

Best Evidence Summaries of Topics in Mental Healthcare

BEST *in* **MH** *clinical question-answering service*

Question

In adults of a working age with symptoms of psychosis, how effective is cognitive behavioural therapy (CBT) when compared to any other treatment in achieving improved patient outcomes (recovery in terms of improved quality of life; employment prospects; relapse frequency, duration and intensity; admission to hospital; social inclusion; hope; acceptance of mental health condition)?

Clarification of question using PICO structure (PICTRO for diagnostic questions)

Patients: In adults of a working age with symptoms of psychosis

Intervention: cognitive behavioural therapy

Comparator: any other treatment

Outcome: improved patient outcomes

Clinical and research implications

No *definite* clinical recommendations were made in the identified literature, although many of the authors made conclusions regarding the effectiveness of CBT for improving various patient outcomes. The need for trials that evaluate the effects of CBT over different lengths of time was commonly stated.

One SR made a number of suggestions for a future research CBT research programme (Wykes et al. 2008). They stated that it should include:

- methodologically rigorous efficacy trials of well defined treatment programs;
- measures of treatment process which allow an estimate of the dose of treatment that is more sophisticated than “number of sessions”;
- outcome measures that are acceptable not only to the clinical and academic community but also to the patients themselves;
- studies of effectiveness with different models, staff training methods, and background service provision;
- long-term follow-up studies of the durability of treatment effects.

What does the evidence say?

Number of included studies/reviews (number of participants)

We identified two SRs (one included 22 RCTs with 2469 participants; the other included 34 RCTs [number of participants was not clear]) (Sarin et al. 2011; Wykes et al. 2008) and 4 RCTs that met the inclusion criteria. One RCT, including 88 participants, compared a CBT intervention with a psychoeducational programme (PE) in patients with acute schizophrenia (Bechdolf et al. 2010). Another RCT, with 100 patients, evaluated the effects of CBT on enhancing work functioning in people with schizophrenia or schizoaffective disorder (Lysaker et al. 2009). A third RCT evaluated CBT compared with a treatment as usual (waiting list) on a number of outcomes in 74 participants with psychosis (Peters et al. 2010). The last RCT compared CBT with treatment as usual (TAU) in people with schizophrenia who had persistent and recurrent symptoms of psychosis (van der Gaag et al. 2011).

Main Findings

One SR found no benefit of CBT on relapse rates when compared to treatment as usual or when compared to other psychological treatments in patients with schizophrenia (Sarin et al. 2011). Another SR reported beneficial effects with CBT treatment for function (n=867, 15 studies, WMD 0.378 CI 0.154 to 0.602) and social anxiety (effects ranged from 0.35 to 0.44, two studies), but found no effect on hopelessness. Other outcomes of interest for this BEST summary question were not evaluated in these two SRs.

One of the RCTs compared CBT with a psychoeducational programme (PE), and the other three compared CBT with TAU. This first RCT focused on quality of life (QoL) outcomes, and found no significant differences between CBT and PE for any dimension (Bechdolf et al. 2010). There were however, significant improvements within both treatment groups over time.

Of the RCTs that compared CBT with TAU, one focused on work outcomes, and reported that those who received the CBT programme (the Indianapolis Vocational Intervention Program) worked more hours ($p < 0.01$) and had generally better work performance ($p < 0.05$) than participants who received support services (Lysaker et al. 2009).

The other two RCTs evaluated functioning. One reported a significant improvement in the *Social and Occupational Functioning Assessment Scale* (SOFAS) scores in the CBT group compared to the waiting list control group at the end of 6 months of therapy in patients with psychosis: 6.0 (2.1 to 9.9), $P = 0.002$, but not at follow-up (2.9 (-1.0 to 6.9), $P = 0.14$) (Peters et al. 2010). The other RCT reported that participants who received CBT demonstrated significantly better functioning at 3 months ($p = 0.000$), 6 ($p = 0.018$), 12 ($p = 0.014$), and 15 months ($p = 0.037$), but not at 9 and 18 months. They also reported that participants in the CBT group had on average 183 days of normal functioning compared with 106 days in the TAU group. The mean difference of 77 days of normal functioning between groups was significant (95% CI 29.7–124.0) (van der Gaag et al. 2011).

One of the RCTs reported no significant differences between groups in self-esteem or number of days spent in hospital (Peters et al. 2010). The other RCT reported on quality of life and reported no significant differences between groups on WHO–QoL scores (van der Gaag et al. 2011).

Authors Conclusions

The authors of SRs did not make specific conclusions regarding the outcomes relevant to this BEST question. The authors of one SR noted that the lack of effect of CBT on relapse rates was consistent with other meta-analyses (Sarin et al. 2011). The authors of the other SR noted that CBT approaches were not beneficial for hopelessness, and may even be detrimental for this specific outcome (Wykes et al. 2008).

One RCT concluded that both CBT (in a brief group format) and group psychoeducation – as adjuncts to routine care – had a positive impact on QoL in patients with schizophrenia (Bechdolf et al. 2010). Another RCT concluded that there may be a connection between CBT and higher levels of work performance (Lysaker et al. 2009). A third RCT did not make any conclusions regarding outcomes of interest to this BEST summary, but concluded that CBT for psychosis is effective in reducing depression (Peters et al. 2010). The authors of the last RCT concluded that participants in the CBT group attained normal functioning more often than those who received treatment as usual (van der Gaag et al. 2011).

Reliability of conclusions/Strength of evidence

Both SRs were considered to be methodologically well-reported, and their conclusions are likely to be reliable. One RCT was deemed to have a high risk of bias, and the other three had an unclear risk of bias, making the reliability of their results uncertain.

What do guidelines say?

NICE guidance on schizophrenia provides the following recommendations for CBT:

Offer cognitive behavioural therapy (CBT) to all people with schizophrenia. This can be started either during the acute phase or later, including in inpatient settings.

How to deliver psychological interventions

CBT should be delivered on a one-to-one basis over at least 16 planned sessions and:

- follow a treatment manual so that:
 - people can establish links between their thoughts, feelings or actions and their current or past symptoms, and/or functioning
 - the re-evaluation of people's perceptions, beliefs or reasoning relates to the target symptoms
- also include at least one of the following components:
 - people monitoring their own thoughts, feelings or behaviours with respect to their symptoms or recurrence of symptoms
 - promoting alternative ways of coping with the target symptom
 - reducing distress
 - improving functioning.

Promoting recovery

Offer CBT to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission. Deliver CBT as described above.

Research recommendations

- An adequately powered RCT should be conducted to investigate the most appropriate duration and number of sessions for CBT in people with schizophrenia.
- An adequately powered RCT should be conducted to investigate CBT delivered by highly trained therapists and mental health professionals compared with brief training of therapists in people with schizophrenia.
- Research is needed to identify the competencies required to deliver effective CBT to people with schizophrenia.

Date question received: 27/02/2012

Date searches conducted: 29/02/2012

Date answer completed: 25/04/2012

References

Systematic Reviews

1. Sarin F, Wallin L, Widerlöv B. Cognitive behavior therapy for schizophrenia: A meta-analytical review of randomized controlled trials. *Nord J Psychiatry* 2011;65:162–174.
2. Wykes T, Steel C, Everitt B, Tarrier N. Cognitive behavior therapy for schizophrenia: effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin* vol. 34 no. 3 pp. 523–537, 2008.

RCTs

3. Bechdolf A, Knost B, Nelson B, Schneider N, Veith, Yung A R, Pukrop R. Randomized comparison of group cognitive behaviour therapy and group psychoeducation in acute patients with schizophrenia: effects on subjective quality of life. *Australian and New Zealand Journal of Psychiatry*, 2010, vol./is. 44/2, 144-150, 2010.
4. Lysaker P H, Davis L W, Bryson G J, Bell M D. Effects of cognitive behavioral therapy on work outcomes in vocational rehabilitation for participants with schizophrenia spectrum disorders. *Schizophrenia Research*, February 2009, vol./is. 107/2-3(186-191), 0920-9964.
5. Peters, E, Landau, S, McCrone, P, Cooke, M, Fisher, P, Steel, C, Evans, R, Carswell, K, Dawson, K, Williams, S, Howard, A, Kuipers, E. A randomised controlled trial of cognitive behaviour therapy for psychosis in a routine clinical service. *Acta Psychiatr Scand* 2010; 122: 302–318.
6. Van Der Gaag M, Stant A D, Wolters K J K, Buskens E., Wiersma D. Cognitive-behavioural therapy for persistent and recurrent psychosis in people with schizophrenia-spectrum disorder: cost-effectiveness analysis. *British Journal of Psychiatry*, January 2011, vol./is. 198/1(59-65), 0007-1250;1472-1465 (January 2011).

Guidelines

7. NICE Clinical Guideline 82 Schizophrenia Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care (Updated Edition) 2010 <http://www.nice.org.uk/nicemedia/live/11786/43607/43607.pdf>

Results

Systematic Reviews

Author (year)	Search Date	Inclusion criteria	Number of included studies	Summary of results	Risk of bias
Sarin et al. (2011)	October 2010	People with schizophrenia-like illness (schizophrenia, schizoaffective syndrome or delusion disorder) were included. The diagnosis criteria that apply to this meta-analysis are ICD-10 and DSM-III R or IV. Irrespective of whether they had CBT, the individuals who participated in the studies always required standard care. The review included only RCTs with a low risk of bias. Only published studies were included, and the participants had to be over 18 years old. Small studies (with less than 10 participants) were excluded from the meta-analysis.	22 RCTs (n=2469)	<p>Relapse</p> <p>CBT vs. treatment as usual (TAU): There was a significant difference in favour of TAU directly after treatment (n=189, one RCT, RR 1.48 CI 1.07 to 2.04, p=0.02) and no significant difference between groups at follow-up (n=520, five RCTs, RR 0.93 CI 0.71 to 1.22, p=0.59).</p> <p>CBT vs. other psychological treatments: There were no significant differences between CBT and other psychological treatments directly after the study (n=49, one RCT, RR 1.34 CI 0.49 to 3.66, p=0.56) or at follow-up (n=379, four RCTs, RR 1.15 CI 0.82 to 1.61, p=0.41).</p> <p>Other outcomes reported in the SR included <i>symptoms</i> (positive, negative, general, hallucination, delusion, depression, anxiety), <i>clinically important improvement</i> (a reduction of symptoms 25% or greater than at baseline), and <i>medication use</i>.</p>	Low
Wykes et al. (2008)	2006	The studies sample had to contain a majority of people with a diagnosis of schizophrenia; all	34 RCTs (n=not clearly reported)	CBT vs. control group (the control group was considered to be TAU group or a control adjunct treatment that had been	Low

		<p>patients received standard psychiatric care (TAU, treatment as usual) including appropriate medication; in the experimental group, CBT was an adjunct to TAU; there was a control group; there was an allocation procedure; CBT treatment was targeted at one of the following: positive or negative symptoms of psychosis, functioning, mood, hopelessness/suicidality, or social anxiety.</p>	<p>hypothesized to be inactive for the main outcome). The results were reported after treatment.</p> <p>There was significant effect for <i>functioning</i>, such that patients who received treatment with CBT had better outcomes (n=867, 15 studies, WMD 0.378 CI 0.154 to 0.602). There was, however, significant heterogeneity between the studies.</p> <p>There was a non-significant effect between treatment groups for <i>hopelessness</i> after (n=431, four studies, WMD -0.190 CI -0.547 to 0.166).</p> <p>Results for <i>social anxiety</i> were not analysed in a meta-analysis. Effect sizes ranged from 0.35 to 0.44 (two studies).</p> <p>Other outcomes reported in the SR included <i>symptoms</i> (positive, negative, target) and <i>mood</i>.</p>	
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RCTs/DTAs

Author (year)	Inclusion criteria	Number of participants	Summary of results	Risk of bias
Bechdolf et al. (2010)	<i>Population:</i> Participants were aged 18–64 years, met criteria for an episode of schizophrenia, schizoaffective or other	88	CBT vs. group psychoeducation (PE) There were no significant differences between treatment groups for QoL dimensions (physical health, vitality, psychosocial QoL, material QoL, spare time QoL, affective	High









	<p>psychotic disorder (ICD-10: F20, F23, F25) and were recommended antipsychotic medication. Any patient with a primary diagnosis of drug or alcohol dependence, organic brain disease, learning disability or hearing impairment was excluded from the study.</p> <p><i>Intervention:</i> Brief Group CBT.</p> <p><i>Comparator:</i> Group Psychoeducational Programme.</p> <p><i>Outcome:</i> Quality of Life.</p> <p><i>Duration:</i> 8 weeks</p>		<p>QoL and General QoL) after treatment, or at 6 month follow-up. There were however, significant improvements within both treatment groups over time. Within group effect sizes for general QoL at follow up were 0.25 for CBT and 0.29 for PE.</p> <p>The primary outcome measures of this RCT were readmission, relapse, clinical symptoms as measured on the Positive And Negative Syndrome Scale and compliance with medication. This current paper focused on QoL which was a secondary outcome; QoL data were available for 68 (77%) of the participants.</p>	
Lysaker et al. (2009)	<p><i>Population:</i> Participants with a diagnosis of schizophrenia or schizoaffective disorder. All were in post-acute phase of illness as defined by having no hospitalization or changes in psychotropic medication or housing or housing in the month before entering the study.</p> <p><i>Intervention:</i> Indianapolis Vocational Intervention Programme (IVIP) – a programme of cognitive behavioural group and individual interventions.</p>	100	<p>Cognitive behavioural intervention (IVIP) vs. support services</p> <p>Participants who received IVIP worked significantly more hours over a 26 week period compared to those who received support services: mean 360.86 (SD 246.6) hours vs. 228.8 (SD 193.4) hours , $p < 0.01$. Work behavioural inventory scores (assessing behaviour at work) were significantly greater in those who received IVIP compared to controls: mean 113.3 (SD 13.1) vs. 105.4 (SD 15.8), $p < 0.05$.</p>	Unclear

	<p><i>Comparator: Support services.</i></p> <p><i>Outcomes:</i> Number of hours worked weekly, number of weeks worked, job/work performance.</p> <p><i>Duration:</i> 26 weeks</p>			
Peters et al. (2010)	<p><i>Population:</i> Participants were included if they were aged between 18 and 65 years, had at least one distressing and persistent positive symptom of psychosis (score of 3 or above on at least one of the positive symptoms items of the PANSS, accompanied by reported subjective distress), and did not have a primary diagnosis of alcohol or substance abuse or of an organic condition. Only patients who had been stable on medication for a period of at least 3 months were included. Patients who were suitable but were either unable to complete (e.g., due to language difficulties), or distressed by, the baseline assessments, were also excluded.</p> <p><i>Intervention:</i> Cognitive</p>	74	<p>CBT vs. waiting list control</p> <p>There was no significant differences between groups in <i>self esteem</i>, at the end of therapy (-1.2 CI, -2.6 to 0.18), P = 0.09 or at follow-up (-1.2, CI -2.6 to 0.21), P = 0.09.</p> <p>There was a significant improvement in the <i>Social and Occupational Functioning Assessment Scale (SOFAS)</i> scores in the therapy group compared to the waiting list control group at the end of therapy: 6.0 (2.1 to 9.9), P = 0.002, but not at follow-up (2.9 (-1.0 to 6.9), P = 0.14.</p> <p>There were no significant differences between the immediate and waiting list control groups for <i>number of days spent in hospital</i> (9 months after randomisation) (Mann–Whitney U = 611.5; P = 0.19).</p> <p>Other outcomes reported in the RCT included symptoms (positive, negative, general), depression, anxiety, suicidal ideation, insight, beliefs about voices, omnipotence, resistance, and cost analysis.</p>	Unclear





















	<p>Behavioural Therapy for psychosis.</p> <p><i>Comparator:</i> Waiting list control (treatment as usual).</p> <p><i>Outcomes:</i> Psychotic symptoms (including positive symptoms, negative symptoms, general symptoms), emotional problems (including depression, anxiety, suicidal ideation, and self esteem), social and cognitive functioning (including executive functioning and cognitive flexibility), insight, beliefs about symptoms (including uncontrollability of thoughts), economic evaluation.</p> <p><i>Duration:</i> 6 months' therapy</p>			
van der Gaag et al. (2011)	<p><i>Population:</i> The inclusion criteria were:</p> <p>(a) age 18–64;</p> <p>(b) diagnosis of schizophrenia or schizoaffective disorder (DSM–IV–TR, 295.xx)</p> <p>(c) Positive and Negative Syndrome Scale (PANSS) scores of delusions ≥ 4 OR hallucinations ≥ 4 OR suspiciousness ≥ 4) AND Psychotic Symptoms</p>	216	<p>CBT vs. treatment as usual (TAU)</p> <p>Participants in the CBT group demonstrated significantly better <i>functioning</i> at 3 months ($p=0.000$), 6 ($p=0.018$), 12 ($p=0.014$), and 15 months ($p=0.037$), but not at 9 and 18 months. Participants in the CBT group had on average 183 days of normal functioning compared with 106 days in the TAU group. The mean difference of 77 days of normal functioning between groups was significant (95% CI 29.7–124.0).</p> <p>The authors stated that a breakdown of the composite dichotomous normal functioning outcome measure showed</p>	Unclear

	<p>Rating Scale (PSYRATS) scores delusions-suffering ≥ 2 AND delusions-impact ≥ 2 OR hallucinations-suffering ≥ 2 AND hallucinations-impact ≥ 2;</p> <p>(d) treatment resistance defined as failure of two or more antipsychotic treatments of at least 6 weeks over the past 2 years.</p> <p><i>Intervention:</i> Cognitive-behavioural therapy.</p> <p><i>Comparison:</i> Treatment as usual.</p> <p><i>Outcomes:</i> Normal social functioning, days spent in hospital, cost effectiveness.</p> <p><i>Duration:</i> 6 months' treatment, overall 18 months</p>		<p>that the gain in social functioning (SFS) was comparable in both groups, but the CBT group experienced less suffering and impact of symptoms Psychotic Symptom Rating Scales (PSYRATS) on daily living than the TAU group did. The number needed to treat varied from 5 to 10.</p> <p>The differences between groups on <i>WHO-QoL</i> were not statistically significant.</p> <p>Other outcomes reported in the RCT included <i>symptoms</i> (Positive and Negative Syndrome Scale (PANSS)).</p>	
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Risk of Bias: SRs

Author (year)	Risk of Bias				
	Inclusion criteria	Searches	Review Process	Quality assessment	Synthesis
Sarin et al. 2011					
Wykes et al. 2008					

RCTs

Study	RISK OF BIAS					
	Random allocation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective Reporting
Bechdolf et al. 2010			NA			
Lysaker et al. 2009			NA			
Peters et al. 2010			NA			
van der Gaag et al. (2011)			NA			

 Low Risk

 High Risk

 Unclear Risk

Search Details

Source	Search Strategy	Number of hits	Relevant evidence identified
SR's and Guidelines			
NICE	(cognitive behavio* therapy OR CBT) AND (schizophrenia OR psychosis)	75	1
DARE	1. (psychosis) 195 2. (psychotic) 308 3. MeSH DESCRIPTOR Psychotic Disorders EXPLODE ALL TREES 107 4. (cbt) 303 5. (psychotherapy) 690 6. (cognitive behavio*) 388 7. (cognitive adj2 therapy) 846 8. MeSH DESCRIPTOR Cognitive Therapy EXPLODE ALL TREES 481 9. MeSH DESCRIPTOR Psychotherapy	98	2

	EXPLODE ALL TREES 1299 10. #1 OR #2 OR #3 408 11. #4 OR #5 OR #6 OR #7 OR #8 OR #9 1694 12. #10 AND #11 98		
Primary Studies			
CENTRAL	#1 MeSH descriptor Psychotic Disorders explode all trees 1330 edit delete #2 MeSH descriptor Cognitive Therapy explode all trees 3808 edit delete #3 cbt 1835 edit delete #4 (cognitive behaviour therapy) 4823 edit delete #5 (#2 OR #3 OR #4) 7339 edit delete #6 (#1 AND #5) 151 edit delete #7 (#6), from 2007 to 2012 92 edit delete #8 (psychosis or psychotic) 4396 edit delete #9 (#1 OR #8) 4396 edit delete #10 (#9 AND #5) 670 edit delete #11 (#10), from 2007 to 2012 518 edit delete Central results only 98	98	4
MEDLINE	33. MEDLINE; exp PSYCHOSIS/; 34870 results. 34. MEDLINE; (psychosis OR psychotic).ti,ab; 34873 results. 35. MEDLINE; ("cognitive behavioural therapy" OR CBT).ti,ab;	163	

	<p>4410 results.</p> <p>36. MEDLINE; "cognitive behavioral therapy".ti,ab; 2886 results.</p> <p>37. MEDLINE; "cognitive behavior* therapy".ti,ab; 3756 results.</p> <p>38. MEDLINE; "cognitive behaviour* therapy".ti,ab; 1950 results.</p> <p>39. MEDLINE; exp COGNITIVE THERAPY/; 12482 results.</p> <p>40. MEDLINE; 33 OR 34; 55283 results.</p> <p>41. MEDLINE; 35 OR 36 OR 37 OR 38 OR 39; 15175 results.</p> <p>42. MEDLINE; 40 AND 41; 601 results.</p> <p>43. MEDLINE; "randomized controlled trial".pt; 322347 results.</p> <p>44. MEDLINE; "controlled clinical trial".pt; 83717 results.</p> <p>45. MEDLINE; randomized.ab; 238425 results.</p> <p>46. MEDLINE; placebo.ab; 134006 results.</p> <p>47. MEDLINE; "drug therapy".fs; 1511332 results.</p> <p>48. MEDLINE; randomly.ab; 175345 results.</p> <p>49. MEDLINE; trial.ab; 246233 results.</p> <p>50. MEDLINE; groups.ab; 1147873</p>		
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	<p>results.</p> <p>51. MEDLINE; 43 OR 44 OR 45 OR 46 OR 47 OR 48 OR 49 OR 50; 2892241 results.</p> <p>52. MEDLINE; 42 AND 51; 293 results.</p> <p>53. MEDLINE; 52 [Limit to: Publication Year 2007-Current]; 163 results.</p>		
EMBASE	<p>1. EMBASE; exp PSYCHOSIS/; 186832 results.</p> <p>2. EMBASE; (psychosis OR psychotic).ti,ab; 46630 results.</p> <p>3. EMBASE; COGNITIVE THERAPY/; 26800 results.</p> <p>4. EMBASE; ("cognitive behavioural therapy" OR CBT).ti,ab; 6539 results.</p> <p>5. EMBASE; "cognitive behavioral therapy".ti,ab; 4074 results.</p> <p>6. EMBASE; "cognitive behavior* therapy".ti,ab; 5367 results.</p> <p>7. EMBASE; "cognitive behaviour* therapy".ti,ab; 3022 results.</p> <p>8. EMBASE; 3 OR 4 OR 5 OR 6 OR 7; 29264 results.</p> <p>9. EMBASE; 1 OR 2; 195513 results.</p> <p>10. EMBASE; 8 AND 9; 3184 results.</p> <p>11. EMBASE; random*.ti,ab; 711167 results.</p> <p>12. EMBASE; factorial*.ti,ab; 18452</p>	390	

	<p>results.</p> <p>13. EMBASE; (crossover* OR cross-over*).ti,ab; 60004 results.</p> <p>14. EMBASE; placebo*.ti,ab; 171418 results.</p> <p>15. EMBASE; (doubl* ADJ blind*).ti,ab; 125724 results.</p> <p>16. EMBASE; (singl* ADJ blind*).ti,ab; 11915 results.</p> <p>17. EMBASE; assign*.ti,ab; 199022 results.</p> <p>18. EMBASE; allocat*.ti,ab; 66529 results.</p> <p>19. EMBASE; volunteer*.ti,ab; 153413 results.</p> <p>20. EMBASE; CROSSOVER PROCEDURE/; 33346 results.</p> <p>21. EMBASE; DOUBLE BLIND PROCEDURE/; 107813 results.</p> <p>22. EMBASE; RANDOMIZED CONTROLLED TRIAL/; 318508 results.</p> <p>23. EMBASE; SINGLE BLIND PROCEDURE/; 15595 results.</p> <p>24. EMBASE; 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23; 1177104 results.</p> <p>25. EMBASE; 10 AND 24; 688 results.</p> <p>26. EMBASE; 25 [Limit to: Publication Year 2007-2012]; 390 results.</p>		
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<p>PsychINFO</p>	<p>27. PsycINFO; exp PSYCHOSIS/; 82576 results. 28. PsycINFO; (psychosis OR psychotic).ti,ab; 44663 results. 29. PsycINFO; ("cognitive behavioural therapy" OR CBT).ti,ab; 6378 results. 30. PsycINFO; "cognitive behavioral therapy".ti,ab; 5682 results. 31. PsycINFO; "cognitive behavior* therapy".ti,ab; 7963 results. 32. PsycINFO; "cognitive behaviour* therapy".ti,ab; 2201 results. 33. PsycINFO; COGNITIVE BEHAVIOR THERAPY/; 8315 results. 34. PsycINFO; 27 OR 28; 101984 results. 35. PsycINFO; 29 OR 30 OR 31 OR 32 OR 33; 13951 results. 36. PsycINFO; 34 AND 35; 895 results. 37. PsycINFO; CLINICAL TRIALS/; 5895 results. 38. PsycINFO; random*.ti,ab; 107243 results. 39. PsycINFO; groups.ti,ab; 320519 results. 40. PsycINFO; (double adj3 blind).ti,ab; 15788 results. 41. PsycINFO; (single adj3 blind).ti,ab; 1169 results. 42. PsycINFO; EXPERIMENTAL DESIGN/; 8179 results.</p>	<p>177</p>	
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	<p>43. PsycINFO; controlled.ti,ab; 67082 results.</p> <p>44. PsycINFO; (clinical adj3 study).ti,ab; 6696 results.</p> <p>45. PsycINFO; trial.ti,ab; 56448 results.</p> <p>46. PsycINFO; "treatment outcome clinical trial".md; 21407 results.</p> <p>47. PsycINFO; 37 OR 38 OR 39 OR 40 OR 41 OR 42 OR 43 OR 44 OR 45 OR 46; 491467 results.</p> <p>48. PsycINFO; 36 AND 47; 330 results.</p> <p>49. PsycINFO; 48 [Limit to: Publication Year 2007-2012]; 177 results.</p>		
Summary	NA	NA	

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