Data Supplement for Bormann et al., Individual Treatment of Posttraumatic Stress Disorder Using Mantram Repetition: A Randomized Clinical Trial. Am J Psychiatry (doi: 10.1176/appi.ajp.2018.17060611)

CONTENTS

APPENDIX 1. Frequency of Mantram Skills Practice

The Mantram Repetition Program teaches three portable skills of 1) choosing and repeating a mantram, 2) slowing down thoughts and reactivity, and 3) practicing one-pointed attention while attending to one task at a time. These three skills are believed to work synergistically to raise awareness, increase mindfulness, and improve emotional self-regulation. Although these skills are the practice components of the program, other key aspects of the intervention include psycho-education about the stress response, social support, and fostering a therapeutic relationship with the facilitator.

As with any intervention, it is important to determine whether or not participants practice these tools and, if so, how frequently they practice. Participants in the Mantram Repetition Program are given instructions to silently repeat a mantram "as much as possible" intermittently throughout the day and at night before sleep. They are given examples of situations where mantram repetition is recommended. Some examples include while waiting (for traffic, an interview, doctor's appointment, or people who are late); while exercising, walking, or running; during mechanical tasks such as washing dishes, sweeping, bathing; when dealing with difficult people or boring situations, etc. Initially, they are encouraged to repeat a mantram while calm, during non-stressful situations or whenever they think about it. Later, they are instructed to also repeat mantram in anticipation of, as well as during, stressful situations to help them manage triggering events, unwanted thoughts, or harmful behaviors. Thus, the instructions for practice are to "use a mantram when you need it, and use it when you don't." The concepts of slowing down intentionally and practicing one-pointed attention are also emphasized to employ throughout the day, as much as possible.

Because it is impossible to mentally count every single repetition of a mantram, we previously developed a method of tracking the frequency of mantram "sessions" per day. A session involves the intentional choice of repeating a mantram at least once, but typically, participants repeat their mantrams several times within a session. Sessions were then counted

using a wrist-worn counter and the number recorded on a paper and pencil tracking log every night. To assess the reliability of recall, we developed a list of mantram practice questions and asked participants to retrospectively estimate the number of days per week (in past 7 days) that they had used a mantram and the average number of mantram sessions per day. To assess slowing down and one-pointed attention, we also asked yes/no questions as to whether they were intentionally practicing those skills, too.

In a prior study, we then compared self-report estimates with tracking log data in samples of veterans and healthcare employees.[1] We found a significant positive correlation between counter-tracked data and self-reported mantram data (r = .84, p < .001) suggesting that a short-term, past 7-day recall of mantram practice was a moderately reliable method to measure adherence to mantram practice.[1]

In the current study, participants were asked about their mantram practice over the immediately preceding 7 days at post-treatment and follow-up. Wrist counters were not used. Results of participant's self-report of mantram practice are shown for all participants who completed the post-treatment (94% response rate) and follow-up practice questions (91% response rate) in Table S1. These results are comparable to other studies of mantram practice in a variety of groups.[2-5] It is plausible, however, that they may overstate the average amount of mantram practice conducted by the entire mantram sample, since only those who completed treatment or the entire study were assessed. It is reasonable to expect these individuals may have been more adherent to mantram practice as well, to an uncertain degree.

TABLE S1. Self-Reported Frequency of Mantram Practice over the Past 7 Days at Post-treatment and 2-Month Follow-up

Mantram practice questions reported by completers	Post-treatment (*n*=65)[a]		2-month follow-up (*n*=59)[b]	
	n	%	*n*	%
Still using mantram? (yes)	65	100	57	96.6
Use mantram when you don't need it? (yes)	49	75.4	42	71.2
Practice slowing down? (yes)	59	90.8	50	84.7
Practice one-pointed attention? (yes)	61	93.8	49	83.1

[a] Represents 94% of the participants who completed post-treatment assessments.
[b] Represents 91% of the participants who completed the 2-month follow-up assessments.

Frequency of Mantram Practice reported by completers	Post-treatment (*n*=65)[a]			2-month follow-up (*n*=59)[b]		
	M	*SD*	range	*M*	*SD*	Range
Number of days per week used mantram (0-7 days)	6.05	1.49	1-7	5.29	1.79	1-7
Number of mantram sessions per day?	10.23	14.61	1-85	8.69	16.47	1-100
Number of nights per week used mantram? (0-7 nights)	5.38	1.94	1-7	4.88	2.17	0-7

[a] Represents 94% of the participants who completed post-treatment assessments.
[b] Represents 91% of the participants who completed the 2-month follow-up assessments.

APPENDIX 2. Treatment Credibility and Expectancy Between Treatments at Baseline and Posttreatment

To control for some important nonspecific effects of therapy, we measured levels of treatment credibility (Table S2) and expectancy (Table S3) using the Devilly and Borkovec[6] credibility/expectancy questionnaire. Data were collected at baseline and posttreatment from participants of each treatment condition: Mantram Repetition Program versus Present-Centered Therapy. Descriptive statistics and results of repeated measures analysis of variance are presented below. In general, there was modestly greater credibility and expectancy for the Mantram Repetition Program than Present-Centered Therapy (positive values versus negative values) as measured by this questionnaire, but these differences were not significant. No significant differences between treatments suggests that changes in study outcomes are unlikely to be fully accounted for by nonspecific effects related to treatment credibility or expectancy.

To be more specific, both credibility and expectancy are measured by 3 items each, which use either 9 point visual analog scales or (for 2 of the 3 expectancy questions) 11 point percentage scales). To put these nonsignificant changes in context, a difference of 0.25 points on Baseline Credibility could be viewed as roughly equivalent to 1 in 4 people ranking Mantram as more credible (approximately by 1 out of 9 increments on 1 of the 3 questions). Another approach to putting these results in context, although also a simplification, would note that the Mantram group could be viewed as endorsing approximately 1% greater credibility in the treatment they received. The difference in baseline expectancy was slightly smaller and could be seen as approximately 1 in 6 individuals endorsing a 1 point higher expectancy on 1 of the 3 questions, or a 0.5% difference. Post-treatment expectancy was equivalent to approximately between 1 in 3 and 1 in 2 individuals endorsing a 1 point change, or alternatively approximately a 1% difference in expectancy. None of these simplifications is ideal, but we provide them in

the hopes they give some sense of the magnitude of the nonsignificant differences in treatment credibility and expectancy reported by participants in the two treatment groups.

TABLE S2. Descriptive Statistics of Treatment Credibility by Intervention at Baseline and Post-treatment

		Mean	Std. Deviation	*n*
Baseline Credibility	Control	-0.03	2.96	69
	Mantram	0.22	2.46	67
	Total	0.09	2.72	136
Posttreatment Credibility	Control	-0.08	2.81	69
	Mantram	0.11	2.61	67
	Total	0.011	2.71	136

Test of Within Subjects Contrasts

Source		Type III Sum of Squares	*df*	Mean Square	*F*	*p* value	Partial Eta Squared	Noncent. Parameter	Observed Power[a]
Time	Linear	0.46	1	0.46	0.13	0.72	0.001	0.12	0.07
Time * Group	Linear	0.04	1	0.04	0.01	0.91	0.00	0.01	0.05
Error(Time)	Linear	488.86	134	3.64					

[a]Computed using alpha = .05

Tests of Between-Subjects Effects

Source	Type III Sum of Squares	*df*	Mean Square	*F*	*p* value	Partial Eta Squared	Noncent. Parameter	Observed Power[a]
Intercept	0.80	1	0.80	0.07	0.79	0.001	0.072	0.06
Group	3.62	1	3.62	0.32	0.57	0.002	0.324	0.09
Error	1498.54	134	11.18					

TABLE S3. Descriptive Statistics of Patient Expectancy by Treatment at Baseline and Post-treatment

		Mean	Std. Deviation	*n*
Baseline Expectancy	Control	-0.07	3.03	69
	Mantram	0.09	2.66	67
	Total	0.01	2.84	136
Posttreatment Expectancy	Control	-0.16	2.78	69
	Mantram	0.22	2.73	67
	Total	0.02	2.75	136

Tests of Within-Subjects Contrasts

Source		Type III Sum of Squares	*df*	Mean Square	*F*	*p* value	Partial Eta Squared	Noncent. Parameter	Observed Power[a]
Time	Linear	0.01	1	0.02	0.01	0.94	0.00	0.01	0.05
Time * Group	Linear	0.80	1	0.80	0.22	0.64	0.002	0.22	0.08
Error(Time)	Linear	482.94	134	3.60					

[a] Computed using alpha = .05

Tests of Between-Subjects Effects

Source	Type III Sum of Squares	*df*	Mean Square	*F*	*p* value	Partial Eta Squared	Noncent. Parameter	Observed Power[a]
Intercept	0.11	1	0.11	0.01	0.93	0.00	0.01	0.05
Group	5.26	1	5.26	0.43	0.51	0.01	0.43	0.10
Error	1630.62	134	12.17					

[a]Computed using alpha = .05

APPENDIX 3. Sensitivity Analyses and Additional Analyses Concerning Clinical Significant Change in CAPS Score

Appendix 3A. Sensitivity Analyses Results using Study Completers

These sensitivity analyses restrict the patient participants to only those individuals who completed a given assessment at all 3 time points (*n*=136 for the Clinician-Administered PTSD Scale, and slightly fewer for other outcomes). Also referred to as a "per protocol" analysis, this sample can give a sense of what differences might be observed between the groups for individuals who completed the treatment as it was intended, however it also can be more sensitive to bias since it includes less of the overall, randomized participant sample.

As Table S4 indicates, the sensitivity analysis on study completers indicated that significantly greater decreases were observed in Mantram compared to Present-Centered Therapy participants at post-treatment in both the CAPS and PCL-M, but not at 17-week follow-up. (The CAPS score changes were slightly smaller and the PCL-M somewhat larger than in the "as randomized" sample at post-treatment; the CAPS change was smaller than in the "as randomized" sample and the PCL-M change almost identical at 17-week follow-up). Reductions in insomnia remained significant at each time point, with the effect being very slightly larger at post-treatment and somewhat smaller at 17-week follow-up than the reductions observed in the "as randomized" sample.

TABLE S4. Sensitivity Analyses

Measures[a]	Time From Baseline	*n*	Mantram Effect (*SE*[b])	FDR[c] Adjusted *p*-value
Primary Outcome: Clinician Administered PTSD Scale	Post-treatment	136	-9.28 (3.42)	0.014

(CAPS) Total Score[d]				
	17-week follow-up		-8.05 (4.25)	0.081
Self-reported PTSD symptom score on the PCL-M[e]		122		
	Post-treatment		-6.63 (2.24)	0.008
	17-week follow-up		-4.53 (2.83)	0.13
Self-reported insomnia scores on the ISI[f]	Post-treatment	125	-4.22 (1.04)	0.0008
	17-week follow-up		-4.33 (1.33)	0.005
Self-reported depressive symptom scores on PHQ-9[g]		123		
	Post-treatment		-2.02 (0.82)	0.07
	17-week follow-up		-1.11 (1.08)	0.54
State anger[h]		123		
	Post-treatment		-1.02 (1.86)	0.75
	17 week follow-up		-0.05 (2.21)	0.98
Trait Anger[i]		124		
	Post-treatment		-0·62 (0·87)	0·64
	17-week follow-up		-0·10 (1·14)	0·95
FACIT-SP-12[j]		121		
	Post-treatment		3·24 (1·35)	0·07
	17-week follow-up		1·87 (1·77)	0·54
FFMQ Total Score[k]		121		
	Post-treatment		4·37 (2·34)	0·19

	17-week follow-up	2·32 (3·09)	0·64
Self-reported quality of life on WHO-QOL-BREF[l]		122	
	Post-treatment	4.17 (1.84)	0.09
	17-week follow-up	2.70 (2.39)	0.50

[a] Higher scores indicate higher levels of variables

[b] Standard Error

[c] False Discovery Rate adjusted *p*-values to account for multiple hypothesis testing

[d] Clinician Administered PTSD Scale (CAPS) range 0-136; higher scores indicate more severe PTSD symptoms with clinically significant improvement in symptom severity defined as reduction in 10 points or more.

[e] PTSD Checklist-Military (PCL-M); range 17-85; higher scores indicate more severe PTSD symptoms with clinically significant improvement in PTSD symptom severity defined as reduction in 10 points or more.

[f] Insomnia Severity Index (ISI) range 0-28; higher scores indicate greater levels of insomnia with clinically meaningful improvement defined as a reduction of 7 points or more; cut-off for insomnia diagnosis $\geq$ 11 on the ISI.

[g] Patient Health Questionnaire-9 (PHQ-9) range 0-27; higher scores indicate greater depressive symptoms with clinically significant improvement defined as a reduction of 5 points or more.

[h] Spielberger State Anger Scale range 10 to 40; higher scores indicate greater intensity of angry feelings.

[l] Spielberger Trait Anger Scale range 10 to 40; higher scores indicate greater frequency of angry feelings.

[j] Functional Assessment of Chronic Illness Therapy Spiritual Wellbeing 12-item Scale range 0 to 48; higher scores indicate greater levels of existential spiritual wellbeing.

[k] Five Facet Mindfulness Questionnaire range 39 to 195; higher scores indicate greater mindfulness.

[l] World Health Organization Quality of Life-Brief (WHOQOL-BREF) range 0-130; higher scores indicate greater quality of life.

Appendix 3B. Additional Analyses Concerning Clinical Significant Change in CAPS Score

In addition to our analyses of participants either no longer meeting PTSD criteria or no longer having substantial PTSD symptoms overall presented in the main manuscript, we also analyzed the proportion of patients in each treatment group who experienced what is commonly considered a clinically meaningful change in CAPS score (≥ 10-point reduction in CAPS score). Significant differences were not observed between the treatment groups either post-treatment or at 2-month follow-up. However, both groups experienced relatively high rates of clinically meaningful changes in CAPS score (i.e., >50% of participants at both groups, at both time points. The results were as follows:

Post-Treatment: 50 (72%) of Mantram participants and 43 (60%) of Present-Centered Therapy participants experienced a decrease in CAPS score of ≥ 10 points (Odds Ratio (*OR*) = 1.49, 95% Confidence Interval (*CI*) 0.69 - 3.21).

2-month follow-up: 49 (75%) of Mantram and 43 (61%) of Present-Centered Therapy participants experienced a decrease in CAPS score of ≥ 10 points (*OR* = 1.67, 95% *CI* 0.73 - 3.81).

NOTE: These results are consistent with the fact that, as indicated in Table 2 of the article text, both treatment groups experienced an average change in CAPS score in excess of 10 points at both post-treatment and 2-month follow-up, although the decrease in mean CAPS score was almost 10 points greater for the Mantram than Present-Centered group, and this difference was statistically significant.

APPENDIX 4. Characteristics of Treatment Completers Versus Dropouts.

This Appendix discusses information comparing the characteristics of individuals who did complete study treatments (*n*=141) versus those who did not complete study treatments (*n*=32). It should be noted that, like many psychotherapy trials, the only information we have from participants right at the time of their discontinuation from the study is the information they provided concerning their reasons for discontinuation. Examining that information, it is interesting to note that most of the identified reasons for dropping out of the treatments did not appear related to response or non-response to treatment. For instance, of the 27 individuals who provided a reason for not completing the treatment, only 14.8% (*n*=4) said that the treatment was not helping (Figure 1 in the Manuscript). Another 11.1% (*n*=3) said that they preferred another treatment. Regarding the concern that individuals were preferentially dropping out of the Mantram arm who were not responding to treatment, only 1 of the 16 individuals providing a reason for discontinuing treatment (6.25%) said they did so because they were not responding to treatment. In contrast, 3 out of 12 individuals (25%) dropping out of the Present-Centered Therapy treatment arm indicated that they were not responding to treatment. What cannot be determined is whether those individuals who, for instance, indicated they had scheduling or transportation difficulties would have found a way to solve these issues if they felt the treatment was working more dramatically, etc. Nevertheless, if the endorsed reason for dropping out of the study is taken at face value, there is little to suggest that those dropping out was systematically less treatment-responsive than those completing the Mantram treatment.

However, it is important to examine the baseline characteristics of all participants who completed treatments (*n*=141) versus those who did not (*n*=32) as shown in Table S5. The only baseline characteristic that differed significantly between these groups was age. Those who did complete study treatments were significantly older (*M* = 50 years, *SD* = 14.59) than those who

did not complete treatments (M = 43 years, SD = 13.41), $F(1,171) = 4.78$, $p < 0.05$, as shown in Table S5.

TABLE S5. Characteristics of Treatment Completers Versus Dropouts.

	Completers(n=141)		Dropouts(n=32)		Fisher Exact Test p
	n	**%**	***n***	**%**	
Male sex	123	87	24	75	0.100
Race (Self-reported)					
White	97	69	22	69	1.00
Married/ Partnered	92	65	23	72	0.54
Education					0.19
High school or less	37	26	6	19	
Some college	77	55	15	47	
Bachelor degree or higher	27	19	11	34	
Employment					0.65
Full-time	21	15	6	19	
Part-time	12	8	1	3	
Unemployed	108	77	25	78	
Income					0.28
$20,000 or less	53	38	8	25	
$20,001 – $40,000	43	30	14	44	
$40,000 or greater	45	32	10	31	
Receiving PTSD Medication	92	65	21	66	1.00

	Completers (*n*=141)		Dropouts (*n*=32)			
	Mean	*SD*	Mean	*SD*	*F* (df)	*p*
Age	50.04	14.59	43.88	13.41	4.78 (1,171)	0.03
Clinician-Administered PTSD Scale (CAPS)	75.61	16.63	80.75	16.24	2.51 (1,171)	0.12
Self-reported PTSD (PCL-M)	57.96	11.18	60.66	14.54	1.24 (1,162)	0.27
Insomnia (Insomnia Severity Index)	17.27	6.245	17.77	7.98	0.15 (1,168)	0.70
PHQ-9 Depression (Patient Health Questionnaire-9)	15.16	5.83	15.87	5.25	0.39 (1,167)	0.53
State-Anger Inventory	23.19	9.78	23.35	10.86	0.007 (1,167)	0.93
Trait-Anger Inventory	21.98	6.66	22.77	6.58	0.36 (1,168)	0.55
Spiritual Wellbeing (Functional Assessment of Chronic Illness Therapy – Spirituality)	22.23	10.51	20.83	9.41	0.45 (1,164)	0.34
Five Facet Mindfulness Questionnaire	117.99	18.26	115.53	19.63	0.43 (1,167)	0.57
Quality of Life (World Health Organization - Quality of Life Brief	75.74	12.85	74.83	13.09	0.12 (1,164)	0.73

It is also important to determine how similar or dissimilar individuals who dropped out of each treatment were. Of those who completed the Mantram treatment (*n*=69) versus those who did not (*n*=20), there were significantly different values for both age and CAPS scores. Those who did not complete Mantram were significantly younger in age (*M*=41 years, *SD*=12.56) than

those who did (*M*=50, *SD*=14.59), *F*(1,88)=6.84, *p* <0.05. Similarly, those who did not complete Mantram had significantly greater PTSD symptom severity as measured by CAPS scores (*M*=85.05, *SD*=16.06) than those who completed Mantram (*M*=75.26, *SD*=1605), *F*(1,88)=5.76 (1,88), *p*<0.01.

In contrast, there were no differences in any baseline characteristics between those who completed the Present Centered Therapy arm versus those who did not.

APPENDIX 5. Comparison of Effect Sizes Observed for Mantram and Trauma-Focused Psychotherapies in Comparison to Present-Centered Therapy, and Factors Complicating this Comparison.

Table S6 below presents the effect size (Cohen's *d*) for the CAPS observed for Mantram therapy in this trial versus that observed for the trauma-focused therapies Prolonged Exposure and Cognitive Processing Therapy.

TABLE S6. Comparison of PTSD Trials using Present-Centered Therapy as an Active Comparator

Therapy Tested	Investigators	Post-Treatment Effect Size (CAPS)	Participant Population	Duration of Present-Centered Therapy	Dropout
Mantram	Bormann et al. (this study)	0.49 Study Completers (0.46 at 2-month follow-up)	85% Male	Eight 60 minute sessions	22% Mantram 14% Present-Centered Therapy
Prolonged Exposure	Schnurr et al., (2007)[7]	0.29	100% Female	Ten 90 minute sessions	38% Prolonged Exposure 21% Present-Centered Therapy
Cognitive Processing Therapy	Suris et al., (2013)[8]	0.49	85% Female	12 sessions, unclear duration	35% Cognitive Processing Therapy 18% Present-Centered Therapy
Cognitive Behavioral Therapy (with prolonged imaginal exposure, in vivo exposure, and cognitive restructuring)	McDonagh et al., 2005[9]	-0.22 (Intent-to-Treat Post-treatment) 0.26 (Completers Post-Treatment) +0.61 (3-month follow-up)	100% Female, all survivors of child sexual abuse	14 sessions, averaging 1.75 hour long	41% Cognitive Behavioral therapy 9% Present-Centered Therapy

While the effect size observed for Mantram is generally similar to that reported for Prolonged Exposure and Cognitive Processing Therapy when they were compared to Present-Centered Therapy, with the possible exception of the McDonagh, 2005 study, Table S7 demonstrates that participant populations and study designs for these trials varied widely (even varying in the total duration of Present-Centered Therapy). For instance, one reason why the McDonagh trial Cognitive Behavioral Therapy treatment may give such different results in comparison to Present-Centered is because of the very specialized study population it examined: exclusively female participants who were survivors of childhood sexual abuse.

When the comparison is just restricted to the studies that did not involve survivors of childhood sexual abuse (this study, the Schnurr et al. 2007 study,[7] and the Suris et al. 2007 study[8]), it can also be observed that participants in this Mantram trial experienced a post-treatment improvement in CAPs score (mean decrease 13.5 points (Table 2 in the article text) that was slightly less than the 15.2 – 17.8 point decreases observed in participants receiving the lengthier duration Present-Centered therapy in the Schnurr et al. and Suris et al. studies. This modest difference may be the result of the briefer duration Present-Centered Therapy delivered in this (the Mantram) trial, or may be due to other factors. It should be noted that in all three of these studies, the decrease in CAPS observed among participants receiving Present-Centered therapy is less than the 20.5-22.2 point decreases observed when 12-14 session Present-Centered Therapy was found to be superior to wait-list controls.[9,10]

In summary, although it is useful to know whether the results in our Mantram trial compare in general to the results observed in other studies using Present-Centered therapy as a comparison, given the wide differences in study design and study populations, inferences about relative efficacy of the treatments should not be made on the basis of the above information. Nor should it be conclusively determined that Present-Centered Therapy in these particular trials was clearly superior to no treatment. No comparative inferences about rates of study non-completion should be made either, given these differences between the studies.

Head-to-head trials would be needed to make judgments about the relative efficacy or tolerability of Mantram compared to these or other evidence-based PTSD treatments.

APPENDIX 6. Implications for Future Research

Given that this study is the first of individually-delivered Mantram therapy among Veterans, it is to be expected that our results raise several topics that might be explored in future research. These might include further comparison of Mantram to active treatments, including evidence-based trauma-focused treatments such as Prolonged Exposure or Cognitive Processing Therapy, potentially in trials that include a wait list control to confirm efficacy of the active treatments being studied. Use of more broadly generalizable samples (given that this study examined only participants at two medical centers on the East and West Coast) in any such trials would also be desirable. Consideration could also be given to including more repeated assessments during treatment to better assess the degree of response participants were experiencing at each time point, and that participants not completing the study were experiencing just prior to when they exited the study or were lost to follow-up. Similarly, measuring mantram practice more frequently and assessing the relationship between mantram practice and outcomes maybe helpful. (This analysis might benefit from differentiating from triggered and non-triggered use of the mantram, as well as consistency of use before sleep for insomnia-related analyses). Although we obtained data about participants' credibility and expectancy concerning the treatment, data could also be gathered in the future about participant alliance with the therapist and therapist credibility and expectancy concerning the treatment they delivered.

Consideration could also be given to providing further sensitivity analyses, examining whether greater symptom improvements might be evident with longer treatment, and whether of modifications might be considered to the Mantram treatment. This might include more

thoroughly assessing reasons participants choose to stop the treatment, participants' perception of why they think the intervention helps them, and specifically their sense of the importance of the treatments' effects on spirituality, mindfulness, and self-efficacy. For instance, the question could be investigated of whether varying the amount of perceived spiritual content would enhance the effectiveness or acceptability of Mantram further. The therapy, as now designed, allows clients considerable latitude (by allowing participants to self-select their mantram) to self-specify the degree of overtly spiritual content of their mantram.

Finally, the use of Mantram, given its relatively brief course of instruction and convenience in application, as an adjunct to other evidence-based psychotherapies could be explored.

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