Réseau de Recherches Fondées sur les Pratiques Psychothérapiques...

Jean-Michel Thurin & Monique Thurin

Cahier des Posters & Publications du Réseau

MINISTÈRE DES SOLIDARITÉS ET DE LA SANTÉ
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FÉDÉRATION FRANÇAISE DE PSYCHIATRIE
Ecole de psychosomatique EPS

PRÉSENTATION DE CE CAHIER

Les pages qui suivent apportent deux sources complémentaires d'information au livret sur les processus et mécanismes de changement chez les enfants/adolescents avec autisme observés à partir des 66 études de psychothérapies individuelles menées en conditions naturelles avec cette indication.

La première source est constituée par les posters qui ont été présentés dans des manifestations scientifiques nationales et internationales au cours des dix dernières années ;

- Les posters ont été d'une grande aide non seulement pour promouvoir la recherche qui se faisait dans le *Réseau de Recherches Fondées sur les Pratiques Psychothérapiques* mais aussi, et surtout, pour les discussions qu'ils ont suscitées au cours des congrès et colloques sur les sujets et questions abordés, tant au niveau de la création et du fonctionnement d'un réseau de recherche associant les chercheurs et les cliniciens, que des méthodes adoptées et des résultats.

- De fait, les thèmes présentés dans les posters constituent la mémoire d'une activité de recherche dans ses différents registres, d'abord dans la constitution d'une action répondant aux limites de l'expertise collective de 2004 " Psychothérapie, trois approches évaluées ", ensuite d'approfondissement et de test de la possibilité de modéliser et comprendre ce qui se déroulait au cours des trajectoires de psychothérapies complexes dans un contexte développemental particuilier, celui de l'autisme.

- De nombreux posters ont été présentés à la *Society Psychotherapy Research* dans différents pays. D'autres en France au cours de colloques : IRIA, colloque international qui s'est tenu à Tours en 2012, et plusieurs à Paris (MIRE, CIPPA, séminaire sur expertise clinique), ainsi qu'au cours des journées de thèse organisées par l'École doctorale ED 3C "Cerveau, Cognition, Comportement".

La seconde source est celle des références bibliographiques, dont une part importante a été publiée dans *Pour la recherche*, le bulletin de la Fédération Française de Psychiatrie, et une autre part a été publiée dans tout un ensemble de revues.

Comme les posters, c'est également une mémoire de ce travail qui se trouve consignée sous forme d'articles très précis et détaillés sur les questions qui se sont posées et les résultats tels qu'ils se sont montrés.

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1. Madison SPR 2007 (USA, Wiscontin)

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

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

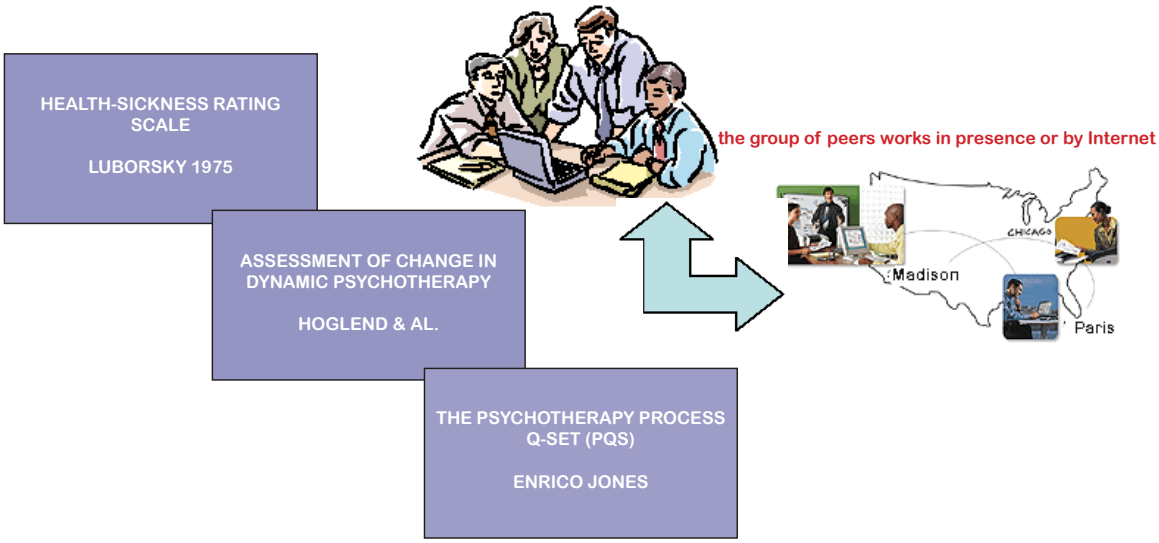
The methodology is based on intensive single-case studies of complex disorders' psychotherapies.

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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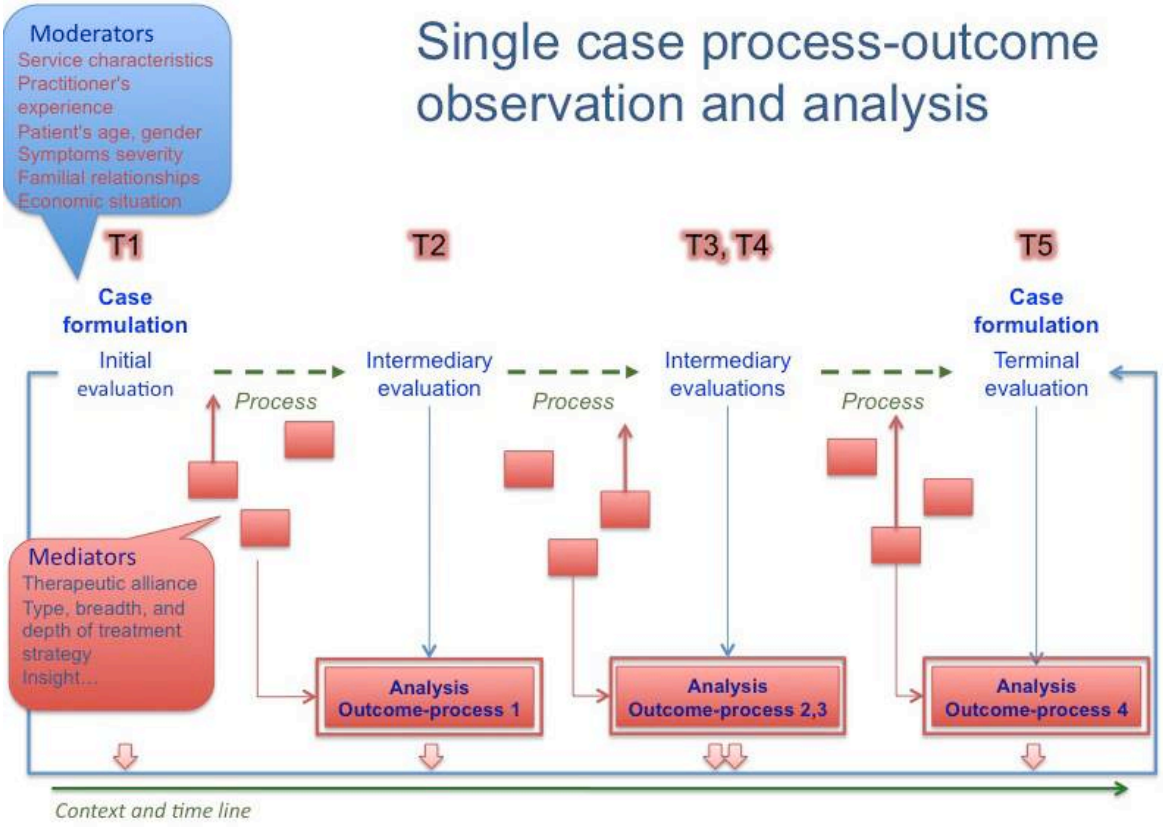
2. Barcelone SPR EU 2008 (Espagne)

French Psychotherapy Practice Research Network. Single case process-outcome observation and analysis. Design. Indicators and instruments..

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*

3. Asilomar 1 SPR 2010 (USA, Californie)

French Psychotherapy Practice Research Network. Bridging the gap between practice and research Difficulties, Initiatives and solving.

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/

● **Inserm 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/

● **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).

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

● **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 quasi-experimental 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

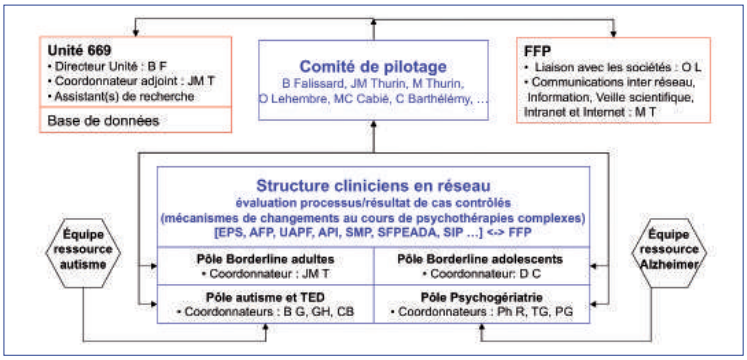
Financial support : National Institute of Health and Medical Research - Head Office of Health

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/



4. Asilomar 2 SPR 2010 (USA, Californie)

French Psychotherapy Practice Research Network. From systematic case studies to their aggregation in a database. Comparative analysis and metasynthesis.

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..

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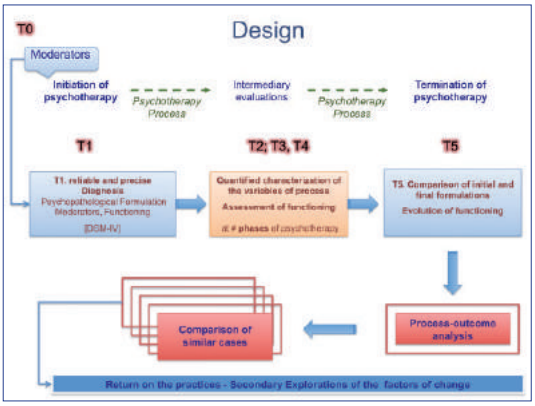


Borderline Pole

● **Functioning indicators (10)**

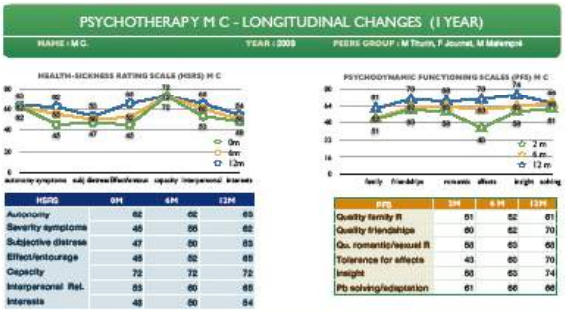
Autonomy, Symptoms' severity, Suffering and subjective distress, Consequences of patient's problems on the entourage, Ability to use capacities, in particular in work, Quality of the interpersonal relationships, Width and depth of the interests, Emotional expression and tolerance, Insight, Problem's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

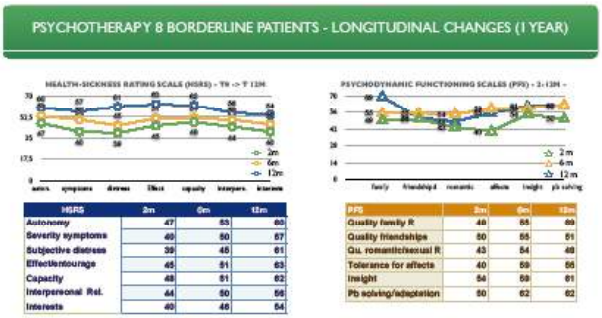
Process indicators (6)

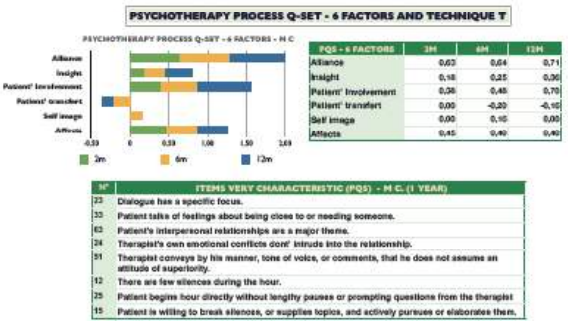
Attitude, behavior or experience of the patient, therapist actions and attitudes, nature of the interaction of the dyad, climate or atmosphere of the encounter.

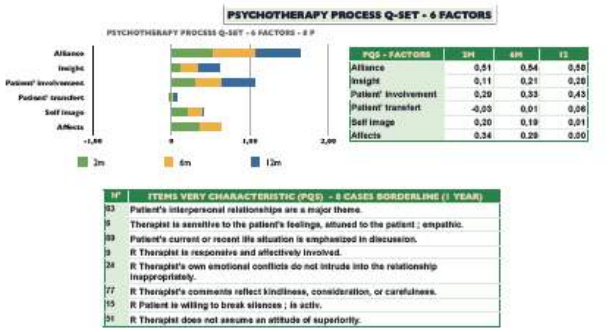
Functioning and Process Instruments

- 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









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) ; 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. 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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5. Bern 1 SPR 2011 (Suisse)

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

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)***
  - **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.)***
  - **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.

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 very 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. of birth.

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 with 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 + developmental gain).
2. **Extraction of classes** in change trajectories.
3. **Correlations of trajectories with mediators and moderators** of potential change

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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6. Bern 2 SPR 2011 (Suisse)

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

French Psychotherapy Practice Research Network

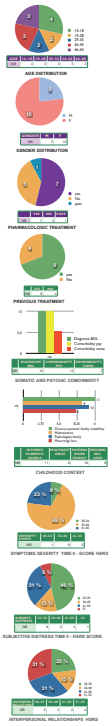
Case formulation in a Practice-Based Research Network. Is standardization compatible with complexity ?

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



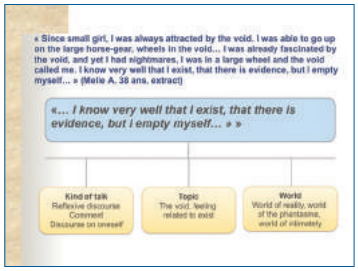
Discourse analysis

- 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	Instabiity 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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7. Tours IRIA 2012 (France)

French Psychotherapy Practice Research Network. High emotional modulation insufficiency and ajustment of the therapist's attitude for children suffering from autistic disorder.

French Psychotherapy Practice Research Network

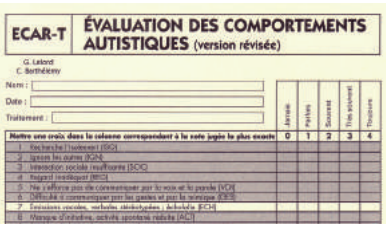
High emotional modulation insufficiency and ajustment of the therapist's attitude for children suffering from autistic disorder

● **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.

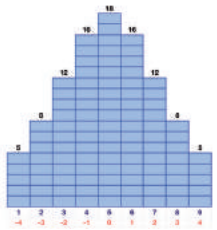
● *CARS (Childhood Autism Rating Scale of Barthelemy)*



❍ 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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8. Virginia Beach 1 SPR 2012 (USA, Virginia)

Change mechanisms in psychotherapies of 41 children suffering from autism and PDD. Measures ; Baseline: diversity of the cases ; Change Process ; Case to case comparison: one example.

French Psychotherapy Practice Research Network

Change mechanisms in psychotherapies of 41 children suffering from autism and PDD

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*

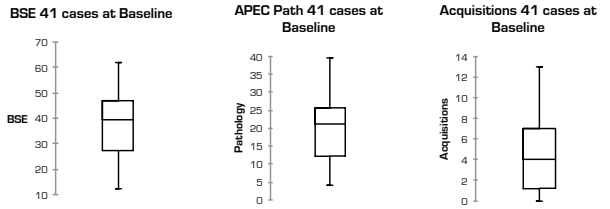
Describes the development of the autistic child during 5 evolutionary stages in 7 dimensions: emotional expressions in the relation, glance, image of the body, verbal language, exploration of space and objects, temporal location, aggressive demonstrations

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



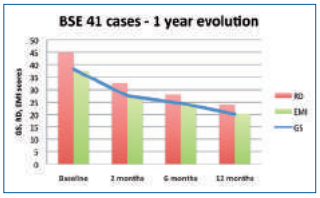
BSE: scores from 12 to 62 APEC: scores from 4 to 39 Acq: scores from 0 to 13/14

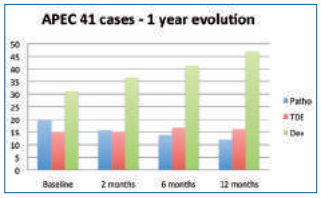
2. Moderators

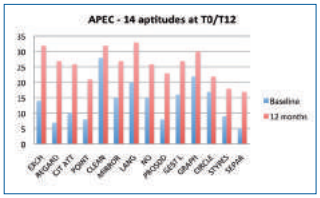
Age: 3-15 years, 22 of ≤ 6 years and 6 ≥ 12 years
Beginning of the treatment: 22 between 3-4 yrs, 12 between 5-6 yes, 7 between 7-13 yrs.
Context of development: easy for 16, difficult for 25
Context of trauma: absent for 18; at least one traumatic event for 23
Family support: 31 have a very good family 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)

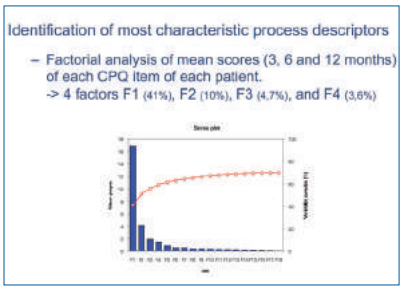


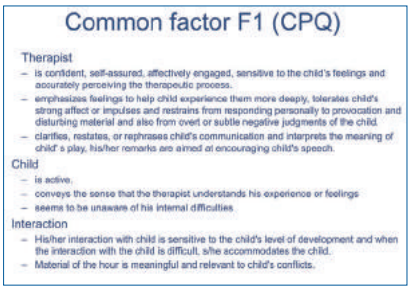


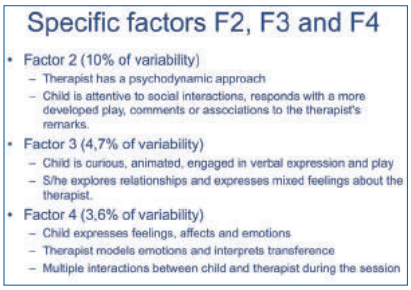


14 Aptitudes
Search of true exchanges (EXCH)
Regard with a good exchange (REGARD)
Search other's eyes for joint attention (CJT ATT)
Proto declarative pointing (POINT)
Cleanliness acquired (CLEAN)
Mirror stage (MIRROR)
Language acquired (LANG)
Emergence of No (N0)
Development of prosody (PROSOD)
Gestural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

Process (CPQ)







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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9. Virginia Beach 2 SPR 2012 (USA, Virginia)

French Psychotherapy Practice Research Network Does case formulation predicts the change process in psychotherapy? Contribution of 15 pragmatic cases studies of borderline patients.

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.

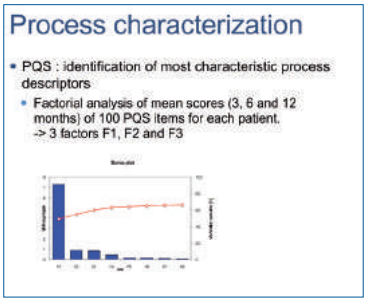
❍ **Informed for 70 % patients**
- Self and identity fragility remain important problems
- Psychical conflicts: dependance, abandonment anxiety, ego ideal

❍ **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.

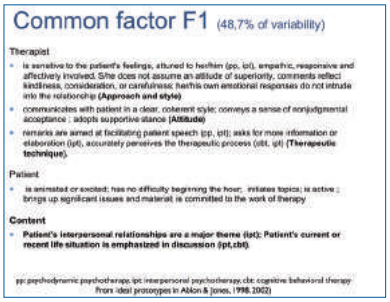
Is Practice correlated with Case formulation?

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



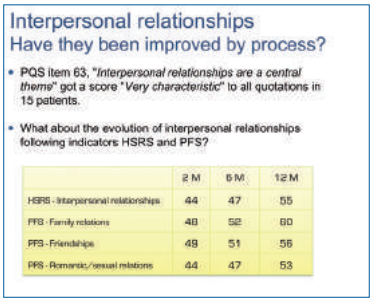
A complex common factor for borderline patients

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



Is Outcome correlated with Case formulation?

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



❍ **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.

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and the clinicians : Diogo Alves de Oliveira, Hélène Artigala, Dominique Bilani, Nathalie Duriez, Marie-Françoise Gausset, Jean-Yves Gautier, François Journet, Nicolas Juskewycz, Maud Julie, Isabelle Lemaire, Marc Malempré, Jacqueline Massonnet, Magali Molinié, Rodolphe Snapir, Agathe Sultan, and Michèle Vitry.
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10. Paris ED 3C 1ère Journée doctorale de thèse 2014

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

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

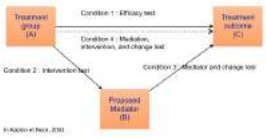
Jean-Michel THURIN Inserm U 669. ED3C : Cerveau, Cognition, Comportement

Thesis Director : Pr Bruno Falissard Inserm U 669

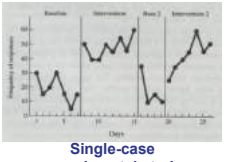
BACKGROUND: EVOLUTION OF PSYCHOTHERAPY RESEARCH

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*»?

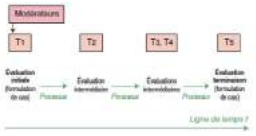
This trend is reflected in the adjustment of the methodology.



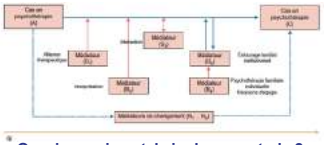
Pre-post group outcome studies



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.

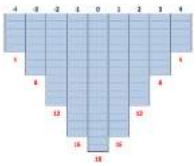
Step Three: Correlation. A correlation matrix is established between the sorts to describe the degree of similarity or dissimilarity in perspective.

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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11. Paris MIRE ED 3C Évaluation du risque suicidaire dans troubles personnalité 2015.

Troubles de la personnalité borderline et risque suicidaire. Évaluation, modèles psychopathologiques et méthodologies. .

Troubles de la personnalité borderline et risque suicidaire
Évaluation, modèles psychopathologiques et méthodologies

Jean-Michel Thurin

Positionnement de la question

- Le lien entre trouble de la personnalité borderline et risque suicidaire est établi. Celui entre automutilations et suicide ne l'est que partiellement (Oumaya et al. 2008)
- Les psychothérapies psychodynamiques ont été évaluées (Thurin 2004, Oumaya, Clarkin et al 2007, Fonagy 2015)
- Leur mise en oeuvre se réfère à un modèle psychopathologique de la constitution du moi ou du soi impliquant le cadre et des actions spécifiques
- Plusieurs variantes ont été évaluées concernant les actions spécifiques de changement
- Une méthodologie intégrant les facteurs individuels et le processus de changement en psychothérapie est nécessaire. Elle peut être complétée par une méthodologie centrée sur le processus interne de la crise automutilatoire voire suicidaire.

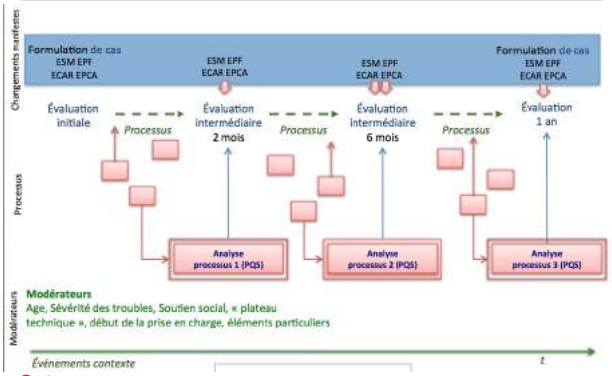
Aspects méthodologiques

- La recherche en psychothérapie a longtemps été davantage dominée par l'intérêt porté au résultat de différentes stratégies de traitement que par une recherche préliminaire sur les dysfonctionnements nécessitant une intervention psychothérapique spécifique.
- Depuis les années 2000, les études processus-résultats de cas individuels se sont développées. Elles prennent en compte la nature des dysfonctionnements cliniques, spécifient le traitement, ses bases psychopathologiques et théoriques, recherchent les chaines causales et les mécanismes de changement. Cette évolution méthodologique repousse les limites des approches expérimentales et vise à établir les actions psychothérapiques les mieux adaptées chez un patient donné dans une situation clinique spécifiée (Kazdin 2001-2009, Clarkin & Levy 2006, Thurin et al. 2008).
- Cette évolution a été rendue possible par l'extension du champ psychothérapique aux troubles borderline, le développement d'outils d'analyse du processus et de méthodes statistiques appropriées, ainsi que par la constitution de réseaux de recherches (*Practice-Research Networks*) permettant la reprise d'une collaboration étroite entre cliniciens et chercheurs.

Études et modèles psychopathologiques

- **Adler 1989. Revue de la littérature. Psychothérapies longues. Modèle psychopathologique** :
  - «Les troubles de la personnalité borderline sont une pathologie des phases précoces de l'individuation dans le rapport à l'autre».
- **Ogrodniczuc 1999. Les interprétations de transfert peuvent avoir des effets différents pour différents types de patients et suivant le stade précoce ou tardif de leur application dans le traitement.**
  - Il sera nécessaire, pour guider le traitement dans le futur, d'examiner la technique psychothérapique à différentes étapes de la psychothérapie et d'explorer soigneusement les multiples facteurs opérant simultanément dans le traitement.
- **Yeomans et al. 1994. Les études centrées sur les sorties de traitement peuvent atteindre des taux de 30 à 50% au cours des 3 premiers mois**
  - La technique du thérapeute et ses outils jouent un rôle significatif dans l'engagement du patient dans la thérapie. L'impulsivité serait la seule variable patient impliquée dans la réduction de la durée du traitement.
- **Monsen et al. 1995. Objectifs structuraux de développement :**
  - Individuation : conscience affective et distinction du soi / image parentale idéalisée,
  - Constitution d'un espace personnel intériorisé, autonomie par rapport à se concevoir en relation permanente à l'attente et à la reconnaissance de l'autre, régulation des contacts sociaux, ouverture vers l'atteinte d'ambitions et de buts personnels.
- **Meares et al. 1999. Le trouble bdl est une conséquence d'une interruption du développement du moi**
  - Le développement peut être repris à partir d'une activité mentale tenue dans la rêverie et se situant en deça du jeu symbolique.

  Cette activité mentale peut s'établir lorsque les réponses du thérapeute entrent en relation avec ce que le patient lui communique et expriment la reconnaissance et la compréhension de son expérience. Elle permet aussi l'élaboration de vécus traumatiques antérieurs.
- **Clarkin, Yeomans, Kernberg et al. 2001 2006. Études en ambulatoire centrées sur le transfert**
- **Bateman et Fonagy 2014. L'axe central du changement**
  - Il se situe dans la tolérance à la séparation, la capacité de penser sur soi et sa relation aux autres (mindfulness), la capacité de se représenter le vécu et l'état d'esprit de l'autre (mindedness).



Études processus-résultats quasi-expérimentales de cas sur 1 an

- À partir de notes extensives et/ou enregistrement audio de séances (données), sont réalisés : une formulation de cas intiale, au moins 4 évaluations avec échelles de changement et questionnaire structuré de processus (ou méthode qualitative alternative) validés, un recensement des modérateurs et une évaluation des menaces à la validité interne. Les effets observés sont répliqués dans différentes études, échantillons, et conditions (par exemple, configurations naturalistes et de laboratoire). (Kazdin 2003, Hilsenroth 2010, Eells 2011)

Méthodologie d'analyse des événements en psychothérapie

- En psychothérapie d'orientation psychanalytique, les vécus associés aux passages à l'acte d'auto-mutilation (se couper plus ou moins gravement), auto-agression (se taper dessus, se taper la tête contre le mur), et même au passage à l'acte suicidaire sont exprimés.

Ces vécus du patient sont caractérisés par un débordement émotionnel et un un sentiment envahissant de détresse, de solitude, d'impuissance lié à un événement externe impliquant autrui. Toute réponse verbale circonstanciée est ou lui paraît impossible.

Une analyse des événements en thérapie peut être intégrée à l'étude intensive de cas.

C'est une stratégie observationnelle, inductive et itérative dans laquelle les investigateurs utilisent les observations des thérapeutes de leurs interventions. L'objectif est d'améliorer progressivement la façon dont elle peuventt être le mieux exécutées, avec trois étapes : 1. Description précise de l'événement ou des problèmes rencontrés et de la façon dont il a été traité ; 2. Construction d'un modèle rationnel et mise en relation avec des observations, et 3. Évolution vers un modèle rationnel empirique (Elliott 2009).

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12. Paris ED 3C 2ème Journée doctorale de thèse 2015

Structural equation modeling of the psychotherapy change process: stages of the construction of the model and preliminary results.

Structural equation modeling of the psychotherapy change process : stages of the construction of the model and preliminary results

Jean-Michel THURIN Inserm U 1178. ED3C : Cerveau, Cognition, Comportement

Thesis Director : Pr Bruno Falissard Inserm U 1178

BACKGROUND AND OBJECTIVES : Since 2000, the evaluation of psychotherapy has associated to the outcomes research, a new line of research on understanding the mechanisms of therapeutic efficacy in naturalistic conditions (Kazdin and Nock 2003, Thurin and Briffault 2006). A research network based on Psychotherapies' Practices (RRFPP) was established on this basis (Thurin et al., 2008). The objective of one of its poles is to understand why and how psychotherapy conducted by experienced practitioners may be effective in children / adolescents with autism spectrum disorders. An article presenting the preliminary results of the first 50 cases was published (Thurin et al. 2014), as well as a general report prepared following a first level of analysis (Thurin Thurin Falissard & 2013).

A second generation of statistical methods developed since the early 90s, including that of structural equation modeling. This method allows to combine multiple linear regression analyzes and design «paths» or «causal paths.» It is also possible to consider the latent variables apprehended from variables measures involved in their construct or their expression (Falissard 2005, pp 203-215, 2011, pp 205-221, Hair et al. 2014). The possibility of applying this method to data collected in the network was first tested using isolated cases. Their analysis developed with R showed great diversity of individual situations and adjusting to the needs and therapists possibiltés of each patient. This individualized and interactive dynamics seemed to make impossible any possibility of modeling the process with a group. However, the application of a basic model has also shown the benefits of formalization of psychotherapy steps and ingredients from component variables psychotherapeutic process and those that make up the indicators of change. This poster presents the first phase of this work.

METHODOLOGY

Objective of the structural model

This model attempts to explain the action of psychotherapy (AT) exerted in its natural context on autistic behaviors of the child. This model uses data from RRFPP where 60 children and adolescents with autism and PDD were assessed 4 times for a period of one year (initially and then at 2, 6 and 12 months) as part of a intensive case study.

Assessments are conducted individually by three clinicians gathered in peer group. The interrater variance are discussed until approved agreement.

The behavioral state (EC) is measured by two dimensions: the relational disabilities (CD) and impaired emotion modulation (IM), from the two corresponding scales in the ECAR.

The therapeutic action (AT) is a latent variable that involves the therapist in his approach and technique, the child and functioning, and their interaction. It is represented by the attitude of the therapist (ATT) and its specific actions (ACT) centered on verbalization, language, emotion and pathological behaviors that accompany them. It also involves the psychological disposition of the child, which determines its openness and participation in therapeutic activities. The child's psychological state is formed by a group of items (AAR) of the process scale (CPQ) that capture his activity, his inner experience and its relationship with the therapist as part of psychotherapy. These items describe the pathological and normal components of these dimensions *. ECAR and CPQ are two validated scales.

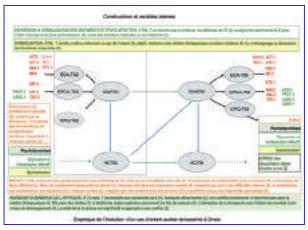
Construction of the model

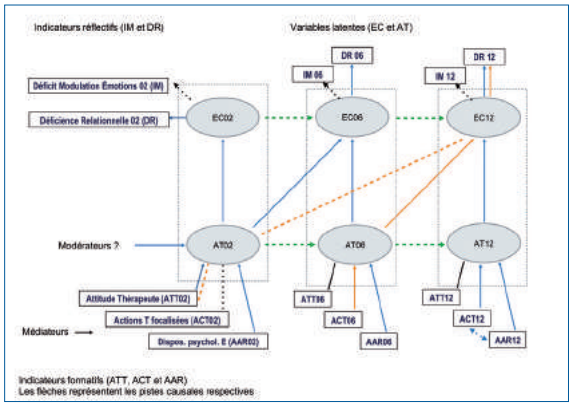
It builds on the findings of in-depth analysis performed of single cases with R and methods presented by B Falissard and Hair.

The first step was the creation of a first graph involving variables to explain (CD and IM) and the explanatory variables (ATT, ACT and AAR).

The second step was the selection of explanatory variables. It was carried out from the squared cosines of the observations (items CPQ).

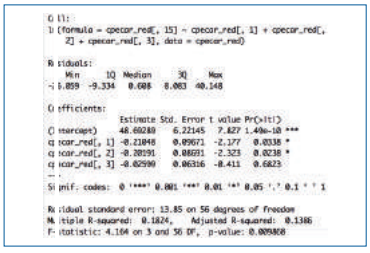
The third step was the test of their commitment to the 3-time feedback from linear regression equations (2, 6 and 12 months).



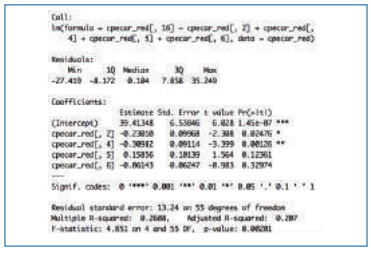


● The first graph shows an extract of modeling an single case and the second graph represents a first modeling of the 60 cases' group.

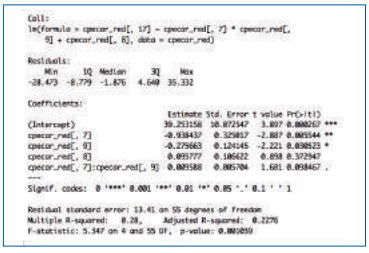
RESULTS



● The variable « relational disability » of the child to T02 (DR02) is significantly dependent on the psychological disposition of the child (AAR02) (0.03) and the attitude of the therapist (ATT02) (0.02) at T02.



● The variable « relational disability » of the child to T06 (DR06) is significantly dependent on the psychological disposition of the child (AAR06) to T06 and the attitude of the therapist (ATT02) to T02.



● The variable « relational disability » of the child to T12 (DR12) is significantly dependent on the disposition of the Child (AAR12) (0.005), the action of the therapist (ACT12) (0.03), and their interaction (0.09) to T12.

● Linear regressions for Relational impairment of the child (CD) establish that the «child in his/her therapy» mediator (AAR) is very significant to each of quotations. The attitude of the therapist is also significant to each of the quotes to a lesser extent. The action of the therapist (ACT) is only weakly significant at 6 months of therapy and intervenes on DR at 12 months. The lack of correlation with the lack of emotion modulation (IM) can be explained by the fact that this deficit strongly concerned about a quarter of children (17/60).

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13. Klagenfurt SPR 2015 (Autriche)

Psychotherapy of children with autism spectrum disorders: When the approach and specific actions of the experienced therapist depend on the child's clinical condition.

Psychotherapy of children with autism spectrum disorders: When the approach and specific actions of the experienced therapist depend on the child's clinical condition

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OBJECTIVES: MODELLING PARAMETERS AND MECHANISMS OF CHANGE

As part of the French Psychotherapy Practice-Based Research Network, 60 intensive single case studies, conducted during 1 year with children suffering autistic disorder, have already been completed. The analysis focuses on each case individually and on the aggregated cases. Here we present: 1. the first step of methodology for analyzing the psychotherapy process with the *Child Psychotherapy Process Q-set* (CPQ) and 2. the results regarding the distinction between common and specific factors.

METHODOLOGY FOR ANALYSING THE PSYCHOTHERAPY PROCESS: 1. Application of the Q-sort methodology with CPQ

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: Q sample. 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.

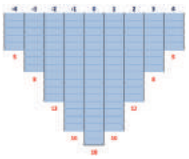
Step Two: Q sorting. The Q sorter is instructed to sort the statements along a continuum from «most agree» at one end to «most disagree» at the other. To assist in the Q sorting task, the person is provided with a scale and a suggested distribution.

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. In Q methodology, the factor scores are weighted to take into account that some are closer approximations of the factor than others.

Developped by Schneider and Jones (2003), Child Psychotherapy Process Q-set (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 between the one hundred eighty Q sorts to describe the degree of similarity or dissimilarity in perspective.

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 3 main factors (eigenvalue > 6.5). One «common» factor (eigenvalue = 54.3) and 2 «specfic» factors (eigenvalues = 11.8 & 6.8). Factor analysis tells us how many different families (factors), there are and in each family which are the most characteristic formulations. Factor loadings differenciate in each family the level of similarity of each psychotherapy at each time (2, 6 and 12 months).

Step Five: Interpretation of factors. The F1 (common factor) loadings are all positive, but vary from 0.02 to 0.78 (median: 0.57). 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 (description below). 49-53 psychotherapies are mainly in F1 (with loadings 0.32-0.71), 8-4 in F2 and 1-3 in F3 .

RESULTS

F1. Child feels trusting and secure, understood by the therapist; he directs angry or aggressive feelings outward. Therapist is affectively engaged and sensitive to the child's feelings. He clarifies, restates, or rephrases child's communication and emphasizes verbalization of internal states and affects. His interaction with child is sensitive to the child's level of development and demonstrates a shared vocabulary or understanding.

F2. Child is socially misattuned or inappropriate, anxious and tense, provocative ; he has difficulty understanding the therapist's comments ; his play is fragmented, sporadic. Therapist actively exerts control over the interaction, is directly reassuring, behaves in a didactic manner, comments on the child's nonverbal behavior, sets limits..

F3. Child is curious, animated, active, joyous, close from his or her feelings. His communications are affect-laden, his play is imaginative, lively, Therapist is neutral, interprets the meaning of child' s play, points out child's use of defences, Therapist makes links between child's feelings and experience. Different topics are discussed.

DISCUSSION

The CPQ comprises three types of items: (a) those describing child attitude and behavior or experience, (b) those reflecting the therapist's actions and attitudes, and (c) those attempting to capture the nature of the interaction in the dyad or the climate or atmosphere of the encounter.

In F1, the 20 most characteristic items are centered on the general approach of the therapist, his adjustment to the child's development, and specific technique for language and affect. Child feels trusting and secure and understood by the therapist. Therapist and child demonstrate a shared vocabulary or undersanding; psychotherapy is associated with significant changes.

In F2, Child is socially misattuned or inappropriate, anxious, and not involved. Therapist tries, with his approach and technical tools, to control the situation but changes are interrupted.

In F3, the child is much better, his autistic symptoms and functioning have already greatly reduced and he even expresses a well-being. Therapeutic activity is multi-modal and therapist can fully apply his technique (psychodynamic).

Each factor includes specific ingredients, adjusted to the child's condition and his current possibilities, within a general approach supported by theory.

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http://www.techniques-psychotherapiques.org/Reseau

14. L'Expertise Clinique comme source de données probantes 2015 (APA 2006)

Placer l'expertise clinique comme source de données probantes. La formulation de cas (FC) : une première étape [Evidence-based practice in psychology. American Psychological Association].

Placer l'expertise clinique comme source des données probantes

La formulation de cas (FC) : une première étape

Auteurs : Monique Thurin* & Jean-Michel Thurin**

Positionnement de la question

- Les données probantes sont actuellement essentiellement issues des études expérimentales portant sur des groupes
- Les données probantes peuvent être issues de la pratique clinique sous certaines conditions méthodologiques :
- Élaboration d'un diagnostic approfondi des problèmes, des troubles, des fonctionnements du patient dans son contexte permettant des objectifs et une stratégie de traitement -> La formulation de cas

Différentes sources de données pour la réalisation d'une FC

Ce que dit le patient. Ce qui est évalué par le thérapeute. La connaissance : résultats de recherches, expériences similaires issues d'autres patients, les conseils d'experts… Les intuitions du thérapeutes. Les éventuels test psychométriques.

Ces éléments n'ont pas la même valeur pour constituer des données probantes : penser un continuum force de la preuve...

Les recommandations...

- **(APA 2002)**

Guides de traitements basés sur les troubles.

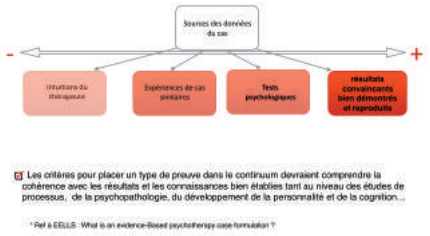
Limites de l'approche fondée sur les troubles : comorbidités fréquentes ; problèmes au delà du diagnostic habituel...

- **(APA 2005)**

L'expertise clinique est essentielle pour identifier et intégrer les meilleures preuves de recherche aux données cliniques pour atteindre avec la plus haute probabilité les objectifs de la thérapie.

L'expertise clinique se manifeste dans toutes les activités cliniques et pour commencer dans le développement de formulations de cas systématiques, la planification du traitement, et l'établissement des buts...

Penser un continuum force de la « preuve »*

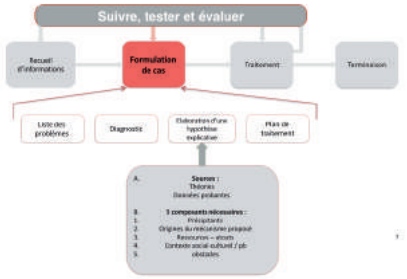


Les critères pour placer un type de preuve dans le continuum devraient comprendre la cohérence avec les résultats et les connaissances bien établies tant au niveau des études de processus, de la psychopathologie, du développement de la personnalité et de la cognition...

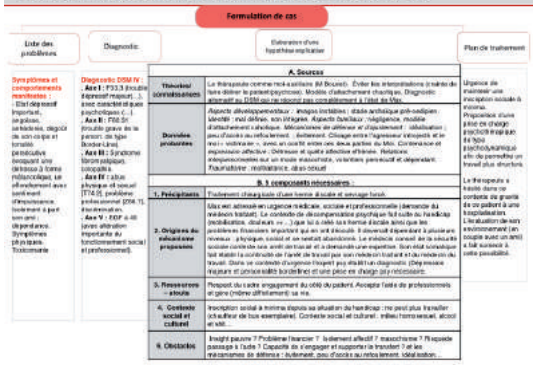
* Ref à EELLS What is an evidence-Based psychotherapy case formulation ?

Propostion d'un cadre de Formulation de cas

Cadre proposé par EELLS in *Psychotherapy* div. 29 de l'APA (2011).
What Is an Evidence-Based Psychotherapy Case Formulation?



Cadre pour valider des données probantes d'une formulation de cas



Données probantes dans ce cas

L'accord inter clinicien qui se fait à partir de la description clinique et de la cohérence entre l'exposé des problèmes du patient et les hypothèses explicatives qui peuvent être proposées.

Les instruments :

- Des instruments validés.
- Formation à l'instrument assurée
- L'instrument n'est pas une fois pour toute dans la tête du cotateur,
- Les évaluations doivent être suffisamment nombreuses
- Se soumettre au codage standardisé d'une échelle, s'éloigner d'un codage personnel.

Le diagnostic :

- Évaluation de la nécessité d'un diagnostic alternatif de type DESNOS (Disorder of Extrem Stress Not Otherwise Spécified).

le concept d'insight signalé dans la première FC « désespérément pauvre », remis en question à la relecture des données cliniques :

- Point aveugle du thérapeute ?
- Pour Max l'insight peut-il être indépendant de la relation thérapeutique ?
- Max a-t-il un insight en dehors de la thérapie ?
- La définition de l'insight en relation avec l'instrument EFP est relue

Rapports entre la réalité interne et externe:

- Modèle d'attachement chaotique, on va s'intéresser à la réalité interne et externe du patient, car on pense que les problèmes du patient vont être liés aux choses de l'ordre de la peur.

Les cauchemars récurrents de Max : doivent être notés comme facteur précipitant. Ils maintiennent le tableau clinique. Une fois qu'il est exprimé, le cauchemar devient comme un symptôme de la réalité externe (faire des cauchemars à répétition, c'est usant, un cycle de causalité du stress) mais un cauchemar c'est particulièrement en lien avec la réalité interne.

Les priorités dans ce cas grave ? : se concentrer sur des causes qui soient accessibles à l'action thérapeutique, les plus pertinentes possibles. La détresse et le risque d'exclusion comme premier objectif…

Et pour terminer, à partir de la parole du clinicien de Max *« Être là sans contredire, ne pas faire d'interprétations »*. Cela prend une dimension de non hiérarchisation dans la relation, ce n'est pas simplement un élément technique qui est décrit, cela vient à bon escient dans la problématique du patient, c'est cela qui est très fort. Cela veut dire que le thérapeute à la limite va contre sa référence technique dont il se libère dans ce cas là. Le cadre psychosocial renforce la position du psychanalyste, cela ouvre à des aspects novateurs.

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15. Roscoff 3ème Journée doctorale de thèse 2016

Modeling the psychotherapy change process: From single-case reports with R to aggregated cases with PLS-SEM.

Modeling the psychotherapy change process From single-case reports with R, to aggregated cases with PLS-SEM

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BACKGROUND

❍ The core symptoms of autism (social deficits, language disorder, and stereotypic behavior) often respond well to intensive behavioral interventions, demonstrating that they are indeed malleable. However, this possibility is not related to an understanding of mechanisms of therapeutic action. Access to this knowledge is a challenge for research and practice (Kazdin 2008). But, by what method ?

❍ Designs that seem to be most appropriate and necessary are small *N* or single-case studies focused on change process. With these designs it is possible to identify, describe, infer assumptions about how the therapist's interventions, patient's responses and their interactions (i.e., the therapeutic process) contribute to predict the therapeutic outcome. Single-case research can be of *experimental* type (with manipulation) or *observational* type. There is nothing inherent in single-case designs that requires either direct manipulation or passive observation.

❍ Characteristic of all single-case research is a focus on variation within subjects over time and the attempt to understand this variation as a fonction of other variables that vary *within subject* over time or as a fonction of variables that vary *across subjects*. According Hilliard (1993), global aggregation across cases must be avoided and the generality of one's findings can be addressed through direct and systematic replication on a case-by-case basis. Actually, different methods, where conceptualisation, modeling and tests succeed, seem open the possibilities of generalisability (Carey & Stiles 2015).

MODELING INVOLVES SEVERAL ISSUES

1. Epistemological: the transactional nature of the relationship between patient and therapist determines the therapeutic action's process (Jones *et al.* 1992). The term *process* implies the temporal unfolding of variables within therapeutic dyads. The term *case* or *subject* may refer either to a single individual (the patient or therapist) or to a therapeutic dyad, depending on whether the phenomenon of interest is analyzed at the individual or dyadic level.

2. Methodological: single-case measures, at a fine grain level, are collected; measures of the variable(s) are repeated over time; a consensual description of the internal process is obtained from a specific instrument; activity of the therapeutic process and the associated results are described; qualitatively and quantitatively; assumptions about active variables are infered and tested (Kazdin & Kendall 1998); variations *intra* and *inter subjects* are distinguished. Quasi-experimental single-case studies, carried out in natural conditions as part of a clinical research network, may meet these criteria (Thurin et *al.* 2015); the Child psychotherapy Process Questionnaire (CPQ) (Schneider & Jones 2006) is a central tool of process investigation.

3. Analytical: based on data from individual cases, case-to-case comparisons, and secondarily aggregated cases after replication, descriptive and statistical methods can be applied without the direct manipulation of any of the variables studied (i.e., measures of external indicators of change, mediators, moderators, case profiles, sequential and growth curve analysis, causal chains). Each approach may contribute to modeling.

SINGLE-CASE ANALYSIS

❍ Intrasubject design refers to research that focuses on the temporal unfolding of variables within individual subjects. Five steps of data analysis are described:

1. Initial Case Formulation and functional analysis

A case formulation, as a summarization and integration of pre-treatment and first sessions clinical assesment, is realized. Case Formulation is complemented by a functional analysis that describes the relations between clinical features and variables associated outside and in therapy.

2. Longitudinal quantitative assessment of external indicators of change (behavior, development, functioning)

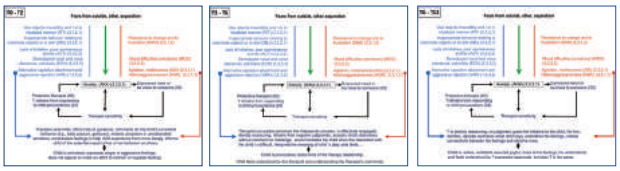
3. The ranking of the 100 variables of the CPQ characterizes the internal process of therapy. Measures follow a normal distribution.

Variables always very characteristic and 20 most characteristic variables at each phase of therapy (e.g. beginning, middle an end) are selected and grouped by theme. They represent the range of potential mediators from the therapeutic dyad. Mechanisms of their potential impact and expected outcomes are inferred.

4. Results. The relationship between 1) the external indicators; 2) the potential mediators; and 3) the moderators are examined and described in the 3 periods of the evaluation. Variation between initial and one year case formulation is assessed.

5. Discussion and conclusions. Threats to internal validity for this case are examined, strengths and limits are presented. Remaining questions are underlined.

Below, we present the simplified change process of a case in the 3 study periods: 0-2, 2-6, 6-12 months.



The three graphs above describe the main characteristics of the change process of Caesar, an autistic child who started psychotherapy at the age of 9 years and whose main problems were: high anxiety about the outside, intolerance to frustration and to separation from his mother. Various defense mechanisms are associated: ritualisation, aggressiveness ... Behaviors (upper graph part) are evaluated with the BSE-R. Items of permanent dyadic interaction during the year are presented in the center part and the specific interactions at 2, 6 and 12 months, in the graphs lower part.

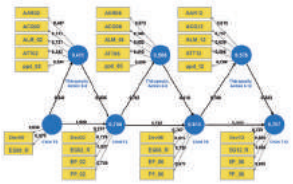
AGGREGATION ACROSS CASES and ANALYSIS

❍ Intersubject variation refers to differences between or across subjects. Cross-sectional perspective and direct aggregation across cases are avoided. Intersubject variability may be studied in patterns of intrasubject variability of change. The generality of findings is usually addressed through replication on a case-by-case basis.

❍ Two types of *replication* across subjects are described (Kazdin, 1982). The first, designated *direct replication*, refers to the attempt to replicate the findings in subjects that are similar in terms of the individual-differences variables that are viewed as affecting the phenomenon of interest. The second type of replication, *systematic replication*, refers to the attempt to show that the findings differ in predictable ways when one selects subjects that differ along the critical individual-difference variables. The comparison of subjects highly similar in terms of certain individual-difference variables (sex, age, initial disorder severity), but whose outcome is different is a fruitful way of single-case research.

❍ Once the phenomenon of interest is sufficiently well understood at the single-case level, intelligent aggregation over truly homogeneous groups may be possible. Three factors are to be considered when exploring the issue of true *homogeneity*: (a) the nature of the question being asked, (b) how the pattern of intrasubject variation differs across subjects, and (c) the particular aggregational statistic that can be used.

❍ The aggregational statistics are multilevel statistics : growth curve, factor analysis, principal component regression, PLS-SEM (Falissard 2014, Hair *et al.* 2014). Below, we present the simplified figure of the main variables involved in the evolution of 60 cases, calculated with PLS-SEM method.



Structural Equation Modeling (SEM) allows the researcher to incorporate unobservable variables indirectly measured by indicators variables. PLS focuses on explaining the variance in the dependent variables when considering the model. This graph shows the relationship between latent variables describing evolution of the clinical status of the child and latent variables describing therapeutic action. The chain is initiated by the initial status of the child, from which therapeutic action is committed. Therapeutic action involves the therapist and the child (dyad).

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16. Paris Cippa 1 2017

La causalité des changements au centre de la recherche.

La causalité des changements au centre de la recherche

Réseau de Recherches Fondées sur les Pratiques psychothérapiques (RRFPP) : Pôle autisme

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● **Contexte :** Une intolérance au changement et/ou à la frustration dans le cadre de la psychothérapie de 66 enfants autistes.

● **Rappel de la méthodologie d'évaluation dans le RRFPP**

Une année d'évaluation en groupe de pairs, 4 types d'outils : Formulation de cas, ECAR (symptômes et comportements), EPCA (pathologie, développement), CPQ (processus de la psychothérapie).

● **Comment se constituent les informations qui nous permettent de concevoir des chaînes causales ?**

Les chaînes causales sont issues des hypothèses relatives à (1) la causalité de la psychopathologie et (2) aux processus de réduction des troubles et de reprise développementale.

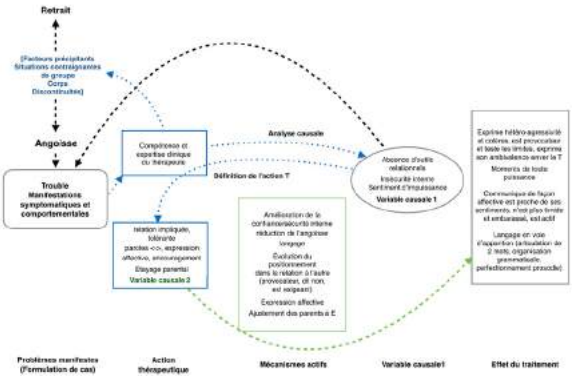
Pour les concevoir, nous disposons des connaissances et des théories existantes auxquelles s'associe la constellation d'éléments issus des formulations de cas et des trois instruments utilisés dans la recherche (ECAR, EPCA, CPQ).

● **Identification du problème posé**

1. Consultation des 66 premières formulations de cas (FC)
   • 25 FC identifient une Intolérance à la frustration et/ou au changement (une situation fréquente habituellement difficile à gérer par l'entourage).
2. Un des 29 items de l'ECAR, l'item 11, identifie spécifiquement ce problème
   • Consultation des scores aux 4 temps de l'évaluation pour les 25 enfants.
3. Dans le contexte d'une tendance générale à l'amélioration du groupe initial (M: 57 ->31), sélection des 4 enfants présentés ici : deux enfants dont l'item 11 reste élevé à 12 mois ; deux enfants dont l'item 11, initialement très élevé, s'est réduit au cours des évaluations.

● **Qu'est-ce qu'une chaîne causale ?**

1. Nous nous appuyons sur les éléments qui sous-tendent le problème posé, les symptômes associés et les conditions d'apparition ici de l'intolérance à la frustration ou au changement identifiée par le thérapeute.
2. Nous posons un premier jeu d'hypothèses sur le dysfonctionnement qui sous tend le ou les comportements manifestes.
3. Nous cherchons ce que fait le thérapeute, si l'action thérapeutique est susceptible de répondre au dysfonctionnement, par quel mécanisme, et si l'observation se retrouve dans des cas répliqués.
4. Si c'est le cas, c'est un argument pour penser que l'hypothèse a une certaine pertinence. Sinon la théorie provisoire initiale doit être réévaluée.



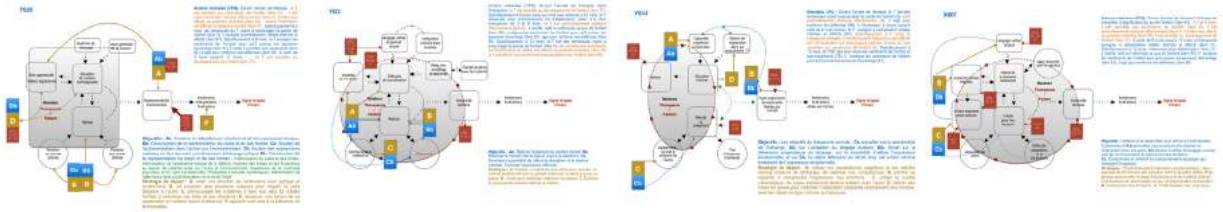
Un exemple : Chaînes causales 1 et 2, à partir des manifestations émotionnelles aigues chez un enfant autiste (Y020)

● **Construire une chaîne causale : 4 exemples**

Pour construire la chaine causale, nous partons du signe d'appel, les crises de colère ou de violence de l'enfant, identifiées par le thérapeute comme étant le résultat, dans certains cas, d'une intolérance au changement et/ou à la frustration. Cliniquement, nous en déduisons un dysfonctionnement, une hypersensibilité sensorielle ou émotionnelle, une insécurité de base... Nous portons attention ensuite à ce qui déclenche ce processus, les situations de relation contraignante, une situation d'échec...et le mécanisme de défense que met en place l'enfant, par exemple, par le retrait et/ou l'évitement.

À ce modèle, viennent s'ajouter pour chacun des enfants des spécificités particulières par rapport à sa capacité d'exprimer ses émotions (acquisition du langage par exemple, situation scolaire bien ou mal installée, peur générale de la relation ou dans certaines situations...).

L'hypothèse concernant la réduction du dysfonctionnement s'établit à partir de la relation patient/thérapeute et les actions de ce dernier dans les différents aspects du problème concerné (en gris dans les schémas).



Y020. Le symptôme d'appel initial n'est pas résolu à 12 mois. Cependant, une réduction à 2 mois, non maintenue, est observée (ECAR).
Par ailleurs, langage en voie d'apparition (EPCA), réduction de l'auto agressivité. L'enfant devient plus actif et exprime sa colère (CPQ), il sort un peu de son repli et développe une relation à l'autre. Avec l'amélioration à 2 mois, nous inférons des progrès à venir....

Yi23. Le symptome d'appel initial n'est pas résolu à 12 mois. Cependant, les scores agitation, turbulence, troubles de l'humeur, recherche d'isolement, s'apaisent et l'enfant s'efforce de communiquer (ECAR). Il est moins triste, timide et embarrasé (CPQ). Ces deux descriptions indiquent que l'enfant sort de son retrait et de sa dépression. Il conserve cependant une difficulté forte à partager l'émotion (ECAR)....

Y044. Le symptome d'appel initial est plutôt résolu à 12 mois. Le retrait massif de départ ainsi que le non partage d'émotions sont améliorés, même s'ils demeurent encore avec des scores moyens (2). À l'EPCA, Les colères violentes, voire tantrum ont disparu. L'image du corps s'améliore avec une confirmation du stade de miroir et une propreté acquise. On note également l'acquisition du graphisme....

X007. Le symptôme d'appel initial n'est pas complètement résolu mais en bonne voie. Le retrait important de l'enfant a beaucoup régressé et au CPQ on note une confiance établie avec le thérapeute.
Les difficultés concernant les relations avec ses pairs et avec le monde scolaire (problème majeur), demeurent. mais une relation privilégiée avec deux enfants est rapportée à 12 mois.

● **Commentaire**

À partir d'une manifestation d'appel similaire, des éléments communs et des éléments différents sont observés. **Communs :** *du côté de l'enfant,* le symptôme d'appel n'est pas isolé. Il peut être rapporté à plusieurs causes déclenchantes (telle qu'une situation relationnelle contraignante ou difficile, un échec à la réussite d'une action), qui sont accompagnées d'une communauté de mécanismes de défense (retrait, évitement). Des hypothèses sur des troubles du développement primaire peuvent être également posées (image du corps, contexte psycho-sensoriel, fragilité de l'identité...). **Différents :** le symptôme d'appel peut être accompagné par de l'agressivité, un retrait affectif, des crises d'angoisse ou des colères. *L'attitude générale du thérapeute* est similaire dans les différents cas et ses actions spécifiques sont ajustées aux problèmes particuliers de chaque enfant. *La relation dans la thérapie est ainsi un des axes explicatifs majeurs de l'action thérapeutique.*

Pôle Autisme 2017 : Réseau de Recherches Fondées sur les Pratiques Psychothérapiques (RRFPP)
http://www.techniques-psychotherapiques.org/Reseau/

17. Paris Cippa 2 2017

Une méthodologie innovante et une formation intégrée à la recherche clinique : Pôle autisme du Réseau de recherches fondées sur les pratiques psychothérapiques.

Une méthodologie innovante et une formation intégrée à la recherche clinique : Pôle autisme

Réseau de Recherches Fondées sur les Pratiques psychothérapiques

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CESP - Inserm U 1178

● Une méthodologie innovante centrée sur l'étude de cas...

▸ Suivi intensif d'une année de psychothérapie en conditions naturelles

▸ 4 types d'instruments (formulation de cas, symptômes et comportements, développement, processus)

▸ Une discussion clinique en groupe de pairs sous tendue par des données qualitatives et quantitatives à quatre temps de la psychothérapie

▸ Analyse des données : une représentation synthétique multidimentionnelle des principales caractéristiques de la psychothérapie et des changements qui s'y produisent incluant leur évolution quantitative (stagnation, amélioration, reprise développementale)

● Pourquoi avoir choisi les études de cas ?

La recherche ne se satisfait plus des ECRs pour plusieurs raisons...

Les cliniciens se posent des questions sur ce qui provoque le changement...

● Le travail en groupes de pairs : une validation « interjuges » des cotations

▸ Un groupe de pairs est composé de trois cliniciens qui évaluent trois patients dont les données cliniques sont cotées par chacun et validées au cours de réunions de discussion. Ces réunions peuvent se tenir en présence directe ou par internet (via skype).

▸ À ce jour ...
- 16 groupes de pairs français et 12 italiens se sont constitués
- Potentiellement 84 enfants dont une année de psychothérapie est en évaluation
- L'évaluation de la psychothérapie pour 66 enfants autistes est terminée

● Les instruments d'évaluation

La formulation de cas

° Plan d'organisation des données cliniques pour une stratégie de traitement

L'échelle d'évaluation ECA-r
(C. Barthelemy et col.)

Échelle des comportements autistiques

La grille EPCA
(G Haag et col.)

Évaluation psychodynamique des changements dans l'autisme

Child Psychotherapy Q-Set
(Celeste Schneider et Enrico Jones)

Questionnaire du processus psychothérapique chez l'enfant

● Où en est le réseau ?

▸ 66 études terminées dans le pôle autisme !

▸ 2 rapports, des publications...

▸ Un site internet : http://www.techniques-psychotherapiques.org/Reseau/

▸ Un Webséminaire mensuel : depuis deux ans, plusieurs cas sont travaillés en profondeur. Pour 2017, le séminaire propose de travailler sur l'expression et la modulation des émotions chez l'enfant/l'adolescent souffrant de troubles autistiques. Que faire devant une crise émotionnelle intense déclenchée par une frustration, une séparation, un changement ? Ou, à l'inverse, une absence d'expression émotionnelle …

▸ En préparation, une formation à la grille EPCA dans le même esprit que les MOOCs, dispensés actuellement par internet. Cette formation qui devrait commencer bientôt sera un des volets de celle qui se met en place actuellement par la CIPPA. Le MOOC sera une découverte approfondie de l'instrument, la formation de la CIPPA une application pratique.

Pôle Autisme 2017 : Réseau de Recherches Fondées sur les Pratiques Psychothérapiques (RRFPP)
http://www.techniques-psychotherapiques.org/Reseau/

18. Oxford 1 SPR 2017 (U.K.)

Causality of changes in psychotherapy. Analysis of risk factors and therapeutic action during one year of psychotherapy.

Causality of changes in psychotherapy

Analysis of risk factors and therapeutic action during one year of psychotherapy in 25/66 children with significant intolerance to change and / or to frustration

Monique Thurin - Jean-Michel Thurin

French Psychotherapy Practice-Based Research Network
CESP, Inserm, U 1178, mthurin@me.com

Reminder of the evaluation methodology in the French Psychotherapy Practice-Based Research Network

One year of peer group assessment, 4 types of tools:

• Case formulation, ECA-r (symptoms and behaviors), EPCA (pathology, development), CPQ (process of psychotherapy).

Identification of the problem.

1. Consultation of the first 66 Case Formulations (CF)

• 25/66 Case Formulations identify an « Intolerance to frustration and/or to change » (a common situation usually difficult to manage by the entourage)

2. One of the 29 ECA-r items, item 11, specifically identifies this problem

• Consultation of the scores of this item at the 4 times of the evaluation for the 25 children

3. In the context of a general tendency of the initial group to improve

• Mean reduction of ECA-r scores: 56 -> 36 - sd: 1,19

How do we build up the information that makes it possible to conceive causal chains?

The causal chains are derived from the questions and assumptions about (1) the causality of psychopathology and (2) the processes of disorder reduction, developmental recovery and their causality.

To design them, we start from the existing knowledge base and theories associated with the constellation of elements included in the case formulations and described by the three instruments used in research (ECA-r, EPCA, CPQ).

Construction of the causal chain (1)

1. Based on the elements that accompany the problem, the associated symptoms and the conditions of occurrence of the intolerance to the frustration or change identified by the therapist.

2. We present a first set of hypothesis about the dysfunction underlying the manifest behavior (s).

3. We observe, from the CPQ, what the therapist does, if and how the therapeutic action is likely to respond to the dysfunction, by what mechanisms, and if the observation is found in replicated cases.

4. If this is the case, it is an argument to think that the hypothesis has some relevance. Otherwise, the initial provisional theory of change must be re-evaluated.

One of the general principles of causality is the coherence between the observed effect and the mechanism(s) that can explain it

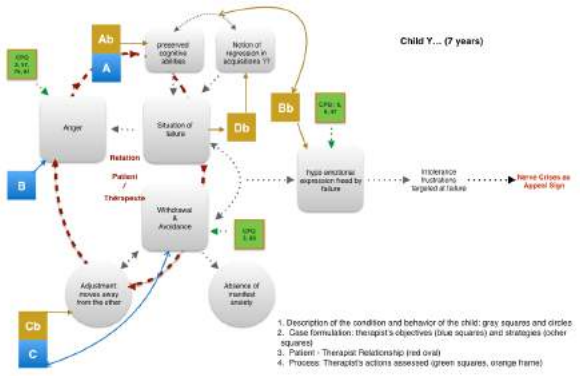
CF: Situation = Intolerance to frustration and/or to change -> ECAr: behavioral score
-> EPCA: pathology, dévelopment
Objectives and strategy of therapist -> CPQ: therapeutic action of therapist
Evolution of the problem (description of the child: ECAr, EPCA, CPQ)

Construction of the causal chain (2) : exemple

To build the causal chain, we start from the sign of appeal, the anger or violence of the child, identified by the therapist as the result, in some cases, of an intolerance to change and / or frustration. Clinically, we observe a dysfunction, the triggering factor and the vulnerability that underlie it. For example, a sensory or emotional hypersensitivity, a basic insecurity ... We then pay attention to what underlies this process: situations of encounter to relationship, a situation of failure ... and the defense mechanism put in place by the child: for example, withdrawal and / or avoidance.

In addition to this model, each child has special characteristics in relation to his / her ability to express his / her emotions (eg. acquisition of language, well or poorly placed school situation, general fear of the relationship or in certain situations).

The hypothesis concerning the reduction of dysfunction is based on the relationship between the patient and the therapist and the actions of the latter in the various aspects of the problem concerned (in gray in the diagrams). Other explanations are systematiquely explored.



• The initial prevalent symptom is rather resolved at 12 months. Massive withdrawal and non-sharing of emotions are improved, although they still remain with average scores (2). At EPCA, violent anger, or even tantrum, disappeared. The image of the body improves with confirmation of the stage of mirror and cleanliness acquired. We also note the acquisition of graphic design ....

Legend of the diagram

1. Description of the *condition and behavior* of the child.

2. *Objectives:* The therapist's objectives are to work: A. the use of existing language, B. the pragmatic dimension of language, the possibility of using emotional expression, and C. the spontaneity of exchange and the defensive value of withdrawal in this child as the avoidance of emotional expression.

Starting strategy: Ab: Using cognitive skills and Child's interests as engines of exchange, valuing these skills. B. Verify his / her ability to understand the expression of emotions; Cb. Use the «dramatic» quality of emotional overlay in the relationship. Db. Use staging to mobilize the relatively little invested body involvement of the Child with the objects he/she proposes (cars).

3. It is in the relationship *Patient / Therapist* that this work will be put in place and be more dynamic. This relation is represented in the diagram by a red oval whose arrows recall the dynamic aspect of the elements.

4. *Process (CPQ):* During the therapy year, the therapist makes remarks aimed at encouraging the child's speech (3), he/she is particularly involved emotionally (9), acts to strengthen the defenses (89). At the 2-month to 6-month evaluation, the therapist emphasizes the verbalization of internal and affective states (97). Specifically at 6 months, the therapist adapts to the child when interaction is difficult (47). At the 6-month to 12-month assessment, T is sensitive to the child's feelings (6). Specifically at twelve months, he/she makes connections between the child's feelings and experience (76), he emphasizes the child's feelings so that he/she may experience them more (81).

Comment

From a similar appeal manifestation *common elements* and *different elements* are observed among the 25 selected children.

• **Common**: *on the side of the child*, the appeal symptom is not isolated. It can be related to several triggering causes (such as a constraining or difficult relational situation, failure to achieve an action), which are accompanied by a community of defense mechanisms (withdrawal, avoidance). Assumptions about primary developmental disorders may also be posed (body image, psycho-sensory context, fragility of identity ...).

• **Different**: the appeal symptom may be accompanied by aggressiveness, emotional withdrawal, anxiety attacks or anger.

The general attitude of the therapist is similar in the different cases and his specific actions are adjusted to the particular problems of each child. *The relationship in therapy is thus one of the major explanatory axes of therapeutic action.*

19. Oxford 2 SPR 2017 (U.K.)

Understanding mechanisms of psychotherapeutic action in a population of 66 children/adolescents suffering from autism.

Understanding mechanisms of psychotherapeutic action

in a population of 66 children and adolescents suffering from autism

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French Psychotherapy Practice-Based Research Network

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French Federation of Psychiatry

BACKGROUND

The core symptoms of autism (emotional modulation deficit, social deficits, and stereotypic behavior) often respond well to intensive intensive psychodynamic interventions, demonstrating that they are at least partially functional. However, this possibility is not related to an understanding of mechanisms of therapeutic action. Access to this knowledge is a challenge for research and practice (Kazdin2001 … 2008). But, by what method ?

Designs that are the most appropriate and necessary are single-case studies targeted at the internal process of change in psychotherapy. With these designs it is possible to identify, describe, and infer assumptions about how the therapist's interventions, patient's responses and their interactions contribute to predict the therapeutic outcome. There is nothing inherent in single-case designs that requires either direct manipulation or passive observation.

Characteristic of all single-case research is a focus on variation within subjects over time and the attempt to understand this variation as a fonction of other variables that vary *within subject* over time or as a fonction of variables that vary *across subjects*. Global aggregation across cases must be avoided and the generality of one's findings can be addressed firstly through direct and systematic replication on a case-by-case basis (Hilliard 1993). Actually, different methods, where conceptualisation, modeling and tests succeed, seem open the possibilities of generalisability (Kazdin & Kendall 1998, Carey & Stiles 2015, Thurin 2017).

MODELING MECHANISMS OF PSYCHOTHERAPEUTIC ACTION INVOLVES SEVERAL ISSUES

1. Epistemological: the transactional nature of the relationship between patient and therapist determines the therapeutic action's process (Jones *et al.* 1992). The term *process* implies the temporal unfolding of variables within therapeutic dyads. The term *case* or *subject* may refer either to a single individual (the patient or therapist) or to a therapeutic dyad, depending on whether the phenomenon of interest is analyzed at the individual or dyadic level.

2. Methodological: single-case measures, at a fine grain level, are collected; measures of the variable(s) are repeated over time; a consensual description of the internal process is obtained from a specific instrument; activity of the therapeutic process and the associated results are described; qualitatively and quantitatively assumptions about active variables are infered and tested (Kazdin & Kendall 1998); variations *intra* and *inter subjects* are distinguished. Quasi-experimental single-case studies, carried out in natural conditions as part of a clinical research network, may meet these criteria (Thurin et *al.* 2015); the Child psychotherapy Process Questionnaire (CPQ) (Schneider & Jones 2006) is a central tool of internal process investigation.

3. Analytical: based on data from individual cases, case-to-case comparisons, and secondarily aggregated cases after replication, descriptive and statistical methods can be applied without the direct manipulation of any of the variables studied (i.e., measures of external indicators of change, mediators, moderators). Case profiles, sequential and growth curve analysis, causal chains are obtained. Each approach contributes to modeling.

SINGLE-CASE ANALYSIS. Each case study is organized as following

1. Initial Case Formulation (C.F.), complemented by a functional analysis focused on the risk and inferred resolution factors;

2. Longitudinal quantitative and qualitative assessment of external indicators of change (behavior, development, psychic functioning);

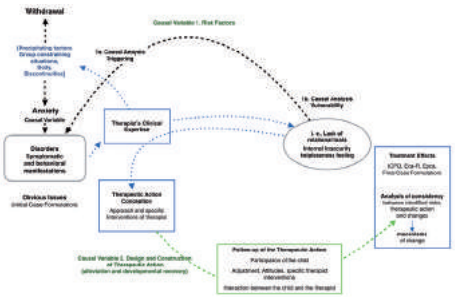
3. On the basis of appeal symptoms and of the mechanisms of adaptation and defense associated with them, determination of the main risk factor and the potential dysfunction that underlies it;

4. Analysis of the therapeutic action (most characteristic elements of the CPQ at 2, 6 and 12 months = mediators), its consistency with (a) initial objectives (C.F.), (b) evolution of risk factor, and (c) the outcome (change in manifest indicators). Analysis examines whether there is a causal relationship between the risk factor and the outcome, *ie, whether the change in the risk factor leads to a change in the outcome, with the mediation of therapeutic action*. Mechanisms of its potential impact on dysfunctions and outcome are inferred;

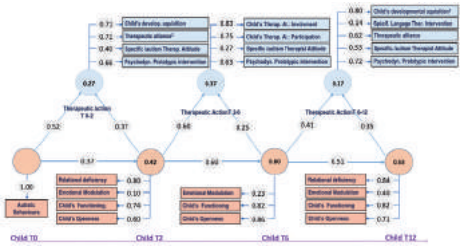
5. Discussion and conclusions. Final C.F. and outcome. Threats to internal validity for each case are examined, strengths and limits are presented. Remaining questions are underlined.

The risk factor method can be supplemented by a sequential, quantitative and qualitative analysis describing child's expressions in psychotherapy and therapist's adjoining responses.

Causal chain process for one patient



Causal chain process with PLS-SEM for 66 patients



REPLICATION. As a result of replication, inter-case analysis establishes the same function as that of the control group in group experimental studies; the development of theory, from the replication of observations is the ultimate goal of exploratory research.

AGGREGATED CASES ANALYSIS. PLS-SEM analysis, method of structural equation modeling, makes it possible to integrate quantitatively unobservable variables directly by indirectly measuring them by indicator variables. It deals with the psychotherapeutic action as a specific mediation represented by the variables associating the therapeutic alliance, the specific approach of the therapist and the development of the child.

RESULTS AND DISCUSSION. Applicated to a population of 66 children with autistic disorder, individual case studies provide important individual information for describing the characteristics of the initial situation, external and internal process of change and understanding mechanisms underlying them. Risk factor method extended to related therapeutic action is a major step of this process. Sequential analysis of individual cases and PLS-SEM analysis with aggregated cases, which share a common structural model, bring interesting complement.

Among the most significant explicative items in the internal process of psychotherapy, we find therapist's sensitivity, involvement, tolerance and adjustment of his action to the clinical situation and possibilities of the child. On the part of the child, and especially in the subgroup with initial intolerance to frustration, an emotional transfer is established with the therapist with successive expression of aggressiveness, ambivalence and desire for closeness.

The essential dimension that is affirmed is that the child is confronted with situations that he can't assume and to which he/she initially reacts by emotional responses and / or withdrawal (mechanisms of defense). Psychotherapy allows him to acquire more mature forms of adaptation. The therapist intervenes with his individual and technical skills to help the child reduce his fear of the world and others, that he also expresses in psychotherapy. Gains of aptitude and psychic health are expressed in the child in his relations with himself, the world and others.

With the second-generation case studies focused on process of change, there are now a number of approaches to address central clinical and theoretical issues. Collaboration between researchers and clinicians is more than ever on the agenda with a view to broadening the knowledge base and improving practices' quality.

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20. Krakow SPR 2019 (Polonia)

Analyse multiséquentielle

Une pratique innovante pour l'analyse multiséquentielle d'un cas complexe (Léo, 6 ans)

Réseau de Recherches Fondées sur les Pratiques psychothérapiques : Pôle autisme

● 1ère analyse des données cliniques de Léo, en groupe de pairs, sur une période d'un an

La formulation de cas
Plan d'organisation des données cliniques pour une stratégie de traitement

L'échelle d'évaluation ECA-r
(C. Barthelemy et col.)
Échelle des comportements autistiques
56 versus 41

La grille EPCA
(G Haag et col.)
Évaluation psychodynamique des changements dans l'autisme
D : 26 vs 31

Child Psychotherapy Q-Set
(Celeste Schneider et Enrico Jones)
Questionnaire du processus psychothérapique chez l'enfant

● **Léo est un enfant porteur d'un autisme sévère.** À un an de l'évaluation, l'analyse des données issues des instruments indiquent que le score des comportements autistiques a baissé et que le score développement a augmenté. La formulation de cas à un an signale également des acquisitions, une amélioration des moments d'angoisse, des crises de tantrum qui ont disparu, etc. Aller plus loin pour mieux comprendre ce qui a provoqué ces changements...

● Reprise des verbatim des séances de psychothérapie de Léo par 12 cliniciens-chercheurs* en séminaire via internet..

1ère séance à 12 mois de Léo

●Léo apporte un jouet-garage de son groupe ● (cela me rappelle le jouet- champignon qu'il avait apporté en présence de sa maman il y a de cela quelques mois). Il ne me regarde pas, pose le garage sur le matelas, il mâche la manche de son pull (dont il a dégagé le bras, ce qui lui permet d'avoir les deux mains libres et la bouche pleine de sa manche). ●Il mastique avec application et émet de nombreux sons dans différents registres.
●Il s'assied sur le matelas rose à côté du garage et dos au miroir. Il passe sa main dans les différents espaces du garage, rampes d'accès, ascenseurs, plate-forme, épouse la forme du toboggan. Son regard suit sa main, il s'en approche très près comme s'il voulait entrer dans le garage. Il mord alors le bord et son regard se dirige vers moi.
● - Bonjour Leo, je suis contente de te revoir, les vacances ont été longues mais maintenant nous allons nous revoir régulièrement.
●Léo pose brusquement le garage, il se lève et se dirige vers l'étagère à livre. Il y trouve un livre cartonné percé de deux trous de part en part et qui représente les yeux d'un loup. Il met ses deux index dans les trous des yeux et ouvre les pages une à une. Il cherche très vite à plier en deux les pages cartonnées.
● - Tu as peut-être ressenti que tout ce temps d'absence était comme le lien que nous faisons exister par le regard qui se casse, nos rencontres étaient comme cassées.
●Léo me fixe du regard très franchement, c'est un regard approbateur. Il accentue les pliures et le livre se déchire peu à peu.
● - C'est toi maintenant qui veut être maître de la séparation, de la présence-absence, mais je ne peux pas te laisser casser les livres. À la maison, tu déchirais beaucoup les revues de papa et cela le mettait en colère, il était obligé de les mettre dans l'armoire et de fermer l'armoire à clé. Cela déclenchait de terribles colères et tu te jetais par terre. Je sais que maintenant tu peux regarder les images des revues de papa sans les déchirer. Il peut te les prêter. ●Ces éléments m'ont été rapportés par la maman juste avant les vacances. ●Il continue à plier le livre et m'oblige à intervenir.
Je saisis un tissu dans lequel Léo a souvent cherché à s'envelopper et entoure le livre de ce tissu. Léo, séparé du livre, tombe à terre sur ses genoux mais l'effondrement n'est pas total, le geste était mimé, il observe mes réactions.
● - Tu viens de me montrer comme tu as pu tomber dans les moments ou tu étais séparé. La partie déchirée, cassée pouvais devenir méchante pour toi, dangereuse. Je vais prendre soin de cette partie détachée. ● Je place le livre dans la petite poussette.
●Léo se redresse, prend la poussette (et le livre), il se dirige vers la porte et sort de mon bureau. Il laisse la porte ouverte, je ne le suis pas tout de suite, il revient me chercher. Il me prend la main et m'entraîne dans le couloir, il tire la poussette de l'autre main. Il me montre la porte du « sas » entre la salle de bains et le couloir et cherche la clé dans ma poche pour l'ouvrir. Il place la poussette dans le sas et referme la porte.
C'est l'heure de nous séparer, je range la poussette dans mon bureau et le raccompagne dans son groupe. Je lui tends la main pour le saluer, il me tend la sienne en me regardant....

●*Notes de la T décrivant les actions de l'enfant* ●Action/interprétation de la T ●Commentaire/action T

● Les étapes du travail

●15 séminaires de deux heures
●Compte-rendus de 9 séances
●Analyse séquentielle
- Discussions et commentaires
●Séquences clé & Hypothèses fortes
●Identification de causalité et de mécanismes de changement
●1 document de synthèse

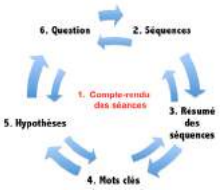
● Des objets qui émergent

●Le matelas rose
●La petite voiture
●Le garage
●Le placard
●Les couloirs
●La poussette

● Des questions qui émergent

●Le déraidissement
●Accordage, désaccordage, réaccordage
●L'ajustement du thérapeute
●Interprétation : pourquoi, comment, dans quelles conditions ?
●Ce qui a changé d'une séance à l'autre
●...

● Les étapes du travail en séminaire (exemple avec la séance n° 1)

1. Compte-rendus des séances	2. Les séquences clés	3. Résumé formulé des séquences	4. Les mots clés	5. Les Hypothèses	6. Formulation de questions	7
Léo vient seul. Léo me jette un regard furtif. Il me prend la main et me conduit vers ma salle.Il se saisit du matelas qu'il pose à terre et me prend la main pour que je l'aide à l'y installer. Je l'aide puis m'éloigne de lui. Il recherche manifestement ma présence pour une séquence de portage et de balancement comme nous avions coutume de le faire avant les vacances. « tu recherches le portage dans le matelas comme avant les vacances…, » Je me contente de verbaliser mais ne le porte pas. Léo écarte les bords du matelas, il me jette un regard triste, il se lève et se dirige vers l'armoire où il prend la petite voiture. Il semble renoncer très vite à m'adresser une demande et saisit son Object autistique (la petite voiture en métal). Il se met dans un coin, me tourne le dos…,	Séquence 1. L'enfant rentre en contact avec sa thérapeute dès le début de la séance. Il cherche à reproduire la situation de bercement dans « son » petit matelas, situation qu'il a connue avant la séparation d'avec sa thérapeute durant les vacances. La thérapeute verbalise la situation sans la reproduire. L'enfant manifeste une tristesse/détresse et se dirige vers l'armoire pour retrouver « sa » petite voiture « rassurante » (« objet autistique »?). Séquence 2. La thérapeute se réengage dans l'activité partagée. L'enfant se détend et entame des lallations et babillages à laquelle la thérapeute répond en imitation ; puis il sourit et anticipe le « plouf dans l'eau » de la comptine. ...	La dimension principale qui est abordée dans cette séance est la relation entre la distance / séparation perçue par E concernant sa T et le retrait avec saisie de l'objet autistique, puis le réaccordage attentionnel initié par une interprétation de la thérapeute ciblée sur le lâchage perçu par l'enfant lorsque sa mère doit s'occuper de son frère. Ce réaccordage est accompagné par un portage et un chant de la T. Il donne lieu à un babillage partagé, puis à un jeu symbolique séparation / rapprochement, ...	Regard furtif, regard triste, regard appel (Levinas), affectif, objet autistique, [frustration / présence maternelle], régression autistique, ajustement, interprétation, maman, ré accordage, jeu avec la ficelle, demande, appel ?, entourance	1/L'enfant exprime par ses comportements une réponse à sa perception de l'environnement qui comporte souvent des angoisses corporelles, spatiales et des menaces perçues dans les rencontres. 2/ Un type particulier de situation ou d'événement (facteur déclenchant) peut conduire à une crise ou au retrait 3/ Des formes particulière de vulnérabilité chez l'enfant (sensorielles, corporo psychiques, émotionnelles, …) font que certains événements/situations ont un effet démultiplié. Ils constituent des variables de risque. Si on réduit la vulnérabilité qui leur est associée, les troubles doivent se réduire (cf Kazdin et al. 1997). Dans certains cas, l'enfant peut ressentir un sentiment de peur et de totale impuissance. Il peut s'inverser en sentiment de puissance au cours de la thérapie. ...	1) L'enfant réagit-il aux commentaires, aux gestes de sa thérapeute ou à la tonalité de sa voix ? 2) Le comportement de Léo traduit-il la recherche d'une situation connue antérieurement ou une vraie (nouvelle) demande d'interaction avec sa thérapeute ? (ou les deux) 	SYNTHESE

Les étapes de 2 à 7 sont réalisées et validées lors du séminaire en tenant compte des commentaires pendant les relectures faites par les 12 cliniciens-chercheurs. Une synthèse est issue de ce travail.

● Des objets qui émergent et qui bougent…

●Le matelas rose (toutes les séances sauf 3 et 6), le point d'ancrage, à partiir d'où quelquechose est possible : se faire porter par la T et en être proche physiquement, déambuler dans les couloirs, poser ses objets essentiels...

● La petite voiture (séances 1 et 4), objet refuge (autistique ? dans la détresse), à distance de la T mais en contact visuel avec manipulation bruyante des portières, incorporé dans la bouche en réponse au stress...

●Le garage (séances 8 et 9), objet que Léo apporte en séance. Il permet à Léo d'appréhender l'espace de l'objet et de lui par rapport à l'objet dont il s'approche très près ou le mord, qu'il quitte aussi brutalement dans un stress. Il est le lieu aussi d'un objet rapporté par la T (une balle) qui se promène sur le garage mais qui fait s'aggriper Léo au garage lorsqu'elle en sort. Un objet initiateur avec la balle d'une étrange contorsion...

●Le placard et les couloirs (séances 3, 4 6 et 7). D'abord le placard à double entrée permet une expérience d'un espace séparé, interprétée par T et dont le résultat est une grande excitation de Léo. Ensuite l'expérience d'un espace fermé/ouvert, noir total mais rai de lumière, entrer/sortir, déambulation/silence/excitation...

●La poussette (séances 5 et 8). Suite à la déambulation dans et hors le placard, la T instaure un jeu avec la poussette, elle se déplace avec puis Léo la prend et laisse la T dans le sas, puis c'est au tour de Léo de rester dans le sas pendant que la T déambule avec la poussette, ainsi de suite une jubilation termine ce jeu lorsque ouvrant doucement la porte il trouve sa T dans le sas.
Suite à un livre déchiré par Léo, la T place le livre dans la poussette. Léo s'empare de la poussette avec le livre dedans et sort dans le couloir seul mais revient chercher sa T qu'il prend par la main en tirant la poussette de l'autre main. Il place la poussette dans le sas, fait le tour puis la retrouve dans une jubilation. À la fin de la séance pour la première fois, il serre la main de la T en partant de la séance en la regardant.

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Separation et Unity
SPR - Krakow, Poland
19-21 september 2019

Pôle Autisme 2019 : Réseau de Recherches Fondées sur les Pratiques Psychothérapiques (RRFPP)
http://www.techniques-psychotherapiques.org/Reseau/

21. Publications dans *Pour la recherche*

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- PLR 55 (décembre 2007). Réseau de Recherches Fondées sur les Pratiques Psychothérapiques (RRFPP). Publication et projet de la réponse à l'appel d'offre Inserm. Éditorial (JM. Danion), Appel à participation, Projet de l'appel d'offre JM. Thurin, B. Falissard, M. Thurin, MC. Cabié, B. Golse, Ph. Robert, G. Haag, C. Barthélémy et D. Mellier.

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- PLR 61 (juin 2009). Traduction et manuel d'utilisation du PQS (*Psychotherapy Process Q-Set*). Éditorial (Comité de rédaction). Questionnaire de configuration psychothérapique. Traduction française de M. Thurin, B. Lapeyronnie, JM. Thurin et JS. Ablon. Qui était Enrico Jones ? Comment a été construit le PQS JM. Thurin ?

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- PLR 84-85 (Mars-Juin 2015). L'expérience des cliniciens italiens du pôle autisme du Réseau de Recherches Fondées sur les Pratiques Psychothérapiques (2). Éditorial (M. Thurin) La psychothérapie psychanalytique des enfants appartenant au spectre autistique dans la recherche Inserm (S. Maiello). Passages évolutifs dans le parcours d'une psychothérapie (M. Lezzi). Une expérience de thérapie commencée en présence de la mère (A. Rossi).

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- PLR 99 (Décembre 2018). Étude pilote de l'évaluation de la psychothérapie de trois patients autistes adultes en institution réalisée dans le pôle autisme du RRFPP. Éditorial (JM Thurin), Présentation de la situation des 3 adultes et analyse approfondie du processus et résultats des psychothérapies à 1 an (M. Thurin et JM Thurin). Critique de la recommandation par consensus formalisé de la HAS ANESM : Trouble du spectre de l'autisme : interventions et parcours de vie de l'adulte (I. Secret-Bobolakis).

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Cahier des Posters & Publications du Réseau

Ce cahier contient "la mémoire" du Réseau de Recherches Fondées sur les Pratiques Psychothérapiques sous la forme de 20 posters présentés dans les manifestations scientifiques nationales et internationales au cours des dernières années. Les références bibliographiques spécifiques au Réseau sont également indiquées. On pourra demander les articles par mail et les obtenir sous format .pdf.

Cette mémoire est également un condensé théorique et pratique des étapes de la construction d'un réseau de recherche fondé sur la pratique et de l'abord méthodologique des données en relation à la complexité inhérente du travail d'analyse.

Ce cahier accompagne le document "Processus et mécanismes de changement dans la psychothérapie d'enfants avec autisme" qui contient la méthodologie, les principaux résultats et les méthodes d'analyse utilisées dans la recherche menée dans le réseau à partir de la psychothérapie de 66 enfants avec autisme.

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