heterogeneity not accounted for by chance (I^2) in this meta-analysis were all high. The question therefore arises, 'For whom is CBT in psychosis most effective and for what outcome?' Likely groups are individuals at ultra-high risk for psychosis,[1] those in the early phase of psychosis[1] and perhaps those with chronic stable symptoms, appearing to benefit the most; the Prevention of Relapse in Psychosis trial suggests that those beginning treatment early in the course of recovery from acute symptoms do not benefit. These trials focus on individuals in receipt of medication, with enduring symptoms. They therefore ask the question, 'Does CBT offer added value compared with medication alone?' We might also ask the converse, 'Does antipsychotic medication offer added value to CBT alone?' It is known that up to 50% of individuals will not adhere to medication; a recent pilot trial of CBT in those not taking medication showed an effect of CBT equivalent to that of drugs.[4] Given the low acceptability of antipsychotic medications and their serious impact on health, this is an important question for further research.[1] We note that our trial of CBT for commanding hallucinations is included in the analysis for hallucinations; however, this trial did not predict a reduction in hallucinations, but reported a 'high' effect size for harmful compliance (not reported), which has been the subject of a large multicentre trial, soon to report. We argued some time ago that CBT for psychosis should not be conceived and evaluated as a 'quasi-neuroleptic':[5] the dimensions of delusions (power, distress) and general affective dysfunction are, we believe, among the most appropriate targets for CBT, with strong theoretical justification. Given the evidence from systematic reviews of antipsychotics[6] that the improvements claimed for antipsychotics are of questionable clinical utility, with most trials failing to demonstrate minimal clinical improvement using the Positive and Negative Syndrome Scale, with effect sizes smaller than for adverse side-effects, there is clearly much work to be done to improve care, as the Schizophrenia Commission outlined in their 2012 review of current treatment and services (www.schizophreniacommission.org.uk).

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Jauhar and colleagues'[1] review and meta-analysis of cognitive–behavioural therapy (CBT) for the reduction of particular symptoms associated with schizophrenia is interesting but incomplete. For example, the review does not examine the clinical significance of dose or duration of CBT treatment. This limitation is considerable, as an analysis of effective elements of CBT for psychosis found that 'consistent delivery of full therapy, including specific cognitive and behavioural techniques, was associated with clinically and statistically significant increases in months in remission, and decreases in psychotic and affective symptoms', while 'delivery of partial therapy involving engagement and assessment was not effective'.[2]

Jauhar *et al* have also excluded measurement of long-term outcomes from their analysis, measuring only end-of-study data. This is another considerable limitation, as symptom reductions maintained at 9- or 18-month follow-up represent a substantial benefit of effective CBT. Further, although reduction of psychotic symptoms is an important treatment outcome to measure, CBT is particularly focused on reducing distress associated with such symptoms and improving an individual's ability to cope with them. As psychotic symptoms can continue even with administration of powerful antipsychotic medication, improvements in these areas may be clinically significant for many CBT recipients. Indeed, a comprehensive synthesis of qualitative research into patients' experiences of CBT for psychosis[3] found that the most commonly identified 'key ingredients' of CBT included increased understanding of psychosis and of coping strategies, reappraisal of distressing beliefs, and normalisation: 'Participants did not necessarily experience an actual reduction in the frequency or distressing content of psychotic experiences, but instead gained an increased ability to cope and an increased perception of personal power'. It is also important to consider that not all individuals want their 'symptoms' eradicated, and such appraisals are common in the wider literature on recovery from psychosis or schizophrenia: 'Learning to cope to accept that you hear voices or whatever your symptoms are. Recovery is . . . to be able to live with it'.[4] So, although analyses of CBT that focus only on psychotic symptom reduction are important, they are also incomplete; 'secondary' outcomes such as reduced distress or self-defined recovery may be valued more highly than symptom reduction alone by many patients, and such outcomes are increasingly well measured in CBT trials.[5] Future meta-analyses of CBT will contribute more meaningfully to our understanding of its effectiveness by examining these wider outcome domains and acknowledging their value as long-term benefits.

Declaration of interest

R.E.B. was a member of the National Institute for Health and Care Excellence guideline development group 'Psychosis and schizophrenia in children and young people', and is involved in National health Service-funded CBT for psychosis research.

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