CPTSD index |
| Schnyder 2011 | No useable CPTSD index |
| Scott 2017 | Study has overlapping sample with another study |
| Shea 2013 | Sample not suitable |
| Shnaider 2017 | No relevant psychological intervention |
| Sikkema 2007 | No useable CPTSD index |
| Sin 2017 | Not RCT |
| Slade 2017 | Study has overlapping sample with another study |
| Sloan 2012 | No useable CPTSD index |
| Spence 2011 | No relevant psychological intervention |
| Steinert 2017 | No useable CPTSD index |
| Study Ref | Reason for Exclusion |
| Tarrier 1999 (a) | No useable CPTSD index |
| Tarrier 1999 (b) | No useable CPTSD index |
| Taylor 2003 | Baseline CPTSD index/indices not clinically significant |
| van den Berg 2016 | Study has overlapping sample with another study |
| van der Kolk 2007 | No relevant comparator |
| van der Kolk 2016 | No relevant psychological intervention |
| van Emmerik 2008 | No useable CPTSD index |
| Vaughan 1994 | No useable CPTSD index |
| Wahbeh 2016 | Baseline CPTSD index/indices not clinically significant |
| Wells 2015 | No useable CPTSD index |
| Wilson 1995 | No useable CPTSD index |
| Wilson 1997 | Study has overlapping sample with another study |
| Wolf 2015 | Not RCT |
| Zang 2013 | No useable CPTSD index |
| Zang 2014 | No useable CPTSD index |
| Zang 2017 | No useable CPTSD index |
| Zlotnick 1997 | No useable CPTSD index |
| Zlotnick 2009 | No useable CPTSD index |
| Zoellner 1999 | Study has overlapping sample with another study |
| Zoellner 2017 | No relevant psychological intervention |

**D. Table D.1. Summary of Characteristics of the 51 Included Studies**

| **Study Ref** | **Groups included** | **N**  | **Country** | **Participants** | **Age, mean (SD)** | **% female** | **Duration & N sessions available** | **Drops outs N (%)** | **Trauma exposure** | **Type of Trauma** | **Trauma onset** | **Treatment setting** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ahmadi 2015  | EMDR | 16 | Iran | Military servicemen | 29.4 (6.8) | 0 | Unclear | 5 (31.3) | Single | Non- sexual | Adult | Community |
|  | REM | 16 |  |  | 30.8 (6.9) |  | Unclear | 6 (37.5) |  |  |  |  |
|  | Control | 16 |  |  | 29.8 (9.7) |  |  | 4 (25.0) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Azad marzabadi 2014 | Mindfulness | 14 | Iran | War victims with PTSD | Not reported | 0 | 90mins, 8 | 2 (14.3) | Single | Non- sexual | Adult | Community  |
|  | Control | 14 |  |  |  |  |  | 2 (14.3) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Basoglu 2007 | SSBT | 16 | Turkey | Earthquake survivors  | 34.0 (11) | 87 | 60 mins, 1 | 1 (6.3) | Single | Non- sexual | Adult | Community  |
|  | RA | 15 |  |  |  |  |  | 0(0) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Beidel 2011 | TMT | 18 | USA | Combat Veterans | 58.93 (NR) | 0 | 90 mins, 29 | 4 (22.2) | Single | Non- sexual | Adult | Community  |
|  | EXP | 17 |  |  | 59.76 (NR)  |  | 90 mins, 29 | 1 (5.9) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Beidel 2019 | TMT | 49 | USA | Military veterans | 37.67 (8.51) | 7 | 90 mins, 29 | 14 (28) | Single | Non- sexual | Adult | Community  |
|  | EXP | 43 |  |  | 33.26 (11.31) |  | 90 mins, 29 | 22 (50) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bryant 2013 | Support/CBT | 34 | Australia | Adult civilian patients  | 41.15 (12.92) | 54 | 90 mins, 12 | 13 (38.2) | Single | Non- sexual | Adult | Community  |
|  | Skills/CBT | 36 |  |  | 37.86 (12.70) |  | 90 mins, 12 | 3 (8.3) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Butollo 2016 | DET | 74 | Germany | Trauma survivors  | 37.99 (12.1) | 66 | 90 mins, max, 24 | 9 (12.2) | Multiple | Sexual and non-sexual | Adult | Community  |
|  | CPT | 67 |  |  | 33.67 (10.3) |  | 90 mins, max, 24 | 11(14.9) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Cloitre 2002 | STAIR+MPE | 31 | USA | CSA survivors | 34 (7.22) | 100 | 60 -90 mins, 16 | 9 (29) | Single & Multiple | Sexual & Non-sexual | Child | Community  |
|  | MA WL | 27 |  |  |  |  | 15 mins,12 | 3 (11) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Difede 2007 | CBT | 15 | USA | Disaster workers | 45.77 (7.72)  | NR | 75mins ,12 |  8 (53.3) | Single | Non- sexual | Adult | Community |
|  | TAU | 16 |  |  |  |  |  |  2(12.5) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dorrepaal 2012 | EXP | 38 | Netherlands | CSA survivors | 40.3 (10.7) | NR | 120mins, 20 | 7(18.4) | Multiple | Sexual and non-sexual | Child | Community |
|  | TAU | 33 |  |  | 37.1 (10.3) |  |  | 5 (15.1) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Duffy 2007 | CT | 29 | Ireland | Trauma survivors  | NR | NR | NR, 12 | 9 (31.0) | Multiple  | Non- sexual | Adult  | Community  |
|  | WL | 29 |  |  |  |  |  | 3 (10.3) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dunn 2007 | SMT | 51 | USA | Veterans | 54.7 (6.9) | 0 | 90 mins, 14 | 17(33.3) | Single  | Non-sexual | Adult | Community |
|  | PGT | 50 |  |  | 55.0 (7.6) |  | 90 mins, 14 |  6(12.0) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dunne 2012 | TF-CBT | 13 | Australia | MVA survivors  | 32.54 (7.09) | 50 | 60mins,10 | 1 (7.7) | Single  | Non-sexual | Adult | Community |
|  | WL | 13 |  |  |  |  |  | 2(15.4) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ehlers 2003 | CT | 28 | UK | MVA survivors | NR | NR | 60-90mins, 12 | 0 (0) | Single  | Non- sexual | Adult | Community |
|  | SHB | 28 |  |  |  |  | 40mins,1 | 3 (10.7) |  |  |  |  |
|  | RA | 29 |  |  |  |  | 20mins, 1 | 2 (6.9) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ehlers 2005 | CT | 14 | UK | PTSD patients | 35.4 (10.9) | 53.6 | 60-90mins, 4-20 | 0 (0) | Single  | Non-sexual | Adult | Community |
|  | WL | 14 |  |  | 37.8 (11.2) |  |  | 0 (0) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ehlers 2014 | Intensive CT | 30 | UK | Chronic PTSD | 39.7 (12.4) | 58.7 | 18hrs over 5-7 days | 1(3.3) | Multiple | Sexual and /or non-sexual | Adult | Community |
|  | Weekly CT | 31 |  |  | 41.5 (11.7) |  | 100mins,12 | 1(3.2) |  |  |  |  |
|  | Weekly ST | 30 |  |  | 37.8 (9.9) |  | 100mins, 12 | 3 (10) |  |  |  |  |
|  | WL | 30 |  |  | 36.8 (10.5) |  |  | 0 (0) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Foa 1999 | PE | 25 | USA | Chronic PTSD  | 34.9 (10.6) | 100 | 90-120mins, 9 | 2 (8) | Single | Sexual or non-sexual | Adult  | Community |
|  | SIT | 26 |  |  |  |  | 90-120mins, 9 | 7(27) |  |  |  |  |
|  | PE-SIT | 30 |  |  |  |  | 90-120mins, 9 | 8 (27) |  |  |  |  |
|  | WL | 15 |  |  |  |  |  | 0 (0) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Foa 2005 | PE | 79 | USA | Assault survivors  | 31.3 (9.8) | 100 | 90-120mins, 9-12 | 27 (34.1) | Single | Sexual or non-sexual | Adult  | Community orUniversity -based |
|  | PE-CR | 74 |  |  |  |  | 90-120mins, 9-12 | 30(40.5) |  |  |  |  |
|  | WL | 26 |  |  |  |  |  |  1 (3.8) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Forbes 2012 | CPT | 30 | Australia | Military veteran | 53.13 (13.97) | 3.4 | 60-90 mins, 12 | 9(30.0) | Single  | Non-sexual | Adult | Community |
|  | TAU | 29 |  |  | 53.62 (13.33) |  |  | 9 (31.1) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ford 2011 | TARGET | 48 | USA | Mothers with PTSD | 30.7(6.9) | 100 | 50mins, 12 | 12(25) | Unclear | Unclear | Adult  | Community  |
|  | PCT | 53 |  |  |  |  |  NR, 12 | 14 (26) |  |  |  |  |
|  | WL | 45 |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Galovski 2012 | MCPT | 53 | USA | Trauma survivors | 39.80 (11.74) | 69 | NR, 12 | 14 (26.4) | Single | Sexual or non-sexual | Child | Community |
|  | SMDT | 47 |  |  |  |  | NR, 12 | 7 (14.9) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ghafoori 2017 | PE | 24 | USA | Trauma survivors | 35.2 (12.0) | 83.1 | 60-90 mins, 12 | 34 (72) | Multiple | Sexual and /or non-sexual | Adult  | Community |
|  | PCT | 47 |  |  |  |  | 60-90 mins,12 | 16 (66) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Harned 2014 | DBT | 9 | USA | Women with BPS & PTSD | 32.6 (12.0) | 100 | 1 year of treatment | 4(44.4) | Single | Sexual or non-sexual | Child | Community |
|  | DBT -PE | 17 |  |  |  |  | 1 year of treatment | 7(41.2) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hinton 2009 | IT-CBT | 12 | USA | Refugees | 49.92 (9.23) | 60 | NR, 12 | 0 (0) | Single | Non-sexual  | Adult | Community |
|  | DT- CBT | 12 |  |  | 49.08 (7.56) |  | NR,12 | 0 (0) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hinton 2011 | CA-CBT | 12 | USA | Female Latino patients | 47.6 (8.2) | 100 | 60 mins, 14 | 0 | Unclear | Unclear | Unclear | Community |
|  | AMR | 12 |  |  | 51.4 (5.9) |  | 60 mins, 14 | 0 |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hogberg 2007 | EMDR | 13 | Sweden | Public transportation workers | 43 (8) | 20.8 | 90mins, 5 | 0 (0) | Single  | Non-sexual  | Adult | Community |
|  | WL | 11 |  |  | 43 (11) |  |  | 2 (18.2) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hollified 2007 | CBT | 28 | USA | Adults with PTSD | 40.9 (13.4) |  | 120mins,12 | 7 (25) | Multiple | Unclear | Child | Community |
|  | WL | 27 |  |  | 43.4 (13.5) |  |  | 6 (22.2) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Jung 2013 | CRIM | 17 | Germany | CSA survivors | 37.18 (10.85) | 100 | 50 & 90mins, 2 | 0 (0) | Multiple | Sexual | Child | Community  |
|  | WL | 17 |  |  |  |  |  | 0 (0) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Keane 1989 | Implosive (flooding) | 11 | USA | Veterans  | 34.7 (4.3) | 0 | 90 minutes,14-16 | 1 (9.1) | Single | Non-sexual | Adult | Community |
|  | WL | 13 |  |  | 34.5 (2.1) |  |  | 1(7.7) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Kip 2013 | ART | 29 | USA | Veterans  | 41.0 (12.4) | 20 | 60-75mins, 2-5 | 3 (10.3) | Single  | Sexual or non-sexual | Adult | Community |
|  | AC | 28 |  |  |  |  | 60mins, 2 | 4 (14.3) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Krakow 2001 | CIT | 88 | USA | Sexual Assault survivors  | 40 (11.2) C37 (12.7) NC | 100 | 60-180 mins, 3 | 22 (25) | Multiple | Sexual | Child | Community |
|  | WL | 80 |  |  | 36 (9.3) C31 (10.5) NC |  |  | 20 (25) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Krupnick 2008 | IPT | 32 | USA | Trauma survivors | 32 (10.2) | 100 | 120 mins, 16 | NR | Multiple | Sexual & or non-sexual | Child | Community  |
|  | WL | 16 |  |  |  |  |  | NR |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Kubany 2003 | Immediate CTT-BW | 19 | USA | Battered women | 36.4 (9.1) | 100 | 90 mins, 8-11 | 1 (5.3) | Multiple | Non-sexual | Adult | Community |
|  | Delayed CTT-BW | 18 |  |  |  |  | 90 mins, 8-11 | 4 (22.2) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Kubany 2004 | Immediate CTT-BW | 63 | USA | Battered women | 42.2 (10.1) | 100 | 90 mins, 8-11 | 18 (28.6) | Multiple | Non-sexual | Adult | Community |
|  | Delayed CTT-BW | 62 |  |  |  |  | 90 mins, 8-11 | 22 (35.5) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Lindauer 2005 | BEP | 12 | Netherlands | Trauma survivors | 37.6 (10.2) | 54 | 45-60 mins, 16 | 3(25) | Multiple | Non-sexual | Adult | Community |
|  | WL | 12 |  |  | 40.3 (8.9) |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Marks 1998 | Exposure | 23 | UK | Outpatients with PTSD | 39 (11) | 36 | 90 mins,10 | 3(13) | Single | Sexual or non-sexual | Adult | Community |
|  | Cognitive | 19 |  |  | 39 (9) |  | 90 mins,10 | 1(5.3) |  |  |  |  |
|  | E+C | 24 |  |  | 38 (9) |  | 105 mins,10 | 5(20.8) |  |  |  |  |
|  | Relaxation | 21 |  |  | 36 (10) |  | 90 mins,10 | 1(4.8) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| McDonagh 2005 | CBT | 29 | USA | CSA survivors | 39.8 (9.9) | 100 | 90-120mins, 14 | 12(41) | Multiple | Sexual | Child  | Community |
|  | PCT | 22 |  |  | 39.6 (9.6) |  | 90-120mins, 14 | 2(9) |  |  |  |  |
|  | WL | 23 |  |  | 42.0 (9.8) |  |  | 3(13) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Monson 2006 | CPT | 30 | USA | Veterans | 54.0 (6.3) | 10 | 2p/w, 12 | 6(20) | Single  | Sexual or Non-sexual | Adult | Community |
|  | WL | 30 |  |  |  |  |  | 4(13) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mueser 2008 | CBT | 54 | USA | Severe Mental Illness patients | 44.21 (10.64) | 79 | NR,12-16 | 19 | Single | Sexual or non-sexual | Child | Community  |
|  | TAU | 54 |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mueser 2015 | CBT | 104 | USA | Severe Mental Illness patients | 42.96 (10.46) | 72.3 | NR,12- 16 | 37 (35.6) | Single | Sexual or non-sexual | Unclear | Community |
|  | BT | 97 |  |  | 44.52 (11.60) |  | NR, 3 | 14 (14.3) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Nijdam 2012 | BEP | 70 | Netherlands | Trauma survivors | 37.3 (10.6) | 56.4 | 45-60 mins,15 | 25 (36) | Single  | Sexual or non-sexual |  Adult | Community |
|  | EMDR | 70 |  |  | 38.3 (12.2) |  | 90 mins, NR  | 20 (29) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Pacella 2012 | PE | 40 | USA | Adults with HIV | 46.37 (6.30) | 36.9 | 90-120 mins, 10 | 17 (42.5) | Multiple  | Sexual or non-sexual | Adult | Community |
|  | WL | 24 |  |  |  |  |  | 0 (0) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Power 2002 | EMDR | 39 | UK | Adults with PTSD | 38.6 (11.8) | 41.7 | 90 mins,10 | 12 (31) | Single  | Sexual or non-sexual | Adult  | Community |
|  | E+CR | 37 |  |  | 43.2 (11.0) |  | 90 mins, 10 | 16 (43) |  |  |  |  |
|  | WL | 29 |  |  | 36.5 (11.6) |  |  | 5 (17) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Resick 2002 | CPT | 41 | USA | Female Rape Victims | 32 (9.9) | 100 | 2 p/w 13hrs,12 | 11(26.8) | Multiple | Sexual & /or Non-sexual | Adult | Community |
|  | PE | 40 |  |  |  |  | 2 p/w 13hrs, 9 | (27.3) |  |  |  |  |
|  | MA | 40 |  |  |  |  |  | (14.9) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Scheck 1998 | EMDR | 30 | USA | Traumatised Young Women | 20.93 (NR) | 100 | 90mins, 2 | 0 (0) | Single  | Sexual  | Child | Community |
|  | AL | 30 |  |  |  |  | 90mins, 2 | 1 (3.3) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Steel 2017 | CBT | 30 | UK | Adults with schizophrenia | 42.3 (10.2) | 37.7 | NR, 12-16 | 4(13.0) | Single or Multiple | Sexual or non-sexual | Unclear | Community |
|  | TAU | 31 |  |  |  |  |  | 5 (16.1) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Suris 2013 | CPT | 72 | USA | Veterans  | 46.1 (9.8) | 84.9 | Unclear, 12 | 25(35) | Single  | Sexual | Adult | Community |
|  | PCT | 57 |  |  |  |  | Unclear, 10-12 | 10(18) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Talbot 2014 | CBT-I | 29 | USA | Adults with PTSD  | 37.1 (10.4) | 68.9 | Unclear | 2 (6.9) | Unclear | Unclear | Unclear | Community  |
|  | WL | 16 |  |  | 37.3(11.0) |  |  | 1 (6.3) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| ter Heide 2011 | EMDR | 10 | Netherlands | Asylum seekers and refugees | 40.00 (9.31) | 40 | 90 mins, 11 | 5 (50) | Multiple | Non-sexual | Adult | Community |
|  | Stabilisation | 10 |  |  | 43.00 (7.93) |  | 60 mins, 11 | 5(50) |  |  |  |  |
|  |  |  |  |  |   |  |  |  |  |  |  |  |
| ter Heide 2016 | EMDR | 37 | Netherlands | Refugees | 43.1(10.7) | 27.8 | 60-90 mins, 9  | 6 (16.7) | Multiple | Non-sexual | Adult | Community |
|  | Stabilisation | 37 |  |  | 39.8(11.9) |  | 60 mins, 12  | 8 (22.2) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| van den Berg 2015 | PE | 53  | Netherlands | Severe Mental Illness patients | 41.2 (10.5) | 54.2 | 90 mins, 8 | 13(24.5) | Single or Multiple | Sexual &/or Non-sexual | Adult | Community |
|  | EMDR | 55 |  |  |  |  | 90 mins, 8 | 11(20.0) |  |  |  |  |
|  | WL | 47 |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

Abbreviations: AC, Attention Control; AL, Active Listening Control; AMR, Applied Muscle Relaxation; ART, Accelerated Resolution Therapy; BEP, Brief Eclectic Psychotherapy; BPS, Borderline Personality disorder; BT, Brief Treatment; CA-CBT, Culturally Adapted Cognitive Behaviour Therapy; CBT, Cognitive Behaviour Therapy; CBT-I, Cognitive Behavioral Therapy for Insomnia; CIT, Cognitive Imagery Treatment; CPT, Cognitive Processing Therapy; CRIM, Cognitive Restructuring and Imagery Modification; CSA, Childhood Sexual Abuse; CT, Cognitive Therapy; CTT-BW, Cognitive Trauma Therapy for Battered Women; DBT, Dialectical Behavior Therapy; DBT PE, Dialectical Behavior Therapy Prolonged Exposure; DET, Dialogical Exposure Therapy; DT –CBT, Delayed Treatment Cognitive Behaviour Therapy;E+C, Exposure and Cognitive; E+CR, Exposure plus Cognitive Restructuring; EMDR, Eye Movement Desensitization and Reprocessing Therapy; EXP, Experimental Treatment; EXP, Exposure Therapy Only; Intensive CT, Intensive Cognitive Therapy; IPT, Interpersonal Psychotherapy; MA, Minimal Attention; MA WL, Minimal Attention Wait List; MCPT, Modified Cognitive Processing Therapy Intervention; MVA, Motor Vehicle Accident; PCT, Present Centred Therapy; PE, Prolonged exposure; PE-CR, Prolonged Exposure plus Cognitive Restructuring; PE-SIT, Prolonged Exposure + Stress Inoculation Training; PGT, Psychoeducational Group Therapy; PTSD, Post-traumatic Stress Disorder; RA, Repeated Assessments; REM, Rapid Eye Movement; SHB, Self-help booklet; SIT, Stress inoculation training; SMDT, Symptom –Monitoring Delayed Treatment; SMT, Self- Management Therapy; SSBT, Single Session of Behavioural Treatment; STAIRS + MPE, Skills Training in Affective and Interpersonal Regulation with modified Prolonged Exposure; TARGET, Trauma Affect Regulation: Guide for Education and Therapy; TAU, Treatment as usual; TFCBT, Trauma-Focused Cognitive-Behavioural Therapy; TMT, Trauma Management Therapy; Weekly CT, Weekly Cognitive Therapy; Weekly ST, Weekly Supportive Therapy ;WL, Waitlist.

**E. Table E.1. Participants’ baseline scores on the CPTSD symptom clusters and corresponding norms**

| **Study Ref** | **Groups included** | **Name of AD assessment, baseline mean (SD)** | **Normative AD data for interpretation, mean (SD)** | **Name of NSC assessment, baseline mean (SD)** | **Normative NSC data for interpretation, mean (SD)** | **Name of DR assessment, baseline mean (SD)** | **Normative DR data for interpretation, mean (SD)** | **Other information for interpretation** | **Decision** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |
| Ahmadi 2015  | EMDR | Emotional control subscale of the Mississippi Scale for PTSD, -5.3 (4.4) [these are the mean (SD) change scores] | - | - | - | Interpersonal relation subscale of the Mississippi Scale for PTSD, -4.7 (5.2) | - | Only change scores were reported (no baseline scores). | Include – although exclude in sensitivity analysis. |
| REM | -6.4 (3.9) [these are the mean (SD) change scores] | - | -1.3 (2.7) |
| Control | 0.7 (2.5) [these are the mean (SD) change scores] | - | -0.08 (2.3) |
|  |  |  |  |  |  |  |  |  |  |
| Azad marzabadi 2014 | Mindfulness | - | - | - | - | Social life subscale of the WHOQOL-26, 5.5 (1.65) | - | Baseline scores indicate that the participants were on average at least dissatisfied in their social life. | Include |
| Control | - | - | 5.21 (0.97) |
|  |  |  |  |  |  |  |  |  |  |
| Basoglu 2007 | SSBT | - | - | - | - | WSAS, 4.1 (0.8) | - | Baseline scores above 4 on the WSAS suggest moderately severe or worse psychopatholo-gy (Mundt et al., 2002). | Include |
| RA | - | - | 4.1 (0.9) |
|  |  |  |  |  |  |  |  |  |  |
| Beidel 2011 | TMT | CAPS social and emotional subscale, 22.6 (5.3) | - | - | - | CAPS social and emotional subscale, 22.6 (5.3) | - | Using the "1, 2" rule (i.e., a frequency score of 1 and an intensity score of 2) to determine symptom severity, scores above 12 on this subscale meet the clinical threshold (Weathers, Ruscio, & Keane, 1999). | Include |
| EXP | 22.4 (3.8) | - | 22.4 (3.8) |
|  |  |  |  |  |  |  |  |  |  |
| Beidel 2019 | TMT | - | - | - | - | Duration of Daily Social Interaction (outside of family interactions at home) (mins per day), 49.7 (54.3) | - | On average, a non-clinicalgroup aged 16–36 years engage in 63.49 h of structuredactivity per week, and activity levels below 30 h areindicative of poor social functioning (Hodgekins et al., 2015). | Include |
| EXP | - | - | 52.7 (61.9) |
|  |  |  |  |  |  |  |  |  |  |
| Bryant 2013 | Support/CBT | - | -- | PTCI-self, 4.08 (1.29)  | Median (SD) among people with no trauma: 1.08 (0.76) (Foa et al., 1999) | - | - | - | Include |
| Skills/CBT | - | 4.41 (1.18) | - |
|  |  |  |  |  |  |  |  |  |  |
| Butollo 2016 | DET | - | - | PTCI-self, 3.71 (1.2) [these are the mean (SD) across both groups] | Median (SD) among people with no trauma: 1.08 (0.76) (Foa et al., 1999)  | IIP-C, 1.34 (0.59) | 1.28 (0.52) (non-clinical) (Brahler et al., 1999) | - | Include NSC data but not DR data. |
| CPT | - | 1.38 (0.57) |
|  |  |  |  |  |  |  |  |  |  |
| Cloitre 2002 | STAIR+MPE | NMR, 85 (15.6) | 101.6 (15.43) (non-clinical) (Cantanzaro & Mearns, 1990) | - | - | IIP, 1.88 (0.57)  | 1.28 (0.52) (non-clinical) (Brahler et al., 1999) | - | Include AD data but not DR data. |
| MA WL | 84 (17.9) | - | 1.70 (0.46) (the weighted mean across these groups is 1.79) |
|  |  |  |  |  |  |  |  |  |  |
| Difede 2007 | CBT | - | - | - | - | SAS-SR, 2 (0.4)  | 1.59 (0.33) (non-clinical) (Weissman et al., 1978)  | - | Include |
| TAU | - | - | 2.28 (0.44) |
|  |  |  |  |  |  |  |  |  |  |
| Dorrepaal 2012 | EXP | - | - | - | - | - | - | As all participants in this study had to meet diagnostic criteria for complex PTSD as assessed by the SIDES, this study is relevant. | Include |
| TAU | - | - | - |
|  |  |  |  |  |  |  |  |  |  |
| Duffy 2007 | CT | - | - | - | - | SDS-social subscale, 7.7 (2.4) [these are the mean (SD) across both groups] | - | A score of 7 or above on this subscale indicates a marked impairment. Moreover, it has been suggested that clinicians should pay special attention to patients who score 5 or greater on this subscale (Rush et al., 2000). | Include |
| WL | - | - |
|  |  |  |  |  |  |  |  |  |  |
| Dunn 2007 | SMT | SCQD, 86.14 (12.95) | 101.2 (15.46) (non-clinical) (Mezo & Heiby, 2004) | - | - | - | - | - | Include |
| PGT | 79.74 (17.77) | - | - |
|  |  |  |  |  |  |  |  |  |  |
| Dunne 2012 | TF-CBT | - | - | - | - | SF-36 social functioning subscale, 43.46 (18.12) | 85.66 (19.83) (among male norms aged 25-44); 88.54 (18.09) (among male norms aged 35-55); numerous other norms are available as well (Ware et al., 1993). | - | Include |
| WL | - | - | 45.42 (13.97) |
|  |  |  |  |  |  |  |  |  |  |
| Ehlers 2003 | CT | - | - | - | - | SDS, 5.9 (2.4) | - | A score of 4 to 6 on this scale indicates a moderate impairment. Moreover, it has been suggested that clinicians should pay special attention to patients who score 5 or greater on this subscale (Rush et al., 2000).  | Include |
| SHB | - | - | 6.3 (2) |
| RA | - | - | 6.1 (1.9) |
|  |  |  |  |  |  |  |  |  |  |
| Ehlers 2005 | CT | - | - | - | - | SDS, 7.6 (1.9) | - | A score of 7 or above on this scale indicates a marked impairment. Moreover, it has been suggested that clinicians should pay special attention to patients who score 5 or greater on this subscale (Rush et al., 2000).  | Include |
|  | WL | - | - | 6.7 (1.9) |
|  |  |  |  |  |  |  |  |  |  |
| Ehlers 2014 | Intensive CT | - | - | - | - | SDS, 20.48 (5.55) | - | Each of the baseline mean SDS scores need to be divided by 3 so they are comparable to those of Ehlers, 2003 and 2005 above (e.g., 21.39/3 = 7.13).  | Include |
| Weekly CT | - | - | 21.39 (5.11) |
| Weekly ST | - | - | 19.65 (6.97) |
| WL | - | - | 17.28 (7.74) |
|  |  |  |  |  |  |  |  |  |  |
| Foa 1999 | PE | - | - | - | - | SAS (interview version), 3.73 (0.83) | - | Normative data for the interview version of the SAS were not available. This version of the SAS is a 7-point scale. Assuming a 0-6 scoring method, scores of 3 or greater indicate that participants are closer to being impaired than intact. | Include |
| SIT | - | - | 3.79 (1.23) |
| PE-SIT | - | - | 4 (1.11) |
| WL | - | - | 3.93 (1.16) |
|  |  |  |  |  |  |  |  |  |  |
| Foa 2005 | PE | - | - | - | - | SAS social subscale (interview version), 4 (0.9) | - | Normative data for the interview version of the SAS social subscale were not available. This version of the SAS social subscale is a 7-point scale. Assuming a 0-6 scoring method, scores of 3 or greater indicate that participants are closer to being impaired than intact. | Include |
| PE-CR | - | - | 3.9 (1) |
| WL | - | - | 3.9 (1.2) |
|  |  |  |  |  |  |  |  |  |  |
| Forbes 2012 | CPT | - | - | - | - | Social subscale of the WHO-QOL Bref, 8.1 (2.8) [this is the mean (SD) across both groups] | - | Normative data for this subscale were not available. If a participant were to answer "neither satisfied or dissatisfied" on 2 of the items and "dissatisfied" on the other item they would receive a score of 8. Therefore, a score of 8.1 indicates that participants are closer to being impaired than intact.  | Include |
| TAU | - | - |
|  |  |  |  |  |  |  |  |  |  |
| Ford 2011 | WL | NMR, 96.9 (20) | 101.6 (15.43) (non-clinical) (Cantanzaro & Mearns, 1990) | PTCI-self, 67.1 (28.3) [A mean of 67.1 is equivalent to a mean of 3.2 when scored the same way as the normative data] | Median (SD) among people with no trauma: 1.08 (0.76) (Foa et al., 1999) | RSQ secure attachment subscale, 13.5 (3.3) | 15.57 (SD = 3.01) (non-clinical) (Bäackström & Holmes, 2001) | - | Include NSC data but not AD or DR data. |
| TARGET | 106.1 (18.1) | 51.3 (23.5) [A mean of 51.3 is equivalent to a mean of 2.44 when scored the same way as the normative data] | 13.7 (3.8) |
| PCT | 103.1 (20.2) | 53.7 (25.4) [A mean of 53.7 is equivalent to a mean of 2.56 when scored the same way as the normative data] | 14 (3.5) |
|  |  |  |  |  |  |  |  |  |  |
| Galovski 2012 | MCPT | - | - | TRGI guilt cognitions subscale, 1.57 (0.11) [this is the least square mean (SE)] | 1 (0.5) (among participants with a history of potentially traumatic CSA/CPA without any axis-I disorder; these are more severe than healthy individuals) (Rausch et al., 2016) | SF-36 social functioning subscale, 42.87 (4.06) [this is the least square mean (SE)] | 85.66 (19.83) (among male norms aged 25-44); 88.54 (18.09) (among male norms aged 35-55); numerous other norms are available as well (Ware et al., 1993). | - | Include both NSC and DR data |
| SMDT | - | 1.62 (0.12) [this is the least square mean (SE)] | 37.45 (4.29) [this is the least square mean (SE)] |
|  |  |  |  |  |  |  |  |  |  |
| Ghafoori 2017 | PE | - | - | - | - | SDS social subscale, 7 (2.6) | - | A score of 7 or above on this subscale indicates a marked impairment. Moreover, it has been suggested that clinicians should pay special attention to patients who score 5 or greater on this subscale (Rush et al., 2000). | Include |
| PCT | - | - | 7.3 (2.5) |  |
|  |  |  |  |  |  |  |  |  |  |
| Harned 2014 | DBT | - | - | TRGI guilt cognitions subscale, 2.4 (0.9) | 1 (0.5) (among participants with a history of potentially traumatic CSA/CPA without any axis-I disorder; these are more severe than healthy individuals) (Rausch et al., 2016)  | - | - | - | Include |
| DBT -PE | - | 2.4 (0.8) | - |
|  |  |  |  |  |  |  |  |  |  |
| Hinton 2009 | IT-CBT | ERS, 0.9 (0.6)  | - | - | - | - | - | Normative data for this scale were not available. This scale is rated on a 0-4 Likert-type scale, rating the ability to distance from affects, ranging from “not at all” to “very much so.” These scores appear to indicate that participants are only edging towards somewhat being able to distance from affects. | Include |
| DT-CBT | 0.8 (0.5) | - | - |
|  |  |  |  |  |  |  |  |  |  |
| Hinton 2011 | CA-CBT | ERS, 0.7 (0.5) | - | - | - | - | - | As above with Hinton, 2009, these scores appear to indicate that participants are only edging towards somewhat being able to distance from affects. | Include |
| AMR | 0.9 (0.4) | - | - |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Hogberg 2007 | EMDR | - | - | - | - | SDI, 4.5 (2.3) | 1.53 (1.13) (among subjects who had experienced traumatic events but who had never developed PTSD) (Nardo et al., 2011)  | - | Include |
| WL | - | - | 5.9 (4.5) |
|  |  |  |  |  |  |  |  |  |  |
| Hollified 2007 | CBT | - | - | - | - | SDS global rating scale, 4.09 (0.81) | - | Normative data for this scale were not available. Participants’ scores on this scale appear to be impaired as possible scores on this scale appear to range from 0 to 5, with higher scores indicating greater impairment.  | Include |
| WL | - | - | 4 (1.02) |
|  |  |  |  |  |  |  |  |  |  |
| Jung 2013 | CRIM | - | - | RSES, 22.1 (7.8) | 49.2 (8.2) (non-clinical) (Roth et al., 2008)  | - | - | This version of the RSES appears to range from 1-60.  | Include |
| WL | - | 20.6 (5.7) | - |
|  |  |  |  |  |  |  |  |  |  |
| Keane 1989 | Implosive (flooding) | - | - | - | - | Social subscale of the Social Adjustment Measures, 4 (1.9)  | - | Normative data for this scale were not available. The weighted mean of participants’ scores on this scale indicate that participants are closer to being extremely dissatisfied than extremely satisfied with their social life.  | Include |
| WL | - | - | 2.6 (1.7) |
|  |  |  |  |  |  |  |  |  |  |
| Kip 2013 | ART | - | - | TRGI guilt cognitions subscale, 26.7 (no SD reported) | 21 (10.5) (among participants with a history of potentially traumatic CSA/CPA without any axis-I disorder; these are more severe than healthy individuals) (the mean and SD were rescaled in light of the scoring method of Kip, 2013) (Rausch et al., 2016)  | Relating to others subscale of the PTGI, 11.6 (7.92; SD imputed from Nijdam, 2018) | 23.04 (no SD reported) (non-clinical) (Tedeschi & Calhoun, 1996)  | - | Include DR data but not NSC data. |
| AC | - | 20.2 (no SD reported) | 13 (7.92; SD imputed from Nijdam, 2018) |
|  |  |  |  |  |  |  |  |  |  |
| Krakow 2001 | CIT | - | - | - | - | SDS social life/leisure activities index (no baseline scores were reported) | - | Inferential statistics including effect sizes showing changes in the SDS social life/leisure activities index in the groups were reported (no baseline scores). | Include – although exclude in sensitivity analysis. |
| WL | - | - |
|  |  |  |  |  |  |  |  |  |  |
| Krupnick 2008 | IPT | - | - | - | - | IIP | - | Patients with a score of 3 or higher on any item of the IIP (indicating significant interpersonal distress) qualified for participation in the study. | Include |
| WL | - | - |  |
|  |  |  |  |  |  |  |  |  |  |
| Kubany 2003 | Immediate CTT-BW | - | - | RSES, 13.6 (5.2) | 22.62 (5.80) (non-clinical) (Sinclair et al., 2010) | - | - | It is also worth noting that an inclusion criterion in this study was a score on the TRGI global guilt scale reflecting at least moderate abuse-related guilt. | Include |
| Delayed CTT-BW | - | 12.7 (6.7) |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Kubany 2004 | Immediate CTT-BW | - | - | RSES, 14.8 (5.4) | 22.62 (5.80) (non-clinical) (Sinclair et al., 2010)  | - | - | It is also worth noting that an inclusion criterion in this study was a score on the TRGI global guilt scale reflecting at least moderate abuse-related guilt. | Include |
| Delayed CTT-BW | - | 14.5 (4.5) | - |
|  |  |  |  |  |  |  |  |  |  |
| Lindauer 2005 | BEP | - | - | - | - | Relationships Questionnaire, 50% of participants across groups had problems with relationships (binary measure, not a continuous measure; therefore no means or SDs were reported) | - | At least 50% of the sample had problems with relationships.  | Include |
| WL | - | - |
|  |  |  |  |  |  |  |  |  |  |
| Marks 1998 | Exposure | - | - | - | - | WSAS, 21.5 (8.9) | - | Baseline scores above 20 on the WSAS suggest moderately severe or worse psychopatholo-gy (Mundt et al., 2002). | Include |
| Cognitive | - | - | 26.9 (8.8) |
| E+C | - | - | 29.4 (7.9) |
| Relaxation | - | - | 22.1 (9.5) |
|  |  |  |  |  |  |  |  |  |  |
| McDonagh 2005 | CBT | - | - | TSI, 3.1 (0.6)  | 1.83 (0.34) (non-clinical) (the mean and SD were rescaled in light of the scoring method of McDonagh, 2014) (Kadambi & Truscott, 2004) | - | - | - | Include |
| PCT | - | 2.9 (0.5) | - |
| WL | - | 3.2 (0.6) | - |
|  |  |  |  |  |  |  |  |  |  |
| Monson 2006 | CPT | ACS | - | TRGI guilt cognitions subscale | - | SAS-SR, 2.48 (0.39) | 1.59 (0.33) (non-clinical) (Weissman et al., 1978) | - | Include (exclude AD and NSC data in sensitivity analysis, as baseline AD and NC data were not available) |
| WL |  |  | 2.68 (0.54) |
|  |  |  |  |  |  |  |  |  |  |
| Mueser 2008 | CBT | - | - | PTCI-self, 3.89 (1.11) | Median (SD) among people with no trauma: 1.08 (0.76) (Foa et al., 1999) | - | - | - | Include |
| TAU | - | 3.64 (1.14) | - |
|  |  |  |  |  |  |  |  |  |  |
| Mueser 2015 | CBT | - | - | PTCI-self, 4.10 (1.36) | Median (SD) among people with no trauma: 1.08 (0.76) (Foa et al., 1999) | CAPS social functioning subscale, 2.35 (0.79) | - | Using the "1, 2" rule (i.e., a frequency score of 1 and an intensity score of 2) for the CAPS social functioning subscale to determine symptom severity, scores above 3 meet the clinical threshold (Weathers et al., 1999) | Include NSC data but not DR data. |
| BT | - | 4.15 (1.31) | 2.36 (0.81) |
|  |  |  |  |  |  |  |  |  |  |
| Nijdam 2012 | BEP | - | - | - | - | Relating to others subscale of the PTGI, 14.38 (7.92) [this is the mean (SD) across both groups] | 23.04 (no SD reported) (non-clinical) (Tedeschi & Calhoun, 1996)  | - | - |
| EMDR | - | - |  |
|  |  |  |  |  |  |  |  |  |  |
| Pacella 2012 | PE | - | - | PTCI-self, 3.23 (1.19) | Median (SD) among people with no trauma: 1.08 (0.76) (Foa et al., 1999) | - | - | - | Include |
| WL | - | 3.04 (1.38) | - |
|  |  |  |  |  |  |  |  |  |  |
| Power 2002 | EMDR | - | - | - | - | SDS, 21.3 (5.4) | - | Each of the baseline mean SDS scores need to be divided by 3 so they are comparable to those of Ehlers, 2003 and 2005 above (e.g., 21.3/3 = 7.1).  | Include |
|  | E+CR | - | - | 22.8 (6.3) |
|  | WL | - | - | 23.3 (4.7) |
|  |  |  |  |  |  |  |  |  |  |
| Resick 2002 | CPT | - |  | TRGI global guilt subscale, 2.34 (1.13) | 0.6 (0.8) (among participants with a history of potentially traumatic CSA/CPA without any axis-I disorder; these are more severe than healthy individuals) (Rausch et al., 2016) | - | - | - | Include |
| PE | - | 2.53 (1.11) | - |
| MA | - | 2.60 (1.03) | - |
|  |  |  |  |  |  |  |  |  |  |
| Scheck 1998 | EMDR | - | - | TSCS, 284.57 (40.94) | 345.75 (38.72) (non-clinical) (Caplan, Henderson, Henderson, & Fleming, 2002)  | - | - | - | Include |
| AL | - | 285.24 (38.23) | - |
|  |  |  |  |  |  |  |  |  |  |
| Steel 2017 | CBT | - | - | PTCI-self, 4.46 (1.13) [this is the mean (SD) across both groups] | Median (SD) among people with no trauma: 1.08 (0.76) (Foa et al., 1999) | - | - | - | Include |
| TAU | - | - |
|  |  |  |  |  |  |  |  |  |  |
| Suris 2013 | CPT | - | - | PTCI-self, 4.80 (1.12) | Median (SD) among people with no trauma: 1.08 (0.76) (Foa et al., 1999) | - | - | - | Include |
| PCT | - | 4.82 (1.25) | - |
|  |  |  |  |  |  |  |  |  |  |
| Talbot 2014 | CBT-I | - | - | - | - | WSAS, mean of >24 for both groups (as depicted in a graph) | - | Baseline scores above 20 on the WSAS suggest moderately severe or worse psychopatholo-gy (Mundt et al., 2002). | Include |
| WL | - | - |
|  |  |  |  |  |  |  |  |  |  |
| ter Heide 2011 | EMDR | - | - | - | - | Social subscale of the WHO-QOL Bref, 2.4 (0.86) | - | Normative data for this subscale were not available. A weighted mean of less than 3 represents being between dissatisfied (2) and neither satisfied nor dissatisfied (3; which is in the middle) on the different items of this subscale. Therefore, participants are closer to being impaired than intact.  | Include |
| Stabilisation | - | - | 3.07 (0.49) |
|  |  |  |  |  |  |  |  |  |  |
| ter Heide 2016 | EMDR | - | - | - | - | Social subscale of the WHO-QOL Bref, 2.71 (0.80) | - | Normative data for this subscale were not available. A weighted mean of less than 3 represents being between dissatisfied (2) and neither satisfied nor dissatisfied (3; which is in the middle) on the different items of this subscale. Therefore, participants are closer to being impaired than intact.  | Include |
|  | Stabilisation | - | - | 2.55 (0.98) |
|  |  |  |  |  |  |  |  |  |  |
| van den Berg 2015 | PE | - | - | PTCI-self, 4.52 (1.22) | Median (SD) among people with no trauma: 1.08 (0.76) (Foa et al., 1999) | - | - | - | Include |
| EMDR | - | 4.4 (1.12) | - |
| WL | - | 4.26 (0.96) | - |
|  |  |  |  |  |  |  |  |  |  |

Abbreviations: AC, Attention Control; ACF, Affect Control Scale; AL, Active Listening Control; AMR, Applied Muscle Relaxation; ART, Accelerated Resolution Therapy; BEP, Brief Eclectic Psychotherapy; BPS, Borderline Personality disorder; BT, Brief Treatment; CA-CBT, Culturally Adapted Cognitive Behaviour Therapy; CAPS, Clinician-Administered PTSD Scale; CBT, Cognitive Behaviour Therapy; CBT-I, Cognitive Behavioral Therapy for Insomnia; CIT, Cognitive Imagery Treatment; CPT, Cognitive Processing Therapy; CRIM, Cognitive Restructuring and Imagery Modification; CSA, Childhood Sexual Abuse; CT, Cognitive Therapy; CTT-BW, Cognitive Trauma Therapy for Battered Women; DBT, Dialectical Behavior Therapy; DBT PE, Dialectical Behavior Therapy Prolonged Exposure; DET, Dialogical Exposure Therapy; DT –CBT, Delayed Treatment Cognitive Behaviour Therapy;E+C, Exposure and Cognitive; E+CR, Exposure plus Cognitive Restructuring; EMDR, Eye Movement Desensitization and Reprocessing Therapy; ERS, Emotion Regulation Scale; EXP, Experimental Treatment; EXP, Exposure Therapy Only; Intensive CT, Intensive Cognitive Therapy; IIP, Inventory of Interpersonal Problems; IIP-C, Inventory of Interpersonal Problems – Circumplex Version; IPT, Interpersonal Psychotherapy; MA, Minimal Attention; MA WL, Minimal Attention Wait List; MCPT, Modified Cognitive Processing Therapy Intervention; MVA, Motor Vehicle Accident; NMR, General Expectancy for Negative Mood Regulation Scale; PCT, Present Centred Therapy; PE, Prolonged exposure; PE-CR, Prolonged Exposure plus Cognitive Restructuring; PE-SIT, Prolonged Exposure + Stress Inoculation Training; PGT, Psychoeducational Group Therapy; PTCI, Posttraumatic Cognitions Inventory; PTGI, Post-Traumatic Growth Inventory; PTSD, Post-traumatic Stress Disorder; RA, Repeated Assessments; REM, Rapid Eye Movement; RSES, Rosenberg Self-Esteem Scale; SAS, Social Adjustment Scale; SAS-SR, Social Adjustment Scale-Self-Report; SCQD, Self-Control Questionnaire for Depression; SDI, Social Disability Index; SDS, Sheehan Disability Scale; SF-36, Short Form-36 Health Survey; SHB, Self-help booklet; SIDES, Structured Interview for Disorders of Extreme Stress; SIT, Stress inoculation training; SMDT, Symptom –Monitoring Delayed Treatment; SMT, Self- Management Therapy; SSBT, Single Session of Behavioural Treatment; STAIRS + MPE, Skills Training in Affective and Interpersonal Regulation with modified Prolonged Exposure; TARGET, Trauma Affect Regulation: Guide for Education and Therapy; TAU, Treatment as usual; TFCBT, Trauma-Focused Cognitive-Behavioural Therapy; TMT, Trauma Management Therapy; TRGI, Trauma Related Guilt Inventory; TSCS, Tennessee Self-Concept Scale; TSI, Traumatic Stress Institute Beliefs Scale; Weekly CT, Weekly Cognitive Therapy; Weekly ST, Weekly Supportive Therapy ;WL, Waitlist; WHOQOL-26, World Health Organization Quality of Life Questionnaire; WHO-QOL Bref, The short form of the World Health Organization Quality of Life scale; WSAS, Work and Social Adjustment Scale.

**References for comparator samples or scoring guidelines referred to in Table E.1 above**

Bäckström, M., & Holmes, B. M. (2001). Measuring adult attachment: a construct validation of two self-report instruments. *Scandinavian Journal of Psychology*, 42(1), 79–86. <https://doi.org/10.1111/1467-9450.00216>

Brahler, E., Horowitz, L. M., Kordy, H., Schumacher, J., & Strauss, B. (1999). Validation of the Inventory of Interpersonal Problems (IIP)--Results of a representative study in East and West Germany. *Psychotherapie Psychosomatik Medizinische Psychologie,* 49(11), 422–431.

Caplan, S. M., Henderson, C. E., Henderson, J., & Fleming, D. L. (2002). Socioemotional Factors Contributing to Adjustment Among Early-Entrance College Students. *Gifted Child Quarterly*, 46(2), 124–134. <https://doi.org/10.1177/001698620204600205>

Catarizaro, S. J., & Mearns, J. (1990). Measuring Generalized Expectancies for Negative Mood Regulation: Initial Scale Development and Implications. *Journal of Personality Assessment,* 54(3–4), 546–563. <https://doi.org/10.1080/00223891.1990.9674019>

Foa, E. B., Tolin, D. F., Ehlers, A., Clark, D. M., & Orsillo, S. M. (1999). The Posttraumatic Cognitions Inventory (PTCI): Development and validation. *Psychological Assessment*, 11(3), 303–314. <https://doi.org/10.1037/1040-3590.11.3.303>

Hodgekins, J., French, P., Birchwood, M., Mugford, M., Christopher, R., Marshall, M., … Fowler, D. (2015). Comparing time use in individuals at different stages of psychosis and a non-clinical comparison group. *Schizophrenia Research*, 161(2–3), 188–193. <https://doi.org/10.1016/j.schres.2014.12.011>

Kadambi, M. a, & Truscott, D. (2004). Vicarious Trauma Among Therapists Working with Sexual Violence, Cancer, and General Practice. *Canadian Journal of Counselling*, 38, 260–276.

Mezo, P. G., & Heiby, E. M. (2004). A comparison of four measures of self-control skills. *Assessment*, 11(3), 238–250. <https://doi.org/10.1177/1073191104268199>

Mundt, J. C., Marks, I. M., Shear, M. K., & Greist, J. M. (2002). The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *The British Journal of Psychiatry*, 180(5), 461–464.

Nardo, D., Högberg, G., Flumeri, F., Jacobsson, H., Larsson, S. A., Hällström, T., & Pagani, M. (2011). Self-rating scales assessing subjective well-being and distress correlate with rCBF in PTSD-sensitive regions. *Psychological Medicine*, 41(12), 2549–2561. <https://doi.org/10.1017/S0033291711000912>

Rausch, S., Herzog, J., Thome, J., Ludï¿½scher, P., Mï¿½ller-Engelmann, M., Steil, R., … Kleindienst, N. (2016). Women with exposure to childhood interpersonal violence without psychiatric diagnoses show no signs of impairment in general functioning, quality of life and sexuality. *Borderline Personality Disorder and Emotion Dysregulation*, 3(1). <https://doi.org/10.1186/s40479-016-0048-y>

Roth, M., Decker, O., Herzberg, P. Y., & Brähler, E. (2008). Dimensionality and norms of the Rosenberg self-esteem scale in a German general population sample*. European Journal of Psychological Assessment*, 24(3), 190–197. <https://doi.org/10.1027/1015-5759.24.3.190>

Rush, J.A. (2000). *American Psychiatric Association: Handbook of Psychiatric Measures*. Washington, DC, American Psychiatric Press.

Sinclair, S. J., Blais, M. A., Gansler, D. A., Sandberg, E., Bistis, K., & LoCicero, A. (2010). Psychometric properties of the Rosenberg Self-Esteem Scale: Overall and across demographic groups living within the United States. *Evaluation and the Health Professions,* 33(1), 56–80. <https://doi.org/10.1177/0163278709356187>

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9(3), 455–471. <https://doi.org/10.1002/jts.2490090305>

Ware, J. E., Snow, K. K., Kosinski, M., & Grandek, B. (1993). *SF-36 health survey : manual and interpretation guide*. Boston, MA: The Health Institute

Weathers, F. W., Ruscio, A. M., & Keane, T. M. (1999). Psychometric properties of nine scoring rules for the Clinician-Administered Posttraumatic Stress Disorder Scale. *Psychological Assessment*, 11(2), 124–133. <https://doi.org/10.1037/1040-3590.11.2.124>

Weissman, M. M., Prusoff, B. A., Douglas Thompson, W., Harding, P. S., & Myers, J. K. (1978). Social adjustment by self-report in a community sample and in psychiatric outpatients. *Journal of Nervous and Mental Disease*, 166(5), 317–326. https://doi.org/10.1097/00005053-197805000-0000

**F. Risk of Bias Criteria**

*Selection Bias: random sequence generation*

A judgement of unclear risk of bias was made where randomisation was referred to but described in insufficient detail to determine independent random sequence generation. There was judged to be low risk of bias where this procedure was explicitly reported.

*Selection Bias: allocation concealment*

A judgement of unclear risk of bias was made where randomisation was referred to but described in insufficient detail to determine allocation concealment. There was judged to be low risk of bias where this procedure was explicitly reported.

*Performance Bias: blinding of participants and personnel*

Blinding of participants and personnel was not possible due to the nature of the interventions, as is the case with trials of psychosocial interventions in general. This resulted in a judgement of high risk of performance bias across studies.

*Detection Bias: blinding of assessments*

Detection bias was judged to be high where non-blinding of assessors was stated or where no information was given, and low if blinding was explicitly reported.

*Attrition Bias: incomplete outcome data*

A judgement of high risk of attrition bias was made where data for ≥ 25% of those randomised was missing (Xia et al., 2009) or if attrition was not reported (or clearly reported) and a completer analysis was carried out. If attrition was low (<25%) and completer analysis was used risk of attrition bias was rated as low.

*Reporting Bias: selective outcome reporting*

If outcomes are pre-specified and reported a low risk of reporting bias rating was given. However, if no protocol is reported a high risk of reporting bias rating was given. If subgroup analysis is reported but not pre-specified a high risk of reporting bias rating was given.

*Overall Quality*

An overall quality rating for each study was also produced. Performance bias was not taken into consideration when producing this rating, as blinding of participants was not possible due to the nature of the interventions. All of the other criteria above were considered (i.e., selection bias: random sequence generation and allocation concealment, detection bias, attrition bias, and reporting bias). A high overall quality rating was given if a study received a low risk of bias rating for detection bias, at least another low risk of bias rating, and ≤2 high risk of bias ratings. A low overall quality rating was given if a study did not meet these criteria.

**G. Table F.1. Risk of Bias in Included Studies – Summary**

| **Study** | **Selection Bias: random sequence generation** | **Selection Bias: allocation concealment** | **Performance Bias: blinding of participants and personnel** | **Detection Bias: blinding of assessments** | **Attrition Bias: incomplete outcome data** | **Reporting Bias: selective outcome reporting** | **Overall Quality** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Ahmadi 2015 | Unclear | Unclear | High risk | High risk | High risk | High risk | Low quality |
| Azad marzabadi 2014 | Unclear | Unclear | High risk | High risk | Low risk | High risk | Low quality |
| Basoglu 2007 | Low risk | Unclear | High risk | Low risk | Low risk | High risk | High quality |
| Beidel 2011 | Unclear | Unclear | High risk | High risk | High risk | High risk | Low quality |
| Beidel 2019 | Unclear | Unclear | High risk | High risk | High risk | High risk | Low quality |
| Bryant 2013 | Low risk | Low risk | High risk | Low risk | High risk | High risk | High quality |
| Butollo 2016 | Unclear | Unclear | High risk | High risk | Low risk | High risk | Low quality |
| Cloitre 2002 | Unclear | Unclear | High risk | Low risk | Low risk | High risk | High quality |
| Difede 2007 | Unclear | Unclear | High risk | High risk | High risk | High risk | Low quality |
| Dorrepaal 2012 | Unclear | Low risk | High risk | Low risk | Low risk | High risk | High quality |
| Duffy 2007 | Unclear | Unclear | High risk | High risk | Low risk | High risk | Low quality |
| Dunn 2007 | Low risk | High risk | High risk | Low risk | High risk | High risk | High quality |
| Dunne 2012 | Unclear | Unclear | High risk | High risk | Low risk | High risk | Low quality |
| Ehlers 2003 | Low risk | Low risk | High risk | Low risk | Low risk | High risk | High quality |
| Ehlers 2005 | Unclear | Unclear | High risk | Low risk | Low risk | High risk | High quality |
| Ehlers 2014 | Low risk | Low risk | High risk | Low risk | Low risk | High risk | High quality |
| Foa 1999 | Unclear | Unclear | High risk | Low risk | Low risk | High risk | High quality |
| Foa 2005 | Unclear | Unclear | High risk | Low risk | High risk | High risk | Low quality |
| Forbes 2012 | Low risk | Low risk | High risk | Low risk | Low risk | High risk | High quality |
| Ford 2011 | Low risk | Low risk | High risk | High risk | High risk | High risk | Low quality |
| Galovski 2012 | Low risk | Unclear | High risk | Low risk | High risk | High risk | High quality |
| Ghafoori 2017 | Low risk | Unclear | High risk | High risk | High risk | High risk | Low quality |
| Harned 2014 | Low risk | Unclear | High risk | Low risk | High risk | High risk | High quality |
| Hinton 2009 | Low risk | Unclear | High risk | Low risk | Low risk | High risk | High quality |
| Hinton 2011 | Unclear | Unclear | High risk | High risk | Low risk | High risk | Low quality |
| Hogberg 2007 | Unclear | Low risk | High risk | High risk | Low risk | High risk | Low quality |
| Hollified 2007 | Low risk | Low risk | High risk | High risk | High risk | High risk | Low quality |
| Jung 2013 | Unclear | Unclear | High risk | High risk | Low risk | High risk | Low quality |
| Keane 1989 | Unclear | Unclear | High risk | High risk | Low risk | High risk | Low quality |
| Kip 2013 | Low risk | Unclear | High risk | High risk | Low risk | Low risk | Low quality |
| Krakow 2001 | Low risk | Unclear | High risk | Low risk | Low risk | High risk | High quality |
| Krupnick 2008 | Unclear | Unclear | High risk | High risk | High risk | High risk | Low quality |
| Kubany 2003 | Unclear | Unclear | High risk | Low risk | Low risk | High risk | High quality |
| Kubany 2004 | Unclear | Unclear | High risk | Low risk | High risk | High risk | Low quality |
| Lindauer 2005 | Low risk | Unclear | High risk | Low risk | High risk | High risk | High quality |
| Marks 1998 | Unclear | Unclear | High risk | Low risk | Low risk | High risk | High quality |
| McDonagh 2005 | Unclear | Unclear | High risk | Low risk | Low risk | High risk | High quality |
| Monson 2006 | Unclear | Unclear | High risk | Low risk | Low risk | High risk | High quality |
| Mueser 2008 | Low risk | Low risk | High risk | Low risk | High risk | High risk | High quality |
| Mueser 2015 | Low risk | Low risk | High risk | Low risk | Low risk | Low risk | High quality |
| Nijdam 2012 | Low risk | Low risk | High risk | Low risk | High risk | Low risk | High quality |
| Pacella 2012 | Low risk | Unclear | High risk | Low risk | Low risk | High risk | High quality |
| Power 2002 | Low risk | Low risk | High risk | Low risk | High risk | High risk | High quality |
| Resick 2002 | Unclear | Unclear | High risk | High risk | High risk | High risk | Low quality |
| Scheck 1998 | Low risk | Low risk | High risk | Low risk | High risk | High risk | High quality |
| Steel 2017 | Low risk | Low risk | High risk | Low risk | Low risk | Low risk | High quality |
| Suris 2013 | Low risk | Low risk | High risk | Low risk | High risk | High risk | High quality |
| Talbot 2014 | Low risk | Low risk | High risk | Low risk | Low risk | High risk | Low quality |
| ter Heide 2011 | Low risk | Unclear | High risk | High risk | High risk | High risk | High quality |
| ter Heide 2016 | Low risk | Unclear | High risk | Low risk | Low risk | Low risk | High quality |
| van den Berg 2015 | Low risk | Low risk | High risk | Low risk | Low risk | Low risk | High quality |

**H. Table H.1. Risk of Bias in Included Studies – Detailed**

| **Study** | **Selection Bias: random sequence generation** | **Selection Bias: allocation concealment** | **Performance Bias: blinding of participants and personnel** | **Detection Bias: blinding of assessments** | **Attrition Bias: incomplete outcome data** | **Reporting Bias: selective outcome reporting** |
| --- | --- | --- | --- | --- | --- | --- |
| Ahmadi 2015  | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Not reported. | *“The drop-out rate from the study was also high comprising over 31% of the initial participants.”* No follow-up data – beyond post-intervention data. | Protocol not available. |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **High risk** | **High risk** |
| Azad marzabadi 2014 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Not reported. | *“Two participants dropped out in each group as the study continued (due to reasons like being discharged from the hospital or stopping participation in the study).”* | Protocol not available. |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **Low risk** | **High risk** |
| Basoglu 2007 | *“A computer-generated sequence of random numbers that ensured equal cell sizes and did not lead to allocation of more than two consecutive cases to the same experimental condition was used in the randomization.”* | Not reported.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“The assessors were blind as to the participants’ experimental condition at the week 4 and week 8 assessments.”* | Only four non-completer cases, and ITT was used. | Protocol not available. |
| **Low risk** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Beidel 2011 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Not reported (for the relevant assessments). | 5 of the 35 participant did not complete the intervention and then another 5 did not complete the relevant post-intervention assessments. ITT was used. 10/35 = 29%. No follow-up data – beyond post-intervention data. | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **High risk** | **High risk** |
| Beidel 2019 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | *“Participants were randomized to either TMT or EXP prior to initiating treatment. However, clinicians and participants were blinded to group assignment until VRET and the mid-treatment assessment were completed.”* | Not reported. | *“The overall dropout rate was 39%, consistent with other clinical trials examining treatment for combat-related PTSD (Reger et al., 2016; Resick et al., 2015). The dropout rate was 28% for TMT and 50% for EXP, which was not signiﬁcantly diﬀerent (χ2 = 2.14, df = 91, p < 0.14).”* | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **High risk** | **High risk** |
| Bryant 2013 | *“Randomization was conducted by a process of minimization stratiﬁed on gender, trauma type and Clinician Administered PTSD Scale-2 (CAPS-2; Blake et al. 1995) total score. Participants were randomly assigned according to a random numbers system administered by an individual who was independent of the study and who worked at a site that was distant from the treatment centre.”* | Distance randomisation – “*Participants were randomly assigned according to a random numbers system administered by an individual who was independent of the study and who worked at a site that was distant from the treatment centre.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Post-treatment and 6-month follow-up assessments were conducted by independent clinicians who were unaware of the treatment condition of participants. Blindness was maintained by ensuring that clinicians who conducted assessments did not have access to (a) participant notes or (b) condition allocation of participants.”* | *“Of the participants, 51 (73%) completed treatment and 32 (46%) completed the 6-month follow-up assessment.”* | Protocol not available.  |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **High risk** | **High risk** |
| Butollo 2016 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“The IES-R [36] , a self-report instrument that measures the intensity of PTSD symptoms, was our primary outcome measure. It was administered by the therapist before each session as a process measure, as well as before and after treatment and at the follow-up.”* | *“Drop-out rates at the posttreatment assessment* *were 12.2% for DET (4.1% of those allocated to DET did not start treatment, 8.1% dropped out of treatment) and 14.9% for CPT (6.0% declined treatment after allocation, 9.0% dropped out of treatment). At the 6-month follow-up, study drop-out rates were markedly higher, increasing the overall study dropout to 47.3% in the DET and 37.3% in the CPT condition.”* | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **Low risk** | **High risk** |
| Cloitre 2002 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Clinician raters of the CAPS (PTSD measure) were blind to treatment condition at pre- and posttreatment. No reference to any blinding (e.g., re scoring) the NMR and IIP.  | *“Of the 58 women who entered treatment, 12 dropped out: 9 from the active treatment (29%) and 3 from the wait list (11%).”* This is <25% overall.  | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Difede 2007 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Not reported. | *“Our dropout rate of 40% was higher than the typical exposure therapy study for PTSD, where dropouts are reported in the 20% to 30% percent range (Bradley et al., 2005).”* Also, >30% dropped out of the allocated intervention.  | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **High risk** | **High risk** |
| Dorrepaal 2012 | *“The randomization was performed independently on a 1: 1 basis, stratified per site, by a methodologist not involved in the study. Condition assignments were e-mailed to the group leader, who then informed the patient without informing the researchers or assessors.”* No more relevant information.  | *“The randomization was performed independently on a 1: 1 basis, stratified per site, by a methodologist not involved in the study. Condition assignments were e-mailed to the group leader, who then informed the patient without informing the researchers or assessors.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“The interviews were conducted by trained independent assessors, who were blind to the treatment condition and were audiotaped for use in supervision.”* | Attrition was 16%.  | Protocol not available.  |
| **Unclear** | **Low risk** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Duffy 2007 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Not reported. | 21% dropped out.  | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **Low risk** | **High risk** |
| Dunn 2007 | *“The study statistician (J. Souchek [J.So.]) provided randomization numbers and group assignments from a list generated by the PLAN procedure in SAS, version 6.11. We randomized in blocks of two, in the order of participants’ enrollment, to facilitate equal participant numbers in each group.”* | The list of random numbers provided could suggest that investigators could possibly foresee assignments.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Interviewers were blind to participants’ therapy group assignments throughout the study.”* | 30% of those allocated to the interventions did not complete them, and 41% of those allocated to the interventions were lost to follow-up at 12 months.  | Protocol not available.  |
| **Low risk** | **High risk** | **High risk** | **Low risk** | **High risk** | **High risk** |
| Dunne 2012 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | *“Participants in this study were also not blinded to condition.”* | *“Although the use of the same assessor for the diagnostic interview for all participants at all 3 time points is a methodological strength, this also meant the assessor was not blinded to the treatment condition representing a potential bias in postassessment and follow-up assessment.”* | *“A further strength of the study was the use of the intent-to-treat sample for data analyses, despite the relatively low attrition in this study (9% at 6-mo follow-up).”* | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **Low risk** | **High risk** |
| Ehlers 2003 | Reference to using the random permuted blocks within strata algorithm.  | Investigators enrolling participants could not possibly foresee assignments as the allocation list was kept locked in a central office and the patient’s allocation was only revealed three weeks later – following the self-monitoring assessment.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Independent assessors, blind to treatment condition, administered the CAPS. No reference to how the SDS (which is a self-report measure) was scored.  | Attrition was < 25%.  | Protocol not available.  |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Ehlers 2005 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Independent assessors, blind to treatment condition, administered the CAPS. No reference to how the SDS (which is a self-report measure) was scored.  | No patient dropped out.  | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Ehlers 2014 | *“The participants were then randomly allocated to one of the four trial conditions by an independent researcher who was not involved in assessing patients using the minimization procedure (15) to stratify for sex and severity of PTSD symptoms. The assessors determining the suitability of a patient for inclusion were not informed about the stratiﬁcation variables and algorithm.”* | *“The participants were then randomly allocated to one of the four trial conditions by an independent researcher who was not involved in assessing patients using the minimization procedure (15) to stratify for sex and severity of PTSD symptoms. The assessors determining the suitability of a patient for inclusion were not informed about the stratiﬁcation variables and algorithm.”* | *“Participants were not blind to the nature of the treatment, but care was taken to create similarly positive expectations in each treatment group by informing them that several psychological treatments were effective in PTSD and it was unknown which worked best, and by giving a detailed rationale for the treatment condition to which the patient was allocated.”* | *“The assessments of treatment outcome were conducted by independent evaluators without knowledge of the patient’s treatment condition. Patients were asked not to reveal their group assignment to the evaluators.”* | Attrition was < 25%.  | Protocol not available.  |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Foa 1999 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Assessors were unaware of treatment assignment.  | 17.7 dropped out altogether; although drop-out were not spread evenly throughout the groups – 8% dropped out of the PE group, 27% of the SIT group, 27% of the PE-SIT group, 0% of the WL group. ITT was used. | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Foa 2005 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Independent evaluations were conducted at pretreatment and posttreatment and 3-, 6-, and 12-month posttreatment. All evaluations were conducted by trained doctoral or master’s level CTSA clinicians who were blind to study condition.”* | *“The overall dropout rate was 32.4% and was lower for WL (3.8%) than PE/CR (40.5%)… and PE (34.2%)”* These were not available for post-intervention assessment.  | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **Low risk** | **High risk** | **High risk** |
| Forbes 2012 | A random number ordered list was used.  | After full assessment by an independent clinical assessor, participants were randomised by the project manager at an independent research centre.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Assessors were blind to allocation and treatment.  | 20% did not complete the post-intervention assessment and 31% did not complete the 3 month follow-up (which is a short-term follow-up. | Protocol not available.  |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Ford 2011 | *“One hundred forty six women (ages 18–45; M=30.7, SD=6.9) completed the screening and baseline assessment and then were randomized (by a study assessor using numbers concealed in sealed envelopes previously prepared by a different study staff member using the Excel random number generator) to WL (N=45), TARGET (N=48), or PCT (N=53).”* | *“One hundred forty six women (ages 18–45; M=30.7, SD=6.9) completed the screening and baseline assessment and then were randomized (by a study assessor using numbers concealed in sealed envelopes previously prepared by a different study staff member using the Excel random number generator) to WL (N=45), TARGET (N=48), or PCT (N=53).”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“All interviewers were blind to the experimental condition in baseline interviews, but due to technical difficulties they were not blind to experimental condition at posttherapy or follow-up interviews.”* | 32% of those allocated to treatment did not complete the post-intervention assessment.  | Protocol not available.  |
| **Low risk** | **Low risk** | **High risk** | **High risk** | **High risk** | **High risk** |
| Galovski 2012 | *“If eligible, participants were randomly assigned in a 1:1 ratio using computer generated simple randomization to MCPT or to SMDT following the pre-treatment assessment.”* | No more relevant information other than what is in the previous column.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Finally, because it is technically possible to remain PTSD positive with a score of 20 on the PDS and reporting bias can exist in the therapy situation (e.g., patient wants to please therapist), a blind rater conducted the CAPS to ensure that the participant no longer met criteria for PTSD.”* The other relevant measures were self-report, and no reference to any blind scoring of these. | 27% of those randomised did not complete an assessment at the time of the completion of the CBT intervention.  | Protocol not available.  |
| **Low risk** | **Unclear** | **High risk** | **Low risk** | **High risk** | **High risk** |
| Ghafoori 2017 | A pre-determined, computer-generated, randomised list was used.  | No more relevant information other than what is in the previous column.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Outcome assessors were not blind to participant assignments.  | More than half of the sample terminated prematurely before completion of the treatment, and follow-up assessment time points were included.  | Protocol not available.  |
| **Low risk** | **Unclear** | **High risk** | **High risk** | **High risk** | **High risk** |
| Harned 2014 | *“A minimization randomization procedure was used.”* | No more relevant information other than what is in the previous column.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“All assessments were conducted by independent clinical assessors who were blind to treatment condition.”* | *“Completion rates for the one year of treatment did not differ between conditions (DBT=55.6%, DBT + DBT PE=58.8%).”* | Protocol not available.  |
| **Low risk** | **Unclear** | **High risk** | **Low risk** | **High risk** | **High risk** |
| Hinton 2009 | Coin was tossed.  | No more relevant information other than what is in the previous column.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Outcome assessor was blind to treatment condition.  | *“All 24 randomized patients completed the study, and there were no missing data.”* | Protocol not available.  |
| **Low risk** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Hinton 2011 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | All assessments were self-report, although it does not clarify whether or not these were scored blind.  | *“There was no missing data.”* | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **Low risk** | **High risk** |
| Hogberg 2007 | No more relevant information other than what is in the next column. | *“The randomization was done by picking a sealed ballot in the presence of a research nurse who coordinated the study and followed the participants through all phases.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Not reported. | *“Three subjects dropped out after randomization but before treatment/WL. One of them had a strong aversive reaction to the SPECT examination and decided to interrupt the examination. Two other subjects left the study because of difficulty with finding time for the study.”* 5/24 = 21%. | Protocol not available.  |
| **Unclear** | **Low risk** | **High risk** | **High risk** | **Low risk** | **High risk** |
| Hollified 2007 | *“Before enrolling participants, 90 study ID numbers were prerandomized to study group (acupuncture, CBT or WLC) by the research coordinator (RC) using a computerized random numbers procedure without restrictions.”* | *“When a participant was enrolled, the RC opened the assignment program to reveal the participant’s group assignment. This allocation procedure was concealed from clinicians.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“The research coordinator collected, entered, and helped analyze the data. Although he was aware of participant group allocation at the time he collected data, he did not assist participants in completing the self-rated assessments. It is possible, yet we think quite unlikely, that he could have systematically inﬂuenced participant reports.”* | *“Eighty-four participants were randomized, 73 began the protocol, and 61 (73% of those randomized and 84% of those who began the protocol (acupuncture 79% vs. CBT 84% vs. WLC 88%) completed treatment or wait-list assessments. End treatment and 3-month follow-up assessments were obtained for 60 and 58 participants, respectively.”* 24/84 = 29%.  | Protocol not available.  |
| **Low risk** | **Low risk** | **High risk** | **High risk** | **High risk** | **High risk** |
| Jung 2013 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | The PDS and RSES (the relevant measures) were self-report, but there is no reference to these being blindly scored.  | *“34 participants were randomly assigned to either the CRIM group (n = 17) or WL group (n = 17). Two patients in each condition decided against treatment after randomization and were defined as nonstarters. Further, 2 patients (1 in each condition) were excluded from the study due to protocol violations, specifically, because they had received further psychological treatment while participating in the study. No patient dropped out of treatment.”* 6/34 = 18%.  | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **Low risk** | **High risk** |
| Keane 1989 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Post-test assessments for the Wait-list Control were conducted either by the therapist who would then treat the patient or, in the case of patients to be treated elsewhere, by an unsystematically assigned therapist from the four in- volved in the study.”* | No reference to any missing data at post-assessment.  | *“The original design of this study involved random assignment of subjects to the implosive therapy group, a stress management group wherein subjects were taught behavioral skills to re- duce anxiety but exposure to traumatic memories was limited, and the waiting list control. Only 5 subjects completed the stress management condition, and thus, these data are not included in the present manuscript.”* |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **Low risk** | **High risk** |
| Kip 2013 | *“Eligible service members/veterans were randomly assigned to the ART or AC regimen in a 1:1 ratio using a random number generator and variable blocking scheme (blocks of 4, 6, and 8).”* | No more relevant information other than what is in the previous column.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Random assignment was unblinded; hence, the potential existed for over-reporting of reductions in pain with the ART intervention.”* | Attrition was <25%.  | *“The trial was registered with ClinicalTrials.gov (NCT01559688).”* The relevant PTSD measure was reported as the primary outcome in this protocol.  |
| **Low risk** | **Unclear** | **High risk** | **High risk** | **Low risk** | **Low risk** |
| Krakow 2001 | *“To mask treatment assignment, patients mailed back a postcard after intake to complete entry into the protocol. The postcard’s time and date were logged into a computer and entered into a previously generated list of numbers that randomly assigned participants to treatment and control groups. All numbers and group assignments were generated at the start of the protocol.”* | No more relevant information other than what is in the previous column.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“To limit external bias, blinding occurred at 3 points of data collection: (1) at intake, group assignment had not been established; (2) at 3-month follow-up, questionnaires were completed through the mail; and (3) at 6-month follow-up, interviewers were unaware of group status.”* | *“Of the 168 randomized participants, 96 completed 3-month follow-ups by mail, and 99 completed the 6-month follow-ups in person. In total, 114 individuals completed at least 1 follow-up, and 77 participants completed both follow-ups.”* | Protocol not available.  |
| **Low risk** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Krupnick 2008 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Not reported. | *“At termination, we obtained assessments for only 20 (out of 32) treatment and 7 (out of 16) control participants. These figures increased to 26 treatment and 10 control participants for the 4-month follow-up interview.”* Therefore, attrition at termination was >25%. | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **High risk** | **High risk** |
| Kubany 2003 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | The assessors (of the CAPS; the PTSD measure) were blind to participants’ condition assignments. The RSES was also used, but this is a self-report measure and there is no reference to this being blindly scored.  | *“Eighteen of 19 women assigned to the Immediate CTT-BW condition completed CTT-BW. Fourteen of 18 women assigned to the Delayed CTT-BW condition completed CTT-BW. Overall, 86% of the 37 women who started CTT-BW (n = 32) completed treatment.”* It appears these participants also completed the assessment at the time of the completion of Immediate CTT-BW condition; therefore there was <25% attrition. Re follow-ups, *“three-month follow-up data was obtained for 78% of the women who completed Immediate CTT-BW (n = 14) and for 79% of the women who completed Delayed CTT- BW (n = 11).”* | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Kubany 2004 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | The assessors (of the CAPS; the PTSD measure) were blind to participants’ condition assignments. The RSES was also used, but this is a self-report measure and there is no reference to this being blindly scored.  | Posttreatment assessment data were only available for 84 of 125 randomised participants; there attrition was >25%.  | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **Low risk** | **High risk** | **High risk** |
| Lindauer 2005 | *“A colleague who had done no assessments used a computer program to randomly assign 12 patients to each condition in a block design.”* | No more relevant information other than what is in the previous column.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Each patient was assessed by a researcher (R.J.L.L. or E.P.M.M.), who were blind to all patients’ condition.”* | *“In the per-protocol analysis (patients who completed the treatment), the sample sizes were 7 (58%) for the treatment group and 11 (92%) for the waitlist group”.* Attrition = 25%. | Protocol not available.  |
| **Low risk** | **Unclear** | **High risk** | **Low risk** | **High risk** | **High risk** |
| Marks 1998 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Assessors were kept unaware of the treatment condition.”* | *“Ten subjects (11%) dropped out but they did not differ signiﬁcantly by group.”* | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| McDonagh 2005 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“A separate group of female clinicians, who were blind to treatment condition and who had no other role in the study conducted the four CAPS interviews.”* | *“The dropout rate for the study was 23%, with a rate of 41% (12 of 29) for CBT, 9% (2 of 22) for PCT, and 13% (3 of 23) for WL.”* | Protocol not available. Moreover, the following suggests a deviation from the protocol: *“When it became clear that the dropout rate was greater for CBT, we changed the random assignment process to increase the chance of assignment to CBT.”* |
| **Unclear** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Monson 2006 | Randomisation was referred to, but there was no more relevant information. | *“The study biostatistician provided the participants’ condition assignment to the study coordinator.”* This does not necessarily suggest allocation concealment.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“The independent clinician assessors were blinded to condition assignment and participants were instructed to not disclose their condition assignment to them.”* | *“The overall drop-out rate was 16.6% (20% from CPT, 13% from the wait-list condition).”* | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Mueser 2008 | *“Randomization was conducted at a central location in the research center by a computer based randomization program with assignments not known in advance by either clinical or research staff…”* | *“Randomization was conducted at a central location in the research center by a computer based randomization program with assignments not known in advance by either clinical or research staff…”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Assessments were conducted by blinded interviewers at baseline, following the 4-6 months treatment period for the CBT program, and 3- and 6-months later.”* | Only 59/108 were analysed at post-treatment.  | Protocol not available.  |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **High risk** | **High risk** |
| Mueser 2015 | *“Participants were randomised to the CBT or brief groups via a computer program operated by an off-site data manager, with no study personnel aware of assignments in advance.”* | *“Participants were randomised to the CBT or brief groups via a computer program operated by an off-site data manager, with no study personnel aware of assignments in advance.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“All interviewers were masked to treatment assignment.”* | 20% of randomised participants were not analysed at post-treatment. | *“All study procedures were approved by the Rutgers and Dartmouth Institutional Review Boards (trial registration: clinicaltrials.gov identifier: NCT00494650).”* |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **Low risk** | **Low risk** |
| Nijdam 2012 | *“Random assignment was done on a 1:1 basis by a computer program, with a weighted maximum of subscribing four times the same treatment in a row.”* | *“To ensure masking of assessors, one psychologist who had no other engagement in the study, had access to the computer program, kept a log file of all random assignments and assigned the patients to the therapists.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Assessments were conducted by trained, independent, masked assessors who were master’s level clinical psychologists or master’s level psychology students supervised by an experienced clinical psychologist.”* | 32% of randomised participants were lost to the first post-assessment.  | *“Trial registration: Dutch Trial Register, number NTR46 and ISRCTN64872147.”* |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **High risk** | **Low risk** |
| Pacella 2012 | *“The principal investigator (DLD) generated the allocation sequence using blocked randomization (4:3 ratio of experimental:control participants).”* | No more relevant information other than what is in the previous column.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“The graduate student conducting the assessments remained blind to group membership.”* | *“At the post-intervention assessment, 23 participants were retained in the PE group (32% drop-out rate) and 24 participants were retained in the control group (0% drop-out rate).”* It also says: *“Unequal numbers of participants were assigned to each group, as it was anticipated that the PE group would have a higher dropout rate.”* | Protocol not available.  |
| **Low risk** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| Power 2002 | *“Randomization was by means of a predetermined schedule unbeknown to the assessors, therapists or patients.”* | *“Following completion of the entire initial assessment, for those patients who met entry criteria, the blind assessor then opened a sealed envelope that informed as to which group patients were to be allocated.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Assessments pre- and post-treatment were conducted by two independent assessors respectively, who were blind to treatment conditions.”* | *“A total of 105 patients met entry criteria and were randomized to groups as follows: 39 to EMDR, 37 to ECCR and 29 to WL. Drop-out rates between these three groups were as follows, 12 (31%) from EMDR, 16 (43%) from E+CR and ﬁve (17%) from WL.”* | Protocol not available.  |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **High risk** | **High risk** |
| Resick 2002 | Randomisation was referred to, but there was no more relevant information. | Randomisation was referred to, but there was no more relevant information. | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Not reported. | Attrition was > 25%.  | Protocol not available.  |
| **Unclear** | **Unclear** | **High risk** | **High risk** | **High risk** | **High risk** |
| Scheck 1998 | *“Envelopes filled with papers labeled either EMDR or AL were shuffled and numbered 1 though 100.”* | *“During each interview, envelopes were opened consecutively to identify which therapy was to be assigned to the participant.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“During the post-test assessment, a trained volunteer who was blind to group assignment administered the standardized instru- ments”.* | 29% dropped out.  | Protocol not available.  |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **High risk** | **High risk** |
| Steel 2017 | *“Block randomization was conducted independently of the research team through the OpenCDMS database speciﬁcally developed for the study.”* | *“Block randomization was conducted independently of the research team through the OpenCDMS database speciﬁcally developed for the study.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Robust procedures were adopted to minimize the risk of interviewers being able to identify the group allocation of participants…”* | 50/61 were analysed at post-treatment.  | *“The trial was given ethical approval by Berkshire Research Ethics Committee (SC/09/ H0505/85) and was registered as ISTCRN 67096137.”* |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **Low risk** | **Low risk** |
| Suris 2013 | *“For the purpose of randomization, participants were assigned sequential PIN numbers as they entered the study. Blocks of random numbers were generated for each therapist, and were allocated to either CPT or PCT using a conditional statement.”*  | *“The random number sequence was maintained on an Excel spreadsheet, and as subjects’ PINs were entered into the spreadsheet, the preassigned condition was revealed.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Assessors were blind to treatment condition. | *“Excluding data from this therapist reduced the ﬁnal sample to 86 participants from the original 129.”* | This study has a high risk of reporting bias as lots of participants were removed from the analysis due to low treatment fidelity of a certain clinician. |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **High risk** | **High risk** |
| Talbot 2014 | *“Blind assignment was determined by a computer generated random allocation schedule operated by the study statistician.”* | *“Group allocation was provided to the study coordinator in opaque, sealed envelopes that were opened by the study coordinator with the participant following the completion of baseline measures.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Clinical interviewers and the polysomnography technician were blind to participants’ treatment conditions during both pretreatment and posttreatment administration and scoring.”* | Only 16% in total were lost to follow-up. | Protocol not available.  |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **Low risk** | **High risk** |
| ter Heide 2011 | Coin was tossed.  | No more relevant information.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | The relevant measures were self-report and there is no reference to these being blindly scored. Re the clinician administered measure – “*blindness was maintained only in 70% of SCID interviews, thus threatening the reliability of clinician rated outcomes.”*  | 10/20 (50%) dropped out.  | Protocol not available.  |
| **Low risk** | **Unclear** | **High risk** | **High risk** | **High risk** | **High risk** |
| ter Heide 2016 | Coin was tossed.  | No more relevant information.  | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | *“Interviews were administered by trained Master’s students in psychology who were kept masked to treatment condition by having limited access to participant data and by asking participants not to reveal treatment content.”* | Attrition was <25%. | *“Trial registration: NARCIS (Dutch National Academic Research and Collaborations Information System) OND1324839; ISRCTN20310201.”* |
| **Low risk** | **Unclear** | **High risk** | **Low risk** | **Low risk** | **Low risk** |
| van den Berg 2015 | *“An independent randomization bureau randomized the treatment condition using stratified randomization blocks per therapist with equal strata sizes.”* | *“An independent randomization bureau randomized the treatment condition using stratified randomization blocks per therapist with equal strata sizes.”* | Blinding of participants is generally not possible due to the nature of psychological trials. Nothing in this trial to suggest otherwise. | Assessors were blind to treatment allocation.  | Attrition was <25%. | *“The trial design was approved by the medical ethics committee of the VU University Medical Center and was registered at isrctn.com (ISRCTN79584912).”* |
| **Low risk** | **Low risk** | **High risk** | **Low risk** | **Low risk** | **Low risk** |

**I. GRADE Assessment Criteria**

We applied the following criteria for downgrading to each outcome.

*Risk of Bias*

If >50% of studies had a low overall quality rating, the quality of the outcome was downgraded by 1. If >75% of studies had a low overall quality rating, the quality of the outcome was downgraded by 2.

*Imprecision*

We downgraded an outcome for imprecision by 1 point if *“a recommendation or clinical course of action would differ if the upper versus the lower boundary of the CI represented the truth”* and/or the number of events and sample size meant the optimal information size was not reached (Guyatt et al., 2011). We downgraded by 2 points if an analysis was based on only 1-2 studies.

*Inconsistency*

We downgraded an outcome for inconsistency by 1 point if the I2 statistic was ≥40% in the context of an unclear direction of effect or ≥75% in the context of a clear direction of effect. We downgraded by 2 points if the I2 statistic was ≥75% in the context of an unclear direction of effect.

*Publication Bias*

We downgraded an outcome for publication bias by 1 point when, for outcomes with at least 10 studies (Higgins & Green, 2011),the funnel-plots showed asymmetry and this was not better explained by selective reporting bias or some other factor. However, if the ‘trim and fill’ method indicated that any publication bias was not likely to affect the overall magnitude of the effect size, we did not downgrade.

*Indirectness*

Indirectness was assessed by considering the relevance of the outcome data to the construct of interest for each outcome, together with that of the study population, nature of the intervention under investigation and the control condition.

**J. Table J.1. Other Comparisons**

| **Studies** | **Outcome** | **Comparison (A vs B)** | **k included studies** | **Group A N** | **Group B N** | **Hedges’ g (95% CI), p-value** | **Heterogeneity, I2, p-value** | **Quality (GRADE)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Versus TAU/WL* |
| Krupnick 2008 | PTSD + DR | IPT vs WL | 1 | 32 | 16 | -1.02 (-1.65, -0.39), 0.002 | - | Very low-2 RoB-2 imprecision |
| Azad marzabadi 2014 | DR | Mindfulness vs TAU | 1 | 14 | 14 | -1.60 (-2.43, -0.77), <0.001 | - | Very low-2 RoB-2 imprecision |
| *Head-to-head comparisons* |
| Beidel 2011 | PTSD, DR & AD | TMT vs exposure | 1 | 14 | 16 | -0.09 (-0.79, 0.61), 0.801 | - | Very low-2 RoB-2 imprecision |
| Beidel 2019 | PTSD & DR | TMT vs exposure | 1 | 43 | 49 | -0.05 (-0.46, 0.36), 0.815 | - | Very low-2 RoB-2 imprecision |
| Butollo 2016 | PTSD & NSC | DET vs CBT | 1 | 66 | 72 | 0.27 (-0.07, 0.60), 0.118 | - | -Very low-2 RoB-2 imprecision |
| Bryant 2013 | PTSD & NSC | CBT + ERT vs CBT + SC | 1 | 36 | 34 | -0.04 (-0.51, 0.43), 0.866 | - | Low-2 imprecision |
| Harned 2014 | PTSD & NSC | DBT + Exposure vs DBT | 1 | 12 | 6 | 0.51 (-0.43, 1.45), 0.291  | - | Low-2 imprecision |
| ter Heide 2011, ter Heide 2016 | PTSD & DR | EMDR vs STBT | 2 | 36 | 34 | -0.16 (-0.61, 0.29), 0.486 | 0%, 0.360 | Low-2 imprecision |

Abbreviations: AD=affect dysregulation; CBT=cognitive behavioural therapy; DBT=dialectical behaviour therapy; DET=dialogical exposure therapy; DR=disturbances in relationships; EMDR=eye-movement and desensitisation and reprocessing therapy; ERT=emotion regulation training; IPT=interpersonal psychotherapy; NSC=negative self-concept; PTSD=posttraumatic stress disorder; SC=supportive counselling; STBT=stabilisation treatment; TAU=treatment as usual; TMT=trauma management therapy; WL=waiting list.

**K. Table K.1. Clinically Significant Response (number needed to treat per control group event rate)**

| **Treatment** | **Comparator** | **Outcome** | **g (95% CI), p-value** | **10% CER\*** | **22% CER\*** | **50% CER\*** |
| --- | --- | --- | --- | --- | --- | --- |
| CBT | vs TAU/WL | DR | -0.66 (-0.84, -0.48), <0.001 | 6B (4B, 9B) | 4B (3B, 6B) | 4B (3B, 5B) |
| CBT | vs control | DR | -0.32 (-0.60, -0.03), 0.029 | 15B (7B, 186B) | 9B (5B, 111B) | 8B (4B, 84B) |
| CBT | vs TAU/WL | AD | -1.42 (-2.20, -0.65), <0.001 | 2B (1B, 6B) | 2B (1B, 4B) | 2B (2B, 4B) |
| CBT | vs control | AD | -0.82 (-2.91, 1.26), 0.440  | 5B (1B, 3H) | 3B (1B, 2H) | 3B (2B, 3H) |
| CBT | vs TAU/WL | NSC | -0.82 (-1.19, -0.44), <0.001 | 5B (3B,10B) | 3B (2B, 7B) | 3B (3B, 6B) |
| CBT | vs control | NSC | -0.24 (-0.69, 0.21), 0.295 | 20B (6B, 24H) | 13B (4B, 15H) | 11B (4B, 12H) |
| CBT | vs TAU/WL | PTSD | -0.90 (-1.11, -0.68), <0.001 | 4B (3B, 6B) | 3B (2B, 4B) | 3B (3B, 4B) |
| CBT | vs control | PTSD | -0.37 (-0.66, -0.09), 0.011 | 12B (6B 60B) | 8B (4B, 36B) | 7B (4B, 28B) |
| CBT | vs TAU/WL | PTSD + 1, 2 or 3 | -0.81 (-1.00, -0.62), <0.001 | 5B (3B, 6B ) | 3B (3B, 5B) | 3B (3B, 4B) |
| CBT | vs TAU/WL | PTSD + 2 or 3 | -0.78 (-1.31, -0.24), 0.005 | 5B (2B, 20B) | 4B (2B, 13B) | 4B (2B, 11B) |
| CBT | vs TAU/WL | PTSD + 3 | -0.53 (-0.96, -0.09), 0.017 | 8B (4B, 60B) | 5B (3B, 36B) | 5B (3B, 28B) |
| CBT | vs control | PTSD + 1, 2 or 3 | -0.34 (-0.62, -0.06), 0.019 | 14B (6B, 91B) | 9B (5B, 55B) | 8B (4B, 42B) |
| CBT | vs control | PTSD + 2 or 3 | - |  |  |  |
| CBT | vs control | PTSD + 3 | - |  |  |  |
| Exposure | vs TAU/WL | DR | -0.59 (-1.12, -0.07), 0.028 | 7B (3B, 78B) | 5B (2B, 47B) | 5B (3B, 36B)  |
| Exposure | vs control | DR | -0.12 (-0.60, 0.37), 0.642 | 44B (7B, 12H) | 27B (5B, 8H) | 21B (4B, 7H) |
| Exposure | vs TAU/WL | AD | - |  |  |  |
| Exposure | vs control | AD | - |  |  |  |
| Exposure | vs TAU/WL | NSC | -0.73 (-1.03, -0.43), <0.001 | 5B (3B, 10B) | 4B (3B, 7B) | 4B (3B, 6B) |
| Exposure | vs control | NSC | - |  |  |  |
| Exposure | vs TAU/WL | PTSD | -1.05 (-1.52, -0.58), <0.001 | 3B (2B, 7B ) | 3B (2B, 5B) | 3B (2B, 5B) |
| Exposure | vs control | PTSD | -0.08 (-0.47, 0.30), 0.675 | 68B (9B, 16H) | 41B (6B 10H) | 31B (6B, 8H) |
| Exposure | vs TAU/WL | PTSD + 1, 2 or 3 | -0.86 (-1.25, -0.47), <0.001 | 4B (3B, 9B) | 3B (2B, 6B) | 3B (3B, 6B) |
| Exposure | vs TAU/WL | PTSD + 2 or 3 | -0.56 (-0.99, -0.14), 0.009 | 7B (4B, 37B) | 5B (3B, 23B) | 5B (3B, 18B) |
| Exposure | vs TAU/WL | PTSD + 3 | - |  |  |  |
| Exposure | vs control | PTSD + 1, 2 or 3 | -0.19 (-0.57, 0.20), 0.336 | 27B (7B, 25H) | 17B (5B, 16H) | 13B (5B, 13H) |
| Exposure | vs control | PTSD + 2 or 3 | - |  |  |  |
| Exposure | vs control | PTSD + 3 | - |  |  |  |
| EMDR | vs TAU/WL | DR | -0.76 (-1.35, -0.16), 0.012 | 5B (2B, 32B) | 4B (2B, 20B) | 4B (2B , 16B) |
| EMDR | vs control | DR | -0.35 (-1.01, 0.31), 0.312 | 13B (3B, 15H), | 9B (3B, 10H ) | 7B (3B, 8H) |
| EMDR | vs TAU/WL | AD | -1.64 (-2.56, -0.72), 0.000 | 2B (1B, 5B ) | 2B (1B, 4B) | 2B (2B, 4B) |
| EMDR | vs control | AD | 0.25 (-0.57, 1.08), 0.548 | 20H (5B, 3H ) | 12H (5B, 2H) | 10H (5B, 3H) |
| EMDR | vs TAU/WL | NSC | -0.61 (-1.04, -0.17), 0.006 | 7B (3B , 30B) | 5B (3B, 19B) | 4B (3B, 15B) |
| EMDR | vs control | NSC | -0.78 (-1.56, -0.01), 0.049 | 4B (2B, 566B) | 4B (2B, 336B) | 4B (2B, 251B) |
| EMDR | vs TAU/WL | PTSD | -1.26 (-2.01, -0.51), 0.001 | 3B (2B, 8B) | 2B (1B, 6B) | 3B (2B, 5B) |
| EMDR | vs control | PTSD | -0.69 (-1.35, -0.03), 0.041 | 6B (2B, 186B) | 4B (2B, 111B) | 4B (2B , 84B) |
| EMDR | vs TAU/WL | PTSD + 1, 2 or 3 | -1.15 (-1.92, -0.37), 0.004 | 3B (2B, 12B) | 2B (2B, 8B) | 3B (2B, 7B) |
| EMDR | vs TAU/WL | PTSD + 2 or 3 | -1.36 (-3.13, 0.42), 0.134 | 2B (1B, 11H) | 2B (1B, 7H) | 2 (2B , 6H) |
| EMDR | vs TAU/WL | PTSD + 3 | - |  |  |  |
| EMDR | vs control | PTSD + 1, 2 or 3 | -0.52 (-0.97, -0.08), 0.020 | 8B (4B, 68B) | 6B (3B, 41B)  | 5B (3B, 31B) |
| EMDR | vs control | PTSD + 2 or 3 | -0.44 (-1.31, 0.43), 0.321 | 10B (2B, 10H) | 7B (2B, 7H)  | 6B (2B, 6H) |
| EMDR | vs control | PTSD + 3 | - |  |  |  |
| CBT (T) | vs exposure (C) | DR | 0.07 (-0.26, 0.39), 0.689 | 78C (19T, 12C)  |  47C (12T, 8C) | 36C (10T, 7C) |
| CBT (T) | vs exposure (C) | AD | - |  |  |  |
| CBT (T) | vs exposure (C) | NSC | -0.31 (-0.67, 0.04), 0.082 | 15T (6T, 139C) | 10T (4T, 83C) | 8T (4T, 63C) |
| CBT (T) | vs exposure (C) | PTSD | -0.03 (-0.23, 0.17), 0.784 | 186T (22T, 30C) | 111T (14T, 19C) | 84T (11T, 15C) |
| CBT (T) | vs exposure (C) | PTSD + 1, 2, or 3 | -0.04 (-0.27, 0.19), 0.719 | 139T (18T, 27C) | 83T (11T, 17C) | 63T (9T, 13C) |
| CBT (T) | vs exposure (C) | PTSD + 2 or 3 | - |  |  |  |
| CBT (T) | vs exposure (C) | PTSD + 3 | - |  |  |  |
| CBT (T) | EMDR (C) | DR | 0.28 (-0.29, 0.34), 0.338 | 17C (16T, 14C) | 11C (11T, 9C) | 9C (9T, 8C) |
| CBT (T) | EMDR (C) | AD | - |  |  |  |
| CBT (T) | EMDR (C) | NSC | - |  |  |  |
| CBT (T) | EMDR (C) | PTSD | 0.37 (0.03, 0.71), 0.031 | 12C (186C, 5C) | 8C (111C, 4C) | 7C (84C, 4C) |
| CBT (T) | EMDR (C) | PTSD + 1, 2, or 3 | 0.31 (-0.07, 0.68), 0.111 | 15C (78T, 6C) | 10C (47T, 4C) | 8C (36T, 4C) |
| CBT (T) | EMDR (C) | PTSD + 2 or 3 | - |  |  |  |
| CBT (T) | EMDR (C) | PTSD + 3 | - |  |  |  |
| EMDR (T) | Exposure (C) | DR | -0.10 (-0.51, 0.31), 0.640 | 54T (8T, 15C) | 33T (6T, 10C) | 25T (5T, 8C) |
| EMDR (T) | Exposure (C) | AD | - |  |  |  |
| EMDR (T) | Exposure (C) | NSC | 0.16 (-0.25, 0.57), 0.444 | 32C (20T, 7C) | 20C (12T, 47C) | 16C (10T, 5C) |
| EMDR (T) | Exposure (C) | PTSD | 0.10 (-0.28, 0.49), 0.604 | 54C (17T, 9C) | 33C (11T, 6C) | 25C (9T, 5C) |
| EMDR (T) | Exposure (C) | PTSD + 1, 2, or 3 | 0.06 (-0.35, 0.46), 0.789 | 91C (35T, 9C) | 55C (9T, 6C) | 42C (7T, 6C) |
| EMDR (T) | Exposure (C) | PTSD + 2 or 3 | 0.06 (-0.35, 0.46), 0.789 | 91C (35T, 9C) | 55C (9T, 6C) | 42C (7T, 6C) |
| EMDR (T) | Exposure (C) | PTSD + 3 | - |  |  |  |
| IPT | vs TAU/WL | PTSD + DR | -1.02 (-1.65, -0.39), 0.002 | 3B (2B, 12B) | 3B (2B, 8B) | 3B (2B, 7B) |
| Mindfulness | vs TAU/WL | DR | -1.60 (-2.43, -0.77), <0.001 | 2B (1B, 5B) | 2B (1B, 4B) | 2B (2B, 4B) |
| TMT (T) | Exposure (C) | PTSD + DR + AD | -0.09 (-0.79, 0.61), 0.801 | 60T (5T, 7C) | 36T (3T, 5C) | 28T (4T, 4C) |
| TMT (T) | Exposure (C) | PTSD + DR | -0.05 (-0.46, 0.36), 0.815 | 110T (9T, 13C) | 66T (6T, 8C) | 50T (6T, 7C) |
| DET (T) | CBT (C) | PTSD + NSC | 0.27 (-0.07, 0.60), 0.118 | 18C (78T, 7C) | 11C (47T, 5C) | 9C (36T, 4C) |
| CBT + ERT (T) | CBT + SC (C) | PTSD + NSC | -0.04 (-0.51, 0.43), 0.866 | 139T (8T, 10C) | 83T (6T, 7C) | 63T (5T, 6C) |
| DBT + Exp (T) | CBT (C) | PTSD + NSC | 0.51 (-0.43, 1.45), 0.291  | 8C (10T, 2C) | 7C (7T, 2C) | 5C (6T, 2C) |
| EMDR (T) | STBT (C) | PTSD + DR | -0.16 (-0.61, 0.29), 0.486 | 32T (7T, 16C) | 20T (5T, 11C) | 16T (4T, 9C) |
|  |  |  |  |  |  |  |

Abbreviations: AD=affect dysregulation; CBT=cognitive behavioural therapy; CPTSD=complex posttraumatic stress disorder; CER=control event rate; DBT=dialectical behaviour therapy; DET=dialogical exposure therapy; DR=disturbances in relationships; DSO=disturbances in self-organisation; EMDR=eye-movement and desensitisation and reprocessing therapy; ERT=emotion regulation training; IPT=interpersonal psychotherapy; NSC=negative self-concept; PTSD=posttraumatic stress disorder; PTSD + 1, 2 or 3=PTSD + 1, 2 or 3 CPTSD (DSO) outcomes; PTSD + 2 or 3=PTSD + 2 or 3 CPTSD (DSO) outcomes; PTSD + 3=PTSD + all 3 CPTSD (DSO) outcomes; SC=supportive counselling; STBT=stabilisation treatment; TAU=treatment as usual; TMT=trauma management therapy; WL=waiting list. \*Note: B = benefit; H = harm; T = favours T; C = favours C

**L. Table L.1. Meta-regression Moderators (univariate)**

| **Moderator (univariate)** | **Coefficients (95% CI)** | **R2 or ∆R2** | **p-value** | **Effects per group** | **Quality** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Random sequence generation (low vs unclear or high risk of bias, k=52) | Unclear risk of bias-0.14 (-0.43, +0.16) | 2% | 0.358 | Low (k=26) -0.64 (-0.84, -0.45)Unclear (k=26)-0.78 (-0.99, -0.56)High (k=0) | Low-1 missing information-1 imprecise |
| Allocation concealment (low vs unclear or high risk of bias, k=52) | Unclear risk of bias-0.24 (-0.53, +0.06) | 5% | 0.112 | Low (k=20)-0.57 (-0.79, -0.35)Unclear (k=32)-0.80 (-0.99, -0.61)High (k=0) | Low-1 missing information-1 imprecise |
| Detection bias (low vs unclear or high risk of bias, k=52) | High risk of bias-0.04 (-0.35, +0.28) | 1% | 0.820 | Low (k=35)-0.69 (-0.87, -0.52)Unclear (k=0)High (k=17)-0.72 (-0.99, -0.47) | Moderate-1 imprecise |
| Selective reporting bias (low vs unclear or high risk of bias, k=52) | High risk of bias-0.35 (-0.81, +0.11) | 7% | 0.131 | Low (k=5)-0.39 (-0.82, 0.04)Unclear (k=0)High (k=47)-0.74 (-0.89, -0.59) | Moderate-1 imprecise |
| Attrition bias (low vs unclear or high risk of bias, k=52) | High risk of bias+0.10 (-0.20, +0.39) | 1% | 0.524 | Low (k=31)-0.65 (-0.87, -0.42)Unclear (k=0)High (k=21)-0.74 (-0.93, -0.55) | Moderate-1 imprecise |
| Quality (high quality vs low quality, k=52) | Low quality+0.05 (-0.26, +0.35) | 0% | 0.754 | Low quality (k=20)-0.67 (-0.91, -0.44)High quality (k=32)-0.72 (-0.91, -0.54) | Moderate-1 imprecise |
| CPTSD symptoms (PTSD alone vs various CPTSD, k=52) | PTSD + ER-0.57 (-1.44, +0.32)PTSD + NC + ID + ER-0.03 (-1.01, +0.50)PTSD + ID-0.20 (-0.92, 0.53)PTSD + NC-0.11 (-0.85, 0.63)PTSD + NC + ID-0.26 (-1.11, +0.59) | PTSD + AD1%PTSD + NSC + DR + AD2%PTSD + DR3%PTSD + NSC3%PTSD + NSC + DR7%Overall7% | PTSD + AD0.215PTSD + NSC + DR + AD0.955PTSD + DR0.593PTSD + NSC0.778PTSD + NSC + DR0.548Overall0.741 | PTSD (k=3)-0.53 (-1.25, 0.18)PTSD + AD (k=4)-1.09 (-1.66, -0.53)PTSD + NSC + DR + AD (k=2)-0.55 (-1.27, 0.17)PTSD + DR (k=24)-0.72 (-0.94, -0.50)PTSD + NSC (k=15)-0.63 (-0.90, -0.36)PTSD + NSC + DR (k=4)-0.78 (-1.29, -0.27) | Moderate-1 imprecise |
| Comparator (TAU/WL vs control, k=52) | Control +0.48 (+0.18, +0.77) | 28% | 0.001 | TAU/WL (k=38)-0.83 (-0.99, -0.67)Control (k=14)-0.35 (-0.60, -0.10) | Moderate-1 imprecise |
| Treatments (individual CBT vs others, k=52) | EMDR -0.08 (-0.53, +0.38)Exposure +0.04 (-0.53, +0.38)Group CBT +0.42 (-0.15, +0.99)Group IPT-0.29 (-1.34, +0.75) | EMDR 1%Exposure 0%Group CBT 7%Group IPT 2%Overall 10% | EMDR 0.736Exposure 0.834Group CBT 0.150Group IPT 0.581Overall 0.608 | CBT (k=33)-0.73 (-0.91, -0.54)EMDR (k=7)-0.80 (-1.23, -0.38)Exposure (k=8)-0.68 (-1.06, -0.31)Group CBT (k=3)-0.30 (-0.86, 0.25)Group IPT (k=1)-1.02 (-2.07, 0.04) | Moderate-1 imprecise |
| Therapy format (individual vs group, k=52) | Group only or in addition+0.27 (-0.25, +0.78) | 4% | 0.309 | Individual (k=48)-0.73 (-0.88, -0.58)Group only or in addition (k=4)-0.46 (-0.95, 0.03) | Moderate-1 imprecise |
| Trauma onset (Adult vs child, k=48) | Child +0.18 (-0.16, +0.52) | 2% | 0.308 | Adult (k=37)-0.76 (-0.93, -0.59)Child (k=11)-0.58 (-0.88, -0.29) | Moderate-1 imprecise |
|  |  |  |  |  |  |

Abbreviations: AD=affect dysregulation; CBT=cognitive behavioural therapy; DR=disturbances in relationships; EMDR=eye-movement and desensitisation and reprocessing therapy; k= number of included comparisons; NSC=negative self-concept; PTSD=posttraumatic stress disorder; CPTSD=complex posttraumatic stress disorder; TAU=treatment as usual; WL=waiting list.

**M. Table M.1. Meta-regression Moderators (multivariate)**

| **Moderator (k=48, multivariate)** | **Coefficients (95% CI)** | **∆R2** | **p-value** | **Narrative summary** | **Quality** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Quality (high vs low) | Low +0.30 (+0.00, +0.61)  | Low1% | Low0.048 | The effect for low quality studies is 0.30 lower than high quality studies | Moderate-1 imprecise |
| CPTSD symptoms (PTSD alone vs various CPTSD) | PTSD + AD-0.13 (-1.06, +0.80)PTSD + NSC + DR + AD+0.39 (-0.62, +1.40)PTSD + DR+0.28 (-0.43, +1.00)PTSD + NSC+0.06 (-0.63, +0.75)PTSD + NSC + DR+0.25 (-0.52, +1.02) | PTSD + AD-1%PTSD + NSC + DR + ER1%PTSD + DR0%PTSD + NSC0%PTSD + NSC + DR2%Overall2% | PTSD + AD0.783PTSD + NSC + DR + ER0.447PTSD + DR0.437PTSD + NSC0.860PTSD + NSC + DR0.518Overall0.504 | No association between number or type of CPTSD symptoms reported and effect size was observed (direction of effect favoured smaller effects with more CPTSD symptoms). | Moderate-1 imprecise |
| Comparator (TAU/WL vs control) | Control +0.69 (+0.38, +1.00) | Control34% | Control <0.0001 | Use of a control condition is associated with a moderate to large reduction in effect size. | High |
| Treatments (individual CBT vs others) | EMDR -0.25 (-0.69, +0.18)Exposure +0.07 (-0.30, +0.44)Group CBT +0.23 (-0.36, 0.82)Group IPT-0.70 (-1.66, 0.25) | EMDR 3%Exposure 0%Group CBT 7%Group IPT1%Overall11% | EMDR 0.254Exposure 0.697Group CBT 0.441Group IPT0.147Overall0.282 | No association between overall effect size and type of intervention was observed. | Moderate-1 imprecise |
| Trauma onset (adult vs child) | Child +0.35 (+0.02, +0.69) | Child5% | Child 0.038 | Inclusion of participants with predominantly childhood-onset trauma is associated with a small-moderate reduction in effect size, compared to trials where participants have mainly adult-onset trauma | Low-1 imprecise-1 ecological bias |
|  |  |  |  |  |  |

Abbreviations: AD=affect dysregulation; CBT=cognitive behavioural therapy; DR=disturbances in relationships; EMDR=eye-movement and desensitisation and reprocessing therapy; k= number of included comparisons; NSC=negative self-concept; PTSD=posttraumatic stress disorder; CPTSD=complex posttraumatic stress disorder; TAU=treatment as usual; WL=waiting list.

**N. Forest Plots – Cognitive/imagery modification with or without exposure vs TAU/WL or non-specific control**

**Fig. N.1. Disturbances in relationships (DR): Cognitive/imagery modification with or without exposure vs TAU/WL**



Difede 2007 vs TAU DR

Ehlers 2005 vs WL DR

Dunne 2012 vs WL DR

Talbot 2014 vs WL DR

Foa 1999 vs WL DR

Monson 2006 vs WL DR

Power 2002 vs WL DR

Hollifield 2007 vs WL DR

Duffy 2007 vs WL DR

Galovski 2012 vs WL DR

Basoglu 2007 vs WL DR

Ehlers 2003 vs SH + WL DR

Foa 2005 vs WL DR

Ehlers 2014 vs WL DR

Krakow 2001 vs WL DR

Lindauer 2005 vs WL DR

**Fig. N.2. Disturbances in relationships (DR): Cognitive/imagery modification with or without exposure vs non-specific control**



Ehlers 2014 vs ST DR

Marks 1998 vs relax DR

Forbes 2012 vs range DR

**Fig. N.3. Affect dysregulation (AD): Cognitive/imagery modification with or without exposure vs TAU/WL**



Hinton 2009 vs WL AD

Cloitre 2002 vs WL AD

Monson 2006 vs WL AD

**Fig. N.4. Affect dysregulation (AD): Cognitive/imagery modification with or without exposure vs non-specific control**



Dunn 2007 PsyEd AD

Hinton 2011 vs PMR AD

**Fig. N.5. Negative self-concept (NSC): Cognitive/imagery modification with or without exposure vs TAU/WL**



Kubany 2003 vs WL NSC

Jung 2013 vs WL NSC

Monson 2006 vs WL NSC

McDonagh 2005 vs WL NSC

Mueser 2008 vs TAU NSC

Galovski 2012 vs WL NSC

Ford 2011 vs WL NSC

Resick 2002 vs WL NSC

Kubany 2004 vs WL NSC

**Fig. N.6. Negative self-concept (NSC): Cognitive/imagery modification with or without exposure vs non-specific control**



Suris 2013 vs PCT NSC

McDonagh 2005 vs PCT NSC

Ford 2011 vs control NSC

Mueser 2015 vs control NSC

**Fig. N.7. PTSD: Cognitive/imagery modification with or without exposure vs TAU/WL**



**Fig. N.8. PTSD: Cognitive/imagery modification with or without exposure vs non-specific control**



**Fig. N.9. PTSD plus 1, 2 or 3 CPTSD outcomes: Cognitive/imagery modification with or without exposure vs TAU/WL**



Kubany 2003 vs WL PTSD + NSC

Hinton 2009 vs WL PTSD + AD

Ehlers 2005 vs WL PTSD + DR

Dunne 2012 vs WL PTSD + DR

Difede 2007 vs TAU + DR

Jung 2013 vs WL PTSD + NSC

Cloitre 2002 vs WL PTSD + AD

Foa 1999 vs WL PTSD + DR

Talbot 2014 vs WL PTSD + DR

Power 2002 vs WL PTSD + DR

Steel 2017 vs TAU PTSD + NSC

Monson 2006 vs WL PTSD + AD + DR + NSC

Hollifield 2007 vs WL PTSD + DR

McDonagh 2005 vs WL PTSD + NSC

Duffy 2007 vs WL PTSD + DR

Lindauer 2005 vs WL PTSD + DR

Galovski 2012 vs WL PTSD + NSC + DR

Mueser 2008 vs TAU PTSD + NSC

Basoglu 2007 vs WL PTSD + DR

Ehlers 2003 vs SH + WL PTSD + DR

Dorrepaal 2012 vs TAU PTSD + AD + DR + NSC

Ehlers 2014 vs WL PTSD + DR

Foa 2005 vs WL PTSD + DR

Ford 2011 vs WL PTSD + NSC

Resick 2002 vs WL PTSD + NSC

Krakow 2001 vs WL PTSD + DR

Kubany 2004 vs WL PTSD + NSC

**Fig. N.10. PTSD plus 2 or 3 CPTSD outcomes: Cognitive/imagery modification with or without exposure vs TAU/WL**



Monson 2006 vs WL PTSD + AD + DR + NSC

Galovski 2012 vs WL PTSD + NSC + DR

Dorrepaal 2012 vs TAU PTSD + AD + DR + NSC

**Fig. N.11. PTSD plus all 3 CPTSD outcomes: Cognitive/imagery modification with or without exposure vs TAU/WL**



Monson 2006 vs WL PTSD + AD + DR + NSC

Dorrepaal 2012 vs TAU PTSD + AD + DR + NSC

**Fig. N.12. PTSD plus 1, 2 or 3 CPTSD outcomes: Cognitive/imagery modification with or without exposure vs non-specific control**



Hinton 2011 vs PMR PTSD + AD

McDonagh 2005 vs PCT + NSC

Marks 1998 vs relax PTSD + DR

Suris 2013 vs PCT PTSD + NSC

Forbes 2012 vs range PTSD + DR

Ehlers 2014 vs ST PTSD + DR

Ford 2011 vs control PTSD + NSC

Dunn 2007 vs PsyEd PTSD + AD

Mueser 2015 control PTSD + NSC

**O. Forest Plots – Exposure only vs TAU/WL or non-specific control**

**Fig. O.1. Disturbances in relationships (DR): Exposure only vs TAU/WL**



Foa 1999 vs WL DR

Keane 1989 vs WL DR

Foa 2005 vs WL DR

van den Berg 2015 vs WL DR

**Fig. O.2. Disturbances in relationships (DR): Exposure only vs non-specific control**



Ghafoori 2017 vs PCT DR

**Fig. O.3. Negative self-concept (NSC): Exposure only vs TAU/WL**



van den Berg 2015 vs WL NSC

Resick 2002 vs WL NSC

Pacella 2012 vs WL NSC

**Fig. O.4. PTSD: Exposure only vs TAU/WL**



**Fig. O.5. PTSD: Exposure only vs non-specific control**



**Fig. O.6. PTSD plus 1, 2 or 3 CPTSD outcomes: Exposure only vs TAU/WL**



Foa 1999 vs WL PTSD + DR

Keane 1989 vs WL PTSD + DR

Pacella 2012 vs WL PTSD + NSC

Foa 2005 vs WL PTSD + DR

van den Berg 2015 vs WL PTSD + NSC + DR

Resick 2002 vs WL PTSD + NSC

**Fig. O.7. PTSD plus 2 or 3 CPTSD outcomes: Exposure only vs TAU/WL**



van den Berg 2015 vs WL PTSD + NSC + DR

**Fig. O.8. PTSD plus 1, 2 or 3 CPTSD outcomes: Exposure only vs non-specific control**



Marks 1998 vs relax PTSD + DR

Ghafoori 2017 vs PCT DR

**P. Forest Plots – EMDR vs TAU/WL or non-specific control**

**Fig. P.1. Disturbances in relationships (DR): EMDR vs TAU/WL**



Ahmadi 2015 vs TAU DR

Hogberg 2007 vs WL DR

Power 2002 vs WL DR

van den Berg 2015 vs WL DR

**Fig. P.2. Disturbances in relationships (DR): EMDR vs non-specific control**



Ahmadi 2015 vs REM DR

Kip 2013 vs control DR

**Fig. P.3. Affect dysregulation (AD): EMDR vs TAU/WL**



Ahmadi 2015 vs TAU AD

**Fig. P.4. Affect dysregulation (AD): EMDR vs non-specific control**



Ahmadi 2015 vs REM AD

**Fig. P.5. Negative self-concept (NSC): EMDR vs TAU/WL**



van den Berg 2015 vs WL NSC

**Fig. P.6. Negative self-concept (NSC): EMDR vs non-specific control**



Kip 2013 vs control NSC

Scheck 1998 vs AL NSC

**Fig. P.7. PTSD: EMDR vs TAU/WL**



**Fig. P.8. PTSD: EMDR vs non-specific control**



Ahmadi 2015 vs REM PTSD

Kip 2013 vs control PTSD

Scheck 1998 vs AL PTSD

**Fig. P.9. PTSD plus 1, 2 or 3 CPTSD outcomes: EMDR vs TAU/WL**



Ahmadi 2015 vs TAU PTSD

Hogberg 2007 vs WL PTSD + DR

Power 2002 vs WL PTSD + DR

van den Berg 2015 vs WL PTSD + NSC + DR

**Fig. P.10. PTSD plus 2 or 3 CPTSD outcomes: EMDR vs TAU/WL**



Ahmadi 2015 vs TAU PTSD

van den Berg 2015 vs WL PTSD + NSC + DR

**Fig. P.11. PTSD plus 1, 2 or 3 CPTSD outcomes: EMDR vs non-specific control**



Ahmadi 2015 vs REM PTSD

Kip 2013 vs control PTSD + NSC + DR

Scheck 1998 vs AL PTSD + NSC

**Fig. P.12. PTSD plus 2 or 3 CPTSD outcomes: EMDR vs non-specific control**



Ahmadi 2015 vs REM PTSD

Kip 2013 vs control PTSD + NSC + DR

**Q. Forest Plots – Comparison of CBT, Exposure and EMDR**

**Fig. Q.1. Disturbances in relationships (DR): CBT vs Exposure alone**



Marks 1998 vs Exp DR

Foa 1999 vs Exp DR

Foa 2005 vs Exp DR

**Fig. Q.2. Negative self-concept (NSC): CBT vs Exposure alone**



Resick 2002 vs Exp NSC

**Fig. Q.3. PTSD: CBT vs Exposure alone**



**Fig. Q.4. PTSD plus 1, 2 or 3 CPTSD outcomes: CBT vs Exposure alone**



Marks 1998 vs Exp PTSD + DR

Foa 1999 vs Exp PTSD + DR

Resick 2002 vs Exp PTSD + NSC

Foa 2005 vs Exp PTSD + DR

**Fig. Q.5. Disturbances in relationships (DR): CBT vs EMDR**



Power 2002 vs EMDR DR

Nijdam 2012 vs EMDR DR

**Fig. Q.6. PTSD: CBT vs EMDR**



**Fig. Q.7. PTSD plus 1, 2 or 3 CPTSD outcomes: CBT vs EMDR**



Power 2002 vs EMDR PTSD + DR

Nijdam 2012 vs EMDR PTSD + DR

**Fig. Q.8. Disturbances in relationships (DR): EMDR vs Exposure alone**



van den Berg 2015 vs Exp DR

**Fig. Q.9. Negative self-concept (NSC): EMDR vs Exposure alone**



van den Berg 2015 vs Exp NSC

**Fig. Q.10. PTSD: EMDR vs Exposure alone**



**Fig. Q.11. PTSD plus 1, 2 or 3 CPTSD outcomes: EMDR vs Exposure alone**



van den Berg 2015 vs Exp PTSD + NSC + DR

**Fig. Q.12. PTSD plus 2 or 3 CPTSD outcomes: EMDR vs Exposure alone**



van den Berg 2015 vs Exp PTSD + NSC + DR

**R. Bubble Plots – Meta-regression Moderators (univariate)**

**Fig. R.1. Random sequence generation (low vs unclear or high risk of bias, k=52)**



**Fig. R.2. Allocation concealment (low vs unclear or high risk of bias, k=52)**



**Fig. R.3. Detection bias (low vs unclear or high risk of bias, k=52)**



**Fig. R.4. Selective reporting bias (low vs unclear or high risk of bias, k=52)**



**Fig. R.5. Attrition bias (low vs unclear or high risk of bias, k=52)**



**Fig. R.6. Overall quality (high quality vs low quality, k=52)**



**Fig. R.7. CPTSD symptoms (PTSD alone vs various CPTSD, k=52)**



 PTSD PTSD + AD PTSD + AD + DR + NSC PTSD + DR PTSD + NSC PTSD + NSC + DR

**Fig. R.8. Comparator (TAU/WL vs control, k=52)**



**Fig. R.9. Treatments (individual CBT vs others, k=52)**



**Fig. R.10. Therapy format (individual vs group, k=52)**



**Fig. R.11. Trauma onset (Adult vs child, k=48)**



**S. Bubble Plots – Meta-regression Moderators (multivariate)**

**Fig. S.1. Overall quality (high vs low)**



**Fig. S.2. CPTSD symptoms (PTSD alone vs various CPTSD)**



 PTSD PTSD + AD PTSD + AD + DR + NSC PTSD + DR PTSD + NSC PTSD + NSC + DR

**Fig. S.3. Comparator (TAU/WL vs control)**



**Fig. S.4. Treatments (individual CBT vs others)**



**Fig. S.5. Trauma onset (adult vs child)**



**T. Funnel Plots for Meta-analyses (where publication bias is indicated)**

**Fig. T.1. Disturbances in relationships (DR): Cognitive/imagery modification with or without exposure vs TAU/WL**



**Fig. T.2. PTSD: Cognitive/imagery modification with or without exposure vs TAU/WL**



**Fig. T.3. PTSD plus 1, 2 or 3 CPTSD outcomes: Cognitive/imagery modification with or without exposure vs TAU/WL**



**U. PRISMA Checklist**

| **Section/topic**  | **#** | **Checklist item**  | **Reported** |
| --- | --- | --- | --- |
| **TITLE**  |  |
| Title  | 1 | Identify the report as a systematic review, meta-analysis, or both.  | Yes |
| **ABSTRACT**  |  |
| Structured summary  | 2 | Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.  | Yes |
| **INTRODUCTION**  |  |
| Rationale  | 3 | Describe the rationale for the review in the context of what is already known.  | Yes |
| Objectives  | 4 | Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).  | Yes |
| **METHODS**  |  |
| Protocol and registration  | 5 | Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.  | Yes |
| Eligibility criteria  | 6 | Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.  | Yes |
| Information sources  | 7 | Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.  | Yes |
| Search  | 8 | Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.  | Yes |
| Study selection  | 9 | State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).  | Yes |
| Data collection process  | 10 | Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.  | Yes |
| Data items  | 11 | List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.  | Yes |
| Risk of bias in individual studies  | 12 | Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.  | Yes |
| Summary measures  | 13 | State the principal summary measures (e.g., risk ratio, difference in means).  | Yes |
| Synthesis of results  | 14 | Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I2) for each meta-analysis.  | Yes |

| **Section/topic**  | **#** | **Checklist item**  | **Reported** |
| --- | --- | --- | --- |
| Risk of bias across studies  | 15 | Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).  | Yes |
| Additional analyses  | 16 | Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.  | Yes |
| **RESULTS**  |  |
| Study selection  | 17 | Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.  | Yes |
| Study characteristics  | 18 | For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.  | Yes |
| Risk of bias within studies  | 19 | Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).  | Yes |
| Results of individual studies  | 20 | For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.  | Yes |
| Synthesis of results  | 21 | Present results of each meta-analysis done, including confidence intervals and measures of consistency.  | Yes |
| Risk of bias across studies  | 22 | Present results of any assessment of risk of bias across studies (see Item 15).  | Yes |
| Additional analysis  | 23 | Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).  | Yes |
| **DISCUSSION**  |  |
| Summary of evidence  | 24 | Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).  | Yes |
| Limitations  | 25 | Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).  | Yes |
| Conclusions  | 26 | Provide a general interpretation of the results in the context of other evidence, and implications for future research.  | Yes |
| **FUNDING**  |  |
| Funding  | 27 | Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.  | N/A |

**V. References for the 51 Included Studies**

**Ahmadi K, Hazrati M, Ahmadizadeh M and Noohi S** (2015)REM desensitization as a new therapeutic method for post-traumatic stress disorder: a randomized controlled trial. *Acta Medica Indonesian,* **47**, 111–119.

**Azad Marzabadi E and Hashemi Zadeh SM** (2014) The Effectiveness of Mindfulness Training in Improving the Quality of Life of the War Victims with Post Traumatic stress disorder (PTSD) *Iranian Journal of Psychiatry* **9,** 228–236.

**Başoǧlu M, Şalcioǧlu 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**, 203–213.

**Beidel DC, Frueh BC, Neer SM, Bowers CA , Trachik B, Uhde TW and Grubaugh A** (2019)Trauma management therapy with virtual-reality augmented exposure therapy for combat-related PTSD: A randomized controlled trial. *Journal of Anxiety Disorders* **61**, 64–74.

**Beidel DC, Frueh BC, Uhde TW, Wong N and Mentrikoski, JM** (2011) Multicomponent behavioral treatment for chronic combat-related posttraumatic stress disorder: A randomized controlled trial. *Journal of Anxiety Disorders* **25**, 224–231.

**Bryant RA, Mastrodomenico J, Hopwood S, Kenny L, Cahill C, Kandris E and Taylor K** (2013) Augmenting cognitive behaviour therapy for post-traumatic stress disorder with emotion tolerance training: A randomized controlled trial. *Psychological Medicine* **43**, 2153–2160.

**Butollo W, Karl R, König J, and Rosner R** (2016) 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* **85**, 16–26.

**Cloitre M, Koenen KC, Cohen LR and Han H** (2002) Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology* **70**, 1067–1074.

**Difede J, Malta LS, Best S, Henn-Haase C, Metzler T, Bryant R and Marmar C** (2007) A Randomized Controlled Clinical Treatment Trial for World Trade Center Attack-Related PTSD in Disaster Workers. *The Journal of Nervous and Mental Disease* **195**, 861–865.

**Dorrepaal E, Thomaes K, Smit JH, Van Balkom AJLM , Veltman DJ, Hoogendoorn AW and Draijer N** (2012**)** Stabilizing group treatment for complex posttraumatic stress disorder related to child abuse based on psychoeducation and cognitive behavioural therapy: A multisite randomized controlled trial. *Psychotherapy and Psychosomatics* **81**, 217–225.

**Duffy M, Gillespie K and Clark DM** (2007) Post-traumatic stress disorder in the context of terrorism and other civil conflict in Northern Ireland: randomised controlled trial. *British Journal of Medicine* **334**, 1147. doi: 10.1136/bmj.39021.846852.BE.

**Dunn NJ, Rehm LP, Schillaci J, Souchek J, Mehta P, Ashton CM, Yanasak E and Hamilton JD** (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**, 221–237.

**Dunne RL, Kenardy J and Sterling M** (2012) A Randomized Controlled Trial of Cognitive-behavioral Therapy for the Treatment of PTSD in the Context of Chronic Whiplash. *The Clinical Journal of Pain* **28,** 755–765.

**Ehlers A, Hackmann A, Grey N, Wild J, Liness S, Albert I, Deale A,** Stott R and Clark **DM** (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**, 294–304.

**Ehlers A, Clark DM, Hackmann A, McManus F and Fennell M** (2005) Cognitive therapy for post-traumatic stress disorder: development and evaluation. *Behaviour Research and Therapy***43**, 413–431*.*

**Ehlers A, Clark DM, Hackmann A , McManus F, Fennell M, Herbert C and Mayou R** (2003) A randomized controlled trial of cognitive therapy, a self-help booklet, and repeated assessments as early interventions for posttraumatic stress disorder. *Archives of General Psychiatry* **60**, 1024–1032.

**Foa EB, Dancu CV, Hembree EA, Jaycox LH, Meadows EA and Street GP** (1999) A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology* **67**, 194–200.

**Foa EB, Hembree E, Cahill S, Rauch S, Riggs D, Feeny N and Yadin E** (2005) Randomized Trial of Prolonged Exposure for Posttraumatic Stress Disorder With and Without Cognitive Restructuring: Outcome at Academic and Community Clinics. *Journal of Consulting and Clinical Psychology* **73**, 953–964.

**Forbes D, Lloyd D, Nixon RD, Elliott P, Varker T, Perry D, Bryant RA and Creamer M.** (2012) A multisite randomized controlled effectiveness trial of cognitive processing therapy for military-related posttraumatic stress disorder. *Journal of Anxiety Disorders* **26**, 442–452.

**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**, 560-78.

**Galovski TE, Blain LM, Mott JM, Elwood L and Houle T** (2012) Manualized therapy for PTSD: Flexing the structure of cognitive processing therapy. *Journal of Consulting and Clinical Psychology* **80**, 968–981.

**Ghafoori B, Hansen MC, Garibay E and Korosteleva O** (2017) Feasibility of training frontline therapists in prolonged exposure a randomized controlled pilot study of treatment of complex trauma in diverse victims of crime and violence. *Journal of Nervous and Mental Disease* **205**, 283–293.

**Harned MS, Korslund KE and Linehan MM** (2014) 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* **55,** 7–17.

**Hinton DE, Hofmann SG, Pollack MH and Otto MW** (2009) Mechanisms of efficacy of CBT for cambodian refugees with PTSD: Improvement in emotion regulation and orthostatic blood pressure response. *CNS Neuroscience and Therapeutics* **15**, 255–263.

**Hinton DE, Hofmann SG, Rivera E, Otto MW and Pollack MH** (2011) Culturally adapted CBT (CA-CBT) for Latino women with treatment-resistant PTSD: A pilot study comparing CA-CBT to applied muscle relaxation. *Behaviour Research and Therapy* **49,** 275–280.

**Högberg G, Pagani M, Sundin O, Soares J, Aberg-Wistedt A, Tärnell B and Hällström** T (2007) 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* **61**, 54–61.

**Hollifield M, Sinclair-Lian N, Warner TD and Hammerschlag R** (2007) Acupuncture for posttraumatic stress disorder: a randomized controlled pilot trial. *Journal of Nervous and Mental Disease* **195**, 504–513.

**Jung, K and Steil R** (2013) A randomized controlled trial on cognitive restructuring and imagery modification to reduce the feeling of being contaminated in adult survivors of childhood sexual abuse suffering from posttraumatic stress disorder. *Psychotherapy & Psychosomatics* **82**, 213–220.

**Keane TM, Fairbank, JA, Caddell JM and Zimering, RT** (1989) Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans. *Behavior Therapy* **20,** 245–260.

**Kip KE, Rosenzweig L, Hernandez DF, Shuman A, Sullivan KL, Long CJ, Taylor J, McGhee S, Girling SA, Wittenberg T, Sahebzamani FM, Lengacher CA, Kadel R and Diamond DM** (2013) Randomized Controlled Trial of Accelerated Resolution Therapy (ART) for Symptoms of Combat-Related Post-Traumatic Stress Disorder (PTSD) *Military Medicine* **178**, 1298–1309.

**Krakow B, Hollifield M, Johnston L, Koss M, Schrader R, Warner TD, Tandberg D, Lauriello J, McBride L, Cutchen L, Cheng D, Emmons S, Germain A, Melendrez D, Sandoval D and Prince H** (2001) Imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder: A randomized controlled trial. *Journal of the American Medical Association* **286**, 537–545.

**Krupnick JL, Green BL, Stockton P, Miranda J, Krause E and Mete M** (2008) Group interpersonal psychotherapy for low-income women with posttraumatic stress disorder. *Psychotherapy Research* **18**, 409–507.

**Kubany ES, Hill EE and Owens JA** (2003) Cognitive trauma therapy for battered women with PTSD: preliminary findings. *Journal of Traumatic Stress* **16**, 81–91.

**Kubany ES, Hill EE, Owens JA, Iannce-Spencer C, McCaig MA, Tremayne KJ and Williams PL** (2004) Cognitive Trauma Therapy for Battered Women with PTSD (CTT-BW) *Journal of Consulting and Clinical Psychology* **72**, 3–18.

**Lindauer RJ, Gersons BP, van Meijel EP, Blom K, Carlier IV, Vrijlandt I and Olff M** (2005) Effects of brief eclectic psychotherapy in patients with posttraumatic stress disorder: Randomized clinical trial. *Journal of Traumatic Stress* **18,** 205–212.

**Marks I, Lovell K and Noshirvani H** (1998) Treatment of posttraumatic stress disorder by exposure and/or cognitive restructuring: a controlled study. *Archives of General* **55**, 317–325.

**McDonagh A, Friedman M, McHugo G, Ford J, Sengupta A, Mueser K, Demment CC, Fournier D, Schnurr PP and Descamps M** (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**, 515–524.

**Monson CM, Schnurr PP, Resick PA, Friedman MJ, Young-Xu Y and Stevens SP.** (2006) Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology* ***74***, 898–907.

**Mueser KT, Gottlieb JD, Xie H, Lu W, Yanos PT, Rosenberg SD, Silverstein SM, Duva SM, Minsky S, Wolfe RS and McHugo GJ** (2015) Evaluation of cognitive restructuring for post-traumatic stress disorder in people with severe mental illness. *British Journal of Psychiatry* **206**, 501–508.

**Mueser KT, Rosenberg SD, Xie H, Jankowski MK, Bolton EE, Lu W, Hamblen JL, Rosenberg HJ, McHugo GJ and Wolfe R** (2008) A Randomized Controlled Trial of Cognitive-Behavioral Treatment for Posttraumatic Stress Disorder in Severe Mental Illness*. Journal of Consulting and Clinical Psychology* **76**, 259–271.

**Nijdam MJ, Gersons BP, Reitsma JB, de Jongh A and Olff M** (2012) Brief eclectic psychotherapy v. eye movement desensitisation and reprocessing therapy for post-traumatic stress disorder: Randomised controlled trial. *British Journal of Psychiatry* **200**, 224–231.

**Pacella ML, Armelie A, Boarts J, Wagner G, Jones T, Feeny N and Delahanty DL** (2012) The impact of prolonged exposure on PTSD symptoms and associated psychopathology in people living with HIV: A randomized test of concept. *AIDS and* *Behavior* **16**, 1327–1340.

**Power K, McGoldrick T , Brown K, Buchanan R , Sharp D, Swanson V and Karatzias A** (2002) A controlled comparison of Eye Movement Desensitization and Reprocess- ing versus exposure plus cognitive restructuring versus waiting list in the treatment of Post-traumatic Stress Disorder. *Clinical Psychology and Psychotherapy* **9**, 299–318.

**Resick PA, Nishith P, Weaver TL, Astin MC and Feuer CA** (2002) A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology* **70**, 867–879.

**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**, 25–44.

**Steel C, Hardy A, Smith B, Wykes T, Rose S, Enright S, Hardcastle M, Landau S, Baksh MF, Gottlieb JD, Rose D and Mueser KT** (2017) Cognitive–behaviour therapy for post-traumatic stress in schizophrenia. A randomized controlled trial. *Psychological Medicine* **47**, 43–51.

**Surís A, Link-Malcolm J, Chard K, Ahn C and North C** (2013) A randomized clinical trial of cognitive processing therapy for veterans with PTSD related to military sexual trauma. *Journal of Traumatic Stress* **26**, 28–37.

**Talbot LS, Maguen S, Metzler TJ, Schmitz M, McCaslin SE, Richards A, Perlis ML, Posner DA, Weiss B, Ruoff L, Varbel J and Neylan TC** (2014) Cognitive behavioral therapy for insomnia in posttraumatic stress disorder: a randomized controlled trial. *Sleep* **37**, 327–341.

**Ter Heide FJ, Mooren TM, Kleijn W, de Jongh A and Kleber RJ** (2011) EMDR versus stabilisation in traumatised asylum seekers and refugees: results of a pilot study. *European Journal of Psychotraumatology* **2**, 5881. doi: 10.3402/ejpt.v2i0.5881

**Ter Heide FJ, Mooren TM, van de Schoot R, de Jongh A and Kleber RJ** (2016) Eye movement desensitisation and reprocessing therapy v. stabilisation as usual for refugees: Randomised controlled trial. *British Journal of Psychiatry* **209**, 311–318.

**Van den Berg DP, de Bont PA, van der Vleugel BM, de Roos C, de Jongh A, Van Minnen A and van der Gaag M** (2015) Prolonged Exposure vs Eye Movement Desensitization and Reprocessing vs Waiting List for Posttraumatic Stress Disorder in Patients With a Psychotic Disorder. *Journal of the American Medical Association* *Psychiatry* **72** , 259- 267.

**W. References for Excluded Studies**

**Acarturk C, Konuk E, Cetinkaya M, Senay I, Sijbrandij M, Gulen B and Cuijpers P** (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**, 2583- 2593.

**Acierno R, Knapp R, Tuerk P, Gilmore AK, Lejuez C, Ruggiero K, Muzzy W, Egede L, Hernandez-Tejada MA and Foa EB** (2017) A non-inferiority trial of Prolonged Exposure for posttraumatic stress disorder: In person versus home-based telehealth. *Behaviour Research and Therapy* **89**, 57–65.

**Akbarian F, Bajoghli H, Haghighi M, Kalak N, Holsboer-Trachsler E and Brand S** (2015) The effectiveness of cognitive behavioral therapy with respect to psychological symptoms and recovering autobiographical memory in patients suffering from post-traumatic stress disorder. *Neuropsychiatric Disease and Treatment* **11**, 395–404.

**Alghamdi M, Hunt N and Thomas S** (2015) The effectiveness of Narrative Exposure Therapy with traumatised firefighters in Saudi Arabia: A randomized controlled study. *Behaviour Research and Therapy* **66**, 64–71.

**Arntz A, Tiesema M and Kindt M** (2007) Treatment of PTSD: A comparison of imaginal exposure with and without imagery rescripting. *Journal of Behavior Therapy and Experimental Psychiatry* **38**, 345–370.

**Asukai N, Saito A, Tsuruta N, Kishimoto J and Nishikawa T** (2010) Efficacy of exposure therapy for Japanese patients with posttraumatic stress disorder due to mixed traumatic events: A randomized controlled study. *Journal of Traumatic Stress* **23**, 744–750.

**Badura-Brack A, McDermott TJ, Becker KM, Ryan TJ, Khanna MM, Pine DS, Bar-Haim Y, Heinrichs-Graham E and Wilson TW** (2018) Attention training modulates resting-state neurophysiological abnormalities in posttraumatic stress disorder. *Psychiatry Research – Neuroimaging* **271**, 135–141.

**Bass J, Murray S, Cole G, Bolton P, Poulton C, Robinette K, Seban J, Falb K and Annan J** (2016)Economic, social and mental health impacts of an economic intervention for female sexual violence survivors in Eastern Democratic Republic of Congo. *Global Mental Health*  **6**, doi: 10.1017/gmh.2016.13.

**Beidel DC, Stout JW, Neer SM, Frueh BC and Lejuez C** (2017) An intensive outpatient treatment program for combat-related PTSD: Trauma management therapy. *Bulletin of the Menninger Clinic* **81**, 107–122.

**Belleau EL, Chin EG, Wanklyn SG, Zambrano-Vazquez L, Schumacher JA and Coffey SF** (2017) 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* **91**, 43–50.

**Betancourt TS, McBain R, Newnham EA, Akinsulure-Smith AM, Brennan RT, Weisz JR and Hansen NB** (2014) A behavioral intervention for war-affected youth in Sierra Leone: A randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry* **53**, 1288–1297.

**Bichescu D, Neuner F, Schauer M and Elbert T** (2007) Narrative exposure therapy for political imprisonment-related chronic posttraumatic stress disorder and depression. *Behaviour Research and Therapy* **45**, 2212–2220.

**Blanchard EB, Hickling EJ, Devineni T, Veazey CH, Galovski TE, Mundy E, Malta LS and Buckley TC** (2003) A controlled evaluation of cognitive behavioral therapy for posttraumatic stress in motor vehicle accident survivors. *Behaviour Research and Therapy* **41**, 79–96.

**Boden MT, Kimerling R, Jacobs-Lentz J, Bowman D, Weaver C, Carney D, Walser R and Trafton JA** (2012) Seeking Safety treatment for male veterans with a substance use disorder and post-traumatic stress disorder symptomatology. *Addiction* 107, 578–586.

**Bohus M, Dyer AS, Priebe K, Krüger A, Kleindienst N, Schmahl C, Niedtfeld I and Steil R.** (2013) Dialectical behaviour therapy for post-traumatic stress disorder after childhood sexual abuse in patients with and without borderline personality disorder: A randomised controlled trial. *Psychotherapy and Psychosomatics* **82**, 221-233.

**Bormann JE, Hurst S and Kelly A** (2013) Responses to Mantram Repetition Program from Veterans with posttraumatic stress disorder: A qualitative analysis. *Journal of Rehabilitation Research and Development* **50**, 769–784.

**Bormann JE, Oman D, Walter KH and Johnson BD** (2014) Mindful Attention Increases and Mediates Psychological Outcomes Following Mantram Repetition Practice in Veterans With Posttraumatic Stress Disorder. *Medical Care* **52**, S13–S18.

**Bradley RG and Follingstad DR** (2003) Group therapy for incarcerated women who experienced interpersonal violence: A pilot study. *Journal of Traumatic Stress* **16**, 337–340.

**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. *Frontiers in Psychiatry* **8**, 157.

**Brom D, Kleber RJ and Defares PB** (1989) Brief psychotherapy for posttraumatic stress disorders. *Journal of Consulting and Clinical Psychology* **57**, 607–612.

**Brunet A (2013)** Randomized controlled trial of a brief dyadic cognitive-behavioral intervention designed to prevent PTSD. *European Journal of Psych traumatology* **4**, doi: 10.3402/ejpt.v4i0.21572

**Bryan CJ, Clemans TA, Hernandez AM, Mintz J, Peterson AL, Yarvis JS, Resick PA and STRONG STAR Consortium** (2016) Evaluating Potential Iatrogenic Suicide Risk in Trauma-Focused Group Cognitive Behavioral Therapy for the Treatment of PTSD in Active Duty Military Personnel. *Depression and Anxiety* **33**, 549–557.

**Bryant RA, Moulds ML and Nixon RV** (2003) Cognitive behaviour therapy of acute stress disorder: a four-year follow-up. *Behaviour Research and Therapy* **41**, 489–494.

**Bryant RA, Felmingham K, Whitford TJ, Kemp A, Hughes G, Peduto A and Williams LM** (2008) Rostral anterior cingulate volume predicts treatment response to cognitive-behavioural therapy for posttraumatic stress disorder. *Journal of Psychiatry and Neuroscience* **33**, 142–146.

**Buhmann CB, Nordentoft M, Ekstroem M, Carlsson J and Mortensen EL** (2016) The effect of flexible cognitive-behavioural therapy and medical treatment, including antidepressants on post-traumatic stress disorder and depression in traumatised refugees: pragmatic randomised controlled clinical trial. *The British Journal of Psychiatry* **208**, 252-259.

**Carlson JG, Chemtob CM, Rusnak K, Hedlund NL and Muraoka MY** (1998) Eye movement desensitization and reprocessing (EDMR) treatment for combat-related posttraumatic stress disorder. *Journal of Traumatic Stress*, **11**, 3-24.

**Castillo DT, Chee CL, Nason E, Keller J, C'de Baca J, Qualls C, Fallon SK, Haaland KY, Miller MW and Keane TM** (2016) Group-delivered cognitive/exposure therapy for PTSD in women veterans: A randomized controlled trial. *Psychological Trauma: Theory, Research, Practice and Policy* **8**, 404–412.

**Catani C, Kohiladevy M, Ruf M, Schauer E, Elbert T and Neuner F** (2009) Treating children traumatized by war and Tsunami: A comparison between exposure therapy and meditation-relaxation in North-East Sri Lanka. *BioMed Central Psychiatry* **9**, doi: 10.1186/1471-244X-9-22

**Chard KM** (2005) An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology* **73**, 965–971.

**Classen C, Butler LD, Koopman C, Miller E, DiMiceli S, Giese-Davis J, Fobair P, Carlson RW, Kraemer HC and Spiegel D** (2001) Supportive expressive group therapy and distress in patients with metastatic breast cancer: a randomized clinical intervention trial. *Archives of General Psychiatry* **58**, 494–501.

**Cloitre M, Stovall-Mc Clough KC, Nooner K, Zorbas P, Cherry S, Jackson CL Gan W and Petkova E** (2010) Treatment for PTSD related to childhood abuse: A randomized controlled trial. *American Journal of Psychiatry* **167**, 915–924.

**Cloitre M, Petkova E, Wang J and Lu Lassell F** (2012) 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* **29**,709–717.

**Coffey SF, Schumacher JA, Nosen E, Littlefield AK, Henslee AM, Lappen A, Stasiewicz PR** (2016)Trauma-focused exposure therapy for chronic posttraumatic stress disorder in alcohol and drug dependent patients: A randomized controlled trial. *Psychology of Addictive Behaviors* **30**, 778-790.

**Cook JM, Harb GC, Gehrman PR, Cary MS, Gamble GM, Forbes D and Ross RJ** (2010) Imagery rehearsal for posttraumatic nightmares: A randomized controlled trial. *Journal of Traumatic Stress* **23**, 553–563.

**Cooper NA and Clum GA** (1989) Imaginal flooding as a supplementary treatment for PTSD in combat veterans: a controlled study. *Behavior Therapy* **20**, 381–391.

**Cooper AA, Kline AC, Graham B, Bedard-Gilligan M, Mello PG, Feeny NC and Zoellner LA** (2017) Homework “Dose,” Type, and Helpfulness as Predictors of Clinical Outcomes in Prolonged Exposure for PTSD. *Behavior Therapy* **48**, 182–194.

**Cottraux J, Note I, Yao SN, de Mey-Guillard C, Bonasse F, Djamoussian D, Mollard E, Note B and Chen Y** (2008) Randomized controlled comparison of cognitive behavior therapy with rogerian supportive therapy in chronic post-traumatic stress disorder: A 2-year follow-up. *Psychotherapy and Psychosomatics* **77**, 101–110.

**De Bont PA, van den Berg DP, van der Vleugel BM, de Roos C, de Jongh A, van der Gaag M and van Minnen AM** (2016) Prolonged exposure and EMDR for PTSD v. a PTSD waiting-list condition: Effects on symptoms of psychosis, depression and social functioning in patients with chronic psychotic disorders. *Psychological Medicine* **46**, 2411–2421.

**Devilly, GJ, Spence SH and Rapee RM** (1998) Statistical and reliable change with eye movement desensitization and reprocessing: Treating trauma within a veteran population. *Behaviour Therapy* **29**, 435–455.

**Devilly GJ and Spence SH** (1999) 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* **13**,131–157.

**Echeburúa E, de Corral P, Zubizarreta I and Sarasua B** (1997) Psychological treatment of chronic posttraumatic stress disorder in victims of sexual aggression. *Behavior Modification* **21**, 433–456.

**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**, 69–86.

**Edmond T, Rubin A and Wambach KG** (1999)The effectiveness of EMDR with adult female survivors of childhood sexual abuse. *Social Work Research* **23**, 103–116.

**Ertl V, Pfeiffer A, Schauer E, Elbert T and Neuner F** (2011) Community-implemented trauma therapy for former child soldiers in Northern Uganda: a randomized controlled trial. *Journal of the American Medical Association* **306**, 503-512.

**Fecteau G and Nicki R** (1999) Cognitive behavioural treatment of post-traumatic stress disorder after motor vehicle accident. *Behavioural and Cognitive Psychotherapy* **27**, 201–214.

**Feeny NC Zoellner LA and Foa EB** (2002) Treatment Outcome for Chronic PTSD Among Female Assault Victims With Borderline Personality Characteristics : a Preliminary Examination. *Journal of Personality Disorders* **16**, 30-40.

**Feske U(2008)** 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*, **23**, 1027–1040.

**Foa EB, Asnaani A, Rosenfield D, Zandberg LJ, Gariti P and Imms P** (2017) Concurrent varenicline and prolonged exposure for patients with nicotine dependence and PTSD: A randomized controlled trial. *Journal of Consulting and Clinical Psychology* **85,** 862–872.

**Foa EB, Rothbaum BO, Riggs DS and Murdock TB** (1991) Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counselling. *Journal of Consulting and Clinical Psychology* **59,** 715–723.

**Foa EB and Rauch SA** (2004) 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* **72**, 879–884.

**Foa EB, Yusko DA, McLean CP, Suvak MK, Bux DA Jr, Oslin D, O'Brien CP, Imms P, Riggs DS and Volpicelli J** (2013) Concurrent naltrexone and prolonged exposure therapy for patients with comorbid alcohol dependence and PTSD: a randomized clinical trial. *Journal of the American Medical Association*, **310**, 488–495.

**Fredman SJ, Pukay-Martin ND, Macdonald A, Wagner AC, Vorstenbosch V and Monson CM** (2016) Partner Accommodation Moderates Treatment Outcomes for Couple Therapy for Posttraumatic Stress Disorder. *Journal of Consulting & Clinical Psychology* **84,** 79–87.

**Gamito P, Oliveira J, Rosa P, Morais D, Duarte N, Oliveira S and Saraiva T** (2010) PTSD Elderly War Veterans: A Clinical Controlled Pilot Study. *Cyberpsychology, Behavior, and Social Networking*, **13**, 43–48.

**Gersons BP, Carlier IV, Lamberts RD and van der Kolk BA** (2000) Randomized clinical trial of brief eclectic psychotherapy for police officers with posttraumatic stress disorder. *Journal of Traumatic Stress* **13**, 333-47.

**Gilboa-Schechtman E, Foa EB, Shafran N, Aderka IM, Powers MB, Rachamim L, Rosenbach L, Yadin E and Apter A (2010)** Prolonged exposure versus dynamic therapy for adolescent PTSD : a pilot randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry* **49**, 1034–1042.

**Glynn SM, Eth S, Randolph ET, Foy DW, Urbaitis M, Boxer L, Paz GG, Leong GB, Firman G, Salk JD, Katzman JW and Crothers J** (1999) A test of behavioral family therapy to augment exposure for combat-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology* **67**, 243–251.

**Goldstein LA, Mehling WE, Metzler TJ, Cohen BE, Barnes DE, Choucroun GJ, Silver A, Talbot LS, Maguen S, Hlavin JA, Chesney MA and Neylan TC** (2018) Veterans Group Exercise: A randomized pilot trial of an Integrative Exercise program for veterans with posttraumatic stress. *Journal of Affective Disorders* **227**, 345-352.

**Gutner CA, Gallagher MW, Baker AS, Sloan DM and Resick PA** (2016) Time Course of Treatment Dropout in Cognitive-Behavioral Therapies for Posttraumatic Stress Disorder. *Psychological Trauma: Theory, Research, Practice and Policy* **8**, 115–121.

**Hien DA, Cohen LR, Miele GM, Litt LC and Capstick** C (2004) Promising Treatments for Women With Comorbid PTSD and Substance Use Disorders. *The American Journal of Psychiatry* **161**, 1426-32.

**Hien DA, Lopez-Castro T, Papini S, Gorman B and Ruglass LM** (2017) Emotion dysregulation moderates the effect of cognitive behavior therapy with prolonged exposure for co-occurring PTSD and substance use disorders. *Journal of Anxiety Disorders* **52**, 53–61

**Hien DA, Ruglass L and Back S** (2017) Concurrent treatment with prolonged exposure for co-occurring PTSD and substance use disorders: A randomized clinical trial. *Drug and Alcohol Dependence* **171,** e88-e89.

**Hien DA, Wells EA, Jiang H, Suarez-Morales L, Campbell AN, Cohen LR, Miele GM, Killeen T, Brigham GS, Zhang Y, Hansen C, Hodgkins C, Hatch-Maillette M, Brown C, Kulaga A, Kristman-Valente A, Chu M, Sage R, Robinson JA, Liu D and Nunes EV** (2009) Multi-site randomized trial of behavioral interventions for women with co-occurring PTSD and substance use disorders. Journal of Consulting and Clinical Psychology**77,** 607–619. <https://doi.org/10.1037/a0016227>

**Hinton DE, Chhean D, Pich V, Safren SA, Hofmann SG and Pollack MH (2005)** A randomized controlled trial of cognitive-behavior therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: A cross-over design. *Journal of Traumatic Stress* **18,** 617–629.

**Holliday R, Link-Malcolm J, Morris EE and Surís A** (2014) Effects of Cognitive Processing Therapy on PTSD-Related Negative Cognitions in Veterans With Military Sexual Trauma. *Military Medicine* **179**, 1077–1082.

**Holliday R, Williams R, Bird J, Mullen K and Surís A** (2015) 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* **12**, 428-34.

**Ironson G, Freund B, Strauss JL and Williams J** (2002) Comparison of two treatments for traumatic stress: A community-based study of EMDR and prolonged exposure. *Journal of Clinical Psychology* **58**, 113–128.

**Jacob N, Neuner F, Maedl A, Schaal S and Elbert T** (2014) Dissemination of psychotherapy for trauma spectrum disorders in postconflict settings: A randomized controlled trial in Rwanda. *Psychotherapy and Psychosomatics* **83,** 354–363.

**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. *Behaviour Therapy* **25,** 311–325.

**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**, 351746. doi: 10.1155/2015/351746

**Johnson DM, Johnson NL, Perez SK, Palmieri PA and Zlotnick C** (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**, 365–373.

**Johnson DM, Zlotnick C and Perez S** (2011) Cognitive-Behavioral Treatment of PTSD in Residents of Battered Women Shelters: Results of a Randomized Clinical Trial. *Journal of Consulting and Clinical Psychology* **79**, 542–551.

**Kearney DJ, McDermott K, Malte C, Martinez M and Simpson T** (2013) Effects of Participation in a Mindfulness Program for Veterans With Posttraumatic Stress Disorder: A Randomized Controlled Pilot Study. *Journal of Clinical Psychology* **69,** 14–27.

**Kearney DJ, Simpson TL, Malte CA, Felleman B, Martinez ME and Hunt SC** (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. *American Journal of Medicine* **129**, 204–214.

**Kip KE, Rosenzweig L, Hernandez DF, Shuman A, Diamond DM, Girling SA, Sullivan KL, Wittenberg T, Witt AM, Lengacher CA, Anderson B and McMillan SC** (2014) Accelerated Resolution Therapy for treatment of pain secondary to symptoms of combat-related posttraumatic stress disorder. *European Journal of Psychotraumatology* **5**, 10.3402/ejpt.v5.24066. doi:10.3402/ejpt.v5.24066

**König J, Onnen M, Karl R, Rosner R and Butollo W** (2016) Interpersonal Subtypes and Therapy Response in Patients Treated for Posttraumatic Stress Disorder. *Clinical Psychology & Psychotherapy* **23,** 97–106.

**Kruse J, Joksimovic L, Cavka M, Wöller W and Schmitz N** (2009) Effects of trauma-focused psychotherapy upon war refugees. *Journal of Traumatic Stress* **22**, 585–592.

**Lange A, Rietdijk D, Hudcovicova M, van de Ven JP, Schrieken B and Emmelkamp PM (2003)** Interapy: A controlled randomized trial of the standardized treatment of posttraumatic stress through the internet. *Journal of Consulting and Clinical Psychology* **71**, 901–909.

**Lee C, Gavriel H, Drummond P, Richards J and Greenwald R** (2002) Treatment of PTSD: Stress inoculation training with prolonged exposure compared to EMDR. *Journal of Clinical Psychology* **58**, 1071–1089.

**Levi O, Bar-Haim Y, Kreiss Y and Fruchter E** (2016) Cognitive-Behavioural Therapy and Psychodynamic Psychotherapy in the Treatment of Combat-Related Post-Traumatic Stress Disorder: A Comparative Effectiveness Study. *Clinical Psychology & Psychotherapy* **23**, 298-307.

**Liedl A, Müller J, Morina N, Karl A, Denke C and Knaevelsrud C** (2011) Physical Activity within a CBT Intervention Improves Coping with Pain in Traumatized Refugees: Results of a Randomized Controlled Design. *Pain Medicine* **12**, 234–245.

**Litz BT, Engel CC, Bryant RA and Papa A (2007)** A randomized, controlled proof-of-concept trial of an internet-based, therapist-assisted self-management treatment for posttraumatic stress disorder. *American Journal of Psychiatry* **164,** 1676–1683.

**Lovell K, Marks IM, Noshirvani H, Thrasher S, and Livanou M** (2001) Do cognitive and exposure treatments improve various PTSD symptoms differently? A randomized controlled trial. *Behavioural and Cognitive Psychotherapy* **29**, 107–112.

**Macdonald A, Pukay-Martin ND, Wagner AC, Fredman SJ, Monson CM** (2016) Cognitive-behavioral conjoint therapy for PTSD improves various PTSD symptoms and trauma-related cognitions: Results from a randomized controlled trial. *Journal of Family Psychology* **30**, 157–162.

**Marcus SV, Marquis P and Sakai C** (1997) Controlled study of treatment of PTSD using EMDR in an HMO setting. *Psychotherapy* **34,** 307–315.

**Markowitz JC, Petkova E, Neria Y, Van Meter PE, Zhao Y, Hembree E, Lovell K, Biyanova T and Marshall RD** (2015) Is exposure necessary? A randomized clinical trial of interpersonal psychotherapy for PTSD. *American Journal of Psychiatry* **172**, 430–440.

**Markowitz JC, Neria Y, Lovell K, Van Meter PE and Petkova E** (2017) History of sexual trauma moderates psychotherapy outcome for posttraumatic stress disorder. *Depression and Anxiety* **34**, 692-700.

**Maxwell K, Callahan JL, Holtz P, Janis BM, Gerber MM and Connor DR** (2016) Comparative study of group treatments for posttraumatic stress disorder. *Psychotherapy (Chicago, Ill.)* **53**, 433–445.

**McGovern MP, Lambert-Harris C, Xie H, Meier A, McLeman B and Saunders E** (2015) A randomized controlled trial of treatments for co-occurring substance use disorders and post-traumatic stress disorder. *Addiction* **110**, 1194–1204.

**McLay RN, Baird A, Webb-Murphy J, Deal W, Tran L, Anson H, Klam W and Johnston S** (2017) A Randomized, Head-to-Head Study of Virtual Reality Exposure Therapy for Posttraumatic Stress Disorder. *Cyberpsychology, Behavior, and Social Networking* **20,** 218–224.

**McLean CP, Su YJ and Foa EB** (2014) Posttraumatic stress disorder and alcohol dependence: Does order of onset make a difference? *Journal of Anxiety Disorders* **28**, 894–901.

**Meier A, McGovern MP, Lambert-Harris C, McLeman B, Franklin A, Saunders EC and Xie H** (2015) Adherence and competence in two manual-guided therapies for co-occurring substance use and posttraumatic stress disorders: Clinician factors and patient outcomes. *American Journal of Drug and Alcohol Abuse* **4**1, 527–534.

**Mills KL, Teesson M, Back SE, Brady KT, Baker AL, Hopwood S, Sannibale C, Barrett EL, Merz S, Rosenfeld J and Ewer PL** (2012) Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: A randomized controlled trial. *Journal of the American Medical Association*, **308**, 690–699.

**Monson CM, Fredman SJ, Macdonald A, Pukay-Martin ND, Resick PA and Schnurr PP** (2012) Effect of cognitive-behavioral couple therapy for PTSD: a randomized controlled trial. *Journal of the American Medical Association* **308**, 700-709.

**Moradi AR, Moshirpanahi S, Parhon H, Mirzaei J, Dalgleish T and Jobson L** (2014) A pilot randomized controlled trial investigating the efficacy of Memory Specificity Training in improving symptoms of posttraumatic stress disorder. *Behaviour Research and Therapy* **56**, 68-74.

**Morath J, Gola H, Sommershof A, Hamuni G, Kolassa S, Catani C, Adenauer H, Ruf-Leuschner M, Schauer M, Elbert T, Groettrup M and Kolassa IT** (2014) The effect of trauma-focused therapy on the altered T cell distribution in individuals with PTSD: Evidence from a randomized controlled trial. *Journal of Psychiatric Research* **54**, 1–10.

**Morland LA, Mackintosh MA, Greene CJ, Rosen CS, Chard KM, Resick P and Frueh BC** (2014) Cognitive processing therapy for posttraumatic stress disorder delivered to rural veterans via telemental health: a randomized noninferiority clinical trial. *Journal of Clinical Psychiatry* **75**, 470–476.

**Moser JS, Cahill SP and Foa EB** (2010) 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. *Journal of Nervous and Mental Disease* **198,** 72–75.

**Nacasch N, Foa EB, Huppert JD, Tzur D, Fostick L, Dinstein Y, Polliack M and Zohar J.** (2011) Prolonged exposure therapy for combat- and terror-related posttraumatic stress disorder: A randomized control comparison with treatment as usual. *Journal of Clinical Psychiatry* **72**, 1174–1180.

**Nacasch N, Huppert JD, Su YJ, Kivity Y, Dinshtein Y, Yeh R and Foa EB** (2015) Are 60-Minute Prolonged Exposure Sessions With 20-Minute Imaginal Exposure to Traumatic Memories Sufficient to Successfully Treat PTSD? A Randomized Noninferiority Clinical Trial. *Behaviour Therapy* **46**, 328–341.

**Neuner F, Kurreck S, Ruf M, Odenwald M, Elbert T and Schauer M** (2010) Can asylum-seekers with posttraumatic stress disorder be successfully treated? A randomized controlled pilot study. *Cognitive Behaviour Therapy* **39**, 81-91.

**Neuner F, Onyut PL, Ertl V, Odenwald M, Schauer E and Elbert T (2008)** Treatment of Posttraumatic Stress Disorder by Trained Lay Counselors in an African Refugee Settlement: A Randomized Controlled Trial. *Journal of Consulting and Clinical Psychology* **76,** 686–694.

**Neuner F, Schauer M, Klaschik C, Karunakara U and Elbert T** (2004) A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology* **72**, 579–587.

**Nijdam MJ, van der Meer CAI, van Zuiden M, Dashtgard P, Medema D, Qing Y, Zhutovsky P, Bakker A and Olff M** (2018) Turning wounds into wisdom: Posttraumatic growth over the course of two types of trauma-focused psychotherapy in patients with PTSD. *Journal of Affective Disorders* **227**, 424–431.

**Nosen E, Littlefield AK, Schumacher JA, Stasiewicz PR and Coffey SF** (2014) 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* **61**, 35–42.

**Øktedalen T, Hoffart A and Langkaas TF** (2015) 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* **25**, 518–532.

**Pabst A, Schauer M, Bernhardt K, Ruf-Leuschner M, Goder R, Elbert T , Rosentraeger R, Robjant K, Aldenhoff J and Seeck-Hirschner M** (2014) Evaluation of narrative exposure therapy (NET) for borderline personality disorder with comorbid posttraumatic stress disorder. *Clinical Neuropsychiatry* **11**, 108–117.

**Paivio SC, Jarry JL, Chagigiorgis H, Hall I and Ralston M** (2010) Efficacy of two versions of emotion-focused therapy for resolving child abuse trauma. *Psychotherapy Research* **20**, 353–366.

**Paunovic N and Ost LG (2001)** Cognitive-behavior therapy vs exposure therapy in the treatment of PTSD in refugees. *Behaviour Research and Therapy* **39**, 1183–1197.

**Peniston EG and Kulkosky PJ** (1991) Alpha-theta brainwave neuro-feedback therapy for Vietnam veterans with combat-related post-traumatic stress disorder. *Medical Psychotherapy: An International Journal*, **4**, 47–60.

**Polusny MA, Erbes CR, Thuras P, Moran A, Lamberty GJ, Collins RC, Rodman JL and Lim KO** (2015) Mindfulness-Based Stress Reduction for Posttraumatic Stress Disorder Among Veterans. A Randomized Clinical Trial. *Journal of the American Medical Association* **314**, 456-465.

**Possemato K, Bergen-Cico D, Treatman S, Allen C, Wade M and Pigeon W (2016)** A Randomized Clinical Trial of Primary Care Brief Mindfulness Training for Veterans With PTSD. *Journal of Clinical Psychology* **72**, 179-93.

**Pruiksma KE, Taylor DJ, Wachen JS, Mintz J, Young-McCaughan S, Peterson AL, Yarvis JS, Borah EV, Dondanville KA, Litz BT , Hembree EA and Resick PA** (2016) Residual Sleep Disturbances Following PTSD Treatment in Active Duty Military Personnel. *Psychological Trauma: Theory, Research, Practice, and Policy* **8**, 697-701.

**Reger GM, Koenen-Woods P, Zetocha K, Smolenski DJ, Holloway KM, Rothbaum BO, Difede J, Rizzo AA, Edwards-Stewart A, Skopp NA, Mishkind M, Reger MA and Gahm GA** (2016) Randomized controlled trial of prolonged exposure using imaginal exposure vs. virtual reality exposure in active duty soldiers with deployment-related posttraumatic stress disorder (PTSD) *Journal of Consulting and Clinical Psychology* **84,** 946–959.

**Resick PA, Galovski TE, Uhlmansiek MO, Scher CD, Clum GA and Young-Xu Y** (2008) 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* **76,** 243–258.

**Resick PA, Nishith P and Griffin MG** (2003) How well does cognitive-behavioral therapy treat symptoms of complex PTSD? An examination of child sexual abuse survivors within a clinical trial. *CNS Spectrums* **8**, 340–355.

**Resick PA, Wachen JS, Dondanville KA, Pruiksma KE, Yarvis JS, Peterson AL, Mintz J and the STRONG STAR Consortium, Borah EV, Brundige A, Hembree EA, Litz BT, Roache JD and Young-McCaughan S** (2017) Effect of Group vs Individual Cognitive Processing Therapy in Active-Duty Military Seeking Treatment for Posttraumatic Stress Disorder: a Randomized Clinical Trial. *Journal of the American Medical Association Psychiatry* **74,** 28–36.

**Resick PA, Wachen JS, Mintz J, Young-McCaughan S, Roache JD, Borah AM, Borah EV, Dondanville KA, Hembree EA, Litz BT and Peterson AL** (2015) 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* **83,** 1058-1068.

**Roberts NP, Roberts PA, Jones N and Bisson JI** (2016) Psychological therapies for post-traumatic stress disorder and comorbid substance use disorder. *Clinical Psychology Review* **38**, 25–38.

**Rothbaum BO** (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.

**Rothbaum BO, Astin MC and Marsteller F** (2005) Prolonged exposure versus Eye Movement Desensitization and Reprocessing (EMDR) for PTSD rape victims. *Journal of Traumatic Stress* **18,** 607–616.

**Rothbaum BO, Cahill SP, Foa EB, Davidson JR, Compton J, Connor KM, Astin MC and Hahn CG** (2006) Augmentation of sertraline with prolonged exposure in the treatment of posttraumatic stress disorder. *Journal of Traumatic Stress* **19**, 625–638.

**Rothbaum BO, Price M, Jovanovic T, Norrholm SD, Gerardi M, Dunlop B, Davis M, Bradley B, Duncan EJ, Rizzo A and Ressler KJ** (2014) A Randomized, Double-Blind Evaluation of d-Cycloserine or Alprazolam Combined With Virtual Reality Exposure Therapy for Posttraumatic Stress Disorder in Iraq and Afghanistan War Veterans. *American Journal of Psychiatry* **171**, 640-648.

**Ruglass LM, Shevorykin A, Radoncic V, Smith KM, Smith PH, Galatzer-Levy IR, Papini S and Hien DA** (2017) Impact of cannabis use on treatment outcomes among adults receiving cognitive-behavioral treatment for PTSD and substance use disorders. *Journal of Clinical Medicine* **6**, doi.org/10.3390/jcm6020014

**Sack M, Zehl S, Otti A, Lahmann C, Henningsen P, Kruse J and Stingl M (2016)** 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 Psychosomatics* **85**, 357–365.

**Sannibale C, Teesson M, Creamer M, Sitharthan T, Bryant RA, Sutherland K, Taylor K, Bostock-Matusko D, Visser A and Peek-O'Leary M** (2013) Randomized controlled trial of cognitive behaviour therapy for comorbid post-traumatic stress disorder and alcohol use disorders. *Addiction* **108,** 1397–1410.

**Sautter FJ, Glynn SM, Cretu JB, Senturk D and Vaught AS** (2015) Efficacy of structured approach therapy in reducing PTSD in returning veterans: A randomized clinical trial. *Psychological Services* **12,** 199–212.

**Schaal S, Elbert T and Neuner F (2009)** Narrative exposure therapy versus interpersonal psychotherapy. A pilot randomized controlled trial with Rwandan genocide orphans. *Psychotherapy and Psychosomatics* **78,** 298–306.

**Schneier FR, Neria Y, Pavlicova M, Hembree E, Suh EJ, Amsel L and Marshall RD** (2012) Combined prolonged exposure therapy and paroxetine for PTSD related to the World Trade Center attack: A randomized controlled trial. *American Journal of Psychiatry* **169,** 80–88.

**Schnurr PP** (2007) Cognitive behavioral therapy for posttraumatic stress disorder in women: a randomized controlled trial. *Journal of the American Medical Association* **297**, 820–830.

**Schnurr PP, Friedman MJ, Foy DW, Shea MT, Hsieh FY, Lavori PW, Glynn SM, Wattenberg M and Bernardy NC** (2003) Randomized trial of trauma-focused group therapy for posttraumatic stress disorder: Results from a department of veterans affairs cooperative study. *Archives of General Psychiatry* **60,** 481–489.

**Schnurr PP, Friedman MJ, Engel CC, Foa EB, Shea MT, Chow BK, Resick PA, Thurston V, Orsillo SM, Haug R, Turner C and Bernardy N** (2007) Cognitive behavioral therapy for posttraumatic stress disorder in women - A randomized controlled trial. *Journal of the American Medical Association* **297**, 820–830.

**Schnyder U, Müller J, Maercker A and Wittmann L** (2011) Brief eclectic psychotherapy for PTSD: A randomized controlled trial. *Journal of Clinical Psychiatry* **72**, 564–566.

**Scott JC, Harb G, Brownlow JA, Greene J, Gur RC and Ross RJ** (2017) Verbal memory functioning moderates psychotherapy treatment response for PTSD-Related nightmares. *Behaviour Research and Therapy* **91**, 24–32.

**Shea MT, Lambert J and Reddy MK** (2013) A randomized pilot study of anger treatment for Iraq and Afghanistan veterans*. Behaviour Research and Therapy* **51,** 607–613.

**Shnaider P, Sijercic I, Wanklyn SG, Suvak MK, & Monson CM** (2016)The Role of Social Support in Cognitive-Behavioral Conjoint Therapy for Posttraumatic Stress Disorder. *Behaviour Therapy* **48,** 285–294.

**Sikkema KJ, Hansen NB, Kochman A, Tarakeshwar N, Neufeld S, Meade CS and Fox AM** (2007) Outcomes from a group intervention for coping with HIV/AIDS and childhood sexual abuse: Reductions in traumatic stress. *AIDS and Behaviour* **11**, 49–60.

**Sin J, Spain D, Furuta M, Murrells T and Norman** I (2017) Psychological interventions for post-traumatic stress disorder (PTSD) in people with severe mental illness. *Cochrane Database of Systematic Reviews* **1,** CD011464. doi 10.1002/14651858.CD011464.pub2.

**Slade EP, Gottlieb JD, Lu W, Yanos PT, Rosenberg S, Silverstein SM, Minsky SK and Mueser KT** (2017) Cost-Effectiveness of a PTSD Intervention Tailored for Individuals With Severe Mental Illness. *Psychiatric Services* **68,** 1225-1231.

**Sloan DM, Marx BP, Bovin MJ, Feinstein BA and Gallagher MW** (2012) Written exposure as an intervention for PTSD: A randomized clinical trial with motor vehicle accident survivors. *Behaviour Research and Therapy* **50,** 627–635.

**Spence J, Titov N, Dear BF, Johnston L, Solley K, Lorian C, Wootton B, Zou J and Schwenke G** (2011) Randomized controlled trial of Internet-delivered cognitive behavioral therapy for posttraumatic stress disorder. *Depression and Anxiety* **28,** 541-550.

**Steinert C, Bumke PJ, Hollekamp RL, Larisch A, Leichsenring F, Mattheß H, Sek S, Sodemann U, Stingl M, Ret T, Vojtová H, Wöller W and Kruse J (2017**) Resource activation for treating post-traumatic stress disorder, co-morbid symptoms and impaired functioning: A randomized controlled trial in Cambodia. *Psychological Medicine* **47**, 553–564.

**Tarrier N, Pilgrim H, Sommerfield C, Faragher B, Reynolds M, Graham E and Barrowclough C** (1999) A randomized trial of cognitive therapy and imaginal exposure in the treatment of chronic posttraumatic stress disorder. *Journal of Consulting* **67,** 13–18.

**Tarrier N, Sommerfield C, Pilgrim H and 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.

**Taylor S, Thordarson DS, Maxfield L, Fedoroff IC, Lovell K and Ogrodniczuk J** (2003) Comparative efficacy, speed, and adverse effects of three PTSD treatments: Exposure therapy, EMDR, and relaxation training. *Journal of Consulting and Clinical Psychology* **71**, 330–338.

**van den Berg DP, de Bont PA, van der Vleugel BM, de Roos C, de Jongh A, van Minnen A and van der Gaag M** (2016) Trauma-focused treatment in PTSD patients with psychosis: Symptom exacerbation, adverse events, and revictimization. *Schizophrenia Bulletin* **42,** 693–702.

**van der Kolk B, Hamlin E, Gapen M, Hodgdon H, Musicaro R, Suvak M and Spinazzola J (2016)** A Randomized Controlled Study of Neurofeedback for Chronic PTSD. *PLoS ONE* **11**, 10.1371/journal.pone.0166752.

**van der Kolk BA, Spinazzola J, Blaustein ME, Hopper JW, Hopper EK, Korn DL and Simpson WB**  (2007) A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: treatment effects and long-term maintenance. *Journal of Clinical Psychiatry* **68**, 37-46.

**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**, 93–100.

**Vaughan K, Armstrong MS, Gold R, O'Connor N, Jenneke W and 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 Behaviour Therapy and Experimental Psychiatry* **25**, 283–291.

**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,** 365–383.

**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**, 70–80.

**Wilson SA, Becker LA and Tinker RH** (1995) Eye movement desensitization and reprocessing (EMDR) treatment for psychologically traumatized individuals. *Journal of Consulting and Clinical Psychology* **63**, 928–937.

**Wilson SA, Becker LA and Tinker RH** (1997) Fifteen-month follow-up of eye movement desensitization and reprocessing (EMDR) treatment for posttraumatic stress disorder and psychological trauma. *Journal of Consulting and Clinical Psychology* **65**, 1047–1056.

**Wolff N, Huening J, Shi J, Frueh BC, Hoover DR and McHugo G** (2015) Implementation and effectiveness of integrated trauma and addiction treatment for incarcerated men. *Journal of Anxiety Disorders* **30,** 66–80.

**Zang Y, Hunt N and Cox T** (2013) A randomised controlled pilot study: the effectiveness of narrative exposure therapy with adult survivors of the Sichuan earthquake*. BMC Psychiatry* **31,** doi:10.1186/1471-244X-13-41

**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**, 262. doi: 10.1186/s12888-014-0262-3.

**Zang Y, Yu J, Chazin D, Asnaani A, Zandberg LJ and Foa EB** (2017) Changes in coping behavior in a randomized controlled trial of concurrent treatment for PTSD and alcohol dependence*. Behaviour Research and Therapy* **90,** 9–15.

**Zlotnick C, Johnson J and Najavits LM** (2009) Randomized controlled pilot study of cognitive-behavioral therapy in a sample of incarcerated women with substance use disorder and PTSD. *Behaviour Therapy* **40**, 325–336.

**Zlotnick C, Shea TM, Rosen K, Simpson E, Mulrenin K, Begin A and Pearlstein T**(1997) An affect-management group for women with posttraumatic stress disorder and histories of childhood sexual abuse. *Journal of Traumatic Stress* **10,** 425–436.

**Zoellner LA, Foa EB and Brigidi BD** (1999) Interpersonal friction and PTSD in female victims of sexual and nonsexual assault. *Journal of Traumatic Stress* **12**, 689–700.

**Zoellner LA, Telch M, Foa EB, Farach FJ, McLean CP, Gallop R, Bluett EJ, Cobb A and Gonzalez-Lima F** (2017) Enhancing extinction learning in posttraumatic stress disorder with brief daily imaginal exposure and methylene blue: A randomized controlled trial. *Journal of Clinical Psychiatry* **78,** e782–e789.

**X. Other References**

**Benish SG, Imel ZE and Wampold BE** (2008) The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review* **28**, 746–758.

**Cloitre M, Garvert DW, Brewin CR, Bryant RA and Maercker A** (2013) Evidence for proposed ICD-11 PTSD and complex PTSD: a latent profile analysis. *European Journal of Psychotraumatology* **4**, 10.3402/ejpt.v4i0.20706. doi:10.3402/ejpt.v4i0.20706

**Guyatt G, Oxman AD, Akl EA, Kunz R, Vist G, Brozek J, Norris S, Falck-Ytter Y, Glasziou P, DeBeer H, Jaeschke R, Rind D, Meerpohl J, Dahm P and Schünemann HJ** (2011) GRADE guidelines: 1. Introduction-GRADE evidence profiles and summary of findings tables. *Journal of Clinical Epidemiology* **64**, 383-94.

**Higgins JP, Altman DG, Gøtzsche PC, Jüni P, Moher D, Oxman AD, Savovic J, Schulz KF, Weeks L, Sterne JA; Cochrane Bias Methods Group and Cochrane Statistical Methods Group** (2011) The Cochrane Collaboration’s tool for assessing risk of bias in randomised trials. *British Medical Journal* **343**, d5928.

**Higgins JPT and Green S** (2011) Cochrane Handbook for Systematic Reviews of Interventions. The Cochrane Collaboration and John Wiley & Sons Ltd: England.

**Xia J, Adams C, Bhagat N, Bhagat V, Bhoopathi P, El-Sayeh H, Pinfold V and Takriti Y** (2009) Losing participants before the trial ends erodes credibility of findings. *Psychiatric Bulletin* **33**, 254–257.