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POUR LA RECHERCHE

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BULLETIN DE LA FÉDÉRATION FRANÇAISE DE PSYCHIATRIE

Editorial

- Comité de Rédaction -

Suivi du Réseau de Recherches Fondées sur les Pratiques Psychothérapiques

● Depuis la sélection, en 2008 par l'Inserm, du projet de *Réseau de Recherches Fondées sur les Pratiques Psychothérapiques*, *Pour la Recherche* a présenté sa mise en place, sa méthodologie, ses outils d'évaluation, des études de cas individuelles, des résultats préliminaires...

Une partie importante de l'activité du Réseau a concerné la présentation de posters dans différents colloques internationaux. Ces posters constituent une synthèse précieuse du travail qui a été réalisé par étapes. Ils renseignent également sur les thèmes émergents des congrès consacrés à la recherche psychothérapique dans lesquels ils ont été sélectionnés et discutés. Dans le cadre de ces présentations et des échanges qui les ont accompagnées, des liens se sont tissés sur des sujets d'intérêt commun. Ils se poursuivent aujourd'hui, directement et à partir du réseau en ligne *ResearchGate.*

La mise en page des posters suit la chronologie de leur affichage dans les congrès. Ils sont restés dans la langue de leur présentation (anglais). L'ensemble témoigne de la dynamique qui s'est engagée pour une véritable recherche clinique dans laquelle des cliniciens et des chercheurs, soutenus par différentes institutions, peuvent travailler ensemble. L'adage suivant lequel « Le mouvement se prouve en marchant » se trouve ici confirmé.

Les dix posters présentés sont les suivants :

2007 - From intensive naturalistic single case studies to a practice-based research network in France. Madison (Wiscontin).

2008 - French Psychotherapy Practice Research Network (présentation de la méthodologie du réseau. Barcelone) (Espagne)

2010 - 1. Bridging the gap between practice and research

2. From systematic case studies to their aggregation in a database. Comparative analysis and metasynthesis. Asilomar (Californie)

2011 - 1. Why and how a psychotherapy works? Three complementary levels for analyzing the process of change in 20 intensive case studies of autistic children.

2. Case formulation in a Practice-Based Research Network. Is standardization compatible with complexity ? Bern (Suisse)

2012 - 1. High emotional modulation insufficiency and ajustment of the therapist's attitude for children suffering from autistic disorder. Colloque international IRIA (Tours)

2. Change mechanisms in psychotherapies of 41 children suffering from Autism Spectrum Disorders (ASD). Virginia Beach (Virginie)

3. Does case formulation predicts the change process in psychotherapy? Contribution of 15 pragmatic cases studies of borderline patients. Virginia Beach (Virginie).

2014 - Modeling processes, mechanisms and conditions of changes. Jean-Michel THURIN Inserm U 669. ED3C : Cerveau, Cognition, Comportement

Le Réseau poursuit son activité avec l'inclusion de nouveaux cas, l'approfondissement de l'analyse des données, la mise en place d'une formation en ligne aux instruments et l'ouverture de trois Web-séminaires dont l'objectif est de présenter, discuter et théoriser l'apport des études fondées sur les pratiques et leur contribution à la construction de la « preuve ». ●

From intensive naturalistic single case studies to a practice-based research network in France

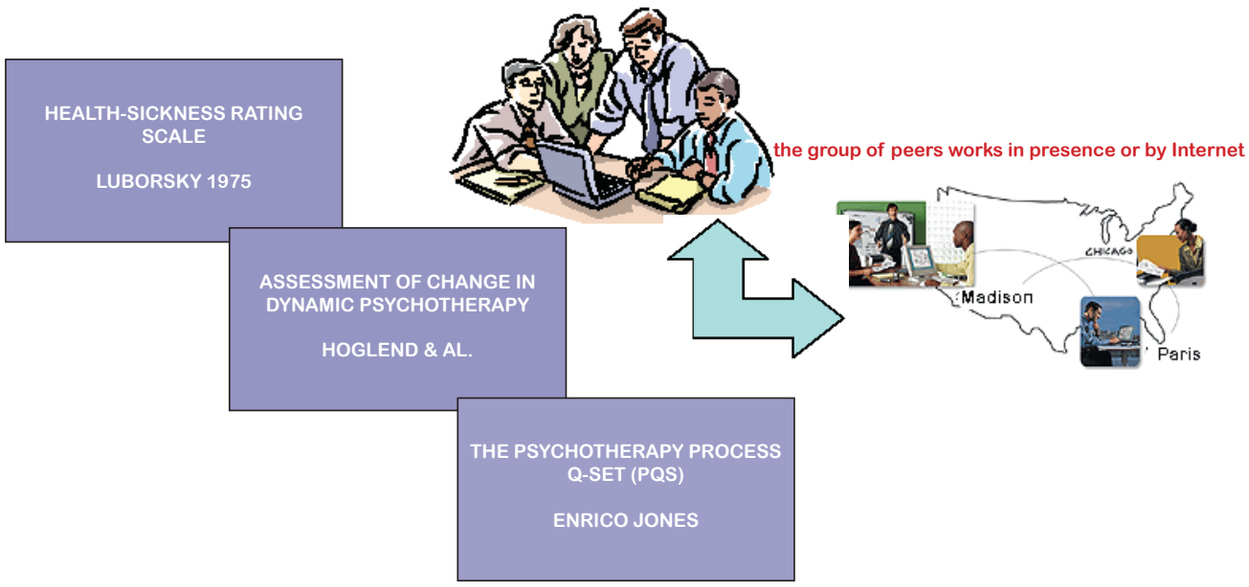
The methodology is based on intensive single-case studies of complex disorders' psychotherapies.

Quantitative and qualitative data are associated for the definition of the diagnostic, as well as initial, intermediate and final measures. Process analysis is used to describe at different moments in time the main characteristics of the on-going psychotherapy. It is thus possible to gain access to what is really done during the therapy, and not only to what is supposed to be done, based on a manual or even the name of the theory used by the therapist.

This methodology was tested during a one year pilot study, in real conditions of psychotherapy with outpatients. Observation, formalization and data analysis are integrated in a coherent iterative process during the whole therapy. Various tools (ESM, PQS, Hoglend's scales, DSM) are used as well as a case formulation, at the beginning and the end (or 1 year) of psychotherapy..

This protocol constitutes the first level of a more important project. A practice-based research network structured by peers groups and a database designed to collect and analyze the data constitute the second level of the project.

This framework is offering two possibilities at the same time : it provides therapists with the ability to follow the evolution of their cases, and to compare them with similar cases. It provides researchers with the ability to drive true comparative analysis, based on psychotherapies done in real situations, and on detailed enough descriptions to get significant outcomes.



SPR - Madison (Wisconsin) - 2007

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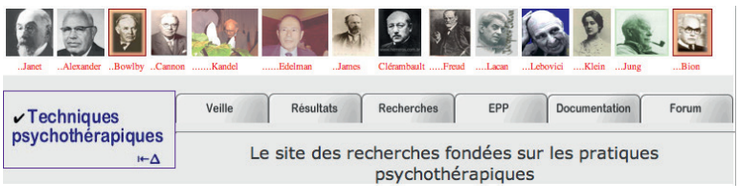
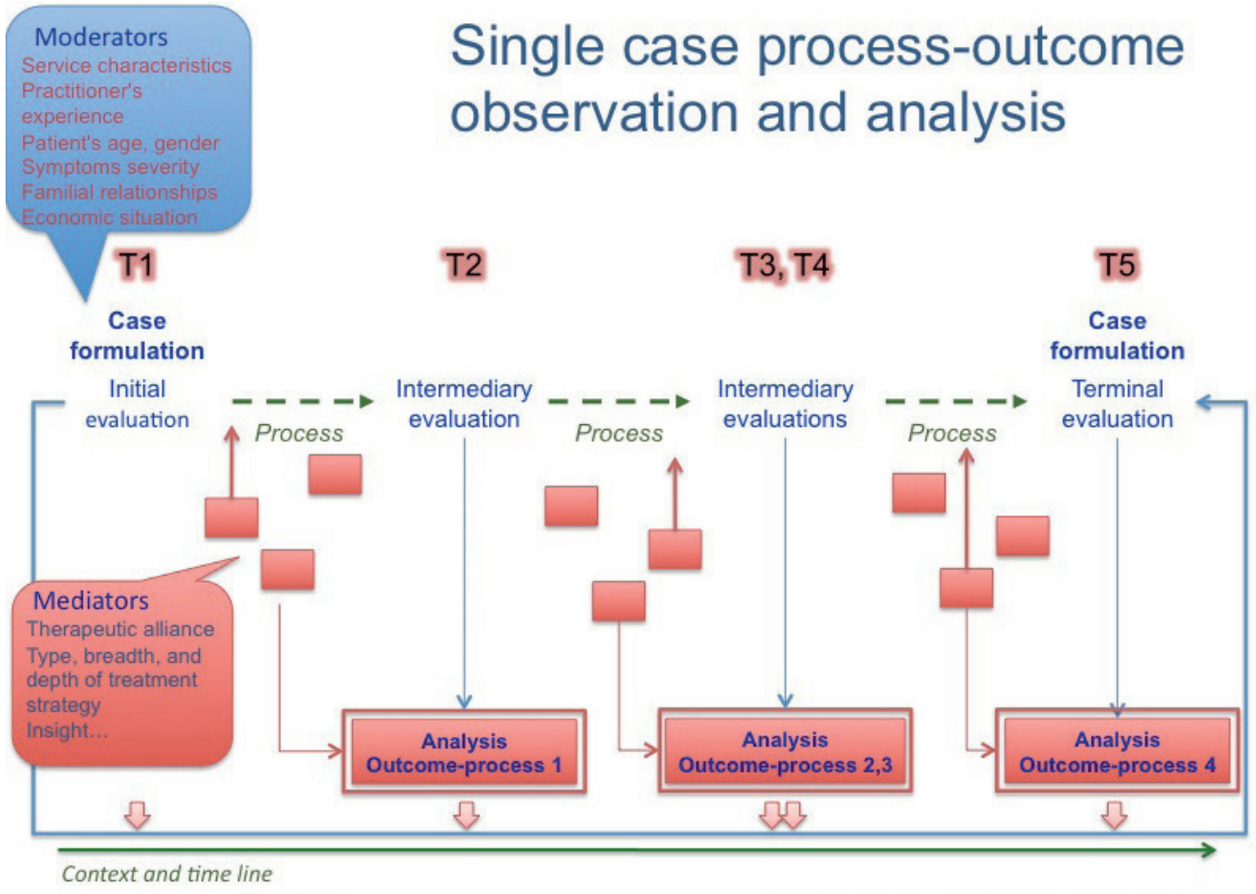


French Psychotherapy Practice Research Network

Objectives : Studying outcome and mechanisms of change in naturalistic therapies for three major clinical problems : ● Self-damaging or mutilating acting processes at adolescents and adults with borderline personality disorder ● Development and emergences in the psychotherapy process of children with autistic syndrome ● Behavioral problems of Alzheimer patients.

Method : Prospective, longitudinal, observational study of more than 300 cases of patients from 150-300 clinicians working in peer's groups. Case formulation by clinicians and standardized assessments from verbatim and audio data. Comprehensive analysis of process with *Psychotherapy Process Q-sort* (Jones) and of functioning with *HSRS* (Luborsky) and *Psychodynamic Functioning Scales* (Hoglend). Analysis of data using differences between analogous cases, statistical mediation approach and chronological changes.



Design

1. Systematic case studies
   - peers groups
     - 3 clinicians
     - 1 clinician = 2 cases
   - duration : 1 year
   - standardized assessment from verbatim and audio data
   - Content's analysis (exploratory) and statistics (confirmatory)
2. Comparative studies between analogous cases

1. Variables to be explained
   - Borderline patient's self-damaging or self-mutilating acting processes
   - Autistic patient's developmental evolution
   - Alzheimer patient's behavior or depression disorders
2. Explanatory variables
   - Quality of therapeutic alliance
   - Success of a targeted intervention
   - ...

Systematic case studies are related to a descriptive epidemiological study

Indicators and instruments

for borderline patients

Functioning indicators (10)

1. Autonomy
2. Symptoms' severity
3. Suffering and subjective distress
4. Consequences of the state of the patient on the entourage
5. Ability to use capacities, in particular in work
6. Quality of the interpersonal relationships
7. Width and the depth of the interests
8. Expression and emotional tolerance
9. Insight
10. Problem's resolution and capacity of adaptation

Functioning Instruments

Health-Sickness Rating Scale. Luborsky 1975

Pychodynamic functioning scales. Hoglend P. & al. 2000

Process indicators (6)

1. Self representation, ability to think
2. Psychic conflictuality
3. Therapeutic alliance
4. Involvement in therapy
5. Defense mechanisms and coping abilities.
6. Therapeutic action

Process Instruments

Psychotherapy Process Q-set, Jones E., 2000

Child Psychotherapy Q-set, Schneider C. 2006

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● *The network is coordinated by Bruno Falissard & Jean-Michel Thurin*

French Psychotherapy Practice Research Network

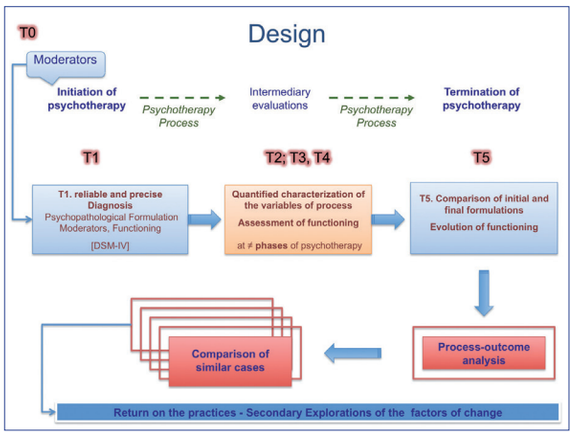
From systematic case studies to their aggregation in a database. Comparative analysis and metasynthesis

● **The methodology** is based on intensive single-case studies of complex disorders' psychotherapies.

Quantitative and qualitative data are associated for the definition of the diagnostic, as well as initial, intermediate and final measures. Process analysis is used to describe at different moments in time the main characteristics of the on-going psychotherapy. It is thus possible to gain access to what is really done during the therapy, and not only to what is supposed to be done, based on a manual or even the name of the theory used by the therapist.

Observation, formalization and data analysis are integrated in a coherent iterative process during the whole therapy. Various tools are used as well as a case formulation, at the beginning and the end (or 1 year) of psychotherapy..

This framework is offering two possibilities at the same time : it provides therapists with the ability to follow the evolution of their cases, and to compare them with similar cases. It provides researchers with the ability to drive true comparative analysis, based on psychotherapies carried out in real situations, and on detailed enough descriptions to get significant outcomes.



Borderline Pole

● **Functioning indicators (10)**

Autonomy, Symptoms' severity, Suffering and subjective distress, Consequences of the state of the patient on the entourage, Ability to use capacities, in particular in work, Quality of the interpersonal relationships, Width and the depth of the interests, Expression and emotional tolerance, Insight, Problem's resolution and capacity of adaptation.

Process indicators (6)

Attitude, behavior or experience of the patient, therapist actions and attitudes, nature of the interaction of the dyad, climate or atmosphere of the encounter.

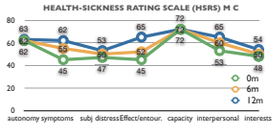
Functioning and Process Instruments

- Health-Sickness Rating Scale. Luborsky 1975
- Pychodynamic functioning scales. Hoglend P. & al. 2000
- Psychotherapy Process Q-set, Jones E., 2000
- Child Psychotherapy Q-set, Schneider C. 2006

PSYCHOTHERAPY M C - LONGITUDINAL CHANGES (1 YEAR)

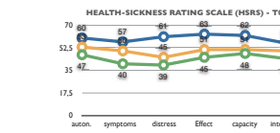
NAME : M C. **YEAR :** 2008 **PEERS GROUP :** M Thurin, F Journet, M Malempré

HEALTH-SICKNESS RATING SCALE (HSRS) M C



HSRS	0M	6M	12M
Autonomy	62	62	63
Severity symptoms	45	55	62
Subjective distress	47	50	53
Effect/entourage	45	52	65
Capacity	72	72	72
Interpersonal Rel.	53	60	65
Interests	48	50	54

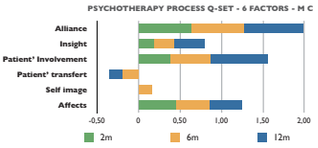
PSYCHODYNAMIC FUNCTIONING SCALES (PFS) M C



PFS	2M	6 M	12M
Quality family R	51	52	61
Quality friendships	60	62	70
Qu. romantic/sexual R	58	63	68
Tolerance for affects	43	60	70
insight	58	63	74
Pb solving/adaptation	61	66	66

PSYCHOTHERAPY PROCESS Q-SET - 6 FACTORS AND TECHNIQUE T

PSYCHOTHERAPY PROCESS Q-SET - 6 FACTORS - M C



PQS - 6 FACTORS	2M	6M	12M
Alliance	0,63	0,64	0,71
Insight	0,18	0,25	0,36
Patient' Involvement	0,38	0,48	0,70
Patient' transfert	0,00	-0,20	-0,16
Self image	0,00	0,16	0,00
Affects	0,45	0,40	0,40

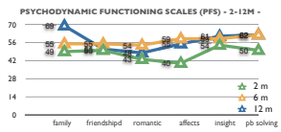
N°	ITEMS VERY CHARACTERISTIC (PQS) - M C. (1 YEAR)
23	Dialogue has a specific focus.
33	Patient talks of feelings about being close to or needing someone.
63	Patient's interpersonal relationships are a major theme.
24	Therapist's own emotional conflicts dont' intrude into the relationship.
51	Therapist conveys by his manner, tone of voice, or comments, that he does not assume an attitude of superiority.
12	There are few silences during the hour.
25	Patient begins hour directly without lengthy pauses or prompting questions from the therapist
15	Patient is willing to break silences, or supplies topics, and actively pursues or elaborates them.

PSYCHOTHERAPY 8 BORDERLINE PATIENTS - LONGITUDINAL CHANGES (1 YEAR)

HEALTH-SICKNESS RATING SCALE (HSRS) - T0 -> T 12M

HSRS	2m	6m	12m
Autonomy	47	53	60
Severity symptoms	40	50	57
Subjective distress	39	45	61
Effect/entourage	45	51	63
Capacity	48	51	62
Interpersonal Rel.	44	50	56
Interests	40	46	54

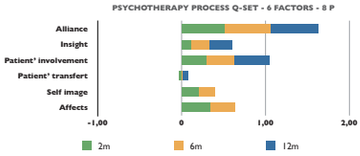
PSYCHODYNAMIC FUNCTIONING SCALES (PFS) - 2-12M -



PFS	2m	6m	12m
Quality family R	49	55	69
Quality friendships	50	55	51
Qu. romantic/sexual R	43	54	48
Tolerance for affects	40	59	55
Insight	54	59	61
Pb solving/adaptation	50	62	62

PSYCHOTHERAPY PROCESS Q-SET - 6 FACTORS

PSYCHOTHERAPY PROCESS Q-SET - 6 FACTORS - 8 P



PQS - FACTORS	2M	6M	12
Alliance	0,51	0,54	0,58
Insight	0,11	0,21	0,28
Patient' involvement	0,29	0,33	0,43
Patient' transfert	-0,03	0,01	0,06
Self image	0,20	0,19	0,01
Affects	0,34	0,29	0,00

N°	ITEMS VERY CHARACTERISTIC (PQS) - 8 CASES BORDERLINE (1 YEAR)
63	Patient's interpersonal relationships are a major theme.
6	Therapist is sensitive to the patient's feelings, attuned to the patient ; empathic.
69	Patient's current or recent life situation is emphasized in discussion.
9	R Therapist is responsive and affectively involved.
24	R Therapist's own emotional conflicts do not intrude into the relationship inappropriately.
77	R Therapist's comments reflect kindliness, consideration, or carefulness.
15	R Patient is willing to break silences ; is activ.
51	R Therapist does not assume an attitude of superiority.

Preliminary results M C.

◗ **Level 1 -** Functioning and symptoms (HSRS - PFS)

Scores are in constant progression, except one which remains stable but was high at the beginning : « Adaptive capacity » (61-67). One notes a clear progression for « Tolerance for affects » (43-70), « Insight » (58-74), « Gravity of symptoms » (45-62) and « Consequences for entourage » (45-65).

◗ **Level 2 -** Psychotherapy process (PQS). Crucial factors are : A good and increasing alliance (0,63-0,71) ; a strong involvement of the patient (0,38 to 0,70) ; Insight evolves moderately (0,18-0,36) ; negative affects (anxiety/depression) remain quasi constant (0,45-0,40) and constitute a significant moderator.

According to the specific criteria from the PQS, the therapist used a psychodynamic interpersonal approach during this first year of psychotherapy.

◗ **Level 3 -** Evolutions of Case formulation are : Persistence of the tendency in the overflow and the abandonic strategies but in a less intense way. Improvement of the capacities of introspection. Better control of aggressiveness, less recourse to the splitting of the object, less systematic projection. Absence of new violent acting out. The therapist ensured a empathic presence. He avoided (too much) active and interpretative interventions. Subjective discomfort remains an important problem. A vigilance with the separations must be maintained.

Preliminary results (8 cases)

◗ **Level 1 -** Functioning and symptoms (HSRS - PFS)

The scores of the different dimensions are in constant progression. The most important improvements are: « Gravity of symptoms » (40-56,5), « Subjective distress » (38,9-60,8), « Consequences for entourage » (45,6-63,4), « Quality of relationships », in particular Family R (49-63) and « Tolerance for affects » (40-54,5).

◗ **Level 2 -** Psychotherapy process (PQS). Three factors are increasing : « Alliance » (0,51-0,58) ; « Patient's Involvement » (0,29-0,43) and « Insight » which remains weak (0,1-0,3). Two factors are reducing to 0 : « Negative affects » and « Self image » expression. The transfert of the patient towards the person of the therapist is not mobilized.

According to the specific criteria from the PQS, the therapist used a psychodynamic interpersonal approach during this first year of psychotherapy.

◗ **Level 3 -** Correlations of factors with outcome. The scores of the different symptomatic and functional dimensions, and crucial process operations have a parallel linear evolution.

◗ **Level 4 -** Examination of individual differences (outcome, factors and moderators) : not presented here.

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French Psychotherapy Practice Research Network

Bridging the gap between practice and research

● **French Federation of Psychiatry**

The FPP was founded with the support of Inserm in 1992 to develop research in all the fields of psychiatry and the mental health. It congregate the scientific societies of psychiatry. It is the privileged interlocutor of the Institutions of health. It is in relation with the professionals and associations of users from the field of the mental health. http://www.psydoc-france.fr/

● **U 669**

The U 669 is an INSERM unity whose themes of research are centered on the mental health with an approach of public health. Three research orientations are privileged: 1. conducts of destruction of oneself or others ; 2. evaluation of the practices and the treatments ; 3. methodological innovation in mental health research. http://www.u669.idf.inserm.fr/

The evaluations are validated by peers groups, in the working institution or remotely via new Internet technologies

● **Psychotherapists** : More than 200 clinicians are members of the Network (French, Italians, English and ...1 from New York). 50 Peers Groups are functioning (3 clinicians by group).

Clinicians follow their patients as usual, with their own technique, psychodynamic, interpersonal, behavioral and cognitive, systemic ….

They realize an intensive study of the psychotherapy of one of their patients in natural conditions during one year.

Patients :The program is focused on 3 populations of patients : autism and pervasive developmental disorders, borderline disorders,Alzheimer. 112 patients are included (43 females and 69 males).

● **1 peers group = 3 clinicians**

- Each clinician uses individually the evaluation instruments
- In the peers group, he or she confronts his measures with those of his peers
- If these measures are different, the peers come back to the clinical data
- The clinical discussion leads to a consensual measure.

DIFFICULTIES	INITIATIVES and SOLVING
Reserved opinion of the clinicians and particularly of the psychoanalysts towards evaluative research. Interrogation of the research ' organizations about the possible participation of the clinicians.	With the experience of the Inserm ' Collective expert report, analysis of the limits of RCTs and search for an alternative; extensive bibliographical review; choice of a process-outcome research methodology based on controled single case studies ; Constitution of a liaising group between psychoanalysts of different associations approving a demarche of evaluation compatible with the psychodynamic approach ;realization a one-year pilot study, in true conditions of psychotherapy with outpatients ; extension of the methodology to aggregation of cases and their comparison in a network organization; answer to the call of proposals of Inserm ; publication of articles and a book; creation of an organizational structure binding Inserm U 669 and French Federation of Psychiatry with participation of psychologists.
Initial representation of the clinicians of the difficulty of research.	Redaction of articles and conferences towards different journals, scientific societies, mental health institutions, and groups ; presentation of the general situation of psychotherapy research, of the proposed methodology and instruments; Creation of an Internet site and regular publication of the Bulletin «Pour la Recherche» dedicated to psychotherapy research and the activities of the network.
Absence of formation for clinicians to the instruments of evaluation and to informatics.	Regular training meetings and problems solving; publication of the instruments and/or their presentation on Internet; formation and support for informatics usage.
Appropriation of the methodology by the clinicians, quality of quotations and interrater reliability.	These potential problems were solved by the creation of peers groups ; each clinician and two colleagues realize an individual quotation of one of his patients ; the secondary comparison of these measures in peers groups and search for a consensus are the occasion of a very thorough clinical discussion starting from the data, a time which is very appreciated by the clinicians ; an accompaniment of the groups and a follow-up of coherence of the results are associated to this process.
Cost of time attributed to research and geographical distances between participants.	Use of the institutional possibilities; possibility of remote meetings with the new Internet technologies; cognitive and clinical interests of the research for the practitioners.
Diagnostic, international classifications and psychopathology	Adjonction to the DSM/ICM diagnostic of a case formulation opened to the different theories and psychotherapeutic approaches ; Training to the case formulation.
Data analysis	Weekly meetings of clinicians and statisticians; collaborative construction of the data analysis ; choice, test and usage of several softwares of data analysis ; comparison of the results.

● **Coordinators : Jean-Michel Thurin and Bruno Falissard**

Institutions : Inserm Unity U 669 and French Federation of Psychiatry

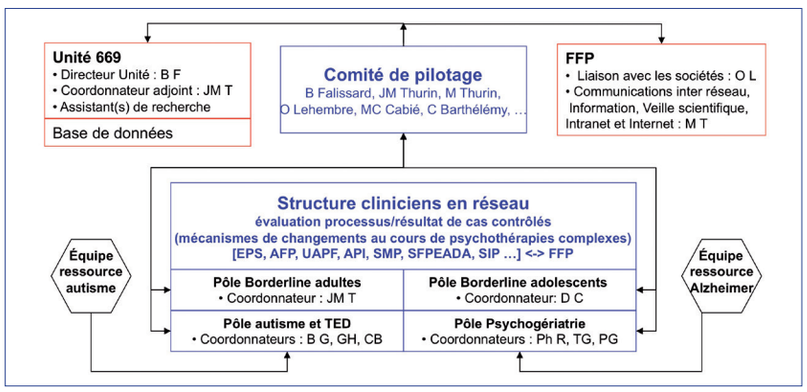
Financial support : National Institute of Health and Medical Research - Head Office of Health

Steering commitee : Dr Jean-Michel Thurin, Pr Bruno Falissard,

Mme Monique Thurin, Pr Bernard Golse, Pr David Cohen, Pr Catherine Barthélémy, Dr Geneviève Haag, Dr Marie-Christine Cabié, Dr Olivier Lehembre, Pr Philippe Robert, Dr Thierry Gallarda, Dr Philippe Guillaumot, M Didier Mellier

Methodology and data analysis : Jean-Michel Thurin, Monique Thurin, Tiba Baroukh, Bruno Falissard (U669)

http://www.techniques-psychotherapiquesorg/Reseau/



French Psychotherapy Practice Research Network

Why and how a psychotherapy works?

Three complementary levels for analyzing the process of change in 20 intensive case studies of autistic children

I. Single Case Intensive Process-Outcome Observational Method

Merlin is five years old when the evaluation of its psychodynamic psychotherapy begins (2 sessions per week), but this work began two years earlier. He is diagnosed of moderate autism. At the time of the case formulation, it is noted that it does not have the language, that he presents an absence of autonomy, food disorders, behavioral problems (aggressiveness, agitation, stereotypies) and a strong withdrawal in the relation. Merlin suffers moreover from an important somatic disease, which involved many hospitalizations. He lived one complicated period with his birth because his mother had to be brutally hospitalized, whereas he was fifteen days old.

- ***CARS (Childhood Autism Rating Scale of Barthelemy) at 0, 2, 6 and 12 months***
  - **Total score: 52, 29, 22, 8 ; Relational deficiency: 50, 23, 17, 0 ; Modulating insufficiency: 67, 25, 17, 25**
- ***APEC (Autism Psychodynamic Evaluation of Changes of Haag and al.) at 0, 2, 6 and 12 months***
  - **1. Emotion relationship:** Expression of infantile power (3,3,2,3). Improvement of reciprocity with search for truth interpersonal exchanges (2,2,2,3).
  - **2. Glance:** Seeks glance of the other with joint attention (2,2,3,3). Development of proto declaratory pointing (0,1,3,3).
  - **3. Image of the body:** Acquisition of cleanliness (0,0,0,3). Seek of "face to face exchange" with a space between the two bodies (2,1,1,3). Confirmation of mirror stage (0,1,2,2).
  - **4. Verbal language:** Existence of a socialized gestural language. Articulation of two words (0, 2,3,3). Improvement of prosody (0,0,2,3). Capacity of saying NO.
  - **5. Graphism:** Possible graphics on a detachable support. Installation of forms, catch tadpole. Closing of the circle.
  - **6. Exploration:** Interest for double objects, comparison similar/not similar (1,0,2,3). Play of "hide-and-seek" (2,2,2,3). Appearance of symbolic plays (1,1,2,2).
  - **7. Temporality:** Oscillating time, control of restarting, belief of reversibility. Better tolerance with the separation.
  - **8. Aggressiveness:** Auto and hetero aggressiveness (2,0,0,0). Attempt at aggressive control of others (2,1,0,0).
- ***CPQ (Child Psychotherapy Process Q-set of Schneider and Jones***

Which was always salient in psychotherapy (+4, +3, -4,-3)

- The child: engages himself in the play of "making believe"
- The therapeutist: tolerates the affect or the violent impulses of the child, interprets the significance of the play of the child. His emotional conflicts do not interfere in the relation.
- Interaction: nothing "very" characteristic.

Which was always not extreme (+2, -2)

- The child: transmits or tests ambivalent or conflictual feelings ; expresses little fear or a phobic behavior ; expresses little anger or aggressive feelings ; is not sad nor depressed.

One year later … **Merlin** acquired cleanliness. The language entered a true phase of acquisition, with problems of grammar.

Socialization remains a problem, as well as the difficulty of tolerating the failure.

Merlin always is not aware of the danger.

He has many obsessional defenses. He expresses his emotions and moments of unhappiness. Defenses remain to be softened as well as the development of his imaginary world, the symbolic plays miss fluidity.

Psychotherapy continues...

II. Individual-Case-Comparison Method

variation score	66	31	8
Moderators	**Merlin**	**Child 2**	**Child 3**
Age	5 years	6 years	4 years
Gender	M	M	M
Psychotropic drugs	not	not	not
Somatic disorders	Yes (current)	No	Yes (2,9)
Psychotherapy Approach	Psychodynamic	Psychodynamic	Exchange and development therapy
Sessions	2 x week - 45mn	1 x week - 45mn	2 x week - 15-25mn
Working with family	Yes	Yes	Social parents follow-up
Former diagnosis	Moderate autism	Severe autism	Severe delay associated with autistic disorder
ICD 10	F 84-0	F 84-0 F 84-0	F 84-0 :F71:281-0; 263-5
Former treatments	Psychotherapy by same therapist	Day hospital	Kinesitherapy, then psychomotricity
Other treatment	Speech therapy 2 / week: 30mn	speech T, psychomotricity, water basin	psychomotricity
Schooling	Yes, partial with AVS	Yes,1/2 J /W with AVS	Yes, 2 ½ D/Week
Social, familial, former treatment contexts	Psychotherapy for 2 years. Collaboration with other therapists. Good collaboration with parents.	Initial daily hospitalization with his brother also autistic, then separated from him. Severe family pathologies.	Familial violence and divorce. Older sister's support. Good integration in halt nursery. Hospitalized for worsened mononucleosis with dyspnea.

Merlin

- **With CARS**, a regularly downward curve (60 -> 9 (max 100)).
- **With APEC**, reduction of pathology (22 -> 6) and gain of development (37 to 62 (max 100)).
- **With CPQ**, a strong ***alliance*** (22) implying the child, the therapist and their interaction.
- ***Other mediators*:** high score of technic actions (affect expression (23.6), interpretation (25)), average score for communication and language, negative score for advices and behavior.
- **About moderators ?**
  - Very early diagnosis and treatment.
  - Very good collaboration with partners and family.

Child 2

- **With CARS**, a score reduction of 15 points (56-41).
- **With APEC**, elevation of the development score (17-32).
- **With CPQ**, a strong ***alliance*** (31) with a significant commitment of the child (20), a very strong commitment and adjustment of the therapist (49 and 65), a positive interaction (12,5).
- ***Other mediators*:** rather important scores of technic actions language communication (27,4) and emotional expression (14,3) factors ; medium score for interpretation-significance (9,4) and negative score for advices and behavior (-15,8).
- **About moderators ?**
  - Early diagnosis.
  - Maternal depression. Difficult birth context.
  - Depressed child.

Child 3

- **With CARS**, a weak variation (43-33).
- **With APEC**, lower pathology (23 -> 16) and significant drop of development (16 -> 3) (to be re-examined).
- **With CPQ**, a weak ***alliance*** (10), with a negative commitment of the child, a strong commitment and adjustment of the therapist (21 and 27), a negative interaction.
- ***Other mediators*:** Very weak emotional expression (1.4), very weak communication language score (- 34), weak interpretation-significance (6) and significant for advices and behavior (27.5).
- **About moderators ?**
  - Important somatic problem with hospitalization.
  - Very important problems of family violence and parental divorce.

III. Class-Case-Comparison Method

Analysis steps

1. **Definition of a general score** of evolution for each case (reduction of pathology + developemental gain).
2. **Extraction of classes** in change trajectories.
3. **Correlations of trajectories with mediators and moderators** of

Mediators

1. alliance with 6 under-factors: Child's involvement, transfer, participation to activities, Therapist' involvement, adjustment, C-T interaction
2. emotion and affective capacity,
3. communication and language,
4. Interpretation and significance,
5. advices and behavior.

Moderators

- delay of diagnosis and treatment beginning,
- comorbidities,
- difficult developmental context,
- traumatic events,
- quality of familial and psychosocial support.

First observations from 20 cases

Do the changes exist and of which nature are they?

- On average, they exist and are important. They relate to the behaviors (average improvement of) and the development (improvement of)

Are the changes of the same importance for all the children?

- No, the evolutions are variable. According to our total score, they vary from 74 to -5 points. Four classes of variations were thus isolated: strong, average +, average - and weak.

Which are the factors that can explain these differences?

The approach (psychoanalytical or cognitivo-behavioral)?

- Not as a single factor. This distinction is distributed since the most important evolutions until the least important.

The initial gravity of the case?

- Perhaps for a share, but in a paradoxical way. In our population, more serious is the case, more the scores varied at one year.

The therapeutic alliance?

- Yes to some extent, 3 of the 4 children who had the best evolution locate in the first third of the highest alliances. The highest under-factors are transfer, therapist' involvement and adjustment.

The technical factors "pivot factors"?

- That which seems to play the most important part is second (ECA).

The moderators?

- The quality of the family support seems to have played a significant role.

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French Psychotherapy Practice Research Network

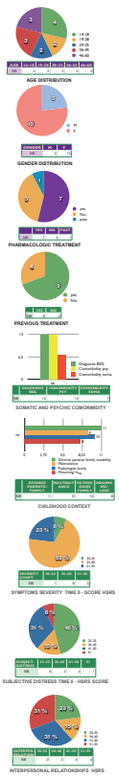
Case formulation in a Practice-Based Research Network. Is standardization compatible with complexity ?

Three questions

- Question 1: Which information respectively bring moderators, discourse analysis, DSM and case formulation?
- Question 2: Is this information common, complementary or divergent at a group of patients carrying the same diagnosis?
- Question 3: Are the case formulation and its standardization compatible with the complexity of the borderline disorder, in its organization and its variables?

Four presentations resulting from the first three clinical talks with a patient consulting a therapist

Moderators



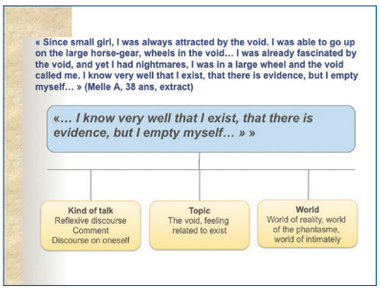
Discourse analysis

- Discourse analysis is focused on the object of the discourse in the patient and his way of meaning it :
  - by using different kinds of discourses (narrative, commentary, description...)
  - by accentuating some elements connecting a privileged topic
  - by locating the objects in a "world" : real, imaginary, current, past

This analysis allows a location on :

- Diagnostic elements : recurrent themes in the discourse. For example, depression, abondonment, interpersonal relationships, …
- Particular elements related to :
  - psychopathology
  - functioning
  - subjectivity : how the patient presents himself in his discourse through the figures of «I»
  - history : how the patient moves in his history when he tells himself : reference mark of the present as lived of the past, for example

Example of an extract of discourse



DSM

Axis DSM
Axe I
…
F45.4, F41.9, F43.2, F32.x...
Axe II
F60-31 - Bdl
F60.5, F60.8, F60.9...
Axe III
…
555.9, 346.20...
Axe IV
…
T74.1, T74.2,T74.0, Z63.0, Z63.8, F93.3...
Axe V
…
35 à 50
Common
Specific

Case Formulation at baseline

Axis	Criteria each axis	* Common * Informed/patient	Precise details
Axe 1 Current problems of the patient and their place in the context of its current life, its history and its development.	Current problems of the patient	Conflictual behavior causing a socio-familial isolation. Patient cannot function without assistance	Acting out or aggravation of a state (drug addiction, social withdrawal, event of life)
	Precipitating events	General feeling to be rejected or abandoned, overflowed	Died of parents or friends, aggressions, stress, incapacity to work, somatizations...
	Predisposing features	Psychic suffering	Stress, dependence, distress, depression
	Interpersonal relationships	Disturbed	More particularly family, friends or sentimental
	Symptoms and behaviors	Depressive elements	Self aggressiveness, food disorders, sleep disorders, distress abandonment, unhappiness, ...
Axe 2 Non dynamic factors which can have contributed to its problem.	Genetic problems	informed 4/13	
	Perinatal problem	informed 3/13	prematurity - maternal stress
	Social problems	Instability of the socio-familial setting	
	Family psychopatho.	Among all patients	
Axe 3 Synthetic integration of the available data opening with an interpretation of precipitating factors and influences which maintain the problems of the person.	Development	Informed 10/13	Psychological ill-treatment and physics expressed in childhood, sexual abuse...
	Psychical conflict	Informed 11/13	Dependance, problems of abandonment, ego ideal
	Family history	Deterioration or defection of family setting	
	Identity	Fragile identity base	
	Mechanisms of defense	Informed 11/13	Aggressiveness, avoidance, splitting, idealization
	Insight	Informed 8/13	poor
	Interpers. relationships	Disturbed	
	Emotional tolerance	Informed 7/13	Lack of control, sideration, little emotional expression
	Supporting elements	Informed 8/13	Investment expressed
Axe 4 First definition of goals and intermediate objectives of psychotherapy	Symptomatic objectives	Informed 7/13	Return of sleep, reduction of stress and anxiety...
	Functional objectives	Informed 10/13	Restoring self-confidence, working the acting, developing insight...
	Structural objectives	Informed 10/13	To build identity, narcissistic base, structuring of ego...
Axe 5 Strategy	Therapeutic approach	Informed 5/13	1 family, 4 psychodynamic
	Médiators	Informed 12/13	interpret/no interpret, narcissistic reinsurance...
	Setting	Informed 9/13	Very important

Comparative discussion of the presentations and response to our central question about case formulation

- **Moderators** bring recurring information in the group of the 13 evaluated patients borderline:
  - All have psychiatric comorbidities.
  - Half have somatic comorbidities.
  - Almost all have a very difficult context of childhood: instability of the familial setting, maltreatment, mournings and losses.
  - Severity of the symptoms is important (score of 45/100 at HSRS of Luborsky).
- **Discourse analysis** brings diagnostic and psychopathological information about the links which the patient establishes between the topics that he approaches, through his way of meaning them and of locating them in his worlds.
- **DSM IV** confirms the data resulting from the moderators and the discourse analysis:
  - Axis 5 notes a score from 35 to 50 for the whole of the patients.
  - The only common axis to all the patients is axis 2 concerning the diagnosis of personality borderline.
- **Case Formulation** makes it possible to build a synthetic representation of the complexity which associates the problems of the patient with his history and the organization of its functioning, as well as the way in which they are translated into objectives and strategies by the therapist.

We announced in red the elements present among all patients. It is in addition indicated in this column the number of patients for whom information was filled by each peer group carrying out the evaluation.

Concerning **the strictly similar data**, the patients present all with a conflictual behavior causing a social and familial isolation so important that they cannot function without assistance. They have the general feeling to be rejected or abandoned, overflowed. They express a psychic suffering, their interpersonal relationships are disturbed and they all present depressive symptoms. In addition, their history is marked by an unstable socio-familial setting and their identity base is fragile.

The clinicians strongly insist on the attention to the setting, as one of the strategies to carry out the objectives which they set in the short or medium term.
The column "Precise details" describes the aspects specific to the various patients.

- These elements bring a standardized description of the clinical and psychopathological situation of the patient as well as of the therapeutist strategy. This description is anchored on 22 key words and standardisable. This first analysis will be to confirm with the other cases which are in the course of evaluation.

Case formulation at one year of psychotherapy

- This new case formulation made it possible for the clinicians to define the modifications which have occurred in four of the 5 axes concerned. We report here, the most common elements of the group of evaluated patients. They confirm that the standardization is compatible with complexity, without evacuating the individual elements.

Axis 1: The current problems of patients are centered by school failures, professional projects and drug-addiction (improved but still significant). One notes a movement towards outside. As a whole, a reduction of acting out, the stop of scarifications are found among several patients, as well as a less important gravity of the symptoms. Some of which persist however like anxiety and depression… The interpersonal relationships are improved, but reach different qualities. They remain sensitive.

Axis 2 et 3 : Few significant elements noted by the clinicians, except within the supporting factors where a movement of the patient towards a more important positive implication in its relations is described.

Axe 4 : The symptomatic goals were achieved on the level of a significant "appeasing" of the various symptoms. The functional objectives are less significant, but it is noted a movement towards the improvement. Even for a patient who wished to leave the treatment in one paranoid tranferential living, the conflict with the parents disappeared and there were less actings out… The structural objectives are less perceptible by the therapists, which seems coherent after only one year of therapy with cases whose gravity is manifest.

Axe 5 : As for the structural objectives, the therapists did not express themselves much concerning their strategy with mediators such as "to interpret / not to interpret". These elements are observable with the process instrument and this axis should be the object of a special attention for the future cases. Concerning the strategies, the setting was maintained throughout this year and as sometimes the therapists say it with difficulty "but it resisted"…

- To answer our three questions, the information brought by the moderators, the discourse analysis, the DSM and the case formulation are at the same time different and complementary. Significant elements are common to the whole of the patients of the group. The case formulation and the discourse analysis bring specific information on the organization of functioning, the dynamics of the evolution and its points of anchoring. It is compatible with a complex disorders such as borderline and standardisable.

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French Psychotherapy Practice Research Network

Change mechanisms in psychotherapies of 41 children suffering from autism Spectrum Disorders (ASD)

Measures

BSE *(Behavioral Summarized Scale of Barthelemy) at 0, 2, 6 and 12 months*

Explores the various domains of the autistic child's behavior: social withdrawal, verbal and non verbal communication, adaptation to environmental situations, tonus, motility, affect, shady reactions of the main instinctive functions, attention disorders, perceptions and intellectual functions.

APEC *(Autism Psychodynamic Evaluation of Changes of Haag and al.) at 0, 2, 6 and 12 months*

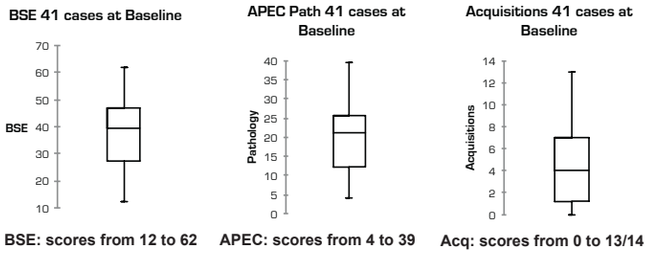
Describes the development of the autistic child during 5 evolutionary stages in 7 dimensions: emotional expressions in the relation, glance, image of the body, verbal language, exploration of space and objects, temporal location, aggressive demonstrations

CPQ *(Child Psychotherapy Process Q-set of Schneider and Jones) at 2, 6 and 12 months*

A common language to describe, classify and quantify the process of therapy from 100 items. Each item is designed to be observable, avoid references to a specific theory. It is intended to be largely neutral and can be used for any therapy. CPQ includes 3 types of items: 1- elements describing attitudes, feelings, behavior or experience of the child, 2- elements describing the actions and attitudes of the psychotherapist, 3- elements concerning the nature of the interactions within the dyad, the climate or the atmosphere of the session.

Baseline: diversity of the cases -

1. Pathology and development



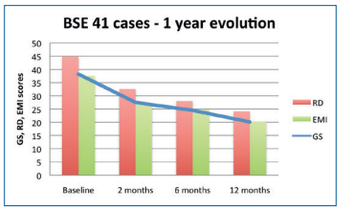
BSE: scores from 12 to 62 **APEC: scores from 4 to 39** **Acq: scores from 0 to 13/14**

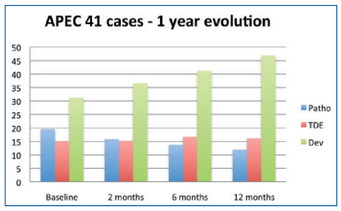
2. Moderators

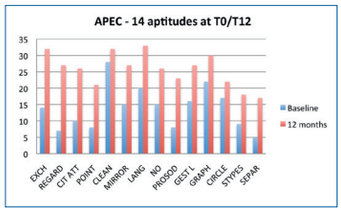
Age: 3-15 years, 22 of ≤ 6 years and 6 ≥ 12 years
Beginning of the treatment: 22 between 3-4 yrs, 12 between 5-6 yes, 7 between 7-13 yrs.
Context of development: easy for 16, difficult for 25
Context of trauma: absent for 18; at least one traumatic event for 23
Family support: 31 have a very good family support
Psychosocial support: 38 have a good psychosocial support
Parental support of psychotherapy: yes for 34
Psychic comorbidity: in 9 children (depression, panic, sleep, hyperactivity)
Somatic comorbidity: in 15 children (important sleep disorder, asthma,…)
Quality of technical support: good for all children
Schooling: for 35 children

Change Process

Outcome (BSE, APEC)





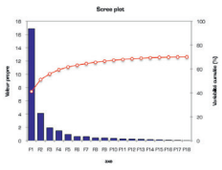


14 Aptitudes
Search of true exchanges (EXCH)
Regard with a good exchange (REGARD)
Search other's eyes for joint attention (CJT ATT)
Proto declarative pointing (POINT)
Cleanliness acquired (CLEAN)
Mirror stage (MIRROR)
Language acquired (LANG)
Emergence of No (N0)
Development of prosody (PROSOD)
Gestural language (GEST L)
Graphics acquired (GRAPH)
Closing the circle (CIRCLE)
Stereotypes (-) and symbolic play (+) (STYPES)
Time and tolerance to separation (SEPAR)

Process (CPQ)

Identification of most characteristic process descriptors

– Factorial analysis of mean scores (3, 6 and 12 months) of each CPQ item of each patient.
-> 4 factors F1 (41%), F2 (10%), F3 (4,7%), and F4 (3,6%)



Common factor F1 (CPQ)

Therapist
– is confident, self-assured, affectively engaged, sensitive to the child's feelings and accurately perceiving the therapeutic process.
– emphasizes feelings to help child experience them more deeply, tolerates child's strong affect or impulses and restrains from responding personally to provocation and disturbing material and also from overt or subtle negative judgments of the child.
– clarifies, restates, or rephrases child's communication and interprets the meaning of child' s play, his/her remarks are aimed at encouraging child's speech.

Child
– is active.
– conveys the sense that the therapist understands his experience or feelings
– seems to be unaware of his internal difficulties

Interaction
– His/her interaction with child is sensitive to the child's level of development and when the interaction with the child is difficult, s/he accommodates the child.
– Material of the hour is meaningful and relevant to child's conflicts.

Specific factors F2, F3 and F4

- Factor 2 (10% of variability)
  - Therapist has a psychodynamic approach
  - Child is attentive to social interactions, responds with a more developed play, comments or associations to the therapist's remarks.
- Factor 3 (4,7% of variability)
  - Child is curious, animated, engaged in verbal expression and play
  - S/he explores relationships and expresses mixed feelings about the therapist.
- Factor 4 (3,6% of variability)
  - Child expresses feelings, affects and emotions
  - Therapist models emotions and interprets transference
  - Multiple interactions between child and therapist during the session

Therapeutic alliance (patient's commitment and participation, therapist's commitment and adjustment, and their interaction), ACE (expression and awareness of the affects), CVL (communication, language and verbalization), PA (psychodynamic approach), CBT (cognitive behavioral approach), Insight, RRO (relation with reality and others) and EAD (working with emotion, affects, defenses) are also systematically evaluated.

Case to case comparison: one example

Impact of Insight and mediators on change trajectories

Similarities at baseline between Jade and Yann						
	Age	Acq	T	IPD	Psychot. Ant.	Support parents
Jade	5 years	8	ppd	2	2 years	Very good
Yann	5 years	7	ppd	2	2 years	Very good

Differences at Baseline					Similarities at 12 months		
	sexe	Soma comorbidity	BSE	EPCA Dev		Acq	BSE
Jade	F	no	16	55	Jade	14/14	7
Yann	M	yes	56	39	Yann	14/14	8

	SGV	F1	F2	F3
Jade	32	0,721	0,231	0,236
Yann	66	0,772	0,379	0,150

❍ **Jade et Yann are two children of the same age. They are both in psychodynamic psychotherapy for two years (CPQ validates this psychotherapeutic approach). Their overall score of change (change at BSE + change at APEC) is however very different: 32 for Jade and 66 for Yann. However, after one year of therapy, severity of symptoms (BSE: 7 vs. 8) is similar for two children, as well as for acquisitions (14 and 14)). How can we explain the process that allowed Yann fill his baseline handicap from Jade?**

What say the mediators of change?

Yann has an insight present from the start (+10), while it is very negative (-35) for Jade. Scores of EAD (working with Emotion, Affects, Defenses) and RRO (Relation with Reality and Others) are relatively strong in Yann (respectively 36 and 29) while they are respectively 0 and 6 for Jade.

What say the CPQ factors?

Patient's commitment and participation, and Therapist's commitment and adjustment scores are quite similar for both patients, as their interaction. However, both EAA (Expression and Awareness of the Affects) and CLV (Communication, Language and Verbalization) factors show differences in weight. They are higher for to Yann. (EAA: 24 vs. 13 and CLV: 18 vs. 1).

Psychodynamic and cognitive behavioral scores are equivalent for both children (psychodynamic: 68 and 68; cognitive-behavioral: -22 and -17)

In conclusion: the difference between the scores of overall variation of the two children can be explained by the fact that Yann, despite his higher level of autistic symptoms and lower development than Jade, benefited from this insight from the start of therapy. Mediators of change (EAD and RRO as well as ACE CVL) show a clear difference in both children. It would be the more developed ability of insight and therapeutic work focused on emotional expression, communication and language that allowed Yann to catch Jade, as shown by the final scores to a year of psychotherapy.

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French Psychotherapy Practice Research Network

Does case formulation predicts the change process in psychotherapy?

Contribution of 15 pragmatic cases studies of borderline patients.

Baseline case formulation : dimensions and elements common to the 15 cases

5 dimensions of Case formulation

Dimension 1
Current problems of the patient and their place in the context of her/his current life, history and development.

Dimension 2
Non dynamic factors which can have contributed to her/his problem.

Dimension 3
Synthetic integration of the available data opening with an interpretation of precipitating factors and influences which maintain the problems of the person.

Dimension 4
First definition of goals and intermediate objectives of psychotherapy

Dimension 5
Strategy

● Contribution of case formulation at Baseline

❍ **Informed for 100% patients**
- Instability of the social and family environment in childhood
- Self and identity fragility
- 0ppositional behavior causing social and family isolation with impossibility of functioning without help.
- General feeling of being rejected, abandoned or overwhelmed.
- Interpersonal relationships disturbed
- Psychic pain and depressive position

❍ **Informed for 87 % patients**
- Mechanisms of defense : Aggressiveness, avoidance, splitting, idealization
- Psychical conflict : Dependance, problems of abandonment, ego ideal

❍ **Informed for 50 % patients**
- Insight : poor

❍ **Clinicians**
- Special importance given to the psychotherapeutic setting, with objectives of identity development and reduction of acting out
- Primary theoretical orientation : psychodynamic.
- 9 were psychiatrists and 6 clinician psychologists. All are experienced

● Case formulation, 12 months later

❍ **Informed for 100% patients**
- Interpersonal relationships are improved but always disturbed
- Psychic pain and depressive position are very improved
- Important reduction in acting out (only persistent in 5 patients / 12 at baseline)

❍ **Informed for 80 % patients**
- Mechanisms of defense are always present: Aggressiveness, Avoidance, Splitting (sometimes noted as exceptional by the patient), Idealization, Projection.

❍ **Informed for 70 % patients**
- Self and identity fragility remain important problems
- Psychical conflicts: dependance, abandonment anxiety, ego ideal

❍ **Informed for 60 % patients**
- Insight: remains poor but an improvement is perceptible (mean +12%).

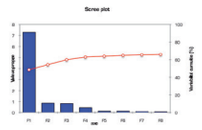
❍ **Clinicians**
- Their objectives are not fundamentally different, but more specific, in particular towards more structural problems: self-esteem, identity construction. Several clinicians plan to continue the original objectives, not yet achieved. Three patients out of treatment after several years of psychotherapy were evaluated after a discussion with the therapist.

Is Practice correlated with Case formulation?

(Psychotherapy Process Q-set *(PQS, Jones et al. 2000)*

Process characterization

- PQS : identification of most characteristic process descriptors
  - Factorial analysis of mean scores (3, 6 and 12 months) of 100 PQS items for each patient.
    -> 3 factors F1, F2 and F3



A complex common factor for borderline patients

(Psychotherapy Process Q-set *(PQS, Jones et al. 2000)*

Common factor F1 (48,7% of variability)

Therapist
- is sensitive to the patient's feelings, attuned to her/him (pp, ipt), empathic, responsive and affectively involved. S/he does not assume an attitude of superiority, comments reflect kindliness, consideration, or carefulness; her/his own emotional responses do not intrude into the relationship **(Approach and style)**
- communicates with patient in a clear, coherent style; conveys a sense of nonjudgmental acceptance ; adopts supportive stance **(Attitude)**
- remarks are aimed at facilitating patient speech (pp, ipt); asks for more information or elaboration (ipt), accurately perceives the therapeutic process (cbt, ipt) **(Therapeutic technique).**

Patient
- is animated or excited; has no difficulty beginning the hour; initiates topics; is active ; brings up significant issues and material; is committed to the work of therapy

Content
- **Patient's interpersonal relationships are a major theme (ipt); Patient's current or recent life situation is emphasized in discussion (ipt,cbt).**

pp: psychodynamic psychotherapy, ipt: interpersonal psychotherapy, cbt: cognitive behavioral therapy
From ideal prototypes in Ablon & Jones, 1998, 2002)

Is Outcome correlated with Case formulation?

HSRS (Luborsky, 1975) ; PFS (Hoglend, 2000)

Interpersonal relationships
Have they been improved by process?

- PQS item 63, "*Interpersonal relationships are a central theme*" got a score "*Very characteristic*" to all quotations in 15 patients.
- What about the evolution of interpersonal relationships following indicators HSRS and PFS?

	2 M	6 M	12 M
HSRS - Interpersonal relationships	44	47	55
PFS - Family relations	48	52	60
PFS - Friendships	49	51	56
PFS - Romantic/sexual relations	44	47	53

❍ **Factor F1** is not only composed of general elements such as involvement of the patient and the attitude of kindliness, consideration, or carefulness of therapist. Items focused on *interpersonal relationships* and *current or recent life situations* topics are included. Precisions about technical specificities of the borderline psychotherapies are present with descriptors of interpersonal, psychodynamic and cognitive-behavioral therapy. So, at the level of the aggregated cases, psychotherapy is integrative. Patient is active and committed to the work of therapy.

❍ **Factor 2** (5,7 of variability) refers particularly to the technique of the therapist and is convergent with the prototypes of psychotherapy of *Jones*.

❍ **Factor 3** (5,5 of variability) refers to the distance that the patient maintains with his/her psychic reality (resistance, defense mechanisms), the focusing of the therapist on conscious material. Somatic concerns and sexuality are discussed.

❍ The PQS item 63, **"Interpersonal relationships are a central theme"** gets a score "Very characteristic" to all quotations (2 months, 6 months, 12 months) in 15 patients.

The evolution of interpersonal relationships following indicators HSRS and PFS are consistent with a correlation between the sessions focus on interpersonal relationships and their improvement.

Discussion

Case formulation predicts the psychotherapeutic process in three areas.

- Interpersonal relationships, that are the main problem of the 15 borderline patients. This problem is expressed in today's world of the person (although it was felt in childhood).

Instruments show that psychotherapeutic work was focused on these difficulties and that the gain at this level is significant. PQS shows that the current situation or recent life of the patient and the interpersonal relationships are the main discussed topics. PFS and HSRS show significant improvement in this area.

- Another very important problem for these patient is the construction of their identity. Self and identity are fragile among all patients at baseline case formulation and remain for 70% of them after one year of therapy. We don't have specific instrument to evaluate their evolution, but F1 shows that the therapist adjusts her/his approach to this personality trait and that the patient is active and initiates topics. Therapists' attention to this problem can be found in the description of the case (dimension 1) and in its objectives (dimension 4).

- Defense mechanisms are present at baseline and 1 year, although some clinicians found splitting less frequent with time of psychotherapy.

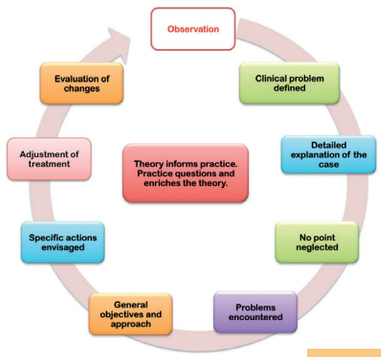
These common elements have to be complemented by a benchmarking case to case of evolutionary trajectories.

● Which are the theoretical and practical implications?

"The case formulation is an interesting stage to define the indication of a psychotherapy and its objectives" (sd 1,81, p < 0.0001) *cf* Does participation in research lead to changes in attitudes among clinicians? Report on a survey of those involved in a French practice research network. (Thurin JM, Thurin M, Midgley N, *Counselling and Psychotherapy Research,* forthcoming 2012).

Theoretical and practical implications are interwoven. Theoretical knowledge is necessary to organize data in a clinical case formulation. Practical implications are questioning the theory and lead to clear and enrich it.

Case formulation synthesizes information starting from the theoretical framework and multiple observations of the clinician. It rests on the clinical expertise which makes it possible: to conceive assumptions, to construct an individualized therapeutic strategy, to anticipate potential difficulties and to readjust, if necessary, the plan of treatment during the process.



Monique Thurin, Jean-Michel Thurin, Bruno Falissard,
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Society for Psychotherapy Research
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French Psychotherapy Practice Research Network

High emotional modulation insufficiency and ajustment of the therapist's attitude for children suffering from autistic disorder

● **BACKGROUND:** Outcomes of psychotherapeutic approaches for autistic children and potential mediators of change were subject to very little research. A Practice-based Research Network was opened in France to develop studies in this area.

● **OBJECTIVE:** In the semiology of autism, inability to modulate emotions involves child's suffering and has both behavioral and cognitive consequences. The present study focuses on evolution of this dimension during one year of psychotherapy for 41 autistic children and how the adjustment of the therapist' attitude can contribute to improve this insufficiency when it is particularly high.

● **METHOD:** Psychotherapies of 41 children were observed intensively during one year (process-outcome studies) and then aggregated for group and sub group analyses. Emotional modulation insufficiency (EMI) was studied with the Behavioral Summarized Scale (BSE, Barthelemy et al., 1997). Process was rated with Child Psychotherapy Process Q-sort (CPQ, Schneider and Jones, 2007) that describes the main features of psychotherapy: child and his/her problems, therapist, his approach and technique, and their interaction. Cases whose EMI / General Score (GS) ratios were ≥ 1.5 at baseline were selected. The most characteristic items describing the psychotherapeutic process in the group EMI / GS ≥ 1.5 were compared to those of all other cases and the EMI evolution of these cases observed.

● ***CARS (Childhood Autism Rating Scale of Barthelemy)***

ECAR-T **ÉVALUATION DES COMPORTEMENTS AUTISTIQUES** (version révisée)

G. Lelord
C. Barthélemy

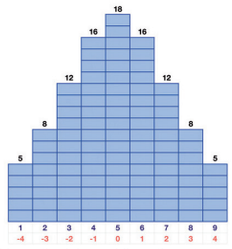
Nom :
Date :
Traitement :

Mettre une croix dans la colonne correspondant à la note jugée la plus exacte	Jamais	Parfois	Souvent	Très souvent	Toujours
	0	1	2	3	4
1 Recherche l'isolement (ISO)					
2 Ignore les autres (IGN)					
3 Interaction sociale insuffisante (SOC)					
4 Regard inadéquat (REG)					
5 Ne s'efforce pas de communiquer par la voix et la parole (VOI)					
6 Difficulté à communiquer par les gestes et par la mimique (GES)					
7 Émissions vocales, verbales stéréotypées ; écholalie (ECH)					
8 Manque d'initiative, activité spontanée réduite (ACT)					

❍ BSE was validated in the hospital department of pedopsychiatry of Tours. BSE has 29 items, rated from 0 to 4 according to the frequency or severity of symptoms. It allows to explore the various domains of the autistic child's behavior: social withdrawal, verbal and non verbal communication, adaptation to environmental situations, tonus, motivity, affect, shady reactions of the main instinctive functions, attention disorders, perceptions and intellectual functions. Symptomatic profiles are obtained that can be followed over several months. It is possible to analyze the evolution of this profile, symptom by symptom, or by taking into account various factors. It lists, for the different behaviors observed, spontaneous variations over time and improvements induced by treatment and rehabilitations.

Quantitative data collected from the scale are also used as clinical variables to explore possible relationships with other variables. It is thus possible to follow the evolution of «relational disability» and «emotional modulation insufficiency» intolerance to change, frustration, agitation, turbulence, hetero-aggressiveness.

● ***CPQ (Child Psychotherapy Process Q-set of Schneider and Jones***



❍ *CPQ is a common language* to describe, classify and quantify the process of therapy from 100 items. Each item is designed to be observable, avoid references to a specific theory. It is intended to be largely neutral and can be used for any therapy. The CPQ is used to represent a range of therapeutic interactions including systematic characterization of therapist-patient interaction.

Items are sorted into one of nine categories ranging from most characteristic (+4) to the most uncharacteristic (-4), through a neutral box (0) with a forced distribution (see diagram).

This methodology obliges the rater to assess the relative significance of each item to this particular therapeutic hour and avoids the well-known halo effect, by which raters tend to avoid using the two extremes of a rating scale.

● **RESULTS/DISCUSSION:** Nine of the 41 children had EMI / GS ≥ 1.5. After one year, their EMI score reduced by 46%. The analysis shows several differences between the ten most characteristic items of the EMI subgroup and the whole group. Six most characteristic process items are common with those of all cases, but have a different ranking. The most important differences are: 1)Therapist is more confident and self-assured, his/her remarks are aimed at encouraging child's speech, h/she tolerates child's strong affect or impulses and refrains from overt or subtle negative judgments against him or her 2) Child is active, His/her is imaginative, lively, and generates new ideas.

❍ **IM/ EG is ≥ 1.5**

❍ 9 children have a ratio IM/ EG ≥ 1.5.

- *Strong EMI variation:* 2 children (Y1 and Y2) show an EMI variation of 41.7 points, respectively 83.3% and 71.4%, corresponding to a variation of EMI / EG of 3.2 and 1.7.

- *Medium EMI variation:* 4 children (Y3, Y4, Y5, Y6), show a variation of 25 points, corresponding to a variation of EMI/EG of 2.2, 2.9, 1.8 and 1.7.

- *Low EMI variation:* 1 child (Y7) shows an EMI variation of 16.7 points, corresponding to a variation of IM/EG = 1.3.

- *No EMI variation:* 2 children (Y8 and X9), have a variation of EMI = 0. cases are very different.

Question 1

Does therapist has implemented with EMI children a special technique (different from that of 32 other children)?

❍ In addition to the elements similar to all patients, Therapist has particularly encouraged child's speech. He tolerated his/her strong affects or impulses, without judgment or emphasizing his/her emotional experiences. Children were particularly active and their play imaginative,lively (see attached table).

Question 2

EMI of 2 children (Y8 and X9) did not evolve while their EMI/EG was identical to that of 7 other children. Why?

❍X9. Therapist is particularly sensitive to the childs feelings. Therapy session has a specific focus and its material is relevant to child's conflicts. T avoids explicit instruction or education. The child draws the T into play and engages in make-believe play...

❍Y8. T is highly affectively engaged, tolerates his strong affects or impulses of the child, restrains from responding personally to provocations, adjusts to him. Child rejects therapist's advice or information. His communications are affect-laden.

Question 3

What can reveal the specific situation of these two children?

❍X9 is 5 years old. She is in psychotherapy for 2 years and goes to school. Moderators' Index is favorable 8/10. Much improvement during the year: 8/14 acquisitions at T0, 14/14 at 12 months. Birth of a little sister between times 2 and 3 of study, problematic in the organization of the family ....

❍Y8 is 11 years old. Developmental disabilities from infancy, is hospitalized. Moderators' Index favorable 6/10. Decreased in his acquisitions (T0 6/14, T12 4/14). General improvement during the year but developmental age between 2 and 3 years. Stressors: the little brother came into the language and the older sister left home ....

n°	items characteristic	32 P	9 P	X9	Y8
9	R. Therapist is affectively engaged.	3.20	3.00	3.33	3.67
6	Therapist is sensitive to the child's feelings.	3.05	3.11	3,33	3.00
77	Therapist's interaction with child is sensitive to the child's level of development.	2.90	2.56		
47	When the interaction with the child is difficult, the therapist adjusts to the child.	2.48	2.00		3.67
24	R. Therapist restrains from responding personally to provocation and disturbing material.	2.47	2.44		3.67
88	Material of the hour is meaningful and relevant to child's conflicts.	2.28	2.22	4.00	
65	Therapist clarifies, restates, or rephrases child's communication.	2.13	2.00		
86	Therapist is confident, self-assured.	2.08	2.67		
81	Therapist emphasizes feelings to help child experience them more deeply.	1.94	1.11		
3	Therapist's remarks are aimed at encouraging child's speech.	1.93	2.78		
18	R. Therapist refrains from overt or subtle negative judgments of the child		2.56	3,33	
45	Therapist tolerates child's strong affect or impulses.		2,56		3.67
95	R. Child's play is imaginative, lively.		2.56		
72	Child is active.		2.33		
23	Therapy session has a specific focus or theme.			4.00	
64	Child draws therapist into play.			4.00	
21	R. Therapist refrains from self-disclosure even when child exerts pressure for therapist to do so.			4,00	
71	Child engages in make-believe play.			3.67	
37	R. Therapist avoids explicit instruction or education.			3.33	
55	R. Therapist does not attempt to shape or reward behavioral changes.			3.33	
54	R. Child rambles, frequently digresses, or is vague.				3.67
20	Child is provocative; tests limits of the therapy relationship.				3.67
19	R. Child refuses or rejects therapist's advice or information.				3.33
61	R. Child appears un-self-conscious and assured.				3.33
40	R. Child's communications are affect-laden.				3.00

❍ Table : Scores items PQS very characteristic 32 children 9 children Child X9 Child Y8

● **CONCLUSION:** Therapists of children with high EMI scores adjusted their approach in a tolerant, non-judgmental, and expressive way, allowing the child to have an imaginative and lively therapeutic playing and helping him to contain his affects when they appear overwhelming him.

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Modeling processes, mechanisms and conditions of changes associated with psychotherapy of children with autism spectrum disorders

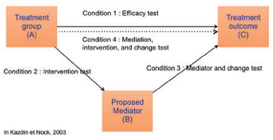
Jean-Michel THURIN Inserm U 669. ED3C : Cerveau, Cognition, Comportement

Thesis Director : Pr Bruno Falissard Inserm U 669

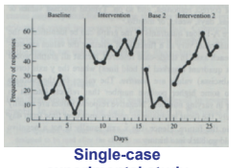
BACKGROUND: EVOLUTION OF PSYCHOTHERAPY RESEARCH

Focused 1980s to the 2000s on the overall efficacy of interventions and psychotherapeutic approaches, psychotherapy research has evolved towards a research on the change process related to mediators inside a therapy adjusted to patient. From «*What works for whom ?*» (in general), research questions became: «*When, why, how and under what conditions, a common or specific psychotherapeutic factor can produce changes for this patient*»?

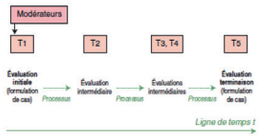
This trend is reflected in the adjustment of the methodology.



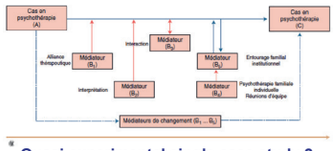
Pre-post group outcome studies



Single-case experimental study



Quasi-experimental single case study 1 Course of change



Quasi-experimental single case study 2 Mechanisms of change

Application of this evolution of methodology is particularly important for autism spectrum disorders because of the heterogeneity of cases and their situations, their developmental dimension, and differences that affect their approach. It is implemented in the Inserm clinical practice research network on psychotherapy (U 669) where, to this day, 50 intensive case studies in natural conditions have been completed.

OBJECTIVES: MODELLING PARAMETERS AND MECHANISMS OF CHANGE

An analysis plan in 5 steps: For each case and aggregated cases, 1) Characterise mediators and moderators : indexing external parameters (moderators) and configurations of process observations (mediators) of therapeutic action, 2) Describe comportemental and functional trajectories of change ; 3) Among cases, distinguish the good and bad trajectories and search for explicative settings ; 4) Model processes and mechanisms of change associated with each psychotherapy ; 5) Propose assumptions about some predictive factors of change.

In this poster, we focus on the presentation on the first step of describing therapeutic action, using a process instrument developped from Q methodology, the Child Psychotherapy Process Q-set (CPQ).

METHODOLOGY

Presentation of Q methodology

- **Developed by W. Stephenson (1953), Q Methodology rests on the rating and ranking of a set descriptive formulations concerning a particular object. The ranking highlights what appears to be the most and least characteristic for the rater in the range of descriptions that are submitted.**

Step One: A set of statements, called a « Q sample » is drawn from an exhaustive search of descriptive subject formulations. Recoveries of meaning are avoided, missing items are added. Statements are categorized and categories are equalized. Statements are numbered randomly.

Step Two: Q sorting. The Q sorter is instructed to sort the statements along a continuum from «most agree» at one end to «most disagree» at the other. To assist in the Q sorting task, the person is pro. vided with a scale and a suggested distribution.

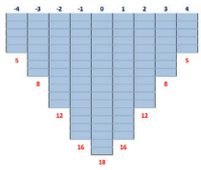
Step Three: Correlation. A correlation matrix is established between the sorts to describe the degree of similarity or dissimilarity in perspective.

Step Four: Factor analysis. It examines a correlation matrix and determines how many basically different Q sorts are in evidence: Q sorts which are highly correlated with one another may be considered to have a family resemblance, those belonging to one family being highly correlated with one another but uncorrelated with members of other families. Factor analysis tells us how many different families (factors), there are.

Step Five: Interpretation of factors. The interpretation of factors in Q methodology proceeds primarily in terms of factor scores rather than (as is typical in R methodology) in terms of factor loadings. A factor score is the score for a statement as a kind of average of the scores given that statement by all of the Q sorts associated with the factor. For the sake of precision, in Q methodology, the factor scores are weighted to take into account that some are closer approximations of the factor than others.

Application with CPQ (Child Psychotherapy Process Q-set)

- **Developped by Schneider and Jones, CPQ is a common language to describe, classify and quantify the process of therapy from 100 items. Each item is designed to be observable, avoid references to a specific theory. It is intended to be largely neutral and can be used for any therapy. The CPQ is used to represent a range of therapeutic interactions including systematic characterization of therapist-patient interaction.**



Step One: CPQ has been constructed from an exhaustive search of existing process descriptions. Their main formulations were selected and others were built from detailed discussions with clinical investigators. Each item was discussed in terms of its clarity, its importance for psychotherapy and implications of his choice for the set number of total items.

Step Two: Items are sorted into one of nine categories ranging from most characteristic (+4) to the most uncharacteristic (-4), through a neutral box (0) with a forced distribution (see diagram). This methodology obliges the rater to assess the relative significance of each item to this particular therapeutic hour and avoids the well-known halo effect, by which raters tend to avoid using the two extremes of a rating scale.

Step Three: Correlation. A correlation matrix is established which compares each of the fifty Q sorts with the others. The result is a 50x 50 correlation matrix.

Step Four: factor analysis determines how many basically different Q sorts of 100 observations describing patient, therapist and their interactions are in evidence. Q sorts which are highly correlated with one another may be considered to have a family resemblance. They define one common factor and 3 specfic factors. Factor loadings differenciate in each family their level of similarity. Factor analysis tells us how many different families (factors), there are and in each family which are the most characteristic formulations.

Step Five: Interpretation of factors. The F1 (common factor) loadings are all positive, but vary from 0.28 to 0.84 (median: 0.69). F2 distinguishes psychotherapeutic approaches (psychodynamic and cognitive-behavioral) and the compliant or chaotic participation of the child in psychotherapy. F3 describes a curious, bright and imaginative child that can express his feelings to his therapist (or vice versa) and the psychotherapeutic approach adopted by the therapist. F4 decribes the passage from a very close attachment towards a beginning of autonomy.

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Quelques nouvelles du Réseau de Recherches Fondées sur les Pratiques Psychothérapiques (RRFPP)...

◆ Un premier rapport a été réalisé en 2010. Il présente la mise en place du réseau et de ses réalisations jusqu'à la présentation des premières études de cas finalisées dans chacun des pôles au cours de la Journée de retour d'expérience du 22 janvier 2010.

◆ Un second rapport a été réalisé en 2013. Il présente les 50 études de cas terminées (pôle autisme)[1]. Ce rapport est consultable en ligne sur demande. Il est traduit en Anglais et en Italien.

◆ Une enquête a été réalisée auprès des cliniciens concernant leur implication dans la recherche. Cette enquête a donné lieu à un article[2].

◆ Un article de 2014 présente les 50 études de cas terminées (pôle autisme)[3].

◆ Depuis janvier 2013, le *pôle Borderline* du réseau a ouvert un Webseminaire mensuel intitulé *Données probantes issues de la pratique psychothérapique.* Il réunit un groupe de cliniciens ayant tous participé aux études avec l'évaluation d'un ou de plusieurs de leurs cas. Il décortique les résultats d'un cas en élaborant des questions cliniques, théoriques et sur les instruments d'évaluation. Ce séminaire a pour but de faire sortir les données probantes issues de la pratique psychothérapique.

◆ En décembre 2014, un second Websminaire mensuel a été ouvert, intitulé « Recherche & Pratiques ». Il est consacré à la présentation de l'analyse approfondie d'un cas d'enfant autiste et à la discussion des hypothèses qui peuvent être proposées concernant le processus de changement et les éléments qui y ont contribué. Comme pour le séminaire *borderline*, il est découpé en trois parties 1. Présentation de l'analyse des données. 2. Discussion par le clinicien ayant suivi l'enfant 3. Discussion avec le groupe des participants.

◆ Plusieurs articles du numéro spécial de « Richard et Piggle », consacré à la recherche italienne sur l'autisme concernent les travaux du pôle autisme du RRFPP. Il sont écrits par des cliniciens qui ont engagé un enfant dans les études du réseau[4].

◆ Actuellement, plusieurs groupes de pairs poursuivent l'évaluation de leurs cas. Le Réseau reste ouvert à de nouvelles candidatures de cliniciens pour participer à cette recherche.

◆ Nous venons de prendre connaissance du rapport Belge « Prise en charge de l'autisme chez les enfants et les adolescents : un guide de pratique clinique », réalisé par le *Centre Fédéral d'Expertise des Soins de Santé* (KCE).

Nous avons eu le plaisir de constater que la recherche du RRFPP est présentée dans la partie « Recommandations de recherche pour le futur », à la fois dans le rapport et dans la synthèse traduite en français, avec un renvoi à l'article paru dans *Neuropsychiatrie de l'Enfance et de l'Adolescence.*

C'est à la fois un point d'appui important, une responsabilité et une forte stimulation pour le travail en cours qui reste à mener à bien.

◆ Nous avons répondu à un appel d'offres de la *Fondation de France* qui permettrait de faire une évaluation à distance des études de cas d'enfants autistes terminées. De nombreux cliniciens sont partants. Nous avons passé la première étape, réponse finale de la *Fondation de France* en décembre prochain...

1. Thurin JM, Falissard B, et Thurin M. (2013). Rapport d'étape à 4 ans du Réseau de Recherches Fondées sur les Pratiques Psychothérapiques, pôle autisme. Paris: Inserm.

2. Thurin JM, Thurin M & Midgley N. (2012). Does participation in research lead to changes in attitudes among clinicians? Report on a survey of those involved in a French practice research network. *Counselling and Psychotherapy Research* ; 12(3): 187-193.

3. Thurin JM et al (2014). Approches psychothérapiques de l'autisme. Résultats préliminaires à partir de 50 études intensives de cas. *Neuropsychiatrie de l'enfant et de l'adolescent.*

4. La ricerca sull'autismo INSERM in Studi psicoanalitici del bambino e dell'adolescente 4/2013, *Il Pensiero Scientifico Editore.* pp 358-389.

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