

Supplementary Table S1 Records excluded after full-text assessment

Identification	Article	Reason
1	Andrews et al. 2010 ¹	Not specific to PD
2	Andrews et al. 2018 ²	Not specific to PD
3	Andrisano et al. 2013 ³	AMSTAR 2: Low
4	Archer et al. 2025 ⁴	Not specific to PD
5	Ballenger et al. 2004 ⁵	Not specific to PD
6	Bandelow et al. 2007 ⁶	Not specific to PD
7	Barkowski et al. 2020 ⁷	AMSTAR 2: Low
8	Bartley et al. 2013 ⁸	Not specific to PD
9	Barton et al. 2014 ⁹	Not specific to PD
10	Berney et al. 2008 ¹⁰	Not specific to PD
11	Berryhill et al. 2019 ¹¹	Not specific to PD
12	Bighelli et al. 2017 ¹²	AMSTAR 2: Critically low
13	Bschor et al. 2024 ¹³	Not specific to PD
14	Caldirola et al. 2016 ¹⁴	Not about treatment
15	Cardirola et al. 2020 ¹⁵	AMSTAR 2: Critically low
16	Carpenter et al. 2018 ¹⁶	Not specific to PD
17	Chawla et al. 2021 ¹⁷	AMSTAR 2: Low
18	Cirillo et al. 2019 ¹⁸	Not specific to PD
19	Cuijpers et al. 2016 ¹⁹	AMSTAR 2: Low
20	Cuijpers et al. 2024 ²⁰	Not specific to PD
21	de Vries et al. 2016 ²¹	AMSTAR 2: Critically low
22	Depping et al. 2010 ²²	Not specific and no PD trials found
23	Domhardt et al. 2020 ²³	AMSTAR 2: Critically low
24	Donovan et al. 2010 ²⁴	AMSTAR 2: Critically low
25	Esfandiari et al. 2021 ²⁵	Not specific to PD
26	Efron and Wooton 2021 ²⁶	AMSTAR 2: Low
27	Firth et al. 2017 ²⁷	Not specific to PD
28	Freire et al. 2015 ²⁸	AMSTAR 2: Critically low
29	Freire et al. 2011 ²⁹	Not specific to PD
30	Furukawa et al. 2006 ³⁰	AMSTAR 2: Critically low
31	Furukawa et al. 2007 ³¹	AMSTAR 2: Critically low
32	Haby et al. 2006 ³²	AMSTAR 2: Low
33	Hedman et al. 2012 ³³	Not specific to PD
34	Imai et al. 2014 ³⁴	Negative results
35	Jakubovski et al. 2018 ³⁵	AMSTAR 2: Low
36	Jayakody et al. 2014 ³⁶	AMSTAR 2: Critically low
37	Kitchiner et al. 2012 ³⁷	Not specific to PD
38	Li et al. 2014 ³⁸	AMSTAR 2: Low
39	Lewis et al. 2012 ³⁹	Not specific to PD
40	Machado et al. 2021 ⁴⁰	AMSTAR 2: Critically low
41	Mendez et al. 2024 ⁴¹	AMSTAR 2: Critically low
42	Meyerbröker et al. 2010 ⁴²	Not specific to PD
43	Mitte et al. 2005 ⁴³	AMSTAR 2: Critically low
44	Miyasaka et al. 2006 ⁴⁴	Not specific to PD
45	Miyasaka et al. 2007 ⁴⁵	Not specific to PD
46	Montero-Marin et al. 2017 ⁴⁶	Not specific to PD
47	Offidani et al. 2013 ⁴⁷	AMSTAR 2: Critically low
48	Olantunji et al. ⁴⁸	Not specific to PD

Identification	Article	Reason
49	Ori et al. 2015 ⁴⁹	Not specific to PD
50	Olthuis et al. 2015 ⁵⁰	Not specific to PD
51	Papola et al. 2021 ⁵¹	AMSTAR 2: Critically low
52	Perna et al. 2016 ⁵²	AMSTAR 2: Critically low
53	Patterson et al. 2016 ⁵³	Not specific to PD
54	Pigot et al. 2008 ⁵⁴	Not specific to PD
55	Pilkington et al. 2007 ⁵⁵	Not specific to PD
56	Reger and Gahm 2009 ⁵⁶	Not specific to PD
57	Quagliato et al. 2019 ⁵⁷	AMSTAR 2: Critically low
58	Sánchez-Meca et al. 2010 ⁵⁸	AMSTAR 2: Critically low
59	Sarris et al. 2009 ⁵⁹	Not specific to PD
60	Schiele et al. 2021 ⁶⁰	Not specific to PD
61	Schröder et al. 2023 ⁶¹	AMSTAR 2: Low
62	Siev and Chambless 2007 ⁶²	AMSTAR 2: Critically low
63	Stech et al. 2019 ⁶³	AMSTAR 2: Critically low
64	Steen et al. 2015 ⁶⁴	Not specific to PD
65	Stimpfl et al. 2023 ⁶⁵	Not specific to PD
66	Sugarman et al. 2014 ⁶⁶	AMSTAR 2: Critically low
67	Tully et al. 2014 ⁶⁷	Not specific
68	van Dis et al. 2019 ⁶⁸	Not specific to PD
69	Vicario et al. 2019 ⁶⁹	Not specific
70	Watanabe et al. 2007 ⁷⁰	AMSTAR 2: Critically low
71	Wiebe et al. 2022 ⁷¹	Not specific to PD
72	Zhang et al. 2020 ⁷²	AMSTAR 2: Low
73	Zwanzger et al. 2009 ⁷³	Not specific to PD

AMSTAR 2 = A MeaSurement Tool to Assess systematic Reviews, version 2; PD = panic disorder.

AMSTAR 2 rating overall confidence in the results of the review⁷⁴:

- High: No or one non-critical weakness: the systematic review provides an accurate and comprehensive summary of the results of the available studies that address the question of interest.
- Moderate: More than one non-critical weakness[†]: the systematic review has more than one weakness but no critical flaws. It may provide an accurate summary of the results of the available studies that were included in the review.
- Low: One critical flaw with or without non-critical weaknesses: the review has a critical flaw and may not provide an accurate and comprehensive summary of the available studies that address the question of interest.
- Critically low: More than one critical flaw with or without non-critical weaknesses: the review has more than one critical flaw and should not be relied on to provide an accurate and comprehensive summary of the available studies.

[†] Multiple non-critical weaknesses may diminish confidence in the review and it may be appropriate to move the overall appraisal down from moderate to low confidence.

Supplementary Table S2 Amstar 2⁷⁴ classification of selected articles

Author	Year	Topic	Patient type	A1	A2	A3	A4	A5	A6	A7	A8	A9	A10	A11	A12	A13	A14	A15	A16	Classification
Andrisano et al.	2013	Antidepressants	PD with/without comorbidades	No	Yes	No	PY	No	No	PY	PY	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Low
Barkowski et al.	2020	Group psychotherapy	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Low
Bighelli et al.	2016	Antidepressants and benzodiazepines	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
Bighelli et al.	2017	Efficacy of antidepressants	Panic disorder	No	PY	Yes	Yes	No	Yes	No	PY	Yes	No	Yes	No	No	No	No	Yes	Critically low
Bighelli et al.	2018	Antidepressants versus placebo	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
Breilmann et al.	2019	Benzodiazepines versus placebo	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
Caldirola et al.	2020	Pharmacotherapy	Panic disorder	Yes	No	Yes	Yes	No	Yes	No	Yes	No	No	Yes	No	No	No	No	Yes	Critically low
Chawla et al.	2021	Medications	PD with and without agoraphobia	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Low
Cuijpers et al.	2016	Psychotherapies	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Low
de Vries et al.	2016	Antidepressant efficacy for anxiety disorders	Anxiety disorders	No	No	Yes	No	No	No	No	PY	No	No	Yes	No	Yes	Yes	No	Yes	Critically low
Domhardt et al.	2020	Internet- and mobile-based interventions	PD with and without agoraphobia	Yes	No	Yes	No	Yes	Yes	No	PY	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Critically low
Donovan et al.	2010	Antidepressants in relapse	Anxiety disorders	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No	Yes	No	No	Yes	No	Yes	Critically low
Du et al.	2021	Antidepressants and benzodiazepines	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	No	PY	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Low
Efron and Wooton.	2021	Remote Cognitive Behavioral Therapy	Panic disorder	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Low
Freire et al.	2015	Treatment	Resistant panic disorder	No	No	Yes	PY	Yes	Yes	PY	PY	No	No	No	No	No	No	Yes	Yes	Critically low
Furukawa et al.	2007	Combined psychotherapies versus antidepressants	PD with and without agoraphobia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
Furukawa et al.	2007	Cognitive Behavioral Therapy	Panic disorder	Yes	No	Yes	PY	Yes	Yes	No	Yes	No	No	Yes	No	No	Yes	No	Yes	Critically low
Furukawa et al.	2006	Psychotherapy plus antidepressants	PD with and without agoraphobia	No	Yes	Yes	No	Yes	Yes	No	PY	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Critically low
Guaiana et al.	2023	Pharmacotherapy	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
Haby et al.	2006	Cognitive Behavioral Therapy	Panic disorder	Yes	PY	Yes	PY	Yes	Yes	Yes	PY	Yes	No	Yes	Yes	No	Yes	Yes	No	Critically low
Imai et al.	2014	Azapirones versus placebo	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
Imai et al.	2016	Psychological therapies versus pharmacological interventions	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
Jakubovski et al.	2018	Dose-response curve of SSRIs and SNRIs in anxiety disorders	Anxiety disorders	No	PY	Yes	Yes	No	No	No	No	Yes	No	Yes	No	No	Yes	Yes	Yes	Critically low
Jayakody et al.	2014	Exercise	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	PY	Yes	Yes	No	Yes	No	No	No	No	Yes	Critically low
Li et al.	2014	Repetitive transcranial magnetic stimulation	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Low
Machado et al.	2021	Exercise	Panic disorder	Yes	PY	Yes	PY	Yes	Yes	No	Yes	Yes	No	NMC	NMC	Yes	No	No	Yes	Critically low
Mendez et al.	2024	Trajectory and magnitude of response in adults with anxiety disorders	Anxiety disorders	No	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes	No	Yes	No	Yes	Critically low
Mitte et al.	2005	Psycho and pharmacotherapy	PD with and without agoraphobia	No	Yes	No	Yes	No	No	No	No	Yes	No	Yes	Yes	Yes	No	No	No	Critically low
Offidani et al.	2013	Benzodiazepines vs. Antidepressants	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	Yes	Yes	Critically low
Papola et al.	2022	Cognitive Behavioral Therapy treatment delivery formats	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
Papola et al.	2021	Psychotherapies	Panic disorder	No	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes	No	Yes	High
Perna	2016	Pharmacotherapy	Anxiety disorders	No	No	Yes	PY	No	No	No	Yes	No	No	NMC	NMC	No	No	No	Yes	Critically low
Pompoli et al.	2016	Psychological therapies	PD with and without agoraphobia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
Pompoli et al.	2018	Cognitive-behaviour therapy	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
Quagliato et al.	2019	Selective serotonin reuptake inhibitors and benzodiazepines	Panic disorder	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Critically low
Sánchez-Meca et al.	2010	Psychological treatment	PD with and without agoraphobia	No	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes	Yes	Yes	No	No	Critically low
Schröder et al.	2023	Virtual Reality	Panic disorder	No	Yes	Yes	Yes	Yes	Yes	No	PY	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Low
Siev and Chambless	2007	Cognitive Therapy and Relaxation	Panic disorder	No	No	No	No	No	No	No	PY	No	No	No	No	No	Yes	No	No	Critically low
Stech et al.	2019	Internet-delivered cognitive behavioral therapy	PD with and without agoraphobia	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Critically low
Surgaman et al.	2014	Paroxetine versus placebo	Panic disorder	No	No	Yes	No	No	No	No	No	No	No	Yes	No	No	Yes	No	No	Critically low
van Dis et al.	2019	Long-term Outcomes of Cognitive Behavioral Therapy	Anxiety disorders	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	No	No	No	Yes	Yes	Low
Watanabe et al.	2009	Combination of psychotherapy and benzodiazepines	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	High
Watanabe et al.	2007	Combination of psychotherapy and benzodiazepines versus either therapy alone	Panic disorder	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No	Yes	No	Yes	Critically low
Zhang et al.	2020	Paroxetine versus placebo	Panic disorder	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Low

A1-A16 = Amstar 2 item; PY = partial yes; NMC = no meta-analysis conducted; SSRIs = selective serotonin reuptake inhibitors; SNRIs = serotonin-norepinephrine reuptake inhibitors.

A1: Did the research questions and inclusion criteria for the review include the components of PICO?

A2: Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review, and did the report justify any significant deviations from the protocol?

A3: Did the review authors explain their selection of the study designs for inclusion in the review?

A4: Did the review authors use a comprehensive literature search strategy?

A5: Did the review authors perform study selection in duplicate?

A6: Did the review authors perform data extraction in duplicate?

A7: Did the review authors provide a list of excluded studies and justify the exclusions?

A8: Did the review authors describe the included studies in adequate detail?

A9: Did the review authors use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that were included in the review?

A10: Did the review authors report on the sources of funding for the studies included in the review?

A11: If meta-analysis was performed, did the review authors use appropriate methods for statistical combination of results?

A12: If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?

A13: Did the review authors account for RoB in primary studies when interpreting/discussing the results of the review?

A14: Did the review authors provide a satisfactory explanation for, and discussion of, any heterogeneity observed in the results of the review?

A15: If they performed quantitative synthesis, did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review?

A16: Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?

AMSTAR 2 rating overall confidence in the results of the review⁷⁴:

- High: No or one non-critical weakness: the systematic review provides an accurate and comprehensive summary of the results of the available studies that address the question of interest.
- Moderate: More than one non-critical weakness[†]: the systematic review has more than one weakness but no critical flaws. It may provide an accurate summary of the results of the available studies that were included in the review.
- Low: One critical flaw with or without non-critical weaknesses: the review has a critical flaw and may not provide an accurate and comprehensive summary of the available studies that address the question of interest.
- Critically low: More than one critical flaw with or without non-critical weaknesses: the review has more than one critical flaw and should not be relied on to provide an accurate and comprehensive summary of the available studies.

[†] Multiple non-critical weaknesses may diminish confidence in the review, and it may be appropriate to move the overall appraisal down from moderate to low confidence.

For more details: Shea BJ, Reeves BC, Wells G, Thuku M, Hamel C, Moran J, et al. AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ*. 2017;358:j4008.

Supplementary Table S3 Response for the treatment of PD with and without agoraphobia for adults

Author	Intervention and comparator	Studies	Sample	GRADE	Effect	Comments
Bighelli et al. ⁷⁵	Antidepressants vs benzodiazepines (failure to respond)	2	215	Low	RR = 0.99 (0.67-1.47)	No difference.
	TCAs vs benzodiazepines (failure to respond)	1	61	Very low	RR = 1.02 (0.63-1.97)	No difference.
	SSRIs vs benzodiazepines (failure to respond)	1	154	Very low	RR = 0.93 (0.48-1.80)	No difference.
	TCAs vs SSRIs (failure to respond)	4	438	Low	RR = 1.08 (0.71 to 1.66)	No difference.
	TCAs vs MAOIs (failure to respond)	1	135	Low	RR = 0.59 (0.28 to 1.26)	In favor of TCAs.
	SSRIs vs MAOIs (failure to respond)	2	396	Moderate	RR = 1.12 (0.83 to 1.52)	No difference.
	SSRIs vs SNRIs (failure to respond)	2	991	High	RR = 0.96 (0.75 to 1.23)	No difference.
Bighelli et al. ⁷⁶	Antidepressants vs placebo (failure to respond)	30	6,500	Low	RR = 0.72 (0.66 to 0.79)	A RR of 0.72 means that the treatment with antidepressants decreases the risk of nonresponse to treatment by 28% compared to placebo.
	Antidepressants vs placebo (panic symptoms – mean change)	10	2,010	Low	0.53 SDs lower	The results show a benefit for antidepressants compared to placebo. The size of effect can be considered moderate.
	TCAs vs placebo (failure to respond)	9	829	Moderate	RR = 0.73 (0.63 to 0.86)	A RR of 0.73 means that treatment with TCA decreases the risk of nonresponse to treatment by 27% compared to placebo.
	TCAs vs placebo (panic symptoms – mean change)	2	70	Very low	2.09 SDs lower	The results show a benefit for TCA compared to placebo. The size of effect can be considered large.
	SSRIs vs placebo (failure to respond)	21	4,000	Low	RR = 0.75 (0.67 to 0.84)	A RR of 0.75 means that treatment with SSRI decreases the risk of failure by 25% compared to placebo.
	SSRIs vs placebo (panic symptoms – mean change)	7	1,255	Moderate	0.28 SDs lower	The results show a benefit for SSRI compared to placebo. The size of effect can be considered between small and moderate.
	SNRIs vs placebo (failure to respond)	4	1,531	Low	RR=0.61 (0.41 to 0.91)	A RR of 0.61 means that treatment with SNRIs decreases the risk of nonresponse to treatment by 39% compared to placebo.
	SNRIs vs placebo (panic symptoms – mean change)	2	685	High	0.41 SDs lower	The results show a benefit for SNRI compared to placebo. The size of effect can be considered between small and moderate
Breilmann et al. ⁷⁷	Benzodiazepines vs placebo (response)	16	2,476	Low	RR = 1.65 (1.39 to 1.96)	Low-quality evidence shows a possible superiority of benzodiazepine over placebo in the short-term treatment of panic disorders.
	Benzodiazepines vs placebo (panic symptoms – mean change)	4	719	Very low	SMD 0.5 lower	Low-quality evidence shows a possible superiority of benzodiazepine over placebo in the short-term treatment of panic disorders.
Furukawa et al. ⁷⁸	Combined psychotherapy and antidepressant vs antidepressant alone (response at 2-4 months)	11	669	Moderate	RR = 1.24 (1.02, 1.51)	Combined therapy was superior to antidepressant pharmacotherapy.
	Combined behavior therapy and antidepressant vs antidepressant alone (response at 2-4 months)	4	193	Low	RR = 1.06 (0.80, 1.40)	Authors concluded the superiority of combined therapy.
	Combined CBT and antidepressant vs antidepressant alone	5	336	Moderate	RR = 1.46 (1.05, 2.02)	Authors concluded the superiority of combined therapy.
	Psychodynamic psychotherapy and others and antidepressants vs antidepressants alone	2	140	Very low	RR = 1.10 (0.65, 1.85)	Authors concluded the superiority of combined therapy.
	TCA: vs. antidepressants alone (Response at 2-4 months)	7	421	Moderate	RR = 1.23 (1.04, 1.45)	

Author	Intervention and comparator	Studies	Sample	GRADE	Effect	Comments
	TCA: BT + antidepressants vs. antidepressants alone (Response at 2-4 months)	4	193	Low	RR = 1.06 (0.80, 1.40)	
	TCA: CBT + antidepressants vs antidepressants alone (Response at 2-4 months)	2	188	Moderate	RR = 1.27 (0.94, 1.71)	
	TCA: psychodynamic psychotherapy and others + antidepressants vs antidepressant alone (tesponse at 2-4 months)	1	10	Very low	RR = 1.41 (1.05, 1.90)	
	SSRI: vs. antidepressants alone (response at 2-4 months)	3	218	Moderate	RR = 1.23 (0.75, 2.03)	
	SSRI: BT + antidepressants vs. antidepressant alone (response at 2-4 months)	0	0	-	-	No evidence.
	SSRI: CBT + antidepressants vs. antidepressant alone (response at 2-4 months)	2	118	Moderate	RR = 1.68 (0.69, 4.05)	
	SSRI: psychodynamic psychotherapy and others + antidepressants vs. antidepressant alone (response at 2-4 months)	1	100	Very low	RR = 0.85 (0.63, 1.15)	Result in favor of antidepressant alone.
Guaiana et al. ⁷⁹	Antidepressants vs placebo (response)	48	10,118	Moderate	SSRIs: RR = 0.83 (95%CrI 0.63 to 0.96), mean rank 5 (95%CrI 2 to 6). SNRIs: RR = 0.85 (95%CrI 0.63 to 0.97), mean rank 5 (95%CrI 1 to 6). TCAs: RR = 0.82 (95%CrI 0.57 to 0.96), mean rank 4 (95%CrI 1 to 6). MAOIs: RR = 0.79 (95%CrI 0.52 to 0.96), mean rank 3 (95%CrI 1 to 6). BDZs: RR = 0.78 (95%CrI 0.52 to 0.95), mean rank 3 (95%CrI 1 to 6)	All intervention classes were effective compared with placebo.
				Moderate	SNRIs vs SSRIs: RR = 1.01 (95%CrI 0.86 to 1.21). TCAs vs SSRIs: RR = 0.98 (95%CrI 0.81 to 1.13).	There was no difference between the following classes, with all 95%CrIs remaining within the equivalence range.
Imai et al. ⁸⁰	CBT vs SSRIs (short-term response)	5	277	Low	RR = 0.97 (0.51, 1.86)	No difference.
	CBT vs SSRIs (short-term improvement)	5	242	Moderate	SMD = -0.20 (-1.09, 0.69)	In favor of psychotherapy but crossed equivalence range.
	CBT vs TCAs (short-term response)	4	192	Low	RR = 0.79 (0.51, 1.25)	In favor of psychotherapy but crossed equivalence range.
	CBT vs TCAs (short-term improvement)	5	342	Moderate	SMD = 0.13 (-0.14, 0.40)	In favor of TCAs but crossed equivalence range.
	BT vs TCAs (short-term response)	1	36	Very low	RR = 1.0 (0.10, 9.96)	No difference.
	BT vs TCAs (short-term improvement)	1	30	Very low	SMD = 0.47 (-0.30, 1.24)	In favor of TCAs but crossed the equivalence range.
	SP vs TCA (short-term response)	1	42	Very low	RR = 0.6 (0.27, 1.32)	In favor of psychotherapy but crossed equivalence range.
	SP vs TCA (short-term improvement)	1	42	Very low	SMD = 0.56 (-0.12, 1.24)	In favor of TCAs but crossed the equivalence range.
	CBT vs benzodiazepines (short-term response)	2	75	Low	RR = 1.08 (0.70, 1.65)	In favor of benzodiazepines but crossed the equivalence range.
	CBT vs benzodiazepines (short-term improvement)	2	69	Low	SMD = -0.16 (-0.82, 0.50)	In favor of CBT but crossed equivalence range.
Papola et al. ⁸¹	CBT vs other psychotherapies and placebo	74	6,699	Moderate /Low	Face-to-face group [standardized mean differences (SMD) -0.47, 95%CI -0.87 to -0.07; CINeMA = moderate], face-to-face individual (SMD -0.43, 95%CI -0.70 to -0.15; CINeMA = moderate), and guided self-help (SMD -0.42, 95%CI -0.77	CBT face-to-face group, face-to-face individual, and guided self-help are indicated.

Author	Intervention and comparator	Studies	Sample	GRADE	Effect	Comments
					to -0.07; CiNeMA = low) are superior to treatment as usual in terms of efficacy, whilst unguided self-help is not (SMD -0.21, 95%CI -0.58 to -0.16; CiNeMA = low).	
Papola et al. ⁵¹	10 different psychotherapies vs TAU	136	7,352	Moderate Moderate Low Very low Very low Low Very low Moderate Low	BT: RR = -0.78 (-1.14, -0.42) CBT: RR = -0.67 (-0.95, -0.39) STPD: RR = -0.61 (-1.15, -0.07) IPT: RR = -0.58 (-1.64, 0.48) SP: RR = -0.57 (-1.23, 0.08) CT: RR = -0.47 (-0.86, -0.09) PE: RR = -0.33 (-1.46, 0.79) PT: RR = -0.26 (-0.62, 0.10) 3W: RR = -0.09 (-0.71, 0.53)	
Pompoli et al. ⁸²	CBT compared to no treatment for panic disorder with or without agoraphobia in adults (short-term response)	7	357	Very low	OR = 7.14 (1.25 to 50)	
	CBT compared to no treatment for panic disorder with or without agoraphobia in adults (short-term improvement)	1	27	Low	SMD = -0.83 (95%CI -1.5 to -0.16)	Large effect size in favor of CBT.
	Network meta-analysis rankings of psychological therapies for panic disorder with or without agoraphobia in adults (short-term response)	37	2,240	Low	WL vs CBT: NMA = 0.16 (0.10 to 0.16) WL vs PT: NMA = 0.25 (0.12 to 0.50) WL vs SP: NMA = 0.17 (0.05 to 0.53) WL vs BT: NMA = 0.29 (0.15 to 0.54) CBT vs BT: NMA = 1.77 (1.02 to 3.04) PD vs WL: NMA = 6.02 (1.60 to 22.61)	Recommended: CBT, PD, SP, BT, and PT CT se than WL WL
	Network meta-analysis rankings of psychological therapies for panic disorder with or without agoraphobia in adults (short-term improvement)	57	2,318	Low	Treatment hierarchy (in descending order by SUCRA: CBT (84)-PD (74)-SP (72)-BT (53)-PT (52)-WL (31)-CT (27)-NT (7) WL vs SP: SMD = 1.05 (0.49 to 1.60) WL vs PT: SMD = 0.80 (0.47 to 1.13) WL vs BT: SMD = 0.89 (0.57 to 1.20) WL vs CT: SMD = 0.88 (0.34 to 1.42) NT vs CBT: SMD = 0.83 (0.16 to 1.50) Treatment hierarchy (in descending order): PD(83)-CBT(79)-SP(69)-CT(54)-3W(53)-BT(52)-PT(43)-NT(14)-WL(4)	All recommended.
Pompili et al. ⁸³	CBT vs other psychotherapies, waiting list (WL), no treatment, attention/psychological placebo (response)	55	3,275	Moderate	Interceptive exposure: iOR= 1.43 (CrI 0.94 to 2.16) Face-to-face setting: iOR= 1.79 (CrI 0.93 to 3.53) Breathing retraining: iOR= 1.16 (CrI	Effective CBT packages for panic disorder would include face-to-face and interoceptive exposure components.

Author	Intervention and comparator	Studies	Sample	GRADE	Effect	Comments
					0.81 to 1.67) Psychoeducation: iOR= 1.17 (CrI 0.68 to 2.03)	
Watanabe et al. ⁸⁴	Combining psychotherapy (behavior therapy) and benzodiazepines vs psychotherapy alone (behavior therapy)	166	2	Low	RR = 1.25 (0.78 to 2.03)	In favor of combination.
	or benzodiazepine alone	77	1		RR = 1.53 (0.83 to 2.98)	In favor of combination.
	(Response during intervention)					
	Combining psychotherapy (behavior therapy) and benzodiazepines vs psychotherapy alone (behavior therapy)	2	166	Low	RR = 0.78 (0.45 to 1.35)	In favor of psychotherapy alone.
	or benzodiazepine alone	1	77	Low	RR = 3.39 (1.09 to 11.21)	In favor of combination.
	(Response at the end of the intervention)					

3W = third-wave cognitive-behavior therapy; BDZ = benzodiazepines; BT = behavior therapy; CBT = cognitive-behavior therapy; CT = cognitive therapy; IPT = interpersonal therapy; MAOIs = monoamine oxidase inhibitors; NMA = network meta-analysis rankings; NT = no treatment; OR = odds ratio; PD = panic disorder; PDT = psychodynamic therapies; PE = psychoeducation; PT = physiological therapies; RR risk ratio; SMD = standardized mean differences; SNRIs = serotonin-norepinephrine reuptake inhibitors; SSRIs = selective serotonin reuptake inhibitors; SP = supportive psychotherapy; SUCRA = cumulative ranking curve; TCAs = tricyclic antidepressants; WL = wait-list.

Supplementary Table S4 Remission for the treatment of PD with and without agoraphobia for adults

Author	Intervention and comparator	Studies	Sample	GRADE	Effect	Comments
Bighelli et al. ⁷⁵	Antidepressants vs benzodiazepines (failure to remit)	3	1,002	Moderate	RR=1.18 (1.01, 1.37)	No difference.
	TCAs vs benzodiazepines (failure to remit)	2	848	Moderate	RR=1.19 (1.00, 1.41)	In favor of benzodiazepines.
	SSRIs vs benzodiazepines (failure to remit)	1	154	Very low	RR=1.12 (0.79, 1.59)	No difference.
	TCAs vs SSRIs (failure to remit)	5	475	Moderate	RR=0.89 (0.63 to 1.26)	No difference.
	TCAs vs MAOIs (failure to remit)	1	135	Very low	RR=0.59 (0.28, 1.26)	In favor of TCAs.
	SSRIs vs MAOIs (failure to remit)	1	366	Moderate	RR=0.93 (0.74 to 1.17)	No difference.
	SSRIs vs SNRIs (failure to remit)	2	991	High	RR=1.05 (0.91 to 1.21)	No difference.
Bighelli et al. ⁷⁶	Antidepressants vs placebo (failure to remit)	24	6,164	Moderate	RR=0.83 (0.78 to 0.88)	A RR of 0.83 means that the treatment with antidepressants decreases the risk of not reaching remission by 17% compared to placebo.
	TCAs vs placebo (failure to remit)	8	1,294	Low	RR=0.82 (0.69 to 0.99)	A RR of 0.82 means that treatment with TCA decreases the risk of not reaching remission by 18% compared to placebo.
	SSRIs vs placebo (failure to remit)	16	3,339	Moderate	RR=0.81 (0.75 to 0.88)	A RR of 0.81 means that treatment with SSRI decreases the risk of not reaching remission by 19% compared to placebo.
	SNRIs vs placebo (failure to remit)	4	1,531	Moderate	RR=0.84 (0.75 to 0.95)	A RR of 0.84 means that treatment with SNRI decreases the risk of not reaching remission by 16% compared to placebo.
Breilmann et al. ⁷⁷	Benzodiazepines vs placebo (remission; follow-up: range 5 weeks to 15 weeks)	15	2,508	Low	RR=1.61 (1.38 to 1.88)	Low-quality evidence shows a possible superiority of benzodiazepine over placebo in the short-term treatment of panic disorders.
Furukawa et al. ⁷⁸	Combined psychotherapy + antidepressant vs antidepressant alone (remission at 2-4 months)	7	506	Low	RR=1.19 (0.97, 1.45)	Combined therapy was superior to antidepressant pharmacotherapy.
	BT + antidepressants vs antidepressant alone (remission at 2-4 months)	2	114	Very low	RR=0.97 (0.62, 1.51)	No difference.
	CBT + antidepressants vs antidepressants alone (remission at 2-4 months)	3	252	Moderate	RR=1.40 (0.92, 2.14)	Authors concluded the superiority of combined therapy.
	Psychodynamic psychotherapy and others and antidepressants vs antidepressant alone (remission at 2-4 months)	2	140	Very low	RR=0.86 (0.28, 2.61)	No difference.
	TCA: psychotherapy + antidepressants vs antidepressant alone (remission at 2-4 months)	4	302	Moderate	RR=1.26 (1.06, 1.51)	In favor of combined therapy.
	TCA: BT + antidepressants vs antidepressants alone (remission at 2-4 months)	7	369	Moderate	RR= 1.38 (1, 1.9)	In favor of combination.
	TCA: CBT + antidepressants vs antidepressant alone (remission at 2-4 months)	1	148	Moderate	RR=1.34 (1.01, 1.79)	In favor of combined therapy.
	TCA: psychodynamic psychotherapy and others + antidepressant vs antidepressant alone (remission at 2-4 months)	1	40	Low	RR = 1.32 (1.02, 1.72)	In favor of combined therapy.
	SSRI: psychotherapy + antidepressants vs Antidepressant alone (response at 2-4 months)	2	174	Low	RR=0.80 (0.38, 1.70)	In favor of SRIs alone.
	SSRI: BT + antidepressants vs antidepressants alone (response at 2-4 months)	0	0	-	-	No evidence
	SSRI: CBT + antidepressants vs antidepressants alone (response at 2-4 months)	0	0	-	-	No evidence

Author	Intervention and comparator	Studies	Sample	GRADE	Effect	Comments
	SSRI: CBT + antidepressants vs antidepressant alone (response at 2-4 months)	1	74	Low	RR = 1.14 (0.78, 1.66)	In favor of combination
	SSRI: psychodynamic psychotherapy and others + antidepressant vs antidepressant alone (response at 2-4 months)	1	100	Low	RR = 0.54 (0.32,0.9)	In favor of SSRIs alone.
Guaiana et al. ⁷⁹	Antidepressants vs placebo (remission)	32	8,589	Moderate	Desipramine: RR = 0.66 (95%CrI 0.29 to 0.97); mean rank 2 (95%CrI 1 to 13). Alprazolam: RR = 0.65 (95%CrI 0.44 to 0.84); mean rank 2 (95%CrI 1 to 5). Fluoxetine: RR = 0.77 (95%CrI 0.46 to 0.96); mean rank 5 (95%CrI 1 to 13). Clonazepam: RR = 0.76 (95%CrI 0.53 to 0.92); mean rank 5 (95%CrI 1 to 11). Diazepam: RR = 0.74 (95%CrI 0.43 to 0.96); mean rank 5 (95%CrI 1 to 13). Fluvoxamine (RR = 0.77, 95%CrI 0.50 to 0.95; mean rank 6 (95%CrI 1 to 12). Imipramine: RR = 0.79 (95%CrI 0.57 to 0.94); mean rank 7 (95%CrI 2 to 12). Venlafaxine: RR = 0.87 (95%CrI 0.70 to 0.96); mean rank 10 (95%CrI 5 to 13). Paroxetine: RR = 0.88 (95%CrI 0.71 to 0.97); mean rank 10 (95%CrI 6 to 13).	TCAs, SSRIs, SNRIs, and BDZ were superior to placebo for remission.
Imai et al. ⁸⁰	CBT vs SSRIs (short-term remission)	6	334	Very low	RR = 0.85 (0.62, 1.17)	In favor of medication.
	CBT vs TCAs (short-term remission)	3	151	Low	RR = 0.82 (0.62 to 1.09)	In favor of medication.
	BT vs TCAs (short-term remission)	1	36	Very low	RR = 0.7 (0.28, 1.75)	In favor of medication.
	SP vs TCA (short-term remission)	1	32	Very low	RR = 0.69 (0.36, 1.31)	In favor of medication.
	CBT vs benzodiazepines (short-term remission)	2	75	Very low	RR = 1.08 (0.7,1.65)	In favor of psychotherapy.
Pompoli et al. ⁸²	CBT compared to no treatment for panic disorder with or without agoraphobia in adults (short-term remission)	7	357	Very low	OR = 2.78 (0.54 to 14.29)	
	Network meta-analysis rankings of psychological therapies for panic disorder with or without agoraphobia in adults (short-term remission)	40	2,491	Low	CBT vs PT: NMA = 1.95 (1.02-3.97)	Favors CBT.
					CBT vs BT: NMA = 1.77 (1.02-3.11)	Favors CBT.
					WL vs SP: NMA = 0.22 (0.06-0.78)	Favors SP.
					WL vs CBT: NMA = 0.33 (0.16-0.69)	Favors CBT.

Author	Intervention and comparator	Studies	Sample	GRADE	Effect	Comments
					Treatment hierarchy (in descending order by SUCRA: SP (88)-CBT (76)-PD (73)-CT (50)-BT (41)-PT (35)-NT (25)-WL (13)	SP, CBT, PD, CT, BT, PT better than NT and WL for remission.
					PD (74)-SP (72)-BT (53)-PT (52)-WL (31)-CT (27)-NT (7)	
Pompili et al. ⁸³	CBT vs other psychotherapies, waiting list (WL), no treatment, attention/psychological placebo (response)	55	3,275	Moderate	3W: iOR = 1.97 (0.34-14.44) Interceptive exposure: iOR = 1.49 (CrI 0.94 to 2.36) Face-to-face setting: iOR = 1.27 (0.57 to 2.66) Breathing retraining: iOR = 1.16 (CrI 0.81 to 1.67) Cognitive restructuring: iOR = 1.11 (0.73 to 1.73)	

3W = third-wave cognitive-behavior therapy; BDZ = benzodiazepines; BT = behavior therapy; CBT = cognitive-behavior therapy; CT = cognitive therapy; IPT = interpersonal therapy; MAOIs = monoamine oxidase inhibitors; NMA = network meta-analysis rankings; NT = no treatment; OR = odds ratio; PD = Panic disorder; PDT = psychodynamic therapies; PE = psychoeducation; PT = physiological therapies; RR risk ratio; SMD = standardized mean differences; SNRIs = serotonin-norepinephrine reuptake inhibitors; SSRIs = selective serotonin reuptake inhibitors; SP = supportive psychotherapy; SUCRA = cumulative ranking curve; TCAs = tricyclic antidepressants; WL = wait-list.

Supplementary Table S5 Dropout for the treatment of PD with and without agoraphobia for adults

Author	Intervention and comparator	Studies	Sample	GRADE	Effect	Comments
Bighelli et al. ⁷⁵	Antidepressants vs BDZ (total number of dropouts, follow-up: 8-24 weeks)	7	1449	Very low	RR=1.64 (1.03 to 2.63)	In favor of BDZ.
	TCAs vs BDZ (total number of dropouts, follow-up: 8-24 weeks)	6	1295	Very low	RR=RR 1.67 (0.93 to 2.99)	No difference.
	SSRIs vs BDZ (total number of dropouts, follow-up: 8-24 weeks)	1	154	Very low	RR=1.71 (1.03 to 2.84)	No difference.
	TCAs vs SSRIs (total number of dropouts, follow-up: 8-24 weeks)	7	928	Low	RR=0.98 (0.65 to 1.48)	No difference.
	TCAs vs MAOIs (total number of dropouts, follow-up: 8-24 weeks)	2	228	Moderate	RR=0.84 (0.61, 1.17)	No difference.
	SSRIs vs MAOIs (total number of dropouts, follow-up: 8-24 weeks)	1	30	Low	RR=1 (0.07, 14.55)	No difference.
	SSRIs vs SNRIs (total number of dropouts, follow-up: 8-24 weeks)	2	991	Low	RR=1.11 (0.74, 1.65)	No difference.
Bighelli et al. ⁷⁶	Antidepressants vs placebo (total number of dropouts)	38	78500	Moderate	RR=0.88 (0.81 to 0.97)	A RR of 0.72 means that the treatment with antidepressants decreases the risk of nonresponse to treatment by 28% compared to placebo. A RR of 0.74 means that treatment with TCA decreases the risk of leaving the study early by 26% compared to placebo. A RR close to 1 means that the risk of leaving the study early is no different with treatment with SSRI or with placebo. A RR close to 1 means that the risk of leaving the study early is no different with treatment with SNRI or with placebo.
	TCAs vs placebo (total number of dropouts)	17	1906	Moderate	RR=0.74 (0.63 to 0.86)	
	SSRIs vs placebo (total number of dropouts)	23	4302	Moderate	RR=0.99 (0.90 to 1.09)	
	SNRIs vs placebo (failure to respond)	4	1531	Moderate	RR=0.93 (0.69 to 1.26)	
Breilmann et al. ⁷⁷	Benzodiazepines vs placebo (total number of dropouts; follow-up: range 4 weeks to 15 weeks)	21	3558	Low	RR=0.50 (0.39 to 0.64)	In favor of BDZ.
Furukawa et al. ⁷⁸	Combined psychotherapy + antidepressants vs antidepressants alone (dropouts for any reason within 2-4 months)	11	669	Moderate	RR= 0.96 (0.75, 1.23)	No difference.
	Combined psychotherapy + antidepressants vs antidepressants alone (dropouts for any reason on continued treatment)	3	208	Low	RR=0.71 (0.27, 1.9)	In favor of combination but crossed equivalence range.
	BT + antidepressants vs antidepressants alone (dropouts for any reason within 2-4 months)	4	193	Low	RR=1.21 (0.78, 1.88)	In favor of antidepressants alone.
	BT + antidepressants vs antidepressants alone (dropouts for any reason on continued treatment)	1	20	Very low	RR=1 (0.07, 13.87)	No difference.
	Combined antidepressants vs antidepressants alone (dropouts for any reason within 2-4 months)	5	336	Moderate	RR=0.77 (0.55, 1.08)	In favor of combination.
	Combined CBT + antidepressants vs antidepressants alone (dropouts for any reason on continued treatment)	1	148	Low	RR=0.73 (0.22, 2.39)	In favor of combination but crossed equivalence range.
	Psychodynamic psychotherapy and other antidepressants vs antidepressants alone (dropouts for any reason within 2-4 months)	2	140	Low	RR=1.3 (0.69, 2.45)	In favor of antidepressants alone but crossed the equivalence range.

Author	Intervention and comparator	Studies	Sample	GRADE	Effect	Comments
	months) Psychodynamic psychotherapy and others and antidepressant vs antidepressant alone (dropouts for any reason on continued treatment)	1	40	Very low	RR=0.5 (0.05, 5.08)	In favor of combination but crossed equivalence range.
	TCA: psychotherapy + antidepressants vs antidepressants alone (dropouts for any reason within 2-4 months)	5	271	Moderate	RR=0.78 (0.34, 1.83)	In favor of combination but crossed the equivalence range.
	TCA: psychotherapy + antidepressants vs antidepressants alone (dropouts for any reason on continued treatment)	3	108	Low	RR=0.71 (0.27, 1.9)	In favor of combination but crossed equivalence range.
	TCA: BT + antidepressants vs antidepressants alone (dropouts for any reason within 2-4 months)	1	20	Very low	RR=1 (0.07, 13.87)	In favor of combination but crossed equivalence range.
	TCA: BT + antidepressants vs antidepressants alone (dropouts for any reason on continued treatment)	1	19	Very low	RR= 2.73 (0.12, 59.57)	In favor of TCAs alone but crossed the equivalence range.
	TCA: CBT + antidepressants vs antidepressants alone (dropouts for any reason within 2-4 months)	4	324	Moderate	RR=1.17 (0.73, 1.89)	In favor of TCAs alone but crossed the equivalence range.
	TCA: CBT + antidepressants vs antidepressants alone (dropouts for any reason on continued treatment)	2	205	Low	RR= 1.23 (0.93, 1.63)	In favor of combination.
	SSRI: Psychotherapy + antidepressants vs antidepressants alone (dropouts for any reason within 2-4 months)	3	218	Moderate	RR=1.04 (0.68, 1.6)	No difference.
	SSRI: Psychotherapy + antidepressants vs antidepressants alone (dropouts for any reason on continued treatment)	1	38	Very low	RR=3 (0.13, 69.31)	In favor of SSRIs alone but crossed the equivalence range.
	SSRI: BT + antidepressant vs antidepressants alone (dropouts for any reason within 2-4 months)	2	69	Low	RR=5.41 (0.59, 49.42)	In favor of SSRIs alone but crossed the equivalence range.
	SSRI: BT + antidepressants vs antidepressants alone (dropouts for any reason on continued treatment)	1	38	Very low	RR=3 (0.13, 69.31)	In favor of SSRIs alone but crossed the equivalence range.
	SSRI: CBT + antidepressants vs antidepressants alone (dropouts for any reason within 2-4 months)	5	313	Low	RR=1.11 (0.64, 1.93)	In favor of SSRIs alone but crossed the equivalence range.
Guaiana et al. ⁷⁹	Medications vs placebo (dropout rate)	15	2139	Moderate	Alprazolam: RR=0.46 (95% CrI 0.33 to 0.65); mean rank 3, 95% CrI 1 to 6). Diazepam: RR=0.50 (95% CrI 0.23 to 0.91); mean rank 3 (95% CrI 1 to 9).	There was a reduction in dropout rate compared with placebo for the following medications and 95% CrIs did not cross the equivalence range or invariant range.
	Medications vs placebo (dropout rate)	10	3411	Moderate	Venlafaxine: RR=0.99 (95% CrI 0.80 to 1.21); mean rank 12 (95% CrI 6 to 18). Sertraline: RR=1.00 (95% CrI 0.80 to 1.30); mean rank 13 (95% CrI 7 to 18). Paroxetine: RR=1.07 (95% CrI 0.92 to 1.07); mean rank 15 (95% CrI 10 to 19).	There was no difference in dropout rate compared with placebo for the following medications and 95% CrIs did not cross the equivalence range or invariant range
		18	2171	Moderate	Reboxetine: RR=0.40 (95% CrI 0.13 to 1.17); mean rank 3 (95% CrI 1 to 15). Escitalopram: RR=0.68 (95% CrI 0.38 to 1.08); mean rank 6 (95% CrI 2 to 15). Imipramine: RR=0.85 (95% CrI 0.63 to 1.12); mean rank 8 (95% CrI 4 to 15). Citalopram (RR 0.88, 95% CrI 0.62 to 1.20; mean rank 9, 95% CrI 5 to 17).	Medications had a reduced dropout rate compared with placebo, and 95% CrIs crossed the equivalence range but not the invariant range
		2	236	Low	Desipramine (RR=0.63, 95% CrI 0.14 to 1.73); mean rank 5 (95% CrI 1 to 20). Fluoxetine: RR=1.13 (95% CrI 0.62 to 1.94); mean rank 16 (95% CrI 5 to 20).	For two medications compared with placebo, 95% CrIs were wide and crossed the equivalence range in both directions but not the invariant range

Author	Intervention and comparator	Studies	Sample	GRADE	Effect	Comments
Imai et al. ⁸⁰	CBT vs SSRIs (dropouts for any reason)	6	334	Low	RR=1.33 (0.8,2.22)	In favor of SSRIs but crossed equivalence range.
	CBT vs TCAs (dropouts for any reason)	5	352	Low	RR= 0.93 (0.53,1.64)	No difference.
	SPT vs TCA (dropouts for any reason)	1	36	Very low	RR= 0.56 (0.22,1.42)	In favor of psychotherapy but crossed equivalence range.
	CBT vs benzodiazepines (dropouts for any reason)	3	116	Low	RR=1.12 (0.54,2.36)	In favor of benzodiazepines but crossed equivalence range.
Papola et al. ⁸¹	CBT vs other psychotherapies and placebo (acceptability)	74	6699	Moderate	No significant differences were found between different delivery formats, between delivery formats and comparators, and between comparators for the acceptability outcome.	No difference.
Papola et al. ⁵¹	10 different psychotherapies vs TAU (acceptability)	136	7352	Low Low Moderate Low Moderate Very low	IPT: 0.81 (0.37,1.79) EMDR: 0.82 (0.34,1.97) 3W: 0.88 (0.43, 1.84) SP: 0.91 (0.43, 1.91) SPTD: 0.92 (0.54, 1.54) PE: 1.00 (0.02, 48.40)	CBT, PT, BT, and CT are the worst TAU.
Pompili et al. ⁸²	CBT compared to no treatment for panic disorder with or without agoraphobia in adults (short-term dropouts; follow-up: mean 3 months)	4	278	Very low	OR=6.25 (0.26 to 100)	
	Network meta-analysis rankings of psychological therapies for panic disorder with or without agoraphobia in adults (short-term response)	37	2240	Low	WL vs BT: NMA=0.52 (0.30-0.93) Treatment hierarchy (in descending Order by SUCRA: NT (85)-PDT (75) -WL (67)-3W (67)- CBT (51) -APP (42) -PE (42) -PT (38) -CT (29) -BT (28) -SP (26)	All worse than no treatment.
Pompili et al. ⁸³	CBT vs other psychotherapies, waiting list (WL), no treatment, attention/psychological placebo (dropout rate)	55	3275	Moderate	3W: iOR=0.55 (CrI 0.08–3.63) Interceptive exposure: iOR= 0.95 (CrI 0.53–1.70) Face-to-face setting: iOR= 0.54 (CrI 0.17–1.51) Breathing retraining: iOR= 0.71 (CrI 0.45–1.14) Psychoeducation: iOR= 0.93 (CrI 0.43–2.03) <i>In vivo</i> exposure: iOR=0.86 (0.49–1.48)	CBT packages with reduced dropouts. PE reduced dropouts.
Watanabe et al. ⁸⁴	BT and benzodiazepines vs BT alone (dropouts for any reason)	2	166	Low	RR=0.81 (0.47, 1.38)	In favor of combination.
	CBT and benzodiazepines vs psychotherapy alone (dropouts for any reason)	1	50	Low	RR=1.4 (0.51, 3.82)	In favor of psychotherapy alone.

3W = third-wave cognitive-behavior therapy; BDZ = benzodiazepines; BT = behavior therapy; CBT = cognitive-behavior therapy; CT = cognitive therapy; IPT = interpersonal therapy; MAOIs = monoamine oxidase inhibitors; NMA = network meta-analysis rankings; NT = no treatment; OR = odds ratio; PD = Panic disorder; PDT = psychodynamic therapies; PE = psychoeducation; PT = physiological therapies; RR risk ratio; SMD = standardized mean differences; SNRIs = serotonin-norepinephrine reuptake inhibitors; SSRIs = selective serotonin reuptake inhibitors; SP = supportive psychotherapy; SUCRA = cumulative ranking curve; TCAs = tricyclic antidepressants; WL = wait-list.

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