Table S1: Meta-analyses of psychotherapy or pharmacotherapy of common mental disorders in adults (network meta-analyses in italics)

Author	Mental Disorder	Number of RCTs	Number of patients	Treatment	Controls	Bias and quality checks	Quality of Meta-Analysis (Modified JBI Critical Appraisal Checklist) [1, 2]	Results: efficacy SMD (95% CI) [*, τ]	Results: adverse events SMD (95% CI) [*]
Depressive Disorders									
Bai et al. (2019)[3]	Major depressive disorder	8 (mono-therapy)	560	anti-inflammatory agents	placebo	RoB: 54% high quality[$$] 46% moderate quality[$$] NPB	10/11	0.30 (0.02-0.58) I^2=60	not reported
Barth et al. (2016)[4]	Major depressive disorder	68	17646	antidepressants (SSRIs)	placebo	RoB: 49% high, 40% unclear, 12% low [$$]	7/11	response: 0.27 (0.23-0.30) I^2 =0%	0.30 (0.25-0.35) drug > placebo I^2=28I^2= 38%

Cipriani et al. *(2018)*[5]	major depressive disorder	522	116477	21 anti-depressants	placebo	RoB: 9% high, 73% moderate %, 18% low $$ GRADE: 60% of comparisons low or very low quality of evidence SSE; novelty bias	11/11	0.30 (0.26-0.34) "moderate to low heterogeneity" 5, p. 1361	Drop outs due to adverse events: SMD: 0.27-0.82, 95% CIs excluding 0 except agomelatine
Re-analysis of Cipriani et al. (2018) by Munk-holm et al. (2019)[6]		522	116477			RoB: low: 1/522 high: 26%, unclear: 73%	8/11	overall: k=253, 0.29 (0.27-0.31) I^2 =40.1%, published: k=196, 0.33 (0.30-0.35), I^2 =40.0% unpublished: k=57, 0.15 (0.11-0.19), I^2 =0% placebo run-in: k=142, 0.31 (0.28-0.34), I^2 =35%	

								no placebo run-in: k=30, 0.22 (0.16-0.29), I^2 =35.5 sponsored: k=207, 0.27 (0.25-0.30), I^2 =35.4% not sponsored: k=36, 0.41 (0.31-0.52), I^2=55.7%	
Cuijpers et al. (2020) [7]	de-pression	Total: 101 6	Total: 11910 N not reported for the compa-rison with placebo	pharmaco-therapy	placebo	RoB: % not reported	9/11	0.19 (-0-13-0.50), I^2 =48% RR: response: 1.25 (1.09-1.45) I^2 =0% remission: 1.33 (1.10-1.64) I^2 =22%	not reported
Guo et al (2020)[8]	depressio n	134	46,646	pharmaco-therapy	placebo	RoB: 8% low in all domains[$$]	9/11	0.28 (0.25-0.30) 0.27 (0.24-0.30)[b]	not reported
Humes et al. (2017)[9]	de-pression	5	1700 (857,	pharmaco-therapy (vortioxetine)	placebo	Jadad Scale: 5 ≥ 3	8/11	k=5, (symptom severity): SMD: 0.30 (0.09-0.51)	adverse events: nausea 0.61 (0.44-0.78)

Fu et al. (2015) [10 j]			843)			PB: deviating funnel plot, but not statistically significant (few studies)		response (SMD): 0.34 (0.08-0.59) k=5 remission (SMD): 0.21 (-0.03-0.46)	dry mouth, headache, diarrhea: n.s.
Henssler et al. (2018)[11]	depressive disorder	Total:104 8 wk: k=91 12 wk: k=21 16 wk: k=4 20 wk: k= 3 24 wk: k=2	35052 8 wk: 32322 12 wk:5737 16 wk: 905 20 wk:708 24 wk:686	antidepressants	placebo	RoB: 59% low, 41% high or unclearsensitivity analysis for low risk studies PB for 8 weeks NPB for 12 weeks	10/11	treatment duration (weeks): 8wk: 0.27 (0.24-0.30) 0.23 (0.19-0.26)[b] I^2 =37% 12 wk 0.34 (0.25-0.43) I^2 =54%16 wk 0.24 (0.09-0.40) I^2 =17% 20 wk 0.31 (0.12-0.51) I^2 =18% 24 wk 0.34 (0.18-0.50) I^2 =0%	dropouts due to adverse events: 8wk; 0.39 (0.30-0.48) 12 wk: 0.25 (0.09-0.40) drug > placebo

Jakobsen et al. (2017) [12]	major depressive disorder	61	Not reported for the comparison with placebo	antidepressants (SSRIs)	placebo	RoB: high for all studies [$$] NPB	11/11	0.23 (0.14-0.31)	SAEs: 0.17 (0.04-0.31) drug > placebo AEs: drug > placebo (effect size not reported)
Kishi et al. (2014)[13]	major depressive disorder	12	1816	Azapirone 5-HT1A receptor partial agonists	placebo	RoB: low or unclear risk of bias in most studies [§§] NPB	7/11	RR: 1.35 (1.20-1.54) I^2 =48%	RR gepirone > placebo 2.06 (1.20-3.53) azipirones > placebo 1.88 (1.38-2.57) buspirone: 2.29 (0.95-5.50) isapirone: 1.61 (0.44-5,89) zalospirone: 1.71 (0.80-3.65) SSRI+buspirone: 1.06 (0.52-2.16), CLO+tandospirone2.00 (0.21-19.23) azipirone augmentation: 1.12 (0.56-2.21)
Koesters et al. (2017)[14]	depressive disorder	14	7746	vortioxetine	placebo	RoB.: 0% high, 53% low, 47% unclear [$] low quality evidence for response	10/11	response: RR: 1.35 (1.22-1.49) I^2 =60 % k=14, N=6220 remission: RR: 1.32 (1.15-1.53), I^2 =58 %	withdrawal due to AES: drug > placebo: RR: 1.41(1.09-1.81) I^2 =0 % withdrawal due to inefficacy: drug< placebo: RR: 0.56 (0.34-0.90)

						and remission [$$] NPB		k=14, N=6220	I^2 =41 %
Kryst et al. (2020)[15]	major depression	5 (monotherapy)	195	ketamine	placebo	RoB [$] 20% low 20% unclear 60% high	6/11	24 h: 0.83 (0.12-1.55), I^2 =79% 3-4 days: 0.88 (0.46-1.31) I^2 =0 % 7 days: 0.31 (-0.30-0.93) I^2 =73%	not reported
Laoutidis & Kioulus (2015)[16]	de-pression	13	6225	desvenlafaxine	placebo	RoB: [$] High: 67%, Low: 27%, unclear: 7% NPB	8/11	Remission (k=12): 0.19 (0.11-0.26) I^2 =0 % Response (k=13): 0.22 (0.15-0.28) I^2 =0 %	0.40 (0.22-0.59) drug > placebo
Meeker et al. (2015) [17]	MDD	1-6	6145 (total)	vortioxetine	placebo	Quality rating: 7/8 published	11/11	Response RR: 2.5 mg: 1.20 (1.00 1.43), I^2=0, k=2	withdrawals due to AEs: drug > placebo 10 mg, 15 mg, 20 mg

						studies fair or good quality[§§] 3/3 unpublished: fair quality [$$] NPB		5 mg: 1.33 (1.10-1.61), I^2=0.71, k=6 10 mg: 1.42 (1.21-1.67), I^2=0.49, k=6 15 mg: 1.32 (0.98-1.78), I^2=0.71, k=3 20 mg: 1.58 (1.19-2.08), I^2=0.76, k=4 Remission RR: 1 mg: 1.57 (0.98-2.50), I^2=0, k=1 2.5 mg: 0.99 (0.77-1.28, I^2=0, k=2 5 mg: 1.27 (0.98-1.66), I^2=0.70, k=6 10 mg: 1.45 (1.18-1.77), I^2=0.35, k=6 15 mg: 1.26 (0.86-1.84), I^2=0.64, k=3	durg=placebo: 2.5 mg, 5 mg: n.s. 20 mg: nausea, vomiting:Fcau drug > placebo effect sizes not reported

								20 mg: 1.68 (1.19-2.37), I^2=0.67, k=4	
Pae et al. (2015)[18]	major de-pression	11	4947 Drug: 3276 Placebo: 1671	vortioxetine	placebo	RoB: low: 83%, 17% unclear[$] Jadad:12/12≥4 NPB	10/11	0.22 (0.12-0.31) I^2 =60%	withdrawal due to AEs: 0.23 (0.07-0.40) drug > placebo
Taylor et al. (2014)[19]	major depressive disorder	20	7460	agomelatine	placebo	RoB: 75% low, 10% high, 15% unclear [$] PB	10/11	0.24 (0.12-0.35) I^2 =66%	withdrawal due to AEs: agomelatine: 4.2% placebo=4.0%
Cuijpers et al. 2014[20]	depressive disorder	10	1240	psychotherapy	placebo	RoB: 73% high in at least one domain [$$] PB, SSE	8/11	0.25 (0.14-0.36) I^2 =0% 0.25 (0.15-0.36) [a] I^2 =0% 0.21[b] (0.10-0.32)	not reported

Cuijpers et al. 2016[21]	major depressive disorder (and anxiety disorders)	(54) (all comparisons, not only TAU)	(11030) MDD + anxiety disorders	psychotherapy (CBT)	TAU	ROB: 17% met all criteria for low risk PB, SSE	8/11	MDD: 0.60 (0.45-0.75) I^2 =69%, 30 comparisons high-quality: 5 comparisons 0.43 [a] (0.16-0.70), I^2 =46%	not reported
		(54) (all comparisons, not only placebo)	(11030) MDD + anxiety disorders		pill placebo			0.55 (0.28-0.70), 5 comparisons, I^2=45% no data for high quality studies or adjusting for small sample sizes reported	
Cuijpers et al. (2019) [22 h]	de-pression	127	not reported for the com-parison with TAU	psychotherapy	TAU	RoB (all studies): 78% high or unclear, low: 22% [$ $] PB, SSE	9/11	0.61 (0.53-0.68) 0.38[a] (0.32-0.44) I^2 =46% 0.31[a+b] (0.24-0.38)	not reported
Cuijpers et al. (2020)[7]	de-pression	4	not reported for the com-	psychotherapy	placebo	RoB: 57% high or		0.19 (-0.37-0.75) RR: response:1.20	not reported

			parison with placebo			unclear, 43% low [$$]		(0.93-1.59) I^2 =46% remission: 1.37 (1.05-1.79) I^2 =41%	
Driessen et al. (2015)[23]	major depressive disorder	19	2169	psychotherapy	TAU or placebo	RoB: 4% met all criteria for low risk [$$] PB	9/11	unpublished: k=4, 0.11 (-0.12-0.35), I^2=0% published: k=15, 0.37 (0.25-0.48), I^2 =0% published + unpublished, k=19; 0.26 (0.02-0.51), I^2 =0%	not reported
Lopez -Lopez et al. (2019)[24] [h, i]	de-pression	91	(not reported for compari son with TAU)	psychotherapy (CBT: face to face)	TAU	RoB: 100% high [$] 100% high blinding of participants and personnel [§§] 79% high blinding of outcome assesment [§§]	11/11	CBT (face-to-face) post: 1.11 (0.60-1.62) 3-12 months-follow-up: 0.27 (-0.52-1.06) post: response: 0.52 (-0.14-1.24) post: remission: 0.13 (-0.28-0.53)	not reported

Anxiety Disorders									
Bighelli et al. (2018)[25]	panic disorder	41	9377	pharmaco-therapy (anti-depressants)	placebo	RoB: 84% high, 0% low, 16% uncertain [$] PB very low quality [$$] evidence	11/11	SMD: 0.44 (0.30-0.58) response: RR:1.39 (1.27-1.52) I^2 =67% remission: RR: 1.20 (1.14-1.28) I^2 =40%	RR: 1.49 (1.25-1.78) drug > placebo
van Dis et al. (2019)[26]	panic disorder	3	240	psychotherapy (CBT)	pill placebo	RoB: all studies (k=69): 90% high risk, 10% low risk, PB	11/11	Post: 0.42 (0.11-0.74) 6-12 months FU: 0.73 (0.34-1.12)	not reported
Carl et al. (2019)[27]	GAD	43	8776	pharmaco-therapy	placebo	RoB: low: 28%-85%[$$] 28% low for allocation concealment NPB	7/11	0.38 (0.30-0.47)	not reported
Gomez et al. (2018)[28]	GAD	total:56	total: 12655	pharmaco-therapy	placebo	RoB: 17% low, 22%	8/11	overall: 0.37 (0.34-0.41)	not reported

		SSRI: 16 SNRI: 17 BZ: 23	SSRI: 5444 SNRI: 4993 BZ: 2218	(benzo-diazepines and serotonergic anti-depressants)		high, 61% unclear [$$] PB		overall: 0.33[b] (0.28-0.37) SSRIs: 0.33 (0.26-0.39) SNRIs: 0.34 (0.29-0.42) benzodiazepines: 0.50 (0.41-0.58)	
He et al. (2019)[29]	GAD	41 dulox: 7 escita: 7 fluo:1 parox: 7 sert: 2 venla: 13 vila: 3 vortio: 4 aus k und N aus	15739 293 2882 58 3046 699 4071 1471 1827	pharmaco-therapy	placebo	RoB: 37% high, 17% moderate, 46% low[$$] NPB	7/11	Response (SMD): duloxetine: 0.41 (0.47-0.55) escitalopram: 0.38 (0.22-0.57) fluoxetine: 0.29 (-0.25-0.84) paroxetine: 0.26 (0.05-0.48) sertraline: 0.35 (0.14-0.57) venlafaxine; 0.43 (0.32-0.57) vilazodone: 0.29 (0.10-0.53)	SMD: 0.35-0.74 drug > placebo except vortioxetine, sertraline, fluoxetine

		suppl Table 1 27.12.20						vortioxetine 0.19 (-0.006-0.38)	
Kong et al (2020)[30]	GAD	32 (total)	13338 (total)	pharmacotherapy	placebo	RoB [$] 70% high 13% low 17% unclear	8/11	remission rates (SMD) duloxetine 0.35 (0.21-0.48) paroxetine 0.31 (0.12-0.49) lorazepam 0.23 (-0.26-0.72) pregabalin 0.27 (-0.06-0.61) quetiapine 0.35 (0.18-0.52) vortioxetine 0.14 (-0.07-0.36) agomelatine 0.55 (0.31-0.79) tiagabine 0.07 (-0.15-0.29) escilatopram 0.39 (0.22-0.56) sertraline 0.39 (-0.01-0.78) venlafaxine 0.46 (0.29-0.62)	withdrawal due to adverse events: paroxetine, duloxetine, quetiapine, escitalopram, venlafaxine, and lorazepam > placebo
Li et al. (2017)[31]	GAD	14	3622 response: 2913	pharmaco-therapy (venlafaxine)	placebo	RoB: low: 14%, high: 57%,	9/11	response: 0.33 (0.25-0.42) I^2 =71%	dropouts due to adverse events: 0.57 (0.44-0.70) drug > placebo

		response: 11				unclear: 29% [$] NPB			
Man-eeton et al. (2016)[32]	GAD	3	2248	quetiapine	placebo	RoB: low for the 3 RCTs[§§]	6/11	response: RR: 1.24 (1.16-1.32) I^2=7% remission: RR: 1.27 (1.13-1.42) I^2=7%	withdrawal due to AEs: RR=3.18 (2.52, 4.00) drug > placebo
Qin et al. (2019)[33]	GAD	4	1687	pharmaco-therapy (vortioxetine)	placebo	RoB: low: 50% [$] unclear: 50% [$] NPB	9/11	2.5 mg: 0.13 (-0.03-0.29) 5 mg: 0.15 (-0.18-0.48) 10 mg: 0.08 (-0.08-0.24)	Discontinuation due to AEs: OR: 2.5 mg: -0.72 (-1.94-0.52) 5 mg: 0.29 (-0.08-0.66) 10 mg: 0.36 (-0.10-0.74)
Wang et al (2020)[34]	GAD	4	1292	agomelatine	placebo	RoB: 100% low [$$]	7/11	0.56 (0.18-0.94)	agomelatine > placebo: liver function increment: OR: 3.13 (1.26 - 7.78), p = 0.01 Nausea: OR: 3.27 (1.18 - 9.11) p = 0.02)

									no significant differences in somnolence, headache, nasopharyngitis, and dizziness
Zhang et al. (2016)[35]	GAD	7	2674	duloxetine	placebo	RoB (no detailed data reported)	7/11	response: k=6, N=1975: RR 1.48 (1.34-1.63), I^2=0.36 remission: k=7, N=2399:RR: 1.60 (1.43-1.80), I^2=0.40	withdrawal due to AEs: duloxetine: 32.1% placebo: 36.0
Carl et al. (2019) [27]	GAD	11	793	psychotherapy	psycho-logical placebo	RoB: low: 28% - 85%[$$] (overall, not specified per comparison) PB		0.47 (0.25-0.69), k=10	not reported
		4	235		TAU	RoB: low: 28%-85%[$$] (overall, not specified per comparison) PB		0.38 (0.05-0.71), k=5	not reported
		3	74		Pill placebo	RoB: low: 28%-85%[$$]		[1.44 (0.94-1.94), k=3] not reliable according to Carl et al.[27]	not reported

						8overall, not spevified per comparison PB			
Curtiss et al. (2017)[36]	SAD	52	12153	pharmaco-therapy	placebo	RoB: high: 63%, low: 12%, unclear: 25% [$$] NPB	7/11	0.41 (0.36-0.46) 0.35[b] (0.28-0.42)	not reported
Heeren et al. (2015)[37]	SAD	7 (with a clinical diagnosis)	not reported for the comparison with sham training	psychotherapy (Attention Bias Modification; ABM)	sham training	RoB: low: 27%-40% [$$] (all studies, k=15) NPB	8/11	0.16 (-0.04-0.35)	not reported
Mayo-Wilson et al. (2014)[38]	SAD	Total: 101 Total Drugs: 54 SSRIs+ SNRIs: 27	Total: 13.146 Total Drugs: 5042 287	pharmaco-therapy	pill placebo	RoB (all drug studies): 43% low, 55% high, 2% uncertain[$] SSRIs: 57% low, 40%	7/11	SSRIs+SNRIs 0.44 (0.22-0.67)	not reported

		Benzodiazepine: 2 MAOIs: 9 NSSA:1, anti-convul-sants: 5	70 135 60 185			high, 3% uncertain $ PB: not reported		benzodiazepine: 0.49 (-0.10-1.08) MAOIs: 0.53 (0.01- -01.06) NSSA: 0.34 (-0.45-1.13) anti-convulsants: 0.34 (-0.14-0.84)	
Mayo-Wilson et al. (2014)[38]	SAD	Total: 101 Drugs: 54 SSRIs:27 benzo:2 MAOIs:9	Total: 13.146 Drugs: 5042 287 70	pharmaco-therapy	psycho-logical placebo	RoB (all drug studies): 43% low, 55% high, 2% uncertain$ SSRIs: 57% low, 40% high, 3% uncertain $		SSRIs+SNRIs 0.28 (-0.07-0.64)	not reported

		NSSA: 1 anticonv:5	135 60 185			PB: not reported		benzodiazepine: 0.33(-0.30-0.95) MAOIs: ,0.37 (-0.21-0.95) NSSA: 0.17 (-0.66-1.01) anti-convulsants:, 0.18 (-0.37-0.75)	

Mayo-Wilson et al (2014)[38]	SAD	Total: 101 Psycho-therapy, total: 80 individ. CBT: 2 group CBT:4 expo, SHNS, SHWS, PDT, exercise: 0 direct compariso ns	Total: 13146 psychot herapy, total: 2906 individ. CBT: 71 165 0 0 0 0 0	psychotherapy	pill placebo	RoB (total psychother apy): 100% high [§] direct comparison s 100%: (6/6) high PB: not reported	7/11	individual CBT: 0.72 (0.30-1.13) group CBT: 0.45 (0.03-0.88) SHWS: 0.39 (-0.15-0.93) exposition: 0.39 (-0.20-0.98) SHNS [f] 0.28 -(0.26-0.83) PDT: 0.15 (-0.21-0.52) excercise[f]: 0.11 (-0.85-1.09)	not reported

Mayo-Wilson et al. (2014)[38]	SAD	indiv. CBT, SSHW, SSNW, exercise: 0 direct compar-isons Group CBT: 4 expo: 1 PDT:1	0 0 0 0 106 77 40	psychotherapy	psycho-logical placebo	RoB (total psycho therapy) 100% high § direct comparisons: 100% high § (6/6) PB: not reported	7/11	individual CBT: 0.56 (0.11-1.00) group CBT: 0.29 (-0.14-0.72) SHWS: 0.23 (-0.33-0.79) exposition: 0.23 (-0.37-0.82) SHNS[f]: 0.12 (-0.43-0.68) PDT: 0.01(-0.36-0.38) exercise[f]: 0.27 (-0.70-1.26)	not reported
Liu et al. 2018[39]	SAD	5	1001	Fluvoxamine	placebo	RoB: 20% high, 80% low $ NPB	9/11	k=5: response: 0.30 (0.14-0.44), I^2=0.23	discontinuation due to AEs: 0.99 6(0.45-1.53) Any AE: 0.54 (0.32-0.77) SAE: -0.01 (-0.77-0.75)
Liu et al. (2017)[40]	SAD	13 of 36 RCTs included	k=13: 857	psychotherapy (Cognitive Bias Modification, CBM)	psycho-logical placebo	all 36 studies: RoB: 14% met all	8/11	clinical samples: k=13, 0.11 (-0.07-0.27) I^2=14.04	not reported

		clinical samples				criteria for low risk [$$] NPB			
Williams et al. (2017) [41]	SAD	Total: 66 meta-analysis: 63 SSRI: 24 MAOIs: 4 RIMAS: 8 GABA: 3 Benzo-diazepines :2	11.597 (66 studies) SSRI: 4984 MAOIs: 235 RIMAs: 1270 GABA: 532 Benzo-dia-zepines: 132	pharmaco-therapy	placebo	Total: k=66 RoB: 14% low, 23% high, 62% unclear [$] SSRIs: very low quality evidence [$$] MAOIs: low quality evidence[$$] RIMAs: low quality evidence [$$] GABA:moderate quality evidence [$$] Benzos: low quality evidence [$$] PB	10/11	RR SSRI: 1.65 (1.48-1.85) MAOIs: 2.36 (1.48-3.75) RIMAs: 1.83 (1.32-2.55) GABA: 1.60 (1.16-2.20) Benzodiazepines: 4.03 (2.45-6.65)	RR: 0.0-5.0 SSRIs: 2.56 (1.94-3.38) SNRIs: 3.23 (2.15-4.86) RIMAs: 1.42 (0.86-2.34) Benzodiazepines: 1.68 (0.21-13.13)

Sugar-man et al. (2014)[42]	anxiety disorders [and depressive disorders]	12 anxiety 27 de-pression	3385 5186	paroxetine	placebo	No RoB, no quality rating (included as no meta-analysis of paroxetine in anxiety disorders was available)	4/11	anxiety: 0.27 (0.20-0.33), I^2=0.38 published studies: 0.32 (0.23-0.40), k=8 unpublished studies: 0.17 (0.06-0.29), k=4 [depression: 0.32 (0.26-0.38), I^2=0.02 published studies: 0.36 (0.27-0.44), k=16 unpublished studies: 0.28 (0.20-0.37, k=11]	not reported
Carpenter et al. (2018)[43]	anxiety and related disorders (GAD, SAD, PD, OCD, PTSD, acute	41 ITT: 16; completer : 25	2843	psychotherapy (CBT)	placebo	RoB: high risk: 35% $^{\$\$}$ PB	10/11	ITT: 0.40 (0.25-0.56) I^2 =54.43% 0.33[b] (0.19-0.48) Completer: 0.70 (0.54-0.86)	not reported

	stress disorder)								
Cuijpers et al. (2016)[21]	anxiety disorders (+ major depressive disorder)	90 31 GAD 42 PAD 48 SAD	11030 MDD + anxiety disorders	psychotherapy (cognitive-behaviour therapy, CBT)	TAU, pill placebo	ROB: 17% met all criteria for low risk		GAD: CBT vs TAU (k=4, 3 of 4 non-high quality) 0.45 (0.26-0.64) CBT vs. pill placebo (3 non-high quality studies): 1.32 (0.83-1.81) PAD: CBT vs TAU 2 non-high quality studies) 0.27 (-0.12-0.65) CBT vs pill placebo (5 non-high quality studies) 0.28 (0.03-0.54) SAD: CBT vs TAU (3 studies): 0.44 (0.12-0.77) 2 high quality studies: 0.30 (-0.04-0.64)	not reported

								CBT vs pill placebo (k=5, 4 of 5 non-high-quality): 0.47 (0.24-0.70)	
Obsessive-Compulsive disorder									
Skapinakis et al. (2016)[44, 45]	OCD	Total: 54 SSRIs: 19 clomipramine: 4	Total: 6652 3810 803	pharmacotherapy	placebo	RoB: SSRIs: 68% high 21% unclear 11% low [§] Clomipramine: 100% high [§] 50% high 50% low[§] (two comparisons with active drugs)	9/11	0.51[g] (0.33-0.69) 0.66 [g] (0.43-0.88)	not reported

		venla-faxine:1 no direct com-parison with placebo excluding RCTs with waiting list trials						0.45 (-0.090-0.99)	
Skapi-nakis et al. (2016)[44, 45]		Total: 54 1 (behavior therapy) excluding RCTs with waiting list trials CBT, CT: no direct compariso	Total: 6652 61	psychotherapy	placebo	RoB: 100% high[§]	9/11	behavior therapy: 1.46 (0.95-1.97) cognitive-behavior therapy: 1.12 (0.69-1.55) cognitive therapy: 1.33 (0.73-1.94)	not reported

		n with placebo							
Öst el al. (2015)[46]	OCD	6 (all placebos) 5 (psycho-logical placebos)	508 359	psychotherapy (CBT)	pill placebo and psycho-logical placebo	RoB: 67% high , 33% low [$]	7/11	CBT vs all placebos: 1.33 (0.91-1.76), k=8 I^2 =72% CBT vs psychological placebo: 1.29 (0.76-1.81), k=6, I^2 = 77% CBT vs all placebos: 1.03 [b] (CI not reported) CBT vs psychological placebo: 0.91 [b] (CI not reported) Follow-up (all controls) k=27: 0.06 (-0.13-0.24) I^2 =53%	not reported
Post-Traumatic Stress Disorder									
Cipriani et al. (2018)[47]	PTSD	Total: 51	Total: 6189	pharmaco-therapy	placebo	RoB: 29% low, 7% high, 64% unclear [$]	10/11	Phenelzine: 0.97 (0.27-1.68)	drug > placebo sertraline: 0.54 (0.10-0.97)

		Phenel-zine: k=1 Mirta-zapine: k=1 Olanzapine: k=3 Desipra-mine: not reported	Phenel-zine+ Placebo: 37 Mirta-zapine + placebo: 26 Olan-zapin + placebo: 62 Desipra-mine: not reported			low or very low quality [$$] NPB		Mirtazapine: 0.79 (-0.09-1.66) Desipramine: 0.52 (0.02-1.03) Olanzapine: 0.51 (-0.03-1.06) Brofaromine: 0.47 (-0.12-1.06) Paroxetine: 0.38 (0.20- 0.55) Amitriptyline: 0.34 (-0.32-1.01) Venlafaxine: 0.32 (0.12-0.52) Fluoxetine: 0.30 (0.09-0.51) Topiramate: 0.29 (-0.14-0.71) Risperidone: 0.27 (0.01-0.54)	paroxetine: 0.46 (0.06-0.87) others not significant (supplement) I^2 =0%

								Imipramine: 0.27 (-0.39-0.92) Citalopram: 0.33 (-0.24, 0.90) Sertraline: 0.23 (0.09-0.38) Nefazodone: 0.23 (-0.29-0.76) NK1R antagonist: 0.20 (-0.15-0.56) Divalproex: 0.13 (-0.28, 0.55) Guanfacine : 0.12 (-0.33-0.58) Prazosin: 0.06 (-0.20, 0.32) Tiagabine: 0.02 (-0.33, 0.37) Bupropion: -0.10 (-0.91-0.71)	

								overall; I^2 =22%	
de Moraes Costa et al. (2020)[48]	PTSD	58	6766	pharmaco-therapy	placebo	RoB $^{\$}$ 24% high 31% low 45 % unclear NPB	10/11	Topiramate 0.57 (0.09-1.05) I^2 = 0% Risperidone 0.53 (0.14-0.92) I^2 = 0% Olanzapine 0.43 (-0.16-1.02) I^2 = 0% Quetiapine 0.59 (0.12-1.06) I^2 = 0% Paroxetine 0.35(0.22-0.48), I^2 = 37% Desipramine 0.44(-0.18-1.06) I^2 = 0% Venlafaxine 0.25 (0.06-0.44) I^2 = 0% Mirtazapine 0.22(-0.13-0.57) I^2 = 0%	not reported

								Fluoxetine 0.28 (0.09-0.47) I^2 = 0% NK1R antagonist 0.28 (-0.18-0.74) I^2 = 0% Ziprasidone 0.17 (-0.52-0.86) I^2 = 0% Sertraline 0.21(0.09-0.33) I^2 = 19% Guanfacine - 0.05 (-0.57-0.47) I^2 = 0% Nefazodone 0.14(-0.35-0.63) I^2 = 0% Bupropion -0.21 (-1.05-0.63) I^2 = 0% Brofaromiine 0.09 (-0.22-0.40) I^2 = 0% Prazosin -0.01 (-0.19--0.17) I^2 = 0%	

								Vilazodone -0.01(-0.54-0.52) I^2 = 0% Tiagabine 0.02 (-0.31-0.35) I^2 = 0% Citalopram -0.18(-0.65-0.29) I^2 = 0% Divalproex -0.19 (-0.58-0.20) I^2 = 0% Amitriptyline 0.33(-0.35-1.01) I^2 = 0% Lamotrigine 0.10 (-0.91-1.11) I^2 = 0% Phenelzine 0.60 (-0.08-1.28) I^2 = 0% Imipramine 0.18 (-0.44-0.80) I^2 = 0%	
Lee et al (2016) [49]	PTSD	43	5225	pharmaco-therapy [l]	placebo	RoB: 12% low, 9% moderate, 79% high [$$]	8/11	SSRIs 8-12 wk: 0.37 (0.29-0.45)	not reported

								14-27 wk: -0.90 (-0.86-0.67) 34+wk: 0.30 (0.12-0.47) SSRIs + SNRIs 8-12 wk: 0.50 (0.43-0.58) 14-27 wk 0.29 (0.08-0.50) 34+wk: 0.30 (0.12-0.47) [Lee]	
Hoskins et al. (2015)[50]	PTSD	51 21 SSRIs 2 MAOIs 2 venlafaxine 2 olanzapine	4886 3932 159 687 39	pharmaco-therapy	placebo	RoB: high: 73%, low: 4%, unclear: 23%[$]	9/11	SSRIs: 0.23 (0.12-0.33), I^2=0.53 (0.00-0.37) MAOIs: 0.24 (-0.33-0.81), I^2= 0.63 Venlafaxine.: 0.20 (0.05-0.35), I^2=0.00 Olanzapine: 0.61 (-0.05-1.27) I^2=0.53 Topiramate:0.46 (-0.02-0.94),	not reported

		2 topiramate	69					I^2=0.00	
Ehring et al.(2014) [51]	PTSD in adult survivors of childhood abuse	7	574	psychotherapy	TAU/ placebo	No RoB, no quality rating (included as no meta-analysis on complex PTSD was available)	7/11	0.50 (-0.11-1.12) n.s. 0.21 (-0.50-0.92) [b]	not reported
van Dis et al. 2019 [26]	PTSD	9	643	psychotherapy (CBT)	TAU	RoB: all studies (k=69): 90% high risk, 10% low risk	11/11	Post: 0.54 (0.28-0.80), 1-6 months FU: 0.47 (0.17-0.77), k=7 6-12 months FU: 0.49 (0.25-0.74), k=4	not reported
Eating Disorders									
Svaldi et al. (2018)[e] [52]	bulimia nervosa	21	1316	pharmaco-therapy	placebo	RoB: 97% at least one domain high risk; uncertain: 3% 0% low NPB	8/11	0.61 (0.31-0.91) SSRIs: 0.10 (-0.08-0.29) MAOIs: 0.11 (-0.65-0,87)	not reported

								other dugs: 1.00 (0.43-1.58)	
Brownley et al. (2016)[53 m]	binge eating disorder	3	967	pharmaco-therapy (lisdexamfetamine)	placebo	RoB: medium to low[$$] high risk studies excluded	9/11	abstinence from binge eating: RR: 2.61 (2.04-3.33) I^2= 0%	Drug>placebo: insomnia RR=2.80 (1.74-4.51), I^2 =0% general sleep disturbaces: RR: 2.19 (1.36-3.54) I^2 =32% headaches: RR: 1.63 (1.13-2.36), I^2 =0% gastrointestinal upset: RR: 2.71 (1.14-6.44) I^2 =69% sympathetic nervous symptom arousal; RR RR: 4.28 (2.67-6.87)
		8	416	pharmaco-therapy (second generation antidepressants)	placebo			abstinence from binge eating: RR: 1.67 (1.24-2.26) I^2= 0%	not reported quantitatively
Hilbert et al. (2019)[54 m]	binge eating disorder	19	2471	pharmaco-therapy	Placebo	RoB: 67% high, 6% low, 28% unclear	11/11	0.45 (0.34-0.57)	withdrawal due to AEs: 0.44 (0.26-0.63) drug > placebo

de Vos et al (2014)[55]	anorexia nervosa	18 including 2 RCTs on adoles-cents and 3 on adult-adoles-cents	890 830	pharmaco-therapy	placebo	RoB: 28% low, 72% high $$ NPB	7/11	0.33 (0.14-0.52), I^2=0.40 outlier removed: 0.25, I^2=0	not reported
Hay et al. (2015) [56]	anorexia nervosa	2	137 71	psychotherapy	TAU	RoB: CBT vs. TAU: 50% high, 50% low $ CAT vs. TAU: 100% high (2/2)	9/11	CBT vs TAU, k=2: SMD=0.00 (-0.91-0.91) RR: 0.97 (0.37-2.54), cognitive-analytic therapy (CAT) vs TAU: RR: 1.28 (1.00-1.64), k=2	not reported
Solmi et al. (2021)[57]	anorexia	13	1047	psychotherapy	TAU	RoB: $$ 54% low, 23% high 23% unclear NPB (BMI) PB (symptoms)	10/11	0.15 (-0.12-0.42), k=6family-based treatment: 0.22 (-0.30-0.74), k=2CBT-LEAP: 0.31 (-0.29-0-91), k=1 MANTRA: 0.12 (-0.16-0.40), k=3	not reported

								PDT: 0.10 (-0.19-0.39), k=4	
van den Berg et al. (2019)[58]	anorexia nervosa	9 for adults	861	psychotherapy	TAU/pla-cebo	RoB: 67% low, 33% high, 0% unclear [$] NPB	9/11	0.23 (0.06-0.40), I^2 =4%	not reported
Insomnia									
Liang et al. (2019) [59]	insomnia	6	2809	Eszopiclone	placebo	GRADE: 5/6 high certainty	8/11	SMD reported only for 1 of 8 outcome measures (sleep quality): 1 wk: 1.38 (1.03-1.73), I^2 = 43% 1 month: 1.20 (1.00-1.40) I^2 = 0 % 3 months: 0.88 (0.46-1.31), I^2 = 80% 6 months: 1.11 (0.89-1.31), I^2 = 0.38	2mg for elderly: RR: 0.75-19.44 3mg non-elderly: RR: 1.01-11.53

Kishi et al. (2020)[60]	insomnia	4	3237	Lemborexant suvorexant zolpidem tartrate	placebo	RoB: 100% high quality[$$]	8/11	week 1: time to sleep onset: LEM10 = 0.51 (−0.39-0.63) LEM5 = 0.48 (0.36-0.60) SUV20/15 = 0.21 (0.10-0.33) ZOL6.25 = 0.30 (0.14-0.46 subjective total Lsleep time: LEM10 = 0.58 (0.45-0.70) LEM5 = 0.33 (0.21−0.46 SUV20/15 = 0.34 (−0.23-0.46) ZOL6.25 = 0.42 (0.25-0.59) subjective wake after sleep time: LEM10 = 0.42 (0.28-0.57) LEM5 = 0.26 (0.11−0.40) SUV20/15 = 0.18 (0.05-0.32) ZOL6.25 = 0.37 (0.18−0.56	adverse events: ZOL62.5 > Placebo somnolence: LEM10, SUV20/15 > placebo no further significant differences

Kuriyama et al. (2014)[61]	insomnia	13	5812	ramelteon	placebo	RoB: 8% high, 23% low, 69% unclear[$] NPB	10/11	0.07 (0.02-0.13) I^2 =0.00%	somnolence: RR: 1.97 (1.21-3.20) drug > placebo all other AEs: n.s.: abdominal pain, diarrhea, dizziness, dysmenorrhea, dyspepsia, fatigue, headache, nasopharyngitis, nausea, upper respiratory infection
Winkler et al. (2014)[62]	insomnia	31	3820	pharmaco-therapy	placebo	Jadad quality rating: 48%≥4[$$] NPB	9/11	total sleep time: 0.27 (0.17-0.38), I^2=0.47 Subjective total sleep time: 0.21 (0.14-0.28) I^2=0.00	not reported
Somatoform Disorder/ Somatic Symptom Disorder									
Klein-stäuber et al.(2014)[63]	somato-form disorder	tricyclic anti-depressants (TAD): 2 new gen-eration anti-	239	pharmaco-therapy	placebo	RoB: tricyclic antidepress ants (TAD) and natural products: all high in at	9/11	TAD: 0.13 (-0.13-0.39), I^2=0.02 NGAD: 0.91 (0.46-1.36), I^2=0.63 natural products: 0.74	withdrawals due to AEs: antidepressants vs placebo= 0-32% natural products: 0-1.7%

		depressants (NGAD): 3 natural products (St. John´s wort): 2	243 322			least one domain[$] new generation anti-depressants (NGAD): high in 66% (2 of 3 RCTs) in at least one domain[$]		(0.51-0.97), I^2=0.00	
van Dessel et al.(2014)[64]	somato-form disorder	5	624	psychotherapy	enhanced care	RoB[§§]: all studies at least high risk for one domain, low-quality of evidence NPB	10/11	symptom reduction 0.19 (-0.04-0.43)	AEs rarely reported in RCTs K=2: RR: 1.31 (0.47-3.66) N=445, I^2=0
Borderline Personality Disorder									
Storebo et al. (2020)[65]	borderline person-ality disorder (BPD)	20 adults	1088 adults	psychotherapy	TAU	86% high, 14% low[§]	10/11	BPD symptom severity 0.57 (0.37-0.76) I^2 =57% NPB	adverse events: RR: 0.92 (0.45-1.88), k=2, N=381, serious adverse events : RR: 0.86 (0.14-5.09) k=4, N=571, I^2 =46%

Substance-related disorders									
Cheng et al.2020[66]	alcohol use disorder	8	413	gabapentin-noids	placebo	RoB [$] 75% low, 25% high NPB	9/11	*SMD= 0.07* *(* -0.27- 0.41)	gabapentoids= placebo OR: 1.07 [0.91-1.25)
Donog-hue et al. (2015) [67]	alcohol de-pendence	27 naltrexone 22 acamprosate	4199 5236	naltrexone acamprosate	placebo	Quality Rating: Naltrexone: high quality evidence [$$,] NPB Acamprosate: moderate quality PB (relapse 6 months)	6/11	naltrexone: 0.16 (0.03-0.30) acomprosate: 0.35 (0.24-0.45)	withdrawals due to AEs: naltrexone: RR: 1.72 (1.10-2.70) I^2 =0% drug > placebo acamprosate: RR: 1.30 (0.96-1.75), I^2 =0%
Magill et al. (2019)[68]	Substance-related disorders	11	1394	psychotherapy (CBT)	TAU	RoB: 64% low risk [$$] NPB	8/11	Frequency: k=9: 0.18 (0.02-0.35), I^2 =45% Follow-up: k=7	not reported

								0.05 (-0.09-0.19) Quantity:0.42 (0.03-0.81), k=2, I^2 =0%	
Vanderkam et al (2020)[69]	tobacco use disorder alcohol use disorder	7 6	989 319	pharmaco-therapy	placebo	RoB [$]: 69% high 31% low	8/11	smoking cessation: RR: 1.39 (1.04-1.84) alcohol abstinence: RR: 1.00 (0.71-1.41) alcohol consumption: SMD: 0.32 (0.07-0.56) heavy drinking days: SMD: 0.44 (-0.06-0.94)	no data reported
Attention Deficit Hyperactivity Disorder									
Castells et al. (2018)[70]	ADHD	13	2028	amphet-amines	placebo	RoB: 0% low, 55% high, 45% unclear [$] low to very low quality evidence	11/11	0.90 (0.75-1.04) I^2 =47% (clinician ratings) 13% (patient ratings)	withdrawals due to AEs: RR: 2.69 (1.64-4.42) amphetamines: 7.6%

						NPB			
Cunill et al. (2016)[71]	ADHD	44	9952	pharmaco-therapy	placebo	RoB: 9%-27% high, low or unclear for most studies [$$] NPB	10/11	0.45 (0.37-0.52) I^2 =54%	AEs: drug > placebo SMD: 0.46 (0.37-0.54)
Cortese et al. (2018) [72]	*ADHD*	Total: 51 amphet-amines: 11	Total: 10296 amphet-amines: 1662	pharmaco-therapy	placebo	RoB: low: 28%, high: 16%, unclear; 57%[$]	9/11	amphetamines : 0.79 (0.58-0.99) methylphenidate: 0.49 (0.35-0.64) bupropion: 0.46 (0.07 –0·85) atomoxetine: 0.45 (0.32-0·58) modafinil: 0.16 (-0.59-0·28)	withdrawals due to AEs: amphetamines : 0.65 (0.24-1.07) atomoxetine: 0.47 (0.14-0.80) bupropion: 0.52 (-0.61-1.65) methyphenidate: 0.48 (0.19-0.78) modofinil: 0.77 (0.19-1.34)
Lenzi et al. (2018)[73]	ADHD	21	4724	pharmaco-therapy	placebo	RoB: 0% high, *unclear* for most studies[§§] NPB	10/11	k= 13 methyphenidate: 0.34 (0.23-0.45), I^2=0.34 k=5 atomoxetine: 0.24 (0.15-0.34), I^2=0%	not reported

								k=3 lisdexamfetamine: 0.34 (0.12-0.55), I^2=0.37	
Maneeton et al. (2014)[74]	ADHD	4	820	Lisdexam-fetamine	placebo	RoB: low for RCTs[§§]	6/11	0.97 (0.78-1.15), I^2=0.18 response: k=2: RR: 1.99 (1.50-2.63), I^2=0	withdrawals due to AEs: RR: 1.77 (0.71-4.40, I^2= 0
Schizophrenia Spectrum Disorder									
Huhn et al. (2019)[75]	multi-epi-sode schizo-phre-nia	106 Huhn personal communication 06/04/2020	23630 Huhn personal communication 06/04/2020	antipsychotic drugs	placebo	RoB: high:41% unclear:21% low:38% $ PB	11/11	0.45 (0.41-0.49) 0.38 (0.34-0.42) a, b, d	withdrawal due to AEs: drug: 20%
Hutton et al. (2015)[76]	schizo-phre-nia	11	2259	Quietiapine IR (imediate release)	placebo	RoB: 93% high in at least one domain, 7% unclear NPB	10/11	0.33 (0.21-0.44) I^2 =47% Response RR: 0.95 , k=11, N=2258	k=max 9, N=max 1868 Serious AEs; RR 0.94 (0.64 -1.39) Any AES: 1.14 (1.06-1.22)

Kishi et al (2020)[77]	acute schizophrenia	13	3740	aripiprazole brexpiprazole	placebo	RoB[$] 14% high 43% low 43% unclear NPB	9/11	response RR: 1.19 (1.09-1.28) 1.19 (1.09-1.30)	discontinuation due to adverse events (RR) 1.49 (1.03-2.13) 1.56 (1.06-2.17)
Leucht et al. 2017[78]	acute schizo-phre-nia	105	22741	antipsychotic drugs	placebo	RoB: (all studies, k=167) 73% high in at least one domain, 12% low, 15% uncertain [$] PB, SSE	11/11	0.47 (0.42-0.51) I^2 =52% 0.38[b] (0.33-0.43)	AEs: movement disorders: RR 1.93 (1.65-2.29) RR sedating: 2.80 (2.30-3.55) Weight gain: SMD: 0.40 (0.33-0.47) prolactin increase: SMD 0.43 (0.30-0.55) QTc prolongation SMD 0.19 (0.08-0.29), with large hetereogeneity between drugs
McCutcheon et al. (2019)[79]	schizo-phre-nia and related dis-orders (schizo	64	16624	antipsychotic drugs	placebo	RoB: only 17% showed low risk in all domains [§§]	7/11	0.47 (0.42-0.51) 0.46 (0.41-0.50)[b] ES for low risk of bias studies not reported	not reported

	-affect-ive, schizo-phre-nial-form, delu-sional dis-orders)					PB			
Ostuzzi et al et al (2021)[80]	Non-affect-ive psycho ses	78	11505	pharmacotherapy long-acting injectable antipsychotics (maintenance treatment)	placebo	RoB[$] : high: 81% low: 12% unclear: 7%	10/11	RR: Paliperidone (3-month formulation) 3.70 (2.38-5.88) Aripiprazole 3.45 (2.56-4.76) Flupenthixol 3.13 (1.54-6.25) Fluphenazine 2.94 (2.08-4.17) Risperidone 2.94 (1.92-4.35) Pipothiazine 2.86 (1.61-5.00) Olanzapine 2.70 (1.89-3.85) Paliperidone (1-month formulation) 2.56 (2.00-3.33) (Zu)clopenthixol 2.44 (0.76-7.69) Bromperidol	dropouts due to adverse events paliperidone (1-month formulation) > placebo no differences for other drugs.

								2.00 (0.87-4.55) Haloperidol 1.75 (1.03-3.03)	
Zhao et al (2018) [81]	schizo-phre-nia	4	1843	Cariprazine	placebo	RoB: 100% low, NPB	8/11	PANSS-total: 0.37 (0.27-0.47), I^2=0%, PANSS-Negative: 0.32 (0.16-0.48, I^2=61%, PANSS-Positive:0.32 (0.23-0.42), I^2=0%; Response: RR: 1.41 (1.19-1.67)	SAEs: drug < placebo: RR: 0.55 (0.34-0.89, I^2=0% treatment emergent events: drug > placebo RR: 1.10 (1.03-1.18) : I^2=23%
Zheng et al. (2018)[82]	acute schizo phreni a	8	2373	lurasidone	placebo	RoB: 100% low [$] 100% Jadad≥3 Egger´s test: p=0.042, but no RCT was	9/11	Total psychopathology: 0.34 (0.20-0.48), k=7, I^2=57% positive symtoms: 0.47 (0.36.-0.57) k=6, I^2=9%	lurasidone > placebo weight gain: 0.15 (0.06-0.24) BMI: 0.17 (0.07-0.28)

						trimmed and filled in Duval and Tweedie's test		negative symptoms: 0.34 (0.22-0.45) k=6, I^2=26% general psychopathology: 0.36 (0.24-48) k=6, I^2=30%	
Cella et al (2016)[83]	schizo-phre-nia (nega-tive symp-toms)	45	2511	psychotherapy (cognitive remediation)	TAU	Quality Rating (CTMA, Clinical Trials Assessment): 47% < 65 medium to high RoB $$ NPB	10/11	0.30 (0.22-0.36), I^2 =0% follow-up: 0.36 (0.21-0.51), I^2 =0% rigorous studies: 0.40 (0.30-0.51)	not reported
Jauhar et al. 2014 [84]	schizo-phre-nia	31	2508	psychotherapy (CBT)	TAU €	RoB: low: 100% $	9/11	overall: 0.33 (0.21-0.41), k=21 positive symptoms: 0.31 (0.17-0.45) k=19 negative symtoms: 0.17 (0.02-0.33) k=20	not reported

		12	903	psychotherapy (CBT)	nonspecific treatments [€]	RoB: high: 19% low: 63%, unclear: 19%$		overall: 0.32 (0.09-0.74) k=9 positive symptoms: 0.24 (0.06-0.54) k=10 negative symtoms: 0.08 (0.13-0.29) k=12	not reported
		34	2344	psychotherapy (CBT)	all controls [€]	RoB: high: 32% low: 49%, unclear: 19%$ all studies , k=47 PB		overall: 0.33 (0.19-0.47), k=34, I^2 =68% positive symptoms: 0.25 (0.13-0.37) k=33, I^2=49% 0.24 [b] (0.12-0.36) negative symtoms: 0.13 (0.01-0.25), k=34 I^2 =48% non-masking vs. masking overall: 0.62 (0.35-0.88, k=10) vs. 0.15 (0.03-0.27, k=20)	not reported

								positive symptoms: 0.57 (0.39.0.76, k=8) vs. 0.08 (0.03-0.18, k=21) negative symptoms: 0.22 (k=8) vs. 0.04 (k=22) CI´s not reported low or unclear risk of bias (all controls) overall: 0.15 (-0.01-0.32, k=8) positive symptoms: 0.10 (-0.09-0.28, k=9) negative symptoms: 0.02 (-0.11-0.15) ,k=11	
Lutgens et al. (2017)[85] .	psycho-sis (nega-tive)	72	not reported for the comparis on with TAU	psychotherapy (CBT, skills training, exercise, arts therapy, music therapy,	TAU	Quality[$$]: CBT: 42% high, 58% medium	8/11	CBT:0.43 (0.30-0.55), k=17 Exercise therapy: 0.42 (0.09-0.76), k=6	rarely reported in RCTs

	symp-toms)			family therapy, miscellaneous therapy)		skills training: 18% high, 59% medium, 24% low neurocogni tive therapies: 25% high. 69% medium, 6% low excercise therapy: 30% high, 30% medium, 40% low family therapy: 17% high, 67% medium , 17% low arts therapies: 57% high, 43% low		Music-based therapy: k=5, 0.58 (0.33-0.82) Arts therapy: -0.57 (-0.74--0.41) Miscellaneous Therapy: k=6, 0.48 (0.21-0.75)	

						miscellaneous: 10% high, 40% medium, 50% low PB			
Bipolar Disorder									
Bahji et al. (2020)[86]	acute bipolar depression	40	11448 (total)	pharmaco-therapy	placebo	RoB [$]: low: 33% high: 67% NPB	9/11	SMD: Fluoxetine 1.41 (0.27-2.55) Divalproex 1.25 (0.47-2.03) Lurasidone 1.15 (0.37-1.92) Moclobemide 1.09 (-0.45-2.64) Cariprazine 0.85 (0.08-1.62) Imipramine 0.86 (-0.01-1.72) Olanzapine 0.72 (0.09-1.35) Phenelzine 0.77 (-0.38-1.91) Tranylcypromine 0.55 (-0.77-1.87) Quetiapine 0.48 (0.14--0.82) OFC 0.39 (-0.24-1.02) Escitalopram	withdrawals due to AEs: pharmacotherapy= placebo except for aripiprazole SMD: 0.45 (0.98-0.81)

								0.33 (-1.34-2.00) Sertraline 0.24 (-1.26-1.75) Lithium 0.24 (-0.72-1.21) Venlafaxine 0.14 (-1.35- 1.63) Paroxetine 0.18 (-0.79-1.15) Aripiprazole 0.04 (-0.73-0.82) Lamotrigine 0.07 (-0.37-0.51) Ziprasidone -0.05 (-0.64-0.54) Carbamazepine -0.40 (-1.58-0.78) Gabapentin -1.84 (-3.01- -0.67) response : SMD: 1.56 (0.83-2.29) to 0.22 (-0.49-0.05) remission: SMD: 1.61 (0.66-2.55) to -0.16 (-0.55-0.23)	

Kishi et al (2020)[87]	Bipolar disorder	Total: 41	Total: 9821	pharmacotherapy	placebo	RoB[$]: 46% high 46% low 7% unclear	9/11	any mood episode (RR) asenapine 3.82 (1.93-7.52) olanzapine 2.00 (1.60-2.5) aripiprazole one monthly 1.93 (1.25-2.99) quetiapine 1.90 (1.48-2.43) lithium 1.60 (1.38-1.86) risperidone 1.57 (1.19-2.07) valproate 1.58 (1.21-2.06) aripiprazole 1.62 (1.00-1.61) carbamazepine 1.46 (0.95-2.26) lamotrigine 1.31 (1.08-1.59) paliperidone 1.20 (0.83-1.74) depressive episode (RR) quetiapine 2.08 (1.58-2.75) asenapine 2.60 (0.94-7.25)	Asenapine: lower discontinuation rate due to adverse events than placebo 0.363 (0.162–0.812) (21 RCTs, 6107 patients) PB suspected

								lamotrigine 1.40 (1.08-1.83) olanzapine 1.35 (1.02-1.78) lithium 1.26 (1.05-1.52) valproate 1.18 (0.83-1.68) aripiprazole 1.11 (0.51-2.40) aripiprazole once monthly 0.94 (0.51-1.75) risperidone 0.78 (0.52-1.17) paliperidone 0.76 (0.46-1.26) carbamazepine 0.37 (0.09-1.57) manic/hypomanic /mixed episode (RR) asenapine 4.81 (1.89-12.20) aripiprazole once monthly 3.31 (1.82-6.02) olanzapine 2.88 (2.21-3.77) risperidone 2.88	

								(2.21-3.77) aripiprazole 2.40 (1.19-4.85) lithium 1.85 (1.53-2.25) paliperidone 1.69 (1.15-2.48) quetiapine 1.80 (1.41-2.30) valproate 1.56 (1.17-2.10) lamotrigine 1.12 (0.82-1.54 carbamazepine 0.48 (0.06-3.89)	
Li et al. (2017)[88]	bipolar dis-order	3	993	aripiprazole	placebo	Jadad: 3.35 (SD=0.49)	9/11	k=3 mania: 0.16 (-0.003-0.33)	withdrawals due to AEs: SMD: 0.24 (0.08-0.40) drug > placebo: increased appetite, constipation, nausea, akathisia, anxietx, hyper-salvation, fatugue, insomnia, over-sedation, pain
Lindström et al. (2017) [89]	bipolar dis-order, re-lapse	5	olanzapin (k=2) : 628	second generation antipsychotics (SGA)	placebo	RoB: 100% high[§]	9/11	Response: RR: olanzapine: k=2, 1.92 (1.41-2.63) I^2 =66%	drug > placebo SGA: Weight gain aripiprazole: tremor, akathisia risperidone: tremor

	preven-tion		risperi-done: (k=2) 570 quetia-pine(k=2): 1339					risperidone: k=2: 1.64 (1.25-2.13) I^2 =43% quetiapine: k=2, 2.70 (2.38-3.33)	olanzapine, quetiapine: sedation
Liu et al. (2017) [90]	bipolar dis-order, preven-tion of de-press-ive epi-sodes	10	637	pharmaco-therapy (anti-depressants)	placebo	RoB: 27/% high, 36% low, 36% uncertain[$] NPB	8/11	RR=1.56 (1.20-2.04) I^2 =0.00%	not reported
Miura et al. (2014)[91]	bipolar dis-order re-lapse pre-ven-tion	33	6846 ?	pharmaco-therapy	placebo	RoB: 55% high, 45% low [$,] NPB	10/11	RR lithium: 1.61 (1.39-1.89) I^2 =47% olanzapine: 2.00 (1.58-2.56) I^2 =57% quetlapine: 1.92 (1.47-2.5) I^2 =72%	withdrawals due to AEs: RR lithium: 2.58 (1.33-5.39) carbamazepine: 3.60 (1.04-12.94) lithium+ valproate: 4.09 (1.01-16.96) not significant for other drugs.

								valproate: 1.59 (1.20-2.13) I^2 =n.a. lamotigine: 1.32 (1.06-1.61) I^2 =0% aripiprazole: 1.61 (0.97-1.03) I^2 =n.a. imipramine: 1.05 (0.74-1.52) I^2 =0% paliperidone: 1.19 (0.81-1.79) I^2 =n.a. carbamazepine: 1.47 (0.94 - 2.27) I^2 =n.a. fluoxetine: 1.49 (0.18-1.25) I^2 =n.a.	
Pinto et al. (2019) [92]	bipolar dis-order	3 bipolar mania 2-4 bipolar depression	1772	cariprazine	placebo	RoB: high: 14%, low: 86%, unclear: 0% NPB	9/11	acute mania: 3 mg: 0.52 (0.21-0.82) I^2=6% 6 -12 mg: 0.51 (0.22-0.81), I^2=0 remission: 0.40 (0.26-0.53), I^2=0%	AEs: drug > placebo 0.41 (0.17-0.64), I^2=0 dropouts due to AEs: 0.32 (-0.17-0.79), I^2=0

								response: 0.46 (0.17-0.76), I^2=0% acute bipolar depression: 0.75 mg: 0.13 (-0.81-1.06), remission: 0.10 (-0.92-1.12) 1.5 mg: 0.26 (0.02-0.49), I^2=28.9% remission: 0.31 (-0.02-0.65), I^2=0 response: 0.23 (-0.14-0.61), I^2=24.3% 3 mg: 0.21 (0.01-0.41), I^2=3.2% remission: 0.23 (0.17-0.30), I^2=0 response: 0.24 (0.06-0.43), I^2=0	
Talaei [93 k]	bipolar dis-order	2	82	pharmaco-therapy (tamoxifen)	placebo	Quality rating (Oxford Center of	7/11	response: OR=15.36 (2.99-78.73)	1 study reported loss of appetite compared to placebo.

						Evidence-Based Medicine)		SMD=1.51 (0.61-4.96), I^2=?	No study reported withdrawal due to AEs
Oud et al. (2016) [94]	bipolar dis-order	8	683	individual psychotherapy	TAU	RoB: high: 100%[$] most studies of low or very low quality [$$]	7/11	Post-therapy: Depression (k=8, N=683): 0.23 (0.05-0.41), I^2=18% Mania (k=3 N=171): 0.05 (-0.25-0.35), I^2=0 Relapse (k=6, N=365): RR=1.52 (1.09-2.08), I^2=0 Follow-up Depression (26-52 weeks, k=5, N=534): 0.21 (-0.01-0.43), I^2=27% Mania (52-weeks follow-up, k=4, N=164):	not reported

								0.38 (0.04-0.71), I^2=12 Relapse (k=8, N=532): RR=1.35 (1.15-1.58), I^2=0	
Head to head comparisons of psychotherapy and pharmacotherapy									
Amick et al. (2015)[95]	major de-pres-ive dis-order	5 Response: k=6 Remission: k=4	631	psychotherapy (CBT)	second generation anti-depressants	RoB: 100% medium[$$]	9/11	RR: response: 1.10 (0.93-1.30), I^2 =0 remission: 1.02 (0.76-1.37) I^2 =49%	Poor reporting of AEs withdrawals due to AEs: drugs> CBT RR 2.54 (0.39; 16.47)
Cuijpers et al. (2015)[96]	de-pres-sive dis-order with-out pla-cebo: 26	35	3721	psychotherapy	pharmaco-therapy	RoB: 31% met all criteria, 69% failed to meet at least one criterium [$$] NPB	7/11	overall: -0.07 (-0.21-0.07) I^2 =37% without placebo comparator: -0.13 (-0.23—0.03) I^2 =43% with placebo comparator: 0.02(-0.15;0.18), I^2 =0	not reported

Cuijpers et al. (2016)[97]	de-pres-sion	12	not reported for the comparison with pharmaco therapy	psychotherapy (interpersonal therapy)	pharmaco-therapy	RoB (not specified for subsets of studies)	9/11	-0.11 (-0.28-0.07), I^2=51%	not reported
Cuijpers et al. (2020) [7]	de-pres-sion	50	not reported for the comparison with pharmaco therapy	psychotherapy	pharmaco-therapy	RoB: 75% high or unclear 25% low [$$] (all studies psychotherapy vs. pharmacotherapy)	9/11	0.00 (-0.13-0.12) I^2 = 68% RR: response: 0.98 (0.91-1.06) I^2 =41% remission: 1.10 (0.92-1.10) I^2 =29% Low risk of bias (k=14): RR:(response: 1.14 (1.00-1.27), I^2 = 30% 6-12 month follow-up: network meta-analysis: RR: 1.18 (1.02-1.35)	not reported

Driessen et al. (2015)[23]	major de-pres-sive dis-order	18	1906	psychotherapy	pharmaco-therapy	RoB: 33% met all criteria for low risk[§§] PB	9/11	Unpublished, k=2 -0.21 (-0.53-0.11) I^2 =11% published: 0.01, k=15 (-0.13-0.16) I^2 =38% published + unpublished 0.05 (-0.25-0.15), k=18 I^2 =36%	not reported
Imai et al. (2016)[98]	panic dis-order	16 11, 12	966 11: N=663 12: 800	psychotherapy	pharmaco- therapy	RoB: 100% high met at least one criterion for high risk low quality evidence NPB	11/11	remission: RR: 1.16 (0.95-1.41) response: RR: 1.05 (0.84-1.32)	not reported
Mayo-Wilson et	SAD	drugs (total): 54	5042 2906	psychotherapy	pharmaco-therapy	RoB (total drugs+ psycho-therapy)	7/11	indiv CBT vs SSRIs/SNRIs: k=1,	not reported

al. (2014)[p 38]		psychotherapy (total): 80				19% low, 80% high, 1% uncertain[$]		N=60: 0.27 (-0.19-0.72) group CBT vs SSRIs/SNRIs k=2, N=157, 0.00 (-0.47-0.48) Benzo vs group CBT, k=2, N=55, 0.05 (-0.66-0.74) MAOIs vs group CBT k=3, N=121, 0.09 (-0.57-0.75) indiv CBT vs MAOIs, k=2, N=82, 0.18 (-0.47-0.83)	
Merz et al. (2019) [99]	PTSD	12	Total: 922	psychotherapy	pharmaco-therapy	RoB: 8% high, 25% low, 67% medium [$$]	7/11	short-term: k=4 0.03 (-0.23-0.28),	not reported

								I^2=0.20 long-term: k=3 0.83 (0.07-1.59), I^2=0.71	
Sonis et al. (2019) [100]	PTSD	4	399	psychotherapy	medication	50% high, 50% some risk [$$]	7/11	k=4: 0.16 (0.30-0.62) k=2: high RoB: 0.67 (0.14-1.47) k=2 some risk: 0.08 (-0.48-0.64) I^2=81%	not reported
Skapinakis et al (2016a)[44]	OCD	Total: 54 CBT: 3 BT: 1 CT: 0 direct comparison	Total: 6652 227 76	psychotherapy (CBT. BT, CT)	pharmaco-therapy (SSRIs)	RoB: 100% high [§]	9/11	BT: 0.95[g] (0.44-1.47) CBT: 0.61 [g] (0.20-1.03) Cognitive Therapy: 0.82[∞] (0.21-1.43)	not reported

		waiting list trials excluded							
Öst el al. (2015) [46]	OCD	4	409	psychotherapy (CBT)	pharmaco-therapy	RoB: 50% high, 50% low [$]	7/11	0.55 (0.05-1.04), k=4 I^2 = 69% 0.17 (CI not reported) [b] follow-up: 0.38 (-0.81-1.57) k=2, I^2 = 84% no follow-up data adjusted for small sample size reported	not reported
Combination of psychotherapy and pharmacotherapy vs. either monotherapy									
Bürkner et al. (2017)[101]	anxiety dis-orders and ob-sessive comp-ulsive dis-order	23	1314	CBT+d-cycloserine	CBT+placebo	RoB:35% low, 61% high, 4% uncertain [$] NPB	9/11	0.12 (-0.02-0.27) τ = 0.20	not reported

Cuijpers et al. 2014[102]	depres-sive and anxiety dis-orders	52 32 depression 21 anxiety	3623	anti-depressants + psychotherapy	anti-depressants	RoB: 73% high at least in any domain $$ PB, SSE	8/11	depressive + anxiety disorders 0.43 (0.31-0.56) I^2 =0.64 0. 29[b] (0.15-0.43) high-quality : 0.35 (0.16-0.54), I^2 =0.67 long-term outcome: RR: 1.48 (1.23-1.78), I^2 =0.55 Unadjusted for publication bias: MDD: 0.43 (0.29-0.57 dysthymia: 0.20 (-0.21-0.60) anxiety disorders: 0.47 (0.23-0.71)	not reported
Cuijpers et al. (2020) [7]	de-pres-sion	41	not reported for the compar-ison with pharmaco-therapy	psychotherapy + pharmaco-therapy	pharmaco-therapy	RoB: 65% high or unclear, 35% low $$	9/11	0.37 (0.23-0.53) I^2 =68% RR: response: 1.27 (1.12-1.43) I^2 =58%	not reported

								RR: remission: 1.28 (1.10-1.52) I^2 =57% low risk of bias (k=13): RR (response): 1.27 (0.96-1.67), I^2 = 70% network meta-analysis: 6-12 month follow-up: RR: 1.39 (1.20-1.61)	
		19	not reported for the com-parison with psycho-therapy	psychotherapy + pharmaco-therapy	psycho-therapy	RoB:67% high or unclear, 33% low $^{\$\$}$		0.15 (-0.05-0.35) I^2 = 69% RR: response: 1.25 (1.09-1.43) I^2 =44% remission: 1.20 (1.02-1.41) I^2 =25% Low risk of bias (k=5): RR (response): 1.52 (1.32-1.75) I^2 = 0%	not reported

								6-12 month follow-up: network meta-analysis: RR: 1.19 (1.01-1.41)	
Driessen et al (2015)[23]	major depres-sive dis-order	11	897	psychotherapy + pharmaco-therapy	pharmaco-therapy	RoB: 27% met all criteria for low rik [§§]	9/11	unpublished: 0.37 (-0.14-0.89) published: 0.22 (0.00-0.44) published + unpublished: 0.24 (0.04-0.45)	not reported
Driessen et al. (2020)[103]	depres sion	3	244	Psychotherapy + pharmacother apy	Pharmacothe rapy	RoB: low:66% High: 33%	8/11	0.24 SE=0.15 I^2 =0%	not reported
Karyotaki et al. (2016)[104]	depres-sive dis-order, long-term effects	23	2184	psychotherapy + pharmaco-therapy	anti-depressants	RoB: 57% high (RoB>3)[$$] researcher allegiance: 30% high risk [$$]	8/11	≥6MFU: 0.59 (0.42-0.55), I^2 =0 0.55 (0.37-0.73) [b] ≥12MFU: 0.44 (0.20-0.68), I^2 =0 0.30.14-0.61)[b]	not reported

						PB (antidepressants)		≥6MFU: RoB≤3 (low): k=4 , 0.28 (-0.01-0.57), I^2 =0 RoB>3 (high): k=5, 0.45 (0.17-0.73), I^2 =13	
					psychotherapy			≥6MFU: 0.19 (-0.02-(0.40), k=8, I^2 =0, NPB maintenance therapy: ≥6MFU: 0.26 (0.07-0.45), I^2 =0	
Mayo-Wilson et al.[p] [38]	SAD	Total (all studies): 101	Total (all studies): 13146	psychotherapy + drugs	drug	RoB (drug+ combi): 59% high, 39% low, 2% unclear[§] Direct comparisons combined treatments:	7/11	vs. MAOIs: k=2, N=124, -0.30 (-0.35-.0.94) benzo: k=1, N=59, -0.34 (-0.34-1.02) SSSIs+SNRIs: k=2, N=162, -0.39 (-0.06-0.84)	not reported

						100% (4/4) high[$]			
Mayo-Wilson et al. [38]	SAD	Total (all studies): 101	Total (all studies): 13146	psychotherapy + drugs	psycho-therapy	RoB (combi +psychotherapy: 100% high[$] direct comparisons combi: 100% (3/3) high[§]	7/11	vs indiv.CBT: k=1, N=81, 0.11 (-0.42-0.66) group CBT: k=2, N=231, 0.38 (-0.17-0.93) Expo[o]: k=0, 0.44 (-0.24-1.13) SHWS[o]: k=0, 0.44 (-0.21-1.09) SHNS [o] k=0, 0.55 (-0.10-1.20) PDT: k=0, 0.68 (0.17-1.19) exercise[o]: k=0, 0.94 (-0.09-1.98)	not reported

Ori et al.[105]	An-xiety and related dis-orders	9 (adults)	449	CBT + pharmaco-therapy (d-cycloserine)	CBP+ Placebo	RoB: 38% high, 52% low, 10% unclear $ (adults + + children + adolescents) low quality evidence for adults $$	10/11	Response: RR: 1.10 (0.89-1.34) 1-12MFU: k=7: 1.08 (0.90-1.31), N=383	withdrawal due to AEs: RR: 0.96 (0.10-9.00) K=2, N=213
Skapi-nakis et al (2016)[44, 45]	OCD	Total: 54 direct comparisons: 1	Total: 6652 12	CBT + fluvoxamine	SSRIs	RoB: high for 50% of domains	9/11	0.73 (0.05-1.42)	not reported
Hoskins et al (2021)[106]	PTSD	10	k=4: 267 k=4: 224	psychotherapy + pharmaco-therapy MDMA: 3,4-methylenedioxymethamphetamine	mono-therapy + placebo [n]	RoB $ 90% high, 10% low NPB	8/11	SSRI+psychotherapy vs. psychotherapy+ placebo: k=4, I^2=38% 0.22 (-0.14-0.58) d-cycloserine + psychotherapy vs	not reported

			k=2: 75	SSRI + psychotherapy vs. SSRI				psychotherapy +placebo k=4, I^2=59% 0.00 (-0.46-0.45) SSRIs + psychotherapy vs SSRIs: k=2, I^2=58% 0.02 (-1.04-1.01	
Merz et al. (2019) [99]	PTSD	12	Total: 922	psychotherapy + pharmaco-therapy	psycho-therapy	RoB: 8% high, 25% low, 67% medium [$$]	7/11	short-term: k=2 0.09 (-0.19-0.36), I^2=0.20 long-term: k=2 0.13 (-0.87-1.13), I^2=0.71	not reported
Merz et al. (2019) [99]	PTSD	12	Total: 922	psychotherapy + pharmaco-therapy	pharmaco-therapy	RoB: 8% high, 25% low, 67% medium [$$]	7/11	short-term: k=5 0.12 (-0.11-0.34), I^2=0.20 long-term: k=2 0.96 (0.04-1.88) I^2=0.71	not reported

Lopez et al. (2018)[107]	ADHD	2	65	CBT + pharmaco-therapy	pharmaco-therapy	RoB: both RCTs high RoB in at least one domain	9/11	0.80 (0.30-1.31), I^2=0.00	not reported
Öst el al. (2015)[46]	OCD	6	447	Medication+ psychotherapy (CBT)	psycho-therapy (CBT) + placebo	RoB: 100% high [$]		0.25 (-0.03-0.46), k=6, I^2 = 0 -0.25 [b] (-0.46-0.03), follow-up: 0.06 (-0.55-0.66), k=3, I^2 =39%	not reported

Note.

ADHD: attention deficit hyperactivity disorder; BZ: benzodiazepines; Expos: exposure; CBT: cognitive-behaviour therapy; GAD: generalized anxiety disorder; GRADE: Grading of Recommendations Assessment, Development and Evaluation; n.a.: not assessed or reported; NGA: new generation antidepressants (selective serotonin reuptake inhibitors, serotonin and noradrenaline (norepinephrine) reuptake inhibitors or serotonin antagonist and reuptake inhibitors); (N)PB: (no) indication of publication bias according to funnel plot, fail-safe N, Egger test, Begg & Mazumdar test, trim-and-fill analysis. Of note, however, none of these tests have necessarily high sensitivity or specificity for proving or excluding publication bias; PAD: Panic disorder; PDT: psychodynamic therapy; PTSD: posttraumatic stress disorder; RoB: Cochrane risk of bias tool, ratings by the authors of the respective meta-analysis; RR: Relative risk (small, medium, large effect sizes: 1.22, 1.86 and 3.00); SAD: social anxiety disorder; SHNS: self-help without support; SHWS: self-help with support; SSE: small-study effects; TAD: tricyclic antidepressants; TAU: Treatment as usual

[*] A positive sign indicates superiority of the treatment over the control condition, a negative sign indicates superiority of the comparator

[τ] All odds ratios for response and remission in Table S1 were converted to SMDs

[€] type of control had no significant effect on outcome (TAU vs nonspecific treatments)[84]

[$] risk of bias rating: overall risk of bias of a meta-analysis was rated as high if at least one domain was rated as high by the authors of the meta-analysis; overall risk of bias was rated as low if most domains were rated as low (e.g. 3 of 4 or 4 of 6) and none was rated as high and overall risk of bias was rated as unclear if most domains are rated as unclear and none was rated as high, following Higgins et al. [108]

[$$] risk of bias /quality judgment of the authors of the respective meta-analysis

[a] adjusted for risk of bias by the authors of the respective meta-analysis (high-quality studies only)

[b] adjusted for small-study effects by the authors of the respective meta-analysis

[c] adjusted for blinding by the authors of the respective meta-analysis

[d] personal communication Maximilian Huhn, 22 August 2019

[e] For psychotherapy the Svaldi et al. meta-analysis included only comparisons with waiting list.

[f] Whether exercise in SAD (attending a gym for two months[109]) represents psychotherapy is debatable. This is true for self-help without support. Exercise was not superior to waiting list and was directly tested in only one study.[38, 109pp] Due to space limitations, only results of direct comparisons were reported in Table S1.[38]

[g] We calculated SMDs by dividing the mean differences reported by Skapinakis et al. by the pooled standard deviation of the YBOCS mean post-therapy across all treatments.

[h] Our inclusion criteria required that the diagnosis of a mental disorder was given for which a diagnostic interview is required. In some meta-analyses of depression also studies were included in which patients scored above a cut-off on an established self-report instrument. These meta-analysis were included since effect sizes in the treatment of depression were shown not to differ between studies using an interview or a cut-off.[110] However, This does not necessarily generalize to other diagnostic groups in the same way.

[i] For this meta-analysis risk of bias was high (e.g. 100% for risk of blinding) and effect sizes considerably decreased at follow-up (0.27).[24] In addition, publication bias was found but effect sizes were not adjusted for.[24] Some RCTs included in this meta-analysis did not compare CBT alone to TAU but CBT plus TAU, inflating effect sizes.[111]

[j] As shown by Humes and Brunoni, the SMD presented by FU et al. was mistakenly based on the standard error instead of the standard deviation. For this reason, we present the corrected data published by Humes and Brunoni which include one additional study.[9{Fu, 2015 #34573}]

[k] The large effect size [93] may be due to the very small samples which also question that randomization has worked effectively in these studies.[112]

[l] Psychotherapy was not included as it was not compared to TAU but against other active treatments[49]. Some antiepileptics and antipsychotics were given as adjunctive treatments but separate data for only monotherapy were not presented by Lee et al.

[m] For psychotherapy, these meta-analyses reported only data for mixed controls and were not included with regard to SMDs.[53, 54]

[n] MDMA+ psychotherapy was not included (mix of placebo and active placebos)

References

1 Aromataris E, Fernandez R, Godfrey CM, Holly C, Khalil H, Tungpunkom P. Summarizing systematic reviews: Methodological development, conduct and reporting of an umbrella review approach *Int J Evid Based Healthc 2015*; 13 132–140

2 Aromataris et al. The Joanna Briggs Institute Critical Appraisal tools for use in JBI Systematic Reviews Checklist for Systematic Reviews and Research Syntheses *https://joannabriggsorg/research/critical-appraisal-toolshtml 2017*

3 Bai S, Guo W, Feng Y, Deng H, Li G, Nie H, Guo G, Yu H, Ma Y, Wang J, Chen S, Jing J, Yang J, Tang Y, Tang Z. Efficacy and safety of anti-inflammatory agents for the treatment of major depressive disorder: a systematic review and meta-analysis of randomised controlled trials *J Neurol Neurosurg Psychiatry 2020*; 91(1): 21-32 [PMID: 31658959 DOI: 10.1136/jnnp-2019-320912]

4 Barth M, Kriston L, Klostermann S, Barbui C, Cipriani A, Linde K. Efficacy of selective serotonin reuptake inhibitors and adverse events: meta-regression and mediation analysis of placebo-controlled trials *Br J Psychiatry 2016*; 208(2): 114-119 [PMID: 26834168 DOI: 10.1192/bjp.bp.114.150136]

5 Cipriani A, Furukawa TA, Salanti G, Chaimani A, Atkinson LZ, Ogawa Y, Leucht S, Ruhe HG, Turner EH, Higgins JPT, Egger M, Takeshima N, Hayasaka Y, Imai H, Shinohara K, Tajika A, Ioannidis JPA, Geddes JR. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis *Lancet 2018*; 391(10128): 1357-1366 [PMID: 29477251 PMCID: 5889788 DOI: 10.1016/S0140-6736(17)32802-7]

6 Munkholm K, Paludan-Muller AS, Boesen K. Considering the methodological limitations in the evidence base of antidepressants for depression: a reanalysis of a network meta-analysis *BMJ open 2019*; 9(6): e024886 [PMID: 31248914 PMCID: PMC6597641 DOI: 10.1136/bmjopen-2018-024886]

7 Cuijpers P., Noma H, Karyotaki E, Vinkers CH, Cipriani A, Furukawa TA. A network meta-analysis of the effects of psychotherapies, pharmacotherapies and their combination in the treatment of adult depression *World Psychiatry 2020*; 19 92-107

8 Guo X, McCutcheon RA, Pillinger T, Mizuno Y, Natesan S, Brown K, Howes O. The magnitude and heterogeneity of antidepressant response in depression: A meta-analysis of over 45,000 patients *J Affect Disord 2020*; 276: 991-1000 [PMID: 32750615 DOI: 10.1016/j.jad.2020.07.102]

9 Humes EC, Brunoni AR. Comment on Fu, J. and Chen, Y.: The efficacy and safety of 5 mg/d vortioxetine compared to placebo for major depressive disorder: a meta-analysis *Psychopharmacology (Berl) 2017*; 234(5): 903-904 [PMID: 28116478 DOI: 10.1007/s00213-017-4531-y]

10 Fu J, Chen Y. The efficacy and safety of 5 mg/d Vortioxetine compared to placebo for major depressive disorder: A meta-analysis *Psychopharmacology (Berl) 2015*; 232(1): 7-16 [PMID: 24871704 DOI: 10.1007/s00213-014-3633-z]

11 Henssler J, Kurschus M, Franklin J, Bschor T, Baethge C. Long-Term Acute-Phase Treatment With Antidepressants, 8 Weeks and Beyond: A Systematic Review and Meta-Analysis of Randomized, Placebo-Controlled Trials *J Clin Psychiatry 2018*; 79(1) [PMID: 28068463 DOI: 10.4088/JCP.15r10545]

12 Jakobsen JC, Katakam, K. K., Schou, A., Hellmuth, S. G., Stallknecht, S. E., Leth-Moller, K., Iversen, M., Banke, M. B., Petersen, I. J., Klingenberg, S. L., Krogh, J., Ebert, S. E., Timm, A., Lindschou, J. , Gluud, C. . Selective serotonin reuptake inhibitors versus placebo in patients with major depressive disorder. A systematic review with meta-analysis and Trial Sequential Analysis *BMC Psychiatry*

2017; 17, 58

13 Kishi T, Meltzer HY, Matsuda Y, Iwata N. Azapirone 5-HT1A receptor partial agonist treatment for major depressive disorder: systematic review and meta-analysis *Psychol Med 2014*; 44(11): 2255-2269 [PMID: 24262766 DOI: 10.1017/S0033291713002857]
14 Koesters M, Ostuzzi G, Guaiana G, Breilmann J, Barbui C. Vortioxetine for depression in adults *Cochrane Database Syst Rev 2017*; 7: CD011520 [PMID: 28677828 PMCID: 6483322 DOI: 10.1002/14651858.CD011520.pub2]
15 Kryst J, Kawalec P, Mitoraj AM, Pilc A, Lason W, Brzostek T. Efficacy of single and repeated administration of ketamine in unipolar and bipolar depression: a meta-analysis of randomized clinical trials *Pharmacol Rep 2020*; 72(3): 543-562 [PMID: 32301056 PMCID: PMC7329804 DOI: 10.1007/s43440-020-00097-z]
16 Laoutidis ZG, Kioulos KT. Desvenlafaxine for the acute treatment of depression: a systematic review and meta-analysis *Pharmacopsychiatry 2015*; 48(6): 187-199 [PMID: 26205685 DOI: 10.1055/s-0035-1555879]
17 Meeker AS, Herink MC, Haxby DG, Hartung DM. The safety and efficacy of vortioxetine for acute treatment of major depressive disorder: a systematic review and meta-analysis *Systematic reviews 2015*; 4: 21 [PMID: 25874839 PMCID: 4351824 DOI: 10.1186/s13643-015-0001-y]
18 Pae CU, Wang SM, Han C, Lee SJ, Patkar AA, Masand PS, Serretti A. Vortioxetine: a meta-analysis of 12 short-term, randomized, placebo-controlled clinical trials for the treatment of major depressive disorder *J Psychiatry Neurosci 2015*; 40(3): 174-186 [PMID: 25350320 PMCID: 4409435]
19 Taylor D, Sparshatt A, Varma S, Olofinjana O. Antidepressant efficacy of agomelatine: meta-analysis of published and unpublished studies *BMJ 2014*; 348: g1888 [PMID: 24647162 PMCID: 3959623 DOI: 10.1136/bmj.g1888]
20 Cuijpers P, Turner EH, Mohr DC, Hofmann SG, Andersson G, Berking M, Coyne J. Comparison of psychotherapies for adult depression to pill placebo control groups: a meta-analysis *Psychol Med 2014*; 44(4): 685-695 [PMID: 23552610 DOI: 10.1017/S0033291713000457]
21 Cuijpers P, Cristea IA, Karyotak E, Reijnders M, Huibers MHJ. How effective are cognitive behavior therapies for major depression and anxiety disorders? A meta-analytic update of the evidence *World Psychiatry 2016*; 15: 245-258 [DOI: 10.1002/wps.20346]
22 Cuijpers P, Karyotaki E, Reijnders M, Ebert DD. Was Eysenck right after all? A reassessment of the effects of psychotherapy for adult depression *Epidemiology and psychiatric sciences 2019*; 28(1): 21-30 [PMID: 29486804 DOI: 10.1017/S2045796018000057]
23 Driessen E, Hollon SD, Bockting CL, Cuijpers P, Turner EH. Does Publication Bias Inflate the Apparent Efficacy of Psychological Treatment for Major Depressive Disorder? A Systematic Review and Meta-Analysis of US National Institutes of Health-Funded Trials *PLoS ONE 2015*; 10(9): e0137864 [PMID: 26422604 PMCID: 4589340 DOI: 10.1371/journal.pone.0137864]
24 Lopez-Lopez JA, Davies SR, Caldwell DM, Churchill R, Peters TJ, Tallon D, Dawson S, Wu Q, Li J, Taylor A, Lewis G, Kessler DS, Wiles N, Welton NJ. The process and delivery of CBT for depression in adults: a systematic review and network meta-analysis *Psychol Med 2019*; 49(12): 1937-1947 [PMID: 31179960 PMCID: PMC6712954 DOI: 10.1017/S003329171900120X]
25 Bighelli I, Castellazzi M, Cipriani A, Girlanda F, Guaiana G, Koesters M, Turrini G, Furukawa TA, Barbui C. Antidepressants versus placebo for panic disorder in adults *Cochrane Database Syst Rev 2018*; 4: CD010676 [PMID: 29620793 DOI: 10.1002/14651858.CD010676.pub2]
26 van Dis EAM, van Veen SC, Hagenaars MA, Batelaan NM, Bockting CLH, van den Heuvel RM, Cuijpers P, Engelhard IM. Long-term Outcomes of Cognitive Behavioral Therapy for Anxiety-Related Disorders: A Systematic Review and Meta-analysis *JAMA psychiatry 2019* [PMID: 31758858 DOI: 10.1001/jamapsychiatry.2019.3986]
27 Carl E, Witcraft SM, Kauffman BY, Gillespie EM, Becker ES, Cuijpers P, Van Ameringen M, Smits JAJ, Powers MB. Psychological and pharmacological treatments for generalized anxiety disorder (GAD): a meta-analysis of randomized controlled trials *Cogn Behav Ther 2019*: 1-21 [PMID: 30760112 DOI: 10.1080/16506073.2018.1560358]
28 Gomez AF, Barthel AL, Hofmann SG. Comparing the efficacy of benzodiazepines and serotonergic anti-depressants for adults with generalized anxiety disorder: a meta-analytic review *Expert Opin Pharmacother 2018*; 19(8): 883-894 [PMID: 29806492 PMCID: 6097846 DOI: 10.1080/14656566.2018.1472767]

29 He H, Xiang Y, Gao F, Bai L, Fan Y, Lyu J, Ma X. Comparative efficacy and acceptability of first-line drugs for the acute treatment of generalized anxiety disorder in adults: A network meta-analysis *J Psychiatr Res 2019*; 118: 21-30 [PMID: 31473564 DOI: 10.1016/j.jpsychires.2019.08.009]
30 Kong W, Deng H, Wan J, Zhou Y, Zhou Y, Song B, Wang X. Comparative Remission Rates and Tolerability of Drugs for Generalised Anxiety Disorder: A Systematic Review and Network Meta-analysis of Double-Blind Randomized Controlled Trials *Front Pharmacol 2020*; 11: 580858 [PMID: 33343351 PMCID: PMC7741609 DOI: 10.3389/fphar.2020.580858]
31 Li X, Zhu L, Su Y, Fang S. Short-term efficacy and tolerability of venlafaxine extended release in adults with generalized anxiety disorder without depression: A meta-analysis *PLoS ONE 2017*; 12(10): e0185865 [PMID: 28982121 PMCID: 5628888 DOI: 10.1371/journal.pone.0185865]
32 Maneeton N, Maneeton B, Woottiluk P, Likhitsathian S, Suttajit S, Boonyanaruthee V, Srisurapanont M. Quetiapine monotherapy in acute treatment of generalized anxiety disorder: a systematic review and meta-analysis of randomized controlled trials *Drug Des Devel Ther 2016*; 10: 259-276 [PMID: 26834458 PMCID: 4716733 DOI: 10.2147/DDDT.S89485]
33 Qin B, Huang G, Yang Q, Zhao M, Chen H, Gao W, Yang M. Vortioxetine treatment for generalised anxiety disorder: a meta-analysis of anxiety, quality of life and safety outcomes *BMJ open 2019*; 9(11): e033161 [PMID: 31784448 PMCID: 6924794 DOI: 10.1136/bmjopen-2019-033161]
34 Wang SM, Woo YS, Kim NY, Na HR, Lim HK, Bahk WM. Agomelatine for the Treatment of Generalized Anxiety Disorder: A Meta-Analysis *Clinical psychopharmacology and neuroscience : the official scientific journal of the Korean College of Neuropsychopharmacology 2020*; 18(3): 423-433 [PMID: 32702221 PMCID: PMC7383014 DOI: 10.9758/cpn.2020.18.3.423]
35 Zhang Y, Huang G, Yang S, Liang W, Zhang L, Wang C. Duloxetine in treating generalized anxiety disorder in adults: A meta-analysis of published randomized, double-blind, placebo-controlled trials *Asia-Pacific psychiatry : official journal of the Pacific Rim College of Psychiatrists 2016*; 8(3): 215-225 [PMID: 26238298 DOI: 10.1111/appy.12203]
36 Curtiss J, Andrews L, Davis M, Smits J, Hofmann SG. A meta-analysis of pharmacotherapy for social anxiety disorder: an examination of efficacy, moderators, and mediators *Expert Opin Pharmacother 2017*; 18(3): 243-251 [PMID: 28110555 DOI: 10.1080/14656566.2017.1285907]
37 Heeren A, Mogoase C, Philippot P, McNally RJ. Attention bias modification for social anxiety: A systematic review and meta-analysis *Clin Psychol Rev 2015*; 40: 76-90 [PMID: 26080314 DOI: 10.1016/j.cpr.2015.06.001]
38 Mayo-Wilson E, Dias S, Mavranezouli I, Kew K, Clark DM, Ades AE, Pilling S. Psychological and pharmacological interventions for social anxiety disorder in adults: a systematic review and network meta-analysis *Lancet Psychiatry 2014*; 1(5): 368-376 [PMID: 26361000 DOI: 10.1016/S2215-0366(14)70329-3]
39 Liu X, Li X, Zhang C, Sun M, Sun Z, Xu Y, Tian X. Efficacy and tolerability of fluvoxamine in adults with social anxiety disorder: A meta-analysis *Medicine (Baltimore) 2018*; 97(28): e11547 [PMID: 29995828 PMCID: 6076099 DOI: 10.1097/MD.0000000000011547]
40 Liu H, Li X, Han B, Liu X. Effects of cognitive bias modification on social anxiety: A meta-analysis *PLoS ONE 2017*; 12(4): e0175107 [PMID: 28384301 PMCID: 5383070 DOI: 10.1371/journal.pone.0175107]
41 Williams T, Hattingh CJ, Kariuki CM, Tromp SA, van Balkom AJ, Ipser JC, Stein DJ. Pharmacotherapy for social anxiety disorder (SAnD) *Cochrane Database Syst Rev 2017*; 10: CD001206 [PMID: 29048739 PMCID: 6360927 DOI: 10.1002/14651858.CD001206.pub3]
42 Sugarman MA, Loree AM, Baltes BB, Grekin ER, Kirsch I. The efficacy of paroxetine and placebo in treating anxiety and depression: a meta-analysis of change on the Hamilton Rating Scales *PLoS ONE 2014*; 9(8): e106337 [PMID: 25162656 PMCID: 4146610 DOI: 10.1371/journal.pone.0106337]
43 Carpenter JK, Andrews LA, Witcraft SM, Powers MB, Smits JAJ, Hofmann SG. Cognitive behavioral therapy for anxiety and related disorders: A meta-analysis of randomized placebo-controlled trials *Depress Anxiety 2018*; 35(6): 502-514 [PMID: 29451967 PMCID: 5992015 DOI: 10.1002/da.22728]

44 Skapinakis P, Caldwell D, Hollingworth W, Bryden P, Fineberg N, Salkovskis P, Welton N, Baxter H, Kessler D, Churchill R, Lewis G. A systematic review of the clinical effectiveness and cost-effectiveness of pharmacological and psychological interventions for the management of obsessive-compulsive disorder in children/adolescents and adults *Health Technol Assess 2016*; 20(43): 1-392 [PMID: 27306503 PMCID: PMC4921795 DOI: 10.3310/hta20430]
45 Skapinakis P, Caldwell DM, Hollingworth W, Bryden P, Fineberg NA, Salkovskis P, Welton NJ, Baxter H, Kessler D, Churchill R, Lewis G. Pharmacological and psychotherapeutic interventions for management of obsessive-compulsive disorder in adults: a systematic review and network meta-analysis *Lancet Psychiatry 2016*; 3(8): 730-739 [PMID: 27318812 PMCID: PMC4967667 DOI: 10.1016/S2215-0366(16)30069-4]
46 Öst LG, Havnen A, Hansen B, Kvale G. Cognitive behavioral treatments of obsessive-compulsive disorder. A systematic review and meta-analysis of studies published 1993-2014 *Clin Psychol Rev 2015*; 40: 156-169 [PMID: 26117062 DOI: 10.1016/j.cpr.2015.06.003]
47 Cipriani A, Williams T, Nikolakopoulou A, Salanti G, Chaimani A, Ipser J, Cowen PJ, Geddes JR, Stein DJ. Comparative efficacy and acceptability of pharmacological treatments for post-traumatic stress disorder in adults: a network meta-analysis *Psychol Med 2018*; 48(12): 1975-1984 [PMID: 29254516 DOI: 10.1017/S003329171700349X]
48 de Moraes Costa G, Zanatta FB, Ziegelmann PK, Soares Barros AJ, Mello CF. Pharmacological treatments for adults with post-traumatic stress disorder: A network meta-analysis of comparative efficacy and acceptability *J Psychiatr Res 2020*; 130: 412-420 [PMID: 32891916 DOI: 10.1016/j.jpsychires.2020.07.046]
49 Lee DJ, Schnitzlein CW, Wolf JP, Vythilingam M, Rasmusson AM, Hoge CW. Psychotherapy Versus Pharmacotherapy for Posttraumatic Stress Disorder: Systemic Review and Meta-Analyses to Determine First-Line Treatments *Depress Anxiety 2016*; 33(9): 792-806 [PMID: 27126398 DOI: 10.1002/da.22511]
50 Hoskins M, Pearce J, Bethell A, Dankova L, Barbui C, Tol WA, van Ommeren M, de Jong J, Seedat S, Chen H, Bisson JI. Pharmacotherapy for post-traumatic stress disorder: systematic review and meta-analysis *Br J Psychiatry 2015*; 206(2): 93-100 [PMID: 25644881 DOI: 10.1192/bjp.bp.114.148551]
51 Ehring T, Welboren R, Morina N, Wicherts JM, Freitag J, Emmelkamp PM. Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse *Clin Psychol Rev 2014*; 34(8): 645-657 [PMID: 25455628 DOI: 10.1016/j.cpr.2014.10.004]
52 Svaldi J, Schmitz F, Baur J, Hartmann AS, Legenbauer T, Thaler C, von Wietersheim J, de Zwaan M, Tuschen-Caffier B. Efficacy of psychotherapies and pharmacotherapies for Bulimia nervosa *Psychol Med 2018*: 1-13 [PMID: 30514412 DOI: 10.1017/S0033291718003525]
53 Brownley KA, Berkman ND, Peat CM, Lohr KN, Cullen KE, Bann CM, Bulik CM. Binge-Eating Disorder in Adults: A Systematic Review and Meta-analysis *Ann Intern Med 2016*; 165(6): 409-420 [PMID: 27367316 PMCID: 5637727 DOI: 10.7326/M15-2455]
54 Hilbert A, Petroff D, Herpertz S, Pietrowsky R, Tuschen-Caffier B, Vocks S, Schmidt R. Meta-analysis of the efficacy of psychological and medical treatments for binge-eating disorder *J Consult Clin Psychol 2019*; 87(1): 91-105 [PMID: 30570304 DOI: 10.1037/ccp0000358]
55 de Vos J, Houtzager L, Katsaragaki G, van de Berg E, Cuijpers P, Dekker J. Meta analysis on the efficacy of pharmacotherapy versus placebo on anorexia nervosa *Journal of eating disorders 2014*; 2(1): 27 [PMID: 25379181 PMCID: 4221720 DOI: 10.1186/s40337-014-0027-x]
56 Hay PJ, Claudino AM, Touyz S, Abd Elbaky G. Individual psychological therapy in the outpatient treatment of adults with anorexia nervosa *Cochrane Database Syst Rev 2015* (7): CD003909 [PMID: 26212713 PMCID: 6491116 DOI: 10.1002/14651858.CD003909.pub2]
57 Solmi M, Wade TD, Byrne S, Del Giovane C, Fairburn CG, Ostinelli EG, De Crescenzo F, Johnson C, Schmidt U, Treasure J, Favaro A, Zipfel S, Cipriani A. Comparative efficacy and acceptability of psychological interventions for the treatment of adult outpatients with anorexia nervosa: a systematic review and network meta-analysis *Lancet Psychiatry 2021*; 8(3): 215-224 [PMID: 33600749 DOI: 10.1016/S2215-0366(20)30566-6]
58 van den Berg E, Houtzager L, de Vos J, Daemen I, Katsaragaki G, Karyotaki E, Cuijpers P, Dekker J. Meta-analysis on the efficacy of psychological treatments for anorexia nervosa *Eur Eat Disord Rev 2019*; 27(4): 331-351 [PMID: 31124215 DOI: 10.1002/erv.2683]
59 Liang L, Huang Y, Xu R, Wei Y, Xiao L, Wang G. Eszopiclone for the treatment of primary insomnia: a systematic review and meta-analysis of double-blind, randomized, placebo-controlled trials *Sleep Med 2019*; 62: 6-13 [PMID: 31518944 DOI: 10.1016/j.sleep.2019.03.016]

60 Kishi T, Nomura I, Matsuda Y, Sakuma K, Okuya M, Ikuta T, Iwata N. Lemborexant vs suvorexant for insomnia: A systematic review and network meta-analysis *J Psychiatr Res 2020*; 128: 68-74 [PMID: 32531478 DOI: 10.1016/j.jpsychires.2020.05.025]
61 Kuriyama A, Honda M, Hayashino Y. Ramelteon for the treatment of insomnia in adults: a systematic review and meta-analysis *Sleep Med 2014*; 15(4): 385-392 [PMID: 24656909 DOI: 10.1016/j.sleep.2013.11.788]
62 Winkler A, Auer C, Doering BK, Rief W. Drug treatment of primary insomnia: a meta-analysis of polysomnographic randomized controlled trials *CNS Drugs 2014*; 28(9): 799-816 [PMID: 25168785 DOI: 10.1007/s40263-014-0198-7]
63 Kleinstauber M, Witthoft M, Steffanowski A, van Marwijk H, Hiller W, Lambert MJ. Pharmacological interventions for somatoform disorders in adults *Cochrane Database Syst Rev 2014* (11): CD010628 [PMID: 25379990 DOI: 10.1002/14651858.CD010628.pub2]
64 van Dessel N, den Boeft M, van der Wouden JC, Kleinstauber M, Leone SS, Terluin B, Numans ME, van der Horst HE, van Marwijk H. Non-pharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults *Cochrane Database Syst Rev 2014* (11): CD011142 [PMID: 25362239 DOI: 10.1002/14651858.CD011142.pub2]
65 Storebo OJ, Stoffers-Winterling JM, Vollm BA, Kongerslev MT, Mattivi JT, Jorgensen MS, Faltinsen E, Todorovac A, Sales CP, Callesen HE, Lieb K, Simonsen E. Psychological therapies for people with borderline personality disorder *Cochrane Database Syst Rev 2020*; 5: CD012955 [PMID: 32368793 DOI: 10.1002/14651858.CD012955.pub2]
66 Cheng YC, Huang YC, Huang WL. Gabapentinoids for treatment of alcohol use disorder: A systematic review and meta-analysis *Hum Psychopharmacol 2020*; 35(6): 1-11 [PMID: 32667088 DOI: 10.1002/hup.2751]
67 Donoghue K, Elzerbi C, Saunders R, Whittington C, Pilling S, Drummond C. The efficacy of acamprosate and naltrexone in the treatment of alcohol dependence, Europe versus the rest of the world: a meta-analysis *Addiction 2015*; 110(6): 920-930 [PMID: 25664494 DOI: 10.1111/add.12875]
68 Magill M, Ray L, Kiluk B, Hoadley A, Bernstein M, Tonigan JS, Carroll K. A meta-analysis of cognitive-behavioral therapy for alcohol or other drug use disorders: Treatment efficacy by contrast condition *J Consult Clin Psychol 2019* [PMID: 31599606 DOI: 10.1037/ccp0000447]
69 Vanderkam P, Solinas M, Ingrand I, Doux N, Ebrahimighavam S, Jaafari N, Lafay-Chebassier C. Effectiveness of drugs acting on adrenergic receptors in the treatment for tobacco or alcohol use disorders: systematic review and meta-analysis *Addiction 2020* [PMID: 32959918 DOI: 10.1111/add.15265]
70 Castells X, Blanco-Silvente L, Cunill R. Amphetamines for attention deficit hyperactivity disorder (ADHD) in adults *Cochrane Database Syst Rev 2018*; 8: CD007813 [PMID: 30091808 DOI: 10.1002/14651858.CD007813.pub3]
71 Cunill R, Castells X, Tobias A, Capella D. Efficacy, safety and variability in pharmacotherapy for adults with attention deficit hyperactivity disorder: a meta-analysis and meta-regression in over 9000 patients *Psychopharmacology (Berl) 2016*; 233(2): 187-197 [PMID: 26446868 DOI: 10.1007/s00213-015-4099-3]
72 Cortese S, Adamo N, Del Giovane C, Mohr-Jensen C, Hayes AJ, Carucci S, Atkinson LZ, Tessari L, Banaschewski T, Coghill D, Hollis C, Simonoff E, Zuddas A, Barbui C, Purgato M, Steinhausen HC, Shokraneh F, Xia J, Cipriani A. Comparative efficacy and tolerability of medications for attention-deficit hyperactivity disorder in children, adolescents, and adults: a systematic review and network meta-analysis *Lancet Psychiatry 2018*; 5(9): 727-738 [PMID: 30097390 PMCID: 6109107 DOI: 10.1016/S2215-0366(18)30269-4]
73 Lenzi F, Cortese S, Harris J, Masi G. Pharmacotherapy of emotional dysregulation in adults with ADHD: A systematic review and meta-analysis *Neurosci Biobehav Rev 2018*; 84: 359-367 [PMID: 28837827 DOI: 10.1016/j.neubiorev.2017.08.010]
74 Maneeton N, Maneeton B, Suttajit S, Reungyos J, Srisurapanont M, Martin SD. Exploratory meta-analysis on lisdexamfetamine versus placebo in adult ADHD *Drug Des Devel Ther 2014*; 8: 1685-1693 [PMID: 25336914 PMCID: 4199984 DOI: 10.2147/DDDT.S68393]

75 Huhn M, Nikolakopoulou A, Schneider-Thoma J, Krause M, Samara M, Peter N, Arndt T, Backers L, Rothe P, Cipriani A, Davis J, Salanti G, Leucht S. Comparative efficacy and tolerability of 32 oral antipsychotics for the acute treatment of adults with multi-episode schizophrenia: a systematic review and network meta-analysis *Lancet 2019* [PMID: 31303314 DOI: 10.1016/S0140-6736(19)31135-3]
76 Hutton P, Taylor PJ, Mulligan L, Tully S, Moncrieff J. Quetiapine immediate release v. placebo for schizophrenia: systematic review, meta-analysis and reappraisal *Br J Psychiatry 2015*; 206(5): 360-370 [PMID: 25934300 DOI: 10.1192/bjp.bp.114.154377]
77 Kishi T, Ikuta T, Matsuda Y, Sakuma K, Iwata N. Aripiprazole vs. brexpiprazole for acute schizophrenia: a systematic review and network meta-analysis *Psychopharmacology (Berl) 2020*; 237(5): 1459-1470 [PMID: 32002559 DOI: 10.1007/s00213-020-05472-5]
78 Leucht S, Leucht C, Huhn M, Chaimani A, Mavridis D, Helfer B, Samara M, Rabaioli M, Bacher S, Cipriani A, Geddes JR, Salanti G, Davis JM. Sixty Years of Placebo-Controlled Antipsychotic Drug Trials in Acute Schizophrenia: Systematic Review, Bayesian Meta-Analysis, and Meta-Regression of Efficacy Predictors *Am J Psychiatry 2017*; 174(10): 927-942 [PMID: 28541090 DOI: 10.1176/appi.ajp.2017.16121358]
79 McCutcheon RA, Pillinger T, Mizuno Y, Montgomery A, Pandian H, Vano L, Marques TR, Howes OD. The efficacy and heterogeneity of antipsychotic response in schizophrenia: A meta-analysis *Mol Psychiatry 2019* [PMID: 31471576 DOI: 10.1038/s41380-019-0502-5]
80 Ostuzzi G, Bertolini F, Del Giovane C, Tedeschi F, Bovo C, Gastaldon C, Nose M, Ogheri F, Papola D, Purgato M, Turrini G, Correll CU, Barbui C. Maintenance Treatment With Long-Acting Injectable Antipsychotics for People With Nonaffective Psychoses: A Network Meta-Analysis *Am J Psychiatry 2021*: appiajp202020071120 [PMID: 33596679 DOI: 10.1176/appi.ajp.2020.20071120]
81 Zhao MJ, Qin B, Wang JB, Zhang YP, Zhao JT, Mao YG, Zhang XY, Zhang RL. Efficacy and Acceptability of Cariprazine in Acute Exacerbation of Schizophrenia: Meta-Analysis of Randomized Placebo-Controlled Trials *J Clin Psychopharmacol 2018*; 38(1): 55-59 [PMID: 29257786 DOI: 10.1097/JCP.0000000000000834]
82 Zheng W, Cai DB, Yang XH, Li L, Zhang QE, Ng CH, Ungvari GS, Li XB, Ning YP, Xiang YT. Short-term efficacy and tolerability of lurasidone in the treatment of acute schizophrenia: A meta-analysis of randomized controlled trials *J Psychiatr Res 2018*; 103: 244-251 [PMID: 29906709 DOI: 10.1016/j.jpsychires.2018.06.005]
83 Cella M, Preti A, Edwards C, Dow T, Wykes T. Cognitive remediation for negative symptoms of schizophrenia: A network meta-analysis *Clin Psychol Rev 2017*; 52: 43-51 [PMID: 27930934 DOI: 10.1016/j.cpr.2016.11.009]
84 Jauhar S, McKenna PJ, Radua J, Fung E, Salvador R, Laws KR. Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias *Br J Psychiatry 2014*; 204(1): 20-29 [PMID: 24385461 DOI: 10.1192/bjp.bp.112.116285]
85 Lutgens D, Gariepy G, Malla A. Psychological and psychosocial interventions for negative symptoms in psychosis: systematic review and meta-analysis *Br J Psychiatry 2017*; 210(5): 324-332 [PMID: 28302699 DOI: 10.1192/bjp.bp.116.197103]
86 Bahji A, Ermacora D, Stephenson C, Hawken ER, Vazquez G. Comparative efficacy and tolerability of pharmacological treatments for the treatment of acute bipolar depression: A systematic review and network meta-analysis *J Affect Disord 2020*; 269: 154-184 [PMID: 32339131 DOI: 10.1016/j.jad.2020.03.030]
87 Kishi T, Ikuta T, Matsuda Y, Sakuma K, Okuya M, Mishima K, Iwata N. Mood stabilizers and/or antipsychotics for bipolar disorder in the maintenance phase: a systematic review and network meta-analysis of randomized controlled trials *Mol Psychiatry 2020* [PMID: 33177610 DOI: 10.1038/s41380-020-00946-6]
88 Li DJ, Tseng PT, Stubbs B, Chu CS, Chang HY, Vieta E, Fornaro M, Carvalho AF, Solmi M, Veronese N, Chen TY, Chen YW, Lin PY, Chow PC. Efficacy, safety and tolerability of aripiprazole in bipolar disorder: An updated systematic review and meta-analysis of randomized controlled trials *Prog Neuropsychopharmacol Biol Psychiatry 2017*; 79(Pt B): 289-301 [PMID: 28651936 DOI: 10.1016/j.pnpbp.2017.06.023]
89 Lindstrom L, Lindstrom E, Nilsson M, Hoistad M. Maintenance therapy with second generation antipsychotics for bipolar disorder - A systematic review and meta-analysis *J Affect Disord 2017*; 213: 138-150 [PMID: 28222360 DOI: 10.1016/j.jad.2017.02.012]

90 Liu B, Zhang Y, Fang H, Liu J, Liu T, Li L. Efficacy and safety of long-term antidepressant treatment for bipolar disorders - A meta-analysis of randomized controlled trials *J Affect Disord 2017*; 223: 41-48 [PMID: 28715727 DOI: 10.1016/j.jad.2017.07.023]
91 Miura T, Noma H, Furukawa TA, Mitsuyasu H, Tanaka S, Stockton S, Salanti G, Motomura K, Shimano-Katsuki S, Leucht S, Cipriani A, Geddes JR, Kanba S. Comparative efficacy and tolerability of pharmacological treatments in the maintenance treatment of bipolar disorder: a systematic review and network meta-analysis *Lancet Psychiatry 2014*; 1(5): 351-359 [PMID: 26360999 DOI: 10.1016/S2215-0366(14)70314-1]
92 Pinto JV, Saraf G, Vigo D, Keramatian K, Chakrabarty T, Yatham LN. Cariprazine in the treatment of Bipolar Disorder: A systematic review and meta-analysis *Bipolar Disord 2019* [PMID: 31618503 DOI: 10.1111/bdi.12850]
93 Talaei A, Pourgholami M, Khatibi-Moghadam H, Faridhosseini F, Farhoudi F, Askari-Noghani A, Sadeghi R. Tamoxifen: A Protein Kinase C Inhibitor to Treat Mania: A Systematic Review and Meta-Analysis of Randomized, Placebo-Controlled Trials *J Clin Psychopharmacol 2016*; 36(3): 272-275 [PMID: 27088436 DOI: 10.1097/JCP.0000000000000492]
94 Oud M, Mayo-Wilson E, Braidwood R, Schulte P, Jones SH, Morriss R, Kupka R, Cuijpers P, Kendall T. Psychological interventions for adults with bipolar disorder: systematic review and meta-analysis *Br J Psychiatry 2016*; 208(3): 213-222 [PMID: 26932483 DOI: 10.1192/bjp.bp.114.157123]
95 Amick HR, Gartlehner G, Gaynes BN, Forneris C, Asher GN, Morgan LC, Coker-Schwimmer E, Boland E, Lux LJ, Gaylord S, Bann C, Pierl CB, Lohr KN. Comparative benefits and harms of second generation antidepressants and cognitive behavioral therapies in initial treatment of major depressive disorder: systematic review and meta-analysis *BMJ 2015*; 351: h6019 [PMID: 26645251 PMCID: 4673103 DOI: 10.1136/bmj.h6019]
96 Cuijpers P, Karyotaki E, Andersson G, Li J, Mergl R, Hegerl U. The effects of blinding on the outcomes of psychotherapy and pharmacotherapy for adult depression: A meta-analysis *Eur Psychiatry 2015*; 30(6): 685-693 [PMID: 26169475]
97 Cuijpers P, Donker T, Weissman MM, Ravitz P, Cristea IA. Interpersonal Psychotherapy for Mental Health Problems: A Comprehensive Meta-Analysis *Am J Psychiatry 2016*; 173(7): 680-687 [PMID: 27032627 DOI: 10.1176/appi.ajp.2015.15091141]
98 Imai H, Tajika A, Chen P, Pompoli A, Furukawa TA. Psychological therapies versus pharmacological interventions for panic disorder with or without agoraphobia in adults *Cochrane Database Syst Rev 2016*; 10: CD011170 [PMID: 27730622 DOI: 10.1002/14651858.CD011170.pub2]
99 Merz J, Schwarzer G, Gerger H. Comparative Efficacy and Acceptability of Pharmacological, Psychotherapeutic, and Combination Treatments in Adults With Posttraumatic Stress Disorder: A Network Meta-analysis *JAMA psychiatry 2019* [PMID: 31188399 DOI: 10.1001/jamapsychiatry.2019.0951]
100 Sonis J, Cook JM. Medication versus trauma-focused psychotherapy for adults with posttraumatic stress disorder: A systematic review and meta-analysis *Psychiatry Res 2019*; 282: 112637 [PMID: 31690461 DOI: 10.1016/j.psychres.2019.112637]
101 Burkner PC, Bittner N, Holling H, Buhlmann U. D-cycloserine augmentation of behavior therapy for anxiety and obsessive-compulsive disorders: A meta-analysis *PLoS ONE 2017*; 12(3): e0173660 [PMID: 28282427 PMCID: 5345832 DOI: 10.1371/journal.pone.0173660]
102 Cuijpers P, Sijbrandij M, Koole SL, Andersson G, Beekman AT, Reynolds CF, 3rd. Adding psychotherapy to antidepressant medication in depression and anxiety disorders: a meta-analysis *World Psychiatry 2014*; 13(1): 56-67 [PMID: 24497254 PMCID: 3918025 DOI: 10.1002/wps.20089]
103 Driessen E, Dekker JJM, Peen J, Van HL, Maina G, Rosso G, Rigardetto S, Cuniberti F, Vitriol VG, Florenzano RU, Andreoli A, Burnand Y, Lopez-Rodriguez J, Villamil-Salcedo V, Twisk JWR, Cuijpers P. The efficacy of adding short-term psychodynamic psychotherapy to antidepressants in the treatment of depression: A systematic review and meta-analysis of individual participant data *Clin Psychol Rev 2020*; 80: 101886 [PMID: 32650213 DOI: 10.1016/j.cpr.2020.101886]
104 Karyotaki E, Smit Y, Holdt Henningsen K, Huibers MJ, Robays J, de Beurs D, Cuijpers P. Combining pharmacotherapy and psychotherapy or monotherapy for major depression? A meta-analysis on the long-term effects *J Affect Disord 2016*; 194: 144-152 [PMID: 26826534 DOI: 10.1016/j.jad.2016.01.036]

105 Ori R, Amos T, Bergman H, Soares-Weiser K, Ipser JC, Stein DJ. Augmentation of cognitive and behavioural therapies (CBT) with d-cycloserine for anxiety and related disorders *Cochrane Database Syst Rev 2015* (5): CD007803 [PMID: 25957940 DOI: 10.1002/14651858.CD007803.pub2]
106 Hoskins MD, Sinnerton R, Nakamura A, Underwood JFG, Slater A, Lewis C, Roberts NP, Bisson JI, Lee M, Clarke L. Pharmacological-assisted Psychotherapy for Post-Traumatic Stress Disorder: a systematic review and meta-analysis *European journal of psychotraumatology 2021*; 12(1): 1853379 [PMID: 33680344 PMCID: PMC7874936 DOI: 10.1080/20008198.2020.1853379]
107 Lopez PL, Torrente FM, Ciapponi A, Lischinsky AG, Cetkovich-Bakmas M, Rojas JI, Romano M, Manes FF. Cognitive-behavioural interventions for attention deficit hyperactivity disorder (ADHD) in adults *Cochrane Database Syst Rev 2018*; 3: CD010840 [PMID: 29566425 DOI: 10.1002/14651858.CD010840.pub2]
108 Higgins J, P.,, Altman DG, Goetzsche PC, Juni P, Moher D, Oxman AD. The Cochrane Statistical Methods Group. The Cochrane Collaboration´s tool for assesing risk of bias in randomized trials *Br Med J 2011*; 343: d5928
109 Jazaieri H, Goldin PR, Werner K, Ziv M, Gross JJ. A randomized trial of MBSR versus aerobic exercise for social anxiety disorder *J Clin Psychol 2012*; 68(7): 715-731 [PMID: 22623316 PMCID: PMC4136448 DOI: 10.1002/jclp.21863]
110 Cuijpers P, Quero S, Papola D, Cristea IA, Karyotaki E. Care-as-usual control groups across different settings in randomized trials on psychotherapy for adult depression: a meta-analysis *Psychol Med 2019*: 1-11 [PMID: 31843031 DOI: 10.1017/S0033291719003581]
111 Serfaty MA, Haworth D, Blanchard M, Buszewicz M, Murad S, King M. Clinical effectiveness of individual cognitive behavioral therapy for depressed older people in primary care: a randomized controlled trial *Arch Gen Psychiatry 2009*; 66(12): 1332-1340 [PMID: 19996038 DOI: 10.1001/archgenpsychiatry.2009.165]
112 Hsu LM. Random sampling, randomization, and equivalence of contrasted groups in psychotherapy outcome research *J Consult Clin Psychol 1989*; 57(1): 131-137 [PMID: 2647799 DOI: 10.1037//0022-006x.57.1.131]