Appendix 16b: Evidence statements for Pharmacological interventions

Contents

Appendix 16b: Evidence statements for pharmacological interventions

Description	Statement	Statements and Statistics
Paroxetine vs placebo		
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between paroxetine and placebo on reducing the severity of PTSD symptoms (CAPS - clinician) (k = 3; n = 1070; SMD = -0.42; 95% CI, -0.55 to -0.3). I
Severity of PTSD symptoms mean endpoint scores (DTS)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between paroxetine and placebo on reducing the severity of PTSD symptoms (DTS - self-report) (k = 3; n = 1065; SMD = -0.37; 95% CI, -0.49 to -0.24). I
Depression symptoms mean endpoint scores (Montgomery-Asberg Depression Rating Scale)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between paroxetine and placebo on reducing depression symptoms (Montgomery-Asberg Depression Rating Scale - clinician) (k = 3; n = 1069; SMD = -0.34; 95% CI, -0.61 to -0.07). I
Quality of life mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between paroxetine and placebo on improving quality of life (k = 3; n = 1039; SMD = -0.27; 95% CI, -0.4 to -0.14). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between paroxetine and placebo on reducing the likelihood of leaving treatment early. (k = 3; n = 1196; RR = 0.95; 95% CI, 0.79 to 1.15). I
Severity of PTSD symptoms mean endpoint scores (relapse prevention phase)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between paroxetine and placebo on reducing the severity of PTSD symptoms (CAPS - clinician) (relapse prevention phase) (k = 1; n = 129; SMD = 0.19; 95% CI, -0.15 to 0.54). I
Severity of PTSD symptoms mean endpoint scores (DTS) (relapse prevention phase)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between paroxetine and placebo on reducing the severity of PTSD symptoms (DTS - self-report) (relapse prevention phase) (k = 1; n = 127; SMD = 0.06; 95% CI, -0.28 to 0.41). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between paroxetine and placebo on reducing the likelihood of leaving treatment early (k = 1; n = 176; RR = 0.84; 95% CI, 0.51 to 1.38). I

Likelihood of having a PTSD diagnosis after treatment	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between paroxetine and placebo on reducing the likelihood of having a PTSD diagnosis after treatment k = 1; n = 176; RR = 0.81; 95% CI, 0.55 to 1.19). I

Paroxetine 20 mg versus paroxetine 40 mg (acute phase)

the severity of PTSD symptoms as measured by clinician measure CAPS	s3	There is evidence suggesting there is unlikely to be a clinically important difference between paroxetine 20mg and paroxetine 40mg on reducing the severity of PTSD symptoms as measured by clinician measure CAPS (k = 1; n = 365; SMD = -0.06; 95% CI, -0.27 to 0.14). I
the severity of PTSD symptoms as measured by self-report DTS	s3	There is evidence suggesting there is unlikely to be a clinically important difference between paroxetine 20mg and paroxetine 40mg on reducing the severity of PTSD symptoms as measured by self-report DTS (k = 1; n = 365; SMD = -0.08; 95% CI, -0.29 to 0.12). I
depression symptoms as measured by Montgomery-Asberg Depression Rating Scale	s3	There is evidence suggesting there is unlikely to be a clinically important difference between paroxetine 20mg and paroxetine 40mg on reducing depression symptoms as measured by Montgomery-Asberg Depression Rating Scale (k = 1; n = 365; SMD = -0.08; 95% CI, -0.29 to 0.12). I
Quality of life	s3	There is evidence suggesting there is unlikely to be a clinically important difference between paroxetine 20mg and paroxetine 40mg on increasing quality of life (k = 1; n = 365; SMD = -0.08; 95% CI, -0.28 to 0.13). I
the likelihood of leaving treatment early for any reason	s3	There is evidence suggesting there is unlikely to be a clinically important difference between paroxetine 20mg and paroxetine 40mg on reducing the likelihood of leaving treatment early for any reason (k = 1; n = 375; RR = 0.89; 95% CI, 0.68 to 1.15). I

Paroxetine vs trauma-focused CBT

clinician measured PTSD severity (CAPS) post-treatment	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between paroxetine and trauma-focused CBT on reducing clinician measured PTSD severity (using CAPS) post-treatment (k = 1; n = 16; SMD = 0.09; 95% CI, -0.89 to 1.07). I
self-rated PTSD severity (PSS) post-treatment	s2y	There is limited evidence favouring trauma-focused CBT over paroxetine on reducing self-rated PTSD severity (PSS) post-treatment (k = 1; n = 16; SMD = 1.06; 95% CI, -0.01 to 2.13). I
post treatment depression symptoms using clinician measure MADRS	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between paroxetine and trauma-focused CBT on reducing post treatment depression symptoms using clinician measure MADRS (k = 1; n = 16; SMD = -0.37; 95% CI, -1.36 to 0.62). I

self-rated depression symptoms post-treatment using BDI	s2y	There is limited evidence favouring trauma-focused CBT over paroxetine on reducing self-rated depression symptoms post-treatment using BDI (k = 1; n = 16; SMD = 0.55; 95% CI, -0.46 to 1.55). I
post treatment anxiety symptoms using clinician measure HAMA	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between paroxetine and trauma-focused CBT on reducing post treatment anxiety symptoms using clinician measure HAMA (k = 1; n = 16; SMD = -0.26; 95% CI, -1.25 to 0.72). I
the likelihood of leaving the study early due to any reason prior to treatment endpoint	s2y	There is limited evidence favouring trauma-focused CBT over paroxetine on reducing the likelihood of leaving the study early due to any reason prior to treatment endpoint (k = 1; n = 21; RR = 1.36; 95% CI, 0.28 to 6.56). I
the likelihood of leaving the study early due to any reason prior to 6 month follow up	s2x	There is limited evidence favouring paroxetine over trauma-focused CBT on reducing the likelihood of leaving the study early due to any reason prior to 6 month follow up (k = 1; n = 21; RR = 0.57; 95% CI, 0.28 to 1.16). I

Sertraline vs placebo		
Severity of PTSD symptoms mean endpoint scores (clinican rated CAPS)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between sertraline and placebo on reducing the severity of PTSD symptoms as measured by clinician-rated CAPS (k = 6; n = 1123; SMD = -0.26; 95% CI, -0.51 to 0.00). I
Severity of PTSD symptoms mean endpoint scores (self-report DTS)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between sertraline and placebo on reducing the severity of PTSD symptoms as measured by the self-report Davidson Trauma Scale (k = 5; n = 1091; SMD = -0.18; 95% CI, -0.41 to 0.06). I
Severity of PTSD symptoms mean endpoint scores (self-report IES)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between sertraline and placebo on reducing the severity of PTSD symptoms as measured by the self-report Impact of Event Scale (k = 4; n = 739; SMD = -0.06; 95% CI, -0.39 to 0.26). I
Depression symptoms mean endpoint scores (pooled Montgomery-Asberg and Hamilton depression rating scales)	s3	There is evidence suggesting there is unlikely to be a clinically important difference between sertraline and placebo on reducing severity of depression symptoms as measured by pooled Hamilton and Montgomery-Asberg depression scale ratings (k = 3; n = 417; SMD = -0.27; 95% CI, -0.46 to -0.07). I
Anxiety symptoms (Hamilton) mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between sertraline and placebo on reducing anxiety symptoms as measured by the clinician-rated Hamilton anxiety scale (k = 1; n = 202; SMD = -0.17; 95% CI, -0.45 to 0.1). I

Quality of life mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between sertraline and placebo on improving quality of life (k = 2; n = 385; SMD = -0.26; 95% CI, -0.59 to 0.07). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between sertraline and placebo on reducing the likelihood of leaving treatment early for any reason (k = 6; n = 1148; RR = 1.10; 95% CI, 0.90 to 1.33). I
the likelihood of having a post-treatment PTSD diagnosis as measured by clinician-rated CAPS	s3	There is evidence suggesting there is unlikely to be a clinically important difference between sertraline and placebo on reducing the likelihood of having a post-treatment PTSD diagnosis as measured by clinician-rated CAPS (k = 2; n = 747; RR = 0.91; 95% CI, 0.85 to 0.98). I
Severity of PTSD symptoms mean endpoint scores (relapse prevention phase)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between sertraline and placebo on reducing the severity of PTSD symptoms using clinician-rated CAPS-2 (relapse prevention phase) (k = 1; n = 42; SMD = -0.14; 95% CI, -0.75 to 0.47). I
Likelihood of leaving treatment early (relapse prevention phase).	s2x	There is limited evidence favouring sertraline over placebo on reducing the likelihood of leaving treatment early (relapse prevention phase) (k = 1; n = 96; RR = 0.75; 95% CI, 0.52 to 1.08). I

Fluoxetine vs placebo		
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between fluoxetine and placebo on reducing the severity of PTSD symptoms (CAPS - clinician) (k = 1; n = 301; SMD = -0.28; 95% CI, -0.54 to -0.02). I
Severity of PTSD symptoms mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between fluoxetine and placebo on reducing the severity of PTSD symptoms (TOP-8 - clinician) (k = 1; n = 411; SMD = -0.02; 95% CI, -0.21 to 0.26). I
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between fluoxetine and placebo on reducing the severity of PTSD symptoms (DTS - self-report) (k = 3; n = 363; SMD = -0.41; 95% CI, -0.98 to 0.15). I
Depression symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between fluoxetine and placebo on reducing depression symptoms (Montgomery-Asberg Depression Rating Scale - clinician) (k = 1; n = 301; SMD = -0.45; 95% CI, -0.71 to -0.18). I
Depression symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between fluoxetine and placebo on reducing depression symptoms (Hamilton - clinician) (k = 1; n = 301; SMD = -0.42; 95% CI, -0.68 to -0.16). I

Quality of life mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between fluoxetine and placebo on improving quality of life (k = 2; n = 61; SMD = -0.62; 95% CI, -1.13 to -0.1). I
Likelihood of leaving treatment early	s2x	There is limited evidence favouring fluoxetine over placebo on reducing the likelihood of leaving treatment early (k = 2; n = 66; RR = 0.6; 95% CI, 0.28 to 1.3). I
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between fluoxetine and placebo on reducing the severity of PTSD symptoms (CAPS - clinician) (k = 1; n = 98; SMD = -0.28; 95% CI, -0.68 to 0.12). I
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between fluoxetine and placebo on reducing the severity of PTSD symptoms (DTS - self-report) (k = 1; n = 98; SMD = -0.19; 95% CI, -0.59 to 0.21). I
Likelihood of leaving treatment early	s2x	There is limited evidence favouring fluoxetine over placebo on reducing the likelihood of leaving treatment early (k = 1; n = 131; RR = 0.51; 95% CI, 0.28 to 0.96). I

Amitriptyline (tricyclic antidepressant) vs placebo

Severity of PTSD symptoms mean endpoint scores	s2x	There is limited evidence favouring amitriptyline over placebo on reducing the severity of PTSD symptoms (using the total measure of the self-report IES) (k = 1; n = 33; SMD = -0.90; 95% CI, -1.62 to -0.18). I
Depression symptoms mean endpoint scores	s2x	There is limited evidence favouring amitriptyline over placebo on reducing depression symptoms as measured by the clinician-rated Hamilton scale (k = 1; n = 33; SMD = -1.16; 95% CI, -1.90 to –0.41). I
Anxiety symptoms mean endpoint scores	s2x	There is limited evidence favouring amitriptyline over placebo on reducing anxiety symptoms as measured by the clinician-rated Hamilton scale (k = 1; n = 33; SMD = -0.99; 95% CI, -1.72 to -0.26). I
Likelihood of leaving the study early	s2y	There is limited evidence favouring placebo over amitriptyline on reducing the likelihood of leaving the study early for any reason (k = 1; n = 46; RR = 1.34; 95% CI, 0.52 to 3.49). I

Imipramine (tricyclic antidepressant) vs placebo

Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between imipramine and placebo on reducing the severity of PTSD symptoms (as measured by self-report IES) (k = 1; n = 41; SMD = -0.24 ; 95% CI, -0.86 to 0.38). I
Depression symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between imipramine and placebo on reducing depression symptoms as measured by the clinician-rated Hamilton scale (k = 1; n = 41; SMD = -0.22; 95% CI, -0.84 to 0.40). I
Anxiety symptoms mean endpoint scores)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between imipramine and placebo on reducing anxiety symptoms as measured by the Covi Anxiety Scale (k = 1; n = 41; SMD = -0.46; 95% CI, -1.08 to 0.17). I

Likelihood of leaving the study early	s2x	There is limited evidence favouring imipramine over placebo on reducing the likelihood of leaving the study early for any reason (k = 1; n = 41; RR = 0.78; 95% CI, 0.47 to 1.30). I

Imipramine & other psychological therapy vs placebo		
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between imipramine & other psychological therapy and placebo on reducing the severity of PTSD symptoms (IES - self-report) (k = 1; n = 39; SMD = -0.16; 95% CI, -0.8 to 0.48). I

Phenelzine (Monoamine oxidase inhibitor) vs placebo)		
Severity of PTSD symptoms	s2x	There is limited evidence favouring phenelzine over placebo on reducing the severity of PTSD symptoms (as measured by self-report IES) (k = 1; n = 37; SMD = -1.06; 95% CI, -1.75 to -0.36). I
Depression symptoms	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between phenelzine and placebo on reducing depression symptoms as measured by the clinician-rated Hamilton scale (k = 1; n = 37; SMD = -0.4; 95% CI, -1.06 to 0.25). I
Anxiety symptoms	s2x	There is limited evidence favouring phenelzine over placebo on reducing anxiety symptoms as measured by the Covi Anxiety Scale (k = 1; n = 37; SMD = -0.67; 95% CI, -1.34 to -0.01). I
Likelihood of leaving treatment early	s1x	There is evidence favouring phenelzine over placebo on reducing the likelihood of leaving the study early due to any reason (k = 1; n = 37; RR = 0.32; 95% CI, 0.12 to 0.8). I

Brofaromine (Monoamine oxidase inhibitor) vs placebo)		
Severity of PTSD symptoms	s2x	There is limited evidence favouring brofaromine over placebo on reducing the severity of clinician-assessed PTSD symptoms (k = 1; n = 45; SMD = -0.58; 95% CI, -1.18 to 0.02). I
Likelihood of leaving treatment early	s2y	There is limited evidence favouring placebo over brofaromine on reducing the likelihood of leaving the study early due to any reason (k = 1; n = 66; RR = 1.44; 95% CI, 0.69 to 3.01). I

Imipramine & other psychological therapy vs phenelzine & other psychological therapy

Severity of PTSD symptoms mean endpoint scores	s2y	There is limited evidence favouring phenelzine & other psychological therapy over imipramine & other psychological therapy on reducing the severity of PTSD symptoms (as measured by the self-report IES) (k = 1; n = 41; SMD = 0.76; 95% CI, 0.12 to 1.4). I

Phenelzine & other psychological therapy vs placebo

Severity of PTSD symptoms mean endpoint scores	s2x	There is limited evidence favouring phenelzine & other psychological therapy over placebo on reducing the severity of PTSD symptoms (IES - self-report) (k = 1; n = 34; SMD = -1.01; 95% CI, -1.73 to -0.29). I

Mirtazipine vs placebo

Severity of PTSD symptoms mean endpoint scores	s1x	There is evidence favouring mirtazipine over placebo on reducing the severity of PTSD symptoms (Structured Interview for PTSD - clinician) (k = 1; n = 21; SMD = -1.89; 95% CI, -3 to -0.78). I
Severity of PTSD symptoms mean endpoint scores	s2x	There is limited evidence favouring mirtazipine over placebo on reducing the severity of PTSD symptoms (DTS - self-report) (k = 1; n = 26; SMD = -0.76; 95% CI, -1.6 to 0.08). I
Depression symptoms mean endpoint scores	s2x	There is limited evidence favouring mirtazipine over placebo on reducing depression symptoms (HADS-D - self-report) (k = 1; n = 25; SMD = -0.92; 95% CI, -1.81 to -0.04). I
Anxiety symptoms mean endpoint scores	s2x	There is limited evidence favouring mirtazipine over placebo on reducing anxiety symptoms (HADS-A - self-report) (k = 1; n = 25; SMD = -0.88; 95% CI, -1.77 to 0). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between mirtazipine and placebo on reducing the likelihood of leaving treatment early (k = 1; n = 29; RR = 0.9; 95% CI, 0.29 to 2.82)I

Venlafaxine vs placebo

Severity of PTSD symptoms mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between venlafaxine and placebo on reducing the severity of PTSD symptoms (CAPS - clinician) (k = 1; n = 358; SMD = -0.14; 95% CI, -0.35 to 0.06). I
Severity of PTSD symptoms mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between venlafaxine and placebo on reducing the severity of PTSD symptoms (DTS - self-report) (k = 1; n = 358; SMD = -0.19; 95% CI, -0.4 to 0.01). I
Quality of life mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between venlafaxine and placebo on improving quality of life (Quality of Life Enjoyment and Satisfaction Questionnaire - self-report) (k = 1; n = 352; SMD = 0.2; 95% CI, -0.01 to 0.4). I

Quality of life mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between venlafaxine and placebo on improving quality of life (Global Assessment of Functioning - clinician) (k = 1; n = 358; SMD = 0.18; 95% CI, -0.03 to 0.39). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between venlafaxine and placebo on reducing the likelihood of leaving treatment early (k = 1; n = 358; RR = 0.83; 95% CI, 0.62 to 1.12). I
Likelihood of having a post-treatment PTSD diagnosis	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between venlafaxine and placebo on reducing the likelihood of having a post-treatment PTSD diagnosis (using clinician measure CAPS) (k = 1; n = 358; SMD = 0.87; 95% CI, 0.77 to 0.98). I

Venlafaxine vs sertraline

Severity of PTSD symptoms mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between venlafaxine and sertraline on reducing the severity of PTSD symptoms (CAPS - clinician) (k = 1; n = 352; SMD = -0.01; 95% CI, -0.22 to 0.2). I
Severity of PTSD symptoms mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between venlafaxine and sertraline on reducing the severity of PTSD symptoms (DTS - self-report) (k = 1; n = 352; SMD = -0.1; 95% CI, -0.31 to 0.11). I
Quality of life mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between venlafaxine and sertraline on improving quality of life (Q-LES-Q - self-report) (k = 1; n = 352; SMD = -0.02; 95% CI, -0.23 to 0.19). I
Quality of life mean endpoint scores	s3	There is evidence suggesting there is unlikely to be a clinically important difference between venlafaxine and sertraline on improving quality of life (Global Assessment of Functioning - clinician) (k = 1; n = 352; SMD = -0.01; 95% CI, -0.22 to 0.2). I
Likelihood of leaving treatment early	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between venlafaxine and sertraline on reducing the likelihood of leaving treatment early (k = 1; n = 352; RR = 0.84; 95% CI, 0.62 to 1.14). I
Post-treatment PTSD diagnosis	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between venlafaxine and sertraline on reducing the likelihood of having a post-treatment PTSD diagnosis (k = 1; n = 352; RR = 0.92; 95% CI, 0.81 to 1.05). I

Olanzapine vs placebo

Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between olanzapine and placebo on reducing the severity of PTSD symptoms (Structured Interview for PTSD & CAPS - clinician) (k = 1; n = 11; SMD = 0.16; 95% CI, -1.07 to 1.39). I
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between olanzapine and placebo on reducing the severity of PTSD symptoms (DTS - self-report) (k = 1; n = 11; SMD = 0.04; 95% CI, -1.19 to 1.26). I

Quality of life mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between olanzapine and placebo on improving quality of life (Sheehan Disability Scale - self-report) (k = 1; n = 11; SMD = -0.17; 95% CI, -1.4 to 1.06). I
Likelihood of leaving treatment early	s2y	There is limited evidence favouring placebo over olanzapine on reducing the likelihood of leaving treatment early (k = 1; n = 15; RR = 1.5; 95% CI, 0.2 to 11). I

Adjunctive olanzapine (to SSRI) vs placebo

Severity of PTSD symptoms mean endpoint scores	s2x	There is limited evidence favouring adjunctive olanzapine (to SSRI) over placebo on reducing the severity of PTSD symptoms (Structured Interview for PTSD & CAPS - clinician) (k = 1; n = 19; SMD = -0.92; 95% CI, -1.88 to 0.04). I
Depression mean endpoint scores	s2x	There is limited evidence favouring adjunctive olanzapine (to SSRI) over placebo on reducing depression (Center for Epidemiologic Studies Depression Scale - self-report) (k = 1; n = 19; SMD = -1.2; 95% CI, -2.2 to -0.21). I

Adjunctive risperidone (misc.medication) vs placebo

Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between adjunctive risperidone (misc. medn.) and placebo on reducing the severity of PTSD symptoms (CAPS & Structured Interview for PTSD - clinician) (k = 1; n = 37; SMD = 0.1; 95% CI, -0.55 to 0.74). I
Severity of PTSD symptoms mean endpoint scores	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between adjunctive risperidone (misc. medn.) and placebo on reducing the severity of PTSD symptoms (Positive and Negative Symptom Scale - clinician) (k = 1; n = 37; SMD = -0.24; 95% CI, -0.89 to 0.4). I
Likelihood of leaving treatment early	s2x	There is limited evidence favouring adjunctive risperidone (misc. medn.) over placebo on reducing the likelihood of leaving treatment early (k = 1; n = 40; RR = 0.5; 95% CI, 0.05 to 5.08). I

High frequency repetitive transcranial magnetic stimulation (rTMS) vs control

the severity of PTSD symptoms at 14 day follow up (CAPS)	s2x	There is limited evidence favouring high frequency repetitive transcranial magnetic stimulation (rTMS) over control on reducing the severity of PTSD symptoms as measured by clinician-rated CAPS at 14 day follow up (k = 1; n = 16; SMD = -0.72; 95% CI, -1.77 to 0.33). I
the severity of post-treatment PTSD symptoms (PTSD checklist)	S2x	There is limited evidence favouring high frequency repetitive transcranial magnetic stimulation (rTMS) over control on reducing the severity of post-treatment PTSD symptoms as measured by self-report PTSD checklist (k = 1; n = 16; SMD = -1.5; 95% CI, -2.67 to -0.32). I
the severity of PTSD symptoms at 14 day follow	S2x	There is limited evidence favouring high frequency repetitive transcranial magnetic stimulation (rTMS) over control on reducing the severity of PTSD symptoms at 14 day follow up as measured by self-report PTSD checklist (k =

up (PTSD checklist)		1; n = 16; SMD = -0.68; 95% CI, -1.73 to 0.36). I
post treatment depression symptoms (Hamilton)	S4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between high frequency repetitive transcranial magnetic stimulation (rTMS) and control on reducing post treatment depression symptoms as measured by the clinician-rated Hamilton scale (k = 1; n = 16; SMD = -0.3; 95% CI, -1.32 to 0.72). I
Depression symptoms at 14 day follow up (Hamilton)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between high frequency repetitive transcranial magnetic stimulation (rTMS) and control on reducing depression symptoms at 14 day follow up as measured by the clinician-rated Hamilton scale (k = 1; n = 16; SMD = -0.13; 95% CI, -1.14 to 0.89). I
post treatment anxiety (Hamilton)	s2x	There is limited evidence favouring high frequency repetitive transcranial magnetic stimulation (rTMS) over control on reducing post treatment anxiety symptoms as measured by the clinician-rated Hamilton Anxiety Rating Scale (k = 1; n = 16; SMD = -1.38; 95% CI, -2.53 to -0.23). I
anxiety symptoms at 14 day follow up (Hamilton)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between high frequency repetitive transcranial magnetic stimulation (rTMS) and control on reducing anxiety symptoms at 14 day follow up as measured by the clinician-rated Hamilton Anxiety Rating Scale (k = 1; n = 16; SMD = 0; 95% CI, -1.01 to 1.01). I
leaving the study prior to 14 day follow up	s2x	There is limited evidence favouring high frequency repetitive transcranial magnetic stimulation (rTMS) over control on reducing the likelihood of leaving the study early due to any reason prior to 14 day follow up (k = 1; n = 19; RR = 0.36; 95% CI, 0.04 to 3.35). I

Low frequency repetitive transcranial magnetic stimulation (rTMS) vs control

the severity of PTSD symptoms at 14 day follow up (CAPS)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between low frequency repetitive transcranial magnetic stimulation (rTMS) and control on reducing the severity of PTSD symptoms as measured by clinician-rated CAPS at 14 day follow up (k = 1; n = 14; SMD = 0.12; 95% CI, -0.94 to 1.18). I
the severity of post-treatment PTSD symptoms (PTSD checklist)	s2y	There is limited evidence favouring control over low frequency repetitive transcranial magnetic stimulation (rTMS) on reducing the severity of post-treatment PTSD symptoms as measured by self-report PTSD (k = 1; n = 16; SMD = 0.82; 95% CI, -0.25 to 1.88). I
the severity of PTSD symptoms at 14 day follow up (PTSD checklist)	s2y	There is limited evidence favouring control over low frequency repetitive transcranial magnetic stimulation (rTMS) on reducing the severity of PTSD symptoms at 14 day follow up as measured by self-report PTSD checklist (k = 1; n = 14; SMD = 0.67; 95% CI, -0.43 to 1.77). I
post treatment depression symptoms (Hamilton)	S4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between low frequency repetitive transcranial magnetic stimulation (rTMS) and control on reducing post treatment depression symptoms as measured by the clinician-rated Hamilton scale (k = 1; n = 14; SMD = -0.09; 95% CI, -1.15 to 0.97). I
Depression symptoms at 14 day follow up (Hamilton)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between low frequency repetitive transcranial magnetic stimulation (rTMS) and control on reducing depression symptoms at 14 day follow up as measured by the clinician-rated Hamilton scale (k = 1; n = 14; SMD = 0.36; 95% CI, -0.71 to 1.43). I

post treatment anxiety (Hamilton)	s4	The evidence is inconclusive and so it is not possible to determine if there is a clinically important difference between low frequency repetitive transcranial magnetic stimulation (rTMS) and control on reducing post treatment anxiety symptoms as measured by the clinician-rated Hamilton Anxiety Rating Scale (k = 1; n = 14; SMD = 0.15; 95% CI, -0.91 to 1.21). I
anxiety symptoms at 14 day follow up (Hamilton)	s2y	There is limited evidence favouring control over low frequency repetitive transcranial magnetic stimulation (rTMS) on reducing anxiety symptoms at 14 day follow up as measured by the clinician-rated Hamilton Anxiety Rating Scale (k = 1; n = 14; SMD = 0.57; 95% CI, -0.52 to 1.66). I
leaving the study prior to 14 day follow up	s2x	There is limited evidence favouring low frequency repetitive transcranial magnetic stimulation (rTMS) over control on reducing the likelihood of leaving the study early due to any reason prior to 14 day follow up (k = 1; n = 18; RR = 0.8; 95% CI, 0.14 to 4.49). I