CBASP for Treatment resistant depression

Review information

Authors

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Contact person

[Empty name]

Dates

Assessed as Up-to-date:	
Date of Search:	
Next Stage Expected:	
Protocol First Published:	Not specified
Review First Published:	Not specified
Last Citation Issue:	Not specified

What's new

Date / Event	Description

History

Date / Event	Description

Abstract

Background

Objectives

Search methods

Selection criteria

Data collection and analysis

Main results

Declarations of interest

Differences between protocol and review

Published notes

Characteristics of studies

Characteristics of included studies

Keller 2000

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** CBASP only (n=220) ● *Age*: 43.2 (10.8) ● *Gender (female)*: 62.7% Med only (n=216) ● *Age*: 42.2 (11.0) ● *Gender (female)*: 64.2% CBASP and Meds (n=226) ● *Age*: 44.4 (10.3) ● *Gender (female)*: 69.2 Overall ● *Age*: 43 (10.7) ● *Gender (female)*: 65.3 **Included criteria:** Chronic major depressive disorder (at least two years' dura-tion), a current major depressive disorder superimposed on a pre-existing dysthymic disorder, or a recurrent major depressive dis-order with incomplete remission between episodes in a patientwith a current major depressive disorder and a total duration ofcontinuous illness of at least two years.To be eligible for the study, the patients had to be between theages of 18 and 75 years and to have had a score of at least 20 onthe 24-item Hamilton Rating Scale for Depression (HRSD)35 atscreening and, after a two-week drug-free period, at base line.Patients were required to discontinue taking monoamine oxidaseinhibitors and fluoxetine at least four weeks before study entry,depot neuroleptic agents at least six months before entry, andother psychotropic medications at least two weeks before entry. **Excluded criteria:** Patients were excluded from the study if they had any of thefollowing: a history of seizures, abnormal findings on electroen-cephalography, severe head trauma, or stroke; evidence suggest-ing they were at high risk for suicide; a history of psychotic symp-toms or schizophrenia; bipolar disorder, an eating disorder (if ithad not been in remission for at least one year), obsessive–com-pulsive disorder, or dementia; antisocial, schizotypal, or severeborderline personality disorder; a principal diagnosis of panic, gen-eralized anxiety, social phobia, or post-traumatic stress disorders orany substance-related abuse or dependence disorder (except thoseinvolving nicotine) within six months before the study began; ab-sence of a response to a previous adequate trial of nefazodone ora cognitive behavioral-analysis system of psychotherapy; absenceof a response to three previous adequate trials of at least two dif-ferent classes of antidepressants or electroconvulsive therapy or totwo previous adequate trials of empirical psychotherapy in thethree years preceding the study; a serious, unstable medical con-dition; or a positive urine screen for drugs of abuse. Women ofchildbearing potential had to agree to use adequate contraceptionduring the study.

	Pretreatment: There were no significant differences among the groups with respect to base-line demographic and clinical characteristics (see Table 2)
Interventions	**Intervention Characteristics** CBASP only (n=220) ● *Meds only (Nefazodone 12 weeks)*: ● *CBASP (16-20 sessions 12 weeks)*: The cognitive behavioral-analysis system of psychotherapy alsofollowed a manual37 specifying twice-weekly sessions during weeks1 through 4 and weekly sessions during weeks 5 through 12. Twice-weekly sessions could be extended until week 8 if a patient wasnot adequately performing a learned social problem-solving pro-cedure according to the criteria.Psychotherapists (persons who had at least two years' experi-ence after earning an M.D. or Ph.D. or at least five years' experi-ence after earning an M.S.W.) attended a two-day training work-shop and met the criteria for mastery of treatment proceduresinvolved in the cognitive behavioral-analysis system of psycho-therapy, as assessed by evaluation of their performance duringtwo videotaped pilot cases. All psychotherapy sessions conductedduring the study were videotaped, and supervisors reviewed thevideotapes weekly to assess the psychotherapists' adherence to thetreatment procedures. ● *Meds & CBASP (12 weeks)*: Med only (n=216) ● *Meds only (Nefazodone 12 weeks)*: The initial dosewas 200 mg per day (100 mg twice a day) and was increased to300 mg per day during the second week. Thereafter, the dose wasincreased weekly in increments of 100 mg per day to a maximumof 600 mg per day, to maximize the efficacy of the drug withoutproducing intolerable side effects. To remain in the study, patientshad to be receiving a dose of at least 300 mg per day by week 3.Visits for medication were limited to 15 to 20 minutes. Psycho-pharmacologists followed a published manual36 for clinical man-agement (e.g., patients were questioned about the concomitantuse of medications and symptoms, side effects, and illnesses theyhad had between visits). The psychopharmacologists were not al-lowed to make formal psychotherapeutic interventions (such assuggesting ways to cope with stressful life events). ● *CBASP (16-20 sessions 12 weeks)*: ● *Meds & CBASP (12 weeks)*: CBASP and Meds (n=226) ● *Meds only (Nefazodone 12 weeks)*: ● *CBASP (16-20 sessions 12 weeks)*: ● *Meds & CBASP (12 weeks)*:
Outcomes	*Depressive symptoms HAM-D* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: HAM-D ● **Direction**: Lower is better ● **Data value**: Change from baseline ● **Notes**: 24 item version of HAM-DNumbers at completion are based on those that completed HAM-D at 12 weeks (Figure 1) but authors claim to have used ITT without clarifying how they did this. *Adequate Response* ● **Outcome type**: DichotomousOutcome ● **Scale**: HAM-D ● **Direction**: Higher is better *Remission* ● **Outcome type**: DichotomousOutcome ● **Scale**: HAM-D ● **Direction**: Higher is better

Identification	**Sponsorship source:** all but 1 (B.A.) ofthe 12 principal authors have had financial associations with Bris-tol-Myers Squibb — which also sponsored the study — and, inmost cases, with many other companies producing psychoactivepharmaceutical agents. The associations include consultancies, re-ceipt of research grants and honorariums, and participation on ad-visory boards. Of the 17 other authors, 2 are employees of Bris-tol-Myers Squibb, 5 (L.M.K., G.K., I.M., R.M., D.V.) have norelevant additional financial ties, and the others have a variety ofassociations similar to those just mentioned. **Country:** USA **Setting:** Outpatient **Comments:** **Authors name:** MARTIN B. KELLER **Institution:** Department of Psychiatry, Brown University, Providence,R.I. (M.B.K.) **Email:** **Address:**
Notes	*Nicolai Ladegaard* on 13/10/2019 22:57 **Select** studiedesign: farma vs cbasp vs farma + cbasp *Stephen Austin* on 25/10/2019 20:34 **Outcomes** Adequate Response defined as reduction on HAM-D of at least 50% Remission socre of 8 and under on HAM-D

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	
Allocation concealment (selection bias)	Low risk	Judgement Comment: Randomized at central computerized schedule
Blinding of participants and personnel (performance bias)	High risk	
Blinding of outcome assessment (detection bias)	Low risk	
Incomplete outcome data (attrition bias)	Low risk	Quote: "The rates of discontinuation were similar in the three groups (P=0.46)"
Selective reporting (reporting bias)	Unclear risk	

Kocsis 2009

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** CBASP ● *Age*: 45.3 (11.9) ● *Gender (female)*: 56% MEDS ● *Age*: 43.2 (13.4) ● *Gender (female)*: 47 Overall ● *Age*: ● *Gender (female)*:

	Included criteria: Major Depression Episode (MDE) without remission of depressive symptoms in 2 yrs **Excluded criteria:** Psychosis, bipolar, personality disorder, PTSD, OCD, substance abuse disorder **Pretreatment:**
Interventions	**Intervention Characteristics** CBASP ● *MEDS (6 meetings over 12 weeks)* : ● *CBASP (16 sessions over 12 weeks)*: MEDS ● *MEDS (6 meetings over 12 weeks)* : ● *CBASP (16 sessions over 12 weeks)*:
Outcomes	*Depressive symptoms (HAM-D)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: HAM-D ● **Direction**: Lower is better ● **Data value**: Change from baseline ● **Notes**: Missing data at follow-up (not ITT) at 12 weeks *Functioning* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: LIFE-RIFT Scale ● **Direction**: Lower is better ● **Data value**: Change from baseline *Remission* ● **Outcome type**: DichotomousOutcome ● **Notes**: Remission defined as score under 8 on HAM-D and at least a 50% decrease in symptoms from baseline *Dropout* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Direction**: Lower is better ● **Data value**: Endpoint
Identification	**Sponsorship source:** Kocsis **Country:** USA **Setting:** Outpatients **Comments:** Randomized after non or partial repsonse to medication **Authors name:** Kocsis **Institution:** Cornell Medical College New York **Email:** jhk2002@med.cornell.edu **Address:**
Notes	*Nicolai Ladegaard* on 13/10/2019 23:39 **Select** REVAMP hovedstudie

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Quote: "Randomization was done centrally at the Pittsburgh data-coordinating center stratified by site,"
Allocation concealment (selection bias)	Low risk	Judgement Comment: Randomized centrally and off-site
Blinding of participants and personnel (performance bias)	High risk	Judgement Comment: Participants and personel are aware if person receives CBASP or Meds only
Blinding of outcome assessment (detection bias)	Low risk	Judgement Comment: To maintain unbiased estimates of treatment effects, the HAM-Dand LIFE-RIFT evaluations were performed by blinded raters.
Incomplete outcome data (attrition bias)	Low risk	Judgement Comment: Missing data at baseline and follow-up reported. Analysis does not appear to compensate for missing data (imputations or LOCF). However, comparable drop-out rates for all arms.
Selective reporting (reporting bias)	Unclear risk	Judgement Comment: Kan ikke finde forsk. protokol på clinicaltrials.gov

Michalak 2015

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** CBASP ● *Age*: 50.2 years (10.5) ● *Gender (female)*: 62.9% (22) TAU ● *Age*: 54.0 years (13.24) ● *Gender (female)*: 65.7% (23) Overall ● *Age*: ● *Gender (female)*: **Included criteria:** Major depressive episode (MDE) and depressive symptoms 2+ years without remission **Excluded criteria:** Schizophrenia, substance abuse, eating disorder, organic mental disorder, borderline personality disorder , inabilty to engage in treatment **Pretreatment:**
Interventions	**Intervention Characteristics** CBASP ● *CBASP (2 individual, 8 group sessions -8 weeks)*: ● *TAU (weekly meeting with psychiatrist -8 weeks)*: TAU ● *CBASP (2 individual, 8 group sessions -8 weeks)*: ● *TAU (weekly meeting with psychiatrist -8 weeks)*:
Outcomes	*Depressive symptoms Ham-D (interviewer rated)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: Ham-D ● **Direction**: Lower is better ● **Data value**: Change from baseline *Depressive symptoms BDI (self reported)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported

	● **Scale**: Beck Depression Inventory BDI ● **Range**: 0-63 ● **Direction**: Lower is better ● **Data value**: Change from baseline *Remission* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported ● **Scale**: Definition of remission? ● **Range**: 0-100 ● **Direction**: Higher is better ● **Data value**: Endpoint *Social functioning* ● **Outcome type**: ContinuousOutcome ● **Scale**: Short Form Health Survey (social functioning domain) ● **Direction**: Higher is better ● **Data value**: Change from baseline ● **Notes**: Table 5 Fixed Effects of the Multilevel Analyses Investigating the Four Mental Health Subscales of the Short Form Health Survey and the SASS.Effect size is calculated against TAU *Dropout* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Direction**: Lower is better ● **Data value**: Change from baseline
Identification	**Sponsorship source:** Michalak **Country:** Germany **Setting:** Outpatient **Comments:** **Authors name:** Michalak **Institution:** Witten/Herdecke Universiy **Email:** johannes-michalak@uni-wh.de **Address:**
Notes	*Nicolai Ladegaard* on 14/10/2019 21:57 **Select** Patients were randomly assigned to eitherTAU alone or—in addition to TAU— either MBCT or CBASP.TAU: All patients were instructed that they should be inindividual treatment by either a psychiatrist or a licensed psychotherapist (not a member of the study team) during the study period.If patients were already in psychiatric or psychotherapeutic individual treatment at study intake, they continued their treatmentwith this psychiatrist or psychotherapist. Patients were encouragedto continue any current medication and to attend appointmentswith their psychiatrist or psychotherapist

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Judgement Comment: Randomization was performed by the independent allocator using a computer-generated list of random numbers. The central allocator then mailed the allocations back to the treatment sites.
Allocation concealment (selection bias)	Low risk	Judgement Comment: Randomly assigned by independent allocator using computer generated list of random numbers (off site)

Blinding of participants and personnel (performance bias)	High risk	Judgement Comment: Ikke mulig at blinde deltagere ifht MED eller psykoterapi
Blinding of outcome assessment (detection bias)	Low risk	Judgement Comment: To maintain rater blindness, patients were instructed at the beginning ofeach interview not to mention their treatment condition or theirpsychotherapist.
Incomplete outcome data (attrition bias)	Low risk	Judgement Comment: Dropout rates provided and stated that used ITT analysis at post assessment
Selective reporting (reporting bias)	Low risk	Judgement Comment: https://clinicaltrials.gov/ct2/show/NCT01065311

Wiersma 2014

Methods	**Study design:** Randomized controlled trial **Study grouping:**
Participants	**Baseline Characteristics** CBASP ● *Age*: 40.1 years (10.8) ● *Gender (female)*: 68.7% CAU ● *Age*: 43.0 years (10.1) ● *Gender (female)*: 51.4% Overall ● *Age*: ● *Gender (female)*: **Included criteria:** 18-65 YEARSChronic form of MDD (2+yrs)Moderate depression (22+ IDS **Excluded criteria:** Psychotic disorder Bipolar disorderOrganic brain disorderSubstance Abuse **Pretreatment:**
Interventions	**Intervention Characteristics** CBASP ● *CAU Care as usual (23 sessions over a year)*: ● *CBASP 24 sessions over a year (52 weeks)*: CAU ● *CAU Care as usual (23 sessions over a year)*: ● *CBASP 24 sessions over a year (52 weeks)*:
Outcomes	*Depressive symptoms (self-report)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: Inventory for Depressive symptoms (28 items) ● **Direction**: Lower is better ● **Data value**: Change from baseline *Response* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Partially reported ● **Scale**: IDS ● **Range**: 0-100% ● **Direction**: Higher is better ● **Data value**: Endpoint ● **Notes**: Remission defined as 13 or less on IDS (ITT analysis) *Remission* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported ● **Scale**: IDS

	● **Direction**: Higher is better ● **Data value**: Endpoint ● **Notes**: Response defined as 50% reduction on IDS *dropout* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Direction**: Lower is better ● **Data value**: Change from baseline
Identification	**Sponsorship source:** Wiersma **Country:** Netherlands **Setting:** Outpatient **Comments:** **Authors name:** Wiersma **Institution:** Department of Psychiatry, VU Medical Centre, Amsterdam **Email:** j.wiersma@ggzingeest.nl **Address:**
Notes	*Nicolai Ladegaard* on 15/10/2019 00:09 **Select** CBASP + TAU vs. TAU. In both arms algorithm-based pharmacotherapy was provided.

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Judgement Comment: Randomization was performed by an external researcher using a computerized random number generator
Allocation concealment (selection bias)	Low risk	Judgement Comment: Allocation made offsite
Blinding of participants and personnel (performance bias)	High risk	Judgement Comment: Not able to blind therapists of treatment condition
Blinding of outcome assessment (detection bias)	High risk	Judgement Comment: Given the nature of this study, it was not possible to keepthem 100% guaranteed blind for treatment allocation
Incomplete outcome data (attrition bias)	Low risk	Judgement Comment: Comparable drop-out rates in both arms. ITT analysis Imputation
Selective reporting (reporting bias)	Low risk	Judgement Comment: Netherlands Trail Reg.: https://www.trialregister.nl/trial/1057
Other bias	Unclear risk	

Footnotes

Characteristics of excluded studies

Brakemeier 2011

Reason for exclusion	Protocol

Brakemeier 2011a

Reason for exclusion	Wrong study design

Brakemeier 2015

Reason for exclusion	Wrong study design

Forkmann 2016

Reason for exclusion	Wrong outcomes

Guhn 2019

Reason for exclusion	Wrong study design

Klein 2011

Reason for exclusion	Wrong outcomes

NCT02149381 2014

Reason for exclusion	Protocol

Sabas 2018

Reason for exclusion	Wrong study design

Sayegh 2012

Reason for exclusion	Wrong study design

Schramm 2011

Reason for exclusion	Wrong comparator

Schramm 2015

Reason for exclusion	Wrong study design

Schramm 2017

Reason for exclusion	Wrong comparator

Schramm 2019

Reason for exclusion	Wrong comparator

Swan 2014

Reason for exclusion	Wrong study design

Truax 2005

Reason for exclusion	Commentary

Wiersma 2009

Reason for exclusion	Protocol

Footnotes

Characteristics of studies awaiting classification

Footnotes

Characteristics of ongoing studies

Footnotes

Summary of findings tables

Additional tables

References to studies

Included studies

Keller 2000

Keller M.B.; McCullough J.P.; Klein D.N.; Arnow B.; Dunner D.L.; Gelenberg A.J.; Markowitz J.C.; Nemeroff C.B.; Russell J.M.; Thase M.E.; Trivedi M.H.; Zajecka J.; Blalock J.A.; Borian F.E.; Jody D.N.; DeBattista C.; Koran L.M.; Schatzberg A.F.; Fawcett J.; Hirschfeld R.M.A.; Keitner G.; Miller I.; Kocsis J.H.; Kornstein S.G.; Manber R.; Ninan P.T.; Rothbaum B.; Rush A.J.; Vivian, D.. A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression.. New England Journal of Medicine 2000;342(20):1462-1470. [DOI:]

Kocsis 2009

Kocsis J.H.; Gelenberg A.J.; Rothbaum B.O.; Klein D.N.; Trivedi M.H.; Manber R.; Keller M.B.; Leon A.C.; Wisniewski S.R.; Arnow B.A.; Markowitz J.C.; Thase M.E.; Friedman R.A.; Friedman E.S.; Howland R.H.; Barkin J.; Vivian D.; Dowling F.; D'Zurilla T.; Sunderajan P.; Morris D.; Kleiber B.; Dunlop B.; Ninan P.T.; Garlow S.J.; Misiaszek J.; Miller I.; Keitner G.; Raffa S.; Schatzberg A.F.; Brent Solvason H.; McCullough, J.. Cognitive behavioral analysis system of psychotherapy and brief supportive psychotherapy for augmentation of antidepressant nonresponse in chronic depression: The REVAMP trial.. Archives of General Psychiatry 2009;66(11):1178-1188. [DOI:]

Michalak 2015

Michalak J.; Schultze M.; Heidenreich T.; Schramm, E.. A randomized controlled trial on the efficacy of mindfulness-based cognitive therapy and a group version of cognitive behavioral analysis system of psychotherapy for chronically depressed patients.. Journal of consulting and clinical psychology 2015;83(5):951-963. [DOI:]

Wiersma 2014

Wiersma J.E.; Van Schaik D.J.; Hoogendorn A.W.; Dekker J.J.; Van H.L.; Schoevers R.A.; Blom M.B.; Maas K.; Smit J.H.; McCullough J.P.; Beekman A.T.; Van Oppen, P.. The effectiveness of the cognitive behavioral analysis system of psychotherapy for chronic depression: a randomized controlled trial.. Psychotherapy and psychosomatics 2014;83(5):263-269. [DOI:]

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Brakemeier 2011

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Brakemeier 2011a

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analysis system of psychotherapy as an inpatient treatment program.. Psychotherapy and psychosomatics 2015;84(1):51-56. [DOI:]

Forkmann 2016

Forkmann T.; Brakemeier E.L.; Teismann T.; Schramm E.; Michalak, J.. The Effects of Mindfulness-Based Cognitive Therapy and Cognitive Behavioral Analysis System of Psychotherapy added to Treatment as Usual on suicidal ideation in chronic depression: Results of a randomized-clinical trial.. Journal of affective disorders 2016;200(Journal Article):51-57. [DOI:]

Guhn 2019

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Schramm 2011

Schramm E.; Zobel I.; Dykierek P.; Kech S.; Brakemeier E.L.; Kulz A.; Berger, M.. Cognitive behavioral analysis system of psychotherapy versus interpersonal psychotherapy for early-onset chronic depression: A randomized pilot study.. Journal of affective disorders 2011;129(1-3):109-116. [DOI:]

Schramm 2015

Schramm E.; Zobel I.; Schoepf D.; Fangmeier T.; Schnell K.; Walter H.; Drost S.; Schmidt P.; Brakemeier E.L.; Berger M.; Normann, C.. Cognitive behavioral analysis system of psychotherapy versus escitalopram in chronic major depression.. Psychotherapy and psychosomatics 2015;84(4):227-240. [DOI:]

Schramm 2017

Schramm E.; Kriston L.; Zobel I.; Bailer J.; Wambach K.; Backenstrass M.; Klein J.P.; Schoepf D.; Schnell K.; Gumz A.; Bausch P.; Fangmeier T.; Meister R.; Berger M.; Hautzinger M.; Harter, M.. Effect of disorder-specific vs nonspecific psychotherapy for chronic depression: A randomized clinical trial.. JAMA Psychiatry 2017;74(3):233-242. [DOI:]

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Schramm E.; Kriston L.; Elsaesser M.; Fangmeier T.; Meister R.; Bausch P.; Zobel I.; Bailer J.; Wambach K.; Backenstrass M.; Klein J.P.; Schoepf D.; Schnell K.; Gumz A.; Lowe B.; Walter H.; Wolf M.; Domschke K.; Berger M.; Hautzinger M.; Harter, M.. Two-year follow-up after treatment with the cognitive behavioral analysis system of psychotherapy versus supportive psychotherapy for early-onset chronic depression.. Psychotherapy and psychosomatics 2019;88(3):154-164. [DOI:]

Swan 2014

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month clinical outcomes in an open case series.. Journal of affective disorders 2014;152-154(Journal Article):268-276. [DOI:]

Truax 2005

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Wiersma 2009

Wiersma, J. E.; van Schaik, DJF; Blom, MBJ; Bakker, L.; van Oppen, P.; Beekman, ATF. Treatment for chronic depression: cognitive behavioral analysis system of psychotherapy (CBASP). 2009;51(10):727-736. [DOI:]

Studies awaiting classification

Ongoing studies

Other references

Additional references

Other published versions of this review

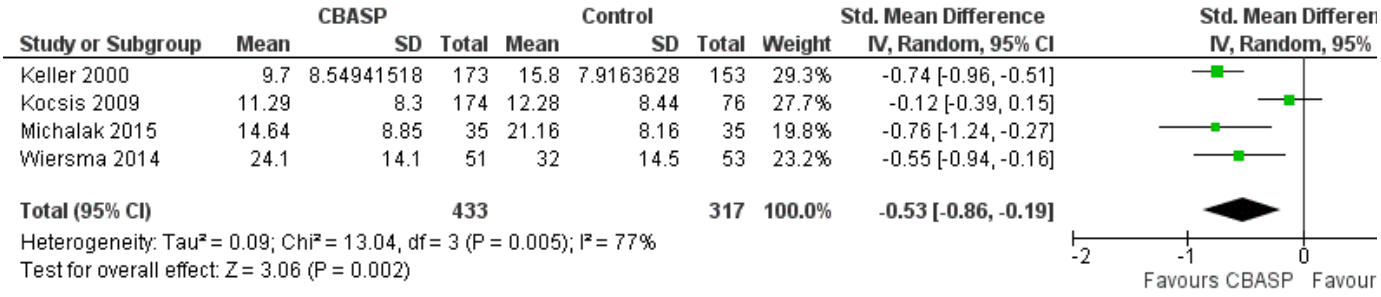
Data and analyses

1 CBASP vs control

Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
1.1 Depressive symptoms	4	750	Std. Mean Difference (IV, Random, 95% CI)	-0.53 [-0.86, -0.19]
1.2 Response	2	134	Risk Ratio (IV, Random, 95% CI)	1.48 [0.75, 2.92]
1.3 Remission	4	302	Risk Ratio (IV, Random, 95% CI)	1.42 [1.01, 1.99]
1.4 Functioning	2		Std. Mean Difference (IV, Random, 95% CI)	0.16 [-0.20, 0.52]
1.5 Frafald (All-cause discontinuation)	4	944	Risk Ratio (IV, Random, 95% CI)	0.80 [0.57, 1.11]

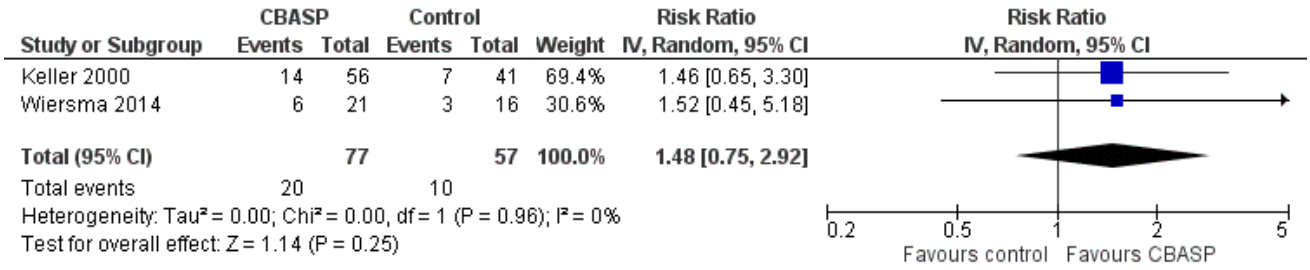
Figures

Figure 1 (Analysis 1.1)



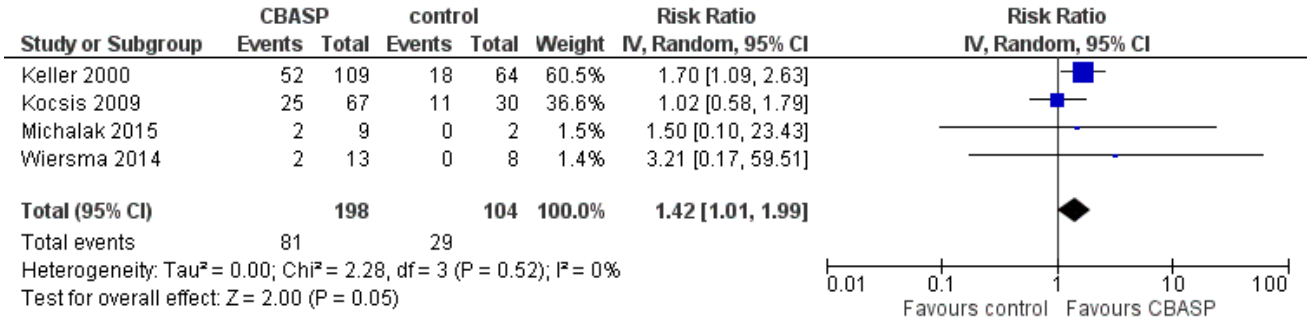
Forest plot of comparison: 1 CBASP vs control, outcome: 1.1 Depressive symptoms.

Figure 2 (Analysis 1.2)



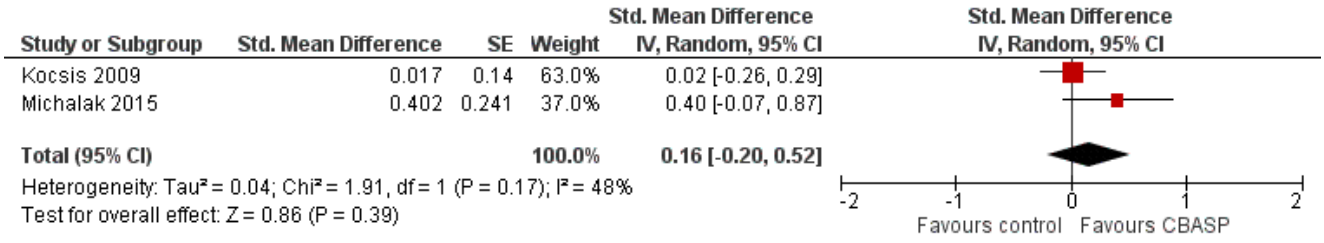
Forest plot of comparison: 1 CBASP vs control, outcome: 1.2 Response.

Figure 3 (Analysis 1.3)



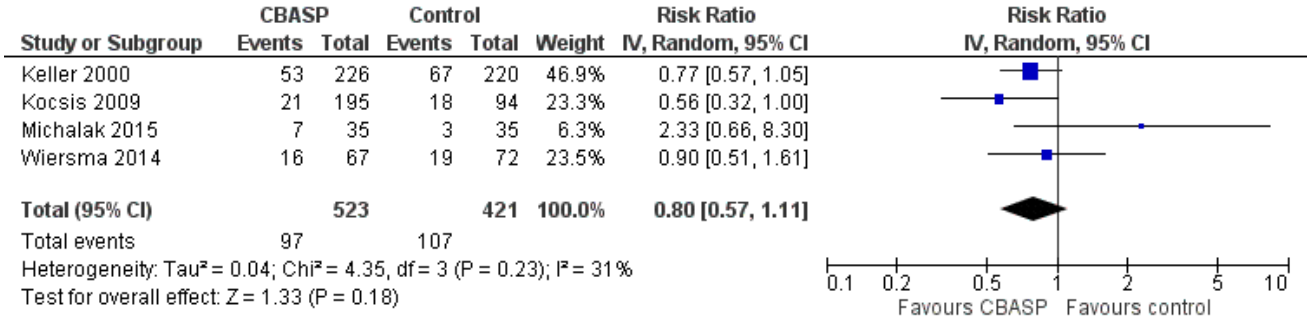
Forest plot of comparison: 1 CBASP vs control, outcome: 1.3 Remission.

Figure 4 (Analysis 1.4)



Forest plot of comparison: 1 CBASP vs control, outcome: 1.4 Functioning.

Figure 5 (Analysis 1.5)



Forest plot of comparison: 1 CBASP vs control, outcome: 1.5 Frafald (All-cause discontinuation).

Sources of support

Internal sources

- No sources of support provided

External sources

- No sources of support provided

Feedback

Appendices