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EFFICACY OF COGNITIVE-BEHAVIOURAL THERAPY IN PATIENTS WITH AN EARLY-PSYCHOSIS EPISODE: A REVIEW

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The efficacy of the psychological treatments in schizophrenia has been explored in several controlled studies for approximately twenty years confirming that these are an important therapeutic complement to the antipsychotic medication in the treatment of the above mentioned disorder. Among these treatments family interventions and cognitive - behavioural treatments have received a major attention in relation to their obtained results. This review article will focus on the existing literature on the techniques and procedures of the cognitive - behavioural therapy applied to reducing the emotional distress and increasing the level of psychosocial functioning in the early phase of the disease (the first psychotic episode or an early- psychosis episode). It will also focus on its efficacy according to the studies realized in the latter years and will draw attention on the phase they are at present.
Key words: *Schizophrenia, Psychological intervention, Early psychosis.*

La eficacia de los tratamientos psicológicos en la esquizofrenia ha sido explorada en varios estudios controlados desde hace unos veinte años, confirmando que éstos son un importante complemento terapéutico a la medicación antipsicótica en el tratamiento de dicho trastorno. Dentro de estos tratamientos, las intervenciones familiares y los tratamientos cognitivo-conductuales son los que han recibido una mayor atención en relación a los resultados conseguidos. Este artículo de revisión primará su atención en la literatura existente sobre las técnicas y procedimientos de la terapia cognitivo-conductual aplicadas a reducir el malestar emocional y aumentar el nivel de funcionamiento psicosocial en la fase temprana de la enfermedad (primer episodio psicótico y/o psicosis de inicio reciente), así como su eficacia a lo largo de los estudios realizados en estos últimos años y esclarecer en qué fase se encuentran actualmente.
Palabras clave: *Esquizofrenia, Intervención psicológica, Psicosis temprana.*

Psychotic disorders in general and schizophrenia in particular, are very disabling mental disorders whose standard treatment, until very recently, has been pharmacological combined with case management (Tarrier, 2008). Over time, and despite pharmacotherapy having evolved over the years, and second generation antipsychotic drugs becoming the first choice owing to the advantages they provide regarding safety and greater tolerance in comparison to classical antipsychotic medication, and therefore, greater long-term treatment adherence (Emsley et al., 1999; Sanger et al., 1999), these have not yet been able to completely resolve what for most patients is essential: the improvement of quality of life, as many of these patients continue to experience social and functional dysfunctions regardless of antipsychotic medication efficacy and the remission of symptoms (Uzenoff et al., 2010).

Cognitive therapy in psychosis has been developed based on the cognitive-behavioral intervention principles previously applied in the treatment of anxiety (Beck, Emery, and Greenberg, 2005) and depression (Rush, 1979), but has been modified and adapted to the treatment of psychotic symptoms according to the vulnerability-stress model and from a biopsychosocial understanding of the disorder (Zubin y Spring, 1977).

Since Beck first described a case of schizophrenia treated with cognitive-behavioral therapy (CBT) (Beck, 2002) in 1952, to date, the necessity of implementing these types of therapies within a comprehensive treatment program has been proposed to help the patient, in addition to improving his/her symptomatology, become integrated in the most efficient manner in our society, improving his/her psychological and psychosocial functioning (Addington and Gleeson, 2005).

During the last decade, special attention has been dedicated to the prevention of the disorder, and today, many studies are being carried out with promising results. For example, the pioneers of the early intervention research EPPIC program (Early Psychosis Prevention and Intervention Centre) from the ORYGEN research center at the University of Melbourne (Australia) have found that 40% of the sample with a high risk for psychosis becomes

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psychotic over a 9 month period (Yung, McGorry, McFarlane, and Jackson, 1996).

The present review paper will be focused on a nonsystematic review of studies that offer evidence of the efficacy of CBT in the cases in which the patient has experienced a first-psychotic episode (PEP) or an initial psychotic episode (within the non-affective schizophrenia-spectrum psychoses) and on the post psychosis phase recovery, a period in which intervention would be key for minimizing the probability and impact of future relapse and posterior recovery. Despite there being some reviews on the use of CBT in early-onset psychosis in English (Marshall and Rathbone, 2006; Liu et al., 2010), it is an area of research in constant growth and the few review studies in our language still need to be updated (Vallina et al., 2006). Thus, it is of particular interest to offer an updated synthesis of the psychological treatment results in this area in the Spanish language.

Cognitive-Behavioral Therapy has played and plays an important role in psychosis treatment, thus, it is necessary to emphasize the administration of said therapy in the apparition of first-episode psychosis (FEP) or psychosis of recent onset given that the main objective of the therapy is to decrease the stress that the psychotic experience causes, through either the reduction of deliria and hallucination severity in some of their quantitative parameters, or increasing the tolerance toward the presence of psychotic experiences so that patients can distance themselves from them and direct their attention to quality of life improvement (Cuevas-Yust, 2006), increase patients' comprehension of the psychotic disorder, reduce the presence of anxiety and prevent future relapse.

The importance of early detection

Currently, it is known that early intervention can reduce the impact that this disorder produces on the functioning of those who suffer from it (Alvarez-Segura, Llorente, and Arango, 2009). The duration of untreated psychosis (DUP), from the first clinical manifestations to the beginning of adequate treatment, correlates in a consistent manner with better course and results the shorter the interval is between the apparition of the psychotic symptoms and the promptness that treatment is implemented; however, the mechanisms by which this relationship takes place have not yet been clarified (Melle et al., 2008). The time elapsed from the apparition of psychotic symptoms and the first therapeutic contact is about 1-2 years with a median of approximately 6 months in patients with schizophrenia (McGlashan, 1999).

Thus, prevention in FEP treatment is justified by the evidence of delay in the provision of specialized treatment following the apparition of the first symptoms of the illness (Larsen et al., 2001). Moreover, it has been demonstrated in prospective longitudinal studies carried out in FEP populations that the first 3-5 years of evolution of the disorder have a great influence on the later course of symptoms and the level of psychosocial functioning (Harrison, Croudace, Mason, and Glazebrook, 1996).

On the other hand, a lengthy DUP and a low insight level merged as predictors of a poor adherence to cognitive-behavioral therapy (Álvarez-Jiménez, et al., 2009). Hence, the preceding years to the first episode are crucial for establishing the parameters for a long-term recovery and its results. Similarly, a delay in treatment could reduce the therapeutic potential of the interventions performed in an early course of the disorder (Gleeson et al., 2009).

In effective interventions, the increase in adherence is crucial in the treatment of early psychoses. Thus, clinicians and researchers should take into account that patients with a long DUP and poor insight are especially vulnerable to withdrawal from treatment and therefore, a series of strategies for promoting therapeutic adherence should be employed.

Cognitive-Behavioral Therapy for schizophrenia: some theoretical aspects.

Once psychosis is detected, treatment must be based on a multimodal perspective that includes pharmacological and psychosocial interventions (Alvarez-Segura, 2009).

The defense of CBT as the psychological treatment in schizophrenia, specifically in the first episodes, is due to the existence of evidence regarding its efficacy on psychotic symptoms (Jackson et al., 2008; Tarrier, 2010) and also, because since it was first conceived, theoretical aspects have been greatly developed that have responded to the necessities of young patients who have recovered from a FEP. Lastly, CBT has not only contributed to ameliorate the most florid psychotic symptomatology, but it has also been focused on solving other aspects that are just as problematic or even more so than this (Haarmans, 2006) as one of the topics that has been scarcely researched in individuals who have recovered from a FEP is the loss of psychological wellbeing, one of the subjective components of quality of life. Factors such as

depression or the lack of social support play an important role in the recovery of the subject. Thus, a greater perception of social support by the patient and lower levels of depression have been found to be predictors of psychological wellbeing (Uzenoff et al., 2010).

Since Beck's pioneer work, a theoretical change in BCT has taken place in the last fifteen years with the development of the "second generation" cognitive models aimed at constructs such as affect, early development, attachment, interpersonal processes and therapeutic relationship (Greenberg and Safran, 1987; Guidano and Liotti, 1983; Ryle and Kerr, 2002; Safran, Vallis, Segal, and Shaw, 1986; Safran and Segal, 1990).

These second generation models have been incorporated into a BCT meta-model within a continuum from rationalism to constructivism.

Essentially, differences between rationalist and constructivist models on which BCT is supported are based on the respective theories of reality/truth, knowledge and change. In the rationalist model, reality is conceptualized as external, stable, and can be verified and validated. In this model, logic and reason validate knowledge, and thought is prioritized over affect. Moreover, the focus is that by controlling thought, emotions are controlled. It is understood that change comes from examining cause and effect of the components of thought, humor, behavior, physiological reaction, and environment. These are the meta-models by Beck (1976) and Ellis (1962).

According to constructivism, reality is subjective, idiosyncratic and the active creation or construction of reality by the individual is emphasized. In these models, knowledge is obtained through the integration of cognitive-behavioral-affective experience. Therapeutic change consists of a structural differentiation of the central scheme of oneself versus peripherical processes or of a lower cognitive level. The therapist helps the patient become aware of his/her own constructs, first transforming them and subsequently refining his/her mental representations in an evolutive manner. Guidano and Liotti (1983) head these constructivist theories along with Mahoney (1991).

Objectives of BCT

When working with patients who are recovering from a FEP, we should not only aim for the treatment of the symptoms of the disorder but also the impact that these produce on the individual (Haarmans, 2006). Hence, the objectives of BCT are the following:

- ✔ increase the patient´s comprehension of the psychotic disorder
- ✔ promote adaptation to the disorder
- ✔ increase self-esteem, coping strategies and adaptive functioning
- ✔ reduce emotional alteration and comorbidity
- ✔ reduce stress associated to the hallucinations and deliria and promote strategies and skills for their daily management, and
- ✔ prevent future relapse

Phases of the BCT model for FEP

One of the advantages of applying a modular approximation of BCT in first episodes of psychosis is that there is an ample range of interventions to treat the different needs of the users.

A treatment model such as BCT in early psychosis can be divided into the following phases: engagement, recovery and reorientation of acute symptoms and late recovery (Haarmans, 2006).

These phases have been guided by a great compendium of texts and manuals with evidence-based treatment models (Birchwood and Spencer, 2001; Chadwick, Birchwood, and Trower, 1996; Fowler, Garety, and Kuipers, 1995; Fowler, 2000; Gumley et al., 2003; Haddock and Slade, 1996; Herrmann-Doig, Maude, and Edwards, 2003; Jackson, Edwards, Hulbert, and McGorry, 1999; Kingdon and Turkington, 1994, 2002; Morrison, 2002; Tarrier, 1992, 2008).

Similarly, we must mention the different manuals recently published in Spanish (Gleeson, 2005; Martindale, Bateman, Crowe, and Marginson, 2010; Caballo, 1996; Chadwick, 2009; Madrid: Ministerio de Sanidad y Consumo, 2009; Edwards and McGorry, 2004; Gleeson and McGorry, 2005; Martindale, Bateman, Crowe, and Marginson, 2009; Penedés and Gastó, 2010; Perona, Cuevas-Yust, Vallina, and Giráldez, 2003; Perris and McGorry, 2004; Roder, Brenner, Kienzle, and Fuentes, 2007; Stone, Faraone, and Tsuang, 2004).

In the last 5-10 years, we have witnessed an increase in the therapeutic approaches that go beyond cognitive therapy in general, which is extended by including an eclectic combination of philosophical theories and influences. Examples of these "third generation" approaches are the techniques of mindfulness, metacognitive therapy, compassionate mind training, and the method of levels (MOL), which are still in their early

stages but have the potential to influence the application of CBT in schizophrenia, and although these are not the main focus of this article, we will briefly describe them due to their interest and their recent application in these disorders.

Mindfulness

Approaches or techniques that involve training the mind to drop habits of automatic and/or unadaptive thought patterns. In addition to learning how to direct attention or concentration, these approaches involve teaching behaviors of kindness, compassion, and generosity, the support of empathy strategies such as not prejudging, and the understanding of the suffering of others (Tai and Turkington, 2009). For example, in the case of psychotic episodes in individuals who experience critical voices that are stressful for them, in traditional BCT the patient would have been motivated to "engage" with the voice with an emphasis on altering the emotional experiences associated to its presence. However, here the person would be trained to accept the presence of said voices and change the focus of attention adopting an indifferent and non-judgmental attitude, making the voices become less stressful and intrusive.

Chadwick and colleagues have applied this technique in individuals with psychotic symptoms, which seems to benefit some patients (Chadwick, 2006; Abba, Chadwick and Stevenson, 2008). This technique has also been used in a group format (Chadwick, Taylor, and Abba, 2005).

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT from here on) uses Relational Frame Theory, behavior analysis, and mindfulness influences. Acceptance and Commitment Therapy does not encourage patients to control their intrapersonal activities (thoughts, feelings...) like in traditional BCT, but rather it shows them to "just notice", accept and encompass internal events. This therapy emphasizes identifying an individual's personal values and encourages them to act according to said values (Tai and Turkington, 2009a). Coping strategies such as cognitive distancing (treatment of thoughts as hypothetical registers in opposition to our acts), acceptance and validated action are used. It is argued that the focus of traditional BCT in symptom reduction can, paradoxically, provoke the opposite effect of that desired; therefore, it can even worsen the symptoms. It seems that recently the use of this technique as a treatment for psychosis has increased although the evidence of its efficacy in clinical trials and longitudinal studies is scarce (Tai and Turkington, 2009b).

Compassionate Mind Training

Compassionate Mind Training (CMT) is an approach that is a part of traditional BCT but with special emphasis on increasing awareness of negative self-to-self relating (Tai and Turkington, 2009). This therapy specifically involves the feeling of shame and self-criticism from the point of view that it can act as an internal hostile signal stimulating submissive and negative affective responses that can maintain mental disorders (Gilbert et al., 2001; Gilbert, 2005).

Cognitive-Behavioral Therapy facilitates individual care for the wellbeing of the patient by responding with warmth and compassion (Gilbert, 2009). Different techniques are employed such as Socratic questioning, mental imagery...which are especially important when working on psychotic symptoms. There is a clear theoretical basis for using this therapy within CBT for common schizophrenic symptoms (MacBeth, Schwannauer, and Gumley, 2008; Mayhew and Gilbert, 2008). Research on the application of CMT in psychosis is still in the initial phases; therefore, more validated studies are needed to establish the potential of said therapy (Tai and Turkington, 2009).

Meta-Cognitive Therapy

Meta-cognitive therapy is based on the Self-regulatory Executive Function model (Wells and Matthews, 1994). From this perspective, psychosis is considered as the result of thinking style and the way in which patients control their thoughts (metacognition). This therapy specifies that there are verbal styles of thinking (worry and rumination), the focus of attention on negative and threatening-type information, and metacognitive actions of thought suppression and avoidance that lead to the disorder. By classifying these metacognitive processes, this therapy focuses on how to change the manner in which patients experience and regulate their thoughts.

Metacognitive therapy involves showing subjects alternative skills for experiencing their thoughts by using techniques such as attention training and altering their metacognitive beliefs or thoughts that worry them too much or cannot be controlled because they are

dangerous. Although there are studies with proven evidence, more clinical trials with a 12-month follow-up period are needed for their comparison with controlled and random studies (Tai and Turkington, 2009).

Method of Levels

Method of Levels (MOL) is a therapy based on the principles of perceptual control theory (Powers, 1973; Carey and Scitl, 2005), which takes into account mechanisms of change within psychotherapy (Carver and Scheir, 2008; Higginson and Mansell, 2008). Its theoretical base also comes from CBT and specifies that people do not attempt to control their behavior but rather their perceptual experiences, when the goal is to make what is perceived from the environment match with "internal standards" (or goals) (Powers, 1990). This therapy postulates that the main feature of successful change is consciousness modification in the subject toward higher perceptual levels, so that conflict in control systems can be reorganized (Carey, Carey, Mullan, Spratt, and Spratt, 2009).

The results of the studies conducted with MOL therapy indicate that it is an effective and acceptable psychotherapy with benefits at the end of therapy, and in short-term follow-up studies (Carey et al., 2009; Carey and Mullan, 2007). These studies have been carried out in clinical communities, thus, more controlled trials are needed.

RESEARCH

Research has shown throughout the years that CBT is effective in schizophrenia treatment (Wykes, Steel, Everitt, and Tarrier, 2008; Tarrier, 2010). Most studies have been conducted in the United Kingdom since the mid-eighties (Beck y Rector, 2000) where the National Health Service recommends said treatment for patients with this disorder. In contrast in the US, the American Psychiatric Association describes this therapy as an added technique that "may benefit" patients (Lehman et al., 2004). This anecdotic evidence reflects the differences in the use and view that English and American clinicians have regarding the attitude and practice of CBT in its sphere of influence. Whereas English patients really value psychological treatment, American patients confer supremacy to pharmacological treatment; however, these discrepancies seem to emerge from the medical assistance model in their respective public health systems in their way of focusing clinical research (Kuller, Ott, Goisman, Wainwright, and Rabin, 2010) or even in the different schizophrenia etiological theories that both models hold. Nevertheless, both countries have included it as the preferred treatment.

Zimmerman et al. (2005), in a metanalysis of 14 studies on BCT in psychosis conducted between the years 1990 and 2004, concluded that CBT is significantly beneficial in the reduction of positive symptomatology (Zimmermann, Favrod, Trieu, and Pomini, 2005).

Although there are several studies that show the efficacy of this therapy in schizophrenia, there are few studies focused on patients who have recently suffered a first psychotic episode and/or psychosis of early onset. The exception is the SOCRATES program (Lewis et al., 2002) based on the pilot study by Haddock et al. (1998), which was a randomized multicentric controlled study on CBT for patients with psychosis onset that has shown certain advantages regarding the application of CBT in the early phases of the disorder. Three hundred and nine patients were randomly assigned to CBT, supportive counseling (SC) or routine care – psychopharmacological (RC). The therapeutic window was of 5 weeks. All groups improved during this period; there was no significant tendency in those who received CBT and they improved more rapidly. However, there were no significant differences between the groups once treatment had ended. At the 18-month follow up, Tarrier et al., (2004) reported that both the CBT and supportive counseling were superior to usual treatment given that they specifically produced symptom reduction, and auditive hallucinations responded better to CBT. Nevertheless, there were no significant differences in the relapse or readmission rates.

Jackson and colleagues conducted a quasi-experimental study in the EPPIC center in Melbourne, where 80 participants with a first episode of psychosis received CBT (n=44), rejected it (n=21) or only received intrahospital care (n=15) (Jackson et al., 1998). At the end of treatment, those who received CBT were more adapted to the disorder, presented increases in their quality of life, insight and more positive attitudes toward treatment as well as a reduction in negative symptoms in comparison to the hospitalized patients. At the one-year follow up, the only difference that remained was that the BCT group was more adapted to the disorder than those who had rejected CBT (Jackson et al., 2001). At the 4-year follow up, there were no significant differences among the groups (Jackson et al., 2005).

In another more recent randomized controlled study by Melbourne´s research team, 62 patients with a FEP were randomly assigned to groups that either received CBT or a support therapy denominated "befriending" (H. J. Jackson et al., 2008), in which CBT surpassed this other therapy at the treatment midpoint, but there were no significant differences at the end of treatment or at follow-up. Another controlled randomized study based on the EPPIC program included 62 participants with a FEP who have attempted suicide who received CBT focused on suicide prevention or usual therapy (Power et al., 2003). These authors found that, whereas both groups were improving, the CBT group was superior in the degree of reduction of despair and quality of life at the end of treatment and subsequent follow-up. Jolley et al., (2003) conducted a small, randomized controlled study (n=21) in which CBT for FEP was compared to routine care from an early intervention service. No significant differences in the symptoms were found, however, CBT reduces the number of hospitalization days. Finally, another study, exploring the effects of a CBT therapy for reducing cannabis use in a first-episode psychosis sample (n=47), did not find significant differences when psychoeducation was used with the same sample (Edwards et al., 2006).

In a small, noncontrolled study of CBT for first-episode psychosis in group format, Lecomte, Leclerc, Wykes, and Lecomte (2003) found that five participants reported being greatly satisfied with the CBT group and showed a reduction in psychotic symptoms using qualitative methods. In the study by Lecomte et al., the efficacy of group CBT for patients with a recent psychosis onset in comparison with the results of an individual intervention in social skills training was assessed using a repeated measures design (baseline, 3 months and 9 months). One hundred and twenty-nine patients participated in a blind randomized control trial under three conditions: group CBT, social skills training for symptom management and/or control group on a waiting list. Both groups improved the positive symptomatology as well as the negative in comparison to the control waiting-list group, although with time, the group that received CBT had significant effects in all symptoms in general, and also postreatment effects in self-esteem and coping strategies as opposed to the waiting-list group and a lower rate of withdrawal when compared to the group that only received social-skills training. The findings of all the chosen studies are summarized in table 1.

There are encouraging conclusions to be drawn from these studies, for example, that those who suggest that individual CBT can help people with a FEP, achieving a more rapid recovery, or that it appears as an acceptable treatment for people suffering from early psychosis. There is also some evidence CBT in FEP can be particularly effective in quality of life improvement and for treating certain symptoms; such as, for example, despair and the hearing of voices. However, the relative lack of significant differences between the groups at the end of treatment and in the subsequent follow-up suggests that the benefits of CBT in these types of patients are moderate. In these studies, there are few differences between the groups at the end of treatment and in the follow-up. The findings suggest that, nevertheless, CBT has important benefits in terms of recovery rates, the improvement of certain symptoms (for example, auditive hallucinations and despair), and quality of life. Regarding the efficacy of this therapy in group format, there are so few studies that no definite conclusions can be drawn, thus, we will have to wait until more research is conducted along these lines.

DISCUSSION

These studies confirmed that the development of early intervention programs in these patients present a series of important advantages given that they clearly imply a reduction in associated social, economic and personal costs. However, in practice, it is not habitual to offer these types of interventions upon the apparition of psychosis.

Although there is a clear message that CBT seems to be beneficial for the treatment of psychotic symptoms and of the potential for this to improve quality of life and reduce stress in these patients, there are some questions to be clarified. One of the mentioned *handicaps* in the studies conducted is that individual therapy does not seem to be effective in reducing the number of relapses or rehospitalization in early psychosis, and some findings even suggest that the gains in early treatment are not sustained over time.

In the same way that we can contend that while the preliminary results of the studies carried out to date are encouraging, they cannot support the hypothesis that CBT will be more effective in individuals with a FEP if we compare it to a sample of psychotic patients resistant to treatment and chronic. In fact, significant differences were often not found among groups and at the end or follow-up of treatment in FEP/early psychosis studies. This was not the case in studies of chronic or patients resistant to treatment in which significant benefits of therapy were repeatedly shown.

This may be owing to reasons such as the lack of significant findings in the studies including difficulties associated with the design of the study, the theoretical support of the interventions and the specific application of CBT in a first-episode population (Morrison, 2009).

It is also necessary to indicate that these studies have a series of limitations that may contribute to the lack of positive findings and, at the end of the day, affect the variability of the studies already carried out given that some of these, such as those conducted by Jolley et al., (2993) and by Jackson et al., (1998) had small sample sizes insufficient in detecting statistically significant changes. Within the SOCRATES trials, there is considerable variability which could be due to the treatment (medication, case management, provision of family therapy) given by different mental health units. Thus, the specific effects of CBT may have been masked by the extensive variability in improvement due to

TABLE 1
STUDIES ON CBT FOR FIRST EPISODES IN EARLY PSYCHOSIS

Study	Program	N	Sample/Disord Phase	Design	Phase	Format	Control	Treatment duration/Follow-up	First results	Results
(Haddock et al., 1998)		21	Early psychosis/Acute phase	CRS	A	I	SC	5 weeks / 4 months	Symptoms	No differences
(Lewis et al., 2002)	SÓCRATES	309	Early psychosis (83 % FEP)/Acute phase	CRS	A	I	SC and RC	5 weeks / 3 months	Symptoms	The CBT group improved more rapidly; the voices responded better to CBT.
(Jolley et al., 2003)		21	Early psychosis/Stable phase (1st and 2nd E)	CRS	M	I	RC	6 months	Symptoms	Less hospitalization time with CBT
(Power et al., 2003)	EPPIC	56	FEP with suicide attempts	CRS	M	I	RC	8-10 sessions / 6 months	Suicide attempts	CBT improved the degree of hope and quality of life
(Tarrier et al., 2004)	SOCRATES	225	Early psychosis (83 % FEP)	CRS	A	I	SC and RC	18-mothn follow-up in the study by Lewis et al. (2002)	Symptoms	Voices responded better to CBT
(Jackson et al., 2008)	EPPIC (ACE project)	62	FEP/ Acute phase	CRS	A	I	RC	20 sessions / 1 year	Symptoms	More rapid improvement with CBT
(Jackson et al., 1998)	EPPIC (COPE)	80	FEP	QE	M	I	RC	12 months	Symptoms	CBT improved the degree of adaptation to the disorder, quality of life, negative symptoms and insight.
(Jackson et al., 2001)	EPPIC (COPE)	51	FEP	QE	M	I	RC	12-month follow-up in the study by Jackson et al. (2008)	Symptoms	CBT improved the degree of adaptation to the illness.
(Jackson et al., 2005)	EPPIC (COPE)	91	FEP	QE	M	I	RC	4-year follow-up in the study by Jackson et al. (2008)	Symptoms	No differences
(Edwards et al., 2006)	EPPIC	47	FEP	CRS	M	I	PE	10 sessions in 3 months/ 6 months	Cannabis use	No differences
(Lecomte, Leclerc, Wykes, and Lecomte, 2003)		5	FEP	OT	M	G		3 months	Symptoms	Great satisfaction reported and the reduction in positive symptoms.
(Lecomte, Leclerc, Corbière, Wykes, Wallace, and Spidel, 2008)		129	Early psychosis	CRS	A	G	SC and RC	24 sessions / 3 months	Symptoms	CBT had a significant effect on general symptoms.

FEP= first episode psychosis; CRS= controlled randomized study; QE= quasi-experimental; OT= open trial; QS= qualitative study; A= Acute phase; M= Mixed phase (acute and recovery); I= individual therapy; G= group therapy; SC=supportive counseling; RC= routine care (only antipsychotics); PE= psychoeducation.

adjustments to different treatments. As a matter of fact, in the study by Tarrier et al., (2004) they noticed a significant effect in the results because of treatment interactions in the 18-month follow up.

Another limitation to be discussed and that influences the long-term results is that some studies used only one control condition, which may have affected the failure in controlling specific factors such as the increase in contact with the therapist (Bendall et al., 2006).

Moreover, the recent development of cognitive treatments has necessitated the development of a wider conceptualization and a therapeutic approach to psychotic symptoms that encompasses the heterogeneity and multimodal nature of the disorder and increases our knowledge as to how they may be applied to specific problems and circumstances. Consequently, efficacy will be better understood through a personalized and multimodal patient formula.

It can be highlighted that an important part of the studies on the efficacy of CBT in first episodes are conducted in the context of specialized services that offer comprehensive care. This situation may mitigate the possibilities of finding an effect over and above the general effect of these specialized programs (and of the medication) and the great majority of studies have examined the administration of CBT in FEPs within the context of multidisciplinary teams frequently guided by the traditional medical model (e.g. SOCRATES), as well as the fact that it is inherently difficult to show the additional effect of CBT in the chronic phase of FEP as many patients recover relatively quickly independent of the type of treatment received. The studies included in the early intervention services have even frequently subscribed a biological understanding of the psychosis. This could lead to different approaches to CBT helping patients face or eliminate the symptoms of a disease, more than normalizing psychotic experiences and promoting a change in the evaluation and response to such experiences, which is more consistent with the Cognitive-Behavioral Theory in general, and more specifically, with the cognitive models of psychosis (Morrison, 2009).

Equally, subsequent studies should place greater emphasis on the assessment of the individual's functional recovery at the social, work, academic performance, and leisure levels, both during and after treatment (Penn, Waldheter, Perkins, Mueser and Lieberman, 2005).

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