2016

Medikamentfrie tiltak i psykisk helsevern

Systematisk litteratursøk med sortering

folkehelseinstituttet

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Kunnskapssenteret for helsetjenesten i Folkehelseinstituttet
Oslo, mars 2016

Hovedbudskap

Kunnskapssenteret for helsetjenesten i Folkehelseinstituttet har utført et systematisk litteratursøk med påfølgende sortering av mulig relevante publikasjoner. Formålet var å finne forskning om effekt av medikamentfrie tiltak til personer med alvorlige psykiske lidelser som ønsker et medikamentfritt behandlingstilbud.

Metode

Vi utarbeidet en søkestrategi for et litteratursøk for å identifisere oppsummert forskning om effekt av medikamentfrie tiltak til personer med alvorlige psykiske lidelser. Vi søkte i ulike forskningsdatabaser etter systematiske oversikter. Søket ble utført 7. desember 2015. Én forsker grovsilet alle titler for å fjerne referanser som åpenbart ikke handlet om psykisk helse eller medikamentfrie tiltak. Deretter vurderte to forskere, uavhengig av hverandre, titler og sammendrag i henhold til inklusjonskriteriene. Fra oversiktenes sammendrag har vi hentet informasjon om populasjon, tiltak, utfall, og oversiktsforfatternes egne konklusjoner. Vi innhentet ikke oversiktene i fulltekst.

Resultater

Oversiktene omhandler mennesker med ulike typer alvorlige psykiske lidelser og symptomer. De vanligste diagnosene er:

- schizofreni eller schizoaffektiv lidelse (41 oversikter)
- depresjon (32 oversikter)
- bipolar lidelse (14 oversikter),

Det finnes en rekke medikamentfrie tiltak. De vanligste tiltakene i oversiktene er:

- ulike psykologiske tiltak (59 oversikter)
- trenings- eller livsstilstiltak (22 oversikter)
- kosttilskudd eller naturpreparater (9 oversikter)

Tittel:
Medikamentfrie tiltak i psykisk helsevern – et systematisk litteratursøk med sortering

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Publikasjonstype:

Systematisk litteratursøk med sortering

Systematisk litteratursøk med sortering er resultatet av å
- søke etter relevant litteratur ifølge en søkestrategi og
- eventuelt sortere denne litteraturen i grupper presentert med referanser og vanligvis sammendrag

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Svarer ikke på alt:

- Ingen kritisk vurdering av studienes kvalitet
- Ingen analyse av studiene
- Ingen anbefalinger

Hvem står bak denne publikasjonen?

Kunnskapssenteret for helsetjenesten i Folkehelseinstituttet har gjennomført oppdraget etter forespørsel fra Psykisk helse- og rusklinikken, Universitetssykehuset Nord Norge

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Når ble litteratursøket utført?

Søk etter studier ble avsluttet desember, 2015.

Key messages

The Knowledge Centre for the Health Services in the Norwegian Institute of Public Health conducted a systematic literature search with subsequent sorting of possible relevant publications. The purpose was to find research on the effectiveness of non-pharmacological interventions for people with severe mental disorders seeking a non-pharmacological treatment option.

Method

We designed a search strategy for a systematic literature search to find research on the effectiveness of non-pharmacological interventions. We searched several research databases to identify systematic reviews. We performed the search on December 7th 2015. First, one researcher screened all titles and abstracts to eliminate references that obviously were not about mental health or non-pharmacological interventions. Thereafter, two researchers independently screened the titles and abstracts according to the inclusion criteria. From the abstract of each review, we obtained information about the population, intervention, outcomes, and the review authors' conclusions. We did not obtain the reviews in full-text.

Results

The reviews focus on people with a variety of severe mental disorders and symptoms. The most common disorders are:

- schizophrenia eller schizoaffectiv disorder (41 reviews)
- depression (32 reviews)
- bipolar disease (14 reviews)

A range of different non-pharmacological interventions exists. The most common interventions in the reviews are:

- different psychological interventions (59 reviews)
- exercise or diet interventions (22 reviews)
- food supplements or herbal medicine (9 reviews)

Title:
Non-pharmacological interventions in psychiatric care – a systematic reference list

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Type of publication:

Systematic reference list

A systematic reference list is the result of a search for relevant literature according to a specific search strategy. The references resulting from the search are then grouped and presented with their abstracts.

Doesn't answer everything:

- No critical evaluation of study quality
- No analysis or synthesis of the studies
- No recommendations

Publisher:

Knowledge Centre for the Health Services, Norwegian Institute of Public Health

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Updated:

Last search for studies: December, 2015.

Innhold

Forord

Kunnskapssenteret for helsetjenesten i Folkehelseinstituttet fremskaffer og formidler kunnskap om effekt av metoder, virkemidler og tiltak og om kvalitet innen alle deler av helsetjenesten. Målet er å bidra til gode beslutninger slik at brukerne får best mulig helse- og omsorgstjenester.

Kunnskapssenteret for helsetjenesten i Folkehelseinstituttet fikk forespørsel fra Psykisk helse- og rusklinikken, Universitetssykehuset Nord Norge om å oppsummere forskning om effekten av medikamentfrie tilbud innen psykisk helsevern. I samråd med bestiller ble vi enige om å utføre et bredt søk etter systematiske oversikter om medikamentfrie tiltak som kan være aktuelle å vurdere som del av behandlingstilbudet ved psykiatriske sykehusavdelinger.

Signe Flottorp	Atle Fretheim	Marita Sporstøl Fønhus
Avdelingsdirektør	*Seksjonsleder*	*Prosjektleder*

Innledning

Styrker og svakheter ved litteratursøk med sortering

Et «litteratursøk med sortering» innebærer at vi gjennomfører systematiske litteratursøk for en gitt problemstilling. Vi presenterer resultatene fra disse søkene i sin helhet, og sorterer ut forskningslitteraturen som vurderes relevant. Vanligvis skjer utvelgelsen på grunnlag av titler og sammendrag.

I våre søk etter forskningslitteratur har vi kun benyttet oss av databaser. Vi har ikke søkt i referanselister, kontaktet fageksperter eller søkt etter upublisert forskningslitteratur. Dermed kan vi ha gått glipp av potensielt relevante systematiske oversikter. Vi har ikke gjort noen kvalitetsvurdering av de inkluderte oversiktene.

I en fullverdig systematisk oversikt ville vi ha innhentet fulltekst, sammenstilt, analysert og diskutert resultatene og angitt hvor stor tillit vi har til resultatene basert på kritisk vurdering av dokumentasjonen.

Problemstilling

Hva finnes av oppsummert forskning om effekt av medikamentfrie tiltak til personer med alvorlige psykiske lidelser?

Metode

Søk etter forskningslitteratur

Vi søkte systematisk etter forskningslitteratur i følgende databaser:

- MEDLINE
- PsycINFO
- CDSR
- Cochrane Library
- HTA
- DARE
- Epistemonikos

Forskningsbibliotekar Marit Johansen planla og utførte samtlige søk. Søk etter studier ble avsluttet 7. desember 2015.

Vi søkte etter oppsummert forskning som oppfylte våre inklusjonskriterier med tanke på publikasjonstype, populasjon, tiltak og utfall. Enkelte presiseringer i inklusjonskriteriene ble gjort underveis i samråd med bestiller. Det ble brukt metodefilter for systematiske oversikter i søket etter den type publikasjoner. Vi la ikke inn noen språkbegrensning i søkene. Den fullstendige søkestrategien ligger i vedlegg 1.

Inklusjonskriterier

Populasjon:	Voksne med alvorlig psykisk lidelse
Tiltak:	Medikamentfrie tiltak som kan tilbys i psykiatriske sykehusavdelinger
Sammenlikning:	Vanlig oppfølging, ingen behandling, medikamentell behandling, andre typer tiltak
Utfall:	Viktige utfall er overlevelse, psykisk og fysisk helse, behov for reinnleggelser, personenes opplevelse av autonomi / selvbestemmelse, livskvalitet, bosituasjon og yrkesaktivitet
Studiedesign	Systematiske oversikter som omhandler effekt av tiltak
Språk:	Ingen begrensing i søket.

Eksklusjonskriterier

Populasjon:	Barn og ungdom samt personer med mildere psykisk lidelse eller problemer (f.eks. inkluderte vi kun oversikter som gjaldt behandling for depresjon dersom det var spesifisert at også personer med alvorlig depresjon er inkludert)
Tiltak:	Elektrokonvulsiv behandling (ECT), transkranial stimulering, kombinasjoner av medikamentfrie og medikamentelle tiltak, tiltak som vanligvis tilbys utenfor spesialisthelsetjenesten (som arbeidstiltak og tiltak myntet på kommunehelsetjenetsten), tiltak spesifikt rettet mot personer med flere psykiske lidelser (komorbiditet), tiltak rettet spesfikt mot personer med psykisk lidelse i direkte tilknytning til somatiske tilstander (f.eks. fødselsdepresjon)
Studiedesign	Oversikter over kvalitative studier eller andre ikke-randomiserte studier
År	Oversikter med publikasjonsdato før 2010

Utvelgelse av forskningslitteratur

Én forsker (MSF) grovsilet alle titler fra litteratursøket for å fjerne referanser som åpenbart ikke handlet om psykisk helse eller medikamentfrie tiltak. To av oss (MSF og AF) gikk deretter gjennom titler og sammendrag i gjenværende referanser for å vurdere mulig relevans. Deretter ble disse vurdert i henhold til inklusjonskriteriene i en ny runde. Vi gjorde vurderingene uavhengig av hverandre, og sammenlignet i etterkant. Der vi var uenige om vurderingene, kom vi til enighet gjennom diskusjon.

Fra sammendraget til de inkluderte oversiktene innhentet vi informasjon om populasjon, tiltak, utfall, og oversiktsforfatternes egne konklusjoner. Vi presenterer disse i tabellform.

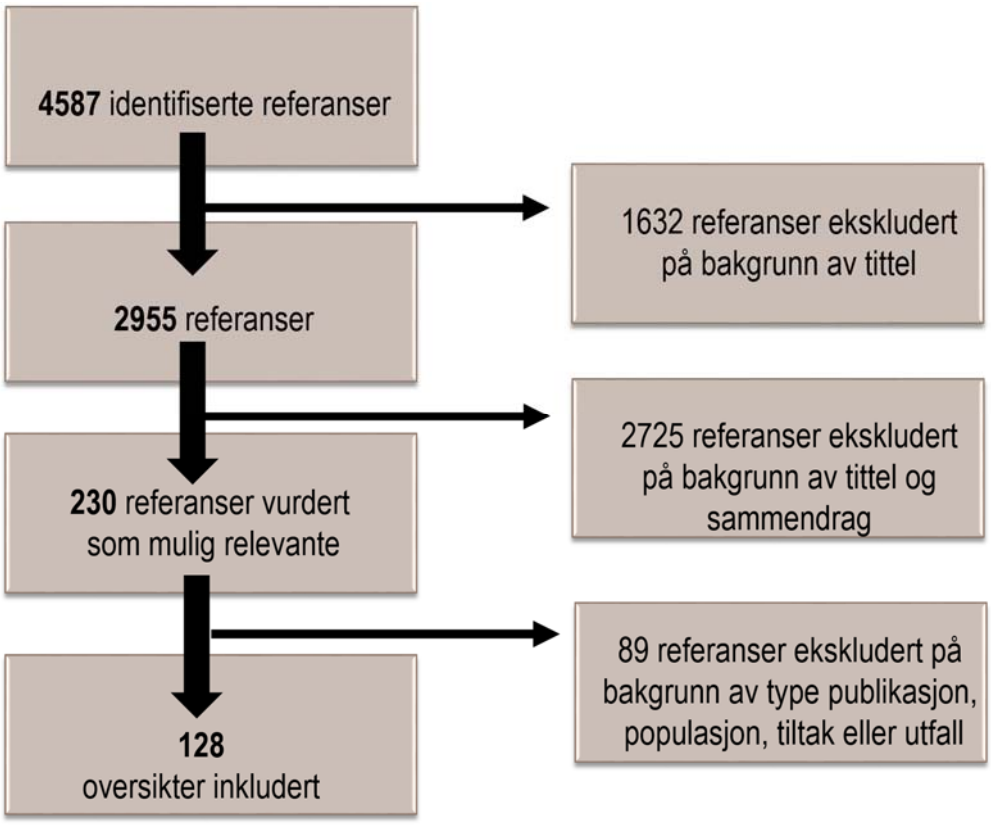
Resultat

Resultat av litteratursøk

Søk etter systematiske oversikter

Søket etter systematiske oversikter resulterte i 4587 referanser. Etter første grovsiling ble antall referanser redusert til 2955, som igjen ble redusert til 231 mulig relevante etter gjennomgang av sammendraget til disse. Av de 230 mulig relevante, inkluderte vi 128.

Vi ekskluderte oversikter der publikasjonstype, populasjon, tiltak eller utfall ikke var i tråd med inklusjonskriteriene (se vedlegg 2). Vi ekskluderte også oversikter hvis vi mente populasjonen, tiltaket eller utfallet er uspesifikt eller for avgrenset i forhold til vår problemstilling.



Figur 1. Flytskjema over identifisert forskningslitteratur

Resultat av sortering

De 128 inkluderte oversiktene (1-128) er presentert i tabell 1 og sortert etter navn på førsteforfatter(e).

Tabell 1. De inkluderte oversiktene (n=128)

Forfatter, årstall	Tittel
Abbass 2011 et al. (1)	The efficacy of short-term psychodynamic psychotherapy for depressive disorders with comorbid personality disorder
Acar og Buldukoğlu 2014 (2)	Effect of Psychoeducation on Relapses in Bipolar Disorder: A Systematic Review
Addington 2013 et al. (3)	Essential evidence-based components of first-episode psychosis services
Aderka et al. 2012 (4)	Sudden gains during psychological treatments of anxiety and depression: A meta-analysis
Agarwal et al. 2011 (5)	Ayurvedic medicine for schizophrenia
Alexandratos et al. 2012 (6)	The impact of exercise on the mental health and quality of life of people with severe mental illness: A critical review
Alvarez-Jimenez et al. 2011 (7)	Preventing the second episode: A systematic review and meta-analysis of psychosocial and pharmacological trials in first-episode psychosis
Anaya et al. 2012 (8)	A systematic review of cognitive remediation for schizo-affective and affective disorders
Andrews et al. 2010 (9)	Computer therapy for the anxiety and depressive disorders is effective, acceptable and practical health care: a meta-analysis
Anestis et al. 2014 (10)	Equine-related treatments for mental disorders lack empirical support: A systematic review of empirical investigations
Annamalai et al. 2014 (11)	Effectiveness of interventions to reduce physical restraint in psychiatric settings: A systematic review
Appleton et al. 2015 (12)	Omega-3 fatty acids for depression in adults
Balasubramaniam et al. 2012 (13)	Yoga on our minds: a systematic review of yoga for neuropsychiatric disorders
Batista et al. 2011 (14)	Efficacy of psychoeducation in bipolar patients: systematic review of randomized trials
Berk et al. 2013 (15)	Lifestyle management of unipolar depression
Bernard og Ninot 2012 (16)	Benefits of exercise for people with schizophrenia: A systematic review
Biesheuvel-Leliefeld et al. 2015 (17)	Effectiveness of psychological interventions in preventing recurrence of depressive disorder: Meta-analysis and meta-regression
Bond og Anderson 2015 (18)	Psychoeducation for relapse prevention in bipolar disorder: A systematic review of efficacy in randomized controlled trials
Boudreau et al. 2010 (19)	Self-directed cognitive behavioural therapy for adults with diagnosis of depression: systematic review of clinical effectiveness, cost-effectiveness, and guidelines
Broderick et al. 2015 (20)	Yoga versus standard care for schizophrenia
Buckley et al. 2015 (21)	Supportive therapy for schizophrenia
Carpenter 2011 (22)	St. John's wort and S-adenosyl methionine as "natural" alternatives to conventional antidepressants in the era of the suicidality boxed warning: what is the evidence for clinically relevant benefit?
Chiesa og Serretti 2011 (23)	Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis
Cramer et al. 2013 (24)	Yoga for schizophrenia: a systematic review and meta-analysis
Crowe et al. 2015 (25)	Non-pharmacological strategies for treatment of inpatient depression
Cuijpers et al. 2011 (26)	Psychological treatment of depression in inpatients: A systematic review and meta-analysis
Cuijpers et al. 2011 (27)	Interpersonal psychotherapy for depression: A meta-analysis
Cuijpers et al. 2014 (28)	The effects of psychotherapies for major depression in adults on remission, recovery and improvement: a meta-analysis
Danielsson et al. 2013 (29)	Exercise in the treatment of major depression: a systematic review grading the quality of evidence
Davis og Kurzban 2012 (30)	Mindfulness-Based Treatment for People With Severe Mental Illness: A Literature Review
de Souza Moura et al. 2015 (31)	Comparison among aerobic exercise and other types of interventions to treat depression: a systematic review
Donker et al. 2013 (32)	Suicide prevention in schizophrenia spectrum disorders and psychosis: a systematic review
Draper et al. 2010 (33)	Cognitive behavioral therapy for schizophrenia: A review of recent literature and meta-analyses
Fiorillo et al. 2013 (34)	Efficacy of supportive family interventions in bipolar disorder: A review of the literature
Firth et al. 2015 (35)	A systematic review and meta-analysis of exercise interventions in schizophrenia patients
Fovet et al. 2015 (36)	Current Issues in the Use of fMRI-Based Neurofeedback to Relieve Psychiatric Symptoms
Freeman et al. 2010 (37)	Complementary and alternative medicine in major depressive disorder: The American Psychiatric Association Task Force report

Freeman et al. 2010 (38)	Complementary and alternative medicine in major depressive disorder: A meta-analysis of patient characteristics, placebo-response rates and treatment outcomes relative to standard antidepressants
Fuhr et al. 2014 (39)	Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: a systematic review and meta-analysis
Galante et al. 2013 (40)	Effects of mindfulness-based cognitive therapy on mental disorders: A systematic review and meta-analysis of randomised controlled trials
Geoffroy et al. 2015 (41)	Bright light therapy in seasonal bipolar depressions
Gorczynski og Faulkner 2010 (42)	Exercise therapy for schizophrenia
Gromer 2012 (43)	Need-adapted and open-dialogue treatments: Empirically supported psychosocial interventions for schizophrenia and other psychotic disorders
Grosso et al. 2014 (44)	Role of omega-3 fatty acids in the treatment of depressive disorders: a comprehensive meta-analysis of randomized clinical trials
Hausenblas et al. 2015 (45)	A systematic review of randomized controlled trials examining the effectiveness of saffron (Crocus sativus L.) on psychological and behavioral outcomes
Hausenblas et al. 2013 (46)	Saffron (Crocus sativus L.) and major depressive disorder: a meta-analysis of randomized clinical trials
Helgason og Sarris 2013 (47)	Mind-body medicine for schizophrenia and psychotic disorders: a review of the evidence
Hidalgo-Mazzei et al. 2015 (48)	Internet-based psychological interventions for bipolar disorder: Review of the present and insights into the future
Holley et al. 2011 (49)	The effects of physical activity on psychological well-being for those with schizophrenia: A systematic review
Hollon og Ponniah 2010 (50)	A review of empirically supported psychological therapies for mood disorders in adults
Hunsley et al. 2014 (51)	The efficacy and effectiveness of psychological treatments for mood, anxiety, and related disorders
Hutton og Taylor 2014 (52)	Cognitive behavioural therapy for psychosis prevention: a systematic review and meta-analysis
Iancu et al. 2014 (53)	Farm-based interventions for people with mental disorders: a systematic review of literature
Jain et al. 2014 (54)	Critical Analysis of the Efficacy of Meditation Therapies for Acute and Subacute Phase Treatment of Depressive Disorders: A Systematic Review
Jakobsen 2014 (55)	Systematic reviews of randomised clinical trials examining the effects of psychotherapeutic interventions versus "no intervention" for acute major depressive disorder and a randomised trial examining the effects of "third wave" cognitive therapy versus mentalization-based treatment for acute major depressive disorder
Jakobsen et al. 2011 (56)	The effect of interpersonal psychotherapy and other psychodynamic therapies versus 'treatment as usual' in patients with major depressive disorder
Jakobsen et al. 2012 (57)	Effects of cognitive therapy versus interpersonal psychotherapy in patients with major depressive disorder: a systematic review of randomized clinical trials with meta-analyses and trial sequential analyses
Jakobsen et al. 2011 (58)	The effects of cognitive therapy versus 'no intervention' for major depressive disorder
Jakobsen et al. 2011 (59)	The effects of cognitive therapy versus 'treatment as usual' in patients with major depressive disorder
Jauhar et al. 2014 (60)	Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias
Jiang et al. 2015 (61)	Metacognitive training for schizophrenia: a systematic review
Jones et al. 2012 (62)	Cognitive behavior therapy versus other psychosocial treatments for schizophrenia
Juanjuan og Jun 2013 (63)	Dance therapy for schizophrenia
Jun et al. 2014 (64)	Herbal medicine (Gan Mai Da Zao decoction) for depression: A systematic review and meta-analysis of randomized controlled trials
Kamioka et al. 2014 (65)	Effectiveness of animal-assisted therapy: A systematic review of randomized controlled trials
Karyotaki et al. 2014 (66)	The long-term efficacy of psychotherapy, alone or in combination with antidepressants, in the treatment of adult major depression
Kelly et al. 2014 (67)	A systematic review of self-management health care models for individuals with serious mental illnesses
Khoury et al. 2013 (68)	Mindfulness interventions for psychosis: A meta-analysis
Kluwe-Schiavon et al. 2013 (69)	Executive functions rehabilitation for schizophrenia: A critical systematic review
Knapen et al. 2015 (70)	Exercise therapy improves both mental and physical health in patients with major depression
Kurtz og Richardson 2012 (71)	Social cognitive training for schizophrenia: a meta-analytic investigation of controlled research
Lampe et al. 2013 (72)	Psychological management of unipolar depression
Leichsenring et al. 2015 (73)	The empirical status of psychodynamic psychotherapy-An update: Bambi's alive and kicking
Leiphart og Valone 2010 (74)	Stereotactic lesions for the treatment of psychiatric disorders
Liebherz og Rabung 2014 (75)	Do patients' symptoms and interpersonal problems improve in psychotherapeutic hospital treatment in Germany? A systematic review and meta-analysis
Lipsman et al. 2010 (76)	Neurosurgical treatment of bipolar depression: Defining treatment resistance and identifying surgical targets
Liu et al. 2014 (77)	Horticultural therapy for schizophrenia

Lloyd-Evans et al. 2014 (78)	A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness
Lolich et al. 2012 (79)	Psychosocial interventions in bipolar disorder: a review
Lynch et al. 2010 (80)	Cognitive behavioural therapy for major psychiatric disorder: Does it really work? A meta-analytical review of well-controlled trials
McGuire et al. 2014 (81)	Illness management and recovery: a review of the literature
Meis et al. 2013 (82)	Couple and family involvement in adult mental health treatment: A systematic review
Miziou et al. 2015 (83)	Psychosocial treatment and interventions for bipolar disorder: a systematic review
Moriana et al. 2015 (84)	Social skills training for schizophrenia
Mossler et al. 2011 (85)	Music therapy for people with schizophrenia and schizophrenia-like disorders
Mould et al. 2010 (86)	The use of metaphor for understanding and managing psychotic experiences: A systematic review
Naeem et al. 2015 (87)	Cognitive behavioural therapy (brief versus standard duration) for schizophrenia
Newton-Howes og Wood 2013 (88)	Cognitive behavioural therapy and the psychopathology of schizophrenia: Systematic review and meta-analysis
Nystrom et al. 2015 (89)	Treating major depression with physical activity: A systematic overview with recommendations
Okpokoro et al. 2014 (90)	Family intervention (brief) for schizophrenia
Orfanos et al. 2015 (91)	Are group psychotherapeutic treatments effective for patients with schizophrenia? A systematic review and meta-analysis
Pearsall et al. 2014 (92)	Exercise therapy in adults with serious mental illness: a systematic review and meta-analysis
Pharoah et al. 2010 (93)	Family intervention for schizophrenia
Piet og Hougaard 2011 (94)	The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis
Pinquart et al. 2014 (95)	Efficacy of systemic therapy on adults with mental disorders: A meta-analysis
Qureshi og Al-Bedah 2013 (96)	Mood disorders and complementary and alternative medicine: A literature review
Rakofsky og Dunlop 2014 (97)	Review of nutritional supplements for the treatment of bipolar depression
Rector og Beck 2012 (98)	Cognitive behavioral therapy for schizophrenia: An empirical review
Riedel-Heller et al. 2012 (99)	Psychosocial interventions in severe mental illness. Evidence and recommendations: Psychoeducation, social skill training and exercise
Roder et al. 2011 (100)	Effectiveness of integrated psychological therapy (IPT) for schizophrenia patients: a research update
Rodriguez et al. 2014 (101)	Group psychoeducation in bipolar treatment: A systematic review of the literature
Rosenbaum et al. 2014 (102)	Physical activity interventions for people with mental illness: A systematic review and meta-analysis
Sarin et al. 2011 (103)	Cognitive behavior therapy for schizophrenia: a meta-analytical review of randomized controlled trials
Sarris et al. 2011 (104)	Bipolar disorder and complementary medicine: Current evidence, safety issues, and clinical considerations
Schottle et al. 2011 (105)	Psychotherapy for bipolar disorder: A review of the most recent studies
Segredou et al. 2012 (106)	Group psychosocial interventions for adults with schizophrenia and bipolar illness: The evidence base in the light of publications between 1986 and 2006
Sevi og Sutcu 2012 (107)	Cognitive-behavioral group treatment for schizophrenia and other psychotic disorders-A systematic review
Shen et al. 2014 (108)	Acupuncture for schizophrenia
Siantz og Aranda 2014 (109)	Chronic disease self-management interventions for adults with serious mental illness: a systematic review of the literature
Sikorski et al. 2011 (110)	Computer-aided cognitive behavioral therapy for depression: A systematic review of the literature
Silveira et al. 2013 (111)	Physical exercise and clinically depressed patients: A systematic review and meta-analysis
Soundy et al. 2015 (112)	Investigating the benefits of sport participation for individuals with schizophrenia: A systematic review
Stanton og Happell 2014 (113)	A systematic review of the aerobic exercise program variables for people with schizophrenia
Stanton og Happell 2014 (114)	Exercise for mental illness: A systematic review of inpatient studies
Stratford et al. 2014 (115)	Psychological therapy for anxiety in bipolar spectrum disorders: A systematic review
Sylvia og Peters 2012 (116)	Nutrient-based therapies for bipolar disorder: A systematic review
Tonelli et al. 2013 (117)	Metacognitive programs focusing social cognition for the rehabilitation of schizophrenia: A systematic review
Turner et al. 2014 (118)	Psychological interventions for psychosis: a meta-analysis of comparative outcome studies
van der Krieke et al. 2014 (119)	E-mental health self-management for psychotic disorders: State of the art and future perspectives
van Hasselt et al. 2013 (120)	Evaluating interventions to improve somatic health in severe mental illness: A systematic review
van Hees et al. 2013 (121)	The effectiveness of individual interpersonal psychotherapy as a treatment for major depressive disorder in adult outpatients: a systematic review
Vancampfort et al. 2010 (122)	The therapeutic value of physical exercise for people with schizophrenia

Vancampfort et al. 2011 (123)	Body-directed techniques on psychomotor therapy for people with schizophrenia: A review of the literature
Velthorst et al. 2014 (124)	Adapted cognitive-behavioural therapy required for targeting negative symptoms in schizophrenia: meta-analysis and meta-regression
Wu et al. 2012 (125)	Acupuncture for depression: A review of clinical applications
Abbass 2011 et al. (1)	A meta-analysis of cognitive remediation for schizophrenia: Methodology and effect sizes
Acar og Buldukoğlu 2014 (2)	Psychoeducation for schizophrenia
Addington 2013 et al. (3)	Shuganjieyu capsule for major depressive disorder (MDD) in adults: A systematic review

Fra sammendraget til hver inkluderte oversikt innhentet vi informasjon om (vedlegg 3):

- populasjon
- tiltak og sammenlikning
- utfall
- oversiktsforfatternes egne konklusjoner

Populasjon

De forskjellige oversiktene omhandler mennesker med ulike typer alvorlige psykiske lidelser og symptomer (se vedlegg 4 for mer detaljert oversikt):

- 41 oversikter handler om personer med schizofreni eller schizoaffektiv lidelse (5, 8, 16, 20, 21, 24, 32, 33, 35, 42, 47, 49, 60-63, 68, 69, 71, 77, 84, 85, 87, 88, 90, 91, 93, 98, 100, 103, 106-108, 112, 113, 117, 122-124, 126, 127)
- 32 oversikter handler om personer med depresjon (avgrenset til oversikter som oppgir at personer med alvorlig depresjon er inkludert jf. inklusjonskriterene) (12, 15, 17, 19, 22, 25-29, 31, 37, 38, 44, 46, 54-59, 64, 66, 70, 72, 89, 94, 110, 111, 121, 125, 128)
- 24 oversikter har en bred populasjonen (personene har en alvorlig psykisk lidelse uten videre spesifisering) (6, 10, 13, 23, 30, 36, 39, 40, 53, 65, 67, 73-75, 78, 80-82, 92, 95, 99, 102, 109, 120)
- 14 oversikter handler om personer med bipolar lidelse (2, 14, 18, 34, 41, 48, 76, 79, 83, 97, 101, 104, 105, 115)
- 10 oversikter handler om personer med ulike psykiske lidelser (f.eks. at personene som deltok i studiene hadde enten schizofreni, depresjon eller angst) (1, 4, 9, 11, 45, 50, 51, 96, 114, 116)
- sju oversikter beskriver populasjonen ut ifra symptomer –disses dreier seg om personer som har, eller står i fare for å utvikle psykoser (3, 7, 43, 52, 86, 118, 119)

Tiltak

De forskjellige oversiktene undersøker effekt av ulike medikamentfrie tiltak (se vedlegg 5 for mer detaljert oversikt):

- 59 oversikter ser på effekten av ulike psykologiske tiltak (1, 2, 4, 8, 9, 14, 17-19, 21, 23, 26-28, 30, 32, 33, 40, 43, 48, 50-52, 55-62, 66, 71-73, 75, 79-81, 86-88, 91, 98-101, 103, 105-107, 110, 115, 117, 118, 121, 124, 126, 127)
- 22 oversikter undersøker effekten av trenings- eller livsstilstiltak (6, 13, 15, 16, 20, 24, 29, 31, 35, 42, 49, 63, 70, 89, 92, 102, 111-114, 122, 123)

- ni oversikter ser på effekten av kosttilskudd eller naturpreparater (12, 22, 37, 38, 44-46, 64, 97, 116, 128)
- fem oversikter undersøker effekten av komplementær alternativ medisin uten nærmere spesifisering (5, 96, 104)
- fire oversikter ser på effekten av familietiltak (34, 82, 90, 93)
- fire oversikter undersøker effekten av kropp-sinn-terapi (47, 54, 68, 94)
- fire oversikter ser på effekten av opplæring eller undervisning (67, 109, 119, 120)
- tre oversikter undersøker effekten av bruk av dyr i terapi (10, 53, 65)
- tre oversikter ser på effekten av medikamentfrie tiltak uten nærmere spesifisering (7, 11, 25)
- to oversikter undersøker effekten av akupunktur (108, 125)
- to oversikter ser på effekten av kirurgisk behandling (74, 76)
- to oversikter undersøker effekten av bruk av likepersoner (39, 78)
- to oversikter ser på effekten av sosiale eller psykososiale tiltak (83, 84)
- to oversikter undersøker effekten av tiltak som ikke er beskrevet, de er kalt henholdsvis «first-episode psychosis service» og «systemic therapy» (3, 95)
- én oversikt hver ser på effekten av hagedyrking (hortikultur), lysterapi (41), musikkterapi (85), nevrofeedback (36), rehabiliteringstiltak (69)

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Vedlegg

Vedlegg 1. Søkestrategier og logg

Søkestrategier

Epistemonikos

1.
("severe mentally" OR "severely mentally" OR "serious mentally" OR "seriously mentally" OR "severe mental" OR "severely mental" OR "serious mental" OR "seriously mental" OR "major mental" OR psychiatric OR psychotic OR bipolar OR "bi polar" OR depressive OR paranoid OR schizophren*)
AND
("non pharmaceutical" OR "non pharmacological" OR nonpharm* OR "non drug" OR nondrug OR "non biological" OR nonbiological OR "non medicine" OR "non medication") (111 SR)
2.
("severe mentally" OR "severely mentally" OR "serious mentally" OR "seriously mentally" OR "severe mental" OR "severely mental" OR "serious mental" OR "seriously mental" OR "major mental" OR psychiatric OR psychotic OR bipolar OR "bi polar" OR depressive OR paranoid OR schizophren*)
AND
(psychotherapy OR "psycho therapy" OR psychoanalysis OR "psycho analysis" OR psychoanalyses OR "psycho analyses" OR psychosocial OR "psycho social" OR "cognitive therapy" OR "behavioral therapy" OR "behavioural therapy" OR psychosurgery OR "psycho surgery" OR psychoeducation OR "psycho education" OR "occupational therapy" OR "alternative therapy" OR "alternative therapies" OR "complementary therapy" OR "complementary therapies" OR mindfulness OR "light therapy" OR "music therapy" OR "diet therapy" OR "exercise therapy" OR "animal therapy" OR "family therapy")

CDSR, Cochrane Library

#	Searches	Results
#1	(sever* or serious*) next "mentally ill":ti,ab,kw	93
#2	(sever* next mental or serious* next mental or psychiatric or psychotic or bipolar or "bi polar" or depressive or paranoid or schizophren* or schizoid or schizotypal) next (disorder* or illness):ti,ab,kw	16154
#3	#1 or #2	16198
#4	(psychotherap* or psycho next therap*):ti,ab,kw	7796
#5	(psychiatric or psycho*) next (therap* or treatment or intervention*):ti,ab,kw	9112
#6	cognitive next (therap* or treatment or intervention*):ti,ab,kw	8272
#7	(behavioral or behavioural) next (therap* or treatment or intervention*):ti,ab,kw	7336
#8	(psychosurgery or "psycho surgery"):ti,ab,kw	20
#9	(electroconvulsive or "electro convulsive" or electroshock or "electro shock" or "electric stimulation" or electroacupuncture or "electro acupuncture" or "transcranial magnetic stimulation" or "vagus nerve stimulation" or "magnetic seizure") next (therap* or treatment or intervention*):ti,ab,kw	2984
#10	(neurofeedback or "neuro feedback"):ti,ab,kw	201
#11	(psychoeducation* or psycho next education*):ti,ab,kw	1492
#12	(light next therap* or phototherap* or photo next therap* or "sleep deprivation"):ti,ab,kw	2682
#13	(diet* or nutrit*) next therap*:ti,ab,kw	2962
#14	(diet* next supplementation or "fatty acid supplementation" or elimination next diet* or artificial next food next color* next exclusion or artificial next food next colour* next exclusion):ti,ab,kw	4029
#15	(exercise next therap* or physical next activ*):ti,ab,kw	15863
#16	(alternative next therap* or complementary next therap* or "traditional medicine" or "folk medicine" or "faith healing" or faith next therap* or spiritual next therap* or art* next therap* or color next therap* or colour next therap* or music next therap* or play next therap* or dance next therap* or laughter next therap* or role next play* next therap* or drama next therap* or psychodrama next therap* or mentalisation or mentalization or meditation or mindfulness or hypnotherap* or hypno next therap* or hypnosis or hypnoses or relaxation next therap* or aromatherap* or aroma next therap* or phytotherap* or phyto next therap* or homeopathy or john* next wort or occupational next therap* or work next therap* or	13886

	animal next therap* or pet next therap* or hippotherap* or hippo next therap* or psychiatric next dog* or "tai ji" or yoga or breathing next exercise next therap* or bibliotherap* or biblio next therap* or poetry next therap*):ti,ab,kw	
#17	(family next therap* or "social support" or self next help next group* or counseling or counselling):ti,ab,kw	14279
#18	(non next pharm* or nonpharm* or non next psychopharm* or nonpsychopharm* or non next drug or nondrug or non next medication or non next medicine* or non next biological or nonbiological) near/3 (intervention* or treatment* or therap* or management or method*):ti,ab,kw	2013
#19	#4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18	71660
#20	#3 and #19 in Cochrane Reviews (Reviews only)	237

HTA and DARE, Cochrane Library

#	Searches	Results
#1	(sever* or serious*) next "mentally ill"	125
#2	(sever* next mental or serious* next mental or psychiatric or psychotic or bipolar or "bi polar" or depressive or paranoid or schizophren* or schizoid or schizotypal) next (disorder* or illness)	17206
#3	#1 or #2	17250
#4	(psychotherap* or psycho next therap*)	10253
#5	(psychiatric or psycho*) next (therap* or treatment or intervention*)	13786
#6	cognitive next (therap* or treatment or intervention*)	8739
#7	(behavioral or behavioural) next (therap* or treatment or intervention*)	8038
#8	(psychosurgery or "psycho surgery")	26
#9	(electroconvulsive or "electro convulsive" or electroshock or "electro shock" or "electric stimulation" or electroacupuncture or "electro acupuncture" or "transcranial magnetic stimulation" or "vagus nerve stimulation" or "magnetic seizure") next (therap* or treatment or intervention*)	3112
#10	(neurofeedback or "neuro feedback")	212
#11	(psychoeducation* or psycho next education*)	1908
#12	(light next therap* or phototherap* or photo next therap* or "sleep deprivation")	2936
#13	(diet* or nutrit*) next therap*	7898
#14	(diet* next supplementation or "fatty acid supplementation" or elimination next diet* or artificial next food next color* next exclusion or artificial next food next colour* next exclusion)	4137
#15	(exercise next therap* or physical next activ*)	17461
#16	(alternative next therap* or complementary next therap* or "traditional medicine" or "folk medicine" or "faith healing" or faith next therap* or spiritual next therap* or art* next therap* or color next therap* or colour next therap* or music next therap* or play next therap* or dance next therap* or laughter next therap* or role next play* next therap* or drama next therap* or psychodrama next therap* or mentalisation or mentalization or meditation or mindfulness or hypnotherap* or hypno next therap* or hypnosis or hypnoses or relaxation next therap* or aromatherap* or aroma next therap* or phytotherap* or phyto next therap* or homeopathy or john* next wort or occupational next therap* or work next therap* or animal next therap* or pet next therap* or hippotherap* or hippo next therap* or psychiatric next dog* or "tai ji" or yoga or breathing next exercise next therap* or bibliotherap* or biblio next therap* or poetry next therap*)	17882
#17	(family next therap* or "social support" or self next help next group* or counseling or counselling)	17469
#18	(non next pharm* or nonpharm* or non next psychopharm* or nonpsychopharm* or non next drug or nondrug or non next medication or non next medicine* or non next biological or nonbiological) near/3 (intervention* or treatment* or therap* or management or method*)	2340
#19	#4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18	85869
#20	#3 and #19 in Technology Assessments	68
#21	#3 and #19 in Other Reviews	512

PsycINFO 1806 to December Week 1 2015, Ovid

#	Searches	Results
1	Mental Disorders/	70816
2	exp Psychosis/	98515
3	exp Schizophrenia/	77344
4	Affective Disorders/	12213
5	Major Depression/	97279
6	Bipolar Disorder/	21680
7	Mania/	4915
8	Psychiatric Patients/	27625
9	((sever* or serious*) adj mentally ill).ti,ab.	1298
10	((sever* mental or serious* mental or psychiatric or psychotic or bipolar or bi polar or depressive or paranoid or schizophren* or schizoid or schizotypal) adj (disorder? or illness)).ti,ab.	86603
11	or/1-10	318512
12	exp Psychotherapy/	188759
13	exp Psychotherapeutic Techniques/	27794
14	Psychosurgery/	743
15	Shock Therapy/ or Electroconvulsive Shock Therapy/	5661
16	Neurotherapy/	1027
17	Cognitive Therapy/	12183
18	Alternative Medicine/ or Acupuncture/ or Aromatherapy/ or Faith Healing/ or Folk Medicine/ or Phototherapy/ or Mind Body Therapy/ or Mindfulness/ or Meditation/ or Relaxation Therapy/ or Bibliotherapy/ or "Medicinal Herbs and Plants"/ or Dietary Supplements/ or Occupational Therapy/ or exp Physical Activity/ or Creative Arts Therapy/ or Art Therapy/ or Dance Therapy/ or Music Therapy/ or Bibliotherapy/ or Poetry Therapy/ or Educational Therapy/ or Psychoeducation/	65989

19	(psychotherap* or psycho therap*).ti,ab.	94171
20	((psychiatric or psycho*) adj (therap* or treatment or intervention?)).ti,ab.	34171
21	(cognitive adj (therap* or treatment or intervention?)).ti,ab.	6764
22	((behavioral or behavioural) adj (therap* or treatment or intervention?)).ti,ab.	25288
23	(psychosurgery or psycho surgery).ti,ab.	555
24	((electroconvulsive or electro convulsive or electroshock or electro shock or electric stimulation or electroacupuncture or electro acupuncture or transcranial magnetic stimulation or vagus nerve stimulation or magnetic seizure) adj (therap* or treatment or intervention?)).ti,ab.	5089
25	(neurofeedback or neuro feedback).ti,ab.	935
26	(psychoeducation* or psycho education*).ti,ab.	8287
27	(light therap* or phototherap* or photo therap* or sleep deprivation).ti,ab.	4614
28	((diet* or nutrit*) adj therap*).ti,ab.	276
29	(diet* supplementation or fatty acid supplementation or elimination diet? or artificial food color* exclusion or artificial food colour* exclusion).ti,ab.	368
30	(exercise therap* or physical activ*).ti,ab.	22964
31	(alternative therap* or complementary therap* or traditional medicine or folk medicine or faith healing or faith therap* or spiritual therap* or art? therap* or color therap* or colour therap* or music therap* or play therap* or dance therap* or laughter therap* or role play* therap* or drama therap* or psychodrama therap* or mentalisation or mentalization or meditation or mindfulness or hypnotherap* or hypno therap* or hypnosis or hypnoses or relaxation therap* or aroma-therap* or aroma therap* or phytotherap* or phyto therap* or homeopathy or (john* adj wort) or occupational therap* or work therap* or animal therap* or pet therap* or hippotherap* or hippo therap* or psychiatric dog? or tai ji or yoga or breathing exercise therap* or bibliotherap* or biblio therap* or poetry therap*).ti,ab.	45983
32	(family therap* or social support or self help group? or counseling or counselling).ti,ab.	118586
33	((non pharm* or nonpharm* or non psychopharm* or nonpsychopharm* or non drug or nondrug or non medication or non medicine? or non biological or nonbiological) adj3 (intervention* or treatment* or therap* or management or method?)).ti,ab.	2865
34	or/12-33	446388
35	11 and 34	53095
36	limit 35 to "reviews (maximizes specificity)"	1771
37	Systematic Review.md.	12996
38	Meta Analysis.md.	13947
39	systematic review.ti.	8688
40	37 or 38 or 39	26106
41	35 and 40	980
42	36 or 41	2032

MEDLINE In-Process & Other Non-Indexed Citations, MEDLINE Daily, MEDLINE and OLDMEDLINE 1946 to Present, Ovid

#	Searches	Re-sults
1	Mental Disorders/	129602
2	Affective Disorders, Psychotic/	2173
3	Bipolar Disorders/	34171
4	Depressive Disorders/	61627
5	Depressive Disorders, Major/	22197
6	Paranoid Disorders/	3861
7	Psychotic Disorders/	34504
8	Schizophrenia/	87773
9	Schizophrenia, Catatonic/	549
10	Schizophrenia, Disorganized/	523
11	Schizophrenia, Paranoid/	3813
12	Shared Paranoid Disorder/	290
13	((sever* or serious*) adj mentally ill).ti,ab.	812
14	((sever* mental or serious* mental or psychiatric or psychotic or bipolar or bi polar or depressive or paranoid or schizo-phren* or schizoid or schizotypal) adj (disorder? or illness)).ti,ab.	88405
15	or/1-14	363661
16	exp Psychotherapy/	160024
17	Psychosurgery/	3534
18	electric stimulation therapy/ or electroacupuncture/ or vagus nerve stimulation/ or transcranial magnetic stimulation/ or electroshock/ or electroconvulsive therapy/	50906
19	"activities of daily living"/ or animal assisted therapy/ or equine-assisted therapy/ or art therapy/ or bibliotherapy/ or exer-cise therapy/ or occupational therapy/	93158
20	nutrition therapy/ or diet therapy/	10919
21	phototherapy/ or heliotherapy/	6590
22	complementary therapies/ or exp medicine, traditional/ or acupuncture therapy/ or mind-body therapies/ or neurofeed-back/ or breathing exercises/ or hypnosis/ or "imagery (psychotherapy)"/ or laughter therapy/ or meditation/ or psychodrama/ or role playing/ or relaxation therapy/ or tai ji/ or yoga/ or phytotherapy/ or sensory art therapies/ or acoustic stimulation/ or aromatherapy/ or art therapy/ or color therapy/ or dance therapy/ or music therapy/ or play ther-apy/ or spiritual therapies/ or faith healing/ or homeopathy/	154332
23	counceling/ or social support/ or self-help groups/ or "patient education as topic"/	133580
24	(psychotherap* or psycho therap*).ti,ab.	34524
25	((psychiatric or psycho*) adj (therap* or treatment or intervention?)).ti,ab.	21242
26	(cognitive adj (therap* or treatment or intervention?)).ti,ab.	2980

27	((behavioral or behavioural) adj (therap* or treatment or intervention?)).ti,ab.	18047
28	(psychosurgery or psycho surgery).ti,ab.	761
29	((electroconvulsive or electro convulsive or electroshock or electro shock or electric stimulation or electroacupuncture or electro acupuncture or transcranial magnetic stimulation or vagus nerve stimulation or magnetic seizure) adj (therap* or treatment or intervention?)).ti,ab.	7129
30	(neurofeedback or neuro feedback).ti,ab.	647
31	(psychoeducation* or psycho education*).ti,ab.	3928
32	(light therap* or phototherap* or photo therap* or sleep deprivation).ti,ab.	13857
33	((diet* or nutrit*) adj therap*).ti,ab.	6023
34	(diet* supplementation or fatty acid supplementation or elimination diet? or artificial food color* exclusion or artificial food colour* exclusion).ti,ab.	7085
35	(exercise therap* or physical activ*).ti,ab.	72720
36	(alternative therap* or complementary therap* or traditional medicine or folk medicine or faith healing or faith therap* or spiritual therap* or art? therap* or color therap* or colour therap* or music therap* or play therap* or dance therap* or laughter therap* or role play* therap* or drama therap* or psychodrama therap* or mentalisation or mentalization or meditation or mindfulness or hypnotherap* or hypno therap* or hypnosis or hypnoses or relaxation therap* or aroma-therap* or aroma therap* or phytotherap* or phyto therap* or homeopathy or (john* adj wort) or occupational therap* or work therap* or animal therap* or pet therap* or hippotherap* or hippo therap* or psychiatric dog? or tai ji or yoga or breathing exercise therap* or bibliotherap* or biblio therap* or poetry therap*).ti,ab.	55212
37	(family therap* or social support or self help group? or counseling or counselling).ti,ab.	96366
38	((non pharm* or nonpharm* or non psychopharm* or nonpsychopharm* or non drug or nondrug or non medication or non medicine? or non biological or nonbiological) adj3 (intervention* or treatment* or therap* or management or method?)).ti,ab.	9273
39	or/16-38	768171
40	15 and 39	63709
41	limit 40 to "reviews (maximizes specificity)"	1643
42	Mental Disorders/dh, su, th [Diet Therapy, Surgery, Therapy]	32085
43	Affective Disorders, Psychotic/su, th [Surgery, Therapy]	238
44	Bipolar Disorders/dh, su, th [Diet Therapy, Surgery, Therapy]	3386
45	Depressive Disorders/dh, su, th [Diet Therapy, Surgery, Therapy]	10441
46	Depressive Disorders, Major/dh, su, th [Diet Therapy, Surgery, Therapy]	4132
47	Paranoid Disorders/su, th [Surgery, Therapy]	320
48	Psychotic Disorders/dh, su, th [Diet Therapy, Surgery, Therapy]	5229
49	exp Schizophrenia/dh, su, th [Diet Therapy, Surgery, Therapy]	9934
50	or/42-49	60705
51	limit 50 to "reviews (maximizes specificity)"	1331
52	41 or 51	2058
53	52 use pmoz	2058
54	remove duplicates from 53	1960

Søkelogg

Databases	Date	Hits total	Hits to screen
MEDLINE In-Process & Other Non-Indexed Citations, MEDLINE Daily, MEDLINE and OLDMEDLINE 1946 to Present, Ovid	04.12.15	1960	**1378**
PsycINFO 1806 to December Week 1 2015, Ovid	04.12.15	2032	**2032**
CDSR Issue 12 2015, Cochrane Library	04.12.15	237	**173**
HTA Issue 4 2015, Cochrane Library	04.12.15	68	**68**
DARE Issue 2 2015, Cochrane Library	04.12.15	512	**241**
Epistemonikos	07.12.15	1107	**695**
EndNote:			**4587**

Vedlegg 2. Ekskluderte referanser

Referanser ekskludert (n=89)	
1.	**Anonym 2014,** *"Neuro-linguistic programming for the treatment of adults with post-traumatic stress disorder, general anxiety disorder, or depression: a review of clinical effectiveness and guidelines"*
	Eksklusjonsårsak: Ikke relevant populasjon
2.	**Barlati 2015,** *"Non-pharmacological interventions in early schizophrenia: Focus on cognitive remediation"*
	Eksklusjonsårsak: Ikke relevant populasjon
3.	**Berget 2011,** *"Animal-assisted therapy with farm animals for persons with psychiatric disorders"*
	Eksklusjonsårsak: Ikke relevant publikasjonstype
4.	**Borschmann 2012** *"Crisis interventions for people with borderline personality disorder"*
	Eksklusjonsårsak: Ikke relevant tiltak
5.	**Bouvet 2014,** *"[The Clubhouse model for people with severe mental illnesses: Literature review and French experiment.]"*
	Eksklusjonsårsak: Ikke relevant tiltak
6.	**Cabral 2011,** *"Effectiveness of yoga therapy as a complementary treatment for major psychiatric disorders: a meta-analysis"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
7.	**Carvalho 2014,** *"The integrative management of treatment-resistant depression: A comprehensive review and perspectives"*
	Eksklusjonsårsak: Ikke relevant populasjon og tiltak
8.	**Chen 2015,** *"Efficacy and safety of extract of Ginkgo biloba as an adjunct therapy in chronic schizophrenia: A systematic review of randomized, double-blind, placebo-controlled studies with meta-analysis"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
9.	**Cuijpers 2011,** *"Psychological treatment of depression: Results of a series of meta-analyses"*
	Eksklusjonsårsak: Ikke relevant populasjon
10.	**Cuijpers 2012,** *"The effects of psychotherapy for adult depression on suicidality and hopelessness: a systematic review and meta-analysis"*
	Eksklusjonsårsak: Ikke relevant populasjon
11.	**Cuijpers 2011,** *"Self-guided psychological treatment for depressive symptoms: a meta-analysis"*
	Eksklusjonsårsak: Ikke relevant populasjon
12.	**de Souza Tursi 2013,** *"Effectiveness of psychoeducation for depression: A systematic review"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
13.	**Eassom 2014,** *"Implementing family involvement in the treatment of patients with psychosis: a systematic review of facilitating and hindering factors"*
	Eksklusjonsårsak: Ikke relevant publikasjonstype
14.	**Fava 2010,** *"New modalities of assessment and treatment planning in depression: The sequential approach"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
15.	**Fusar-Poli 2015,** *"Treatments of negative symptoms in schizophrenia: Meta-analysis of 168 randomized placebo-controlled trials"*
	Eksklusjonsårsak: Ikke relevant tiltak (mange typer tiltak)
16.	**Gaynes 2011,** *"Nonpharmacologic interventions for treatment-resistant depression in adults"*
	Eksklusjonsårsak: Ikke relevant populasjon
17.	**Guidi 2011,** *"Efficacy of the sequential integration of psychotherapy and pharmacotherapy in major depressive disorder: a pre-liminary meta-analysis"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
18.	**Hans 2013** *"Effectiveness of and dropout from outpatient cognitive behavioral therapy for adult unipolar depression: A meta-analysis of nonrandomized effectiveness studies"*
	Eksklusjonsårsak: Ikke relevant publikasjonstype
19.	**Hetrick Sarah 2010,** *"Combined pharmacotherapy and psychological therapies for post traumatic stress disorder (PTSD)"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak) eller populasjon
20.	**Hirjak 2012** *"Prevention of psychosis"*
	Eksklusjonsårsak: Ikke relevant publikasjonstype og populasjon
21.	**Ho 2012,** *"Cognitive behaviour therapy versus eye movement desensitization and reprocessing for post-traumatic disorder – is it all in the homework then?"*
	Eksklusjonsårsak: Ikke relevant populasjon
22.	**Ibrahim 2014 "***The strengths based approach as a service delivery model for severe mental illness: a meta-analysis of clinical trials"*
	Eksklusjonsårsak: Ikke relevant tiltak
23.	**Jakobsen 2012, "***The effect of adding psychodynamic therapy to antidepressants in patients with major depressive disorder. A systematic review of randomized clinical trials with meta-analyses and trial sequential analyses"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
24.	**Jung 2009,** *"Cochrane reviews of non-medication-based psychotherapeutic and other interventions for schizophrenia, psycho-sis, and bipolar disorder: A systematic literature review"*
	Eksklusjonsårsak: Publisert før 2010
25.	**Kamioka 2014,** *"Effectiveness of animal-assisted therapy: A systematic review of randomized controlled trials"*
	Eksklusjonsårsak: Ikke relevant populasjon
26.	**Kiluk 2011,** *"A methodological analysis of randomized clinical trials of computer-assisted therapies for psychiatric disorders: toward improved standards for an emerging field"*
	Eksklusjonsårsak: Ikke relevant publikasjonstype, populasjon og tiltak
27.	**Kim 2013,** *"Mind-body practices for posttraumatic stress disorder"*
	Eksklusjonsårsak: Ikke relevant populasjon

Referanser ekskludert (n=89)	
28.	**Kohler 2013,** *"Effectiveness of cognitive-behavioural therapy plus pharmacotherapy in inpatient treatment of depressive disorders"*
	Eksklusjonsårsak: Ikke relevant publikasjonstype
29.	**Kasckow 2014** *"Telepsychiatry in the assessment and treatment of schizophrenia"*
	Eksklusjonsårsak: Ikke relevant tiltak
30.	**Kriston 2010,** *"Effectiveness of psychotherapeutic, pharmacological, and combined treatments for chronic depression: a systematic review (METACHRON)"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
31.	**Lawrence,** *"Sports and games for post-traumatic stress disorder (PTSD)"*
	Eksklusjonsårsak: Ikke relevant populasjon
32.	**Leichsenring 2014** *"Evidence for psychodynamic psychotherapy in specific mental disorders: A systematic review"*
	Eksklusjonsårsak: Ikke relevant populasjon
33.	**Leichsenring 2011,** *"The empirical status of psychodynamic psychotherapy-An update: Bambi's alive and kicking"*
	Eksklusjonsårsak: Ikke relevant populasjon
34.	**Liu 2010,** *"An evidence map of interventions across premorbid, ultra-high risk and first episode phases of psychosis"*
	Eksklusjonsårsak: Ikke relevant populasjon og tiltak
35.	**Loo 2011,** *"Physical treatments for bipolar disorder: A review of electroconvulsive therapy, stereotactic surgery and other brain stimulation techniques"*
	Eksklusjonsårsak: Ikke relevant tiltak
36.	**Lopresti 2014,** *"Saffron (Crocus sativus) for depression: a systematic review of clinical studies and examination of underlying antidepressant mechanisms of action"*
	Eksklusjonsårsak: Ikke relevant populasjon
37.	**Lyman 2014,** *"Consumer and family psychoeducation: assessing the evidence"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
38.	**Mabey 2014,** *"Treatment of post-traumatic stress disorder in patients with severe mental illness: a review"*
	Eksklusjonsårsak: Irrelevant populasjon
39.	**Malhi 2009,** *"Clinical practice recommendations for bipolar disorder"*
	Eksklusjonsårsak: Publisert før 2010
40.	**Manu 2015,** *"Weight gain and obesity in schizophrenia: Epidemiology, pathobiology, and management"*
	Eksklusjonsårsak: Ikke relevant tiltak og utfall
41.	**Marshall 2011,** *"Day hospital versus admission for acute psychiatric disorders"*
	Eksklusjonsårsak: Ikke relevant tiltak
42.	**Marshall 2011,** *"Early intervention for psychosis"*
	Eksklusjonsårsak: Ikke relevant populasjon og tiltak
43.	**Meekums 2013,** *"Review: Effects of mindfulness-based cognitive therapy on mental disorders: A systematic review and meta-analysis of randomised controlled trials"*
	Eksklusjonsårsak: Ikke relevant populasjon
44.	**Menear 2014,** *"Implementing a continuum of evidence-based psychosocial interventions for people with severe mental illness: part 1-review of major initiatives and implementation strategies"*
	Eksklusjonsårsak: Ikke relevant problemstilling
45.	**Mittal 2012,** *"Empirical studies of self-stigma reduction strategies: A critical review of the literature"*
	Eksklusjonsårsak: Ikke relevant utfall
46.	**Mokhtari 2013,** *"Early intervention and the treatment of prodrome in schizophrenia: A review of recent developments"*
	Eksklusjonsårsak: Ikke relevant problemstilling
47.	**Mura 2014,** *"Exercise as an add-on strategy for the treatment of major depressive disorder: a systematic review"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
48.	**Murphy 2015,** *"Crisis intervention for people with severe mental illnesses"*
	Eksklusjonsårsak: Ikke relevant setting
49.	**Oestergaard 2011** *"Optimal duration of combined psychotherapy and pharmacotherapy for patients with moderate and severe depression: A meta-analysis"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
50.	**Okpokoro 2014,** *"Brief family intervention for schizophrenia"*
	Eksklusjonsårsak: Dobbelpublikasjon
51.	**Papoulias 2014,** *"The psychiatric ward as a therapeutic space: systematic review"*
	Eksklusjonsårsak: Ikke relevant tiltak
52.	**Piskulic 2015,** *"Conventional and alternative preventive treatments in the first stages of schizophrenia"*
	Eksklusjonsårsak: Ikke relevant tiltak
53.	**Pohar 2010,** *"Cognitive behavioural therapy for post traumatic stress disorder: a review of the clinical and cost-effectiveness"*
	Eksklusjonsårsak: Ikke relevant populasjon
54.	**Quide 2012,** *"Differences between effects of psychological versus pharmacological treatments on functional and morphological brain alterations in anxiety disorders and major depressive disorder: A systematic review"*
	Eksklusjonsårsak: Ikke relevant utfall
55.	**Ranasinghe 2014,** *"A systematic review of evidence-based treatment for individuals with treatment-resistant schizophrenia and a suboptimal response to clozapine monotherapy"*
	Eksklusjonsårsak: Ikke relevant populasjon og tiltak (tilleggstiltak)
56.	**Ravindran 2013,** *"Complementary and alternative therapies as add-on to pharmacotherapy for mood and anxiety disorders: A systematic review"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
57.	**Romano 2015,** *"Evaluating the mechanisms of change in motivational interviewing in the treatment of mental health problems: A review and meta-analysis"*

Referanser ekskludert (n=89)	
	Eksklusjonsårsak: Ikke relevant utfall
58.	**Sanches 2015,** *"The Management of Cognitive Impairment in Bipolar Disorder: Current Status and Perspectives"*
	Eksklusjonsårsak: Ikke relevant problemstilling
59.	**Sarin 2014,** *"Cognitive model and cognitive behavior therapy for schizophrenia: An overview. "*
	Eksklusjonsårsak: Ikke relevant problemstilling
60.	**Sarris 2011,** *"Adjunctive nutraceuticals with standard pharmacotherapies in bipolar disorder: A systematic review of clinical trials"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
61.	**Sarris 2012,** *"I Omega-3 for bipolar disorder: meta-analyses of use in mania and bipolar depression"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
62.	**Sarris 2013,** *"Conditional probability of response or nonresponse of placebo compared with antidepressants or St John's Wort in major depressive disorder"*
	Eksklusjonsårsak: Ikke relevant problemstilling
63.	**Sarris 2011,** *"Herbal medicine for depression, anxiety and insomnia: A review of psychopharmacology and clinical evidence"*
	Eksklusjonsårsak: Ikke relevante utfall
64.	**Schlogelhofer 2014,** *"Polyunsaturated fatty acids in emerging psychosis: a safer alternative?"*
	Eksklusjonsårsak: Ikke relevante utfall
65.	**Schoenberg 2014,** *"A Biofeedback for psychiatric disorders: A systematic review"*
	Eksklusjonsårsak: Ikke relevant problemstilling
66.	**Serafini 2015,** *"The effects of repetitive transcranial magnetic stimulation on cognitive performance in treatment-resistant depression. A systematic review"*
	Eksklusjonsårsak: Ikke relevant tiltak
67.	**Shah 2014** *"Efficacy of psychoeducation and relaxation interventions on stress-related variables in people with mental disorders: a literature review"*
	Eksklusjonsårsak: Ikke relevant tiltak
68.	**Sienaert 2013,** *"Evidence-based treatment strategies for treatment-resistant bipolar depression: A systematic review"*
	Eksklusjonsårsak: Ikke relevant tiltak
69.	**Sinclair 2014,** *"Treatment resistant schizophrenia: a comprehensive survey of randomised controlled trials"*
	Eksklusjonsårsak: Ikke relevant tiltak
70.	**Singh 2010,** *"Review and meta-analysis of usage of ginkgo as an adjunct therapy in chronic schizophrenia"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
71.	**Smits 2010,** *"Cognitive behavioural therapy for schizophrenia"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
72.	**Solomon 2015,** *"The use of complementary and alternative medicine in adults with depressive disorders. A critical integrative review"*
	Eksklusjonsårsak: Ikke relevant populasjon
73.	**Stanton 2014,** *"Exercise and the treatment of depression: A review of the exercise program variables"*
	Eksklusjonsårsak: Ikke relevant populasjon
74.	**Steinert 2014,** *"Relapse rates after psychotherapy for depression? Stable long-term effects? A meta-analysis"*
	Eksklusjonsårsak: Ikke relevant populasjon
75.	**Szentagotai 2010,** *"The efficacy of cognitive-behavioral therapy in bipolar disorder: A quantitative meta-analysis"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
76.	**Tomayo 2011,** *"Literature review on management of treatment-resistant depression"*
	Eksklusjonsårsak: Ikke relevant tiltak
77.	**Trivedi 2011,** *"Examination of the utility of psychotherapy for patients with treatment resistant depression: a systematic review"*
	Eksklusjonsårsak: Ikke relevant problemstilling
78.	**Tursi 2013,** *"Effectiveness of psychoeducation for depression: A systematic review"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
79.	**van der Velden 2015,** *"A systematic review of mechanisms of change in mindfulness-based cognitive therapy in the treatment of recurrent major depressive disorder"*
	Eksklusjonsårsak: Ikke relevant problemstilling
80.	**Vancampfort 2012,** *"Yoga in schizophrenia: A systematic review of randomised controlled trials"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
81.	**Vieta 2004,** *"Psychological interventions in bipolar disorder: From wishful thinking to an evidence-based approach"*
	Eksklusjonsårsak: Publisert før 2010
82.	**Vieta 2005,** *"Evidence-based research on the efficacy of psychologic interventions in bipolar disorders: a critical review"*
	Eksklusjonsårsak: Publisert før 2010
83.	**Wolff 2012,** *"Combination of pharmacotherapy and psychotherapy in the treatment of chronic depression: a systematic review and meta-analysis"*
	Eksklusjonsårsak: Ikke relevant tiltak (tilleggstiltak)
84.	**Wood 2013,** *"Is EMDR an evidenced-based treatment for depression? A review of the literature"*
	Eksklusjonsårsak: Ikke relevant populasjon
85.	**Wood 2013,** *"Individual cognitive behavioural therapy for psychosis (CBTp): a systematic review of qualitative literature"*
	Eksklusjonsårsak: Ikke relevant publikasjonstype
86.	**Zhang 2012,** *"Chinese herbal formula Xiao Yao San for treatment of depression: a systematic review of randomized controlled trials"*
	Eksklusjonsårsak: Ikke relevant populasjon
87.	**Zhang 2009,** *"The effectiveness and safety of acupuncture therapy in depressive disorders: systematic review and meta-analysis"*
	Eksklusjonsårsak: Publisert før 2010

Referanser ekskludert (n=89)	
88.	**Zhao 2015,** *"Psychoeducation (brief) for people with serious mental illness"*
Eksklusjonsårsak:	Ikke relevant tiltak (tilleggstiltak)
89.	**Zou 2013,** *"Self-management education interventions for persons with schizophrenia: a meta-analysis"*
Eksklusjonsårsak:	Ikke relevant tiltak (tilleggstiltak)

Vedlegg 3. Innhentet informasjon fra oversiktenes sammendrag

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Abbass 2011 et al. (1)	The efficacy of short-term psychodynamic psychotherapy for depressive disorders with comorbid personality disorder	People with personality and depression disorder (comorbid)	Short-term psychodynamic Psychotherapy	Other psychotherapies, waiting list	Symptoms	Within the limits of this study, these findings suggest that STPP warrants consideration as a first line treatment for combined personality disorder and depression. Future research directions are proposed
Sammendrag: The presence of comorbid personality disorder (PD) is one of the factors that can make the treatment of depression unsuccessful. Short-term Psychodynamic Psychotherapy (STPP) has been shown efficacious in the treatment of personality and depressive disorders (DD). However, the efficacy of STPP for comorbid DD and PD has not been systematically evaluated. In this study, data from patients meeting criteria for both DD and PD participating from randomized controlled trials of STPP was collected, systematically reviewed, and meta-analyzed where possible. Eight studies were included, 6 with major depression and 2 with minor depressive disorders. Pre- to post- treatment effects sizes were large (d = 1.00-1.27), suggesting symptom improvement during STPP, and these gains were maintained in follow-ups averaging over 1.5 years. For major depression, no differences were found comparing STPP to other psychotherapies, and STPP was found superior to a wait-list condition in one study. STPP may have had an advantage over other therapy controls in treating minor depression as noted in ratings of general psychopathology. Patients with Cluster A/B and C PD were responsive to STPP, with the majority of all studied patients showing clinically significant change on self-report measures. Within the limits of this study, these findings suggest that STPP warrants consideration as a first line treatment for combined personality disorder and depression. Future research directions are proposed					
Acar og Buldukoğlu 2014 (2)	Effect of Psychoeducation on Relapses in Bipolar Disorder: A Systematic Review	People with bipolar disorder	Psychoeducation interventions/programs	Not reported	Frequency of relapse and hospitalization, time spent as a patient, serum lithium levels and social functioning	In conclusion, psycho-education programs have positive results on preventing relapse for patients with bipolar disorder
Sammendrag: This study is a systematic review of psychoeducation interventions which aims at preventing relapses in patients with bipolar disorder. This study has been condcuted in order to determine the effects of these interventions. In the present study national and international databases were screened to identify psycho-education initiatives and a total of seven articles that met the criteria for inclusion and exclusion were evaluated. All of the seven studies reviewed, focused on the effects of psy-choeducation on frequency of relapse and hospitalization, time spent as a patient, serum lithium levels and social functioning. The findings of the studies revealed that psychoeducation reduces the frequency of relapse and hospitalization and time spent as a patient. Besides, psychoeducation contributed to the protective levels of serum lithium levels and has a positive impact on the social functioning of bipolar patients. In conclusion, psycho-education programs have positive results on preventing relapse for patients with bipolar disorder.					
Addington 2013 et al. (3)	Essential evidence-based components of first-episode psychosis services	People with first episode psychosis	First-episode psychosis services	Not reported	Not reported	The two-step process yielded a manageable list of 32 evidence-based components of first-episode psychosis services. Given the proliferation of such services and the absence of an evidence-based fidelity scale, this list can form a foundation for developing a fidelity scale for such services. It may also be helpful to funders and providers as a summary of essential services
Sammendrag: OBJECTIVE The purpose of this study was to identify essential evidence-based components of first-episode psychosis services. METHODS The study was conducted in two stages. In the first stage a systematic review of both peer-reviewed and gray literature (January 1980 to April 2010) was conducted. Databases searched included MEDLINE, PsycINFO, and EMBASE. In the second stage, a consensus-building technique, the Delphi, was used with an international panel of experts. The panelists were presented the evidence-based components identified in the review, together with the level of supporting evidence for each component. They rated the importance of each component on a 5-point scale. A score of 5 was required to determine that a component was essential. RESULTS The review identified 1,020 citations; abstracts were reviewed for relevance. A total of 280 peer-reviewed articles met criteria for relevance. Two researchers independently reviewed these articles and identified 75 unique service components. Each component was assigned a level of supporting evidence. Twenty-seven experts completed the first Delphi round, of whom 23 participated in the second. Consensus was achieved in two rounds, with 32 components rated as essential. CONCLUSIONS The two-step process yielded a manageable list of 32 evidence-based components of first-episode psychosis services. Given the proliferation of such services and the absence of an evidence-based fidelity scale, this list can form a foundation for developing a fidelity scale for such services. It may also be helpful to funders and providers as a summary of essential services.					

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Aderka et al. 2012 (4)}	Sudden gains during psychological treatments of anxiety and depression: A meta-analysis	People receiving psychological treatment for major depressive disorder or an anxiety disorder	Psychological treatments (one of the interventions mentioned is CBT)	Not reported	Sudden gains in on treatment outcome (no specification)	These results suggest that sudden gains are associated with short-term and long-term improvements in depression and anxiety, especially in cognitive-behavioral therapy
Sammendrag: Objective: The present study quantitatively reviewed the literature on sudden gains in psychological treatments for anxiety and depression. The authors examined the short- and long-term effects of sudden gains on treatment outcome as well as moderators of these effects. Method: The authors conducted a literature search using PubMed, PsycINFO, the Cochrane Library, and manual searches. The meta-analysis was based on 16 studies and included 1,104 participants receiving psychological treatment for major depressive disorder or an anxiety disorder. Results: Effect size estimates suggest that sudden gains had a moderate effect on primary outcome measures at posttreatment (Hedges's g = 0.62) and follow-up (Hedges's g = 0.56). These effect sizes were robust and unrelated to publication year or number of treatment sessions. The effect size of sudden gains in cognitive-behavioral therapy was higher (Hedges's g = 0.75) than in other treatments (Hedges's g = 0.23). Conclusions: These results suggest that sudden gains are associated with short-term and long-term improvements in depression and anxiety, especially in cognitive-behavioral therapy						
Agarwal et al. 2011 (5)	Ayurvedic medicine for schizophrenia	People with schizophrenia	Ayurvedic medicine or treatments for schizophrenia	Placebo, typical or atypical antipsychotic drugs for schizophrenia and schizophrenia-like psychoses	Global state, use of services, and satisfaction with treatment	When ayurvedic herbs were compared with placebo, about 20% of people left the studies early randomized control trials. Mental state ratings were mostly equivocal with the exception of the brahmyadiyoga group using ayurvedic assessment. Behavior seemed unchanged. Nausea and vomiting were common in the brahmyadiyoga group
Sammendrag: Our objective was to review the effects of ayurvedic medicine or treatments for schizophrenia. We searched the Cochrane Schizophrenia Group Trials Register (March 2007) and Allied and Complementary Medicine Database (March 2007), inspected references of all identified studies and contacted the first author of each included study. We included all clinical randomized trials comparing ayurvedic medicine or treatments with placebo, typical or atypical antipsychotic drugs for schizophrenia and schizophrenia-like psychoses. From the 3 small short included studies, we were unable to extract any data on many broad clinically important outcomes such as global state, use of services, and satisfaction with treatment. When ayurvedic herbs were compared with placebo, about 20% of people left the studies early randomized control trials. Mental state ratings were mostly equivocal with the exception of the brahmyadiyoga group using ayurvedic assessment. Behavior seemed unchanged. Nausea and vomiting were common in the brahmyadiyoga group						
Alexandratos et al. 2012 (6)	The impact of exercise on the mental health and quality of life of people with severe mental illness: A critical review	People with severe mental illness	Physical exercise	Not reported	Mental health and quality of life	The findings show that exercise can contribute to improvements in symptoms, including mood, alertness, concentration, sleep patterns and psychotic symptoms. Exercise can also contribute to improved quality of life through social interaction, meaningful use of time, purposeful activity and empowerment. Implications: Future research is warranted to describe the way exercise can meet the unique needs of this population. Studies with a focus on psychological outcome measures would provide greater evidence for its use in therapy.
Sammendrag: Introduction: Physical exercise has been proven to benefit the general population in terms of mental health and wellbeing. However, there is little research investigating the impact of exercise on mental health and quality of life for people who experience a severe and enduring mental illness. Method: This review aims to describe the effect of physical exercise intervention on the mental health and quality of life of people with severe mental illness. Quantitative and qualitative articles published between 1998-2009 were sourced using electronic databases. Articles were included if the study intervention involved exercise and the outcome measure included mental health or quality of life. Sixteen articles were analysed for common themes and appraised critically. Findings: The findings show that exercise can contribute to improvements in symptoms, including mood, alertness, concentration, sleep patterns and psychotic symptoms. Exercise can also contribute to improved quality of life through social interaction, meaningful use of time, purposeful activity and empowerment. Implications: Future research is warranted to describe the way exercise can meet the unique needs of this population. Studies with a focus on psychological outcome measures would provide greater evidence for its use in therapy						

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Alvarez-Jimenez et al. 2011 (7)	Preventing the second episode: A systematic review and meta-analysis of psychosocial and pharmacological trials in first-episode psychosis	People with first-episode psychosis (FEP)	Pharmacological and non-pharmacological interventions to prevent relapse in people with FEP	Treatment as usual, placebo, other types of psychological interventions (not clearly stated in the abstract)	Relapse	Specialist FEP programs are effective in preventing relapse. Cognitive-based individual and family interventions may need to specifically target relapse to obtain relapse prevention benefits that extend beyond those provided by specialist FEP programs. Overall, the available data suggest that FGAs and SGAs have the potential to reduce relapse rates. Future trials should examine the effectiveness of placebo vs antipsychotics in combination with intensive psychosocial interventions in preventing relapse in the early course of psychosis. Further studies should identify those patients who may not need antipsychotic medication to be able to recover from psychosis
Sammendrag: Objective: The majority of first-episode psychosis (FEP) patients reach clinical remission; however, rates of relapse are high. This study sought to undertake a systematic review and meta-analysis of randomized controlled trials (RCTs) to determine the effectiveness of pharmacological and non-pharmacological interventions to prevent relapse in FEP patients. Methods: Systematic review and metaanalysis of RCTs. Results: Of 66 studies retrieved, 18 were eligible for inclusion. Nine studies investigated psychosocial interventions and 9 pharmacological treatments. The analysis of 3 RCTs of psychosocial interventions comparing specialist FEP programs vs treatment as usual involving 679 patients demonstrated the former to be more effective in preventing relapse (odds ratio [OR] = 1.80, 95% confidence interval [CI] = 1.31-2.48; P < .001; number needed to treat [NNT] = 10). While the analysis of 3 different cognitive-behavioral studies not specifically intended at preventing relapse showed no further benefits compared with specialist FEP programs (OR = 1.95, 95% CI = 0.76-5.00; P = .17), the combination of specific individual and family intervention targeted at relapse prevention may further improve upon these outcomes (OR54.88, 95% CI = 0.97-24.60; P = .06). Only 3 small studies compared first-generation antipsychotics (FGAs) with placebo with no significant differences regarding relapse prevention although all individual estimates favored FGAs (OR = 2.82, 95% CI = 0.54-14.75; P = .22). Exploratory analysis involving 1055 FEP patients revealed that relapse rates were significantly lower with second generation antipsychotics (SGAs) compared with FGAs (OR = 1.47, 95% CI = 1.07-2.01; P < .02; NNT = 10). Conclusions: Specialist FEP programs are effective in preventing relapse. Cognitive-based individual and family interventions may need to specifically target relapse to obtain relapse prevention benefits that extend beyond those provided by specialist FEP programs. Overall, the available data suggest that FGAs and SGAs have the potential to reduce relapse rates. Future trials should examine the effectiveness of placebo vs antipsychotics in combination with intensive psychosocial interventions in preventing relapse in the early course of psychosis. Further studies should identify those patients who may not need antipsychotic medication to be able to recover from psychosis					
Anaya et al. 2012 (8)	A systematic review of cognitive remediation for schizo-affective and affective disorders	People with schizoaffective disorder, affective psychosis, unipolar and/or bipolar disorders	Cognitive remediation	Not reported	Cognitive performance/function	The estimated effect size reflect those reported in the literature on cognitive remediation for schizophrenia. As such a conservative interpretation is that cognitive remediation has at least equivalent benefits in affective and schizo-affective disorder as demonstrated in schizophrenia. Further studies are urgently required to examine the durability of any gains with cognitive remediation in affective populations and to determine if any changes in cognitive deficits lead to improvements in symptoms or functioning and/or whether post-intervention cognitive changes differ in character or magnitude from those reported in schizophrenia
Sammendrag: BACKGROUND: Cognitive remediation is accepted as an important therapeutic intervention in schizophrenia, but few studies provide data on whether the benefits extend to affective disorders. OBJECTIVES: To review quantitatively studies of cognitive remediation with samples that included cases of schizoaffective disorder, affective psychosis, unipolar and/or bipolar disorders. METHODS: Twenty one studies met preliminary inclusion criteria, comprising a total of 940 participants of which 35% had an affective or schizoaffective disorder. Effect sizes (ES) for pre- to post-intervention change in cognitive performance were estimated. RESULTS: A meta-analysis of 16 studies gave a pooled ES for change in cognitive function of 0.32 (95% Confidence Intervals 0.20 to 0.43) and produced statistical homogeneity. Overall, ES were significantly positively correlated with higher proportion of schizo-affective and affective cases (r=0.61; p=0.007), even when age, gender and duration of therapy were included as covariates in the analysis (r=.59, p=0.017). LIMITATIONS: The quality of and small number of affective disorder only studies mean the findings must be treated with caution. CONCLUSIONS: The estimated ES reflect those reported in the literature on cognitive remediation for schizophrenia. As such a conservative interpretation is that cognitive remediation has at least equivalent benefits in affective and schizo-affective disorder as demonstrated in schizophrenia. Further studies are urgently required to examine the durability of any gains with cognitive remediation in affective populations and to determine if any changes in cognitive deficits lead to improvements in symptoms or functioning and/or whether post-intervention cognitive changes differ in character or magnitude from those reported in schizophrenia					
Andrews et al. 2010 (9)	Computer therapy for the anxiety and depressive disorders is effective, acceptable and practical health care: a meta-analysis	People who met diagnostic criteria for major depression, panic disorder, social phobia or generalized anxiety disorder	Computerized cognitive behavior therapy	Treatment or control condition	Acceptability (patient adherence and satisfaction)	Computerized CBT for anxiety and depressive disorders, especially via the internet, has the capacity to provide effective acceptable and practical health care for those who might otherwise remain untreated

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: BACKGROUND: Depression and anxiety disorders are common and treatable with cognitive behavior therapy (CBT), but access to this therapy is limited. OBJECTIVE: Review evidence that computerized CBT for the anxiety and depressive disorders is acceptable to patients and effective in the short and longer term. METHOD: Systematic reviews and data bases were searched for randomized controlled trials of computerized cognitive behavior therapy versus a treatment or control condition in people who met diagnostic criteria for major depression, panic disorder, social phobia or generalized anxiety disorder. Number randomized, superiority of treatment versus control (Hedges g) on primary outcome measure, risk of bias, length of follow up, patient adherence and satisfaction were extracted. PRINCIPAL FINDINGS: 22 studies of comparisons with a control group were identified. The mean effect size superiority was 0.88 (NNT 2.13), and the benefit was evident across all four disorders. Improvement from computerized CBT was maintained for a median of 26 weeks follow-up. Acceptability, as indicated by adherence and satisfaction, was good. Research probity was good and bias risk low. Effect sizes were non-significantly higher in comparisons with waitlist than with active treatment control conditions. Five studies comparing computerized CBT with traditional face-to-face CBT were identified, and both modes of treatment appeared equally beneficial. CONCLUSIONS: Computerized CBT for anxiety and depressive disorders, especially via the internet, has the capacity to provide effective acceptable and practical health care for those who might otherwise remain untreated. TRIAL REGISTRATION: Australian New Zealand Clinical Trials Registry ACTRN12610000030077.					
Anestis et al. 2014 (10)	Equine-related treatments for mental disorders lack empirical support: A systematic review of empirical investigations	People with mental disorder	Equine-related treatments	Not reported	Not reported	The current evidence base does not justify the marketing and utilization of ERT for mental disorders. Such services should not be offered to the public unless and until well-designed studies provide evidence that justify different conclusions
Sammendrag: Context: Equine-related treatments (ERT) for mental disorders are becoming increasingly popular for a variety of diagnoses; however, they have been subjected only to limited systematic investigation. Objective: To examine the quality of and results from peer-reviewed research on ERT for mental disorders and related outcomes. Method: Peer-reviewed studies (k = 14) examining treatments for mental disorders or closely related outcomes were identified from databases and article reference sections. Results: All studies were compromised by a substantial number of threats to validity, calling into question the meaning and clinical significance of their findings. Additionally, studies failed to provide consistent evidence that ERT is superior to the mere passage of time in the treatment of any mental disorder. Conclusion: The current evidence base does not justify the marketing and utilization of ERT for mental disorders. Such services should not be offered to the public unless and until well-designed studies provide evidence that justify different conclusions						
Annamalai et al. 2014 (11)	Effectiveness of interventions to reduce physical restraint in psychiatric settings: A systematic review	People with acute and chronic mental health conditions residing in mental health settings	Non-pharmacological interventions to reduce the use of restraints psychiatric settings	Not reported	Patients' falls, behavioural symptoms and cognition	Multi-interventional effort could support the reduction of physical restraint use in psychiatric settings. Findings could inform mental health professionals of alternatives to the utilisation of physical restraints to manage patients' challenging behaviour and to prevent falls
Sammendrag: Background & Hypothesis: Physical restraints are commonly employed by nurses to manage patients' challenging behaviour and to prevent falls despite the adverse outcomes associated with their use. Though there is a worldwide move towards the reduction of restraints, the effectiveness of non-pharmacological alternatives to restraints in psychiatric settings remains to be investigated. This study aims to critically review the literature to synthesise the best available evidence on non-pharmacological interventions to reduce the use of restraints psychiatric settings. Methods: An extensive literature search was undertaken over multiple databases and libraries using specified keywords and related terms to retrieve published and unpublished studies. Primary studies in line with the eligibility criteria such as adults with acute and chronic mental health conditions residing in mental health settings were considered. Retrieved articles were critically appraised and only articles deemed to be of adequate methodological rigour were included in the review. Results: Across 26 articles, the evidence suggested that the use of restraints can be safely reduced with multiinterventions involving close monitoring of patients' conditions, interventions tailored to patients' needs, as well as staff education and administrative support. In addition, the multi-intervention approach also improved staff's acceptance about alternatives to restraint, reduced the occurrence of patients' falls, and improved the behavioural symptoms and cognition among patients with mental health conditions. Discussion & Conclusion: Multi-interventional effort could support the reduction of physical restraint use in psychiatric settings. Findings could inform mental health professionals of alternatives to the utilisation of physical restraints to manage patients' challenging behaviour and to prevent falls						

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Appleton et al. 2015 (12)	Omega-3 fatty acids for depression in adults	People with major depressive disorder (MDD)	n-3 polyunsaturated fatty acids (also known as omega-3 fatty acids)	Placebo, anti-depressant treatment, standard care, no treatment, wait-list control	Primary outcomes were depressive symptomology and adverse events. Secondary outcomes were depressive symptomology, quality of life, and failure to complete studies	At present, we do not have sufficient high quality evidence to determine the effects of n-3PUFAs as a treatment for MDD. Our primary analyses suggest a small-to-modest, non-clinically beneficial effect of n-3PUFAs on depressive symptomology compared to placebo; however the estimate is imprecise, and we judged the quality of the evidence on which this result is based to be low/very low. Sensitivity analyses, funnel plot inspection and comparison of our results with those of large well-conducted trials also suggest that this effect estimate is likely to be biased towards a positive finding for n-3PUFAs, and that the true effect is likely to be smaller. Our data, however, also suggest similar rates of adverse events and numbers failing to complete trials in n-3PUFA and placebo groups, but again our estimates are very imprecise. The one study that directly compares n-3PUFAs and antidepressants in our review finds comparable benefit. More evidence, and more complete evidence, are required, particularly regarding both the potential positive and negative effects of n-3PUFAs for MDD
Sammendrag: Background: Major depressive disorder (MDD) is highly debilitating, difficult to treat, has a high rate of recurrence, and negatively impacts the individual and society as a whole. One emerging potential treatment for MDD is n-3 polyunsaturated fatty acids (n-3PUFAs), also known as omega-3 oils, naturally found in fatty fish, some other seafood, and some nuts and seeds. Various lines of evidence suggest a role for n-3PUFAs in MDD, but the evidence is far from conclusive. Reviews and meta-analyses clearly demonstrate heterogeneity between studies. Investigations of heterogeneity suggest differential effects of n-3PUFAs, depending on severity of depressive symptoms, where no effects of n-3PUFAs are found in studies of individuals with mild depressive symptomology, but possible benefit may be suggested in studies of individuals with more severe depressive symptomology.Objectives: To assess the effects of n-3 polyunsaturated fatty acids (also known as omega-3 fatty acids) versus a comparator (e.g. placebo, anti-depressant treatment, standard care, no treatment, wait-list control) for major depressive disorder (MDD) in adults. Search methods: We searched the Cochrane Depression, Anxiety and Neurosis Review Group?s Specialised Registers (CCDANCTR) and International Trial Registries over all years to May 2015. We searched the database CINAHL over all years of records to September 2013.Selection criteria: We included studies in the review if they: were a randomised controlled trial; provided n-3PUFAs as an intervention; used a comparator; measured depressive symptomology as an outcome; and were conducted in adults with MDD. Primary outcomes were depressive symptomology (continuous data collected using a validated rating scale) and adverse events. Secondary outcomes were depressive symptomology (dichotomous data on remission and response), quality of life, and failure to complete studies.Data collection and analysis: We used standard methodological procedures as expected by Cochrane.Main results: We found 26 relevant studies: 25 studies involving a total of 1438 participants investigated the impact of n-3PUFA supplementation compared to placebo, and one study involving 40 participants investigated the impact of n-3PUFA supplementation compared to antidepressant treatment.For the placebo comparison, n-3PUFA supplementation results in a small to modest benefit for depressive symptomology, compared to placebo: standardised mean difference (SMD) -0.32 (95% confidence interval (CI) -0.12 to -0.52; 25 studies, 1373 participants, very low quality evidence), but this effect is unlikely to be clinically meaningful (an SMD of 0.32 represents a difference between groups in scores on the HDRS (17-item) of approximately 2.2 points (95% CI 0.8 to 3.6)). The confidence intervals include both a possible clinically important effect and a possible negligible effect, and there is considerable heterogeneity between the studies. Although the numbers of individuals experiencing adverse events were similar in intervention and placebo groups (odds ratio (OR) 1.24, 95% CI 0.95 to 1.62; 19 studies, 1207 participants; very low-quality evidence), the confidence intervals include a significant increase in adverse events with n-3PUFAs as well as a small possible decrease. Rates of remission and response, quality of life, and rates of failure to complete studies were also similar between groups, but confidence intervals are again wide.The evidence on which these results are based is very limited. All studies contributing to our analyses were of direct relevance to our research question, but we rated the quality of the evidence for all outcomes as low to very low. The number of studies and number of participants contributing to all analyses were low, and the majority of studies were small and judged to be at high risk of bias on several measures. Our analyses were also likely to be highly influenced by three large trials. Although we judge these trials to be at low risk of bias, they contribute 26.9% to 82% of data. Our effect size estimates are also impre ise. Funnel plot asymmetry and sensitivity analyses (using fixed-effect models, and only studies judged to be at low risk of selection bias, performance bias or attrition bias) also suggest a likely bias towards a positive finding for n-3PUFAs. There was substantial heterogeneity in analyses of our primary outcome of depressive symptomology. This heterogeneity was not explained by the presence or absence of comorbidities or by the presence or absence of adjunctive therapy.Only one study was available for the antidepressant comparison, involving 40 participants. This study found no differences between treatment with n-3PUFAs and treatment with antidepressants in depressive symptomology (mean difference (MD) -0.70 (95% CI -5.88 to 4.48)), rates of response to treatment or failure to complete. Adverse events were not reported in a manner suitable for analysis, and rates of depression remission and quality of life were not reported.Authors' conclusions: At present, we do not have sufficient high quality evidence to determine the effects of n-3PUFAs as a treatment for MDD. Our primary analyses suggest a small-to-modest, non-clinically beneficial effect of n-3PUFAs on depressive symptomology compared to placebo; however the estimate is imprecise, and we judged the quality of the evidence on which this result is based to be low/very low. Sensitivity analyses, funnel plot inspection and comparison of our results with those of large well-conducted trials also suggest that this effect estimate is likely to be biased towards a positive finding for n-3PUFAs, and that the true effect is likely to be smaller. Our data, however, also suggest similar rates of adverse events and numbers failing to complete trials in n-3PUFA and placebo groups, but again our estimates are very imprecise. The one study that directly compares n-3PUFAs and antidepressants in our review finds comparable benefit. More evidence, and more complete evidence, are required, particularly regarding both the potential positive and negative effects of n-3PUFAs for MDD						

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Balasubramaniam et al. 2012 (13)	Yoga on our minds: a systematic review of yoga for neuropsychiatric disorders	People with selected major psychiatric disorders	Yoga	Not reported	Not reported	There is emerging evidence from randomized trials to support popular beliefs about yoga for depression, sleep disorders, and as an augmentation therapy. Limitations of literature include inability to do double-blind studies, multiplicity of comparisons within small studies, and lack of replication. Biomarker and neuroimaging studies, those comparing yoga with standard pharmaco- and psychotherapies, and studies of long-term efficacy are needed to fully translate the promise of yoga for enhancing mental health
Sammendrag: BACKGROUND: The demand for clinically efficacious, safe, patient acceptable, and cost-effective forms of treatment for mental illness is growing. Several studies have demonstrated benefit from yoga in specific psychiatric symptoms and a general sense of well-being. OBJECTIVE: To systematically examine the evidence for efficacy of yoga in the treatment of selected major psychiatric disorders. METHODS: Electronic searches of The Cochrane Central Register of Controlled Trials and the standard bibliographic databases, MEDLINE, EMBASE, and PsycINFO, were performed through April 2011 and an updated in June 2011 using the keywords yoga AND psychiatry OR depression OR anxiety OR schizophrenia OR cognition OR memory OR attention AND randomized controlled trial (RCT). Studies with yoga as the independent variable and one of the above mentioned terms as the dependent variable were included and exclusion criteria were applied. RESULTS: The search yielded a total of 124 trials, of which 16 met rigorous criteria for the final review. Grade B evidence supporting a potential acute benefit for yoga exists in depression (four RCTs), as an adjunct to pharmacotherapy in schizophrenia (three RCTs), in children with ADHD (two RCTs), and Grade C evidence in sleep complaints (three RCTs). RCTs in cognitive disorders and eating disorders yielded conflicting results. No studies looked at primary prevention, relapse prevention, or comparative effectiveness versus pharmacotherapy. CONCLUSION: There is emerging evidence from randomized trials to support popular beliefs about yoga for depression, sleep disorders, and as an augmentation therapy. Limitations of literature include inability to do double-blind studies, multiplicity of comparisons within small studies, and lack of replication. Biomarker and neuroimaging studies, those comparing yoga with standard pharmaco- and psychotherapies, and studies of long-term efficacy are needed to fully translate the promise of yoga for enhancing mental health					
Batista et al. 2011 (14)	Efficacy of psychoeducation in bipolar patients: systematic review of randomized trials	People with bipolar disorder	Psychoeducation	Control (no further explanation)	Clinical course, treatment adherence,and psychosocial functioning	Psychoeducation reduced relapse rates, improved long-term treatment adherence and improved the knowledge of the illness for patients and caregivers resulting in improved social functioning
Sammendrag: Authors' objectives: To assess the efficacy of psychoeducation on the clinical course, treatment adherence and psychosocial functioning of adult patients with bipolar disorder. Searching: PubMed and Scopus were searched for relevant studies published in English without date limits; limited search terms were reported. The reference lists of retrieved studies were also searched. Study selection: Randomised controlled trials (RCTs) of individuals with either type I or type II bipolar disorder or a combination of the two and/or their family or caregivers that used psychoeducation alone were eligible for the review. Studies were required to assess at least one of the following outcomes: clinical course (time to recurrence, relapse, symptom severity or number and days of hospitalisation), treatment adherence and psychosocial functioning. Studies of psychoeducation combined with other psychosocial approaches were excluded. Studies that included children, adolescents or the elderly with bipolar disorder were also excluded.In the included studies, participants were adults and number of treatment sessions ranged from five to 21 sessions, where reported. More than half of the included studies evaluated psychoeducation treatment in patients with both type I and type II bipolar disorder.The authors did not state how many reviewers selected studies for the review. Validity assessment: The authors did not report whether quality assessment of the included studies was undertaken. Data extraction: Data were extracted on the outcomes according to how they were analysed in the individual studies.The authors did not state how many reviewers extracted data. Methods of synthesis: The studies were synthesized in narrative format. Results of the review: Thirteen RCTs (883 participants) were included in the review. Follow-up ranged from six months to five years, where reported.Clinical course (10 studies): All six studies that evaluated clinical course reported decreases in the relapse rate and increased time to recurrence with psychoeducation. Four of five studies reported decreases in the number of days of hospitalisation. Two studies did not find any significant benefits in the clinical course or number of days hospitalisation and one study did not find a change in bipolar symptoms.Treatment adherence (nine studies): Four of five studies reported no difference in adherence between groups. Two studies found increased mean lithium levels or increased patient and partner knowledge about lithium after psychoeducation. Psychosocial functioning (four studies): One study found increased levels of work functioning and social adjustment, another reported increased overall social functioning and employment and two studies found increased caregiver knowledge of the illness. Cost information: The review addressed a clear research question, supported by appropriate inclusion criteria. A limited number of databases were searched for relevant studies published in English combined with manual searches of the reference lists of retrieved studies. It was possible that some studies may have been missed because the search was restricted to studies in English and no specific attempts were made to find unpublished studies or search larger databases. No methods were reported for the selection of studies and data extraction.No quality assessment of included studies was reported, making it difficult to assess the reliability of results. All studies were reported as randomised, but they all had small sample sizes and details of the control groups were not reported. Details on the characteristics of the participants and the psychoeducation intervention were also not reported. Studies were appropriately synthesized in narrative format but the authors did not clearly report the proportion of studies that found benefits out of the total number assessing the outcome of interest, so it was difficult to interpret the results. Due to major shortcomings in the conduct of the review, potential bias, lack of reporting and a limited evidence base, the authors' conclusions should be treated with caution. Authors' conclusions: Psychoeducation reduced relapse rates, improved long-term treatment adherence and improved the knowledge of the illness for patients and caregivers resulting in improved social functioning					
Berk et al. 2013 (15)	Lifestyle management of unipolar depression	People with unipolar depression	Lifestyle management	Not reported	Not reported	Lifestyle modification, with a focus on exercise, diet, smoking and alcohol, may be of substantial value in reducing the burden of depression in individuals and the community

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Sammendrag: Objective: To be used in conjunction with 'Pharmacological management of unipolar depression' [Malhi et al. Acta Psychiatr Scand 2013;127(Suppl. 443):6-23] and 'Psychological management of unipolar depression' [Lampe et al. Acta Psychiatr Scand 2013;127(Suppl. 443): 24-37]. To provide clinically relevant recommendations for lifestyle modifications in depression, derived from a literature review. Method: A search of pertinent literature was conducted up to August 2012 in the area of lifestyle factors and depression. A narrative review was then conducted. Results: There is evidence that level of physical activity plays a role in the risk of depression, and there is a large and validated evidence base for exercise as a therapeutic modality. Smoking and alcohol and substance misuse appear to be independent risk factors for depression, while the new epidemiological evidence supports the contention that diet is a risk factor for depression; good quality diets appear protective and poor diets increase risk. Conclusion: Lifestyle modification, with a focus on exercise, diet, smoking and alcohol, may be of substantial value in reducing the burden of depression in individuals and the community						
Bernard og Ninot 2012 (16)	Benefits of exercise for people with schizophrenia: A systematic review	People with schizophrenia	Physical activity	Not reported	Aspect of physical or mental health	Research into the efficacy and safety of exercise as an intervention in schizophrenia is required to support the development of detailed, population-specific guidelines. Larger randomised studies are required before any definitive conclusions can be drawn. Although studies included in this review are small and used various measures of physical and mental health, results indicated that regular exercise programmes are possible in this population, and that they can have beneficial effects on both physical and mental health. Future research should address issues of programme adherence
Sammendrag: Introduction: Previous reviews of exercise and mental health have predominantly examined chronic illness and more recently, several psychiatric disorders. There is growing evidence that exercise can also be an effective treatment for major depressive disorders, anxiety disorders and alcohol dependence. Individuals with schizophrenia are more likely to be sedentary than the general population. Objectives: The objectives of this systematic review are to analyse the habits of physical activity and examine the literature that has investigated the use of exercise as treatment for schizophrenia. Method: We systematically reviewed psycINFO, Medline/PubMed, SportDiscus, Web of Sciences, and Cochrane Library. The searches of databases were conducted from database inception until September 2010, using a range of search terms to reflect both physical activity and schizophrenia. Studies were subsequently considered eligible if they reported on quantitative studies investigating the effect of physical activity upon some aspect of physical or mental health in individuals with schizophrenia. Results: Of the 139 articles retrieved, 19 studies met the inclusion criteria. In controlled studies, most authors have underlined the benefits of aerobic exercises. These programs may act both on positive symptoms (hallucinations) and on negative symptoms. According to certain studies, the positive effect may appear in a short time and at the end of the program. No studies assess long-term benefits. Small samples of self selected participants, inadequately selected control groups are common methodological weaknesses. A recent research has directly investigated the potential mechanism underpinning the positive benefits. The results indicated that hippocampal volume is plastic in response to aerobic exercise. Discussion: We discuss methodological and practical challenges to research in this area, and outline several research questions that future work should seek to address. Existing studies do suggest that lifestyles, physical activity interventions, or regular exercise programmes are possible in this population and can have beneficial effects on both the mental and physical health and well being of individuals with schizophrenia. Conclusion: Research into the efficacy and safety of exercise as an intervention in schizophrenia is required to support the development of detailed, population-specific guidelines. Larger randomised studies are required before any definitive conclusions can be drawn. Although studies included in this review are small and used various measures of physical and mental health, results indicated that regular exercise programmes are possible in this population, and that they can have beneficial effects on both physical and mental health. Future research should address issues of programme adherence						
Biesheuvel-Leliefeld et al. 2015 (17)	Effectiveness of psychological interventions in preventing recurrence of depressive disorder: Meta-analysis and meta-regression	People with major depression (MD)	Psychological interventions	(1) treatment-as-usual and (2) the use of antidepressants	Relapse or recurrence rates of depressive disorder	We conclude that there is supporting evidence that preventive psychological interventions reduce the risk of relapse or recurrence in major depression
Sammendrag: Background: Major depression is probably best seen as a chronically recurrent disorder, with patients experiencing another depressive episode after remission. Therefore, attention to reduce the risk of relapse or recurrence after remission is warranted. The aim of this review is to meta-analytically examine the effectiveness of psychological interventions to reduce relapse or recurrence rates of depressive disorder. Methods: We systematically reviewed the pertinent trial literature until May 2014. The random-effects model was used to compute the pooled relative risk of relapse or recurrence (RR). A distinction was made between two comparator conditions: (1) treatment-as-usual and (2) the use of antidepressants. Other sources of heterogeneity in the data were explored using meta-regression. Results: Twenty-five randomised trials met inclusion criteria. Preventive psychological interventions were significantly better than treatment-as-usual in reducing the risk of relapse or recurrence (RR = 0.64, 95% CI = 0.53-0.76, z = 4.89, p < 0.001, NNT = 5) and also more successful than antidepressants (RR = 0.83, 95% CI = 0.70-0.97, z = 2.40, p = 0.017, NNT = 13). Meta-regression showed homogeneity in effect size across a range of study, population and intervention characteristics, but the preventive effect of psychological intervention was usually better when the prevention was preceded by treatment in the acute phase (b = -1.94, SEb=0.68, z = -2.84, p = 0.005). Limitations: Differences between the primary studies in methodological design, composition of the patient groups and type of intervention may have caused heterogeneity in the data, but could not be evaluated in a meta-regression owing to poor reporting. Conclusions: We conclude that there is supporting evidence that preventive psychological interventions reduce the risk of relapse or recurrence in major depression						

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Bond og Anderson 2015 (18)	Psychoeducation for relapse prevention in bipolar disorder: A systematic review of efficacy in randomized controlled trials	People with bipolar disorder, not in an acute illness episode	Psychoeducation	Treatment-as-usual, and placebo or active interventions	Relapse, mood symptoms, quality of life, or functioning	Group psychoeducation appears to be effective in preventing relapse in bipolar disorder, with less evidence for individually delivered interventions. Better understanding of mediating mechanisms is needed to optimize efficacy and personalize treatment
Sammendrag: Objectives: Previous reviews have concluded that interventions including psychoeducation are effective in preventing relapse in bipolar disorder, but the efficacy of psychoeducation itself has not been systematically reviewed. Our aim was to evaluate the efficacy of psychoeducation for bipolar disorder in preventing relapse and other outcomes, and to identify factors that relate to clinical outcomes. Methods: We employed the systematic review of randomized controlled trials of psychoeducation in participants with bipolar disorder not in an acute illness episode, compared with treatment-as-usual, and placebo or active interventions. Pooled odds ratios (ORs) for non-relapse into any episode, mania/hypomania, and depression were calculated using an intent-to-treat (ITT) analysis, assigning dropouts to relapse, with a sensitivity analysis in which dropouts were assigned to non-relapse (optimistic ITT). Results: Sixteen studies were included, eight of which provided data on relapse. Although heterogeneity in the data warrants caution, psychoeducation appeared to be effective in preventing any relapse [n = 7; OR: 1.98-2.75; number needed to treat (NNT): 5-7, depending on the method of analysis] and manic/hypomanic relapse (n = 8; OR: 1.68-2.52; NNT: 6-8), but not depressive relapse. Group, but not individually, delivered interventions were effective against both poles of relapse; the duration of follow-up and hours of therapy explained some of the heterogeneity. Psychoeducation improved medication adherence and short-term knowledge about medication. No consistent effects on mood symptoms, quality of life, or functioning were found. Conclusions: Group psychoeducation appears to be effective in preventing relapse in bipolar disorder, with less evidence for individually delivered interventions. Better understanding of mediating mechanisms is needed to optimize efficacy and personalize treatment					
Boudreau et al. 2010 (19)	Self-directed cognitive behavioural therapy for adults with diagnosis of depression: systematic review of clinical effectiveness, cost-effectiveness, and guidelines	People with Axis I depression (all types)	Self-directed cognitive behavioural therapy	Not reported	Clinical effectiveness and cost-effectiveness	Overall, the reviewed evidence indicated that self-directed CBT improved the clinical ratings of depressive symptoms and that it could be a cost-effective therapy option for individuals with mild to moderate depression. Given the limited evidence, it was uncertain whether self-directed CBT was effective for all individuals with depression; for example, those with more severe depressive symptoms. Also, it was uncertain whether one form of self-directed CBT was superior to another form of self-directed CBT. The factors that optimize the outcomes of selfdirected CBT (for example, degree of assistance) were not explored in this report
Sammendrag: Authors conclusions: Overall, the reviewed evidence indicated that self-directed CBT improved the clinical ratings of depressive symptoms and that it could be a cost-effective therapy option for individuals with mild to moderate depression. Given the limited evidence, it was uncertain whether self-directed CBT was effective for all individuals with depression; for example, those with more severe depressive symptoms. Also, it was uncertain whether one form of self-directed CBT was superior to another form of self-directed CBT. The factors that optimize the outcomes of selfdirected CBT (for example, degree of assistance) were not explored in this report						
Broderick et al. 2015 (20)	Yoga versus standard care for schizophrenia	People with schizophrenia	Yoga	Standard care	Mental state, social functioning, quality of life, drop-outs	Even though we found some positive evidence in favour of yoga over standard-care control, this should be interpreted cautiously in view of outcomes largely based each on one study with limited sample sizes and short-term follow-up. Overall, many outcomes were not reported and evidence presented in this review is of low to moderate quality - -too weak to indicate that yoga is superior to standard-care control for the management of schizophrenia

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Sammendrag: Background: Yoga is an ancient spiritual practice that originated in India and is currently accepted in the Western world as a form of relaxation and exercise. It has been of interest for people with schizophrenia to determine its efficacy as an adjunct to standard-care treatment.Objectives: To examine the effects of yoga versus standard care for people with schizophrenia.Search methods: We searched the Cochrane Schizophrenia Group Trials Register (November 2012 and January 29, 2015), which is based on regular searches of MEDLINE, PubMed, EMBASE, CINAHL, BIOSIS, AMED, PsycINFO, and registries of clinical trials. We searched the references of all included studies. There were no language, date, document type, or publication status limitations for inclusion of records in the register.Selection criteria: All randomised controlled trials (RCTs) including people with schizophrenia comparing yoga to standard-care control.Data collection and analysis: The review team independently selected studies, quality rated these, and extracted data. For binary outcomes, we calculated risk ratio (RR) and its 95% confidence interval (CI), on an intention-to-treat basis. For continuous data, we estimated the mean difference (MD) between groups and its 95% CI. We employed mixed-effect and fixed-effect models for analyses. We examined data for heterogeneity (I2 technique), assessed risk of bias for included studies, and created 'Summary of findings' tables using GRADE (Grading of Recommendations Assessment, Development and Evaluation).Main results: We included eight studies in the review. All outcomes were short term (less than six months). There were clear differences in a number of outcomes in favour of the yoga group, although these were based on one study each, with the exception of leaving the study early. These included mental state (improvement in Positive and Negative Syndrome Scale, 1 RCT, n = 83, RR 0.70 CI 0.55 to 0.88, medium-quality evidence), social functioning (improvement in Social Occupational Functioning Scale, 1 RCT, n = 83, RR 0.88 CI 0.77 to 1, medium-quality evidence), quality of life (average change 36-Item Short Form Survey (SF-36) quality-of-life subscale, 1 RCT, n = 60, MD 15.50, 95% CI 4.27 to 26.73, low-quality evidence), and leaving the study early (8 RCTs, n = 457, RR 0.91 CI 0.6 to 1.37, medium-quality evidence). For the outcome of physical health, there was not a clear difference between groups (average change SF-36 physical-health subscale, 1 RCT, n = 60, MD 6.60, 95% CI -2.44 to 15.64, low-quality evidence). Only one study reported adverse effects, finding no incidence of adverse events in either treatment group. This review was subject to a considerable number of missing outcomes, which included global state, change in cognition, costs of care, effect on standard care, service intervention, disability, and activities of daily living.Authors' conclusions: Even though we found some positive evidence in favour of yoga over standard-care control, this should be interpreted cautiously in view of outcomes largely based each on one study with limited sample sizes and short-term follow-up. Overall, many outcomes were not reported and evidence presented in this review is of low to moderate quality - -too weak to indicate that yoga is superior to standard-care control for the management of schizophrenia						
Buckley et al. 2015 (21)	Supportive therapy for schizophrenia	People with schizophrenia	Supportive therapy in addition to standard care	Standard care, or other treatments	Primary outcomes were relapse, hospitalisation and general functioning. Other outcomes described were clinical improvement in mental state and satisfaction of treatment	There are insufficient data to identify a difference in outcome between supportive therapy and standard care. There are several outcomes, including hospitalisation and general mental state, indicating advantages for other psychological therapies over supportive therapy but these findings are based on a few small studies where we graded the evidence as very low quality. Future research would benefit from larger trials that use supportive therapy as the main treatment arm rather than the comparator
Sammendrag: BACKGROUND: Supportive therapy is often used in everyday clinical care and in evaluative studies of other treatments. OBJECTIVES: To review the effects of supportive therapy compared with standard care, or other treatments in addition to standard care for people with schizophrenia. SEARCH METHODS: For this update, we searched the Cochrane Schizophrenia Group's register of trials (November 2012). SELECTION CRITERIA: All randomised trials involving people with schizophrenia and comparing supportive therapy with any other treatment or standard care. DATA COLLECTION AND ANALYSIS: We reliably selected studies, quality rated these and extracted data. For dichotomous data, we estimated the risk ratio (RR) using a fixed-effect model with 95% confidence intervals (CIs). Where possible, we undertook intention-to-treat analyses. For continuous data, we estimated the mean difference (MD) fixed-effect with 95% CIs. We estimated heterogeneity (I(2) technique) and publication bias. We used GRADE to rate quality of evidence. MAIN RESULTS: Four new trials were added after the 2012 search. The review now includes 24 relevant studies, with 2126 participants. Overall, the evidence was very low quality.We found no significant differences in the primary outcomes of relapse, hospitalisation and general functioning between supportive therapy and standard care.There were, however, significant differences favouring other psychological or psychosocial treatments over supportive therapy. These included hospitalisation rates (4 RCTs, n = 306, RR 1.82 CI 1.11 to 2.99, very low quality of evidence), clinical improvement in mental state (3 RCTs, n = 194, RR 1.27 CI 1.04 to 1.54, very low quality of evidence) and satisfaction of treatment for the recipient of care (1 RCT, n = 45, RR 3.19 CI 1.01 to 10.7, very low quality of evidence). For this comparison, we found no evidence of significant differences for rate of relapse, leaving the study early and quality of life.When we compared supportive therapy to cognitive behavioural therapy CBT), we again found no significant differences in primary outcomes. There were very limited data to compare supportive therapy with family therapy and psychoeducation, and no studies provided data regarding clinically important change in general functioning, one of our primary outcomes of interest. AUTHORS' CONCLUSIONS: There are insufficient data to identify a difference in outcome between supportive therapy and standard care. There are several outcomes, including hospitalisation and general mental state, indicating advantages for other psychological therapies over supportive therapy but these findings are based on a few small studies where we graded the evidence as very low quality. Future research would benefit from larger trials that use supportive therapy as the main treatment arm rather than the comparator						

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Carpenter 2011 (22)	St. John's wort and S-adenosyl methionine as "natural" alternatives to conventional antidepressants in the era of the suicidality boxed warning: what is the evidence for clinically relevant benefit?	People with major depressive disorder (MDD)	St. Johns wort nd S-adenosyl methionine as "natural" alternatives to conventional antidepressants	Placebo	Clinician-rated efficacy parameters, behavioral adverse events	Ten of 14 (71%) SJW studies in mild-to-moderate MDD were positive. The mean and median effect sizes for HAM-D change in those studies were 0.64 and 0.48, respectively, indicative of a moderately large treatment effect. In the few studies that included patients with severe symptoms, however, or which evaluated long-term maintenance of effect, SJW did not differentiate from placebo. The majority of SAM-e studies in MDD were also positive (8/14, 57%); however, most were methodologically flawed to some extent. Based on the magnitude of the treatment-effect size in a number of positive studies, SJW appears to be useful for the short-term treatment of mild-to-moderate depressive illness in adults. Existing data do not support the use of SJW in more severely depressed individuals. The SAM-e clinical data also are strongly suggestive of antidepressant efficacy; however, until more rigorously generated data become available it is not possibleto reach a more defnitive conclusion. There are no long-term treatment data that convincingly demonstrate long-term maintenance of effect for either product. The reviewed studies did not reveal evidence of treatment-emergent suicidality, suggesting that this risk for either product is low. However, the studies examined were not prospectively designed to detect such events and therefore were likely unable to reliably assess this risk this risk
Sammendrag: INTRODUCTION: A boxed-warning in antidepressant labeling now informs prescribers of the potential for treatmentemergent suicidality to occur. Consequently, alternative “natural” antidepressant therapies widely viewed to be devoid of this risk, such as St. John’s wort (SJW) and s-adenosyl methionine (SAM-e), may experience a resurgence in popularity and expansion of use beyond mild forms of depressive illness. The purpose of this article is to critically assess whether the clinical evidence supports the use of SJW and SAM-e as alternatives to conventional antidepressants in the treatment of major depressive disorder (MDD). In addition, this article evaluates whether the behavioral adverse event profiles of SJW and SAM-e suggest an increased risk for suicidality, like their conventional counterparts. METHODS: A comprehensive literature review was performed (Jan 1975-July 2010) to identify all English language reports of placebo-controlled studies of SJW and SAM-e conducted for psychiatric indications. MDD studies were categorized as “positive” or “negative” based on statistical superiority to placebo on prospectively-de!ned, primary, clinician-rated e"cacy parameters (e.g., change in Hamilton Depression scores [HAM-D] or Montgomery-Asberg Depression Rating Scale [MADRS] total). Treatment effect size (Cohen’s d) was also calculated in each case to assess the clinical relevance of the fndings. Behavioral-related adverse events were summarized by treatment. RESULTS: Ten of 14 (71%) SJW studies in mild-to-moderate MDD were positive. The mean and median effect sizes for HAM-D change in those studies were 0.64 and 0.48, respectively, indicative of a moderately large treatment effect. In the few studies that included patients with severe symptoms, however, or which evaluated long-term maintenance of effect, SJW did not differentiate from placebo. The majority of SAM-e studies in MDD were also positive (8/14, 57%); however, most were methodologically flawed to some extent. Based on the magnitude of the treatment-effect size in a number of positive studies, SJW appears to be useful for the short-term treatment of mild-to-moderate depressive illness in adults. Existing data do not support the use of SJW in more severely depressed individuals. The SAM-e clinical data also are strongly suggestive of antidepressant efficacy; however, until more rigorously generated data become available it is not possible to reach a more defnitive conclusion. There are no long-term treatment data that convincingly demonstrate long-term maintenance of effect for either product. The reviewed studies did not reveal evidence of treatment-emergent suicidality, suggesting that this risk for either product is low. However, the studies examined were not prospectively designed to detectsuch events and therefore were likely unable to reliably assess this risk					
Chiesa og Serretti 2011 (23)	Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis	People defined as psychiatric patients	Mindfulness-based Cognitive Therapy (MBCT)	Usual care or continuation of maintenance antidepressants	Relapse and symptoms	Main findings included the following: 1) MBCT in adjunct to usual care was significantly better than usual care alone for reducing major depression (MD) relapses in patients with three or more prior depressive episodes (4 studies), 2) MBCT plus gradual discontinuation of maintenance ADs was associated to similar relapse rates at 1 year as compared with continuation of maintenance antidepressants (1 study), 3) the augmentation of MBCT could be useful for reducing residual depressive symptoms in patients with MD (2 studies) and for reducing anxiety symptoms in patients with bipolar disorder in remission (1 study) and in patients with some anxiety disorders (2 studies). However, several methodological shortcomings including small sample sizes, non-randomized design of some studies and the absence of studies comparing MBCT to control groups designed to distinguish specific from non-specific effects of such practice underscore the necessity for further research

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Sammendrag: Mindfulness- based Cognitive Therapy (MBCT) is a meditation program based on an integration of Cognitive behavioural therapy and Mindfulness-based stress reduction. The aim of the present work is to review and conduct a meta-analysis of the current findings about the efficacy of MBCT for psychiatric patients. A literature search was undertaken using five electronic databases and references of retrieved articles. Main findings included the following: 1) MBCT in adjunct to usual care was significantly better than usual care alone for reducing major depression (MD) relapses in patients with three or more prior depressive episodes (4 studies), 2) MBCT plus gradual discontinuation of maintenance ADs was associated to similar relapse rates at 1 year as compared with continuation of maintenance antidepressants (1 study), 3) the augmentation of MBCT could be useful for reducing residual depressive symptoms in patients with MD (2 studies) and for reducing anxiety symptoms in patients with bipolar disorder in remission (1 study) and in patients with some anxiety disorders (2 studies). However, several methodological shortcomings including small sample sizes, non-randomized design of some studies and the absence of studies comparing MBCT to control groups designed to distinguish specific from non-specific effects of such practice underscore the necessity for further research						
Cramer et al. 2013 (24)	Yoga for schizophrenia: a systematic review and meta-analysis	People with schizophrenia	Yoga	Usual care or non-pharmacological interventions	Primary: symptoms of schizophrenia and quality of life. Secondary: cognitive and social function and hospitalization	This systematic review found only moderate evidence for short-term effects of yoga on quality of life. As these effects were not clearly distinguishable from bias and safety of the intervention was unclear, no recommendation can be made regarding yoga as a routine intervention for schizophrenia patients
Sammendrag: BACKGROUND: The aim of this review was to systematically review and meta-analyze the effects of yoga on symptoms of schizophrenia, quality of life, function, and hospitalization in patients with schizophrenia. METHODS: MEDLINE/Pubmed, Scopus, the Cochrane Library, PsycInfo, and IndMED were screened through August 2012. Randomized controlled trials (RCTs) comparing yoga to usual care or non-pharmacological interventions were analyzed when they assessed symptoms or quality of life in patients with schizophrenia. Cognitive function, social function, hospitalization, and safety were defined as secondary outcomes. Risk of bias was assessed using the risk of bias tool recommended by the Cochrane Back Review Group. Standardized mean differences (SMD) and 95% confidence intervals (CI) were calculated. RESULTS: Five RCTs with a total of 337 patients were included; 2 RCTs had low risk of bias. Two RCTs compared yoga to usual care; 1 RCT compared yoga to exercise; and 2 3-arm RCTs compared yoga to usual care and exercise. No evidence was found for short-term effects of yoga compared to usual care on positive symptoms (SMD = -0.58; 95% CI -1.52 to 0.37; P = 0.23), or negative symptoms (SMD = -0.59; 95% CI -1.87 to 0.69; P = 0.36). Moderate evidence was found for short-term effects on quality of life compared to usual care (SMD = 2.28; 95% CI 0.42 to 4.14; P = 0.02). These effects were only present in studies with high risk of bias. No evidence was found for short-term effects on social function (SMD = 1.20; 95% CI -0.78 to 3.18; P = 0.23). Comparing yoga to exercise, no evidence was found for short-term effects on positive symptoms (SMD = -0.35; 95% CI -0.75 to 0.05; P = 0.09), negative symptoms (SMD = -0.28; 95% CI -1.42 to 0.86; P = 0.63), quality of life (SMD = 0.17; 95% CI -0.27 to 0.61; P = 0.45), or social function (SMD = 0.20; 95% CI -0.27 to 0.67; P = 0.41). Only 1 RCT reported adverse events. CONCLUSIONS: This systematic review found only moderate evidence for short-term effects of yoga on quality of life. As these effects were not clearly distinguishable from bias and safety of the intervention was unclear, no recommendation can be made regarding yoga as a routine intervention for schizophrenia patients						
Crowe et al. 2015 (25)	Non-pharmacological strategies for treatment of inpatient depression	People with moderate to severe depression in an inpatient setting	Non-pharmacological interventions	Control (no further explanation)	Not reported	A diverse range of treatment strategies has been identified in this review. These studies provide evidence that non-pharmacological treatments for depression can be given to enhance outcomes and that research can be undertaken in inpatient settings. Whilst the evidence base has limitations, this review also highlights therapeutic and research opportunities in this area
Sammendrag: Objective: To examine the evidence for non-pharmacological interventions in the treatment of moderate to severe depression in an inpatient setting. Method: An integrative review of original research papers was conducted. The electronic databases CINAHL, MEDLINE and PsychINFO were searched using the following search terms: depression, psychosocial, psychosocial intervention, therapy, and inpatient. Results: Twelve studies were identified in the search for non-psychopharmacological interventions for depression commenced in an inpatient setting. The interventions included psychotherapies, behavioural activation, and chronotherapeutic interventions (controlled exposure to environmental stimuli). These studies suggest it is possible to engage severely depressed inpatients in structured interventions in an inpatient environment. The majority of studies reported favourable outcomes for the interventions compared to a control, but methodological issues were common. Conclusions: A diverse range of treatment strategies has been identified in this review. These studies provide evidence that non-pharmacological treatments for depression can be given to enhance outcomes and that research can be undertaken in inpatient settings. Whilst the evidence base has limitations, this review also highlights therapeutic and research opportunities in this area						
Cuijpers et al. 2011 (26)	Psychological treatment of depression in inpatients: A systematic review and meta-analysis	People who are depressed and described as depressed inpatinets	Psychological treatments	Usual care and structured pharmacological treatments	Depression	Although the number of studies was small, and the quality of many studies was not optimal, it seems safe to conclude that psychological treatments have a small but robust effect on depression in depressed inpatients. More high-quality research is needed to verify these results

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Research on psychological treatment of depression in inpatients is not conclusive,with some studies finding clear positive effects and other studies finding no significant benefit compared to usual care or structured pharmacotherapy. The results of a meta-analysis investigating how effective psychological treatment is for depressed inpatients are presented. A systematic search in bibliographical databases resulted in 12 studies with a total of 570 respondents. This set of studies had sufficient statistical power to detect small effect sizes. Psychological treatments had a small (g = 0.29), but statistically significant additional effect on depression compared to usual care and structured pharmacological treatments only. This corresponded with a numbers-needed-to-be-treated of 6.17. Heterogeneity was zero inmost analyses, and not significant in all analyses. There was no indication for significant publication bias. Effects were not associated with characteristics of the population, the interventions and the design of the studies. Although the number of studies was small, and the quality of many studies was not optimal, it seems safe to conclude that psychological treatments have a small but robust effect on depression in depressed inpatients. More high-quality research is needed to verify these results						
Cuijpers et al. 2011 (27)	Interpersonal psychotherapy for depression: A meta-analysis	People with major depressive disorder (described as unipolar depressive disorders by authors	Interpersonal psychotherapy (IPT)	No treatment, usual care, other psychological treatments, and pharmacotherapy as well as studies comparing combination treatment using pharmacotherapy and IPT	Relapse	There is no doubt that IPT efficaciously treats depression, both as an independent treatment and in combination with pharmacotherapy. IPT deserves its place in treatment guidelines as one of the most empirically validated treatments for depression
Sammendrag: [Correction Notice: An erratum for this article was reported in Vol 168(6) of The American Journal of Psychiatry (see record 2011-15374-020). When the article was posted online March 1, 2011, Figure 2 was not included. Figure 2 has been restored for this article's appearance in the June 2011 issue and for its online posting as part of the issue.] Objective: Interpersonal psychotherapy (IPT), a structured and time-limited therapy, has been studied in many controlled trials. Numerous practice guidelines have recommended IPT as a treatment of choice for unipolar depressive disorders. The authors conducted a meta-analysis to integrate research on the effects of IPT. Method: The authors searched bibliographical databases for randomized controlled trials comparing IPT with no treatment, usual care, other psychological treatments, and pharmacotherapy as well as studies comparing combination treatment using pharmacotherapy and IPT. Maintenance studies were also included. Results: Thirty-eight studies including 4,356 patients met all inclusion criteria. The overall effect size (Cohen's d) of the 16 studies that compared IPT and a control group was 0.63 (95% confidence interval [CI]=0.36 to 0.90), corresponding to a number needed to treat of 2.91. Ten studies comparing IPT and other psychological treatments showed a nonsignificant differential effect size of 0.04 (95% CI=-0.14 to 0.21; number needed to treat=45.45) favoring IPT. Pharmacotherapy (after removal of one outlier) was more effective than IPT (d=-0.19, 95% CI=-0.38 to -0.01; number needed to treat=9.43), and combination treatment was not more effective than IPT alone, although the paucity of studies precluded drawing definite conclusions. Combination maintenance treatment with pharmacotherapy and IPT was more effective in preventing relapse than pharmacotherapy alone (odds ratio=0.37; 95% CI=0.19 to 0.73; number needed to treat=7.63). Conclusions: There is no doubt that IPT efficaciously treats depression, both as an independent treatment and in combination with pharmacotherapy. IPT deserves its place in treatment guidelines as one of the most empirically validated treatments for depression						
Cuijpers et al. 2014 (28)	The effects of psychotherapies for major depression in adults on remission, recovery and improvement: a meta-analysis	People with major depressive disorder (MDD)	Psychotherapy	Control (no further explanation)	Actual improvement, the absolute numbers of patients no longer meeting criteria for major depression, and absolute rates of response and remission	Psychotherapy contributes to improvement in depressed patients, but improvement in control conditions is also considerable

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Background: Standardised effect sizes have been criticized because they are difficult to interpret and offer little clinical information. This meta-analyses examine the extent of actual improvement, the absolute numbers of patients no longer meeting criteria for major depression, and absolute rates of response and remission. Methods: We conducted a meta-analysis of 92 studies with 181 conditions (134 psychotherapy and 47 control conditions) with 6937 patients meeting criteria for major depressive disorder. Within these conditions, we calculated the absolute number of patients no longer meeting criteria for major depression, rates of response and remission, and the absolute reduction on the BDI, BDI-II, and HAM-D. Results: After treatment, 62% of patients no longer met criteria for MDD in the psychotherapy conditions. However, 43% of participants in the control conditions and 48% of people in the care-as-usual conditions no longer met criteria for MDD, suggesting that the additional value of psychotherapy compared to care-as-usual would be 14%. For response and remission, comparable results were found, with less than half of the patients meeting criteria for response and remission after psychotherapy. Additionally, a considerable proportion of response and remission was also found in control conditions. In the psychotherapy conditions, scores on the BDI were reduced by 13.42 points, 15.12 points on the BDI-II, and 10.28 points on the HAM-D. In the control conditions, these reductions were 4.56, 4.68, and 5.29. Discussion: Psychotherapy contributes to improvement in depressed patients, but improvement in control conditions is also considerable						
Danielsson et al. 2013 (29)	Exercise in the treatment of major depression: a systematic review grading the quality of evidence	People with major depression (MD)	Aerobic exercise	Antidepressants, any physical activity, treatmant as usual	Treatment outcome in adults with major depression confirmed by a clinical interview	In general, exercise appears to be beneficial in the treatment of depression when used in combination with medication. A significant issue that is not well addressed in previous studies is the risks associated with exercise. Further, this review indicates that aerobic exercise is not more effective than other types of physical activity, pointing to a need to further investigate active components
Sammendrag: OBJECTIVE: To examine the quality of evidence for exercise in the treatment of major depression, comparing specific study types; aerobic exercise vs. antidepressants, aerobic exercise vs. any physical activity, and aerobic exercise as augmentation therapy to treatment as usual vs. treatment as usual. METHODS: Electronic searches for randomized controlled studies, reporting on treatment outcome in adults with major depression confirmed by a clinical interview. Quality of evidence was assessed using the Grading and Recommendations Assessment, Development and Evaluation and an additional risk of bias-protocol. RESULTS: Fourteen eligible studies were retrieved, of which nine had low risk of bias. We found moderate quality of evidence that aerobic exercise has no significant effect compared to antidepressants. We found moderate quality of evidence that aerobic exercise at a moderate to high intensity has no significant effect compared to other forms of physical activity. We found low quality of evidence that exercise as augmentation to treatment as usual has a small effect - depression scores were on average 0.44 of a standard deviation lower - compared to treatment as usual. CONCLUSION: In general, exercise appears to be beneficial in the treatment of depression when used in combination with medication. A significant issue that is not well addressed in previous studies is the risks associated with exercise. Further, this review indicates that aerobic exercise is not more effective than other types of physical activity, pointing to a need to further investigate active components						
Davis og Kurzban 2012 (30)	Mindfulness-Based Treatment for People With Severe Mental Illness: A Literature Review	People with severe mental illness (SMI)	Mindfulness-based treatment interventions	Not reported	Symptom-associated distress, self-efficacy, and psychiatric hospitalization	Evidence suggests that this approach shows promise in reducing symptom-associated distress, increasing feelings of self-efficacy, and reducing psychiatric hospitalizations for individuals with psychotic disorders. This review also reveals several ongoing challenges in the field including the need for more rigorously controlled studies, further operationalization of the construct of mindfulness and evidence of construct validity, and greater insight into the specific mechanisms of change underlying mindful awareness. Overall, this innovative approach warrants further exploration, having been used as a component of existing evidence-based practices or provided in a stand-alone manner to promote adaptive coping and wellness among individuals with SMI
Sammendrag: This article provides a synthesis of current findings from existing mindfulness-based treatment interventions and their relevance to individuals with severe mental illness (SMI). A mindfulness-oriented approach to coping with SMI goes beyond symptom management and exemplifies key recovery principles such as self-determination and resilience. Although previous studies and critical reviews provide evidence of a relationship between mindfulness training and positive mental health and physical outcomes for various populations, this is the first critical review to systematically examine the efficacy of these methods in treating SMI. Evidence suggests that this approach shows promise in reducing symptom-associated distress, increasing feelings of self-efficacy, and reducing psychiatric hospitalizations for individuals with psychotic disorders. This review also reveals several ongoing challenges in the field including the need for more rigorously controlled studies, further operationalization of the construct of mindfulness and evidence of construct validity, and greater insight into the specific mechanisms of change underlying mindful awareness. Overall, this innovative approach warrants further exploration, having been used as a component of existing evidence-based practices or provided in a stand-alone manner to promote adaptive coping and wellness among individuals with SMI						
de Souza Moura et al. 2015 (31)	Comparison among aerobic exercise and other types of interventions to treat depression: a systematic review	People with mild, moderate and severe depression	Aerobic exercise	Other types of interventions to treat depression	Symptoms	From the sample analyzed, 71.4% was composed of women, and regarding the severity of symptoms, 85% had mild to moderate depression and only 15% had moderate to severe depression. However, there is still disagreement regarding the effect of exercise compared to the use of antidepressants in symptomatology and cognitive function in depression, this suggests that there is no consensus on the correct intensity of aerobic exercise as to achieve the best dose-response, with intensities high to moderate or moderate to mild

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Sammendrag: Depression is a common and disabling disease that affects over 100 million people worldwide and can have a significant impact on physical and mental health, reducing their quality of life. Thus, the aim of this article was to provide information on research results and key chains related to the therapeutic effects of chronic aerobic exercise compared with other types of interventions to treat depression, which may become a useful clinical application in a near future. Researches have shown the effectiveness of alternative treatments, such as physical exercise, minimizing high financial costs and minimizing side effects. In this review, the data analyzed allows us to claim that alternative therapies, such as exercise, are effective on controlling and reducing symptoms. 69.3% of the studies that investigated the antidepressant effects of exercise on depressive were significant, and the other 30.7% of the studies improved only in general physiological aspects, such as increased oxygen uptake, increased use of blood glucose and decreased body fat percentage, with no improvement on symptoms of depression. From the sample analyzed, 71.4% was composed of women, and regarding the severity of symptoms, 85% had mild to moderate depression and only 15% had moderate to severe depression. However, there is still disagreement regarding the effect of exercise compared to the use of antidepressants in symptomatology and cognitive function in depression, this suggests that there is no consensus on the correct intensity of aerobic exercise as to achieve the best dose-response, with intensities high to moderate or moderate to mild						
Donker et al. 2013 (32)	Suicide prevention in schizophrenia spectrum disorders and psychosis: a systematic review	People with schizophrenia spectrum disorders and psychosis	Psychosocial interventions	Attention placebo, treatment as usual (TAU), no intervention or waitlist control groups	Suicidal behaviour	Psychosocial interventions may be effective in reducing suicidal behaviour in patients with schizophrenia spectrum disorders and psychosis, although the additional benefit of these interventions above that contributed by a control condition or treatment-as-usual is not clear
Sammendrag: BACKGROUND: The incidence of suicide is high among patients with schizophrenia spectrum disorders and psychosis. A systematic review was performed to investigate the effectiveness of psychosocial interventions in reducing suicidal behaviour among patients with schizophrenia spectrum disorders and psychosis. METHODS: Cochrane, PubMed and PsycINFO databases were searched to January 2012. Additional materials were obtained from reference lists. Randomised Controlled Trials describing psychosocial interventions for psychotic disorders with attention placebo, treatment as usual (TAU), no intervention or waitlist control groups were included. RESULTS: In total, 11,521 abstracts were identified. Of those, 10 papers describing 11 trials targeting psychosocial interventions for reducing suicidal behaviour in patients with schizophrenia spectrum disorders and psychosic symptoms or disorders met the inclusion criteria. Odds Ratios describing the likelihood of a reduction in suicidal behaviour or ideation ranged from 0.09 to 1.72 at post-test and 0.13 to 1.48 at follow-up. CONCLUSIONS: Psychosocial interventions may be effective in reducing suicidal behaviour in patients with schizophrenia spectrum disorders and psychosis, although the additional benefit of these interventions above that contributed by a control condition or treatment-as-usual is not clear						
Draper et al. 2010 (33)	Cognitive behavioral therapy for schizophrenia: A review of recent literature and meta-analyses	People with schizophrenia	Cognitive behavioral therapy	Not reported	Symptoms (ie., hallucinations, delusions and negative symptoms)	This paper provides an overview of CBTp theory and techniques, a discussion of recent clinical trials for specific symptoms clusters (ie. hallucinations, delusions and negative symptoms) and a review of recent meta-analyses. In addition, future directions for research are proposed
Sammendrag: Cognitive behavioral therapy for schizophrenia (CBTp) is an evidence based practice based on the work by Aaron T. Beck, MD. Initially, CBTp research focused on adjunctive treatment for patients with medication resistant positive symptoms; however, more recent studies have expanded to include areas such as the treatment of negative symptoms, comorbid disorders and the use of a group modality. Several randomized clinical trials and meta-analyses have established CBTp as an effective treatment for the symptoms associated with schizophrenia with moderate effect sizes. This paper provides an overview of CBTp theory and techniques, a discussion of recent clinical trials for specific symptoms clusters (ie., hallucinations, delusions and negative symptoms) and a review of recent meta-analyses. In addition, future directions for research are proposed						
Fiorillo et al. 2013 (34)	Efficacy of supportive family interventions in bipolar disorder: A review of the literature	People with bipolar disorder	Supportive family interventions	Not reported	Patients' clinical and social outcome and family functioning	Supportive family interventions should be an integral part of optimal management of bipolar disorder. Studies on the implementation of these interventions in routine practice are needed
Sammendrag: Background: To review the efficacy of supportive family interventions for bipolar disorder on patients' clinical and social outcome and family functioning. Methods: A review of the studies on supportive family interventions in bipolar disorder carried out in the last 20 years has been performed using the main databases. Searched keywords include "psychoeducational family intervention", "family therapy", "family supportive interventions", "caregivers"; these terms have been matched with "bipolar disorder", "affective disorders" or with "manic-depressive illness". Results: The different approaches developed, alone or integrated with more complex treatment strategies, can improve the course of bipolar disorder, reduce the risk of relapses and hospitalizations and improve patient adherence to pharmacological treatment. Only few studies have tested the efficacy of these interventions on the reduction of suicidal ideation or in patients with an early onset of the disease. Supportive family interventions improve coping strategies of relatives and family burden. Conclusions: Supportive family interventions should be an integral part of optimal management of bipolar disorder. Studies on the implementation of these interventions in routine practice are needed						
Firth et al. 2015 (35)	A systematic review and meta-analysis of exercise interventions in schizophrenia patients	People with schizophrenia (non-affective psychotic disorders)	Exercise interventions	Not reported	Physical and mental health outcomes	Interventions that implement a sufficient dose of exercise, in supervised or group settings, can be feasible and effective interventions for schizophrenia

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Background. The typically poor outcomes of schizophrenia could be improved through interventions that reduce cardiometabolic risk, negative symptoms and cognitive deficits; aspects of the illness which often go untreated. The present review and meta-analysis aimed to establish the effectiveness of exercise for improving both physical and mental health outcomes in schizophrenia patients. Method. We conducted a systematic literature search to identify all studies that examined the physical or mental effects of exercise interventions in non-affective psychotic disorders. Of 1581 references, 20 eligible studies were identified. Data on study design, sample characteristics, outcomes and feasibility were extracted from all studies and systematically reviewed. Meta-analyses were also conducted on the physical and mental health outcomes of randomized controlled trials. Results. Exercise interventions had no significant effect on body mass index, but can improve physical fitness and other cardiometabolic risk factors. Psychiatric symptoms were significantly reduced by interventions using around 90 min of moderate-to-vigorous exercise per week (standardized mean difference: 0.72, 95% confidence interval -1.14 to -0.29). This amount of exercise was also reported to significantly improve functioning, co-morbid disorders and neurocognition. Conclusions. Interventions that implement a sufficient dose of exercise, in supervised or group settings, can be feasible and effective interventions for schizophrenia						
Fovet et al. 2015 (36)	Current Issues in the Use of fMRI-Based Neurofeedback to Relieve Psychiatric Symptoms	People with psychiatric disorders	fMRI-based neurofeedback (fMRI-NF)	Not reported	Clinical improvement	Six relevant references and five ongoing studies were identified according to our inclusion criteria. These studies show that in most psychiatric disorders (major depressive disorder, schizophrenia, personality disorders, addiction) patients are able to learn voluntary control of the neuronal activity of the targeted brain region(s). Interestingly, in some cases, this learning is associated with clinical improvement, showing that fMRI-NF can potentially be developed into a therapeutic tool. However, only low-level evidence is available to support the use of this relatively new technique in clinical practice. Notably, no randomized, controlled trial is currently available in this field of research. Finally, methodological issues and clinical perspectives (especially the potential use of pattern recognition in fMRI-NF protocols) are discussed
Sammendrag: fMRI-based neurofeedback (fMRI-NF) is a non-invasive technique that allows participants to achieve control of their own brain activity using the real-time feedback of the activity (measured indirectly based on the BOLD signal) of a particular brain region or network. The feasibility of fMRI-NF in healthy subjects has been documented for a variety of brain areas and neural systems, and this technique has also been proposed for the treatment of psychiatric disorders in recent years. Through a systematic review of the scientific literature this paper probes the rationale and expected applications of fMRI-NF in psychiatry, discusses issues that must be addressed in the use of this technique to treat mental disorders. Six relevant references and five ongoing studies were identified according to our inclusion criteria. These studies show that in most psychiatric disorders (major depressive disorder, schizophrenia, personality disorders, addiction), patients are able to learn voluntary control of the neuronal activity of the targeted brain region(s). Interestingly, in some cases, this learning is associated with clinical improvement, showing that fMRI-NF can potentially be developed into a therapeutic tool. However, only low-level evidence is available to support the use of this relatively new technique in clinical practice. Notably, no randomized, controlled trial is currently available in this field of research. Finally, methodological issues and clinical perspectives (especially the potential use of pattern recognition in fMRI-NF protocols) are discussed.						
Freeman et al. 2010 (37)	Complementary and alternative medicine in major depressive disorder: The American Psychiatric Association Task Force report	People with major depressive disorder (MDD)	Selected complementary and alternative medicine (CAM) treatments	Not reported	Symptoms, risks and benefits	A review of randomized controlled trials for commonly used CAM treatments such as omega-3 fatty acids, St John's wort (Hypericum), folate, S-adenosyl-L-methionine (SAMe), acupuncture, light therapy, exercise, and mindfulness psychotherapies revealed promising results. More rigorous and larger studies are recommended. Each CAM treatment must be evaluated separately in adequately powered controlled trials. At this time, several CAM treatments appear promising and deserve further study. The greatest risk of pursuing a CAM therapy is the possible delay of other well-established treatments. Clinical, research, and educational initiatives designed to focus on CAM in psychiatry are clearly warranted due to the widespread use of CAM therapies
Sammendrag: Objective: To review selected complementary and alternative medicine (CAM) treatments for major depressive disorder (MDD). Participants: Authors of this report were invited participants in the American Psychiatric Associations Task Force on Complementary and Alternative Medicine. Evidence: The group reviewed the literature on individual CAM treatments for MDD, methodological considerations, and future directions for CAM in psychiatry. Individual CAM treatments were reviewed with regard to efficacy in MDD, as well as risks and benefits. Literature searches included MEDLINE and PsycINFO reviews and manual reference searches; electronic searches were limited to English-language publications from 1965 to January 2010 (but manual searches were not restricted by language). Treatments were selected for this review on the basis of (1) published randomized controlled trials in MDD and (2) widespread use with important clinical safety or public health significance relevant to psychiatric practice. An action plan is presented based on needs pertaining to CAM and psychiatry. Consensus Process: Consensus was reached by group conferences. Written iterations were drafted and sent out among group members prior to discussion, resolution of any differences of interpretation of evidence, and final approval. Conclusions: A review of randomized controlled trials for commonly used CAM treatments such as omega-3 fatty acids, St John's wort (Hypericum), folate, S-adenosyl-L-methionine (SAMe), acupuncture, light therapy, exercise, and mindfulness psychotherapies revealed promising results. More rigorous and larger studies are recommended. Each CAM treatment must be evaluated separately in adequately powered controlled trials. At this time, several CAM treatments appear promising and deserve further study. The greatest risk of pursuing a CAM therapy is the possible delay of other well-established treatments. Clinical, research, and educational initiatives designed to focus on CAM in psychiatry are clearly warranted due to the widespread use of CAM therapies						

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Freeman et al. 2010 (38)	Complementary and alternative medicine in major depressive disorder: A meta-analysis of patient characteristics, placebo-response rates and treatment outcomes relative to standard antidepressants	People with major depressive disorder (MDD)	Complementary and alternative medicine (CAM) treatments	Placebo-CAM and standard antidepressants	Illness seventy, placebo-respons rate, discontinuation due to adverse events	Participants in CAM trials were more likely to be female and to have a lower placebo-response rate compared to those in standard antidepressant trials for MDD. Trials of standard antidepressants and CAM therapies were composed of patients with similar depression severity
Sammendrag: Objective: To compare patient characteristics, placebo-response rates, and outcome differences in active treatment compared to placebo in randomized controlled trials (RCTs) of complementary and alternative medicine (CAM) and standard antidepressants for major depressive disorder (MDD). Data Sources: Eligible studies were first identified using searches of PubMed/MEDLINE, restricted to English, by cross-referencing the search term placebo with each of the antidepressants (those that had received letters of approval by the US, Canadian, or EU drug regulatory agencies for the treatment of MDD) and selected CAM agents. These searches were limited to articles published between January 1, 1980, and September 15, 2009 (inclusive). Reference lists from identified studies were also searched for studies eligible for inclusion. Study Selection: We selected RCTs for MDD that included validated diagnostic assessment and baseline/outcome measures of illness seventy. Assessment was limited to widely used CAM agents most frequently studied in RCTs with pill placebo: St John's wort, omega-3 fatty acids, and S-adenosyl-L-methionine (SAMe). Data Synthesis: Of eligible publications, 173 reported results of 1 trial, and 5 included > 1 trial, representing a total of 185 RCTs. Patient variables, including illness severity, were similar across CAM and antidepressant RCTs, except for a higher proportion of women in CAM studies (P = .0003). Random-effects meta-analysis indicated that both antidepressant and CAM monotherapy resulted in superior response rates compared with placebo. Placebo-response rates were significantly lower for patients enrolled in CAM versus antidepressant RCTs (P = .002). Meta-regression analyses yielded no significant differences in the relative risk of prematurely discontinuing therapy due to any reason between active treatment and placebo for antidepressant and CAM RCTs, although discontinuation due to adverse events was higher in antidepressant RCTs compared to CAM RCTs (P = .007). Conclusions: Participants in CAM trials were more likely to be female and to have a lower placebo-response rate compared to those in standard antidepressant trials for MDD. Trials of standard antidepressants and CAM therapies were composed of patients with similar depression severity					
Fuhr et al. 2014 (39)	Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: a systematic review and meta-analysis	People with severe mental illness and depression	Peer-delivered interventions	Treatment as usual or treatment delivered by a health professional	Clinical and psychosocial outcomes	The limited evidence base suggests that peers may have a small additional impact on patient's outcomes, in comparison to standard psychiatric care in high-income settings. Future research should explore the use and applicability of peer-delivered interventions in resource poor settings where standard care is likely to be of lower quality and coverage. The positive findings of equivalence trials demand further research in this area to consolidate the relative value of peer-delivered vs. professional-delivered interventions
Sammendrag: PURPOSE: To evaluate the effectiveness of peer-delivered interventions in improving clinical and psychosocial outcomes among individuals with severe mental illness (SMI) or depression. METHODS: Systematic review and meta-analysis of randomised controlled trials comparing a peer-delivered intervention to treatment as usual or treatment delivered by a health professional. Random effect meta-analyses were performed separately for SMI and depression interventions. RESULTS: Fourteen studies (10 SMI studies, 4 depression studies), all from high-income countries, met the inclusion criteria. For SMI, evidence from three high-quality superiority trials showed small positive effects favouring peer-delivered interventions for quality of life (SMD 0.24, 95 % CI 0.08-0.40, p = 0.003, I (2) = 0 %, n = 639) and hope (SMD 0.24, 95 % CI 0.02-0.46, p = 0.03, I (2) = 65 %, n = 967). Results of two SMI equivalence trials indicated that peers may be equivalent to health professionals in improving clinical symptoms (SMD -0.14, 95 % CI -0.57 to 0.29, p = 0.51, I (2) = 0 %, n = 84) and quality of life (SMD -0.11, 95 % CI -0.42 to 0.20, p = 0.56, I (2) = 0 %, n = 164). No effect of peer-delivered interventions for depression was observed on any outcome. CONCLUSIONS: The limited evidence base suggests that peers may have a small additional impact on patient's outcomes, in comparison to standard psychiatric care in high-income settings. Future research should explore the use and applicability of peer-delivered interventions in resource poor settings where standard care is likely to be of lower quality and coverage. The positive findings of equivalence trials demand further research in this area to consolidate the relative value of peer-delivered vs. professional-delivered interventions					
Galante et al. 2013 (40)	Effects of mindfulness-based cognitive therapy on mental disorders: A systematic review and meta-analysis of randomised controlled trials	People diagnosed with mental disorders (such as major depression)	Mindfulness-based cognitive therapy (MBCT)	Usual treatment	Mental health (relapse)	Based on this review and meta-analyses, MBCT is an effective intervention for patients with three or more previous episodes of major depression

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Objective: Mindfulness-based cognitive therapy (MBCT) is a programme developed to prevent depression relapse, but has been applied for other disorders. Our objective was to systematically review and meta-analyse the evidence on the effectiveness and safety of MBCT for the treatment of mental disorders. Methods: Searches were completed in CENTRAL, MEDLINE, EMBASE, LILACS, PsychINFO, and PsycEXTRA in March 2011 using a search strategy with the terms 'mindfulness-based cognitive therapy', 'mindfulness', and 'randomised controlled trials' without time restrictions. Selection criteria of having a randomised controlled trial design, including patients diagnosed with mental disorders, using MBCT according to the authors who developed MBCT and providing outcomes that included changes in mental health were used to assess 608 reports. Two reviewers applied the pre-determined selection criteria and extracted the data into structured tables. Meta-analyses and sensitivity analyses were completed. Results: Eleven studies were included. Most of them evaluated depression and compared additive MBCT against usual treatment. After 1 year of follow-up MBCT reduced the rate of relapse in patients with three or more previous episodes of depression by 40% (5 studies, relative risk [95% confidence interval]: 0.61 [0.48, 0.79]). Other meta-analysed outcomes were depression and anxiety, both with significant results but unstable in sensitivity analyses. Methodological quality of the reports was moderate. Conclusion: Based on this review and meta-analyses, MBCT is an effective intervention for patients with three or more previous episodes of major depression						
Geoffroy et al. 2015 (41)	[Bright light therapy in seasonal bipolar depressions]	People with bipolar disorders	Bright-light therapy (BLT)	Not reported	Seasonal bipolar depressive episodes	There are very few specific data on seasonal bipolar depressive episodes. This literature review has highlighted that BLT should be handled as a regular antidepressant treatment in patients suffering from seasonal bipolar depressive episodes
Sammendrag: INTRODUCTION: Bipolar disorders (BD) are frequent mood disorders associated with a poor prognosis mainly due to a high relapse rate. Depressive relapses may follow a seasonal cyclicality, and bright-light therapy (BLT) has been established as the treatment of choice for seasonal affective disorder (SAD). The use of BLT for seasonal unipolar depression is well known, but the scientific literature is much poorer on the management of seasonal depressive episodes in BD. In addition, some specificities related to BD must be taken into account. METHODS: We conducted a comprehensive review using Medline and Google Scholar databases up to August 2014 using the following keywords combination: "bipolar disorder" and "light therapy" or "phototherapy". Papers were included in the review if (a) they were published in an English or French-language peer-reviewed journal; (b) the study enrolled patients with BD and SAD; and (c) the diagnosis was made according to the DSM or ICD criteria. RESULTS: BLT was considered among the first-line treatments for SAD with a size effect similar to antidepressants. Most of the studies did not distinguish between patients with unipolar and bipolar disorders. However, it has been demonstrated that the most significant risk of BLT in patients with BD is the mood shift. Thus, the most important therapeutic adaptation corresponds to the use of an effective mood stabilizer, as with any antidepressant. Another therapeutic adaptation in first intention is that the times of exposure to light should be shifted from morning to midday. This review also includes therapeutic guidelines regarding the management of BLT in seasonal bipolar depressive episodes. DISCUSSION: There are very few specific data on seasonal bipolar depressive episodes. This literature review has highlighted that BLT should be handled as a regular antidepressant treatment in patients suffering from seasonal bipolar depressive episodes.Copyright © 2015 L'Encephale, Paris. Published by Elsevier Masson SAS. All rights reserved						
Gorczynski og Faulkner 2010 (42)	Exercise therapy for schizophrenia	People with schizophrenia or schizophrenia-like illnesses	Exercise/physical activity programs	Standard care or other treatments	Mental health (physical state and well-being also reported)	Although studies included in this review are small and used various measures of physical and mental health, results indicated that regular exercise programs are possible in this population and that they can have healthful effects on both the physical and mental health and well being of individuals with schizophrenia. Larger randomized studies are required before any definitive conclusions can be drawn
Sammendrag: Background: The health benefits of physical activity and exercise arewell documented, and these effects could help peoplewith schizophrenia. Objectives: To determine the mental health effects of exercise/physical activity programs for people with schizophrenia or schizophrenia-like illnesses.Search Methods: We searched the Cochrane Schizophrenia Group Trials Register (December 2008), which is based on regularsearches of CINAHL, EMBASE, MEDLINE, and PsycINFO. We also inspected references within relevant papers. Selection Criteria: We included all randomized controlled trials comparing any intervention where physical activity or exercise was considered to be the main or active ingredient with standard care or other treatments for people with schizophrenia or schizophrenia-like illnesses. Data Collection and Analysis: We independently I spected citations and abstracts, ordered papers, quality assessed, and data extracted. For binary outcomes,we calculated a fixed-effect risk ratio and its 95% CI. Where possible, the weighted number needed to treat/harm statistic (NNT/H) and its 95% CI was also calculated. For continuous outcomes, endpoint data were preferred to change data. We synthesized nonskewed data from valid scales using a weighted mean difference. Results: Three randomized controlled trials met the inclusion criteria. Trials assessed the effects of exercise on physical and mental health. Overall numbers leaving the trials were similar. Two trials compared exercise with standard care and both found exercise to significantly improve negative symptoms of mental state (Mental Health Inventory Depression: 1 RCT, n = 10, Mean Difference [MD] 17.50 CI 6.70–28.30, Positive and Negative Syndrome Scale [PANSS] negative: 1 RCT, n = 10, MD -8.50 CI -11.11 to -5.89; figure 1). No absolute effects were found for positive symptoms of mental state. Physical health improved significantly in the exercise group compared with those in standard care (1 RCT, n = 13, MD 79.50 CI 33.82–125.18; figure 2), but no effect on peoples' weight/BMI was apparent. One study compared exercise with yoga and found that yoga had a better outcome for mental state (PANSS total: 1 RCT, n = 41, MD 14.95 CI 2.60–27.30). The same trial also found that those in the yoga group had significantly better quality of life scores (World Health Organization Quality of Life physical: 1 RCT, n = 41, MD 9.22 CI 18.86 to 0.42). Adverse effects (Abnormal Voluntary Movements Scale total scores) were, however, similar. Authors' Conclusions: Although studies included in this review are small and used various measures of physical and mental health, results indicated that regular exercise programs are possible in this population and that they can have healthful effects on both the physical and mental health and well being of individuals with schizophrenia. Larger randomized studies are required before any definitive conclusions can be drawn						

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Gromer 2012 (43)	Need-adapted and open-dialogue treatments: Empirically supported psychosocial interventions for schizophrenia and other psychotic disorders	People experiencing acute or severe psychosis	Open-dialogue and need-adapted treatments	Standard practice	Not reported	These studies revealed that the open-dialogue and need-adapted treatments had outcomes that were equivalent or superior to those of standard care. Discussion: More research is needed on these promising modalities before they are routinely incorporated into U.S. practice
Sammendrag: Purpose: People experiencing acute or severe psychosis in the United States do not typically have access to alternatives to standard practice. To provide people with psychotic symptoms meaningful choices in treatment, alternative approaches should be evaluated for potential integration into the mental health service system. The need-adapted and open-dialogue approaches are psychotherapeutically focused interventions for psychosis that were developed in Finland. If these treatments are found to be effective, they could potentially be used in the United States. Method: This narrative review uses systematic and transparent methods to locate and synthesize findings from treatment, quasi-treatment, and pretreatment outcome studies of the need-adapted and open-dialogue approaches. Results: One hundred twelve potentially relevant studies were identified for this review using electronic searches and reference harvesting. Of those, 7 met the review's inclusion criteria. These studies revealed that the open-dialogue and need-adapted treatments had outcomes that were equivalent or superior to those of standard care. Discussion: More research is needed on these promising modalities before they are routinely incorporated into U.S. practice					
Grosso et al. 2014 (44)	Role of omega-3 fatty acids in the treatment of depressive disorders: a comprehensive meta-analysis of randomized clinical trials	People with major depressive disorder, MDD (and people with depressive symptomatology without MDD diagnosis)	Omega-3 fatty acids treatment (omega-3 PUFA)	Not reported	Clinical measure of depression severity was primary outcome	The use of omega-3 PUFA is effective in patients with diagnosis of MDD and on depressive patients without diagnosis of MDD
Bakgrunn: BACKGROUND: Despite omega-3 polyunsaturated fatty acids (PUFA) supplementation in depressed patients have been suggested to improve depressive symptomatology, previous findings are not univocal. OBJECTIVES: To conduct an updated meta-analysis of randomized controlled trials (RCTs) of omega-3 PUFA treatment of depressive disorders, taking into account the clinical differences among patients included in the studies. METHODS: A search on MEDLINE, EMBASE, PsycInfo, and the Cochrane Database of RCTs using omega-3 PUFA on patients with depressive symptoms published up to August 2013 was performed. Standardized mean difference in clinical measure of depression severity was primary outcome. Type of omega-3 used (particularly eicosapentaenoic acid [EPA] and docosahexaenoic acid [DHA]) and omega-3 as mono- or adjuvant therapy was also examined. Meta-regression analyses assessed the effects of study size, baseline depression severity, trial duration, dose of omega-3, and age of patients. RESULTS: Meta-analysis of 11 and 8 trials conducted respectively on patients with a DSM-defined diagnosis of major depressive disorder (MDD) and patients with depressive symptomatology but no diagnosis of MDD demonstrated significant clinical benefit of omega-3 PUFA treatment compared to placebo (standardized difference in random-effects model 0.56 SD [95% CI: 0.20, 0.92] and 0.22 SD [95% CI: 0.01, 0.43], respectively; pooled analysis was 0.38 SD [95% CI: 0.18, 0.59]). Use of mainly EPA within the preparation, rather than DHA, influenced final clinical efficacy. Significant clinical efficacy had the use of omega-3 PUFA as adjuvant rather than mono-therapy. No relation between efficacy and study size, baseline depression severity, trial duration, age of patients, and study quality was found. Omega-3 PUFA resulted effective in RCTs on patients with bipolar disorder, whereas no evidence was found for those exploring their efficacy on depressive symptoms in young populations, perinatal depression, primary disease other than depression and healthy subjects. CONCLUSIONS: The use of omega-3 PUFA is effective in patients with diagnosis of MDD and on depressive patients without diagnosis of MDD					
Hausenblas et al. 2015 (45)	Saffron (Crocus sativus L.) and major depressive disorder: a meta-analysis of randomized clinical trials	People with major depressive disorder (MDD)	Saffron supplementation	Placebo control or antidepressant treatment	Depressive symptoms	Findings from clinical trials conducted to date indicate that saffron supplementation can improve symptoms of depression in adults with MDD. Larger clinical trials, conducted by research teams outside of Iran, with long-term follow-ups are needed before firm conclusions can be made regarding saffron's efficacy and safety for treating depressive symptoms

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Sammendrag: BACKGROUND: Due to safety concerns and side effects of many antidepressant medications, herbal psychopharmacology research has increased, and herbal remedies are becoming increasingly popular as alternatives to prescribed medications for the treatment of major depressive disorder (MDD). Of these, accumulating trials reveal positive effects of the spice saffron (Crocus sativus L.) for the treatment of depression. A comprehensive and statistical review of the clinical trials examining the effects of saffron for treatment of MDD is warranted. OBJECTIVE: The purpose of this study was to conduct a meta-analysis of published randomized controlled trials examining the effects of saffron supplementation on symptoms of depression among participants with MDD. SEARCH STRATEGY: We conducted electronic and non-electronic searches to identify all relevant randomized, double-blind controlled trials. Reference lists of all retrieved articles were searched for relevant studies. INCLUSION CRITERIA: The criteria for study selection included the following: (1) adults (aged 18 and older) with symptoms of depression, (2) randomized controlled trial, (3) effects of saffron supplementation on depressive symptoms examined, and (4) study had either a placebo control or antidepressant comparison group. DATA EXTRACTION AND ANALYSIS: Using random effects modeling procedures, we calculated weighted mean effect sizes separately for the saffron supplementation vs placebo control groups, and for the saffron supplementation vs antidepressant groups. The methodological quality of all studies was assessed using the Jadad score. The computer software Comprehensive Meta-analysis 2 was used to analyze the data. RESULTS: Based on our pre-specified criteria, five randomized controlled trials (n = 2 placebo controlled trials, n = 3 antidepressant controlled trials) were included in our review. A large effect size was found for saffron supplementation vs placebo control in treating depressive symptoms (M ES = 1.62, P < 0.001), revealing that saffron supplementation significantly reduced depression symptoms compared to the placebo control. A null effect size was evidenced between saffron supplementation and the antidepressant groups (M ES = -0.15) indicating that both treatments were similarly effective in reducing depression symptoms. The mean Jadad score was 5 indicating high quality of trials. CONCLUSION: Findings from clinical trials conducted to date indicate that saffron supplementation can improve symptoms of depression in adults with MDD. Larger clinical trials, conducted by research teams outside of Iran, with long-term follow-ups are needed before firm conclusions can be made regarding saffron's efficacy and safety for treating depressive symptoms						
Hausenblas et al. 2013 (46)	A systematic review of randomized controlled trials examining the effectiveness of saffron (Crocus sativus L.) on psychological and behavioral outcomes	People with major depressive disorder, premenstrual syndrome , sexual dysfunction and infertility, and weight loss/snacking behaviors	Saffron supplementation	Placebo control or antidepressant treatment	Depressive symptoms, premenstrual symptoms, sexual dysfunction and excessive snacking behavior	Findings from initial clinical trials suggest that saffron may improve the symptoms and the effects of depression, premenstrual syndrome, sexual dysfunction and infertility, and excessive snacking behaviors. Larger multi-site clinical trials are needed to extend these preliminary findings
Sammendrag: BACKGROUND: Throughout the past three decades, increased scientific attention has been given to examining saffron's (Crocus sativus L.) use as a potential therapeutic or preventive agent for a number of health conditions, including cancer, cardiovascular disease, and depression. OBJECTIVE: The purpose of this systematic review is to examine and categorize the current state of scientific evidence from randomized controlled trials (RCTs) regarding the efficacy of saffron on psychological/behavioral outcomes. SEARCH STRATEGY: Electronic and non-electronic systematic searches were conducted to identify all relevant human clinical research on saffron. The search strategy was extensive and was designed according to the "Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)." Reference lists of articles that met the inclusion criteria were searched. Only English language studies were reviewed. INCLUSION CRITERIA: Saffron trials in combination with other substances and saffron safety studies were considered, in accordance with the PRISMA statement. Included studies must have a control group. Included studies must measure a physiological and/or a behavioral outcome. DATA EXTRACTION AND ANALYSIS: The methodological quality of all included studies was independently evaluated by two reviewers using the Jadad score. Mean scores and P-values of measures were compared both inter- and intra-study for each parameter (i.e., depression). RESULTS: Twelve studies met our inclusion criteria. These studies examined the effects of saffron on psychological/behavioral outcomes of: major depressive disorder (n=6), premenstrual syndrome (n = 1), sexual dysfunction and infertility (n=4), and weight loss/snacking behaviors (n=1). The data from these studies support the efficacy of saffron as compared to placebo in improving the following conditions: depressive symptoms (compared to anti-depressants and placebo), premenstrual symptoms, and sexual dysfunction. In addition, saffron use was also effective in reducing excessive snacking behavior. CONCLUSION: Findings from initial clinical trials suggest that saffron may improve the symptoms and the effects of depression, premenstrual syndrome, sexual dysfunction and infertility, and excessive snacking behaviors. Larger multi-site clinical trials are needed to extend these preliminary findings						
Helgason og Sarris 2013 (47)	Mind-body medicine for schizophrenia and psychotic disorders: a review of the evidence	People with schizophrenia and psychotic disorder	Mind-body medicine	Usual care, including medication	Not reported	Due to insufficient data, a conclusion cannot be reached for hypnosis, thermal or EMG biofeedback, dance or drama therapy, or art therapy. No clinical trials were found for guided imagery, autogenic training, journal writing, or ceremony practices. For many techniques, the quality of research was poor, with many studies having small samples, no randomization, and no adequate control. While the above techniques are likely to be safe and tolerable in this population based on current data, more research is required to decisively assess the validity of applying many MBMs in the mainstream treatment of psychotic disorders

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Sammendrag: Over half of psychiatric patients use some kind of Complementary and Alternative Medicine, with Mind-Body Medicine (MBM) being the most commonly used collective modality. To date however, to our knowledge, no overarching review exists examining MBM for psychotic disorders. Thus the purpose of this paper is to present the first review in this area. A MEDLINE search was conducted of articles written in English from 1946 up to January 15, 2011 using a range of MBM and psychotic disorder search terms. Human clinical trials and, where available, pertinent meta-analyses and reviews were included in this paper. Forty-two clinical studies and reviews of MBMs were located, revealing varying levels of evidence. All studies included used MBMs as an adjunctive therapy to usual care, including medication. Overall, supportive evidence was found for music therapy, meditation and mindfulness techniques. Some positive studies were found for yoga and breathing exercises, general relaxation training, and holistic multi-modality MBM interventions. Due to insufficient data, a conclusion cannot be reached for hypnosis, thermal or EMG biofeedback, dance or drama therapy, or art therapy. No clinical trials were found for guided imagery, autogenic training, journal writing, or ceremony practices. For many techniques, the quality of research was poor, with many studies having small samples, no randomization, and no adequate control. While the above techniques are likely to be safe and tolerable in this population based on current data, more research is required to decisively assess the validity of applying many MBMs in the mainstream treatment of psychotic disorders						
Hidalgo-Mazzei et al. 2015 (48)	Internet-based psychological interventions for bipolar disorder: Review of the present and insights into the future	People with bipolar disorder	Psychological interventions	Not reported	Not reported	However, considering the high rates of retention and compliance reported, they represent a potential highly feasible and acceptable method of delivering this kind of interventions to bipolar patients
Sammendrag: BACKGROUND: In the last decade, there has been an increasing advent of innovative concepts in psychological interventions aimed at empowering bipolar patients by means of technological advancements and taking advantage of the proliferation of the Internet. Since the adoption of these technologies for behavioral monitoring and intervention is not trivial in clinical practice, the main objective of this review is to provide an overview and to discuss the several initiatives published so far in the literature related to the Internet-based technologies aimed to deliver evidence-based psychological interventions for bipolar disorder patients. METHODS: We conducted a comprehensive systematic review of the literature from multiple technological, psychiatric and psychological domains. The search was conducted by applying the Boolean algorithm "BIPOLAR AND DISORDER AND (treatment OR intervention) AND (online OR Internet OR web-based OR smartphone OR mobile)" at MEDLINE, SCOPUS, EMBASE, ClinicalTrials, ISI Web of Science and Google Scholar. RESULTS: We identified over 251 potential entries matching the search criteria and after a thorough manual review, 29 publications pertaining to 12 different projects, specifically focusing on psychological interventions for bipolar patients through diverse Internet-based methods, were selected. LIMITATIONS: Taking into consideration the diversity of the initiatives and the inconclusive main outcome results of the studies, there is still limited evidence available to draw firm conclusions about the efficacy of interventions using Internet-based technologies for bipolar disorder. CONCLUSIONS: However, considering the high rates of retention and compliance reported, they represent a potential highly feasible and acceptable method of delivering this kind of interventions to bipolar patients						
Holley et al. 2011 (49)	The effects of physical activity on psychological well-being for those with schizophrenia: A systematic review	People with schizophrenia	Physical activity	Not reported	Psychological well-being	The findings of this systematic review however, suggest that physical activity has a beneficial effect on some attributes associated with psychological well-being in individuals with schizophrenia
Sammendrag: This paper systematically reviews the existing evidence of the effects of physical activity on psychological well-being for those with schizophrenia. A search of 15 databases including for example, PsycINFO, Sport Discus, and Science Direct was conducted to identify studies investigating the effects of physical activity on psychological well-being for those with schizophrenia. The included studies were then assessed, extracted, and synthesized. Fifteen studies met the inclusion criteria: 12 quantitative and 3 qualitative. The physical activity interventions lasted between 3 and 20 weeks and included a wide range of physical activities. The instruments used to measure psychological well-being varied across all studies, this along with the variety of study designs made statistical analysis impossible. The findings of this systematic review however, suggest that physical activity has a beneficial effect on some attributes associated with psychological well-being in individuals with schizophrenia						

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Hollon og Ponniah 2010 (50)	A review of empirically supported psychological therapies for mood disorders in adults	People with various mood disorders (such as bipolar disorder and major depressive disorder)	Psychotherapy	Not reported	Acute symptom reduction and the prevention of subsequent relapse and recurrence	With respect to the treatment of major depressive disorder (MDD), interpersonal psychotherapy (IPT), cognitive behavior therapy (CBT), and behavior therapy (BT) are efficacious and specific and brief dynamic therapy (BDT) and emotion-focused therapy (EFT) are possibly efficacious. CBT is efficacious and specific, mindfulness-based cognitive therapy (MBCT) efficacious, and BDT and EFT possibly efficacious in the prevention of relapse/recurrence following treatment termination and IPT and CBT are each possibly efficacious in the prevention of relapse/recurrence if continued or maintained. IPT is possibly efficacious in the treatment of dysthymic disorder. With respect to bipolar disorder (BD), CBT and family-focused therapy (FFT) are efficacious and interpersonal social rhythm therapy (IPSRT) possibly efficacious as adjuncts to medication in the treatment of depression. Psychoeducation (PE) is efficacious in the prevention of mania/hypomania (and possibly depression) and FFT is efficacious and IPSRT and CBT possibly efficacious in preventing bipolar episodes. Conclusions: The newer psychological interventions are as efficacious as and more enduring than medications in the treatment of MDD and may enhance the efficacy of medications in the treatment of BD
Sammendrag: Background: The mood disorders are prevalent and problematic. We review randomized controlled psychotherapy trials to find those that are empirically supported with respect to acute symptom reduction and the prevention of subsequent relapse and recurrence. Methods: We searched the PsycINFO and PubMed databases and the reference sections of chapters and journal articles to identify appropriate articles. Results: One hundred twenty-five studies were found evaluating treatment efficacy for the various mood disorders. With respect to the treatment of major depressive disorder (MDD), interpersonal psychotherapy (IPT), cognitive behavior therapy (CBT), and behavior therapy (BT) are efficacious and specific and brief dynamic therapy (BDT) and emotion-focused therapy (EFT) are possibly efficacious. CBT is efficacious and specific, mindfulness-based cognitive therapy (MBCT) efficacious, and BDT and EFT possibly efficacious in the prevention of relapse/recurrence following treatment termination and IPT and CBT are each possibly efficacious in the prevention of relapse/recurrence if continued or maintained. IPT is possibly efficacious in the treatment of dysthymic disorder. With respect to bipolar disorder (BD), CBT and family-focused therapy (FFT) are efficacious and interpersonal social rhythm therapy (IPSRT) possibly efficacious as adjuncts to medication in the treatment of depression. Psychoeducation (PE) is efficacious in the prevention of mania/hypomania (and possibly depression) and FFT is efficacious and IPSRT and CBT possibly efficacious in preventing bipolar episodes. Conclusions: The newer psychological interventions are as efficacious as and more enduring than medications in the treatment of MDD and may enhance the efficacy of medications in the treatment of BD					
Hunsley et al. 2014 (51)	The efficacy and effectiveness of psychological treatments for mood, anxiety, and related disorders	People with depression, bipolar disorder, generalised anxiety disorder, social anxiety disorder, specific phobia, panic disorder, obsessive–compulsive disorder, and posttraumatic stress disorde	Psychological treatments	Not reported	Not reported	Based upon data from hundreds of studies and thousands of participants, there is substantial evidence for both the efficacy and effectiveness of specific forms of psychological intervention for these disorders. Moreover, for most disorders, the clinical impact of specific forms of psychological treatment has been found to be at least equal to that of medication. Accordingly, the research evidence strongly supports the use of a number of specific psychological treatments, most of which are cognitive–behavioural treatments, as first-line interventions for these commonly occurring mental disorders among youth, adults, and older adults
Sammendrag: We provide a narrative review of the extensive evidence that supports the efficacy and effectiveness of psychological treatments, across the life span, for common mental health disorders. To this end, relying primarily on meta-analytic studies, we examine the effects of psychological treatments for depression, bipolar disorder, generalised anxiety disorder, social anxiety disorder, specific phobia, panic disorder, obsessive–compulsive disorder, and posttraumatic stress disorder. Based upon data from hundreds of studies and thousands of participants, there is substantial evidence for both the efficacy and effectiveness of specific forms of psychological intervention for these disorders. Moreover, for most disorders, the clinical impact of specific forms of psychological treatment has been found to be at least equal to that of medication. Accordingly, the research evidence strongly supports the use of a number of specific psychological treatments, most of which are cognitive–behavioural treatments, as first-line interventions for these commonly occurring mental disorders among youth, adults, and older adults					

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Hutton og Taylor 2014 (52)	Cognitive behavioural therapy for psychosis prevention: a systematic review and meta-analysis	People at risk or with psychosis	Cognitive behavioural therapy for psychosis prevention	Usual or non-specific control treatment	Symptoms	CBT-informed treatment is associated with a reduced risk of transition to psychosis at 6, 12 and 18-24 months, and reduced symptoms at 12 months. Methodological limitations and recommendations for trial reporting are discussed
Sammendrag: BACKGROUND: Clinical equipoise regarding preventative treatments for psychosis has encouraged the development and evaluation of psychosocial treatments, such as cognitive behavioural therapy (CBT). METHOD: A systematic review and meta-analysis was conducted, examining the evidence for the effectiveness of CBT-informed treatment for preventing psychosis in people who are not taking antipsychotic medication, when compared to usual or non-specific control treatment. Included studies had to meet basic quality criteria, such as concealed and random allocation to treatment groups. RESULTS: Our search produced 1940 titles, out of which we found seven completed trials (six published). The relative risk (RR) of developing psychosis was reduced by more than 50% for those receiving CBT at every time point [RR at 6 months 0.47, 95% confidence interval (CI) 0.27-0.82, p = 0.008 (fixed-effects only: six randomized controlled trials (RCTs), n = 800); RR at 12 months 0.45, 95% CI 0.28-0.73, p = 0.001 (six RCTs, n = 800); RR at 18-24 months 0.41, 95% CI 0.23-0.72, p = 0.002 (four RCTs, n = 452)]. Heterogeneity was low in every analysis and the results were largely robust to the risk of an unpublished 12-month study having unfavourable results. CBT was also associated with reduced subthreshold symptoms at 12 months, but not at 6 or 18-24 months. No effects on functioning, symptom-related distress or quality of life were observed. CBT was not associated with increased rates of clinical depression or social anxiety (two studies). CONCLUSIONS: CBT-informed treatment is associated with a reduced risk of transition to psychosis at 6, 12 and 18-24 months, and reduced symptoms at 12 months. Methodological limitations and recommendations for trial reporting are discussed					
Iancu et al. 2014 (53)	Farm-based interventions for people with mental disorders: a systematic review of literature	People with mental disorders (depressive disorders, schizophrenia or heterogeneous mental disorders)	Farm-based interventions	Not reported	Clinical status	Our results suggest that the farm environment should be considered, especially for patients with mental disorders who do not achieve an adequate response with other treatment options. Further research is needed to clarify potential social and occupational benefits. Implications for Rehabilitation Despite the developments in mental healthcare, in many countries farms still play a role in the provision of psychiatric rehabilitation services. Farm-based interventions can alleviate psychiatric symptoms in patients with persistent mental disorders and can facilitate mental health recovery. The social and occupational aspects of the farm-based interventions are central to the experiences of mental health recovery
Sammendrag: Purpose: Farms are increasingly used in mental healthcare. This study aimed to systematically review the evidence on the effectiveness of farm-based interventions for patients with mental disorders. Methods: Controlled and uncontrolled studies of farm-based interventions were included. Within- and between group effect sizes were calculated. Qualitative data were summarized using thematic synthesis. The review followed the PRISMA, Cochrane and COREQ standards. Results: The eleven articles included reported results of five studies, three of which were randomized control trials (RCTs). Overall, 223 patients with depressive disorders, schizophrenia or heterogeneous mental disorders attended three types of farms-based interventions. Favourable effects on clinical status variables were found in one study in patients with depressive disorders that did not respond to medication and/or psychotherapy, and in one RCT in patients with schizophrenia. Assessment of rehabilitative effects (functioning and quality of life) was limited and yielded conflicting results. Patients' experiences revealed that social and occupational components of interventions were perceived as beneficial, and provided insights into how farm-based interventions may facilitate recovery. Conclusions: Our results suggest that the farm environment should be considered, especially for patients with mental disorders who do not achieve an adequate response with other treatment options. Further research is needed to clarify potential social and occupational benefits. Implications for Rehabilitation Despite the developments in mental healthcare, in many countries farms still play a role in the provision of psychiatric rehabilitation services. Farm-based interventions can alleviate psychiatric symptoms in patients with persistent mental disorders and can facilitate mental health recovery. The social and occupational aspects of the farm-based interventions are central to the experiences of mental health recovery					
Jain et al. 2014 (54)	Critical Analysis of the Efficacy of Meditation Therapies for Acute and Subacute Phase Treatment of Depressive Disorders: A Systematic Review	People with clinically diagnosed depressive disorders (both major and subacute depressive episodes)	Meditation Therapies	Control (no further explanation)	Not reported	A substantial body of evidence indicates that meditation therapies may have salutary effects on patients having clinical depressive disorders during the acute and subacute phases of treatment. Owing to methodologic deficiencies and trial heterogeneity, large-scale, randomized controlled trials with well-described comparator interventions and measures of expectation are needed to clarify the role of meditation in the depression treatment armamentarium

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Sammendrag: BACKGROUND: Recently, the application of meditative practices to the treatment of depressive disorders has met with increasing clinical and scientific interest, owing to a lower side-effect burden, potential reduction of polypharmacy, and theoretical considerations that such interventions may target some of the cognitive roots of depression. OBJECTIVE: We aimed to determine the state of the evidence supporting this application. METHODS: Randomized controlled trials of techniques meeting the Agency for Healthcare Research and Quality definition of meditation, for participants having clinically diagnosed depressive disorders, not currently in remission, were selected. Meditation therapies were separated into praxis (i.e., how they were applied) components, and trial outcomes were reviewed. RESULTS: 18 studies meeting the inclusion criteria were identified, encompassing 7 distinct techniques and 1173 patients. Mindfulness-Based Cognitive Therapy comprised the largest proportion of studies. Studies including patients having acute major depressive episodes (n = 10 studies), and those with residual subacute clinical symptoms despite initial treatment (n = 8), demonstrated moderate to large reductions in depression symptoms within the group, and relative to control groups. There was significant heterogeneity of techniques and trial designs. CONCLUSIONS: A substantial body of evidence indicates that meditation therapies may have salutary effects on patients having clinical depressive disorders during the acute and subacute phases of treatment. Owing to methodologic deficiencies and trial heterogeneity, large-scale, randomized controlled trials with well-described comparator interventions and measures of expectation are needed to clarify the role of meditation in the depression treatment armamentarium					
Jakobsen 2014 (55)	Systematic reviews of randomised clinical trials examining the effects of psychotherapeutic interventions versus "no intervention" for acute major depressive disorder and a randomised trial examining the effects of "third wave" cognitive therapy versus mentalization-based treatment for acute major depressive disorder	People with major depressive disorder (acute)	Psychotherapeutic interventions	No intervention, other intervention	Symptoms	We concluded that cognitive therapy and psychodynamic therapy might be effective interventions for depression measured on HDRS and BDI, but the review results might be erroneous due to risks of bias and random errors. Furthermore, the effects seem relatively small. The trial protocol showed that it was possible to develop a protocol for a randomised trial examining the effects of "third wave" cognitive therapy versus mentalization-based treatment with low risks of bias and low risks of random errors. Our trial results showed that "third wave" cognitive therapy might be a more effective intervention for depressive symptoms measured on the HDRS compared with mentalization-based treatment. The two interventions did not seem to differ significantly regarding BDI II, SCL 90-R, and WHO 5. More randomised trials with low risks of bias and low risks of random errors are needed to assess the effects of cognitive therapy, psychodynamic therapy, "third wave" cognitive therapy, and mentalization-based treatment
Sammendrag: Major depressive disorder afflicts an estimated 17% of individuals during their lifetimes at tremendous suffering and costs. Cognitive therapy and psychodynamic therapy may be effective treatment options for major depressive disorder, but the effects have only had limited assessment in systematic reviews. The two modern forms of psychotherapy, "third wave" cognitive therapy and mentalization-based treatment, have both gained some ground as treatments of psychiatric disorders. No randomised trial has compared the effects of these two interventions for major depressive disorder. We performed two systematic reviews with meta-analyses and trial sequential analyses using The Cochrane Collaboration methodology examining the effects of cognitive therapy and psycho-dynamic therapy for major depressive disorder. We developed a thorough treatment protocol for a randomised trial with low risks of bias (systematic error) and low risks of random errors ("play of chance") examining the effects of third wave' cognitive therapy versus mentalization-based treatment for major depressive disorder. We conducted a randomised trial according to good clinical practice examining the effects of "third wave" cognitive therapy versus mentalisation-based treatment for major depressive disorder. The first systematic review included five randomised trials examining the effects of psychodynamic therapy versus "no intervention' for major depressive disorder. Altogether the five trials randomised 365 participants who in each trial received similar antidepressants as co-interventions. All trials had high risk of bias. Four trials assessed "interpersonal psychotherapy" and one trial "short psychodynamic supportive psychotherapy". Both of these interventions are different forms of psychodynamic therapy. Meta-analysis showed that psychodynamic therapy significantly reduced depressive symptoms on the Hamilton Depression Rating Scale (HDRS) compared with "no intervention" (mean difference -3.01 (95% confidence interval -3.98 to -2.03; p = 0.00001), no significant heterogeneity between trials). Trial sequential analysis confirmed this result. The second systematic review included 12 randomised trials examining the effects of cognitive therapy versus "no intervention" for major depressive disorder. Altogether a total of 669 participants were randomised. All trials had high risk of bias. Meta-analysis showed that cognitive therapy significantly reduced depressive symptoms on the HDRS compared with "no intervention" (four trials; mean difference -3.05 (95% confidence interval, -5.23 to -0.87; p = 0.006)). Trial sequential analysis could not confirm this result. The trial protocol showed that it seemed feasible to conduct a randomised trial with low risks of bias and low risks of random errors examining the effects of "third wave" cognitive therapy versus mentalization-based therapy in a setting in the Danish healthcare system. It turned out to be much more difficult to recruit participants in the randomised trial than expected. We only included about half of the planned participants. The results from the randomised trial showed that participants randomised to "third wave" therapy compared with participants randomised to mentalization-based treatment had borderline significantly lower HDRS scores at 18 weeks in an unadjusted analysis (mean difference -4.14 score; 95% CI -8.30 to 0.03; p = 0.051). In the adjusted analysis, the difference was significant (p = 0.039). Five (22.7%) of the participants randomised to "third wave" cognitive therapy had remission at 18 weeks versus none of the participants randomised to mentalization-based treatment (p = 0.049). Sequential analysis showed that these findings could be due to random errors. No significant differences between the two groups was found regarding Beck's Depression Inventory (BDI II), Symptom Checklist 90 Revised (SCL 90-R), and The World Health Organization-Five Well-being Index 1999 (WHO 5). We concluded that cognitive therapy and psychodynamic therapy might be effective interventions for depression measured on HDRS and BDI, but the review results might be erroneous due to risks of bias and random errors. Furthermore, the effects seem relatively small. The trial protocol showed that it was possible to develop a protocol for a randomised trial examining the effects of "third wave" cognitive therapy versus mentalization-based treatment with low risks of bias and low risks of random errors. Our trial results showed that "third wave" cognitive therapy might be a more effective intervention for depressive symptoms measured on the HDRS compared with mentalization-based treatment. The two interventions did not seem to differ significantly regarding BDI II, SCL 90-R, and WHO 5. More randomised trials with low risks of bias and low risks of random errors are needed to assess the effects of cognitive therapy, psychodynamic therapy, "third wave" cognitive therapy, and mentalization-based treatment					

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Jakobsen et al. 2011 (56)	The effect of interpersonal psychotherapy and other psychodynamic therapies versus 'treatment as usual' in patients with major depressive disorder	People with major depressive disorder (MDD)	Psychodynamic therapies	Treatment as usual	Depressive symptoms	We did not find convincing evidence supporting or refuting the effect of interpersonal psychotherapy or psychodynamic therapy compared with 'treatment as usual' for patients with major depressive disorder. The potential beneficial effect seems small and effects on major outcomes are unknown. Randomized trials with low risk of systematic errors and low risk of random errors are needed
Sammendrag: BACKGROUND: Major depressive disorder afflicts an estimated 17% of individuals during their lifetimes at tremendous suffering and costs. Interpersonal psychotherapy and other psychodynamic therapies may be effective interventions for major depressive disorder, but the effects have only had limited assessment in systematic reviews. METHODS/PRINCIPAL FINDINGS: Cochrane systematic review methodology with meta-analysis and trial sequential analysis of randomized trials comparing the effect of psychodynamic therapies versus 'treatment as usual' for major depressive disorder. To be included the participants had to be older than 17 years with a primary diagnosis of major depressive disorder. Altogether, we included six trials randomizing a total of 648 participants. Five trials assessed 'interpersonal psychotherapy' and only one trial assessed 'psychodynamic psychotherapy'. All six trials had high risk of bias. Meta-analysis on all six trials showed that the psychodynamic interventions significantly reduced depressive symptoms on the 17-item Hamilton Rating Scale for Depression (mean difference -3.12 (95% confidence interval -4.39 to -1.86;P<0.00001), no heterogeneity) compared with 'treatment as usual'. Trial sequential analysis confirmed this result. DISCUSSION: We did not find convincing evidence supporting or refuting the effect of interpersonal psychotherapy or psychodynamic therapy compared with 'treatment as usual' for patients with major depressive disorder. The potential beneficial effect seems small and effects on major outcomes are unknown. Randomized trials with low risk of systematic errors and low risk of random errors are needed					
Jakobsen et al. 2012 (57)	Effects of cognitive therapy versus interpersonal psychotherapy in patients with major depressive disorder: a systematic review of randomized clinical trials with meta-analyses and trial sequential analyses	People with major depressive disorder (MDD)	Cognitive therapy	Interpersonal psychotherapy	Benefits and harms	Randomized trials with low risk of bias and low risk of random errors are needed, although the effects of cognitive therapy and interpersonal psychotherapy do not seem to differ significantly regarding depressive symptoms. Future trials should report on adverse events
Sammendrag: BACKGROUND: Major depressive disorder afflicts an estimated 17% of individuals during their lifetime at tremendous suffering and cost. Cognitive therapy and interpersonal psychotherapy are treatment options, but their effects have only been limitedly compared in systematic reviews. METHOD: Using Cochrane systematic review methodology we compared the benefits and harm of cognitive therapy versus interpersonal psychotherapy for major depressive disorder. Trials were identified by searching the Cochrane Library's CENTRAL, Medline via PubMed, EMBASE, Psychlit, PsycInfo, and Science Citation Index Expanded until February 2010. Continuous outcome measures were assessed by mean difference and dichotomous outcomes by odds ratio. We conducted trial sequential analysis to control for random errors. RESULTS: We included seven trials randomizing 741 participants. All trials had high risk of bias. Meta-analysis of the four trials reporting data at cessation of treatment on the Hamilton Rating Scale for Depression showed no significant difference between the two interventions [mean difference -1.02, 95% confidence interval (CI) -2.35 to 0.32]. Meta-analysis of the five trials reporting data at cessation of treatment on the Beck Depression Inventory showed comparable results (mean difference -1.29, 95% CI -2.73 to 0.14). Trial sequential analysis indicated that more data are needed to definitively settle the question of a differential effect. None of the included trial reported on adverse events. CONCLUSIONS: Randomized trials with low risk of bias and low risk of random errors are needed, although the effects of cognitive therapy and interpersonal psychotherapy do not seem to differ significantly regarding depressive symptoms. Future trials should report on adverse events					
Jakobsen et al. 2011 (58)	The effects of cognitive therapy versus 'no intervention' for major depressive disorder	People with major depressive disorder (MDD)	Cognitive therapy	No intervention	Depressive symptoms and other symptoms	Cognitive therapy might be an effective treatment for depression measured on Hamilton Rating Scale for Depression and Beck Depression Inventory, but these outcomes may be overestimated due to risks of systematic errors (bias) and random errors (play of chance). Furthermore, the effects of cognitive therapy on no remission, suicidality, adverse events, and quality of life are unclear. There is a need for randomized trials with low risk of bias, low risk of random errors, and longer follow-up assessing both benefits and harms with clinically relevant outcome measures

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: BACKGROUND: Major depressive disorder afflicts an estimated 17% of individuals during their lifetimes at tremendous suffering and costs. Cognitive therapy may be an effective treatment option for major depressive disorder, but the effects have only had limited assessment in systematic reviews. METHODS/PRINCIPAL FINDINGS: We used The Cochrane systematic review methodology with meta-analyses and trial sequential analyses of randomized trials comparing the effects of cognitive therapy versus 'no intervention' for major depressive disorder. Participants had to be older than 17 years with a primary diagnosis of major depressive disorder to be eligible. Altogether, we included 12 trials randomizing a total of 669 participants. All 12 trials had high risk of bias. Meta-analysis on the Hamilton Rating Scale for Depression showed that cognitive therapy significantly reduced depressive symptoms (four trials; mean difference -3.05 (95% confidence interval (CI), -5.23 to -0.87; P<0.006)) compared with 'no intervention'. Trial sequential analysis could not confirm this result. Meta-analysis on the Beck Depression Inventory showed that cognitive therapy significantly reduced depressive symptoms (eight trials; mean difference on -4.86 (95% CI -6.44 to -3.28; P=0.00001)). Trial sequential analysis on these data confirmed the result. Only a few trials reported on 'no remission', suicide inclination, suicide attempts, suicides, and adverse events without significant differences between the compared intervention groups. DISCUSSION: Cognitive therapy might be an effective treatment for depression measured on Hamilton Rating Scale for Depression and Beck Depression Inventory, but these outcomes may be overestimated due to risks of systematic errors (bias) and random errors (play of chance). Furthermore, the effects of cognitive therapy on no remission, suicidality, adverse events, and quality of life are unclear. There is a need for randomized trials with low risk of bias, low risk of random errors, and longer follow-up assessing both benefits and harms with clinically relevant outcome measures					
Jakobsen et al. 2011 (59)	The effects of cognitive therapy versus 'treatment as usual' in patients with major depressive disorder	People with major depressive disorder (MDD)	Cognitive therapy	Treatment as usual	Depressive symptoms	Cognitive therapy might not be an effective treatment for major depressive disorder compared with 'treatment as usual'. The possible treatment effect measured on the Hamilton Rating Scale for Depression is relatively small. More randomized trials with low risk of bias, increased sample sizes, and broader more clinically relevant outcomes are needed
Sammendrag: BACKGROUND: Major depressive disorder afflicts an estimated 17% of individuals during their lifetimes at tremendous suffering and costs. Cognitive therapy may be an effective treatment option for major depressive disorder, but the effects have only had limited assessment in systematic reviews. METHODS/PRINCIPAL FINDINGS: Cochrane systematic review methodology, with meta-analyses and trial sequential analyses of randomized trials, are comparing the effects of cognitive therapy versus 'treatment as usual' for major depressive disorder. To be included the participants had to be older than 17 years with a primary diagnosis of major depressive disorder. Altogether, we included eight trials randomizing a total of 719 participants. All eight trials had high risk of bias. Four trials reported data on the 17-item Hamilton Rating Scale for Depression and four trials reported data on the Beck Depression Inventory. Meta-analysis on the data from the Hamilton Rating Scale for Depression showed that cognitive therapy compared with 'treatment as usual' significantly reduced depressive symptoms (mean difference -2.15 (95% confidence interval -3.70 to -0.60; P<0.007, no heterogeneity)). However, meta-analysis with both fixed-effect and random-effects model on the data from the Beck Depression Inventory (mean difference with both models -1.57 (95% CL -4.30 to 1.16; P = 0.26, I(2) = 0) could not confirm the Hamilton Rating Scale for Depression results. Furthermore, trial sequential analysis on both the data from Hamilton Rating Scale for Depression and Becks Depression Inventory showed that insufficient data have been obtained. DISCUSSION: Cognitive therapy might not be an effective treatment for major depressive disorder compared with 'treatment as usual'. The possible treatment effect measured on the Hamilton Rating Scale for Depression is relatively small. More randomized trials with low risk of bias, increased sample sizes, and broader more clinically relevant outcomes are needed					
Jauhar et al. 2014 (60)	Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias	People with schizophrenia	Cognitive-behavioural therapy (CBT)	Not reported	Symptoms	Cognitive-behavioural therapy has a therapeutic effect on schizophrenic symptoms in the 'small' range. This reduces further when sources of bias, particularly masking, are controlled for.
Sammendrag: BACKGROUND: Cognitive-behavioural therapy (CBT) is considered to be effective for the symptoms of schizophrenia. However, this view is based mainly on meta-analysis, whose findings can be influenced by failure to consider sources of bias. AIMS: To conduct a systematic review and meta-analysis of the effectiveness of CBT for schizophrenic symptoms that includes an examination of potential sources of bias. METHOD: Data were pooled from randomised trials providing end-of-study data on overall, positive and negative symptoms. The moderating effects of randomisation, masking of outcome assessments, incompleteness of outcome data and use of a control intervention were examined. Publication bias was also investigated. RESULTS: Pooled effect sizes were -0.33 (95% CI -0.47 to -0.19) in 34 studies of overall symptoms, -0.25 (95% CI -0.37 to -0.13) in 33 studies of positive symptoms and -0.13 (95% CI -0.25 to -0.01) in 34 studies of negative symptoms. Masking significantly moderated effect size in the meta-analyses of overall symptoms (effect sizes -0.62 (95% CI -0.88 to -0.35) v. -0.15 (95% CI -0.27 to -0.03), P = 0.001) and positive symptoms (effect sizes -0.57 (95% CI -0.76 to -0.39) v. -0.08 (95% CI -0.18 to 0.03), P<0.001). Use of a control intervention did not moderate effect size in any of the analyses. There was no consistent evidence of publication bias across different analyses. CONCLUSIONS: Cognitive-behavioural therapy has a therapeutic effect on schizophrenic symptoms in the 'small' range. This reduces further when sources of bias, particularly masking, are controlled for					

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Jiang et al. 2015 (61)	Metacognitive training for schizophrenia: a systematic review	People with schizophrenia	Metacognitive training (MCT), a group psychotherapy method	Control group (no further explanation)	Symptoms	The limited number of RCT trials, the variability of the method and time of the outcome evaluation, and methodological problems in the trials make it impossible to come to a conclusion about the effectiveness of MCT for schizophrenia. More randomized trials that use standardized outcome measures, that use intention-to-treat (ITT) analyses, and that follow-up participants at regular intervals after the intervention are needed to determine whether or not MCT should become a recommended adjunctive treatment for schizophrenia
Sammendrag: Background: Metacognitive training (MCT) is a novel group psychotherapy method for schizophrenia, but there is, as yet, no conclusive evidence of its efficacy. Aims: Conduct a meta-analysis to assess the effectiveness of MCT in schizophrenia. Methods: Electronic and hand searches were conducted to identify randomized controlled trials about the effects of MCT in schizophrenia that met pre-defined inclusion criteria. The Cochrane Risk of Bias tool was employed to assess of risk of biases, and Cochrane Review Manager version 5.3 and R version 3.1.1 were used to conduct the data synthesis. Results: Ten trials from 54 unduplicated reports were included in the review, but differences in the methods of assessing outcomes limited the number of studies that could be included in the meta-analysis. Pooling four studies that assessed the positive symptom subscale of the Positive and Negative Syndrome Scale (PANSS) at the end of the trial identified a small but statistically significant greater reduction in the MCT group than in the control group. But pooling four studies that assessed the delusion subscale of the Psychotic Symptom Rating Scales (PSYRATS) at the end of the trial found no significant difference between the groups. Results from the qualitative assessment of the other results that could not be pooled across studies were mixed, some showed a trend in favor of MCT but many found no difference between the groups. Conclusions: The limited number of RCT trials, the variability of the method and time of the outcome evaluation, and methodological problems in the trials make it impossible to come to a conclusion about the effectiveness of MCT for schizophrenia. More randomized trials that use standardized outcome measures, that use intention-to-treat (ITT) analyses, and that follow-up participants at regular intervals after the intervention are needed to determine whether or not MCT should become a recommended adjunctive treatment for schizophrenia					
Jones et al. 2012 (62)	Cognitive behavior therapy versus other psychosocial treatments for schizophrenia	People with schizophrenia	Cognitive behavior therapy (CBT)	other psychosocial treatments (such as supportive therapy, psycho- education, group, relaxation and family therapy)	Death, mental state, adverse effects, compliance, hospitalisation etc.	Trial-based evidence suggests no clear and convincing advantage for cognitive behavioural therapy over other - and sometime much less sophisticated - therapies for people with schizophrenia
Sammendrag: Cognitive behavioural therapy (CBT) is now a recommended treatment for people with schizophrenia. This approach helps to link the person's distress and problem behaviours to underlying patterns of thinking. Objectives: To review the effects of CBT for people with schizophrenia when compared with other psychological therapies. Search methods: We searched the Cochrane Schizophrenia Group Trials Register (March 2010) which is based on regular searches of CINAHL, EMBASE, MEDLINE and PsycINFO. We inspected all references of the selected articles for further relevant trials, and, where appropriate, contacted authors. Selection criteria: All relevant randomised controlled trials (RCTs) of CBT for people with schizophrenia-like illnesses. Data collection and analysis: Studies were reliably selected and assessed for methodological quality. Two review authors, working independently, extracted data. We analysed dichotomous data on an intention-to-treat basis and continuous data with 65% completion rate are presented. Where possible, for dichotomous outcomes, we estimated a risk ratio (RR) with the 95% confidence interval (CI) along with the number needed to treat/harm. Main results: Thirty one papers described 20 trials. Trials were often small and of limited quality. When CBT was compared with other psychosocial therapies, no difference was found for outcomes relevant to adverse effect/events (2 RCTs, n = 202, RR death 0.57 CI 0.12 to 2.60). Relapse was not reduced over any time period (5 RCTs, n = 406, RR long-term 1.03 CI 0.86 to 1.24) nor was rehospitalisation (6 RCTs, n = 670, RR in longer term 0.96 CI 0.81 to 1.14). Various global mental state measures failed to show difference (4 RCTs, n = 244, RR no important change in mental state 0.84 CI 0.64 to 1.09). More specific measures of mental state failed to show differential effects on positive or negative symptoms of schizophrenia but there may be some longer term effect for affective symptoms (2 RCTs, n = 105, mean difference (MD) Beck Depression Inventory (BDI) -6.21 CI -10.81 to -1.61). Few trials report on social functioning or quality of life. Findings do not convincingly favour either of the interventions (2 RCTs, n = 103, MD Social Functioning Scale(SFS) 1.32 CI -4.90 to 7.54; n = 37, MD EuroQOL -1.86 CI -19.20 to 15.48). For the outcome of leaving the study early, we found no significant advantage when CBT was compared with either non-active control therapies (5 RCTs, n = 495, RR 0.90 CI 0.68 to 1.19) or active therapies (6 RCTs, n = 339, RR 0.75 CI 0.40 to 1.43) Authors' conclusions: Trial-based evidence suggests no clear and convincing advantage for cognitive behavioural therapy over other - and sometime much less sophisticated - therapies for people with schizophrenia					
Juanjuan og Jun 2013 (63)	Dance therapy for schizophrenia	People with schizophrenia or schizophrenia-like illnesses	Dance therapy or dance movement therapy (DMT)	Standard care and other psychological interventions	Symptoms, compliance, satisfaction, quality of life	Based on predominantly moderate quality data, there is no evidence to support - or refute - the use of dance therapy in this group of people. This therapy remains unproven and those with schizophrenia, their carers, trialists and funders of research may wish to encourage future work to increase high quality evidence in this area

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: BACKGROUND: Dance therapy or dance movement therapy (DMT) is defined as 'the psychotherapeutic use of movement as a process which furthers the emotional, social, cognitive, and physical integration of the individual'. It may be of value for people with developmental, medical, social, physical or psychological impairments. Dance therapy can be practiced in mental health rehabilitation units, nursing homes, day care centres and incorporated into disease prevention and health promotion programmes. OBJECTIVES: To evaluate the effects of dance therapy for people with schizophrenia or schizophrenia-like illnesses compared with standard care and other interventions. SEARCH METHODS: We updated the original July 2007 search of the Cochrane Schizophrenia Group' register in July 2012. We also searched Chinese main medical databases. SELECTION CRITERIA: We included one randomised controlled trial (RCT) comparing dance therapy and related approaches with standard care or other psychosocial interventions for people with schizophrenia. DATA COLLECTION AND ANALYSIS: We reliably selected, quality assessed and extracted data. For continuous outcomes, we calculated a mean difference (MD); for binary outcomes we calculated a fixed-effect risk ratio (RR) and their 95% confidence intervals (CI). We created a 'Summary of findings' table using the GRADE approach. MAIN RESULTS: We included one single blind study (total n = 45) of reasonable quality. It compared dance therapy plus routine care with routine care alone. Most people tolerated the treatment package but nearly 40% were lost in both groups by four months (1 RCT n = 45, RR 0.68 95% CI 0.31 to 1.51, low quality evidence). The Positive and Negative Syndrome Scale (PANSS) average endpoint total scores were similar in both groups (1 RCT n = 43, MD -0.50 95% CI -11.80 to 10.80, moderate quality evidence) as were the positive sub-scores (1 RCT n = 43, MD 2.50 CI -0.67 to 5.67, moderate quality evidence). At the end of treatment, significantly more people in the dance therapy group had a greater than 20% reduction in PANSS negative symptom score (1 RCT n = 45, RR 0.62 CI 0.39 to 0.97, moderate quality evidence), and overall, average negative endpoint scores were lower (1 RCT n = 43, MD -4.40 CI -8.15 to -0.65, moderate quality evidence). There was no difference in satisfaction score (average Client's Assessment of Treatment Scale (CAT) score, 1 RCT n = 42, MD 0.40 CI -0.78 to 1.58, moderate quality evidence) and quality of life data were also equivocal (average Manchester Short Assessment of Quality of life (MANSA) score, 1 RCT n = 39, MD 0.00 CI -0.48 to 0.48, moderate quality evidence). AUTHORS' CONCLUSIONS: Based on predominantly moderate quality data, there is no evidence to support - or refute - the use of dance therapy in this group of people. This therapy remains unproven and those with schizophrenia, their carers, trialists and funders of research may wish to encourage future work to increase high quality evidence in this area						
Jun et al. 2014 (64)	Herbal medicine (Gan Mai Da Zao decoction) for depression: A systematic review and meta-analysis of randomized controlled trials	People with depression (any type)	Herbal medicine (Gan Mai Da Zao decoction)	Anti-depressants theraies	Depression	In summary, our systematic review and meta-analysis failed to provide evidence of the superiority of GMDZ decoction over anti-depressant therapies for major depression, post-surgical depression, or depression in the elderly, although there was evidence of an effect in post-stroke depression. The quality of evidence for this finding was low, however, because of a high risk of bias
Sammendrag: The objective of this review was to analyze the trial data on the efficacy and safety of Gan Mai Da Zao (GMDZ) decoction for depression. PubMed, the Cochrane Library, and EMBASE, AMED, Korea Med, DBPIA, OASIS, RISS, KISS, CNKI, Wan Fang Database, and VIP were searched through to May 2014. Randomized controlled trials (RCTs) testing GMDZ decoction for any type of depression were considered. All RCTs of GMDZ decoction or modified GMDZ decoction were included. Data were extracted by 2 independent reviewers. Meta-analysis was used for the pooled data. A total of 298 potentially relevant studies were identified, and 13 RCTs met our inclusion criteria. All of the included RCTs had a high risk of bias across their domains. Three RCTs failed to show favorable effects of GMDZ decoction on response rate or HAMD score in major depression. One RCT showed a beneficial effect of GMDZ decoction on response rate in post-surgical depression, while another failed to do so. Two studies showed favorable effects on response rate in post-stroke depression, while another two failed to do so. A meta-analysis, however, showed that GMDZ decoction produced better response rates than anti-depressants in post-stroke depression (RR: 1.17, I2 = 15%). One trial failed to show any beneficial effects of GMDZ decoction on response rate or HAMD score in depression in an elderly sample. Two trials tested GMDZ decoction in combination with anti-depressants but failed to show effects on response rate in major depression, while another did show beneficial effects on response rate in post-stroke depression. In summary, our systematic review and meta-analysis failed to provide evidence of the superiority of GMDZ decoction over anti-depressant therapies for major depression, post-surgical depression, or depression in the elderly, although there was evidence of an effect in post-stroke depression. The quality of evidence for this finding was low, however, because of a high risk of bias						
Kamioka et al. 2014 (65)	Effectiveness of animal-assisted therapy: A systematic review of randomized controlled trials	People with mental and behavioral disorders such as depression, schizophrenia, and alcohol/drug addictions,	Animal-assisted therapy	Not reported	Not reported	Eleven RCTs were identified, and seven studies were about "Mental and behavioral disorders". Types of animal intervention were dog, cat, dolphin, bird, cow, rabbit, ferret, and guinea pig. The RCTs conducted have been of relatively low quality. We could not perform meta-analysis because of heterogeneity. In a study environment limited to the people who like animals, AAT may be an effective treatment for mental and behavioral disorders such as depression, schizophrenia, and alcohol/drug addictions, and is based on a holistic approach through interaction with animals in nature. To most effectively assess the potential benefits for AAT, it will be important for further research to utilize and describe (1) RCT methodology when appropriate, (2) reasons for non-participation, (3) intervention dose, (4) adverse effects and withdrawals, and (5) cost

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: The objectives of this review were to summarize the evidence from randomized controlled trials (RCTs) on the effects of animal-assisted therapy (AAT). Studies were eligible if they were RCTs. Studies included one treatment group in which AAT was applied. We searched the following databases from 1990 up to October 31, 2012: MEDLINE via PubMed, CINAHL, Web of Science, Ichushi Web, GHL, WPRIM, and PsycINFO. We also searched all Cochrane Database up to October 31, 2012. Eleven RCTs were identified, and seven studies were about "Mental and behavioral disorders". Types of animal intervention were dog, cat, dolphin, bird, cow, rabbit, ferret, and guinea pig. The RCTs conducted have been of relatively low quality. We could not perform meta-analysis because of heterogeneity. In a study environment limited to the people who like animals, AAT may be an effective treatment for mental and behavioral disorders such as depression, schizophrenia, and alcohol/drug addictions, and is based on a holistic approach through interaction with animals in nature. To most effectively assess the potential benefits for AAT, it will be important for further research to utilize and describe (1) RCT methodology when appropriate, (2) reasons for non-participation, (3) intervention dose, (4) adverse effects and withdrawals, and (5) cost. Copyright © 2014 Elsevier Ltd. All rights reserved						
Karyotaki et al. 2014 (66)	The long-term efficacy of psychotherapy, alone or in combination with antidepressants, in the treatment of adult major depression	People with major depression	Psychotherapy alone or in combination with antidepressants	No abstract	No abstract	No abstract
Sammendrag: Kort sammendrag ikke tilgjengelig						
Kelly et al. 2014 (67)	A systematic review of self-management health care models for individuals with serious mental illnesses	People with serious mental illness	Self-management health care models. Collaborative and integrated care models that include self-management components	Not reported	Not reported	This review found preliminary support that self-management interventions targeting the general medical health of those with serious mental illnesses are efficacious, but future work is needed to determine what elements of training or skills lead to the most salient changes
Sammendrag: OBJECTIVE: The general medical health of individuals with serious mental illnesses is compromised relative to those without serious mental illnesses. To address this health disparity, numerous integrated care strategies are being employed from the system level to the level of individual patients. However, self-management of health care, a strategy considered an integral aspect of typical care, has been infrequently included in interventions for this population. Despite reservations about the capacity of those with serious mental illnesses to self-manage health care, a subset of new interventions focused on general medical health in this population has tested whether models including self-management strategies have empirical support. To understand whether these models are supported, the authors reviewed the evidence for self-management models. METHODS: This systematic review examined collaborative and integrated care models that include self-management components for individuals with serious mental illnesses. RESULTS: Across the 14 studies identified in this review, promising evidence was found that individuals with serious mental health issues can collaborate with health professionals or be trained to self-manage their health and health care. The evidence supports the use of mental health peers or professional staff to implement health care interventions. However, the substantial heterogeneity in study design, types of training, and examined outcomes limited conclusions about the comparative effectiveness of existing studies. CONCLUSIONS: This review found preliminary support that self-management interventions targeting the general medical health of those with serious mental illnesses are efficacious, but future work is needed to determine what elements of training or skills lead to the most salient changes						
Khoury et al. 2013 (68)	Mindfulness interventions for psychosis: A meta-analysis	People with with psychosis or schizophrenia	Mindfulness interventions	Control group or no group comparison (no further explanation)	Symptoms	Mindfulness interventions are moderately effective in treating negative symptoms and can be useful adjunct to pharmacotherapy; however, more research is warranted to identify the most effective elements of mindfulness interventions.
Sammendrag: Background: An increasing number of mindfulness interventions are being used with individuals with psychosis or schizophrenia, but no known meta-analysis has investigated their effectiveness. Objective: To evaluate the efficacy of mindfulness interventions for psychosis or schizophrenia, we conducted an effect-size analysis of initial studies. Data sources: A systematic review of studies published in journals or in dissertations in PubMED, PsycINFO or MedLine from the first available date until July 25, 2013. Review methods: A total of 13 studies (n = 468) were included. Results: Effect-size estimates suggested that mindfulness interventions are moderately effective in pre-post analyses (n = 12; Hedge's g = .52). When compared with a control group, we found a smaller effect size (n = 7; Hedge's g = .41). The obtained results were maintained at follow-up when data were available (n = 6; Hedge's g = .62 for pre-post analyses; results only approached significance for controlled analyses, n = 3; Hedge's g = .55, p = .08). Results suggested higher effects on negative symptoms compared with positive ones. When combined together, mindfulness, acceptance, and compassion strongly moderated the clinical effect size. However, heterogeneity was significant among the trials, probably due to the diversity of interventions included and outcomes assessed. Conclusion:Mindfulness interventions are moderately effective in treating negative symptoms and can be useful adjunct to pharmacotherapy; however, more research is warranted to identify the most effective elements of mindfulness interventions						

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Kluwe-Schiavon et al. 2013 (69)	Executive functions rehabilitation for schizophrenia: A critical systematic review	People with schizophrenia	Executive functions rehabilitation	Not reported	Not reported	The reviewed articles corroborate the literature pointing that CR could be a promising therapeutic option for cognitive deficits in schizophrenia. In general, CR could improve cognitive domains and social adjustment either using computerized or paper-and-pencil programs. Additionally, CR combined with cognitive behavioral therapy and/or group sessions is particularly effective. In this paper, we also speculated and discussed optimal doses of treatment and the differences regarding modalities and approaches
Sammendrag: Background: Consistent evidences suggest that poor functional outcomes in schizophrenia are associated with deficits in executive functions (EF). As result cognitive training, remediation and/or rehabilitation (CR) programs have been developed and many theories, methods and approaches have emerged in support of them. This article presents a systematic review of randomized controlled trials (RCT), including EF rehabilitation interventions, with a focus on methodological issues and evidences of EF improvements. Method: Eletronic databases (Medline, Web of Science, PsycINFO and Embase) were searched for articles on schizophrenia, EF and cognitive rehabilitation terms. The methodological quality of each article was measured by 5-point JADAD scale. Results: A total of 184 articles were initially identified, but after exclusion criteria, 30 RCT remained in this review. A proportion of 23% of studies scored higher than 4 points in JADAD scale, 40% scored 3 points, 33% scored 2 points and one study scored only 1 point. The average length of interventions was approximately 80 h distributed around 3.42 h/week. Conclusion: The reviewed articles corroborate the literature pointing that CR could be a promising therapeutic option for cognitive deficits in schizophrenia. In general, CR could improve cognitive domains and social adjustment either using computerized or paper-and-pencil programs. Additionally, CR combined with cognitive behavioral therapy and/or group sessions is particularly effective. In this paper, we also speculated and discussed optimal doses of treatment and the differences regarding modalities and approaches					
Knapen et al. 2015 (70)	Exercise therapy improves both mental and physical health in patients with major depression	People with depression (any type)	Exercise therapy	Not reported but antidepressant medication and psychotherapy are mentioned		Physical therapists should be aware, that several characteristics of major depression (e.g. loss of interest, motivation and energy, generalised fatigue, a low self-worth and self-confidence, fear to move, and psychosomatic complaints) and physical health problems interfere with participation in exercise. Therefore, motivational strategies should be incorporated in exercise interventions to enhance the patients' motivation and adherence in exercise programs.
Sammendrag: Purpose: to present clinical guidelines for exercise therapy in depressed patients derived from recent meta-analyses. Method: four meta-analyses on effects of physical exercise on mental and physical in depression were analysed. Results: For mild to moderate depression the effect of exercise may be comparable to antidepressant medication and psychotherapy; for severe depression exercise seems to be a valuable complementary therapy to the traditional treatments. Depression is associated with a high incidence of co-morbid somatic illnesses, especially cardiovascular diseases, type 2 diabetes and metabolic syndrome. Exercise is extremely powerful in preventing and treating these diseases. Physical exercise is an outstanding opportunity for the treatment of patients who have a mix of mental and physical health problems. Exercise therapy also improves body image, patient s coping strategies with stress, quality of life and independence in activities of daily living in older adults. Conclusions: Physical therapists should be aware, that several characteristics of major depression (e.g. loss of interest, motivation and energy, generalised fatigue, a low self-worth and self-confidence, fear to move, and psychosomatic complaints) and physical health problems interfere with participation in exercise. Therefore, motivational strategies should be incorporated in exercise interventions to enhance the patients' motivation and adherence in exercise programs					
Kurtz og Richardson 2012 (71)	Social cognitive training for schizophrenia: a meta-analytic investigation of controlled research	People with schizophrenia	Social cognitive training (behavioral training programs designed to improve social cognitive function)	Not reported	Symptoms, observer-rated community, and institutional function	Outcome measures were organized according to whether they were social cognitive tests proximal to the intervention or whether they represented measures of treatment generalization (symptoms, observer-rated community, and institutional function). With respect to social cognitive measures, weighted effect-size analysis revealed that there were moderate-large effects of social cognitive training procedures on FAR (identification, d = 0.71 and discrimination, d = 1.01) and small-moderate effects of training on ToM (d = 0.46), while effects on social cue perception and attributional style were not significant. For measures of generalization, weighted effect-size analysis revealed that there were moderate-large effect on total symptoms (d = 0.68) and observer-rated community and institutional function (d = 0.78). Effects of social cognitive training programs on positive and negative symptoms of schizophrenia were nonsignificant. Moderating variables and implications for future research and treatment development are discussed

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: A wealth of evidence has revealed that deficits in social cognitive skills (including facial affect recognition (FAR), social cue perception, Theory of Mind (ToM), and attributional style) are evident in schizophrenia and are linked to a variety of domains of functional outcome. In light of these associations, a growing number of studies have attempted to ameliorate these deficits as a means of improving outcome in the disorder through the use of structured behavioral training. This study used quantitative methods of meta-analysis to assess the efficacy of behavioral training programs designed to improve social cognitive function. A total of 19 studies consisting of 692 clients were aggregated from relevant databases. Outcome measures were organized according to whether they were social cognitive tests proximal to the intervention or whether they represented measures of treatment generalization (symptoms, observer-rated community, and institutional function). With respect to social cognitive measures, weighted effect-size analysis revealed that there were moderate-large effects of social cognitive training procedures on FAR (identification, d = 0.71 and discrimination, d = 1.01) and small-moderate effects of training on ToM (d = 0.46), while effects on social cue perception and attributional style were not significant. For measures of generalization, weighted effect-size analysis revealed that there were moderate-large effect on total symptoms (d = 0.68) and observer-rated community and institutional function (d = 0.78). Effects of social cognitive training programs on positive and negative symptoms of schizophrenia were nonsignificant. Moderating variables and implications for future research and treatment development are discussed					
Lampe et al. 2013 (72)	Psychological management of unipolar depression	People with unipolar depression	Psychological management	Not reported, but authors mention pharmacotherapy	Not reported	Cognitive behaviour therapy and interpersonal therapy can be effective in alleviating acute depression for all levels of severity and in maintaining improvement. Psychological treatments for depression have demonstrated efficacy across the lifespan and may present a preferred treatment option in some groups, for example, children and adolescents and women who are pregnant or postnatal.
Sammendrag: Objective: To be used in conjunction with 'Pharmacological management of unipolar depression' [Malhi et al. Acta Psychiatr Scand 2013;127(Suppl. 443):6-23] and 'Lifestyle management of unipolar depression' [Berk et al. Acta Psychiatr Scand 2013;127(Suppl. 443): 38-54]. To provide clinically relevant recommendations for the use of psychological treatments in depression derived from a literature review. Method: Medical databases including MEDLINE and PubMed were searched for pertinent literature, with an emphasis on recent publications. Results: Structured psychological treatments such as cognitive behaviour therapy and interpersonal therapy (IPT) have a robust evidence base for efficacy in treating depression, even in severe cases of depression. However, they may not offer benefit as quickly as antidepressants, and maximal efficacy requires well-trained and experienced therapists. These therapies are effective across the lifespan and may be preferred where it is desired to avoid pharmacotherapy. In some instances, combination with pharmacotherapy may enhance outcome. Psychological therapy may have more enduring protective effects than medication and be effective in relapse prevention. Newer structured psychological therapies such as mindfulness-based cognitive therapy and acceptance and commitment therapy lack an extensive outcome literature, but the few published studies yielding positive outcomes suggest they should be considered options for treatment. Conclusion: Cognitive behaviour therapy and IPT can be effective in alleviating acute depression for all levels of severity and in maintaining improvement. Psychological treatments for depression have demonstrated efficacy across the lifespan and may present a preferred treatment option in some groups, for example, children and adolescents and women who are pregnant or postnatal					
Leichsenring et al. 2015 (73)	The empirical status of psychodynamic psychotherapy-An update: Bambi's alive and kicking	People with specific mental disorder	Psychodynamic therapy	No treatment, placebo or alternative treatment or equivalent to an established treatment	Not reported	Evidence has emerged that PDT is efficacious or possibly efficacious in a wide range of common mental disorders. Further research is required for those disorders for which sufficient evidence does not yet exist
Sammendrag: Background: The Task Force on Promotion and Dissemination of Psychological Procedures proposed rigorous criteria to define empirically supported psychotherapies. According to these criteria, 2 randomized controlled trials (RCTs) showing efficacy are required for a treatment to be designated as 'efficacious' and 1 RCT for a designation as 'possibly efficacious'. Applying these criteria modified by Chambless and Hollon, this article presents an update on the evidence for psychodynamic therapy (PDT) in specific mental disorders. Methods: A systematic search was performed using the criteria by Chambless and Hollon for study selection, as follows: (1) RCT of PDT in adults, (2) use of reliable and valid measures for diagnosis and outcome, (3) use of treatment manuals or manual-like guidelines, (4) adult population treated for specific problems and (5) PDT superior to no treatment, placebo or alternative treatment or equivalent to an established treatment. Results: A total of 39 RCTs were included. Following Chambless and Hollon, PDT can presently be designated as efficacious in major depressive disorder (MDD), social anxiety disorder, borderline and heterogeneous personality disorders, somatoform pain disorder, and anorexia nervosa. For MDD, this also applies to the combination with pharmacotherapy. PDT can be considered as possibly efficacious in dysthymia, complicated grief, panic disorder, generalized anxiety disorder, and substance abuse/dependence. Evidence is lacking for obsessive-compulsive, posttraumatic stress, bipolar and schizophrenia spectrum disorder(s). Conclusions: Evidence has emerged that PDT is efficacious or possibly efficacious in a wide range of common mental disorders. Further research is required for those disorders for which sufficient evidence does not yet exist					
Leiphart og Valone 2010 (74)	Stereotactic lesions for the treatment of psychiatric disorders	People with psychiatric disorders	Deep brain stimulation (DBS)	Not reported	Not reported	This study provides retrospective data that suggest which anatomical focus may be effective to lesion or stimulate for the treatment of each of several psychiatric disorders

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: OBJECT: The use of deep brain stimulation (DBS) has recently been expanded to the investigational treatment of specific psychiatric disorders. Much like movement disorders, the targets selected for DBS are based on past experience with stereotactic lesions. A literature review of past studies incorporating stereotactic lesions for psychiatric disorders was performed to provide historical context and possible guidance for current and future attempts at treating psychiatric disorders with DBS. METHODS: Original copies of the proceedings of the second, third, fourth, and fifth World Congresses of Psychiatric Surgery meetings were reviewed, and a Medline search was conducted for studies with the word "psychosurgery" and each of 14 highly prevalent psychiatric conditions identified by the National Institute of Mental Health. Postoperative results for 1145 patients with stereotactic brain lesions targeting various anatomical foci were standardized using a 5-point scale (3 [free of symptoms] to -1 [worse]). Each patient was entered into a database as a unique data point and used for this literature review. RESULTS: General anxiety disorder and obsessive-compulsive disorder had the greatest reported improvements from anterior capsulotomy, and bipolar disorder, depression, and schizoaffective disorder had the greatest reported improvements from anterior cingulotomy, supporting these areas for DBS investigation. Addiction and schizophrenia showed the least improvement from surgery. Therefore, pursuing the treatment of these disorders with DBS using the targets in these studies may be ineffective. CONCLUSIONS: This study provides retrospective data that suggest which anatomical focus may be effective to lesion or stimulate for the treatment of each of several psychiatric disorders					
Liebherz og Rabung 2014 (75)	Do patients' symptoms and interpersonal problems improve in psychotherapeutic hospital treatment in Germany? A systematic review and meta-analysis	Mentally ill adults in Germany	Psychotherapeutic hospital treatment	Not reported	Outcomes were required to be quantified by either the Symptom-Checklist (SCL-90-R or short versions) or the Inventory of Interpersonal Problems (IIP-64 or short versions)	Psychotherapeutic hospital treatment may be considered an effective treatment. In accordance with Howard's phase model of psychotherapy outcome, the present study demonstrated that symptom distress changes more quickly and strongly than interpersonal problems. Preliminary analyses show impairment at intake and treatment duration to be the strongest outcome predictors. Further analyses regarding this relationship are required
Sammendrag: BACKGROUND: In Germany, inpatient psychotherapy plays a unique role in the treatment of patients with common mental disorders of higher severity. In addition to psychiatric inpatient services, psychotherapeutic hospital treatment and psychosomatic rehabilitation are offered as independent inpatient treatment options. This meta-analysis aims to provide systematic evidence for psychotherapeutic hospital treatment in Germany regarding its effects on symptomatic and interpersonal impairment. METHODOLOGY: Relevant papers were identified by electronic database search and hand search. Randomized controlled trials as well as naturalistic prospective studies (including post-therapy and follow-up assessments) evaluating psychotherapeutic hospital treatment of mentally ill adults in Germany were included. Outcomes were required to be quantified by either the Symptom-Checklist (SCL-90-R or short versions) or the Inventory of Interpersonal Problems (IIP-64 or short versions). Effect sizes (Hedges' g) were combined using random effect models. PRINCIPAL FINDINGS: Sixty-seven papers representing 59 studies fulfilled inclusion criteria. Meta-analysis yielded a medium within-group effect size for symptom change at discharge (g = 0.72; 95% CI 0.68-0.76), with a small reduction to follow-up (g = 0.61; 95% CI 0.55-0.68). Regarding interpersonal problems, a small effect size was found at discharge (g = 0.35; 95% CI 0.29-0.41), which increased to follow-up (g = 0.48; 95% CI 0.36-0.60). While higher impairment at intake was associated with a larger effect size in both measures, longer treatment duration was related to lower effect sizes in SCL GSI and to larger effect sizes in IIP Total. CONCLUSIONS: Psychotherapeutic hospital treatment may be considered an effective treatment. In accordance with Howard's phase model of psychotherapy outcome, the present study demonstrated that symptom distress changes more quickly and strongly than interpersonal problems. Preliminary analyses show impairment at intake and treatment duration to be the strongest outcome predictors. Further analyses regarding this relationship are required					
Lipsman et al. 2010 (76)	Neurosurgical treatment of bipolar depression: Defining treatment resistance and identifying surgical targets	People with bipolar disorder	Neurosurgical treatment (deep brain stimulation)	Not reported	Not reported	A surgical intervention for bipolar depression would not only be a proof of concept regarding disease modeling but also an important and novel treatment avenue for individuals affected by bipolar depression

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Objectives: Bipolar disorder (BD) is a complex psychiatric disorder that is often underrecognized, misdiagnosed, and challenging to detect. During the past decade, substantial progress has been made in the development of pharmacotherapeutic and psychosocial interventions for various phases of BD. Notwithstanding these developments, the majority of BD individuals, and particularly patients with bipolar depression, receiving guideline concordant care do not experience syndromal or functional recovery, underscoring the need for novel treatments. Early success with deep brain stimulation (DBS) in the treatment of major depressive episodes as part of major depressive disorder (MDD) has provided the impetus to explore its application in other treatment-resistant psychiatric disorders, notably BD. Herein, we provide the rationale for employing DBS as an alternative treatment avenue in individuals with bipolar depression. Methods: We conducted a PubMed literature search, focusing on English language articles beginning in 1950 to the present day, and employed the following search terms: bipolar disorder, neurosurgery, deep brain stimulation, neuroimaging, and circuitry. Search results were then manually reviewed and relevant articles selected for analysis. Relevance was determined by author consensus and overall manuscript quality. We also reviewed articles on currently available treatment options for BD in order to develop a coherent and practical definition of treatment resistance with a focus on surgical intervention. Results: Several lines of evidence indicate that although mania is the defining feature of bipolar I disorder, depressive symptoms and episodes dominate the longitudinal course, account for most of the illness burden including premature mortality, and are least responsive to contemporary treatments. Disease models in bipolar depression implicate abnormalities in the structure and function of discrete neural circuits that subserve affective processing and cognitive function with the subgenual cingulate cortex occupying a central role. Modulation of the cingulate cortex with DBS in treatment-resistant MDD populations has proven to offer acute and sustained antidepressant effects, suggesting possible benefits for other mood disorder populations. Conclusions: A surgical intervention for bipolar depression would not only be a proof of concept regarding disease modeling but also an important and novel treatment avenue for individuals affected by bipolar depression					
Liu et al. 2014 (77)	Horticultural therapy for schizophrenia	People with schizophrenia	Horticultural therapy	Standard care	Wellbeing and symptoms	Based on the current very low quality data, there is insufficient evidence to draw any conclusions on benefits or harms of horticultural therapy for people with schizophrenia. This therapy remains unproven and more and larger randomised trials are needed to increase high quality evidence in this area
Sammendrag: Background: Horticultural therapy is defined as the process of utilising fruits, vegetables, flowers and plants facilitated by a trained therapist or healthcare provider, to achieve specific treatment goals or to simply improve a person's well-being. It can be used for therapy or rehabilitation programs for cognitive, physical, social, emotional, and recreational benefits, thus improving the person's body, mind and spirit. Between 5% to 15% of people with schizophrenia continue to experience symptoms in spite of medication, and may also develop undesirable adverse effects, horticultural therapy may be of value for these people.Objectives: To evaluate the effects of horticultural therapy for people with schizophrenia or schizophrenia-like illnesses compared with standard care or other additional psychosocial interventions.Search methods: We searched the Cochrane Schizophrenia Group Trials Register (Janurary 2013) and supplemented this by contacting relevant study authors, and manually searching reference lists.Selection criteria: We included one randomised controlled trial (RCT) comparing horticultural therapy plus standard care with standard care alone for people with schizophrenia.Data collection and analysis: We reliably selected, quality assessed and extracted data. For continuous outcomes, we calculated a mean difference (MD) and for binary outcomes we calculated risk ratio (RR), both with 95% confidence intervals (CI). We assessed risk of bias and created a 'Summary of findings' table using the GRADE (Grades of Recommendation, Assessment, Development and Evaluation) approach.Main results: We included one single blind study (total n = 24). The overall risk of bias in the study was considered to be unclear although the randomisation was adequate. It compared a package of horticultural therapy which consisted of one hour per day of horticultural activity plus standard care with standard care alone over two weeks (10 consecutive days) with no long-term follow-up. Only two people were lost to follow-up in the study, both in the horticultural therapy group (1 RCT n = 24,RR 5.00 95% CI 0.27 to 94.34, very low quality evidence). There was no clear evidence of a difference in Personal Wellbeing Index (PWI-C) change scores between groups, however confidence intervals were wide (1 RCT n = 22, MD -0.90 95% CI -10.35 to 8.55, very low quality evidence). At the end of treatment, the Depression Anxiety Stress Scale (DASS21) change scores in horticultural therapy group were greater than that in the control group (1 RCT n = 22, MD -23.70 CI -35.37 to - 12.03, very low quality evidence). The only included study did not report on adverse effects of interventions.Authors' conclusions: Based on the current very low quality data, there is insufficient evidence to draw any conclusions on benefits or harms of horticultural therapy for people with schizophrenia. This therapy remains unproven and more and larger randomised trials are needed to increase high quality evidence in this area					
Lloyd-Evans et al. 2014 (78)	A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness	People with sevre mental illness	Non-residential peer support interventions	Not reported	Hospitalisation, overall symptoms or satisfaction with services	Despite the promotion and uptake of peer support internationally, there is little evidence from current trials about the effects of peer support for people with severe mental illness. Although there are few positive findings, this review has important implications for policy and practice: current evidence does not support recommendations or mandatory requirements from policy makers for mental health services to provide peer support programmes. Further peer support programmes should be implemented within the context of high quality research projects wherever possible. Deficiencies in the conduct and reporting of existing trials exemplify difficulties in the evaluation of complex interventions

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: BACKGROUND: Little is known about whether peer support improves outcomes for people with severe mental illness. METHOD: A systematic review and meta-analysis was conducted. Cochrane CENTRAL Register, Medline, Embase, PsycINFO, and CINAHL were searched to July 2013 without restriction by publication status. Randomised trials of non-residential peer support interventions were included. Trial interventions were categorised and analysed separately as: mutual peer support, peer support services, or peer delivered mental health services. Meta-analyses were performed where possible, and studies were assessed for bias and the quality of evidence described. RESULTS: Eighteen trials including 5597 participants were included. These comprised four trials of mutual support programmes, eleven trials of peer support services, and three trials of peer-delivered services. There was substantial variation between trials in participants' characteristics and programme content. Outcomes were incompletely reported; there was high risk of bias. From small numbers of studies in the analyses it was possible to conduct, there was little or no evidence that peer support was associated with positive effects on hospitalisation, overall symptoms or satisfaction with services. There was some evidence that peer support was associated with positive effects on measures of hope, recovery and empowerment at and beyond the end of the intervention, although this was not consistent within or across different types of peer support. CONCLUSIONS: Despite the promotion and uptake of peer support internationally, there is little evidence from current trials about the effects of peer support for people with severe mental illness. Although there are few positive findings, this review has important implications for policy and practice: current evidence does not support recommendations or mandatory requirements from policy makers for mental health services to provide peer support programmes. Further peer support programmes should be implemented within the context of high quality research projects wherever possible. Deficiencies in the conduct and reporting of existing trials exemplify difficulties in the evaluation of complex interventions					
Lolich et al. 2012 (79)	Psychosocial interventions in bipolar disorder: a review	People with bipolar disorder	Multiple psychosocial intervenetions such as cognitive-behavioral, psychoeducational, systematic care models, interpersonal and family therapy interventions	Not reported	Not reported	Although there are currently several validated psychosocial interventions for treating bipolar disorder, their efficacy needs to be specified in relation to more precise variables such as clinical type, comorbid disorders, stages or duration of the disease. Taking into account these clinical features would enable a proper selection of the most adequate intervention according to the patient's specific characteristics
Sammendrag: INTRODUCTION: Multiple psychosocial interventions for bipolar disorder have been proposed in recent years. Therefore, we consider that a critical review of empirically validated models would be useful. METHODS: A review of the literature was conducted in Medline/PubMed for articles published during 2000-2010 that respond to the combination of "bipolar disorder" with the following key words: "psychosocial intervention", "psychoeducational intervention" and "psychotherapy". RESULTS: Cognitive-behavioral, psychoeducational, systematic care models, interpersonal and family therapy interventions were found to be empirically validated. All of them reported significant improvements in therapeutic adherence and in the patients' functionality. CONCLUSIONS: Although there are currently several validated psychosocial interventions for treating bipolar disorder, their efficacy needs to be specified in relation to more precise variables such as clinical type, comorbid disorders, stages or duration of the disease. Taking into account these clinical features would enable a proper selection of the most adequate intervention according to the patient's specific characteristics					
Lynch et al. 2010 (80)	Cognitive behavioural therapy for major psychiatric disorder: Does it really work? A meta-analytical review of well-controlled trials	People with major psychiatric disorder	Cognitive behavioural therapy	Non-specific control conditions	Relapse	CBT is no better than non-specific control interventions in the treatment of schizophrenia and does not reduce relapse rates. It is effective in major depression but the size of the effect is small in treatment studies. On present evidence CBT is not an effective treatment strategy for prevention of relapse in bipolar disorder
Sammendrag: Background: Although cognitive behavioural therapy (CBT) is claimed to be effective in schizophrenia, major depression and bipolar disorder, there have been negative findings in well-conducted studies and meta-analyses have not fully considered the potential influence of blindness or the use of control interventions. Method: We pooled data from published trials of CBT in schizophrenia, major depression and bipolar disorder that used controls for non-specific effects of intervention. Trials of effectiveness against relapse were also pooled, including those that compared CBT to treatment as usual (TAU). Blinding was examined as a moderating factor. Results: CBT was not effective in reducing symptoms in schizophrenia or in preventing relapse. CBT was effective in reducing symptoms in major depression, although the effect size was small, and in reducing relapse. CBT was ineffective in reducing relapse in bipolar disorder. Conclusions: CBT is no better than non-specific control interventions in the treatment of schizophrenia and does not reduce relapse rates. It is effective in major depression but the size of the effect is small in treatment studies. On present evidence CBT is not an effective treatment strategy for prevention of relapse in bipolar disorder					

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
McGuire et al. 2014 (81)	Illness management and recovery: a review of the literature	People with severe mental illness	Illness Management and Recovery (IMR) is a standardized psychosocial intervention	Treatment as usual	Consumer-level outcomes	IMR shows promise for improving some consumer-level outcomes. Important issues regarding implementation require additional study. Future research is needed to compare outcomes of IMR consumers and active control groups and to provide a more detailed understanding of how other services utilized by consumers may affect outcomes of IMR.
Sammendrag: OBJECTIVE: Illness Management and Recovery (IMR) is a standardized psychosocial intervention that is designed to help people with severe mental illness manage their illness and achieve personal recovery goals. This literature review summarizes the research on consumer-level effects of IMR and articles describing its implementation. METHODS: In 2011, the authors conducted a literature search of Embase, MEDLINE, PsycINFO, CINAHL, and the Cochrane Library by using the key words "illness management and recovery," "wellness management and recovery," or "IMR" AND ("schizophrenia" OR "bipolar" OR "depression" OR "recovery" OR "mental health"). Publications that cited two seminal IMR articles also guided further exploration of sources. Articles that did not deal explicitly with IMR or a direct adaptation were excluded. RESULTS: Three randomized-controlled trials (RCTs), three quasi-controlled trials, and three pre-post trials have been conducted. The RCTs found that consumers receiving IMR reported significantly more improved scores on the IMR Scale (IMRS) than consumers who received treatment as usual. IMRS ratings by clinicians and ratings of psychiatric symptoms by independent observers were also more improved for the IMR consumers. Implementation studies (N=16) identified several important barriers to and facilitators of IMR, including supervision and agency support. Implementation outcomes, such as participation rates and fidelity, varied widely. CONCLUSIONS: IMR shows promise for improving some consumer-level outcomes. Important issues regarding implementation require additional study. Future research is needed to compare outcomes of IMR consumers and active control groups and to provide a more detailed understanding of how other services utilized by consumers may affect outcomes of IMR					
Meis et al. 2013 (82)	Couple and family involvement in adult mental health treatment: A systematic review	People with mental illness	Couple and family involvement interventions	Not reported	Not reported	Overall, trials were limited in their methodological quality, and many interventions were evaluated in one trial. Future research is needed to replicate findings for these single trials, examine relationship distress as a moderator of outcome, and examine BCT/BFT among dual substance using couples and outside the research group frequently represented
Sammendrag: We reviewed randomized controlled trials conducted in the United States from January, 1996 through December, 2011 that examined family interventions for adult mental health conditions. We identified 51 articles (39 trials) evaluating 21 different family interventions. Findings for behavioral couple or family therapy (BCT/BFT) and community reinforcement and training (CRAFT) for substance use disorders were each pooled separately for examination in meta-analyses. Findings suggest BCT/BFT reduced substance use (small-to-moderate effects) and improved relationship adjustment (large effects) compared to individually-oriented treatments. CRAFT increased treatment initiation three-fold but did not improve substance use or family functioning over alternative family interventions. Family focused therapy for bipolar disorder improved symptoms over less intensive treatments with mixed findings when compared to equally intensive treatments. For both bipolar disorder and schizophrenia spectrum disorders, the few trials meeting our search criteria and heterogeneity among trials precluded generating broader conclusions regarding which family interventions are most effective for US populations. Overall, trials were limited in their methodological quality, and many interventions were evaluated in one trial. Future research is needed to replicate findings for these single trials, examine relationship distress as a moderator of outcome, and examine BCT/BFT among dual substance using couples and outside the research group frequently represented					
Miziou et al. 2015 (83)	Psychosocial treatment and interventions for bipolar disorder: a systematic review	People with bipolar disorder	Psychosocial treatment and interventions	Not reported	Relapse, remission	The current review suggests that the literature supports the usefulness only of specific psychosocial interventions targeting specific aspects of BD in selected subgroups of patients
Sammendrag: BACKGROUND: Bipolar disorder (BD) is a chronic disorder with a high relapse rate, significant general disability and burden and with a psychosocial impairment that often persists despite pharmacotherapy. This indicates the need for effective and affordable adjunctive psychosocial interventions, tailored to the individual patient. Several psychotherapeutic techniques have tried to fill this gap, but which intervention is suitable for each patient remains unknown and it depends on the phase of the illness. METHODS: The papers were located with searches in PubMed/MEDLINE through May 1st 2015 with a combination of key words. The review followed the recommendations of the Preferred Items for Reporting of Systematic Reviews and Meta-Analyses statement. RESULTS: The search returned 7,332 papers; after the deletion of duplicates, 6,124 remained and eventually 78 were included for the analysis. The literature supports the usefulness only of psychoeducation for the relapse prevention of mood episodes and only in a selected subgroup of patients at an early stage of the disease who have very good, if not complete remission, of the acute episode. Cognitive-behavioural therapy and interpersonal and social rhythms therapy could have some beneficial effect during the acute phase, but more data are needed. Mindfulness interventions could only decrease anxiety, while interventions to improve neurocognition seem to be rather ineffective. Family intervention seems to have benefits mainly for caregivers, but it is uncertain whether they have an effect on patient outcomes. CONCLUSION: The current review suggests that the literature supports the usefulness only of specific psychosocial interventions targeting specific aspects of BD in selected subgroups of patients					
Moriana et al. 2015 (84)	Social skills training for schizophrenia	People with schizophrenia	Social skills training	Not reported	Not reported	We discuss the types of training that have achieved the best results and those contributing to their application and/or adaptation to different areas of daily life as part of the multidimensional and psychosocial treatment of schizophrenia

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Social skills training involves a set of interventional procedures including behavior modification principles and techniques that lead to the acquisition of basic learning experiences. Its main objective is to facilitate the development of a code of conduct aimed at enabling people to live independently; it has been applied in the treatment of schizophrenia and other serious mental disorders. We review the efficacy of such interventions following meta-analyses and randomized clinical trials, and analyzing advantages and disadvantages of recent developments. We discuss the types of training that have achieved the best results and those contributing to their application and/or adaptation to different areas of daily life as part of the multidimensional and psychosocial treatment of schizophrenia						
Mossler et al. 2011 (85)	Music therapy for people with schizophrenia and schizophrenia-like disorders	People with schizophrenia and schizophrenia-like disorders	Music therapy added to standard care.	Placebo therapy, standard care or no treatment	Symptoms	Music therapy as an addition to standard care helps people with schizophrenia to improve their global state, mental state (including negative symptoms) and social functioning if a sufficient number of music therapy sessions are provided by qualified music therapists. Further research should especially address the long-term effects of music therapy, dose-response relationships, as well as the relevance of outcomes measures in relation to music therapy
Sammendrag: BACKGROUND: Music therapy is a therapeutic method that uses musical interaction as a means of communication and expression. The aim of the therapy is to help people with serious mental disorders to develop relationships and to address issues they may not be able to using words alone. OBJECTIVES: To review the effects of music therapy, or music therapy added to standard care, compared with 'placebo' therapy, standard care or no treatment for people with serious mental disorders such as schizophrenia. SEARCH METHODS: We searched the Cochrane Schizophrenia Group Trials Register (December 2010) and supplemented this by contacting relevant study authors, handsearching of music therapy journals and manual searches of reference lists. SELECTION CRITERIA: All randomised controlled trials (RCTs) that compared music therapy with standard care, placebo therapy, or no treatment. DATA COLLECTION AND ANALYSIS: Studies were reliably selected, quality assessed and data extracted. We excluded data where more than 30% of participants in any group were lost to follow-up. We synthesised non-skewed continuous endpoint data from valid scales using a standardised mean difference (SMD). If statistical heterogeneity was found, we examined treatment 'dosage' and treatment approach as possible sources of heterogeneity. MAIN RESULTS: We included eight studies (total 483 participants). These examined effects of music therapy over the short- to medium-term (one to four months), with treatment 'dosage' varying from seven to 78 sessions. Music therapy added to standard care was superior to standard care for global state (medium-term, 1 RCT, n = 72, RR 0.10 95% CI 0.03 to 0.31, NNT 2 95% CI 1.2 to 2.2). Continuous data identified good effects on negative symptoms (4 RCTs, n = 240, SMD average endpoint Scale for the Assessment of Negative Symptoms (SANS) -0.74 95% CI -1.00 to -0.47); general mental state (1 RCT, n = 69, SMD average endpoint Positive and Negative Symptoms Scale (PANSS) -0.36 95% CI -0.85 to 0.12; 2 RCTs, n=100, SMD average endpoint Brief Psychiatric Rating Scale (BPRS) -0.73 95% CI -1.16 to -0.31); depression (2 RCTs, n = 90, SMD average endpoint Self-Rating Depression Scale (SDS) -0.63 95% CI -1.06 to -0.21; 1 RCT, n = 30, SMD average endpoint Hamilton Depression Scale (Ham-D) -0.52 95% CI -1.25 to -0.21); and anxiety (1 RCT, n = 60, SMD average endpoint SAS -0.61 95% CI -1.13 to -0.09). Positive effects were also found for social functioning (1 RCT, n = 70, SMD average endpoint Social Disability Schedule for Inpatients (SDSI) score -0.78 95% CI -1.27 to -0.28). Furthermore, some aspects of cognitive functioning and behaviour seem to develop positively through music therapy. Effects, however, were inconsistent across studies and depended on the number of music therapy sessions as well as the quality of the music therapy provided. AUTHORS' CONCLUSIONS: Music therapy as an addition to standard care helps people with schizophrenia to improve their global state, mental state (including negative symptoms) and social functioning if a sufficient number of music therapy sessions are provided by qualified music therapists. Further research should especially address the long-term effects of music therapy, dose-response relationships, as well as the relevance of outcomes measures in relation to music therapy						
Mould et al. 2010 (86)	The use of metaphor for understanding and managing psychotic experiences: A systematic review	People with psychotic disorders	Metaphor for understanding and managing psychotic experiences	Not reported	Not reported	The use of metaphor as a strategy is a potentially valuable way for both people with psychotic disorders to express their experiences, and for promotion of recovery within this population
Sammendrag: BACKGROUND: Subjective experiences of psychotic disorders are often not communicated because of the difficulty in articulating them. Metaphor is a valuable way of describing these experiences to others. Recovery in psychotic disorders involves consolidation and transitioning processes. The ontological and orientational types of metaphor seem to form the linguistic basis of these processes. AIMS: The aim of this paper is to review and describe how metaphor may be used both as a strategy for people with psychotic disorders to articulate their subjective experiences of self, and also as an approach to support recovery. METHOD: A systematic review of 28 studies was conducted, to examine the nature and function of metaphor used in studies involving an intervention or therapeutic method for psychosis. RESULTS: Sixteen studies contained first-person experiences, 24 studies used metaphor to consolidate the self of the person with psychotic disorder, and 19 studies used metaphor to transition the self of the person, although applied use of metaphor in this way was limited. CONCLUSIONS: The use of metaphor as a strategy is a potentially valuable way for both people with psychotic disorders to express their experiences, and for promotion of recovery within this population						

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Naeem et al. 2015 (87)	Cognitive behavioural therapy (brief versus standard duration) for schizophrenia	People with schizophrenia or related disorders	Brief cognitive behavioural therapy	Standard duration of cognitive behavioural therapy	Not reported	Currently there is no literature available to compare brief with standard CBTp for people with schizophrenia. We cannot, therefore, conclude whether brief CBTp is as effective, less effective or even more effective than standard courses of the same therapy. This lack of evidence for brief CBTp has serious implications for research and practice. Well planned, conducted and reported randomised trials are indicated
Sammendrag: Background: Cognitive behavioural therapy for people with schizophrenia is a psychotherapeutic approach that establishes links between thoughts, emotions and behaviours and challenges dysfunctional thoughts. There is some evidence to suggest that cognitive behavioural therapy for people with psychosis (CBTp) might be an effective treatment for people with schizophrenia. There are however, limitations in its provision due to available resource and training issues. One way to tackle this issue might be to offer a brief version of CBTp.Objectives: To review the effects of brief CBTp (6 to 10 regular sessions given in less than 4 months and using a manual) for people with schizophrenia compared with standard CBTp (12 to 20 regular sessions given in 4 to 6 months and using a manual).Search methods: We searched the Cochrane Schizophrenia Group?s Trials Register (August 21, 2013 and August 26, 2015) which is based on regular searches of CINAHL, BIOSIS, AMED, EMBASE, PubMed, MEDLINE, PsycINFO and registries of Clinical Trials. There are no language, date, document type, or publication status limitations for inclusion of records in the register. We inspected all references of the selected articles for further relevant trials. We also contacted experts in the field regarding brief CBTp studies.Selection criteria: Randomised controlled trials involving adults with schizophrenia or related disorders, comparing brief cognitive behavioural therapy for people with psychosis versus standard CBTp.Data collection and analysis: Two review authors independently screened and assessed studies for inclusion using pre-specified inclusion criteria.Main results: We found only seven studies which used a brief version of CBTp, but no study compared brief CBTp with CBTp of standard duration. No studies could be included.Authors' conclusions: Currently there is no literature available to compare brief with standard CBTp for people with schizophrenia. We cannot, therefore, conclude whether brief CBTp is as effective, less effective or even more effective than standard courses of the same therapy. This lack of evidence for brief CBTp has serious implications for research and practice. Well planned, conducted and reported randomised trials are indicated					
Newton-Howes og Wood 2013 (88)	Cognitive behavioural therapy and the psychopathology of schizophrenia: Systematic review and meta-analysis	People with schizophrenia	Cognitive behavioural therapy	Non-cognitive psychotherapies	Psychopathology	Theoretically based CBT therapies, although proving effective, may not out perform more accessible and simpler forms of therapy for patients with schizophrenia in reducing psychopathology. Consideration of supportive therapy should be made for patients with psychotic mental disorder. PRACTITIONER POINTS: CBT may not be the psychotherapeutic treatment of choice to alleviate the phenomenology of Schizophrenia. It may be valuable trialling simple supportive therapies prior to implementing more costly and complex cognitive therapies. This review, like the Cochrane review and others, does not suggest CBT in psychosis is not effective, simply that it dose not outperform supportive therapy in effecting change in phenomenology
Sammendrag: PURPOSE: To examine whether cognitive behaviour therapy (CBT) reduces psychopathology in patients with schizophrenia more effectively than the use of non-cognitive psychotherapies. METHOD: Systematic review and meta-analysis of the literature was performed. All Randomized Controlled Trials meeting the inclusion criteria were analysed using RevMan software. This design was used to maximize power and study efficacy. Medline, PsycINFO, and Embase were searched using free-text keywords to identify potential papers. Nine were included in the final meta-analysis. Change in psychopathology at the end of therapy was the end point investigated. A random effects model was used to assess the standard mean difference between the CBT and supportive control groups. RESULTS: Meta-analysis of CBT versus supportive therapy did not find significant differences between the therapy groups at the end of treatment in respect of psychopathology. There was no evidence of publication bias. Post hoc power analysis using the Z test ruled out type one error. CONCLUSIONS: Theoretically based CBT therapies, although proving effective, may not out perform more accessible and simpler forms of therapy for patients with schizophrenia in reducing psychopathology. Consideration of supportive therapy should be made for patients with psychotic mental disorder. PRACTITIONER POINTS: • CBT may not be the psychotherapeutic treatment of choice to alleviate the phenomenology of Schizophrenia. • It may be valuable trialling simple supportive therapies prior to implementing more costly and complex cognitive therapies. • This review, like the Cochrane review and others, does not suggest CBT in psychosis is not effective, simply that it dose not outperform supportive therapy in effecting change in phenomenology					
Nystrom et al. 2015 (89)	Treating major depression with physical activity: A systematic overview with recommendations	People with major depressive disorder (MDD)	Physical activity (aerobic and anaerobic)	Any treatment	Not reported	Individually customized PA, for at least 30 minutes, preferably performed under supervision and with a frequency of at least three times per week is recommended when treating MDD. These recommendations must be viewed in light of the relatively few studies matching the inclusion criteria

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: The purpose of this systematic overview was to determine the most effective mode and dose of physical activity (PA) for treating major depressive disorder (MDD), and to suggest guidelines and recommendations for clinicians. The selection process consisted of a comprehensive search that was conducted up until April 2014 in the following databases: PsycINFO, Medline, PubMed and Scopus. The inclusion criteria were: (1) a randomized controlled trial (RCT) design, (2) complete description of intensity, duration and frequency of the PA, (3) the participants had to be diagnosed with MDD according to Diagnostic Statistical Manual 4 th edition (DSM-IV) or International Classification of Disease tenth Revision (ICD-10) criteria (4) if the controls received any treatment, it had to be specified, (5) published after 1990, (6) consist of aerobic or anaerobic treatment PA, and (7) not be a pilotor preliminary study. A quality assessment of each study was conducted independently by two reviewers; this stringent selection process resulted in 12 reviewed studies. Conclusion: individually customized PA, for at least 30 minutes, preferably performed under supervision and with a frequency of at least three times per week is recommended when treating MDD. These recommendations must be viewed in light of the relatively few studies matching the inclusion criteria						
Okpokoro et al. 2014 (90)	Family intervention (brief) for schizophrenia	People with schizophrenia or schizophrenia-like conditions	Brief family-oriented psychosocial interventions	Standard care	Hospital admission, relapse, family outcome of understanding of family member, days in hospital; adverse events; medication compliance; quality of life or satisfaction with care; or any economic outcomes	The findings of this review are not outstanding due to the size and quality of studies providing data; the analysed outcomes were also minimal, with no meta-analysis possible. All outcomes in the 'Summary of findings' table were rated low or very low quality evidence. However, the importance of brief family intervention should not be dismissed outright, with the present state of demand and resources available. The designs of such brief interventions could be modified to be more effective with larger studies, which may then have enough power to inform clinical practice
Sammendrag: BACKGROUND: Supportive, positive family environments have been shown to improve outcomes for patients with schizophrenia in contrast with family environments that express high levels of criticism, hostility, or over-involvement, which have poorer outcomes and have more frequent relapses. Forms of psychosocial intervention, designed to promote positive environments and reduce these levels of expressed emotions within families, are now widely used. OBJECTIVES: To assess the effects of brief family interventions for people with schizophrenia or schizophrenia-like conditions. SEARCH METHODS: We searched the Cochrane Schizophrenia Group Trials Register (July 2012), which is based on regular searches of CINAHL, EMBASE, MEDLINE and PsycINFO. We inspected references of all identified studies for further trials. We contacted authors of trials for additional information. SELECTION CRITERIA: All relevant randomised studies that compared brief family-oriented psychosocial interventions with standard care, focusing on families of people with schizophrenia or schizoaffective disorder were selected. DATA COLLECTION AND ANALYSIS: We reliably selected studies, quality assessed them and extracted data. For binary outcomes, we calculated standard estimates of risk ratio (RR) and their 95% confidence intervals (CI). For continuous outcomes, we estimated a mean difference (MD) between groups and their 95% CIs. We used GRADE to assess quality of evidence for main outcomes of interest and created a 'Summary of findings' table. We assessed risk of bias for included studies. MAIN RESULTS: Four studies randomising 163 people could be included in the review. It is not clear if brief family intervention reduces the utilisation of health services by patients, as most results are equivocal at long term and only one study reported data for the primary outcomes of interest of hospital admission (n = 30, 1 RCT, RR 0.50, 95% CI 0.22 to 1.11, very low quality evidence). Data for relapse are also equivocal by medium term (n = 40, 1 RCT, RR 0.50, 95% CI 0.10 to 2.43, low quality evidence). However, data for the family outcome of understanding of family member significantly favoured brief family intervention (n = 70, 1 RCT, MD 14.90, 95% CI 7.20 to 22.60, very low quality evidence). No study reported data for other outcomes of interest including days in hospital; adverse events; medication compliance; quality of life or satisfaction with care; or any economic outcomes. AUTHORS' CONCLUSIONS: The findings of this review are not outstanding due to the size and quality of studies providing data; the analysed outcomes were also minimal, with no meta-analysis possible. All outcomes in the 'Summary of findings' table were rated low or very low quality evidence. However, the importance of brief family intervention should not be dismissed outright, with the present state of demand and resources available. The designs of such brief interventions could be modified to be more effective with larger studies, which may then have enough power to inform clinical practice						
Orfanos et al. 2015 (91)	Are group psychotherapeutic treatments effective for patients with schizophrenia? A systematic review and meta-analysis	People with schizophrenia	Group psychotherapeutic treatments	Treatment as usual and active sham	Symptoms, social functioning	Group psychotherapeutic treatments can improve negative symptoms and social functioning deficits in the treatment of schizophrenia. The effect occurs across different treatments and appears to be non-specific. Future research should identify the underlying mechanisms for the positive effect of participating in groups and explore how they can be maximised to increase the therapeutic benefit

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Sammendrag: Background: Different psychotherapeutic treatments for schizophrenia are delivered in groups. However, little is known about the effectiveness of these group therapies for people with schizophrenia across different treatments with varying therapeutic orientations. This review aimed to (1) estimate the effect of different group psychotherapeutic treatments for schizophrenia and (2) explore whether any overall 'group effect' is moderated by treatment intensity, diagnostic homogeneity and therapeutic orientation. Methods: A systematic search of randomised controlled trials exploring the effectiveness of group psychotherapeutic treatments for people with schizophrenia was conducted. Random-effect meta-analyses on endpoint symptom scores compared group psychotherapeutic treatments with treatment as usual and active sham groups. Findings on social functioning were described narratively, and meta-regression analyses on group characteristics were carried out. Results: Thirty-four eligible trials were included. A weak-to-moderate significant between-group difference in favour of group psychotherapeutic treatments was found for negative symptom scores (standard mean difference = -0.37, 95% confidence interval -0.60, -0.14; p < 0.01, I2 = 59.8%) only when compared to treatment as usual and not to active sham groups. Improved social functioning was reported as a treatment outcome in the majority of studies compared to treatment as usual. The 'group effect' on negative symptoms was positively related to 'treatment intensity' (beta = 0.32, standard error = 0.121; p < 0.05). Conclusion: Group psychotherapeutic treatments can improve negative symptoms and social functioning deficits in the treatment of schizophrenia. The effect occurs across different treatments and appears to be non-specific. Future research should identify the underlying mechanisms for the positive effect of participating in groups and explore how they can be maximised to increase the therapeutic benefit					
Pearsall et al. 2014 (92)	Exercise therapy in adults with serious mental illness: a systematic review and meta-analysis	People with serious mental illness	Exercise therapy	Usual care or other type of intervention	Symptoms of mental health, body mass index, and body weight, exercise activity	This systematic review showed that exercise therapies can lead to a modest increase in levels of exercise activity but overall there was no noticeable change for symptoms of mental health, body mass index, and body weight
Sammendrag: BACKGROUND: Individuals with serious mental illness are at a higher risk of physical ill health. Mortality rates are at least twice those of the general population with higher levels of cardiovascular disease, metabolic disease, diabetes, and respiratory illness. Although genetics may have a role in the physical health problems of these patients, lifestyle and environmental factors such as levels of smoking, obesity, poor diet, and low levels of physical activity also play a prominent part. METHODS: We conducted a systematic review and meta-analysis of randomised controlled trials comparing the effect of exercise interventions on individuals with serious mental illness.Searches were made in Ovid MEDLINE, Embase, CINAHL, PsycINFO, Biological Abstracts on Ovid, and The Cochrane Library (January 2009, repeated January 2013) through to February 2013. RESULTS: Eight RCTs were identified in the systematic search. Six compared exercise versus usual care. One study assessed the effect of a cycling programme versus muscle strengthening and toning exercises. The final study compared the effect of adding specific exercise advice and motivational skills to a simple walking programme. The review found that exercise improved levels of exercise activity (n=13, standard mean difference [SMD] 1.81, CI 0.44 to 3.18, p=0.01). No beneficial effect was found on negative (n=84, SMD=-0.54, CI -1.79 to 0.71, p=0.40) or positive symptoms of schizophrenia (n=84, SMD=-1.66, CI -3.78 to 0.45, p=0.12). No change was found on body mass index compared with usual care (n=151, SMD=-0.24, CI -0.56 to 0.08, p=0.14), or body weight (n=77, SMD=0.13, CI -0.32 to 0.58, p=0.57). No beneficial effect was found on anxiety and depressive symptoms (n=94, SMD=-0.26, CI -0.91 to 0.39, p=0.43), or quality of life in respect of physical and mental domains. CONCLUSIONS: This systematic review showed that exercise therapies can lead to a modest increase in levels of exercise activity but overall there was no noticeable change for symptoms of mental health, body mass index, and body weight					
Pharoah et al. 2010 (93)	Family intervention for schizophrenia	People with schizophrenia or schizoaffective disorder	Community-orientated family-based psychosocial intervention	Standard care	Relapse, hospitalization, compliance with medication	Family intervention may reduce the number of relapse events and hospitalisations and would therefore be of interest to people with schizophrenia, clinicians and policy makers. However, the treatment effects of these trials may be overestimated due to the poor methodological quality. Further data from trials that describe the methods of randomisation, test the blindness of the study evaluators, and implement the CONSORT guidelines would enable greater confidence in these findings

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Sammendrag: BACKGROUND: People with schizophrenia from families that express high levels of criticism, hostility, or over involvement, have more frequent relapses than people with similar problems from families that tend to be less expressive of emotions. Forms of psychosocial intervention, designed to reduce these levels of expressed emotions within families, are now widely used. OBJECTIVES: To estimate the effects of family psychosocial interventions in community settings for people with schizophrenia or schizophrenia-like conditions compared with standard care. SEARCH STRATEGY: We updated previous searches by searching the Cochrane Schizophrenia Group Trials Register (September 2008). SELECTION CRITERIA: We selected randomised or quasi-randomised studies focusing primarily on families of people with schizophrenia or schizoaffective disorder that compared community-orientated family-based psychosocial intervention with standard care. DATA COLLECTION AND ANALYSIS: We independently extracted data and calculated fixed-effect relative risk (RR), the 95% confidence intervals (CI) for binary data, and, where appropriate, the number needed to treat (NNT) on an intention-to-treat basis. For continuous data, we calculated mean differences (MD). MAIN RESULTS: This 2009-10 update adds 21 additional studies, with a total of 53 randomised controlled trials included. Family intervention may decrease the frequency of relapse (n = 2981, 32 RCTs, RR 0.55 CI 0.5 to 0.6, NNT 7 CI 6 to 8), although some small but negative studies might not have been identified by the search. Family intervention may also reduce hospital admission (n = 481, 8 RCTs, RR 0.78 CI 0.6 to 1.0, NNT 8 CI 6 to 13) and encourage compliance with medication (n = 695, 10 RCTs, RR 0.60 CI 0.5 to 0.7, NNT 6 CI 5 to 9) but it does not obviously affect the tendency of individuals/families to leave care (n = 733, 10 RCTs, RR 0.74 CI 0.5 to 1.0). Family intervention also seems to improve general social impairment and the levels of expressed emotion within the family. We did not find data to suggest that family intervention either prevents or promotes suicide. AUTHORS' CONCLUSIONS: Family intervention may reduce the number of relapse events and hospitalisations and would therefore be of interest to people with schizophrenia, clinicians and policy makers. However, the treatment effects of these trials may be overestimated due to the poor methodological quality. Further data from trials that describe the methods of randomisation, test the blindness of the study evaluators, and implement the CONSORT guidelines would enable greater confidence in these findings					
Piet og Hougaard 2011 (94)	The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis	People with major depressive disorder (MDD)	Mindfulness-based cognitive therapy (MBCT). Group-based	Treatment as usual or placebo controls	Relapse or recurrence	Results of this meta-analysis indicate that MBCT is an effective intervention for relapse prevention in patients with recurrent MDD in remission, at least in case of three or more previous MDD episodes
Sammendrag: Background: Mindfulness-based cognitive therapy (MBCT) is a group-based clinical intervention program designed to reduce relapse or recurrence of major depressive disorder (MDD) by means of systematic training in mindfulness meditation combined with cognitive-behavioral methods. Objective: By means of a meta-analysis to evaluate the effect of MBCT for prevention of relapse or recurrence among patients with recurrent MDD in remission. Method: Electronic databases were searched and researchers were contacted for further relevant studies. Studies were coded for quality. Meta-analyses were performed by means of the Cochrane Collaboration Review Manager 5.1. Results: Six randomized controlled trials with a total of 593 participants were included in the meta-analysis. MBCT significantly reduced the risk of relapse/recurrence with a risk ratio of 0.66 for MBCT compared to treatment as usual or placebo controls, corresponding to a relative risk reduction of 34%. In a pre-planned subgroup analysis the relative risk reduction was 43% for participants with three or more previous episodes, while no risk reduction was found for participants with only two episodes. In two studies, MBCT was at least as effective as maintenance antidepressant medication. Conclusion: Results of this meta-analysis indicate that MBCT is an effective intervention for relapse prevention in patients with recurrent MDD in remission, at least in case of three or more previous MDD episodes					
Pinquart et al. 2014 (95)	Efficacy of systemic therapy on adults with mental disorders: A meta-analysis	People with psychiatric disorders	Systemic therapy	Control groups without alternative treatment, alternative active treatments	Not reported	We conclude that the present meta-analysis found some evidence for the efficacy of systemic therapy on five disorders, but the number of available RCT is still limited. More research is needed on systemic therapy of other disorders, such as anxiety disorders and substance use disorders
Sammendrag: Objective: To evaluate the efficacy of systemic therapy on psychiatric disorders in adulthood. Methods: This meta-analysis integrates results of 37 randomized controlled trials (RCT) of therapy with an explicit systemic focus on adults with psychiatric disorders. Studies were identified through systematic searches in electronic databases and cross-referencing. Results: On average, systemic therapy had stronger short-term (g = .51) and long-term (g = .55) efficacies than control groups without alternative treatment and stronger short-term effects than alternative active treatments (g = .25). In addition, efficacy of systemic therapy was similar to those of other bona fide psychotherapies. Individuals receiving systemic therapy plus medication showed stronger improvements at posttest (g = .71) and follow-up (g = .87) than those receiving only medication. Illness-specific analyses showed positive short-term efficacy of systemic therapy on eating disorders, mood disorders, obsessive-compulsive disorders, schizophrenia, and somatoform disorders. At follow-up, efficacy of systemic therapy was only found on eating disorders, mood disorders, and schizophrenia. In addition, systemic therapy had lower dropout rates than alternative treatments. For certain comparisons, effect sizes were moderated by participant age, study quality, and year of publication. Conclusions: We conclude that the present meta-analysis found some evidence for the efficacy of systemic therapy on five disorders, but the number of available RCT is still limited. More research is needed on systemic therapy of other disorders, such as anxiety disorders and substance use disorders					
Qureshi og Al-Bedah 2013 (96)	Mood disorders and complementary and alternative medicine: A literature review	People with mood disorders	Complementary and alternative medicine	Not reported	Not reported	Currently, although CAM therapies are not the primary treatment of mood disorders, level 1 evidence could emerge in the future showing that such treatments are effective

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Sammendrag: Mood disorders are a major public health problem and are associated with considerable burden of disease, suicides, physical comorbidities, high economic costs, and poor quality of life. Approximately 30%-40% of patients with major depression have only a partial response to available pharmacological and psychotherapeutic interventions. Complementary and alternative medicine (CAM) has been used either alone or in combination with conventional therapies in patients with mood disorders. This review of the literature examines evidence-based data on the use of CAM in mood disorders. A search of the PubMed, Medline, Google Scholar, and Quertile databases using keywords was conducted, and relevant articles published in the English language in the peer-reviewed journals over the past two decades were retrieved. Evidence-based data suggest that light therapy, St John's wort, Rhodiola rosea, omega-3 fatty acids, yoga, acupuncture, mindfulness therapies, exercise, sleep deprivation, and S-adenosylmethionine are effective in the treatment of mood disorders. Clinical trials of vitamin B complex, vitamin D, and methylfolate found that, while these were useful in physical illness, results were equivocal in patients with mood disorders. Studies support the adjunctive role of omega-3 fatty acids, eicosapentaenoic acid, and docosahexaenoic acid in unipolar and bipolar depression, although manic symptoms are not affected and higher doses are required in patients with resistant bipolar depression and rapid cycling. Omega-3 fatty acids are useful in pregnant women with major depression, and have no adverse effects on the fetus. Choline, inositol, 5-hydroxy-L-tryptophan, and N-acetylcysteine are effective adjuncts in bipolar patients. Dehydroepiandrosterone is effective both in bipolar depression and depression in the setting of comorbid physical disease, although doses should be titrated to avoid adverse effects. Ayurvedic and homeopathic therapies have the potential to improve symptoms of depression, although larger controlled trials are needed. Mind-body-spirit and integrative medicine approaches can be used effectively in mild to moderate depression and in treatment-resistant depression. Currently, although CAM therapies are not the primary treatment of mood disorders, level 1 evidence could emerge in the future showing that such treatments are effective					
Rakofsky og Dunlop 2014 (97)	Review of nutritional supplements for the treatment of bipolar depression	People with bipolar disorder	Nutritional supplements	Not reported	Bipolar depression	The findings of this review do not support the routine use of nutritional supplements in the treatment or prophylaxis of BD depression. Studies with more rigorous designs are required before definitive conclusions can be made. Despite the inadequacy of the existing data, clinicians should remain open to the value of nutritional supplements: after all, lithium is a mineral too
Sammendrag: Many patients view psychotropics with skepticism and fear and view nutritional supplements as more consistent with their values and beliefs. The purpose of this review was to critically evaluate the evidence base for nutritional supplements in the treatment of bipolar depression (BD). A literature search for all randomized, controlled clinical trials using nutritional supplements in the treatment of BD was conducted via PubMed and Ovid MEDLINE computerized database. The studies were organized into essential nutrients/minerals, nonessential nutrients, and combinations of nutritional products. Among essential nutrients/minerals, omega-3-fatty acids (O3FAs) have the strongest evidence of efficacy for bipolar depression, although some studies failed to find positive effects from O3FAs. Weak evidence supports efficacy of vitamin C whereas no data support the usefulness of folic acid and choline. Among nonessential nutrients, cytidine is the least supported treatment. Studies of N-acetylcysteine have not resolved its efficacy in treating acute depressive episodes relative to placebo. However, one study demonstrates its potential to improve depressive symptoms over time and the other, though nonsignificant, suggests it has a prophylactic effect. Studies of inositol have been mostly negative, except for 1 study. Those that were negative were underpowered but demonstrated numerically positive effects for inositol. There is no evidence that citicholine is efficacious for uncomplicated BD depression, though it may have value for comorbid substance abuse among BD patients. Finally, combination O3FA-cytidine lacks evidence of efficacy. The findings of this review do not support the routine use of nutritional supplements in the treatment or prophylaxis of BD depression. Studies with more rigorous designs are required before definitive conclusions can be made. Despite the inadequacy of the existing data, clinicians should remain open to the value of nutritional supplements: after all, lithium is a mineral too					
Rector og Beck 2012 (98)	Cognitive behavioral therapy for schizophrenia: An empirical review	People with schizophrenia	Cognitive behavioral therapy	Control treatment conditions	Clinically change	CBT has been shown to produce large clinical effects on measures of positive and negative symptoms of schizophrenia. Patients receiving routine care and adjunctive CBT have experienced additional benefits above and beyond the gains achieved with routine care and adjunctive supportive therapy. These results reveal promise for the role of CBT in the treatment of schizophrenia although additional research is required to test its efficacy, long-term durability, and impact on relapse rates and quality of life. Clinical refinements are needed also to help those who show only minimal benefit with the intervention
Sammendrag: Early case studies and noncontrolled trial studies focusing on the treatment of delusions and hallucinations have laid the foundation for more recent developments in comprehensive cognitive behavioral therapy (CBT) interventions for schizophrenia. Seven randomized, controlled trial studies testing the efficacy of CBT for schizophrenia were identified by electronic search (MEDLINE and PsychInfo) and by personal correspondence. After a review of these studies, effect size (ES) estimates were computed to determine the statistical magnitude of clinical change in CBT and control treatment conditions. CBT has been shown to produce large clinical effects on measures of positive and negative symptoms of schizophrenia. Patients receiving routine care and adjunctive CBT have experienced additional benefits above and beyond the gains achieved with routine care and adjunctive supportive therapy. These results reveal promise for the role of CBT in the treatment of schizophrenia although additional research is required to test its efficacy, long-term durability, and impact on relapse rates and quality of life. Clinical refinements are needed also to help those who show only minimal benefit with the intervention					

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Riedel-Heller et al. 2012 (99)	Psychosocial interventions in severe mental illness. Evidence and recommendations: Psychoeducation, social skill training and exercise	People with serious mental illness	Psychosocial interventions (psychoeducation for patients and relatives, social skill training and physical exercise)	Not reported	Not reported	This paper summarizes the results of a systematic literature search on three widely used psychosocial interventions for people with severe mental illness: psychoeducation for patients and relatives, social skill training and physical exercise. Based on this evidence, recommendations given in the S3 guidelines on psychosocial therapies in severe mental illness of the German Society for Psychiatry, Psychotherapy and Neurology (DGPPN) will be reported. Areas of future research are identified
Sammendrag: This paper summarizes the results of a systematic literature search on three widely used psychosocial interventions for people with severe mental illness: psychoeducation for patients and relatives, social skill training and physical exercise. Based on this evidence, recommendations given in the S3 guidelines on psychosocial therapies in severe mental illness of the German Society for Psychiatry, Psychotherapy and Neurology (DGPPN) will be reported. Areas of future research are identified						
Roder et al. 2011 (100)	Effectiveness of integrated psychological therapy (IPT) for schizophrenia patients: a research update	People with schizophrenia	Integrated psychological therapy (IPT)	Placebo-attention conditions and standard care	Neurocognition, social cognition, psychosocial functioning, and negative symptoms	This analysis summarizes the broad empirical evidence indicating that IPT is an effective rehabilitation approach for schizophrenia patients and is robust across a wide range of sample characteristics as well as treatment conditions. Moreover, the cognitive and social subprograms of IPT may work in a synergistic manner, thereby enhancing the transfer of therapy effects over time and improving functional recovery
Sammendrag: Standardized recovery criteria go beyond symptom remission and put special emphasis on personal and social functioning in residence, work, and leisure. Against this background, evidence-based integrated approaches combining cognitive remediation with social skills therapy show promise for improving functional recovery of schizophrenia patients. Over the past 30 years, research groups in 12 countries have evaluated integrated psychological therapy (IPT) in 36 independent studies. IPT is a group therapy program for schizophrenia patients. It combines neurocognitive and social cognitive interventions with social skills and problem-solving approaches. The aim of the present study was to update and integrate the growing amount of research data on the effectiveness of IPT. We quantitatively reviewed the results of these 36 studies, including 1601 schizophrenia patients, by means of a meta-analytic procedure. Patients undergoing IPT showed significantly greater improvement in all outcome variables (neurocognition, social cognition, psychosocial functioning, and negative symptoms) than those in the control groups (placebo-attention conditions and standard care). IPT patients maintained their mean positive effects during an average follow-up period of 8.1 months. They showed better effects on distal outcome measures when all 5 subprograms were integrated. This analysis summarizes the broad empirical evidence indicating that IPT is an effective rehabilitation approach for schizophrenia patients and is robust across a wide range of sample characteristics as well as treatment conditions. Moreover, the cognitive and social subprograms of IPT may work in a synergistic manner, thereby enhancing the transfer of therapy effects over time and improving functional recovery						
Rodriguez et al. 2014 (101)	Group psychoeducation in bipolar treatment: A systematic review of the literature	People with bipolar disorder	Group psychoeducation	Not reported	Not reported	In this work we make a non-systematic review of literature of group psychoeducation for those patients who suffer from Bipolar Disorder, identifying its objectives and prime procedures.
Sammendrag: Bipolar disorder is a chronic and cyclical disease which has strong destructive effects on personal, family and social levels. Although pharmacotherapy is still a key point for its treatment, during the last decades psychological interventions have become more important as medicine contributors. Empirical evidence shows a life quality improvement in those patients who join psycho-educative groups. Psycho-education emphasizes therapeutic adhesion, symptoms acknowledgement and management, and emotional control. It is one of the different forms of interventions that have received more empirical support. In this work we make a non-systematic review of literature of group psychoeducation for those patients who suffer from Bipolar Disorder, identifying its objectives and prime procedures						

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Rosenbaum et al. 2014 (102)	Physical activity interventions for people with mental illness: A systematic review and meta-analysis	People with mental illness (other than dysthymia or eating disorders)	Physical activity interventions	Not reported	Primary outcome: depressive symptoms Secondary outcomes: symptoms of schizophrenia, anthropometric measures, aerobic capacity, and quality of life	Physical activity reduced depressive symptoms in people with mental illness. Larger effects were seen in studies of poorer methodological quality. Physical activity reduced symptoms of schizophrenia and improved anthropometric measures, aerobic capacity, and quality of life among people with mental illness.
Sammendrag: Objective: To determine effects of physical activity on depressive symptoms (primary objective), symptoms of schizophrenia, anthropometric measures, aerobic capacity, and quality of life (secondary objectives) in people with mental illness and explore between-study heterogeneity. Data Sources: MEDLINE, Cochrane Controlled Trials Register, PsycINFO, CINAHL, Embase, and the Physiotherapy Evidence Database (PEDro) were searched from earliest record to 2013. Study Selection: Randomized controlled trials of adults with a DSM-IV-TR, ICD-10, or clinician-confirmed diagnosis of a mental illness other than dysthymia or eating disorders were selected. Interventions included exercise programs, exercise counseling, lifestyle interventions, tai chi, or physical yoga. Study methodological quality and intervention compliance with American College of Sports Medicine (ACSM) guidelines were also assessed. Data Extraction and Analysis:Iwo investigators extracted data. Data were pooled using random-effects meta-analysis. Meta-regression was used to examine sources of between-study heterogeneity. Results:Thirty-nine eligible trials were identified. The primary meta-analysis found a large effect of physical activity on depressive symptoms (n = 20; standardized mean difference (SMD)=0.80). The effect size in trial interventions that met ACSM guidelines for aerobic exercise did not differ significantly from those that did not meet these guidelines. The effect for trials with higher methodological quality was smaller than that observed for trials with lower methodological quality (SMD=0.39 vs 1.35); however, the difference was not statistically significant. A large effect was found for schizophrenia symptoms (SMD= 1.0), a small effect was found for anthropometry (SMD=0.24), and moderate effects were found for aerobic capacity (SMD=0.63) and quality of life (SMD=0.64). Conclusions: Physical activity reduced depressive symptoms in people with mental illness. Larger effects were seen in studies of poorer methodological quality. Physical activity reduced symptoms of schizophrenia and improved anthropometric measures, aerobic capacity, and quality of life among people with mental illness					
Sarin et al. 2011 (103)	Cognitive behavior therapy for schizophrenia: a meta-analytical review of randomized controlled trials	People with schizophrenia	Cognitive behavior therapy (CBT)	Treatment as usual and other psychological treatments	Symptoms, use of medication, relapse and clinically important improvement	It appears that the effect of CBT is delayed; it could be seen a few months after the treatment had terminated. Therapies for patients with schizophrenia that were 20 sessions long or more had better outcomes than those that were shorter.
Sammendrag: BACKGROUND: In the UK and in Sweden, cognitive behavior therapy (CBT) has been recommended for schizophrenia. The two recent meta-analyses examined results soon after treatment and not at follow-up. AIM: To determine the effectiveness of CBT in people with schizophrenia, both after treatment and at follow-up, and to compare it with treatment as usual (TAU) and other psychological treatments. METHODS: The search was carried in the databases CENTRAL (Cochrane Central Register of Controlled Trials), PsycINFO and PubMed (Medline). Inclusion criteria were randomized controlled trials (RCTs) with low risk of bias. Two reviewers, working independently, extracted data. The results were analyzed using risk ratio (RR), risk difference (RD), mean difference (MD), or standardized mean difference (SMD). Outcome measures were symptoms, use of medication, relapse and clinically important improvement. RESULTS: When CBT was compared with other psychological treatments at follow-up, there was strong evidence (with small treatment effect) that intervention has an effect with positive symptoms (P = 0.02), negative symptoms (P = 0.03) and general symptoms (P = 0.003). After treatment, there was a trend in favor of CBT, but not statistically significantly so. CONCLUSION: It appears that the effect of CBT is delayed; it could be seen a few months after the treatment had terminated. Therapies for patients with schizophrenia that were 20 sessions long or more had better outcomes than those that were shorter					
Sarris et al. 2011 (104)	Bipolar disorder and complementary medicine: Current evidence, safety issues, and clinical considerations	People with bipolar disorder	Nonconventional (complementary and integrative) interventions	Not reported	Not reported	Current evidence supports the integrative treatment of BD using combinations of mood stabilizers and select nutrients. Other CAM or integrative modalities used to treat BD have not been adequately explored to date; however, some early findings are promising. Select CAM and integrative interventions add to established conventional treatment of BD and may be considered when formulating a treatment plan. It is hoped that the safety issues and clinical considerations addressed in this article may encourage the practice of safety-conscious and evidence-based integrative management of BD

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Background: Bipolar disorder (BD) is a debilitating syndrome that is often undiagnosed and undertreated. Population surveys show that persons with BD often self-medicate with complementary and alternative medicine (CAM) or integrative therapies in spite of limited research evidence supporting their use. To date, no review has focused specifically on nonconventional treatments of BD. Objectives: The study objectives were to present a review of nonconventional (complementary and integrative) interventions examined in clinical trials on BD, and to offer provisional guidelines for the judicious integrative use of CAM in the management of BD. Methods: PubMed, CINAHL, Web of Science, and Cochrane Library databases were searched for human clinical trials in English during mid-2010 using Bipolar Disorder and CAM therapy and CAM medicine search terms. Effect sizes (Cohen's d) were also calculated where data were available. Results: Several positive high-quality studies on nutrients in combination with conventional mood stabilizers and antipsychotic medications in BD depression were identified, while branched-chain amino acids and magnesium were effective (small studies) in attenuating mania in BD. In the treatment of bipolar depression, evidence was mixed regarding omega-3, while isolated studies provide provisional support for a multinutrient formula, n-acetylcysteine, and l-tryptophan. In one study, acupuncture was found to have favorable but nonsignificant effects on mania and depression outcomes. Conclusions: Current evidence supports the integrative treatment of BD using combinations of mood stabilizers and select nutrients. Other CAM or integrative modalities used to treat BD have not been adequately explored to date; however, some early findings are promising. Select CAM and integrative interventions add to established conventional treatment of BD and may be considered when formulating a treatment plan. It is hoped that the safety issues and clinical considerations addressed in this article may encourage the practice of safety-conscious and evidence-based integrative management of BD					
Schottle et al. 2011 (105)	Psychotherapy for bipolar disorder: A review of the most recent studies	People with bipolar disorder	Psychotherapy	Not reported	Relapse, functioning, symptoms, quality of life	Recent RCTs evaluating psychosocial interventions for bipolar disorder have added to the evidence, thereby broadening existing therapeutic options. These promising results should encourage future studies leading to a better understanding of what kind of patient or caregiver will benefit from what kind of therapy, and how efficient psychosocial interventions can be under routine conditions
Sammendrag: Purpose of review: The aim of this review is to give an update on recent randomized controlled trials (RCTs) evaluating psychotherapy for bipolar disorder. Recent findings: Methodological issues like the inclusion of differing patient populations, differences in who (patients, family members, caregivers) received psychotherapy, and varying followup periods make it difficult to compare RCTs. Despite heterogeneous results, the majority of the studies showed relevant positive results in terms of reduced relapse rates, increased quality of life, better functioning or more favorable symptomatic outcome. Summary: Recent RCTs evaluating psychosocial interventions for bipolar disorder have added to the evidence, thereby broadening existing therapeutic options. These promising results should encourage future studies leading to a better understanding of what kind of patient or caregiver will benefit from what kind of therapy, and how efficient psychosocial interventions can be under routine conditions						
Segredou et al. 2012 (106)	Group psychosocial interventions for adults with schizophrenia and bipolar illness: The evidence base in the light of publications between 1986 and 2006	People with schizophrenia and bipolar illness	Group psychosocial interventions	Control group (no further explanation)	Skills and functioning	The therapeutic approach in the majority of the studies was along the lines of cognitive behaviour therapy and psychoeducation. All studies reported improvement in at least one parameter. Most of them report improvement in skills and overall functioning
Sammendrag: Aim: The treatment of major mental disorders usually combines medical and psychosocial interventions. The present study reviews research pertaining to the efficacy of group psychosocial interventions for people with psychotic illness. Method: An electronic search was conducted through Medline and PsycINFO to identify articles relevant to group therapy for people with schizophrenia and bipolar affective disorder. Articles published in the English language, between January 1986 and May 2006, were considered. Studies were included if they had a control group and at least 20 participants. The search resulted in 23 articles concerning patients with schizophrenia and five concerning patients with bipolar affective disorder. Results and Conclusion: The therapeutic approach in the majority of the studies was along the lines of cognitive behaviour therapy and psychoeducation. All studies reported improvement in at least one parameter. Most of them report improvement in skills and overall functioning						
Sevi og Sutcu 2012 (107)	Cognitive-behavioral group treatment for schizophrenia and other psychotic disorders-A systematic review	People with schizophrenia and other psychotic disorders	Cognitive-behavioral group treatment	Not reported	Not reported	It can be seen that the cognitive behavioral therapies plus standard treatment that ate applied to people who have schizophrenia and other psychotic disorders are effective in decreasing the symptoms of the disorders (positive and negative symptoms etc.) and/or the problems that accompany the disorder (anxiety, hopelessness etc.)

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Objective: This study aims to revise empirical studies that were used to evaluate the effectiveness of cognitive-behavioral group treatment programs in the treatment for schizophrenia and other psychotic disorders. Method: Articles in English that were published between the years of 1980 and 2011 (July) have been searched in the: PsycINFO, PsycARTICLES and MEDLINE databases by using "(1) psychosis and cognitive treatment (2) schizophrenia and cognitive treatment, (3) schizophrenia and cognitive therapy, (4) psychosis and cognitive therapy, (5) schizophrenia and cognitive intervention (6), psychosis and cognitive intervention, (7) hallucination and cognitive therapy, (8) hallucination and cognitive treatment, (9) hallucination and cognitive intervention" keywords. The articles that were gathered by the search have been read and the ones that were not therapy effectiveness studies, group therapies were eliminated. Results: The remaining 42 studies that were in conformance with the search criteria were introduced in the context of method (properties of population, measures, randomization, results, follow-up, etc.) and therapy characteristics (number of sessions, frequency of sessions, number of therapists and members, etc.). Conclusion: It can be seen that the cognitive behavioral therapies plus standard treatment that ate applied to people who have schizophrenia and other psychotic disorders are effective in decreasing the symptoms of the disorders (positive and negative symptoms etc.) and/or the problems that accompany the disorder (anxiety, hopelessness etc.)						
Shen et al. 2014 (108)	Acupuncture for schizophrenia	People with schizophrenia or related psychoses	Acupuncture alone or in combination treatments	Placebo (or no treatment) or any other treatments	Not reported	Limited evidence suggests that acupuncture may have some antipsychotic effects as measured on global and mental state with few adverse effects. Better designed large studies are needed to fully and fairly test the effects of acupuncture for people with schizophrenia
Sammendrag: BACKGROUND: Acupuncture, with many categories such as traditional acupuncture, electroacupuncture, laser acupuncture, and acupoint injection, has been shown to be relatively safe with few adverse effects. It is accessible and inexpensive, at least in China, and is likely to be widely used there for psychotic symptoms. OBJECTIVES: To review the effects of acupuncture, alone or in combination treatments compared with placebo (or no treatment) or any other treatments for people with schizophrenia or related psychoses. SEARCH METHODS: We searched Cochrane Schizophrenia Group's Trials Register (February 2012), which is based on regular searches of CINAHL, BIOSIS, AMED, EMBASE, PubMed, MEDLINE, PsycINFO and clinical trials registries. We also inspected references of identified studies and contacted relevant authors for additional information. SELECTION CRITERIA: We included all relevant randomised controlled trials involving people with schizophrenia-like illnesses, comparing acupuncture added to standard dose antipsychotics with standard dose antipsychotics alone, acupuncture added to low dose antipsychotics with standard dose antipsychotics, acupuncture with antipsychotics, acupuncture added to Traditional Chinese Medicine (TCM) drug with TCM drug, acupuncture with TCM drug, electric acupuncture convulsive therapy with electroconvulsive therapy. DATA COLLECTION AND ANALYSIS: We reliably extracted data from all included studies, discussed any disagreement, documented decisions and contacted authors of studies when necessary. We analysed binary outcomes using a standard estimation of risk ratio (RR) and its 95% confidence interval (CI). For continuous data, we calculated mean differences with 95% CI. For homogeneous data we used fixed-effect model. We assessed risk of bias for included studies and created 'Summary of findings' tables using GRADE. MAIN RESULTS: After an update search in 2012 the review now includes 30 studies testing different forms of acupuncture across six different comparisons. All studies were at moderate risk of bias.When acupuncture plus standard antipsychotic treatment was compared with standard antipsychotic treatment alone, people were at less risk of being 'not improved' (n = 244, 3 RCTs, medium-term RR 0.40 CI 0.28 to 0.57, very low quality evidence). Mental state findings were mostly consistent with this finding as was time in hospital (n = 120, 1 RCT, days MD -16.00 CI -19.54 to -12.46, moderate quality evidence). If anything, adverse effects were less for the acupuncture group (e.g. central nervous system, insomnia, short-term, n = 202, 3 RCTs, RR 0.30 CI 0.11 to 0.83, low quality evidence).When acupuncture was added to low dose antipsychotics and this was compared with standard dose antipsychotic drugs, relapse was less in the experimental group (n = 170, 1 RCT, long-term RR 0.57 CI 0.37 to 0.89, very low quality evidence) but there was no difference for the outcome of 'not improved'. Again, mental state findings were mostly consistent with the latter. Incidences of extrapyramidal symptoms - akathisia, were less for those in the acupuncture added to low dose antipsychotics group (n = 180, 1 RCT, short-term RR 0.03 CI 0.00 to 0.49, low quality evidence) - as dry mouth, blurred vision and tachycardia.When acupuncture was compared with antipsychotic drugs of known efficacy in standard doses, there were equivocal data for outcomes such as 'not improved' using different global state criteria. Traditional acupuncture added to TCM drug had benefit over use of TCM drug alone (n = 360, 2 RCTs, RR no clinically important change 0.11 CI 0.02 to 0.59, low quality evidence), but when traditional acupuncture was compared with TCM drug directly there was no significant difference in the short-term. However, we found that participants given electroacupuncture were significantly less likely to experience a worsening in global state (n = 88, 1 RCT, short-term RR 0.52 CI 0.34 to 0.80, low quality evidence).In the one study that compared electric acupuncture convulsive therapy with electroconvulsive therapy there were significantly different rates of spinal fracture between the groups (n = 68, 1 RCT, short-term RR 0.33 CI 0.14 to 0.81, low quality evidence). Attrition in all studies was minimal. No studies reported death, engagement with services, satisfaction with treatment, quality of life, or economic outcomes. AUTHORS' CONCLUSIONS: Limited evidence suggests that acupuncture may have some antipsychotic effects as measured on global and mental state with few adverse effects. Better designed large studies are needed to fully and fairly test the effects of acupuncture for people with schizophrenia					
Siantz og Aranda 2014 (109)	Chronic disease self-management interventions for adults with serious mental illness: a systematic review of the literature	People with serious mental illness	Chronic disease self-management interventions	Not reported	Not reported	Given the high chronic disease burden experienced by individuals with SMI combined with our nations health care reform, emphasis on self-management to improve population health, coupled with advancing the quality of research to evaluate CDSM programs for adults with SMI, is critically needed

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: OBJECTIVE: While there is strong evidence in support of chronic disease self-management programs, much less is available with regard to individuals living with serious mental illness (SMI). The objectives of this review are to identify and appraise chronic disease self-management studies tested with samples of US adults living with SMI. We include an appraisal of methodological quality of the chronic disease self-management (CDSM) studies that met our final criteria. METHODS: Systematic search methods were utilized to identify intervention studies published before 2012 that describe CDSM outcomes for adults with SMI. RESULTS: Eighteen unduplicated articles were identified that included outcomes of CDSM studies, while 10 met all inclusion criteria. Favorable treatment effects were observed for adults with SMI across 10 studies that took place in different types of clinical settings. CDSM studies that met all search criteria had a wide range of methodological quality, indicating that this is a nascent field of study. CONCLUSIONS: Given the high chronic disease burden experienced by individuals with SMI combined with our nations health care reform, emphasis on self-management to improve population health, coupled with advancing the quality of research to evaluate CDSM programs for adults with SMI, is critically needed						
Sikorski et al. 2011 (110)	Computer-aided cognitive behavioral therapy for depression: A systematic review of the literature	People with depression (any type)	Computer- and internet-based cognitive behavioural therapy (CCBT).	Waiting list vs. active control group	Not reported	CCBT provides an effective and potentially cost-effective interventional strategy for depressive disorders. Effects of no and minimal contact therapies are confounded with conditions of control groups and need further investigation. While patients with Major Depression seem to benefit from computer-based therapy with regular therapist contact, it remains unclear whether unattended self-help interventions over the internet are effective for this patient population. However, these interventions are effective in patients with mild to moderate depressive symptomatology. CCBT may serve as a first step of treatment within stepped care approaches and may help to offer treatment to individuals in remote areas and to decrease barriers to seek psychiatric care caused by stigma perception
Sammendrag: Objective: The aim of this study was to conduct a systematic literature search in order to assess effectiveness of computer- and internet-based cognitive behavioural therapy (CCBT). Methods: Medline, Cochrane Library, Web of Science and PsycINFO were searched for relevant articles. Only RCTs were included. Effect sizes were calculated and quality of studies was assessed. Results: 16 studies were retrieved and included. Effect sizes depended on therapist time involvement and control group intervention (waiting list vs. active control group) and ranged between 0.0 and 1.1. Conclusions: CCBT provides an effective and potentially cost-effective interventional strategy for depressive disorders. Effects of no and minimal contact therapies are confounded with conditions of control groups and need further investigation. While patients with Major Depression seem to benefit from computer-based therapy with regular therapist contact, it remains unclear whether unattended self-help interventions over the internet are effective for this patient population. However, these interventions are effective in patients with mild to moderate depressive symptomatology. CCBT may serve as a first step of treatment within stepped care approaches and may help to offer treatment to individuals in remote areas and to decrease barriers to seek psychiatric care caused by stigma perception						
Silveira et al. 2013 (111)	Physical exercise and clinically depressed patients: A systematic review and meta-analysis	People with major depressive disorder (MDD)	Physical exercise (aerobic training and strength training)	Control group (no further explanation)	Symptoms	Despite the heterogeneity of the studies, the present meta-analysis concluded that physical exercise improves the response to treatment, especially aerobic training. However, the efficacy of exercise in the treatment of depression was influenced by age and severity of symptoms
Sammendrag: Objective: The aim of this meta-analysis is to evaluate the effect of aerobic training and strength training as a treatment for depression in patients diagnosed with major depressive disorder. Methods: PubMed (Medline), ISI knowledge (Institute for Scientific Information), SciELO (Scientific Electronic Library) and Scopus databases were consulted from January 1970 to September 2011. Data were collected on variables as follows: total number of patients (pre- and postintervention), age, randomized (yes or no), diagnostic criteria, assessment instruments, and the percentage of remission and treatment response. Subsequently, we collected information on time intervention, intensity, duration, frequency, method of training (aerobic training and strength training) and type of supervision. Standardized mean differences were used for pooling continuous variables as endpoint scores. Binary outcomes, such as proportion of remission (no symptoms) and at least 50% reduction of initial scores (response), were pooled using relative risks. Random effects models were used that take into account the variance within and between studies. Results: Ten articles were selected and subdivided by their interventions, controlled training modality and levels of intensity. As there was no statistically significant difference between the two types of intervention (strength or aerobic training), we combined data which finally showed a 0.61 (95% CI: -0.88 to -0.33) standard deviation reduction in the intervention group compared to the control group. When the analysis was restricted only to those studies that used the Hamilton scale (n = 15), we observed a reduction of 3.49 points compared with the control group. Conclusion: Despite the heterogeneity of the studies, the present meta-analysis concluded that physical exercise improves the response to treatment, especially aerobic training. However, the efficacy of exercise in the treatment of depression was influenced by age and severity of symptoms						
Soundy et al. 2015 (112)	Investigating the benefits of sport participation for individuals with schizophrenia: A systematic review	People with schizophrenia schizoaffective spectrum disorders	Sport participation	Not reported	Weight, symptoms, health and wellbeing	Sport participation may result in reduced BMI and psychiatric symptoms in patients with schizophrenia. Sport has the potential to improve an individual's quality of life through providing a meaningful normalizing activity that leads to achievement, success and satisfaction. Well-designed randomised controlled trials are required to fully determine the health effects of sports participation in schizophrenia

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Background: The purpose of this review was to consider the impact of being introduced to a sport and sport participation on (a) weight loss and psychiatric symptoms, (b) any other health benefits in people with schizophrenia, supported by quantitative and qualitative findings. Subjects and Methods: A systematic review in accordance with the PRISMA statement was conducted. Searches were undertaken in January 2014. Articles were eligible that (1) considered the effect (quantitative studies) and experience (qualitative and case studies) of either; being introduced to a 'sport' or undertaking a sport activity, (2) included >85% of patients diagnosed with schizophrenia or schizo-affective spectrum disorders according to recognised criteria. Results: A total of 10 studies including 5 trials (2*pre-experimental, 2*controlled trials, 1*randomised control trial), 2 qualitative studies and 3 case studies were included (n = 185). Two out of 3 studies that considered weight as an outcome measure reported significant reductions in weight and psychiatric symptoms following sports participation. The mean reduction in body mass index (BMI) ranged from -0.7kg.m2 ($p < 0.001$) following 12 weeks of basketball to -1.33 kg.m2 ($p < 0.001$) after 12-weeks of soccer. The mean reduction in the Positive and Negative Symptoms score ranged from 2.4 points ($F = -19.0$, $p < 0.001$) following 12 weeks of basketball to 7.4 points ($t = -5.0$, $p < 0.001$) following a 40 week programme of horse riding. A range of secondary health and wellbeing outcomes identified some significant results. Qualitative findings showed that participants had positive experiences from participating in sports. Conclusions: Sport participation may result in reduced BMI and psychiatric symptoms in patients with schizophrenia. Sport has the potential to improve an individual's quality of life through providing a meaningful normalizing activity that leads to achievement, success and satisfaction. Well-designed randomised controlled trials are required to fully determine the health effects of sports participation in schizophrenia					
Stanton og Happell 2014 (113)	A systematic review of the aerobic exercise program variables for people with schizophrenia	People with schizophrenia or schizoaffective disorder	Aerobic exercise program variables	Not reported	Not reported	We find that aerobic exercise including treadmill walking and cycle exercise undertaken as a supervised group intervention lasting 30 to 40 min per session and undertaken 3 times weekly at moderate intensity appears to be valuable for people with schizophrenia or schizoaffective disorder. Interventions ranged from 10 to 16 wk. No adverse events were reported in the included studies. Evidence suggests that aerobic exercise is safe and beneficial for people with schizophrenia or schizoaffective disorder
Sammendrag: A number of studies demonstrate the positive benefits of exercise for people with schizophrenia and schizoaffective disorders; however the exercise program variables resulting in these positive effects have not been evaluated. Therefore the aim of this systematic review was to describe the aerobic exercise program variables used in randomized controlled trials reporting the positive effect of exercise in the treatment of schizophrenia or schizoaffective disorder. Studies were analyzed for exercise frequency, intensity, session duration, exercise type, intervention duration, delivery of exercise, and level and quality of supervision and adherence. Study quality was assessed using the Physiotherapy Evidence Database scale. Three studies met the inclusion criteria. In general, exercise intervention variables are reported poorly. We find that aerobic exercise including treadmill walking and cycle exercise undertaken as a supervised group intervention lasting 30 to 40 min per session and undertaken 3 times weekly at moderate intensity appears to be valuable for people with schizophrenia or schizoaffective disorder. Interventions ranged from 10 to 16 wk. No adverse events were reported in the included studies. Evidence suggests that aerobic exercise is safe and beneficial for people with schizophrenia or schizoaffective disorder					
Stanton og Happell 2014 (114)	Exercise for mental illness: A systematic review of inpatient studies	People hospitalized with depression, schizophrenia, bipolar disorder, or anxiety disorders	Exercise interventions	Not reported	Health outcomes	Several studies show positive health outcomes from short-term and long-term interventions for people hospitalized due to depression. Although positive, the evidence for inpatients with schizophrenia, bipolar disorder, or anxiety disorders is substantially less. There is an urgent need to address the paucity of literature in this area, in particular the optimal dose and delivery of exercise for people hospitalized as a result of mental illness. Standardization of reporting exercise programme variables, the assessment of mental illness, and the reporting of adverse events must accompany future studies
Sammendrag: Abstract A substantial body of evidence supports the role of exercise interventions for people with a mental illness. However, much of this literature is conducted using outpatient and community-based populations. We undertook a systematic review examining the effect of exercise interventions on the health of people hospitalized with depression, schizophrenia, bipolar disorder, or anxiety disorders. Eight studies met our inclusion criteria. Several studies show positive health outcomes from short-term and long-term interventions for people hospitalized due to depression. Although positive, the evidence for inpatients with schizophrenia, bipolar disorder, or anxiety disorders is substantially less. There is an urgent need to address the paucity of literature in this area, in particular the optimal dose and delivery of exercise for people hospitalized as a result of mental illness. Standardization of reporting exercise programme variables, the assessment of mental illness, and the reporting of adverse events must accompany future studies					

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Stratford et al. 2014 (115)	Psychological therapy for anxiety in bipolar spectrum disorders: A systematic review	People with bipolar spectrum disorders	Psychological therapy	Standard bipolar treatments	Anxiety	Cognitive behavioural therapy [CBT] for BPSD incorporating an anxiety component reduces anxiety symptoms in cyclothymia, "refractory" and rapid cycling BPSD, whereas standard bipolar treatments have only a modest effect on anxiety. Preliminary evidence is promising for CBT for post-traumatic stress disorder and generalised anxiety disorder in BPSD. Psychoeducation alone does not appear to reduce anxiety, and data for mindfulness-based cognitive therapy [MBCT] appear equivocal. CBT during euthymic phases has the greatest weight of evidence. Where reported, psychological therapy appears acceptable and safe, but more systematic collection and reporting of safety and acceptability information is needed. Development of psychological models and treatment protocols for anxiety in BPSD may help improve outcomes
Sammendrag: Comorbid anxiety is common in bipolar spectrum disorders [BPSD], and is associated with poor outcomes. Its clinical relevance is highlighted by the "anxious distress specifier" in the revised criteria for Bipolar Disorders in the Diagnostic and Statistical Manual 5th Edition [DSM-5]. This article reviews evidence for the effectiveness of psychological therapy for anxiety in adults with BPSD (bipolar I, II, not otherwise specified, cyclothymia, and rapid cycling disorders). A systematic search yielded 22 treatment studies that included an anxiety-related outcome measure. Cognitive behavioural therapy [CBT] for BPSD incorporating an anxiety component reduces anxiety symptoms in cyclothymia, "refractory" and rapid cycling BPSD, whereas standard bipolar treatments have only a modest effect on anxiety. Preliminary evidence is promising for CBT for post-traumatic stress disorder and generalised anxiety disorder in BPSD. Psychoeducation alone does not appear to reduce anxiety, and data for mindfulness-based cognitive therapy [MBCT] appear equivocal. CBT during euthymic phases has the greatest weight of evidence. Where reported, psychological therapy appears acceptable and safe, but more systematic collection and reporting of safety and acceptability information is needed. Development of psychological models and treatment protocols for anxiety in BPSD may help improve outcomes					
Sylvia og Peters 2012 (116)	Nutrient-based therapies for bipolar disorder: A systematic review	People with mania and bipolar depression	Nutrient-based therapies alone or in combination with commonly used pharmacotherapies	Not reported	Not reported	Given the potential public health impact of identifying adjunct treatments that improve psychiatric as well as physical health outcomes, nutritional treatments appear promising for the management of bipolar disorder but require further study
Sammendrag: Background: Pharmacotherapy is the first line of treatment for bipolar disorder, but many patients continue to experience persistent subthreshold symptoms. Alternative adjunct treatments, including nutritional therapies, may have the potential to alleviate residual symptoms and improve the outcomes of standard pharmacotherapy. The aim of this paper is to critically review the current clinical evidence and mechanisms of action of nutrient-based therapies alone or in combination with commonly used pharmacotherapies for mania and bipolar depression. Methods: We conducted a Medline search for clinical trials conducted with humans, published in English from 1960 to 2012 using nutritional supplements such as n-3, chromium, inositol, choline, magnesium, folate and tryptophan alone or in combination with pharmacotherapies for the treatment of bipolar disorder. Results: Preliminary data yields conflicting but mainly positive evidence for the use of n-3 fatty acids and chromium in the treatment of bipolar depression. Limited evidence found that inositol may be helpful for bipolar depression, but larger sample sizes are needed. Preliminary randomized, controlled trials suggest that choline, magnesium, folate and tryptophan may be beneficial for reducing symptoms of mania. Conclusions: Given the potential public health impact of identifying adjunct treatments that improve psychiatric as well as physical health outcomes, nutritional treatments appear promising for the management of bipolar disorder but require further study					
Tonelli et al. 2013 (117)	Metacognitive programs focusing social cognition for the rehabilitation of schizophrenia: A systematic review	People with schizophrenia	Metacognitive programs focusing social cognition	Not reported	Not reported	The great majority of papers have shown that their programs are effective in improving measures of psychopathology, SC and social functioning. Future research might clarify about safety, specificity and durability of such interventions
Sammendrag: Objective: To review systematically the literature on psychotherapeutic programs focusing on SC, designed to schizophrenia, which methods include metacognitive strategies. Methods: A search on MedLine base for papers published in English or Portuguese has been performed, using the phrase "Social cognition" AND "Schizophrenia" [Mesh] AND "Psychotherapy" [Mesh] and the limits "Humans","Clinical Trial", "Meta-Analysis" and "Randomized Controlled Trial". Additionally, inclusion criteria have been formulated in order to select papers with metacognitive approach. Results: Seventeen articles have been selected, which comprised essentially facial emotion recognition, emotion recognition, Theory of Mind (ToM), imitation and perspective taking in social situations. Conclusion: The great majority of papers have shown that their programs are effective in improving measures of psychopathology, SC and social functioning. Future research might clarify about safety, specificity and durability of such interventions					

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Turner et al. 2014 (118)	Psychological interventions for psychosis: a meta-analysis of comparative outcome studies	People with psychosis	Psychological interventions	Other interventions	Symptoms	There are small but reliable differences in efficacy between psychological interventions for psychosis, and they occur in a pattern consistent with the specific factors of particular interventions
Sammendrag: Kort sammendrag ikke tilgjengelig						
van der Krieke et al. 2014 (119)	E-mental health self-management for psychotic disorders: State of the art and future perspectives	People with psychotic disorders	E-mental health self-management (such as psychoeducation, medication management, communication and shared decision making, management of daily functioning, lifestyle management, peer support, and real-time self-monitoring by daily measurements)	Usual care or non-technological approaches	Clinical outcome and cost-effectiveness	People with psychotic disorders were able and willing to use e-mental health services. Results suggest that e-mental health services are at least as effective as usual care or nontechnological approaches. Larger effects were found for medication management e-mental health services. No studies reported a negative effect. Results must be interpreted cautiously, because they are based on a small number of studies
Sammendrag: Objective: The aim of this review was to investigate to what extent information technology may support self-management among service users with psychotic disorders. The investigation aimed to answer the following questions: What types of e-mental health self-management interventions have been developed and evaluated? What is the current evidence on clinical outcome and cost-effectiveness of the identified interventions? To what extent are e-mental health self-management interventions oriented toward the service user? Methods: A systematic review of references through July 2012 derived from MEDLINE, PsycINFO, AMED, CINAHL, and the Library, Information Science and Technology database was performed. Studies of e-mental health self-management interventions for persons with psychotic disorders were selected independently by three reviewers. Results: Twenty-eight studies met the inclusion criteria. E-mental health self-management interventions included psychoeducation, medication management, communication and shared decision making, management of daily functioning, lifestyle management, peer support, and real-time self-monitoring by daily measurements (experience sampling monitoring). Summary effect sizes were large for medication management (.92) and small for psychoeducation (.37) and communication and shared decision making (.21). For all other studies, individual effect sizes were calculated. The only economic analysis conducted reported more short-term costs for the e-mental health intervention. Conclusions: People with psychotic disorders were able and willing to use e-mental health services. Results suggest that e-mental health services are at least as effective as usual care or nontechnological approaches. Larger effects were found for medication management e-mental health services. No studies reported a negative effect. Results must be interpreted cautiously, because they are based on a small number of studies					
van Hasselt et al. 2013 (120)	Evaluating interventions to improve somatic health in severe mental illness: A systematic review	People with serious mental illness	Interventions to improve somatic health (such as health education, exercise, smoking cessation, and changes in health care organization)	Not reported	Not reported	Many interventions directed toward improving somatic health for patients with SMI have been started. These studies did not apply similar evaluations, and did not use uniform outcome measures of the effect of their interventions. Valuable comparisons on effectiveness are therefore almost impossible

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Objective: To present a systematic review of the evaluation of randomized interventions directed toward improving somatic health for patients with severe mental illness (SMI). Method: A systematic search in PubMed, Embase, Cinahl, and PsycInfo was performed. The scope of the search was prospective studies for patients aged 18-70, published from January 2000 till June 2011. Randomized interventions directed toward improving somatic health for patients with SMI were selected. We excluded studies on elderly, children, and studies performed before 2000. Information on population, type of intervention, follow-up, outcome measures, and on authors' conclusions were drawn from the original articles. Results: Twenty-two original studies were included, presenting four types of interventions: health education (n = 9), exercise (n = 6), smoking cessation (n = 5), and changes in health care organization (n = 2). To evaluate the effect of these studies 93 different outcome measures were used in 16 categories. Conclusion: Many interventions directed toward improving somatic health for patients with SMI have been started. These studies did not apply similar evaluations, and did not use uniform outcome measures of the effect of their interventions. Valuable comparisons on effectiveness are therefore almost impossible						
van Hees et al. 2013 (121)	The effectiveness of individual interpersonal psychotherapy as a treatment for major depressive disorder in adult outpatients: a systematic review	People with major depressive disorder (MDD)	Individual interpersonal psychotherapy	Standard treatments	Not reported	The differences between treatment effects are very small and often they are not significant. Psychotherapeutic treatments such as IPT and CBT, and/or pharmacotherapy are recommended as first-line treatments for depressed adult outpatients, without favoring one of them, although the individual preferences of patients should be taken into consideration in choosing a treatment.
Sammendrag: BACKGROUND: This systematic review describes a comparison between several standard treatments for major depressive disorder (MDD) in adult outpatients, with a focus on interpersonal psychotherapy (IPT). METHODS: Systematic searches of PubMed and PsycINFO studies between January 1970 and August 2012 were performed to identify (C-)RCTs, in which MDD was a primary diagnosis in adult outpatients receiving individual IPT as a monotherapy compared to other forms of psychotherapy and/or pharmacotherapy. RESULTS: 1233 patients were included in eight eligible studies, out of which 854 completed treatment in outpatient facilities. IPT combined with nefazodone improved depressive symptoms significantly better than sole nefazodone, while undefined pharmacotherapy combined with clinical management improved symptoms better than sole IPT. IPT or imipramine hydrochloride with clinical management showed a better outcome than placebo with clinical management. Depressive symptoms were reduced more in CBASP (cognitive behavioral analysis system of psychotherapy) patients in comparison with IPT patients, while IPT reduced symptoms better than usual care and wait list condition. CONCLUSIONS: The differences between treatment effects are very small and often they are not significant. Psychotherapeutic treatments such as IPT and CBT, and/or pharmacotherapy are recommended as first-line treatments for depressed adult outpatients, without favoring one of them, although the individual preferences of patients should be taken into consideration in choosing a treatment						
Vancampfort et al. 2010 (122)	The therapeutic value of physical exercise for people with schizophrenia	People with schizophrenia	Movement-related interventions	Not reported	Not reported	Physical exercise as part of psychomotor therapy should play an important role within the multidisciplinary treatment of schizophrenia. More research is needed into the effect of physical activity on cognitive functioning
Sammendrag: Background: Only about 25% of people with schizophrenia follow the public health recommendations for a minimum of 150 minutes per week of moderate physical exercise. In their leisure time people diagnosed with schizophrenia take considerably less exercise than their healthy counterparts. Aim: To collect scientific evidence of movement-related interventions in patients with schizophrenia. Method: PubMed, PEDro, CINAHL, PsychINFO and Sport Discus were searched for the period from 2003 up to April 2009 for reports of randomised controlled trials (RCTs) on the basis of the search terms 'schizophrenia', 'exercise' and 'physical activity'. Relevant literature was also traced by means of the reference lists for selected articles. Results: Eight RCTs were selected. Physical exercise was reported to bring about significant improvements in cardiovascular and metabolic parameters and in psychiatric symptomatology. A physical exercise also has social advantages; it helps patients to cope with stress and improves their quality of life. Conclusion: Physical exercise as part of psychomotor therapy should play an important role within the multidisciplinary treatment of schizophrenia. More research is needed into the effect of physical activity on cognitive functioning						
Vancampfort et al. 2011 (123)	Body-directed techniques on psychomotor therapy for people with schizophrenia: A review of the literature	People with schizophrenia	Body-directed techniques on psychomotor therapy	Not reported	Symptoms	A body-directed approach can be effective an deserves to be included in the multidisciplinary treatment of schizophrenia
Sammendrag: Background: Patients with schizophrenia frequently undergo a disturbance of body experience. This can occur during an acute psychotic phase or during a period of remission. Aim: To investigate the scientific evidence of the effects of introducing body-directed techniques into psychomotor therapy for patients with schizophrenia. METHOD: PubMed, PEDro, CINAHL, psycINFO and SPORTDiscus were searched form 1 January, 2000, tot 1 January 2011, for reports of randomised controlled trials, controlled clinical trials and for studies wit a different design. The Tijdschrift voor Psychiatrie (the Dutch Journal of Psychiatry), the Tijdschrift voor Vaktherapie (The Journal for Special therapies) and Actuele Themata (Actual Themes) in psychomotor therapy were also screened. The quality of the methodology was assessed with the help of a checklist. Evidence for the efficacy of the interventions was summarised on the basis of a best-evidence synthesis. Result: Eleven studies satisfied our inclusion and exclusion criteria. There was a strong evidence for the reduction of psychiatric symptoms after yoga and reduced feelings of anxiety and stress after progressive muscle relaxation. There is limited evidence for yoga in reducing feelings of anxiety and stress and for body-directed group techniques in reducing negative symptoms. Qualitative research reported that mindfulness - and massage-techniques were able to considerably reduce feelings of stress. There is no evidence for the beneficial effects of dancing techniques. Conclusion: A body-directed approach can be effective an deserves to be included in the multidisciplinary treatment of schizophrenia						

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Velthorst et al. 2014 (124)	Adapted cognitive-behavioural therapy required for targeting negative symptoms in schizophrenia: meta-analysis and meta-regression	People with schizophrenia	Adapted cognitive-behavioural therapy	Not reported	Negative symptoms	The co-occurring beneficial effect of conventional CBT on negative symptoms found in older studies was not supported by more recent studies. It is now necessary to further disentangle effective treatment ingredients of older studies in order to guide the development of future CBT interventions aimed at negative symptom reduction.
Sammendrag: BACKGROUND: There is an increasing interest in cognitive-behavioural therapy (CBT) interventions targeting negative symptoms in schizophrenia. To date, CBT trials primarily focused on positive symptoms and investigated change in negative symptoms only as a secondary outcome. To enhance insight into factors contributing to improvement of negative symptoms, and to identify subgroups of patients that may benefit most from CBT directed at ameliorating negative symptoms, we reviewed all available evidence on these outcomes. METHOD: A systematic search of the literature was conducted in PsychInfo, PubMed and the Cochrane register to identify randomized controlled trials reporting on the impact of CBT interventions on negative symptoms in schizophrenia. Random-effects meta-analyses were performed on end-of-treatment, short-term and long-term changes in negative symptoms. RESULTS: A total of 35 publications covering 30 trials in 2312 patients, published between 1993 and 2013, were included. Our results showed studies' pooled effect on symptom alleviation to be small [Hedges' g = 0.093, 95% confidence interval (CI) -0.028 to 0.214, p = 0.130] and heterogeneous (Q = 73.067, degrees of freedom = 29, p < 0.001, τ 2 = 0.081, I 2 = 60.31) in studies with negative symptoms as a secondary outcome. Similar results were found for studies focused on negative symptom reduction (Hedges' g = 0.157, 95% CI -0.10 to 0.409, p = 0.225). Meta-regression revealed that stronger treatment effects were associated with earlier year of publication, lower study quality and with CBT provided individually (as compared with group-based). CONCLUSIONS: The co-occurring beneficial effect of conventional CBT on negative symptoms found in older studies was not supported by more recent studies. It is now necessary to further disentangle effective treatment ingredients of older studies in order to guide the development of future CBT interventions aimed at negative symptom reduction					
Wu et al. 2012 (125)	Acupuncture for depression: A review of clinical applications	People with major depressive disorder (MDD)	Acupuncture as monotherapy and agumentation of antidepressants	Not reported	Safety and symptoms	Published data suggest that acupuncture, including manual-, electrical-, and laser-based, is a generally beneficial, well-tolerated, and safe monotherapy for depression. However, acupuncture augmentation in AD partial responders and nonresponders is not as well studied as monotherapy, and available studies have only investigated MDD, but not other depressive spectrum disorders. Manual acupuncture reduced side effects of ADs in MDD. We found no data on depressive recurrence rates after recovery with acupuncture treatment. Acupuncture is a potential effective monotherapy for depression, and a safe, well-tolerated augmentation in AD partial responders and nonresponders. However, the body of evidence based on well-designed studies is limited, and further investigation is called for
Sammendrag: While increasing numbers of patients are seeking acupuncture treatment for depression in recent years, there is limited evidence of the antidepressant (AD) effectiveness of acupuncture. Given the unsatisfactory response rates of many Food and Drug Administration-approved ADs, research on acupuncture remains of potential value. Therefore, we sought to review the efficacy and safety of acupuncture treatment for depression in clinical applications. We conducted a PubMed search for publications through 2011. We assessed the adequacy of each report and abstracted information on reported effectiveness or efficacy of acupuncture as monotherapy for major depressive disorder (MDD) and as augmentation of ADs We also examined adverse events associated with acupuncture, and evidence for acupuncture as a means of reducing side effects of ADs. Published data suggest that acupuncture, including manual-, electrical-, and laser-based, is a generally beneficial, well-tolerated, and safe monotherapy for depression. However, acupuncture augmentation in AD partial responders and nonresponders is not as well studied as monotherapy, and available studies have only investigated MDD, but not other depressive spectrum disorders. Manual acupuncture reduced side effects of ADs in MDD. We found no data on depressive recurrence rates after recovery with acupuncture treatment. Acupuncture is a potential effective monotherapy for depression, and a safe, well-tolerated augmentation in AD partial responders and nonresponders. However, the body of evidence based on well-designed studies is limited, and further investigation is called for					
Wykes et al. 2011 (126)	A meta-analysis of cognitive remediation for schizophrenia: Methodology and effect sizes	People with schizophrenia	Cognitive remediation therapy	Comparison group (no further description)	Global cognition and functioning	Cognitive remediation benefits people with schizophrenia, and when combined with psychiatric rehabilitation, this benefit generalizes to functioning, relative to rehabilitation alone. These benefits cannot be attributed to poor study methods

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Objective: Cognitive remediation therapy for schizophrenia was developed to treat cognitive problems that affect functioning, but the treatment effects may depend on the type of trial methodology adopted. The present meta-analysis will determine the effects of treatment and whether study method or potential moderators influence the estimates. Method: Electronic databases were searched up to June 2009 using variants of the key words "cognitive," "training," "remediation," "clinical trial," and "schizophrenia." Key researchers were contacted to ensure that all studies meeting the criteria were included. This produced 109 reports of 40 studies in which >70% of participants had a diagnosis of schizophrenia, all of whom received standard care. There was a comparison group and allocation procedure in these studies. Data were available to calculate effect sizes on cognition and/or functioning. Data were independently extracted by two reviewers with excellent reliability. Methodological moderators were extracted through the Clinical Trials Assessment Measure and verified by authors in 94% of cases. Results: The meta-analysis (2,104 participants) yielded durable effects on global cognition and functioning. The symptom effect was small and disappeared at follow-up assessment. No treatment element (remediation approach, duration, computer use, etc.) was associated with cognitive outcome. Cognitive remediation therapy was more effective when patients were clinically stable. Significantly stronger effects on functioning were found when cognitive remediation therapy was provided together with other psychiatric rehabilitation, and a much larger effect was present when a strategic approach was adopted together with adjunctive rehabilitation. Despite variability in methodological rigor, this did not moderate any of the therapy effects, and even in the most rigorous studies there were similar small-to-moderate effects. Conclusions: Cognitive remediation benefits people with schizophrenia, and when combined with psychiatric rehabilitation, this benefit generalizes to functioning, relative to rehabilitation alone. These benefits cannot be attributed to poor study methods					
Xia et al. 2011 (127)	Psychoeducation for schizophrenia	People with schizophrenia and/or related serious mental illnesses	Psychoeducation	Standard levels of knowledge provision	Relapse, readmission, medication compliance, hospital stay	Psychoeducation does seem to reduce relapse, readmission and encourage medication compliance, as well as reduce the length of hospital stay in these hospital-based studies of limited quality. The true size of effect is likely to be less than demonstrated in this review - but nevertheless, some sort of psychoeducation could be clinically effective and potentially cost beneficial. It is not difficult to justify better, more applicable, research in this area aimed at fully investigating the effects of this promising approach
Sammendrag: BACKGROUND: Schizophrenia can be a severe and chronic illness characterised by lack of insight and poor compliance with treatment. Psychoeducational approaches have been developed to increase patients' knowledge of, and insight into, their illness and its treatment. It is supposed that this increased knowledge and insight will enable people with schizophrenia to cope in a more effective way with their illness, thereby improving prognosis. OBJECTIVES: To assess the effects of psychoeducational interventions compared with standard levels of knowledge provision. SEARCH STRATEGY: We searched the Cochrane Schizophrenia Group Trials Register (February 2010). SELECTION CRITERIA: All relevant randomised controlled trials focusing on psychoeducation for schizophrenia and/or related serious mental illnesses involving individuals or groups. We excluded quasi-randomised trials. DATA COLLECTION AND ANALYSIS: At least two review authors extracted data independently from included papers. We contacted authors of trials for additional and missing data. We calculated risk ratios (RR) and 95% confidence intervals (CI) of homogeneous dichotomous data. We used a fixed-effects model for heterogeneous dichotomous data. Where possible we also calculated the numbers needed to treat (NNT), as well as weighted means for continuous data. MAIN RESULTS: This review includes a total of 5142 participants (mostly inpatients) from 44 trials conducted between 1988 and 2009 (median study duration ~ 12 weeks, risk of bias - moderate). We found that incidences of non-compliance were lower in the psychoeducation group in the short term (n = 1400, RR 0.52 CI 0.40 to 0.67, NNT 11 CI 9 to 16). This finding holds for the medium and long term. Relapse appeared to be lower in psychoeducation group (n = 1214, RR 0.70 CI 0.61 to 0.81, NNT 9 CI 7 to 14) and this also applied to readmission (n = 206, RR 0.71 CI 0.56 to 0.89, NNT 5 CI 4 to 13). Scale-derived data also suggested that psychoeducation promotes better social and global functioning. In the medium term, treating four people with schizophrenia with psychoeducation instead of standard care resulted in one additional person showing a clinical improvement. Evidence suggests that participants receiving psychoeducation are more likely to be satisfied with mental health services (n = 236, RR 0.24 CI 0.12 to 0.50, NNT 5 CI 5 to 8) and have improved quality of life. AUTHORS' CONCLUSIONS: Psychoeducation does seem to reduce relapse, readmission and encourage medication compliance, as well as reduce the length of hospital stay in these hospital-based studies of limited quality. The true size of effect is likely to be less than demonstrated in this review - but, nevertheless, some sort of psychoeducation could be clinically effective and potentially cost beneficial. It is not difficult to justify better, more applicable, research in this area aimed at fully investigating the effects of this promising approach					
Zhang et al. 2014 (128)	Shuganjieyu capsule for major depressive disorder (MDD) in adults: A systematic review	People with major depressive disorder (MDD)	Shuganjieyu capsule, a herbal pharmaceutical product	Placebo	Effectiveness and safety	Shuganjieyu capsule is superior to placebo in terms of overall treatment effectiveness and safety. Both response rate and remission rate among patients treated with the combination of Shuganjieyu plus venlafaxine were significantly higher than those treated with venlafaxine alone. Due to the considerable risk of bias in majority of trials, recommendations for practice should be cautious, and additional, well-designed RCTs are needed in next step

Forfatter, år	Tittel	Populasjon	Tiltak	Sammenlikning	Utfall	Forfatters konklusjon
Sammendrag: Objectives: Shuganjieyu capsule is a pure herbal pharmaceutical product for depression. Our objective was to explore the effectiveness and safety of Shuganjieyu capsule for the treatment of major depressive disorder in adults. Method: Eight computerized databases were searched. In addition, randomized controlled trials (RCTs) on Shuganjieyu capsule were hand-searched on seven key Chinese journals. Data were extracted and evaluated by two reviewers independently. Analysis was performed by intention-to-treat where possible. Prespecified subgroup analyses were different-dose regimens, patient spectrum, publication status, and treatment duration. Results: Seven RCTs with 595 participants were included. Shuganjieyu capsule was superior than placebo in terms of response rate (RR = 2.42, 95% CI: 1.55-3.79; P = 0.0001), remission rate (RR = 4.29, 95% CI: 1.61-11.45; P = 0.004), the scores of the mean change from baseline of the HAM-D17 (MD = -4.17, 95% CI: -5.61 to -2.73; P < 0.00001) and from baseline of traditional Chinese medicine (TCM) syndrome score scale scores (MD = -6.00, 95% CI: -8.25 to -3.75; P < 0.00001). In addition, Shuganjieyu plus venlafaxine had a significantly higher response rate (RR = 1.56, 95% CI: 1.29-1.88; P < 0.00001) and was superior in terms of the scores of the mean change from baseline of the treatment emergent symptoms scale scores (MD = -0.74, 95% CI:-1.12 to -0.35; P = 0.0002) than venlafaxine alone. Conclusion: Shuganjieyu capsule is superior to placebo in terms of overall treatment effectiveness and safety. Both response rate and remission rate among patients treated with the combination of Shuganjieyu plus venlafaxine were significantly higher than those treated with venlafaxine alone. Due to the considerable risk of bias in majority of trials, recommendations for practice should be cautious, and additional, well-designed RCTs are needed in next step					

Vedlegg 4. Oversikter sortert etter populasjon

Bipolar lidelse (n=14)

Forfatter, år	Tittel	Populasjon
Acar og Buldukoğlu 2014 (2)	Effect of Psychoeducation on Relapses in Bipolar Disorder: A Systematic Review	People with bipolar disorder
Batista et al. 2011 (14)	Efficacy of psychoeducation in bipolar patients: systematic review of randomized trials	People with bipolar disorder
Bond og Anderson 2015 (18)	Psychoeducation for relapse prevention in bipolar disorder: A systematic review of efficacy in randomized controlled trials	People with bipolar disorder, not in an acute illness episode
Fiorillo et al. 2013 (34)	Efficacy of supportive family interventions in bipolar disorder: A review of the literature	People with bipolar disorder
Geoffroy et al. 2015 (41)	[Bright light therapy in seasonal bipolar depressions]	People with bipolar disorders
Hidalgo-Mazzei et al. 2015 (48)	Internet-based psychological interventions for bipolar disorder: Review of the present and insights into the future	People with bipolar disorder
Lipsman et al. 2010 (76)	Neurosurgical treatment of bipolar depression: Defining treatment resistance and identifying surgical targets	People with bipolar disorder
Lolich et al. 2012 (79)	Psychosocial interventions in bipolar disorder: a review	People with bipolar disorder
Miziou et al. 2015 (83)	Psychosocial treatment and interventions for bipolar disorder: a systematic review	People with bipolar disorder
Rakofsky og Dunlop 2014 (129)	Review of nutritional supplements for the treatment of bipolar depression	People with bipolar disorder
Rodriguez et al. 2014 (101)	Group psychoeducation in bipolar treatment: A systematic review of the literature	People with bipolar disorder
Sarris et al. 2011 (104)	Bipolar disorder and complementary medicine: Current evidence, safety issues, and clinical considerations	People with bipolar disorder
Schottle et al. 2011 (105)	Psychotherapy for bipolar disorder: A review of the most recent studies	People with bipolar disorder
Stratford et al. 2014 (115)	Psychological therapy for anxiety in bipolar spectrum disorders: A systematic review	People with bipolar spectrum disorders

Depresjon (n=32)

Forfatter, år	Tittel	Populasjon
Appleton et al. 2015 (12)	Omega-3 fatty acids for depression in adults	People with major depressive disorder (MDD)
Berk et al. 2013 (15)	Lifestyle management of unipolar depression	People with unipolar depression
Biesheuvel-Leliefeld et al. 2015 (17)	Effectiveness of psychological interventions in preventing recurrence of depressive disorder: Meta-analysis and meta-regression	People with major depression (MD)
Boudreau et al. 2010 (19)	Self-directed cognitive behavioural therapy for adults with diagnosis of depression: systematic review of clinical effectiveness, cost-effectiveness, and guidelines	People with Axis I depression (all types)
Carpenter 2011 (22)	St. John's wort and S-adenosyl methionine as "natural" alternatives to conventional antidepressants in the era of the suicidality boxed warning: what is the evidence for clinically relevant benefit?	People with major depressive disorder (MDD)
Crowe et al. 2015 (25)	Non-pharmacological strategies for treatment of inpatient depression	People with moderate to severe depression in an inpatient setting
Cuijpers et al. 2011 (26)	Interpersonal psychotherapy for depression: A meta-analysis	People with major depressive disorder (described as uni-polar depressive disorders by authors
Cuijpers et al. 2011 (27)	Psychological treatment of depression in inpatients: A systematic review and meta-analysis	People who are depressed and described as depressed in-patients
Cuijpers et al. 2014 (28)	The effects of psychotherapies for major depression in adults on remission, recovery and improvement: a meta-analysis	People with major depressive disorder (MDD)
Danielsson et al. 2013 (29)	Exercise in the treatment of major depression: a systematic review grading the quality of evidence	People with major depression (MD)
de Souza Moura et al. 2015 (31)	Comparison among aerobic exercise and other types of interventions to treat depression: a systematic review	People with mild, moderate and severe depression

Forfatter, år	Tittel	Populasjon
Freeman et al. 2010 (37)	Complementary and alternative medicine in major depressive disorder: The American Psychiatric Association Task Force report	People with major depressive disorder (MDD)
Freeman et al. 2010 (38)	Complementary and alternative medicine in major depressive disorder: A meta-analysis of patient characteristics, placebo-response rates and treatment outcomes relative to standard antidepressants	People with major depressive disorder (MDD)
Grosso et al. 2014 (44)	Role of omega-3 fatty acids in the treatment of depressive disorders: a comprehensive meta-analysis of randomized clinical trials	People with major depressive disorder, MDD (and people with depressive symptomatology without MDD diagnosis)
Hausenblas et al. 2013 (46)	Saffron (Crocus sativus L.) and major depressive disorder: a meta-analysis of randomized clinical trials	People with major depressive disorder (MDD)
Jain et al. 2014 (54)	Critical Analysis of the Efficacy of Meditation Therapies for Acute and Subacute Phase Treatment of Depressive Disorders: A Systematic Review	People with clinically diagnosed depressive disorders (both major and subacute depressive episodes)
Jakobsen 2014 (55)	Systematic reviews of randomised clinical trials examining the effects of psychotherapeutic interventions versus "no intervention" for acute major depressive disorder and a randomised trial examining the effects of "third wave" cognitive therapy versus mentalization-based treatment for acute major depressive disorder	People with major depressive disorder (MDD)
Jakobsen et al. 2011 (56)	The effect of interpersonal psychotherapy and other psychodynamic therapies versus 'treatment as usual' in patients with major depressive disorder	People with major depressive disorder (MDD)
Jakobsen et al. 2012 (57)	Effects of cognitive therapy versus interpersonal psychotherapy in patients with major depressive disorder: a systematic review of randomized clinical trials with meta-analyses and trial sequential analyses	People with major depressive disorder (MDD)
Jakobsen et al. 2011 (58)	The effects of cognitive therapy versus 'no intervention' for major depressive disorder	People with major depressive disorder (MDD)
Jakobsen et al. 2011 (59)	The effects of cognitive therapy versus 'treatment as usual' in patients with major depressive disorder	People with major depressive disorder (acute)
Jun et al. 2014 (64)	Herbal medicine (Gan Mai Da Zao decoction) for depression: A systematic review and meta-analysis of randomized controlled trials	People with depression (any type)
Karyotaki et al. 2014 (66)	The long-term efficacy of psychotherapy, alone or in combination with antidepressants, in the treatment of adult major depression	People with major depression
Knapen et al. 2015 (70)	Exercise therapy improves both mental and physical health in patients with major depression	People with depression (any type)
Lampe et al. 2013 (72)	Psychological management of unipolar depression	People with unipolar depression
Nystrom et al. 2015 (89)	Treating major depression with physical activity: A systematic overview with recommendations	People with major depressive disorder (MDD)
Piet og Hougaard 2011 (94)	The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis	People with major depressive disorder (MDD)
Sikorski et al. 2011 (110)	Computer-aided cognitive behavioral therapy for depression: A systematic review of the literature	People with depression (any type)
Silveira et al. 2013 (111)	Physical exercise and clinically depressed patients: A systematic review and meta-analysis	People with major depressive disorder (MDD)
van Hees et al. 2013 (121)	The effectiveness of individual interpersonal psychotherapy as a treatment for major depressive disorder in adult outpatients: a systematic review	People with major depressive disorder (MDD)
Wu et al. 2012 (125)	Acupuncture for depression: A review of clinical applications	People with major depressive disorder (MDD)
Zhang et al. 2014 (128)	Shuganjieyu capsule for major depressive disorder (MDD) in adults: A systematic review	People with major depressive disorder (MDD)

Psykose (n=7)

Forfatter, år	Tittel	Populasjon
Addington 2013 et al. (3)	Essential evidence-based components of first-episode psychosis services	People with first episode psychosis
Alvarez-Jimenez et al. 2011 (7)	Preventing the second episode: A systematic review and meta-analysis of psychosocial and pharmacological trials in first-episode psychosis	People with first-episode psychosis (FEP)
Gromer 2012 (43)	Need-adapted and open-dialogue treatments: Empirically supported psychosocial interventions for schizophrenia and other psychotic disorders	People experiencing acute or severe psychosis
Hutton og Taylor 2014 (52)	Cognitive behavioural therapy for psychosis prevention: a systematic review and meta-analysis	People at risk or with psychosis
Mould et al. 2010 (86)	The use of metaphor for understanding and managing psychotic experiences: A systematic review	People with psychotic disorders
Turner et al. 2014 (118)	Psychological interventions for psychosis: a meta-analysis of comparative outcome studies	People with psychosis
van der Krieke et al. 2014 (119)	E-mental health self-management for psychotic disorders: State of the art and future perspectives	People with psychotic disorders

Psykisk lidelse uten videre spesifisering (n=24)

Forfatter, år	Tittel	Populasjon
Alexandratos et al. 2012 (6)	The impact of exercise on the mental health and quality of life of people with severe mental illness: A critical review	People with severe mental illness
Anestis et al. 2014 (10)	Equine-related treatments for mental disorders lack empirical support: A systematic review of empirical investigations	People with mental disorder
Balasubramaniam et al. 2012 (13)	Yoga on our minds: a systematic review of yoga for neuropsychiatric disorders	People with selected major psychiatric disorders
Chiesa og Serretti 2011 (23)	Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis	People defined as psychiatric patients
Davis og Kurzban 2012 (30)	Mindfulness-Based Treatment for People With Severe Mental Illness: A Literature Review	People with severe mental illness (SMI)
Fovet et al. 2015 (36)	Current Issues in the Use of fMRI-Based Neurofeedback to Relieve Psychiatric Symptoms	People with psychiatric disorders
Fuhr et al. 2014 (39)	Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: a systematic review and meta-analysis	People with severe mental illness and depression
Galante et al. 2013 (40)	Effects of mindfulness-based cognitive therapy on mental disorders: A systematic review and meta-analysis of randomised controlled trials	People diagnosed with mental disorders (such as major depression)
Iancu et al. 2014 (53)	Farm-based interventions for people with mental disorders: a systematic review of literature	People with mental disorders (depressive disorders, schizophrenia or heterogeneous mental disorders)
Kamioka et al. 2014 (65)	Effectiveness of animal-assisted therapy: A systematic review of randomized controlled trials	People with mental and behavioral disorders such as depression, schizophrenia, and alcohol/drug addictions,
Kelly et al. 2014 (67)	A systematic review of self-management health care models for individuals with serious mental illnesses	People with serious mental illness
Leichsenring et al. 2015 (73)	The empirical status of psychodynamic psychotherapy-An update: Bambi's alive and kicking	People with specific mental disorder
Leiphart og Valone 2010 (74)	Stereotactic lesions for the treatment of psychiatric disorders	People with psychiatric disorders
Liebherz og Rabung 2014 (75)	Do patients' symptoms and interpersonal problems improve in psychotherapeutic hospital treatment in Germany? A systematic review and meta-analysis	Mentally ill adults in Germany
Lloyd-Evans et al. 2014 (78)	A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness	People with sever mental illness
Lynch et al. 2010 (80)	Cognitive behavioural therapy for major psychiatric disorder: Does it really work? A meta-analytical review of well-controlled trials	People with major psychiatric disorder
McGuire et al. 2014 (81)	Illness management and recovery: a review of the literature	People with severe mental illness
Meis et al. 2013 (82)	Couple and family involvement in adult mental health treatment: A systematic review	People with mental illness
Pearsall et al. 2014 (92)	Exercise therapy in adults with serious mental illness: a systematic review and meta-analysis	People with serious mental illness
Pinquart et al. 2014 (95)	Efficacy of systemic therapy on adults with mental disorders: A meta-analysis	People with psychiatric disorders
Riedel-Heller et al. 2012 (99)	Psychosocial interventions in severe mental illness. Evidence and recommendations: Psychoeducation, social skill training and exercise	People with serious mental illness
Rosenbaum et al. 2014 (102)	Physical activity interventions for people with mental illness: A systematic review and meta-analysis	People with mental illness (other than dysthymia or eating disorders)
Siantz og Aranda 2014 (109)	Chronic disease self-management interventions for adults with serious mental illness: a systematic review of the literature	People with serious mental illness
van Hasselt et al. 2013 (120)	Evaluating interventions to improve somatic health in severe mental illness: A systematic review	People with serious mental illness

Schizofreni eller schizoaffektiv lidelse (n=41)

Forfatter, år	Tittel	Populasjon
Agarwal et al. 2011 (5)	Ayurvedic medicine for schizophrenia	People with schizophrenia
Anaya et al. 2012 (8)	A systematic review of cognitive remediation for schizo-affective and affective disorders	People with schizoaffective disorder, affective psychosis, unipolar and/or bipolar disorders
Bernard og Ninot 2012 (16)	Benefits of exercise for people with schizophrenia: A systematic review	People with schizophrenia
Broderick et al. 2015 (20)	Yoga versus standard care for schizophrenia	People with schizophrenia
Buckley et al. 2015 (21)	Supportive therapy for schizophrenia	People with schizophrenia
Cramer et al. 2013 (24)	Yoga for schizophrenia: a systematic review and meta-analysis	People with schizophrenia
Donker et al. 2013 (32)	Suicide prevention in schizophrenia spectrum disorders and psychosis: a systematic review	People with schizophrenia spectrum disorders and psychosis
Draper et al. 2010 (33)	Cognitive behavioral therapy for schizophrenia: A review of recent literature and meta-analyses	People with schizophrenia
Firth et al. 2015 (35)	A systematic review and meta-analysis of exercise interventions in schizophrenia patients	People with schizophrenia (non-affective psychotic disorders)
Gorczynski og Faulkner 2010 (42)	Exercise therapy for schizophrenia	People with schizophrenia or schizophrenia-like illnesses
Helgason og Sarris 2013 (47)	Mind-body medicine for schizophrenia and psychotic disorders: a review of the evidence	People with schizophrenia and psychotic disorder
Holley et al. 2011 (49)	The effects of physical activity on psychological well-being for those with schizophrenia: A systematic review	People with schizophrenia
Jauhar et al. 2014 (60)	Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias	People with schizophrenia
Jiang et al. 2015 (61)	Metacognitive training for schizophrenia: a systematic review	People with schizophrenia
Jones et al. 2012 (62)	Cognitive behavior therapy versus other psychosocial treatments for schizophrenia	People with schizophrenia
Juanjuan og Jun 2013 (63)	Dance therapy for schizophrenia	People with schizophrenia or schizophrenia-like illnesses
Khoury et al. 2013 (68)	Mindfulness interventions for psychosis: A meta-analysis	People with with psychosis or schizophrenia
Kluwe-Schiavon et al. 2013 (69)	Executive functions rehabilitation for schizophrenia: A critical systematic review	People with schizophrenia
Kurtz og Richardson 2012 (71)	Social cognitive training for schizophrenia: a meta-analytic investigation of controlled research	People with schizophrenia
Liu et al. 2014 (77)	Horticultural therapy for schizophrenia	People with schizophrenia
Moriana et al. 2015 (84)	Social skills training for schizophrenia	People with schizophrenia
Mossler et al. 2011 (85)	Music therapy for people with schizophrenia and schizophrenia-like disorders	People with schizophrenia and schizophrenia-like disorders
Naeem et al. 2015 (87)	Cognitive behavioural therapy (brief versus standard duration) for schizophrenia	People with schizophrenia or related disorders
Newton-Howes og Wood 2013 (88)	Cognitive behavioural therapy and the psychopathology of schizophrenia: Systematic review and meta-analysis	People with schizophrenia
Okpokoro et al. 2014 (90)	Family intervention (brief) for schizophrenia	People with schizophrenia or schizophrenia-like conditions
Orfanos et al. 2015 (91)	Are group psychotherapeutic treatments effective for patients with schizophrenia? A systematic review and meta-analysis	People with schizophrenia
Pharoah et al. 2010 (93)	Family intervention for schizophrenia	People with schizophrenia or schizoaffective disorder
Rector og Beck 2012 (98)	Cognitive behavioral therapy for schizophrenia: An empirical review	People with schizophrenia
Roder et al. 2011 (100)	Effectiveness of integrated psychological therapy (IPT) for schizophrenia patients: a research update	People with schizophrenia
Sarin et al. 2011 (103)	Cognitive behavior therapy for schizophrenia: a meta-analytical review of randomized controlled trials	People with schizophrenia
Segredou et al. 2012 (106)	Group psychosocial interventions for adults with schizophrenia and bipolar illness: The evidence base in the light of publications between 1986 and 2006	People with schizophrenia and bipolar illness
Sevi og Sutcu 2012 (107)	Cognitive-behavioral group treatment for schizophrenia and other psychotic disorders-A systematic review	People with schizophrenia and other psychotic disorders
Shen et al. 2014 (108)	Acupuncture for schizophrenia	People with schizophrenia or related psychoses

Forfatter, år	Tittel	Populasjon
Soundy et al. 2015 (112)	Investigating the benefits of sport participation for individuals with schizophrenia: A systematic review	People with schizophrenia schizo-affective spectrum disorders
Stanton og Happell 2014 (113)	A systematic review of the aerobic exercise program variables for people with schizophrenia	People with schizophrenia or schizoaffective disorder
Tonelli et al. 2013 (117)	Metacognitive programs focusing social cognition for the rehabilitation of schizophrenia: A systematic review	People with schizophrenia
Vancampfort et al. 2010 (122)	The therapeutic value of physical exercise for people with schizophrenia	People with schizophrenia
Vancampfort et al. 2011 (123)	Body-directed techniques on psychomotor therapy for people with schizophrenia: A review of the literature	People with schizophrenia
Velthorst et al. 2014 (124)	Adapted cognitive-behavioural therapy required for targeting negative symptoms in schizophrenia: meta-analysis and meta-regression	People with schizophrenia
Wykes et al. 2011 (126)	A meta-analysis of cognitive remediation for schizophrenia: Methodology and effect sizes	People with schizophrenia
Xia et al. 2011 (127)	Psychoeducation for schizophrenia	People with schizophrenia and/or related serious mental illnesses

Ulike typer diagnoser (n=10)

Forfatter, år	Tittel	Populasjon
Abbass 2011 et al. (1)	The efficacy of short-term psychodynamic psychotherapy for depressive disorders with comorbid personality disorder	People with personality and depression disorder (comorbid)
Aderka et al. 2012 (4)	Sudden gains during psychological treatments of anxiety and depression: A meta-analysis	People receiving psychological treatment for major depressive disorder or an anxiety disorder
Andrews et al. 2010 (9)	Computer therapy for the anxiety and depressive disorders is effective, acceptable and practical health care: a meta-analysis	People who met diagnostic criteria for major depression, panic disorder, social phobia or generalized anxiety disorder
Annamalai et al. 2014 (11)	Effectiveness of interventions to reduce physical restraint in psychiatric settings: A systematic review	People with acute and chronic mental health conditions residing in mental health settings
Hausenblas et al. 2015 (45)	A systematic review of randomized controlled trials examining the effectiveness of saffron (Crocus sativus L.) on psychological and behavioral outcomes	People with major depressive disorder, premenstrual syndrome , sexual dysfunction and infertility, and weight loss/snacking behaviors
Hollon og Ponniah 2010 (50)	A review of empirically supported psychological therapies for mood disorders in adults	People with various mood disorders (such as bipolar disorder and major depressive disorder)
Hunsley et al. 2014 (51)	The efficacy and effectiveness of psychological treatments for mood, anxiety, and related disorders	People with depression, bipolar disorder, generalised anxiety disorder, social anxiety disorder, specific phobia, panic disorder, obsessive–compulsive disorder, and posttraumatic stress disorde
Qureshi og Al-Bedah 2013 (96)	Mood disorders and complementary and alternative medicine: A literature review	People with mood disorders
Stanton og Happell 2014 (114)	Exercise for mental illness: A systematic review of inpatient studies	People hospitalized with depression, schizophrenia, bipolar disorder, or anxiety disorders
Sylvia og Peters 2012 (116)	Nutrient-based therapies for bipolar disorder: A systematic review	People with mania and bipolar depression

Vedlegg 5. Oversikter sortert etter tiltak

Akupunktur (n=2)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Shen et al. 2014 (108)	Acupuncture for schizophrenia	Acupuncture alone or in combination treatments	Placebo (or no treatment) or any other treatments
Wu et al. 2012 (125)	Acupuncture for depression: A review of clinical applications	Acupuncture as monotherapy and agumentation of antide-pressants	Not reported

Bruk av dyr i terapi (n=3)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Anestis et al. 2014 (10)	Equine-related treatments for mental disorders lack empirical support: A systematic review of em-pirical investigations	Equine-related treatments	Not reported
Iancu et al. 2014 (53)	Farm-based interventions for people with mental disorders: a systematic review of literature	Farm-based interventions	Not reported
Kamioka et al. 2014 (65)	Effectiveness of animal-assisted therapy: A systematic review of randomized controlled trials	Animal-assisted therapy	Not reported

Familietiltak (n=4)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Fiorillo et al. 2013 (34)	Efficacy of supportive family interventions in bipolar disorder: A review of the literature	Supportive family interventions	Not reported
Meis et al. 2013 (82)	Couple and family involvement in adult mental health treatment: A systematic review	Couple and family involvement interventions	Not reported
Okpokoro et al. 2014 (90)	Family intervention (brief) for schizophrenia	Brief family-oriented psychosocial interventions	Standard care
Pharoah et al. 2010 (93)	Family intervention for schizophrenia	Community-orientated family-based psychosocial intervention	Standard care

Hagedyrking (n=1)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Liu et al. 2014 (77)	Horticultural therapy for schizophrenia	Horticultural therapy	Standard care

Kirurgisk behandling (n=2)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Leiphart og Valone 2010 (74)	Stereotactic lesions for the treatment of psychiatric disorders	Deep brain stimulation (DBS)	Not reported
Lipsman et al. 2010 (76)	Neurosurgical treatment of bipolar depression: Defining treatment resistance and identifying surgical targets	Neurosurgical treatment (deep brain stimulation)	Not reported

Komplementær alternativ medisin (KAM) uten nærmere spseifisering(n=5)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Agarwal et al. 2011 (5)	Ayurvedic medicine for schizophrenia	Ayurvedic medicine or treatments for schizophrenia	Placebo, typical or atypical antipsychotic drugs for schizophrenia and schizophrenia-like psychoses
Freeman et al. 2010 (37)	Complementary and alternative medicine in major depressive disorder: The American Psychiatric Association Task Force report	Selected complementary and alternative medicine (CAM) treatments	Not reported
Freeman et al. 2010 (38)	Complementary and alternative medicine in major depressive disorder: A meta-analysis of patient characteristics, placebo-response rates and treatment outcomes relative to standard antidepressants	Complementary and alternative medicine (CAM) treatments	Placebo-CAM and standard antidepressants
Qureshi og Al-Bedah 2013 (96)	Mood disorders and complementary and alternative medicine: A literature review	Complementary and alternative medicine	Not reported
Sarris et al. 2011 (104)	Bipolar disorder and complementary medicine: Current evidence, safety issues, and clinical considerations	Nonconventional (complementary and integrative) interventions	Not reported

Kosttilskudd eller naturpreparater (n=9)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Appleton et al. 2015 (12)	Omega-3 fatty acids for depression in adults	n-3 polyunsaturated fatty acids (also known as omega-3 fatty acids)	Placebo, anti-depressant treatment, standard care, no treatment, wait-list control
Carpenter 2011 (22)	St. John's wort and S-adenosyl methionine as "natural" alternatives to conventional antidepressants in the era of the suicidality boxed warning: what is the evidence for clinically relevant benefit?	St. Johns wort nd S-adenosyl methionine as "natural" alternatives to conventional antidepressants	Placebo
Grosso et al. 2014 (44)	Role of omega-3 fatty acids in the treatment of depressive disorders: a comprehensive meta-analysis of randomized clinical trials	Omega-3 fatty acids treatment (omega-3 PUFA)	Not reported
Hausenblas et al. 2015 (45)	Saffron (Crocus sativus L.) and major depressive disorder: a meta-analysis of randomized clinical trials	Saffron supplementation	Placebo control or antidepressant treatment
Hausenblas et al. 2013 (46)	A systematic review of randomized controlled trials examining the effectiveness of saffron (Crocus sativus L.) on psychological and behavioral outcomes	Saffron supplementation	Placebo control or antidepressant treatment
Jun et al. 2014 (64)	Herbal medicine (Gan Mai Da Zao decoction) for depression: A systematic review and meta-analysis of randomized controlled trials	Herbal medicine (Gan Mai Da Zao decoction)	Anti-depressants theraies

Forfatter, år	Tittel	Tiltak	Sammenlikning
Rakofsky og Dunlop 2014 (97)	Review of nutritional supplements for the treatment of bipolar depression	Nutritional supplements	Not reported
Sylvia og Peters 2012 (116)	Nutrient-based therapies for bipolar disorder: A systematic review	Nutrient-based therapies alone or in combination with commonly used pharmacotherapies	Not reported
Zhang et al. 2014 (128)	Shuganjieyu capsule for major depressive disorder (MDD) in adults: A systematic review	Shuganjieyu capsule, a herbal pharmaceutical product	Placebo

Kropp-sinn-terapi (n=5)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Helgason og Sarris 2013 (47)	Mind-body medicine for schizophrenia and psychotic disorders: a review of the evidence	Mind-body medicine	Usual care, including medication
Jain et al. 2014 (54)	Critical Analysis of the Efficacy of Meditation Therapies for Acute and Subacute Phase Treatment of Depressive Disorders: A Systematic Review	Meditation Therapies	Control (no further explanation)
Khoury et al. 2013 (68)	Mindfulness interventions for psychosis: A meta-analysis	Mindfulness interventions	Control group or no group comparison (no further explanation)
Piet og Hougaard 2011 (94)	The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis	Mindfulness-based cognitive therapy (MBCT). Group-based	Treatment as usual or placebo controls

Likepersoner (n=2)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Fuhr et al. 2014 (39)	Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: a systematic review and meta-analysis	Peer-delivered interventions	Treatment as usual or treatment delivered by a health professional
Lloyd-Evans et al. 2014 (78)	A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness	Non-residential peer support interventions	Not reported

Lysterapi (n=1)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Geoffroy et al. 2015 (41)	[Bright light therapy in seasonal bipolar depressions]	Bright-light therapy (BLT)	Not reported

Medikamentfrie tiltak uten nærmere spesifisering (n=3)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Alvarez-Jimenez et al. 2011 (7)	Preventing the second episode: A systematic review and meta-analysis of psychosocial and pharmacological trials in first-episode psychosis	Pharmacological and non-pharmacological interventions to prevent relapse in people with FEP	Treatment as usual, placebo, other types of psychological interventions (not clearly stated in the abstract)
Annamalai et al. 2014 (11)	Effectiveness of interventions to reduce physical restraint in psychiatric settings: A systematic review	Non-pharmacological interventions to reduce the use of restraints psychiatric settings	Not reported
Crowe et al. 2015 (25)	Non-pharmacological strategies for treatment of inpatient depression	Non-pharmacological interventions	Control (no further explanation)

Musikkterapi (n=1)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Mossler et al. 2011 (85)	Music therapy for people with schizophrenia and schizophrenia-like disorders	Music therapy added to standard care.	Placebo therapy, standard care or no treatment

Nevrofeedback (n=1)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Fovet et al. 2015 (36)	Current Issues in the Use of fMRI-Based Neurofeedback to Relieve Psychiatric Symptoms	fMRI-based neurofeedback (fMRI-NF)	Not reported

Opplæring eller undervisning (n=4)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Kelly et al. 2014 (67)	A systematic review of self-management health care models for individuals with serious mental illnesses	Self-management health care models. Collaborative and integrated care models that include self-management components	Not reported
Siantz og Aranda 2014 (109)	Chronic disease self-management interventions for adults with serious mental illness: a systematic review of the literature	Chronic disease self-management interventions	Not reported
van der Krieke et al. 2014 (119)	E-mental health self-management for psychotic disorders: State of the art and future perspectives	E-mental health self-management (such as psychoeducation, medication management, communication and shared decision making, management of daily functioning, lifestyle management, peer support, and real-time self-monitoring by daily measurements)	Usual care or nontechnological approaches
van Hasselt et al. 2013 (120)	Evaluating interventions to improve somatic health in severe mental illness: A systematic review	Interventions to improve somatic health (such as health education, exercise, smoking cessation, and changes in health care organization)	Not reported

Psykologiske tiltak (n=59)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Abbass 2011 et al. (1)	The efficacy of short-term psychodynamic psychotherapy for depressive disorders with comorbid personality disorder	Short-term psychodynamic Psychotherapy	Other psychotherapies, waiting list
Acar og Buldukoğlu 2014 (2)	Effect of Psychoeducation on Relapses in Bipolar Disorder: A Systematic Review	Psychoeducation interventions/programs	Not reported
Aderka et al. 2012 (4)	Sudden gains during psychological treatments of anxiety and depression: A meta-analysis	Psychological treatments (one of the interventions mentioned is CBT)	Not reported
Anaya et al. 2012 (8)	A systematic review of cognitive remediation for schizo-affective and affective disorders	Cognitive remediation	Not reported
Andrews et al. 2010 (9)	Computer therapy for the anxiety and depressive disorders is effective, acceptable and practical health care: a meta-analysis	Computerized cognitive behavior therapy	Treatment or control condition
Batista et al. 2011 (14)	Efficacy of psychoeducation in bipolar patients: systematic review of randomized trials	Psychoeducation	Not reported
Biesheuvel-Leliefeld et al. 2015 (17)	Effectiveness of psychological interventions in preventing recurrence of depressive disorder: Meta-analysis and meta-regression	Psychological interventions	(1) treatment-as-usual and (2) the use of antidepressants
Bond og Anderson 2015 (18)	Psychoeducation for relapse prevention in bipolar disorder: A systematic review of efficacy in randomized controlled trials	Psychoeducation	Treatment-as-usual, and placebo or active interventions
Boudreau et al. 2010 (19)	Self-directed cognitive behavioural therapy for adults with diagnosis of depression: systematic review of clinical effectiveness, cost-effectiveness, and guidelines	Self-directed cognitive behavioural therapy	Not reported
Buckley et al. 2015 (21)	Supportive therapy for schizophrenia	Supportive therapy in addition to standard care	Standard care, or other treatments
Chiesa og Serretti 2011 (23)	Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis	Mindfulness- based Cognitive Therapy (MBCT)	Usual care or continuation of maintenance antidepressants
Cuijpers et al. 2011 (26)	Psychological treatment of depression in inpatients: A systematic review and meta-analysis	Psychological treatments	Usual care and structured pharmacological treatments
Cuijpers et al. 2011 (27)	Interpersonal psychotherapy for depression: A meta-analysis	Interpersonal psychotherapy (IPT)	No treatment, usual care, other psychological treatments, and pharmacotherapy as well as studies comparing combination treatment using pharmacotherapy and IPT
Cuijpers et al. 2014 (28)	The effects of psychotherapies for major depression in adults on remission, recovery and improvement: a meta-analysis	Psychotherapy	Control (no further explanation)
Davis og Kurzban 2012 (30)	Mindfulness-Based Treatment for People With Severe Mental Illness: A Literature Review	Mindfulness-based treatment interventions	Not reported
Donker et al. 2013 (32)	Suicide prevention in schizophrenia spectrum disorders and psychosis: a systematic review	Psychosocial interventions	Attention placebo, treatment as usual (TAU), no intervention or waitlist control groups
Draper et al. 2010 (33)	Cognitive behavioral therapy for schizophrenia: A review of recent literature and meta-analyses	Cognitive behavioral therapy	Not reported
Galante et al. 2013 (40)	Effects of mindfulness-based cognitive therapy on mental disorders: A systematic review and meta-analysis of randomised controlled trials	Mindfulness-based cognitive therapy (MBCT)	Usual treatment
Gromer 2012 (43)	Need-adapted and open-dialogue treatments: Empirically supported psychosocial interventions for schizophrenia and other psychotic disorders	Open-dialogue and need-adapted treatments	Standard practice
Hidalgo-Mazzei et al. 2015 (48)	Internet-based psychological interventions for bipolar disorder: Review of the present and insights into the future	Psychological interventions	Not reported

Forfatter, år	Tittel	Tiltak	Sammenlikning
Hollon og Ponniah 2010 (50)	A review of empirically supported psychological therapies for mood disorders in adults	Psychotherapy	Not reported
Hunsley et al. 2014 (51)	The efficacy and effectiveness of psychological treatments for mood, anxiety, and related disorders	Psychological treatments	Not reported
Hutton og Taylor 2014 (52)	Cognitive behavioural therapy for psychosis prevention: a systematic review and meta-analysis	Cognitive behavioural therapy for psychosis prevention	Usual or non-specific control treatment
Jakobsen 2014 (55)	Systematic reviews of randomised clinical trials examining the effects of psychotherapeutic interventions versus "no intervention" for acute major depressive disorder and a randomised trial examining the effects of "third wave" cognitive therapy versus mentalization-based treatment for acute major depressive disorder	Psychodynamic therapies	Treatment as usual
Jakobsen et al. 2011 (56)	The effect of interpersonal psychotherapy and other psychodynamic therapies versus 'treatment as usual' in patients with major depressive disorder	Cognitive therapy	No intervention
Jakobsen et al. 2012 (57)	Effects of cognitive therapy versus interpersonal psychotherapy in patients with major depressive disorder: a systematic review of randomized clinical trials with meta-analyses and trial sequential analyses	Cognitive therapy	Treatment as usual
Jakobsen et al. 2011 (58)	The effects of cognitive therapy versus 'no intervention' for major depressive disorder	Cognitive therapy	Interpersonal psychotherapy
Jakobsen et al. 2011 (59)	The effects of cognitive therapy versus 'treatment as usual' in patients with major depressive disorder	Psychotherapeutic interventions	No intervention, other intervention
Jauhar et al. 2014 (60)	Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias	Cognitive-behavioural therapy (CBT)	Not reported
Jiang et al. 2015 (61)	Metacognitive training for schizophrenia: a systematic review	Metacognitive training (MCT), a group psychotherapy method	Control group (no further explanation)
Jones et al. 2012 (62)	Cognitive behavior therapy versus other psychosocial treatments for schizophrenia	Cognitive behavior therapy (CBT)	other psychosocial treatments (such as supportive therapy, psycho- education, group, relaxation and family therapy)
Karyotaki et al. 2014 (66)	The long-term efficacy of psychotherapy, alone or in combination with antidepressants, in the treatment of adult major depression	Psychotherapy alone or in combination with antidepressants	No abstract
Kurtz og Richardson 2012 (71)	Social cognitive training for schizophrenia: a meta-analytic investigation of controlled research	Social cognitive training (behavioral training programs designed to improve social cognitive function)	Not reported
Lampe et al. 2013 (72)	Psychological management of unipolar depression	Psychological management	Not reported, but authors mention pharmacotherapy
Leichsenring et al. 2015 (73)	The empirical status of psychodynamic psychotherapy-An update: Bambi's alive and kicking	Psychodynamic therapy	No treatment, placebo or alternative treatment or equivalent to an established treatment
Liebherz og Rabung 2014 (75)	Do patients' symptoms and interpersonal problems improve in psychotherapeutic hospital treatment in Germany? A systematic review and meta-analysis	Psychotherapeutic hospital treatment	Not reported
Lolich et al. 2012 (79)	Psychosocial interventions in bipolar disorder: a review	Multiple psychosocial interventions such as cognitive-behavioral, psychoeducational, systematic care models, interpersonal and family therapy interventions	Not reported
Lynch et al. 2010 (80)	Cognitive behavioural therapy for major psychiatric disorder: Does it really work? A meta-analytical review of well-controlled trials	Cognitive behavioural therapy	Non-specific control conditions
McGuire et al. 2014 (81)	Illness management and recovery: a review of the literature	Illness Management and Recovery (IMR) is a standardized psychosocial intervention	Treatment as usual

Forfatter, år	Tittel	Tiltak	Sammenlikning
Mould et al. 2010 (86)	The use of metaphor for understanding and managing psychotic experiences: A systematic review	Metaphor for understanding and managing psychotic experiences	Not reported
Naeem et al. 2015 (87)	Cognitive behavioural therapy (brief versus standard duration) for schizophrenia	Brief cognitive behavioural therapy	Standard duration of cognitive behavioural therapy
Newton-Howes og Wood 2013 (88)	Cognitive behavioural therapy and the psychopathology of schizophrenia: Systematic review and meta-analysis	Cognitive behavioural therapy	Non-cognitive psychotherapies
Orfanos et al. 2015 (91)	Are group psychotherapeutic treatments effective for patients with schizophrenia? A systematic review and meta-analysis	Group psychotherapeutic treatments	Treatment as usual and active sham
Rector og Beck 2012 (98)	Cognitive behavioral therapy for schizophrenia: An empirical review	Cognitive behavioral therapy	Control treatment conditions
Riedel-Heller et al. 2012 (99)	Psychosocial interventions in severe mental illness. Evidence and recommendations: Psychoeducation, social skill training and exercise	Psychosocial interventions (psychoeducation for patients and relatives, social skill training and physical exercise)	Not reported
Roder et al. 2011 (100)	Effectiveness of integrated psychological therapy (IPT) for schizophrenia patients: a research update	Integrated psychological therapy (IPT)	Placebo-attention conditions and standard care
Rodriguez et al. 2014 (101)	Group psychoeducation in bipolar treatment: A systematic review of the literature	Group psychoeducation	Not reported
Sarin et al. 2011 (103)	Cognitive behavior therapy for schizophrenia: a meta-analytical review of randomized controlled trials	Cognitive behavior therapy (CBT)	Treatment as usual and other psychological treatments
Schottle et al. 2011 (105)	Psychotherapy for bipolar disorder: A review of the most recent studies	Psychotherapy	Not reported
Segredou et al. 2012 (106)	Group psychosocial interventions for adults with schizophrenia and bipolar illness: The evidence base in the light of publications between 1986 and 2006	Group psychosocial interventions	Control group (no further explanation)
Sevi og Sutcu 2012 (107)	Cognitive-behavioral group treatment for schizophrenia and other psychotic disorders-A systematic review	Cognitive-behavioral group treatment	Not reported
Sikorski et al. 2011 (110)	Computer-aided cognitive behavioral therapy for depression: A systematic review of the literature	Computer- and internet-based cognitive behavioural therapy (CCBT).	Waiting list vs. active control group
Stratford et al. 2014 (115)	Psychological therapy for anxiety in bipolar spectrum disorders: A systematic review	Psychological therapy	Standard bipolar treatments
Tonelli et al. 2013 (117)	Metacognitive programs focusing social cognition for the rehabilitation of schizophrenia: A systematic review	Metacognitive programs focusing social cognition	Not reported
Turner et al. 2014 (118)	Psychological interventions for psychosis: a meta-analysis of comparative outcome studies	Psychological interventions	Other interventions
van Hees et al. 2013 (121)	The effectiveness of individual interpersonal psychotherapy as a treatment for major depressive disorder in adult outpatients: a systematic review	Individual interpersonal psychotherapy	Standard treatments
Velthorst et al. 2014 (124)	Adapted cognitive-behavioural therapy required for targeting negative symptoms in schizophrenia: meta-analysis and meta-regression	Adapted cognitive-behavioural therapy	Not reported
Wykes et al. 2011 (126)	A meta-analysis of cognitive remediation for schizophrenia: Methodology and effect sizes	Cognitive remediation therapy	Comparison group (no further description)
Xia et al. 2011 (127)	Psychoeducation for schizophrenia	Psychoeducation	Standard levels of knowledge provision

Sosiale eller psykososiale tiltak (n=2)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Miziou et al. 2015 (83)	Psychosocial treatment and interventions for bipolar disorder: a systematic review	Psychosocial treatment and interventions	Not reported
Moriana et al. 2015 (84)	Social skills training for schizophrenia	Social skills training	Not reported

Trening eller livsstilstiltak (n=22)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Alexandratos et al. 2012 (6)	The impact of exercise on the mental health and quality of life of people with severe mental illness: A critical review	Physical exercise	Not reported
Balasubramaniam et al. 2012 (13)	Yoga on our minds: a systematic review of yoga for neuropsychiatric disorders	Yoga	Not reported
Berk et al. 2013 (15)	Lifestyle management of unipolar depression	Lifestyle management	Not reported
Bernard og Ninot 2012 (16)	Benefits of exercise for people with schizophrenia: A systematic review	Physical activity	Not reported
Broderick et al. 2015 (20)	Yoga versus standard care for schizophrenia	Yoga	Standard care
Cramer et al. 2013 (24)	Yoga for schizophrenia: a systematic review and meta-analysis	Yoga	Usual care or non-pharmacological interventions
Danielsson et al. 2013 (29)	Exercise in the treatment of major depression: a systematic review grading the quality of evidence	Aerobic exercise	Antidepressants, any physical activity, treatmant as usual
de Souza Moura et al. 2015 (31)	Comparison among aerobic exercise and other types of interventions to treat depression: a systematic review	Aerobic exercise	Other types of interventions to treat depression
Firth et al. 2015 (35)	A systematic review and meta-analysis of exercise interventions in schizophrenia patients	Exercise interventions	Not reported
Gorczynski og Faulkner 2010 (42)	Exercise therapy for schizophrenia	Exercise/physical activity programs	Standard care or other treatments
Holley et al. 2011 (49)	The effects of physical activity on psychological well-being for those with schizophrenia: A systematic review	Physical activity	Not reported
Juanjuan og Jun 2013 (63)	Dance therapy for schizophrenia	Dance therapy or dance movement therapy (DMT)	Standard care and other psychological interventions
Knapen et al. 2015 (70)	Exercise therapy improves both mental and physical health in patients with major depression	Exercise therapy	Not reported but antidepressant medication and psychotherapy are mentioned
Nystrom et al. 2015 (89)	Treating major depression with physical activity: A systematic overview with recommendations	Physical activity (aerobic and anaerobic)	Any treatment
Pearsall et al. 2014 (92)	Exercise therapy in adults with serious mental illness: a systematic review and meta-analysis	Exercise therapy	Usual care or other type of intervention
Rosenbaum et al. 2014 (102)	Physical activity interventions for people with mental illness: A systematic review and meta-analysis	Physical activity interventions	Not reported
Silveira et al. 2013 (111)	Physical exercise and clinically depressed patients: A systematic review and meta-analysis	Physical exercise (aerobic training and strength training)	Control group (no further explanation)
Soundy et al. 2015 (112)	Investigating the benefits of sport participation for individuals with schizophrenia: A systematic review	Sport participation	Not reported
Stanton og Happell 2014 (113)	A systematic review of the aerobic exercise program variables for people with schizophrenia	Aerobic exercise program variables	Not reported
Stanton og Happell 2014 (114)	Exercise for mental illness: A systematic review of inpatient studies	Exercise interventions	Not reported
Vancampfort et al. 2010 (122)	The therapeutic value of physical exercise for people with schizophrenia	Movement-related interventions	Not reported
Vancampfort et al. 2011 (123)	Body-directed techniques on psychomotor therapy for people with schizophrenia: A review of the literature	Body-directed techniques on psychomotor therapy	Not reported

Rehabiliteringstiltak (n=1)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Kluwe-Schiavon et al. 2013 (69)	Executive functions rehabilitation for schizophrenia: A critical systematic review	Executive functions rehabilitation	Not reported

Tiltak som ikke er beskrevet (n=2)

Forfatter, år	Tittel	Tiltak	Sammenlikning
Addington 2013 et al. (3)	Essential evidence-based components of first-episode psychosis services	First-episode psychosis services	Not reported
Pinquart et al. 2014 (95)	Efficacy of systemic therapy on adults with mental disorders: A meta-analysis	Systemic therapy	Control groups without alternative treatment, alternative active treatments

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