Collective Expert Report

Psychotherapy
Three approaches evaluated

Summary

Inserm

Institut national de la santé et de la recherche médicale
(National Institute for health and medical research)

This document presents a review of the work of the expert group convened by Inserm through the collective expert evaluation procedure to answer the questions raised by the General Directorate of Health (Direction générale de la santé, DGS) on the evaluation of psychotherapies.

It is based on the scientific information available as at the last six months of 2003. The documental base for this expert evaluation consisted of approximately 1,000 articles and documents.

The Inserm collective expert evaluation centre co-ordinated this collective work with the Department for facilitation and scientific partnership (Département animation et partenariat scientifique, Daps) to instruct the dossier and with the documentation service of the department for scientific information and communication (Département de l'information scientifique et de la communication, Disc) for the literature search.

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Foreword

Psychotherapies are widely used treatments in health care practice for mental disorders in adults, adolescents and children. They are used alongside drug therapy for some severe disorders (schizophrenia, bipolar disorder etc.) and as an alternative to drug therapy for other, less severe disorders, or for those in which drug therapies are not used (for example, personality disorders).

In France, psychotherapies are generally recommended to patients by medical psychiatrists, psychologists, general practitioners or other health care professionals, although spontaneous requests also occur. The percentage of these latter cannot be quantified as there are no data available on this subject. Psychotherapies are usually practised on an outpatient basis in the setting of care from psychiatrists and psychologists and on an institutional basis by different parties (nurses, psychologists, etc), often under the responsibility of a psychiatrist. Psychotherapies are not included in the listing of technical procedures in French health care regulations, with the exception of group therapies. A category "psychiatric consultation" which does not specify the type of care administered by the psychiatrist in the consultation does however exist.

On an international scale and according to published scientific works, psychotherapies are performed by psychiatrists and psychologists, and to a lesser extent in the United Kingdom and United States by specialist nurses (Nurse therapists), social workers or specialised counsellors and by students as part of psychotherapy research projects, under close supervision. Finally, in some research work, reference is made to general practitioners who have received brief training in applying methods which have already been tested and are suitable for general medical practice in health care or prevention.

Like other treatments, much scientific work has been conducted on the different psychotherapy methods. Some of this work has sought to evaluate the effectiveness of the practices under different conditions.

In the mental health plan implemented by the Minister of Health in 2001, the General Health Directorate (Direction générale de la santé, DGS) approached Inserm to produce a current overview of the international literature on aspects of evaluating the effectiveness of different psychotherapeutic approaches. Two French associations, Unafam1 and Fnap-psy2 worked with the DGS in this approach. With the agreement of these partners, the scope of the expert assessment covered three major psychotherapeutic approaches – the psychodynamic (psychoanalytical) approach, the cognitive-behavioural approach and family and couple therapy - often used to care for defined disorders of adults, adolescents or children.

In order to respond to this request, Inserm convened an expert group in a collective expert evaluation procedure. The group consists of psychiatrists, psychologists, epidemiologists and bio-statisticians. This expert group structured the analysis of the international literature around the following questions.

How can we envisage evaluation of psychotherapies in terms of efficacy?

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[1] Unafam: Union nationale des amis et families de malades psychiques (National union of friends and families of patients with mental diseases)

[1]Fnap-psy:Fédération nationale des associations de patients et ex-patients en psychiatrie (National federation of associations of psychiatry patients and ex-patients)

What are the different types of studies that enable assessment of the efficacy of the psychotherapies?

What are the methodological difficulties encountered in such an evaluation?

What are the historical stages of the assessment of efficacy of the psychotherapies?

What are the theoretical references for the psychodynamic (psychoanalytical), cognitive-behavioural and family approaches?

What information is present in the literature about assessment of the efficacy of the psychodynamic (psychoanalytical), cognitive-behavioural and family approaches?

What information is present in the literature about the comparative assessment of the efficacy of these different psychotherapeutic approaches?

What information is present in the literature about evaluation of the efficacy of these three psychotherapeutic approaches for different diseases?

What information is present in the literature about evaluation of the efficacy of these psychotherapies in children and adolescents?

We collated more than 1,000 articles from an independent interrogation of the international databases conducted by the collective expert evaluation centre. The experts were asked to supplement this bibliography within their own field of competence and within the scope of the objectives of the expert assessment. The experts presented a critical analysis and review of the published work on international and national scales on the different features of the scope of the assessment during eleven working meetings which were organised between the months of May 2002 and December 2003.

Summary

An evaluation of the effects of the psychotherapies appears to be required in order to guide public health decisions and fulfil the wishes of patients who want to know how effective the treatments offered are.

The expert group has analysed three psychotherapy approaches from the work available in the literature providing the basis for a scientific evaluation of their efficacy: the psychodynamic (psychoanalytical) approach, the cognitive-behavioural approach and the family and couple approach. These psychotherapies have in common their length of use and the solid nature of their theoretical conceptualisation, the existence of specific training in their practice by clinicians and their widespread use within the field of health care.

A second a priori option of the expert group was to direct its attention towards application of these psychotherapeutic methods to the treatment of mental disease in adults, a field in which the literature is most advanced in terms of efficacy studies. The following disorders were considered in this expert evaluation: anxiety disorders, mood disorders, schizophrenia, eating disorders, personality disorders and alcohol dependency. In addition, the group was also careful to consider and report on specific work conducted in the age bands for each type of disease which is also seen in children or adolescents. Similarly, some work relates to autism and other invasive developmental disorders, hyperactivity and conduct disorders.

A scientific assessment of the efficacy of psychotherapies assumes firstly, that the characteristics of the patients included (what diseases are the studies based on, level of severity of the disease and possibly its co-morbidities), and secondly, that the level of improvement of the patients at the end of treatment, are known. The description of the target diseases and definition of the objectives of treatment may differ depending on the studies and according to the underlying theoretical frameworks of the psychotherapeutic approaches. This may make comparisons between treatments difficult. Nevertheless, insofar as a therapy is proposed for a given syndrome, improvement in the syndrome represents a common standard to assess the different therapies.

A number of factors may influence the course of a psychotherapy and therefore its assessment: the nature and severity of the disorder, life events, family and social environment, the placebo effect, the treatment method or technique used, the therapeutic relationship with positive or negative combination effects of treatments and biological changes. These features are also described in the analysis of the different approaches.

How do we see the methodological problems in evaluating psychotherapies?

The scientific assessment of a therapy raises at least three methodological questions: What is the definition of the population of patients to be treated? How do we measure the efficacy of the therapy? How do we prove this efficacy?

The definition of the population of patients treated (equivalent to conventional inclusion and exclusion criteria) partly determines the clinical use of the results from the studies. Firstly, diagnoses must be used which are as close as possible to the widest consensual terminological definitions, in order that the conclusions drawn from the study can be easily

generalised. Secondly, it is essential that the diagnostic process be conducted with a minimum of ambiguity in order to guarantee the reproducibility of the experiment. In practice these two constraints are often difficult to reconcile: the diagnosis categories constructed from an optimal reproducibility basis such as the DSM (American association of psychiatry) or CIM (World Health Organisation) are not necessarily those which are most widely used in everyday clinical practice, particularly in France. Although the disorders examined in this evaluation from the available literature are amongst the most common, we must add that a number of varied psychological disorders and symptoms seen in psychotherapy cannot be categorised in terms of the syndromes or diseases which have already been defined.

The choice of efficacy measurement is undoubtedly the most important methodological issue. This raises several questions, the first being to determine whether it is legitimate to use quantitative measurements to describe the improvement in a patient during psychotherapeutic management. Compared to the very great complexity of the subject we must be very cautious about the value we attach to these measurements in the field of psychotherapy. The measurements in reality are only the numerical representation of a characteristic. Commonsense suggests that as an initial approximation, we should observe whether a patient is "more" or "less" improved in a given feature of their functioning. A numerical system can then be used to grade the clinical improvement. Furthermore we must of course be sure that this measurement reliably reflects the improvement, in other words the measurement must be valid. Although this measurement deals with subjective and not objective characteristics, such a subjective measurement of efficacy can be validated. The measurement is, however, always subject to the defining theory which its designers have explicitly or implicitly used. This point is essential, as if we are considering an assessment of psychotherapy, bias may exist because of either antagonism or congruence between the defining theory of the measurement instrument and the theoretical support of the psychotherapy being studied.

The question of proof of efficacy is linked to the partly random nature of any patient's response to a treatment. If a difference in efficacy is observed between two groups of treated patients the question which arises is whether this difference is or is not compatible with spontaneous variations in efficacy which are seen between patients for the same treatment. This problem is often resolved in practice using random allocation of treatments and a statistical test to determine the significance of the difference in efficacy. This unavoidable use of statistics assumes that the effect being studied is reproducible. In the case of psychotherapies as the patient (or the patient-therapist couple) is individual in his/her path through life and normal mental functioning: in that situation how can we envisage reproducible experiments. In reality this question exists for any demonstration of treatment efficacy. If, for example, we assess the efficacy of an antibiotic in the treatment of pulmonary tuberculosis the study will have to last for one or more years. If an investigator wishes to reproduce the study once the results have been published, it is possible that the ecology of the organism has changed and that the experiment would no longer still be entirely the same. The concept of reproducibility in clinical research is weakened compared to the classical experimental sciences such as physics, chemistry or biology. This relative weakening, however, is not enough to make a scientific process unusable, as was clearly shown by advances in our knowledge of treatments during the 19th century.

Overall, there is no clear conceptual restriction to the use of scientific evaluation of efficacy for a psychotherapy. It is possible to envisage testing the hypothesis of the efficacy of these treatments in the context of refutable reproducible experiments. Subtleties must however be introduced into the confirmation: firstly the reproducibility of the study is not 100%, although this problem is not specific to the field of psychotherapies. Secondly, the definitions

of the patients to be treated are not always consensual; this may occasionally hinder the clinical use of the results. Finally, the studies are only interpretable if the measurements taken are valid. In the context of psychotherapies these measurements are sometimes based on a subjective "phenotype" and their validity is easier to demonstrate if they are incorporated into a theoretical field which is compatible with the psychotherapy being studied. The criteria for assessment of efficacy most frequently used in the literature involve symptomatic factors which cannot claim to be universally relevant. This is undoubtedly a limitation, although we must recognise that the symptom remains an irrefutable factor in the state of patients' mental health.

What are the different types of studies taken from the literature to evaluate the psychotherapies?

Evaluation of the efficacy of a treatment relies on comparative controlled trials. It is practically impossible, however, to compare an active psychotherapy with a psychotherapeutically inert "placebo" in a double blind randomised trial based on the models of pharmacological trials, as relationship and situation effects and the expectations of the therapists and patients are active components in any psychotherapeutic system. Different types of "control group" are therefore found in trials, such as the "placebo attention" group, in which the patients have minimal contact with the therapist, who does not use the factors which are assumed to be active in the therapy in question. This helps to remove simple patient management effects. We also see as a comparison group the group of patients still on the waiting list, which only receives simple telephone contact for several months (this may raise ethical problems and often results in drop-outs to another therapy). It is common in trials to compare a therapy to the "treatment as usual (TAU)" of the trouble in question. In addition we must recognise that comparison of psychotherapy with a chemotherapy may produce bias in favour of the psychotherapy if the patients in the study have almost all received chemotherapies without effect (and may for this reason come looking for another treatment).

Double blinding is only possible in evaluation of psychotherapies in the situation where a psychotherapy is compared with medical drug treatment, versus the same therapy against a placebo. In this situation the evaluation concerns the interaction between the psychotherapy and medical drugs.

In order to answer the difficulties of independent and blind evaluation of the test hypotheses, some studies measure the patients' beliefs and those of their therapists in the treatment to which the patient was randomised at the start of treatment and then study the correlation between these measurements and the results. The psychotherapeutic placebo must have characteristics which makes it as similar as possible to a genuine therapy: the placebo must be credible.

A certain number of factors relating to the attitude and behaviour of the therapist towards the patient have long been considered therapeutic. Force of persuasion, the ability to create a family atmosphere, warmth, empathy, genuineness of sentiment and a positive view of the patient have all been reported. To this must be added social-occupational status, credibility, setting and renown. These factors have not been greatly studied empirically. The most recent studies refer to the "therapeutic alliance" which describes the nature and quality of the interaction between the patient and the therapist. The therapeutic alliance in analytical therapy forms the context in which the "transference" may be expressed (the bringing out of unconscious desires and of the problem which is central to the cure). This relies upon mutual

involvement of the psychoanalyst and patient in seeking out the causes of the disorder and planned future changes using the cure process. In cognitive-behavioural therapy the therapeutic alliance describes an empirical relationship of empirical collaboration between the patient and therapist (similar to that of two scientists working on a common problem), which is used for the basis of learning, leading to cognitive changes in the person. The "therapeutic alliance" relationship defined in this way is a necessary but not sufficient condition for change. In family therapy, the therapeutic alliance is based on respecting styles of interaction, value and belief systems, forms of family knowledge and knowhow and the construction of hypotheses which can be changed depending on the experiences shared.

In terms of the measurement of the effects of psychotherapies, the studies use many evaluation scales of symptoms, behaviour and methods of peoples' psychological and interpersonal functioning. These scales have been validated for various psychopathological problems. They may be completed either by the clinician or by the patient him/herself. Personality questionnaires or ad-hoc measurements are also found in some studies depending on the hypotheses tested. In vivo behavioural tests provide a direct measurement of a person's performances and may be very different from the evaluation scales.

Correctly conducted evaluation studies report many criteria and measurements, allowing the range of conclusions to be extended. Some of these studies also analyse features of the therapeutic process in detail. Alongside changes in scores from continuous scales the studies refer occasionally to general discontinuous criteria, criteria for good results or "end point criteria". A single positive/ negative end point criterion (success/failure) may be used, or alternatively a principle end point and secondary end points.

Statistically significant changes measured in a group using a scale may occasionally only reflect mediocre clinical results, the mean value of which is sufficient to make statistical tests significant if the statistical power is high because of a large number of patients included. Conversely, lack of change in the mean value of a scale score may more rarely be accompanied by clinically beneficial changes in some patients or in a subgroup of patients. Expressing the magnitude of the effect obtained in the "average" subject in the study for people receiving the treatment or its comparator (placebo or other treatment) is close to the effect size and is necessary information in addition to the classical statistical tests.

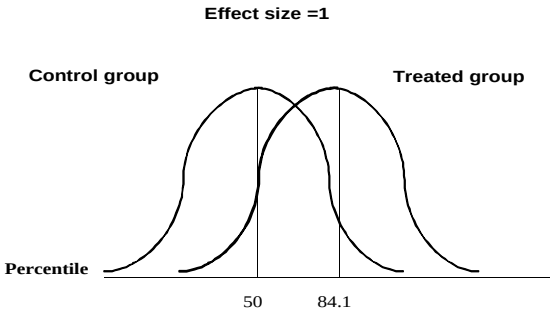
Evaluation criteria for controlled therapeutic trials (from Foa and Meadows, 1997 – revised by Maxfield et al. 2002)

Criteria	Score /10
Clearly defined symptoms	0 0.5 1
Validated measurements	0 0.5 1
Independent blind evaluator	0 0.5 1
Trained reliable evaluator	0 0.5 1
Treatment present in a manual	0 0.5 1
Randomisation	0 0.5 1
Compliance with treatment	0 0.5 1
No other concomitant treatment	0 0.5 1
Multi-modal evaluation measurements and interviews	0 0.5 1
Optimal length of treatment	0 0.5 1

Meta-analysis is a quantitative approach to a literature review which estimates the magnitude of the effect obtained in the "treated subject" compared to the "control subject" from the effect size. This analysis is based on the concept that all of the studies represent a

quantum of information connected to the aim of the research subject and that each study provides its own contribution. The assumption made is that all of the studies included represent a sample of all possible studies on the subject in question.

Meta-analysis therefore involves combining the studies, coding the results and calculating the amplitude or treatment effect size. For a given criterion which is being studied at the end of treatment, this represents the difference in mean values[3] between the study group and its comparator group (control or other treatment group). The criterion is generally the score on an evaluation scale. The effect size therefore reflects the possible gain by the treatment group compared to the control group. An effect size is considered to be small between 0.20 and 0.50, average between 0.50 and 0.80 and large above 0.80. In some studies the effect size is calculated by comparing the pre and post treatment scores[4]. This effect size tends to produce a higher value than the comparison of active treatment versus control situation as the placebo effect is not subtracted.



Distribution of scores and effect size

The aim of meta-analysis is essentially to solve the problem of discordant results by providing more detailed information about the magnitude of the effects. It should also be useful for identifying responders. Starting from these points, the quality criteria for a meta-analysis can then be defined.

Proposed golden rules to evaluate the quality of meta-analyses

Criteria	Score /7
Inclusion of all quality studies on the subject	0 0.5 1
Clearly defined assessment criteria (end points)	0 0.5 1
Use of appropriate statistical methods	0 0.5 1
Taking statistical power into account	0 0.5 1
Comparison of effect sizes	0 0.5 1
Test of study comparability	0 0.5 1
Estimation of unpublished studies	0 0.5 1

[3] The effect size is the mean value of the treatment group less the mean value of the control group divided by the standard deviation of the control group.

[4] This is equal to the difference in score after treatment less the score before treatment divided by the standard deviation.

What are the different forms of the psychodynamic and psychoanalytical approach?

The psychodynamic approach brings together practices ranging from traditional psychoanalysis to psychodynamic (psychoanalytical) psychotherapies, both long and brief. The general underlying psychoanalytical theory to these psychotherapeutic practices is common to them all.

Psychoanalysis was born at the end of the 19th century with Freud's work on hysteria and interpretation of dreams etc. From its very origin and through the precise description of psychological effects and the formulation of hypotheses about the subconscious mechanisms underlying them, Freud was intending to integrate psychoanalysis into the scientific approach. Psychoanalysis now has a century of history of contribution to psychiatric care. It developed more intensely after the Second World War. The stages in development of psychotherapy have been characterised by clinical variants linked to the evolution of models or terminological classification factors.

The psychodynamic (psychoanalytical) psychotherapies stress a patient's awareness of the psychological conflicts he/she is suffering from, together with acquisition of new psychological and developmental abilities (relating to construction of self and symbolisation). All psychotherapies of this type are based on psychoanalytical theories, including transference, although they may differ depending on the submodels to which they refer, the specific objectives they are aiming for and the specific techniques used in reaching these objectives. These psychotherapies adapt to the characteristics of the patient, which are identified through the expression of the transference itself. They are generally broken down into several stages according to the level of psychological organisation of the patient and the relationship interactions established.

Long term psychotherapies can be distinguished from the brief or short term psychotherapies (40 or less sessions). These latter types of psychotherapy have developed more recently in the United States. They may be centred on an event, or alternatively may be interpretative and centred on personality. The aim of treatment is to acquire insight or to obtain a change in personality and the techniques used stress interpretation work and analysis of the transference. Focal psychotherapy identifies a central conflict present since childhood, reactivated during adult life and forming the origin of the problem. In this case the aim is to resolve this problem through a relationship with the therapist, providing new opportunities for emotional assimilation and insight.

Psychoanalytical psychotherapy is a long term process conducted with a trained psychoanalyst, involving several sessions per week over a period lasting at least one year. These sessions allow expression of subconscious conflicts and addressing fixations (libido-related and ontogenetic) which are brought to the surface in the transference relationship with the therapist. Through the construction of the analytical space and interpretation they lead on to work in a (re)constructive process designed to change psychological structure and organisation.

The different techniques in the psychodynamic (psychoanalytical) approach

Technique	Definition
Psychoanalysis	Investigation method involving identification of subconscious significance of a person's words, actions, imaginary constraints (dreams, fantasies, delusions). The method is based on the person's free associations which guarantee the validity of the interpretation.
Psychoanalytical therapy	Psychotherapeutic method based on investigation involving identification of subconscious significance of a person's words, actions or imaginary productions. This method is characterised by controlled interpretation of defence resistance, transference and desire mechanisms and dynamics in the identification processes.
Brief psychodynamic therapy (on average 12 sessions, at a frequency of one session per week)	Specific therapeutic intervention involving a specific "state" or "problem" to obtain a change in the state or resolution of the problem.
Interpersonal psychodynamic therapy (10 to 12 sessions)	The emphasis is placed on the patient's psychosocial and interpersonal experiences.

Therapists' training takes account of the diversity of practices, which range from the psychoanalytical cure to more directive techniques. The term "training" in the psychodynamic (psychoanalytical) approach refers more to transmission of a practice than to communication of knowledge. The practitioner learning to perform psychoanalyses or psychoanalytical psychotherapies must acquire: associative listening allowing him/her to adapt to different techniques; the ability to develop a specific framework for the psychodynamic work and the ability to define the best suited therapeutic indication to evaluate the person's psychological structure.

Training of psychoanalysts is based on three arms: personal analysis, supervision of cases treated by the candidate and theoretical training in educational institutes. These institutes are more or less closely linked to the psychoanalysis societies. At the origin of this, the Association psychanalytique internationale (International Psychoanalytical Association) created in 1910 had the aim of underpinning the principles of training recognised by all of its members. Many divisions and a more decentralised view of the training rules within the association led to a degree of variability in how these principles were applied. Currently in France, psychoanalysts refer to several theoretical frameworks (Freudian, Alderian, Jungian, Kleinian and Lacanian etc.). These practitioners are grouped into two associations which form part of the Association Psychanalytique

Internationale: The Société Psychanalytique de Paris (Paris Psychoanalytical Association) and the Association Psychanalytique de France (French Psychoanalytical Association). In addition the Lacanians belong to different associations including one international association. This diversity has led to several methods of training and practice.

Personal analysis is a strict prerequisite in order to become a psychoanalyst, although its final outcome and practice differs considerably from one "institution" to another. These differences relate in particular to the nature; therapeutic or strictly didactic or designed to promote the psychoanalytical experience. Over time, these differences have become so great that the different "institutions" no longer necessarily see themselves within a common training.

Supervisions are designed to familiarise the candidate to the practice of psychoanalysis. The objective is neither pure technical training nor a form of psychotherapy, but to enable the

candidates to transpose the experiences which they have acquired during their analysis into their practice as an analyst.

In terms of theoretical training the general rule in France is for training outside of any academic framework: free choice of teaching, research training courses and book work, no validation of knowledge. In other countries the training is often closely derived from university methods or even integrated into university education.

Assessment of the candidate before the start of the personal analysis is scarcely performed anymore, particularly in France. Assessments before performing supervised cures, at the end of each of the cures and at the end of the course generally lead to the candidate being admitted to a psychoanalytical association.

The entire training, including the personal analysis, lasts for between five and eight years and provides a qualification to people who have already followed university and clinical education.

Long term psychotherapies run over several years and are applied to complex diseases such as, for example, the severe personality disorders (notably borderline). In borderline personality disorder, the psychotherapy addresses defects which have characterised the early phases of development of the child. These defects result in identity and relationship problems which recur in everyday life situations and are expressed during the psychotherapy. The psychotherapist uses different techniques: expressive, modified analytical, and exploratory. This involves containing, confronting, interpreting and supporting, depending on the degree of severity with which the disease is expressed. It is firstly however essential to establish a stable therapeutic framework in order for the treatment to begin. The technique used for the treatment may evolve during the psychotherapy. "Interpretation" may initially be contraindicated and subsequently be effective.

Brief psychodynamic psychotherapies are relatively little used in France, although a large proportion of the evaluation studies refer precisely to practice of these therapies. They range from the most directive types, centred on the event, to those which are more interpretative and centred on personality. Their indications and contraindications (severe disorders, poor motivation for therapy) are very precise.

In focal psychotherapy (David Malan, a pupil of Balint) the start of treatment is preceded by a very major evaluation phase. Identification of precipitating factors, early traumatic experiences or repeated patterns leads to the definition of an internal conflict which has been present since childhood and which becomes the focal point of treatment. The greater likelihood that the area of conflict emerges during the transference the more likely is the result to be positive. The "transference triangle" (transference, current relationship and past relationship) leads to improvement in the patient's health. 20 to 30 sessions are generally involved and in a few published cases the therapy has been continued for a year.

Brief psychotherapy with anxiety provocation (Peter Sifneos) concentrates exclusively on the Oedipus complex. During the initial phase of treatment the therapist has to establish a good relationship with the patient in order to create a strong therapeutic alliance. The therapist uses confrontations which provoke anxiety in order to clarify the questions troubling the patient in his/her early life and the current conflict. In order to undergo this type of therapy the patient must have a major specific complaint and recognise the psychological nature of his/her symptoms. The patient must be particularly well motivated to change and be seen to be able to interact with the therapist, who evaluates the patient by expressing his/her feelings. Acceptance to make reasonable sacrifices and a realistic expectation of the results of

the psychotherapy are also required. The vast majority of treatments of this type involve 12 to 16 sessions and never go beyond 20 sessions. Each session lasts 45 minutes.

In Mann's time-limited psychotherapy, 2 to 4 evaluation sessions are normally undertaken before beginning the psychotherapy. The psychotherapist explains the therapeutic contract and aim of the therapy to the patient, and uses classical psychoanalytical psychotherapeutic techniques: defence analysis, interpretation of transference and reconstruction. The psychotherapy is limited to a total of 12 hours of treatment divided up depending on the patient's needs. This may take place in the form of weekly sessions lasting half an hour for 24 weeks, or hourly sessions twice per week for 6 weeks.

Davanloo psychotherapy involves 5 to 40 sessions depending on the patient's area of conflict. The treatments generally last for between 15 and 25 sessions. It is not recommended that a specific end date be set, but rather that the patient be told clearly that the treatment will be short. Short periods (5 to 15 sessions) are reserved for patients who mostly have an Oedipus conflict.

Brief adaptive psychotherapy is a more cognitive therapy which concentrates on identification of the most inappropriate pattern and elucidating it in past and current relationships, and very specifically in the relationship between the patient and the therapist. The aim of the therapy is to make the patient able to develop insight into the origins and determining factors of this pattern, in order to develop more appropriate interpersonal relationships.

Strupp and Binder psychotherapy is based on interpersonal transactions and focuses on a linguistic analysis of the description of relationships. It is therefore based on analysis of the patient's current interpersonal relationships, including the relationship with the practitioner, and internal object representations. It brings attention to patients' withdrawal and detachment characteristics which are considered to be defence mechanisms. It is therefore more centred on interpersonal deficiencies than on intrapsychological conflict.

The Gillieron brief psychodynamic investigation technique is designed to identify the nature of the psychological change desired, and the best ways of reaching this with the patient. Its initial results are to enable the patient to construct a request for care which is tailored to the origins of the conflict, to strengthen the therapeutic alliance and sometimes to resolve the crisis which has brought the patient to consult.

The psychodynamic (psychoanalytical) psychotherapies described above in adults are the ones which are most frequently found in the studies assessing efficacy. The aim of these therapies is to achieve profound, sustainable changes in the patient. They seek to obtain these changes through the use of language (they form part of the so-called verbal therapies) as the instrument to reconstruct the persona.

Psychoanalysis has developed differently in its applications to children. The rule of free associations cannot be applied to children and the symbolic value of the game has been taken into account. The game therefore becomes the preferred instrument in psychotherapy, including drawings, toys representing human beings, animals, cars and houses etc. The game is similarly considered to be a means for children to defend themselves against the affects which they are afraid of in the treatment situation.

In principle, frequent sessions are involved. In British and Latin American countries it is usual to see a child 5 to 6 times per week. Many in France consider that 3 or 4 sessions per week are essential although it is often impossible to sustain such a frequency for a long period of time. Commonly, children are analysed for 2 sessions per week. Psychoanalysts are therefore able to use more straightforward psychotherapeutic methods in children, although all are derived from psychoanalysis.

They are based on the following principles: expressional psychotherapy uses mostly children's games, although the game is played in the presence of an adult and has a "regressive" function which cannot be ignored. Relational psychotherapy plays a key role in children. The psychoanalytical interpretations in the different psychotherapeutic interventions are always aimed at verbalising affects.

What are the different forms of cognitive-behavioural psychotherapies?

Behavioural and then cognitive therapies were firstly developed in Britain and Northern European countries at the start of the 1960s. They then spread through all developed countries and have been present in France since the start of the 1970s through private associations, the major two of which are the AFTCC (Association Française de Thérapie Comportementale et Cognitive) (French Association for Behavioural and Cognitive Therapy) which was founded in 1972 and AFFORTHECC (Association Francophone de Formation et de Recherche en Thérapie Comportemental et Cognitive) (French Speaking Association for Training and Research in Behavioural and Cognitive Therapy) founded in 1994. These two associations offer both base training and continuing education in the form of workshops and meetings.

Training in cognitive-behavioural therapies (CBT) in France is aimed at psychiatrists, general practitioners, psychologists and specialist psychiatric nurses. Orthophonists, psychomotor practitioners and specialist educators also have access to some of this training. The training is provided privately by AFTCC and AFFORTHECC and in the public sector by university diplomas (UD). In principle, the training lasts for three years, following the criteria recommended by the European Association for Behavioural and Cognitive Therapy (EABCT).

Training in cognitive-behavioural therapy according to the criteria of the *European Association of Behaviour and Cognitive Therapy (EABCT)*

The training lasts for a minimum of 5 years including the base professional training.
Training: 450 hours, 200 of which from a competent therapist.
Development of competencies: 200 hours.
Supervision: 200 hours by a competent therapist.
At least 8 cases supervised, covering 3 types of problems.
Memory: at least 4 cases (2,000-4,000 words)
Accreditation by an association: the above training followed by continuing education)
Therapy and personal development.
Is didactic therapy required? The choice is left free to each country.
It is stressed, however, that each therapist must know when to ask for assistance.

Behavioural and cognitive therapies represent the application of the principles derived from experimental psychology to clinical practice. These therapies were initially based on learning theories: classical conditioning, operant conditioning and social learning theory. They then referred to the cognitive theories of psychological functioning, particularly the information processing model.

The principles of classical conditioning (respondent or Pavlovian) are based on the concept that a certain number of behaviour patterns result from conditioning through the association of stimuli.

According to operant conditioning described at the end of the 1930s by Skinner as an extension of Darwinian theory of natural selection, the living body acts on the environment and the consequences of its action lead it to change its behaviour. Analysis of the maintenance of a behavioural sequence involves studying its consequences, which allow the final result of a behaviour to be understood. An action which has positive consequences tends to be repeated (positive reinforcement) and conversely, negative consequences of an action the body tends to produce avoidance or escape behaviour from the situation which is liable to produce the unpleasant effects (negative reinforcement). Absence of negative or positive consequences of an action will lead gradually to the disappearance of the action because of the absence of any reinforcement: this is extinction.

The two major principles most frequently used in practice are the principle of difficulty segmentation (this consists for example of classifying stages of confronting a situation depending on the anxiety experienced at each stage) and progressive shaping, with positive reinforcement of behaviours by approval from the therapist. This allows the desired aim to be approached gradually and avoids discouragement both of patients and of therapists.

At the end of the 1970s, the importance of learning by imitation of models was demonstrated experimentally by Bandura. The principles of this were extended to clinical problems and so-called "modelling" techniques are used above all to develop social skills through role-playing. Bandura also developed a general theory of psychotherapeutic change, proposing that there was a specific dimension of mental functioning: perceived self-efficacy. The change takes place depending on whether a person considers him/herself to be capable or incapable of performing a behaviour and whether or not the person considers that the behaviour will lead to a result.

Cognitive therapies are based on the concept of cognitive schemas. A cognitive schema can be described as a cognitive structure printed on the body through experience. Cognitive maps are stored in the long term memory and select and process information subconsciously (in the sense of automatically). These schemas represent personal interpretations of reality and influence individual strategies of adaptation. They represent an interaction between behaviours, emotions, attention and memory. Each psychopathological disorder occurs as a result of inappropriate interpretation of the person's own self, the current environment and the future. There are therefore specific schemas: negative interpretation of events (depression), dangers (phobias, panic attacks), over-responsibility (obsessive compulsive disorder). These schemas are characterised by selective attention towards the events which they confirm: they therefore represent a prediction which comes to course.

Description of the different types of cognitive and behavioural therapies

Technique	Definition
Cognitive therapy	Therapy based on modification of cognitive schemas and processing of information.
Behavioural therapy	Therapy based on the principles of conditioning and social learning.
Cognitive-behavioural therapy	Therapy based both on learning theories and modification of cognitive maps
EMDR therapy (Eye movement desensitisation and reprocessing therapy)	Desensitisation therapy through ocular movements and reprocessing of information.
Group or couple cognitive-behavioural therapy	Most CBT can be performed on an individual, group or couple basis, depending on the indications and specific cases.
Cognitive-behavioural family therapy	This is used above all in the psychoeducational family approach for psychotic patients in a context of psychosocial rehabilitation, and in the treatment of certain childhood and adolescent disorders,

Like any therapy, cognitive-behavioural therapy is based on a therapeutic relationship, the components of which are non-specific: warmth, empathy, genuineness, professionalism, mutual confidence, patient acceptance. These components work concurrently to establish a positive therapeutic alliance and are necessary, but not sufficient. In cognitive-behavioural therapy the therapeutic relationship is based on the here and now, selection of concrete problems to solve with the patient and a constant attitude towards testing therapeutic hypotheses established in collaboration with the patient.

A key stage is the functional analysis, which studies the relationships between "behaviours-problems", thoughts, emotions and the social and physical environment in order to tailor the application of the general principles based on learning theories and cognitive theories to each patient. Functional analysis grids are used which allow the patient's functioning vis-à-vis his/her behaviours – existing problems (synchrony), their establishment and maintenance in the past (diachronic) to be understood and the therapeutic process to be guided from hypotheses which are common to the patient and therapist relating to factors involved in triggering and maintaining the disorder.

Cognitive-behavioural therapy can be used in the form of individual, couple or family therapy. The sessions are limited in number to 10 to 25 (one per week) for anxiety and depression disorders to around a hundred sessions (one or two per week) for personality disorders or rehabilitation of psychotic patients. The sessions last from 30 to 60 minutes. For personality disorders and depression, however, sessions lasting one hour are recommended. Sessions lasting at least one hour and up to three hours have been recommended for serious obsessive compulsive disorders and chronic post-traumatic stress, depending on the individual difficulty of the case.

Many of the cognitive-behavioural techniques which have been developed and used in adults have also been applied to children and/or adolescents. In the best of cases these techniques have been adapted to take account of the specific developmental features associated with age and, in some cases, specific manuals designed for children or adolescents have been published. In other cases the treatments are used in their original form or only slightly changed depending on the discretion of the therapist. Other cognitive-behavioural techniques have been developed directly for children or adolescents and for indications which are specific to this age group.

What techniques are used in family or couple therapy?

The following definition can be offered for the "lowest common denominator" of the family therapies: "Family therapy involves any beneficial form of consultation, either single or repeated, which brings together at least two members who form part of the lives of one or more person(s) suffering distress, one of the persons who is consulting normally being the person in greatest distress".

The beneficial effect of this (these) consultation(s) is assessed from symptoms, the distress, and the problems and relationships of the people who consult. Perception of the benefit may be gained by the people themselves, the people in distress, the therapist involved and also the broader therapeutic entourage and entourage in the lives of the people concerned.

Family therapies were developed in the United States in the 1950s in psychiatric units and Social Service departments as forms of assistance and care for serious mental disorders

considered not to be readily accessible or inaccessible to classical forms of psychotherapy. Although family therapies more specifically target interpersonal problems or behavioural problems, they are also useful for the treatment of different mental disorders. They derive from psychodynamic, cybernetic and systemic ethnological and anthropological principles. Behavioural and cognitive, humanist and narrative currents then developed centred on the solution.

Training of therapists is usually delivered by private institutions. This normally takes place in groups of 10 to 15 people with an average of 200 hours per year for four years. The universities (psychiatric and clinical psychology) have gradually and relatively sparsely integrated training modules for family therapies into the end of courses. Intensive training lasting one to two years is also offered in some universities and is not reserved for psychiatrists or clinical psychologists.

Around twenty countries in Europe take part in the organisation of the European family therapy association (EFTA). The dominant current is the ecosystem current. Approximately 200 French professionals belong directly to the EFTA. Most of these are psychologists, social workers or nurses. The Société Française de Thérapie Familiale (French Family Therapy Association) which belongs to the EFTA and to the FFP (Fédération Française de Psychiatrie - French Federation of Psychiatry) has 300 members, 180 of whom are full members. These latter members must provide evidence of four years of training involving 200 hours per year and 4 years of family therapy practice. It consists of more than 50% psychiatrists and also has doctors, nurses, psychologists, social workers and specialist educators. Some French therapists belong to both associations. There are also several psychoanalytical family therapy currents.

France developed the family approach primarily at the end of the 1970s. Since then the types and techniques of therapeutic intervention with families have diversified and become more complex and interlinked. They are based on eco-etho-anthropological principles.

The most recent currents seek to avoid focusing on the family either by directing the interventions through objectivation of symptoms, conduct and emotional and representational mapping (cognitive-behavioural therapies) or by sharing life experiences, avoiding causalist constructs (humanist, narrative currents centred on the solution) or by broadening the contextual meetings to far wider systems (multi-family sessions, networks). Many changes have taken place between these currents: cognitive-behavioural therapies construct types of meeting adjusted for each objective to be treated (individual, couple, family, multi-family, psychosocial rehabilitation groups); the ecosystem therapies refer more to complexity theory and see the sessions as co-creation and co-evolution devices between family members and therapists, which cannot be reduced to predetermined programmes.

Description of the different types of therapies used in the family approach

Principle currents	Definition
Couple therapy and psychodynamic family therapy	Centred on insight and/or affective experiences, analysis of resistances, intertransference movements, interfantasy processes, and access to subconscious processes. They are frequently based on intergenerational or multigenerational approaches.
Ecosystem couple and family therapies	Centred on improvement in communications in the here and now, on paradoxical prescriptions, resistances, symptoms and tasks, all necessary to take account of the ecosystem. They make take on structural, strategic or narrative forms, centred on the solution.

Cognitive-behavioural couple and family therapies	Centred on improvement of conduct and cognition, evaluation and suppression of symptoms, reduction in the expression of critical and hostile emotions, stress management, learning skills in social relations.
Family psychoeducation	Centred on information relating to problems, diseases, treatments and adaptation attitudes to take faced with disturbances due to the disease.
Humanist family therapies	Centred on the expectations and personality of the patients, their ability for independence and to choose to maintain the symptoms or separate from them.
Eclectic and integrative family therapies	Centred on adjustment of methods, techniques and theories depending on the requirements of the families and treatment projects.
Family therapies for unwilling families	Centred on learning social contexts within which the request for care or demand for treatment emerges: the family as a meta-therapist, assisting the therapists.
Behavioural and cognitive multi-family therapies	Centred on information exchange, mutual aid, problem-sharing and methods of facing up to problems, development of inter-family solidarity.
Psychodynamic psychosocial therapies	Centred on psychodrama inspired from psychoanalysis, role playing, and interpretation of transference.
Behavioural and cognitive psychosocial therapies	Centred on learning social skills, social- occupational rehabilitation, and stress management.

Removal of the family's role in the origin of the problems has become radical in the cognitive-behavioural approach. The family is considered to be a group of people with behavioural, emotional and cognitive maps which may have been disturbed in the presence of mental disorders. In the psychoeducational management of schizophrenic patients and their families, the family is considered to be a "normal" family confronted with a disease or a set of diseases which are cerebral in origin and probably neurodevelopmental in nature. If disturbed intra-family relationships or even disturbed relationships between the family and the social environment exist, these disturbances are considered to be secondary to the disease. The therapists therefore start from the observation of the disease, inform the family about the features of the disease (particularly the importance of genetic and biological factors), its course and its treatment. They offer psychoeducational advice, demonstrating how reducing emotional overload and criticism is liable to lead to improved problem management.

The starting point for the systemic multi-family therapies proposed by Laqueur at the end of the 1970s is to recreate a community and social space for families and patients faced with isolation, suffering or distress, which appears to be incommunicable to others. Families are asked to take part in meetings in which information is shared in a questions and answers mode. These therapies are offered to families facing the same problem (schizophrenia, eating disorders, mood disorders, etc.). Whilst the pathological profile of the patients must be consistent to form these multi-family groups, experience has shown that inclusion in the groups should be as random as possible in terms of other characteristics (ethnic, religious, political, socio-economic, intellectual, belief systems, opinions, politics, etc.). The group should preferably be 4 to 7 families in size. Interaction between several families appears to produce faster changes than single family therapies, which are also performed in some cases. Learning processes are initiated from communication through analogy, indirect interpretation, and cross-identification between members of different families. It appears that this facilitates communication spontaneously, that speaking up is easier and that the atmosphere is more permissive than if the attention is focused on the single family. The

copresence of families facing a recent disease and families with greater experience and maturity with the disease result in these latter families acting as "cotherapists".

McFarlane introduced a distinctly more psychoeducational process than the classic version of systemic approaches in order to avoid spillover due to unbridled emotional expression. This belongs to the cognitive-behavioural current. The process is designed to reduce interpersonal and social isolation, avoid stigmatisation of patients or other members of the family, support each family by reducing the considerable burden which the disease places on its functioning, remove families from tendencies to overprotect and/or disengage, hostility or criticism, and improve intra-family communication, which is facilitated from the outset by the setting of the multi-family exchange itself.

Network therapies, started by Speck at the end of the 1960s, broadened the therapeutic intervention to all people in the environment members of the patient's family. The number of people involved may be as high as 50 or 60. This type of intervention may be considered when other therapeutic methods have failed (individual, family, institutional hospital therapies) or to avoid hospitalisations in highly critical situations: high risk suicide, serious mental disorders with risk of 'committing the act'. The treatment team consists of 4 to 5 people and seeks to restore the "tribal" relationship of the person, which had been broken by modern society. Giving value to the network allows it to operate as a support against the destructuring distresses, restoring confidence in the ability to establish relationships outside of the family. Three forms of network therapy can be distinguished depending on whether or not the primary sector (close contacts of the patient and of the patient's family), secondary sector (professionals meeting the social demand) or a combination of both sectors is involved. Mobilising the entire network has (as in the initial forms of family therapy mobilising the whole family) helped to enrich knowledge on the subject, contexts of life and the follow up of people who suffer.

Although very different in terms of origin and orientation, the humanist, narrative and solution- centred concepts, in common with those above, abandoned focussing on the symptom or searching for its causes. The humanist therapy involves developing each person's potentials, taking account of his/her own strengths and weaknesses, development rates and life projects. Whether the therapeutic contact is short or long, this avoids the creation of dependencies which would reactivate the relationship maps arising from the past and in contrast would promote updating new processes in keeping with the current problems and difficulties.

In narrative therapy, the personal construction of knowledge is achieved by comparing family and social constructs, which in the final analysis only come from a relativist point of view of the state of the world. As each vision of the world is relative to the relationship contexts in which it is produced, none could claim to be pre-eminent.

In solution-centred therapy, the therapist only takes positive experiences from the past and directs his/her interventions from the present towards the future. The therapist considers that the patient has used the correct solutions and suggests new adjustments which confirm these correct solutions. In this context a slight change in a person may have consequences on the entire marital or family system, without necessarily meeting the spouse or other members of the family.

In contrast to cognitive-behavioural therapies which seek to objectivise reproducible procedures possibly using evaluation scales and information and learning guides for patients, the systemic therapies see themselves as contextual intervention projects which enable ways of thinking and doing to be readjusted or even invented depending on the features of each specific clinical situation. The therapeutic project involves delineating the areas of competence and performance of the families and persons involved. This leads to

learning of learning (deutero-learning) which patients and their close contacts do not do spontaneously because of self-contradictory instructions in everyday life. Initiating a therapeutic context involves creating a mechanism in which the options can swing between expression of ordinary conversations and construction of viable projects, through comparative exploration of alternative solutions.

Marital behavioural therapy is based on learning of communication within the couple, and problem-resolution. It offers planning for changes in behaviour in order to increase satisfactory interactions and reduce destructive and negative interactions. It is not only a strategy for intervention but also a treatment based on social learning.

Cognitive marital therapy is centred on irrational relationship mapping and irrational beliefs. It is often associated with behavioural techniques or even training in expressing emotions.

Psychodynamic marital therapies are centred on emotions or directed towards insight. When the therapy is directed towards insight, it stresses conflicting emotional processes affecting each of the partners considered separately and the interactions between the partners and the broad family unit. This therapy includes individual marital and family functioning in terms of development and maturation processes, collusions and divergent contractual expectations, irrational role assignments and maladapted relationship rules. The therapists use probing, clarification and interpretation to discover and explain feelings, beliefs and expectations which the partners have of themselves, their partners and their marriage and which may be partially or totally subconscious and be restructured by conscious renegotiation.

Marital therapy focused on emotions is based on the Bowlby attachment theory and sees relationship distress as weak links in which the needs for attachment are unachievable because of rigid ways of interaction which block emotional engagement. The method involves helping each partner to explore and communicate his or her emotional experiences on subjects such as affiliation dependency (proximity and control) in the context of the normal relationship. Valuable attachment needs are clarified and each person comes to better understand and see his or her partner with greater sympathy. This leads to new and less defensive interactions. This approach appears particularly useful for couples who are not displaying extreme disturbances.

What is the net result of the evaluation studies of psychodynamic (psychoanalytical) psychotherapies?

Started since the end of the 1910s, evaluation of the effects obtained from psychoanalytical psychotherapies in patients has come up against difficulties in analysing the multi-dimensional features of the changes. Quite specific to this approach, psychotherapy is constructed from the patient and the patient's specific problems and methods of functioning. In the most recent studies the evaluation involves not only the effect of therapy on symptoms, without differentiating between terminological categories, but also an evaluation of the changes in the psychodynamic structure which underpins the disorder itself. Evaluation instruments for psychodynamic changes have been developed recently (MSI, ECPD, KAPP…)[5] as have instruments which evaluate use of techniques, adherence with the therapeutic method (PACS-SE, TIRS, PTS, GIS, STT)[6] or the therapeutic alliance (CALPAS)[7]. However, the specific instruments to evaluate the psychodynamic aspects are still little used.

[5] MSI: McGlasham semi-structured interview; ECPD: change in dynamic psychotherapies scale Kapp Karolinsk psychodynamic profile...

[6] PACS-SE: Penn adherence-competence scale for supportive-expressive therapy; TIRS: Therapist intervention rating system; PTS: Perception of technique scale; GIS: General interpersonal skill; STT: Specific therapeutic technique

Some, still preliminary, studies have sought to address the role of specific and non-specific factors in the effects of psychodynamic (psychoanalytical) psychotherapies: do men and women respond in a similar way? What is the impact of a quality of object relationships? What are the interactions between the patient's accounts of a therapy experience and the therapeutic alliance? What is the influence of interpersonal or personal problem typologies and style of principal attachment?

These studies have thrown particular light on the interaction between these different variables. It is likely that early symptomatic improvement plays a role in establishing the therapeutic alliance (these two factors reinforce each other mutually) and thereafter in the effect of the therapy. Some of these parameters, however, appear to have greater prognostic value than others on the results of treatment: the initial quality of object relationships and training of therapists for difficult cases.

Although many research studies have been conducted on long psychodynamic (psychoanalytical) treatments (mostly case and process studies) these have only very recently been extended to studies on clinical populations. Conversely, more evaluation studies have been performed on brief psychodynamic (psychoanalytical) therapies. Three meta-analyses reported the efficacy of brief psychotherapies (on target symptoms, general symptoms or social adaptation) compared to a placebo (waiting list or no treatment) for a set of disorders. It must be noted however that two of these meta-analyses did not examine the effects of psychodynamic psychotherapies independently of those of the non-psychodynamic interpersonal therapy. One of these meta-analyses demonstrated that efficacy was greater for well trained therapists.

Two meta-analyses which combine studies conducted on stabilised schizophrenic patients followed up on an outpatient basis demonstrated that psychodynamic psychotherapy or psychoanalysis had little or no effect. Psychodynamic (psychoanalytical) psychotherapies produced a very small effect size (0.27). Only one study examined hospitalised patients (in the acute phases) and did not find psychodynamic therapy to have additional effect over drug treatment.

For mild or moderate depression in the adult, one meta-analysis combined psychodynamic therapies and interpersonal studies in the term "verbal therapy" and showed these therapies to have global benefit, although it was not possible to conclude what the efficacy of each of the two types of therapy examined separately was. Three studies on depression in the elderly treated on an outpatient basis (in a meta-analysis) compared psychodynamic (psychoanalytical) therapy or its brief form to placebo or to a waiting list and found no significant positive benefit.

The association of psychodynamic psychotherapy with antidepressant treatment in patients managed on an outpatient basis (after hospitalisation) has been assessed in major depression in one randomised controlled trial which demonstrated that the combination of both treatments had significant benefit, with an improvement in global functioning and a fall in the hospitalisation rate at the end of treatment. The psychotherapy was administered by well trained nurses under close supervision. Finally, one randomised controlled trial studied the results of brief psychodynamic interpersonal therapy at six months in adults following a self-poisoning suicide attempt. The results showed a reduction in depressive symptoms, suicidal ideation and relapse, and higher satisfaction.

Two controlled trials on the treatment of anxiety disorders were found in the literature. Horowitz short psychodynamic psychotherapy (centred on resolution of intra-psyche conflicts as a result of a traumatic experience) was shown to be effective in patients with

[7] CALPAS: California psychotherapy alliance scales

post-traumatic stress state compared to a control group. The effects were particularly large on traumatic, avoidance and somatisation symptoms. The other controlled trial, conducted in patients suffering from panic disorder, demonstrated that addition of brief psychodynamic psychotherapy (centred on psychosocial vulnerability) to drug treatment significantly reduced relapse rates (at 18 months) compared to medical drug treatment alone. However, one uncontrolled trial in people with panic disorder suggested that psychotherapy centred on the panic used as monotherapy (with a manual) to be very effective, and that the gains were maintained at 6 months' follow up. The absence of a control group in this case, however, makes it impossible to confirm the result or that treatment was effective.

No controlled trials were found in the literature for eating disorders. One cohort study followed more than 1,000 patients with anorexia or bulimia who received psychodynamic (psychoanalytical) therapy during inpatient hospitalisation, for 2 to 3 months. 33% of the anorexic patients and 25% of the bulimic patients had no further symptoms at follow up at two and a half years. The results correlated with specific patient characteristics: older age in anorexics was a predictive indicator for poorer response to treatment; for bulimic patients, impulsivity, the presence of associated symptoms of anorexia and a large number of previous treatments were associated with less good results whereas good social adaptation was a predictive indicator for improvement. We must remember that this study was limited by the fact that it did not contain a control group and that the observed improvement cannot be attributed with certainty to the therapy.

Personality disorders define several types of very different patients grouped into 3 categories (A, B and C) in the DSM. Category A contains the paranoid, schizoid and schizotypic personalities, category B contains antisocial, borderline, hystrionic and narcissistic personalities and category C contains avoiding, dependent, obsessive compulsive and non-specified personalities. This is therefore a group of disparate disorders which have the common feature of being primary with respect to the development of other problems such as depression, of occurring during development in childhood or adolescence and of continuing in adulthood. Patients with a personality disorder have many problems which are liable to vary over time. Evaluation is based on different aspects of their functioning (reduction in number of suicide attempts and self harm behaviour, quality of object relationships etc. the interpretation of which requires particular attention. For example, the increase in attendance at health care services may be a sign of improvement at the start of treatment whereas a reduction in attendance is expected at the end of treatment. These are also chronic disorders and the effects of therapies may be difficult to interpret because of events, other treatments etc. or simply age. One study clearly shows that improvement in symptoms and functioning in patients who are treated is associated with better interpersonal relationships, whereas that untreated patients progress towards social withdrawal.

For the personality disorders (all disorders combined) the literature contains one meta-analysis conducted in 2003 which grouped 15 trials, two of which compared psychodynamic therapy to a control condition (waiting list or standard care). The overall effect size (calculated from pre and post treatment data for all of the studies in the meta-analysis) was 1.46 for self-assessment measurements and 1.79 for measurements assessed by other people. The effect size compared to control conditions (calculated for both studies) was 1.32 (from self-assessment measurements). Psychodynamic psychotherapy appears to be effective in personality disorders (with two controlled trials).

One controlled trial examined the efficacy of psychoanalytically orientated psychotherapy in a day hospital compared to the standard psychiatric care (monthly consultation with medical drug compliance control) in patients with borderline personality disorders (type B). The treatment was administered by nurses trained in psychiatry (under bi-weekly supervision)

although were not formally qualified in psychotherapy. The scores for all evaluation measurements fell significantly in the psychotherapy patients at 6 and 18 months: improvement in depressive symptoms, reduction in suicidal and self harm acts, reduction in days of inpatient hospitalisation and improved social and interpersonal functioning.

Interpersonal psychodynamic psychotherapy (psychotherapy derived from the Hobson conversational model) was assessed (in a non-randomised controlled trial) in a group of patients suffering from borderline personality disorders, compared to a "usual treatment" group (support therapy, crisis intervention, cognitive therapy, pharmacotherapy, drug therapy). The psychotherapy was based on the concept that borderline personality disorder occurs as a result of interrupted development of the "Ego" and is designed to promote maturation (discovering, constructing, and object relationships expression of personal reality).

Effects of psychodynamic (psychoanalytical) interventions

Diseases	Trials considered	Main results
Schizophrenia		
Acute phase	1 trial	Results not significant
Stabilised	2 meta-analyses	Little or no effect
Mood disorders		
Moderate depression in the adult	1 meta-analysis	Combined BPT and IT (non-psychodynamic) produced positive results although no study on psychodynamic therapy alone.
Moderate depression in the elderly	1 meta-analysis	No significant result
Major depression on antidepressants	1 controlled trial	Positive significant effect of psychodynamic therapy after hospitalisation on global functioning, reduction in relapses.
Depression associated with attempt suicide	1 controlled trial	Positive effect of interpersonal psychodynamic therapy on suicidal ideation and relapse rate at 6 months.
Anxiety disorders		
Panic disorder on anti depressants	1 controlled trial	BPT effective in reducing relapses after stopping antidepressant therapy for 9 months.
Post-traumatic stress	1 controlled trial	BPT effective on symptoms
Personality disorders		
All disorders combined	1 meta-analysis	Significant effects on overall improvement
Borderline personality	(2 controlled trials) 3 controlled trials (one non-randomised trial)	Orientation psychoanalytical psychotherapies effective on all measurements at 6 and 18 months. IT (psychodynamic) effective on diagnostic criteria, maintained from 1 to 5 years; individual and group therapies effective.
Antisocial personality	1 controlled trial	Brief psychodynamic therapy beneficial to patients presenting with depression.
Avoidant or other type C personality	1 controlled trial	BPT effective (Davanloo and adaptive psychotherapy), maintained one and a half years after end of treatment.

BPT: Brief Psychodynamic therapy, IT: interpersonal therapy

30% of the patients treated with interpersonal psychodynamic psychotherapy no longer had the DSM diagnostic criteria for personality disorder after one year, whereas the patients from the control group had not changed. This improvement was maintained at follow up at 1 and 5 years.

Interpersonal group psychodynamic psychotherapy has been compared to individual psychotherapy (randomised controlled trial) in the treatment of borderline personality disorders. Treatment lasted for 35 weeks. The psychotherapists were trained and

experienced in individual psychodynamic therapy and trained, managed and supervised for the dynamic group psychotherapy. The results demonstrated a considerable improvement in behavioural indicators, social adaptation, overall symptoms and depression. No significant difference was found between group and individual psychodynamic therapies at the end of treatment and at 24 months' follow up.

Patients with personality disorders (mostly type C, a few type B disorders) were treated on an outpatient basis with two forms of brief psychodynamic psychotherapy (Davanloo psychotherapy and adaptive psychotherapy). The results demonstrated a significant improvement in those treated with both forms of therapy compared to a waiting list control group. No difference was found between the two therapies and the improvement was maintained one and a half years after the end of treatment. Brief psychodynamic therapy combined with advice was found to be more effective than advice alone in patients with antisocial personality, dependent on opiates and who had associated depression (one controlled trial). Several trials have demonstrated that personality disorders are frequently associated with other disorders (for example depression) and that this co-morbidity influences the results of therapy and often requires longer treatment.

In children, only retrospective uncontrolled trials (from the Anna Freud Centre in London) have examined the short and long term outcome of patients treated with psychoanalysis or psychodynamic (psychoanalytical) psychotherapy. Results showed a 62% improvement in patients treated for one year (4 to 6 sessions per week) although the study methodology (no control group) made it impossible to distinguish the effect of treatment from the natural course of the disorder. The results were consistent over several points, one of the major one of which was patient age: the younger the patient was the better the improvement and results obtained were.

Effects of psychoanalytical interventions in psychological disorders of children and adolescents

Diseases	Trials considered	Main results
Disturbing disorders (hyperactivity with attention deficit, conduct disorders)	Retrospective non-controlled trial (736 cases)*	Improvement observed in 62% of children: not possible to draw conclusion on efficacy in the absence of a control group.
Emotional disorders (anxious and depressive disorders)	Retrospective non-controlled trial (763 cases)*	The probability of improvement falls with age
Disturbing disorders, emotional disorders, personality disorders	Retrospective non-controlled trial (763 cases)*	Better improvement rate in emotional disorders

* this is the same population

Similarly, there were fewer treatment drop-outs in the younger patients (under 12 years old). Assistance provided to the parents during the child's treatment was a factor which helped to promote improvement in the child's psychological state.

As psychoanalysis is a treatment lasting several years and requires major investment for the young patient and his/her family, it is important to define the clinical and environmental conditions which allow the correct indications for use of this treatment to be defined and the expected benefits of this type of treatment in a young child to be identified.

Levels of evidence of psychodynamic (psychoanalytical) therapy in adults

Proven efficacy: established by a meta-analysis and randomised controlled trials

personality disorders, particularly borderline personality disorder.

Presumed efficacy: established by randomised controlled trials

Panic disorder on antidepressants: post-traumatic stress state

What results are obtained with cognitive-behavioural approach techniques?

Many meta-analyses have evaluated cognitive-behavioural therapies (CBT) (21 meta-analyses were identified for the disorders being studied) alongside the randomised control trials. Only the results of the meta-analyses are analysed and, where results are not available we have analysed those of the randomised controlled trials.

CBT has been used very widely in different anxiety disorders and there are many results available from efficacy assessments of these therapies. For panic disorder and agoraphobia, three meta-analyses have demonstrated a significant decline in symptoms in response to CBT compared to control conditions. The most effective therapeutic combination appears to be a combination of in vivo exposure and antidepressants.

The effect of CBT has been compared to that of drug therapy in patients with generalised anxiety (one meta-analysis). The effect sizes were relatively similar (0.70 for CBT and 0.60 for drug therapy) although the effect was maintained after treatment with CBT whereas the effect of drug therapy disappeared after patients were weaned off therapy. The CBT and drugs combination was not evaluated.

In the post-traumatic stress state, one meta-analysis combined trials on different types of behavioural and cognitive therapies (behavioural therapies, EMDR etc.) and drug treatments.

CBT (including EMDR) appeared to be more effective than drug treatment on symptoms of post-traumatic stress. The effects of the psychotherapies were maintained after follow up for an average of 15 weeks. Another meta-analysis specifically examining EMDR demonstrated that this technique (which is considered to be a variant of behavioural exposure therapy) was effective compared to the control group.

Three meta-analyses have examined obsessive compulsive disorders. One of these (combining 86 trials from 1970 to 1993) demonstrated no difference between antidepressants prescribed alone, CBT and a combination of both therapies. The effect size for CBT ranged from 0.70 to 1.46 depending on the criterion evaluated. Another meta-analysis (combining 77 trials between 1973 and 1997) found that the CBT was equivalent or better than treatment with serotonin re-uptake inhibitors. A third meta-analysis demonstrated that serotoninergic drugs, exposure CBT and cognitive and behavioural therapy all to be similarly effective. In order to calculate the long term efficacy of CBT in obsessive compulsive disorders, the results of 9 cohort studies (controlled) were combined. A 70% improvement rate was found over a follow up period of 1 to 6 years (average 3 years), with a 60% mean fall in ritual behaviour. However, as a rule, residual symptoms persisted and the risk of suffering depression remained unchanged.

Three recent meta-analyses provide an overall view of the short and long term effects of CBT in social phobias. One meta-analysis (including 42 trials) demonstrated that cognitive therapy associated with exposure had a greater effect size than placebo (1.06 *versus* 0.48). Additional improvement was also found at follow up. Another meta-analysis (combining 24 studies) showed CBT to have an effect size of 0.74 compared to placebo. The CBT did not demonstrate significant differences in efficacy compared to drug therapy. In the third meta-analysis, several CBT methods were compared to control conditions and to drug therapy. The effect size ranged from 0.6 to 1.0 for all of the forms of CBT and from 1.0 to 2.0 for drug therapy. The improvement in symptoms with CBT was maintained over time.

A few low statistical power controlled trials exist for the specific phobias (flying, dentist, spiders, heights, claustrophobia). These all show the different types of therapy (cognitive, behavioural, exposure in virtual reality, in vivo exposure therapies etc.) to be effective.

For moderate or severe depression, the oldest meta-analysis (which included 28 trials) demonstrated that cognitive therapy was superior to waiting list, to drug therapy and to behavioural therapy. The results of cognitive therapy at the end of treatment were better than those of antidepressants and of waiting list patients. Behavioural therapy was shown in the most recent meta-analyses to be equivalent in efficacy to cognitive therapy (as the technique performed does in fact often associate behavioural and cognitive methods) and antidepressants, and equal to interpersonal therapy in one meta-analysis.

The efficacy evaluation has also addressed prevention of long term relapses in depressed patients. The term relapse refers to redevelopment of a complete depressive state between 6 and 9 months after a remission lasting 2 months: a recurrence occurs beyond that period. The effects of cognitive therapy on prevention of relapses were greater than those of the antidepressants (between 1 and 2 years) in 6 controlled trials out of 8. On average, 60% of patients treated with drug therapy alone relapsed compared to only 30% of patients treated with cognitive therapy alone or combined with antidepressants.

According to the trials which have examined the effects of cognitive therapy on residual symptoms and recurrences in patients receiving antidepressants, the number of recurrences was significantly lower in the group which received cognitive therapy. The authors concluded that CBT was an alternative to continuing antidepressants.

In patients who suffer a major hospitalised episode of depression, one meta-analysis reported an evaluation conducted on discharge from hospital, which demonstrated that cognitive therapy associated with drug therapy was effective. The results of another meta-analysis showed an effect size of 0.96 for behavioural therapy and 0.85 for cognitive therapy compared to a control group in depression in the elderly. Psychoeducational treatments (information, awareness, improvement in interpersonal functioning etc.) have recently been developed for patients suffering from bipolar disorder. These have produced beneficial results in terms of the time to the first relapse of mania (65 weeks compared to 17 weeks in the control group).

In two meta-analyses and in controlled trials the CBT have been shown to have beneficial effects on personality disorders (avoidant, borderline, antisocial). In one of these meta-analyses, the overall effect size for CBT was 1.0 (1.20 for self-evaluation methods and 0.87 for evaluation measurements by other people). Several controlled randomised trials have been conducted with dialectic behavioural therapy (DBT) for borderline personality disorders in women from disadvantaged areas. This therapy involves an eclectic set of techniques based on the behavioural and cognitive principles. A reduction in suicidal and parasuicidal behaviour (35%) was found after one year in patients who received DBT compared to 65% in patients who received usual treatment (psychoanalytical treatment or support). These studies also showed a decrease in pathological anger and days of hospital admission and improved social adjustment in the group treated with DBT.

Effects of cognitive-behavioural interventions

Diseases	Trials considered	Main results
Anxiety disorders		
Agoraphobia	2 meta-analyses	Efficacy of CBT proven
Panic disorders	1 meta-analysis	Efficacy of CBT proven; significant reduction in panic attacks
Generalised anxiety disorder	1 meta-analysis	Efficacy of CBT proven; maintenance of effect after end of treatment
Social phobia	3 meta-analyses	Efficacy of CBT proven; maintenance of effect during follow up period
Post-traumatic stress	2 meta-analyses	Efficacy of CBT proven; maintained at follow up Efficacy proven for EMDR (simple variant of CBT)
Obsessive compulsive disorder	3 meta-analyses	Efficacy of CBT proven
Specific phobia	6 controlled trials	Efficacy of CBT presumed
Mood disorder		
Moderate or mild depression, outpatient basis	3 meta-analyses	Efficacy of CBT proven
Depression, hospitalised	1 meta-analysis	Efficacy of CBT proven
Depression in the elderly	1 meta-analysis	Efficacy of CBT proven
Bipolar disorder on psychotropic drugs	1 meta-analysis	Efficacy of CBT presumed
Schizophrenia		
Chronic schizophrenia on neuroleptics	3 meta-analyses	Efficacy of CBT proven
Schizophrenia in the acute period, on neuroleptics	1 meta-analysis	Efficacy of CBT presumed
Personality disorders		
Borderline personality	2 meta-analyses 5 controlled trials	Efficacy of CBT proven
Avoiding personality	1 controlled trial	Efficacy of CBT presumed
Alcohol dependency	2 meta-analyses 1 review	Efficacy of CBT proven
Eating disorders		
Bulimia	4 meta-analyses	Efficacy of CBT proven in the short term
Binge eating disorder	6 controlled trials	Efficacy of CBT presumed
Anorexia	1 post-hospitalisation controlled trial	Presumed efficacy in the prevention of relapses after weight gain
Anxiety and depressive disorders in children and adolescents		
Moderate depressive disorders	2 meta-analyses	Efficacy of CBT presumed
Anxiety disorders	6 controlled trials	Efficacy of CBT presumed, although no trials specific for this type of disorder

Cognitive-behavioural therapies have been evaluated in alcohol-dependent patients. These therapies use desensitisation, positive reinforcement and motivational and relapse prevention strategies. They are occasionally used in family and couple therapies. Self-efficacy and social anxiety reduction techniques have also been developed. These derive directly from the Dandura theories on social learning and self-efficacy. The Prochaska and DiClemente five stage model (precontemplation, contemplation, preparation, action, maintenance) also applies to the CBT. Cognitive or behavioural therapies may be put in place at each stage. Several studies (meta-analyses, controlled trials) have demonstrated brief interventions to be more effective than long term interventions in patients who are motivated for treatment. However, the effects appear to be greater in patients who suffer less severely.

There is no evidence that programmes designed to control alcohol intake produce better results than those designed to produce total abstinence.

Behavioural therapies and also, although to a lesser extent, the cognitive therapies used in development and social skills programmes have produced beneficial results (in 3 meta-analyses) on short and medium term relapse rates in reducing symptoms and in social re-adaptation of schizophrenic patients. The problem which remains is generalisation of the acquired skills which although appears to be real, is still too limited.

For acute schizophrenia, one meta-analysis conducted mostly on recent studies evaluating the effects of cognitive therapies demonstrated that the hospital admission relapse rate was not systematically reduced when cognitive therapy was compared to standard therapy in schizophrenic patients. A significant difference was, however, found in favour of cognitive therapy for earlier discharge from hospital compared to standard treatment. In terms of overall improvement in mental state, a significant difference was found in favour of cognitive therapy compared to standard therapy at 13 and 26 weeks, although this difference was no longer significant at one year. The conclusion drawn was that cognitive therapy is a promising treatment which requires additional evaluations.

The use of behavioural and cognitive-behavioural techniques is an integral part of most of the multi-modal treatment programmes for anorexia nervosa, whether on an outpatient or inpatient basis. Five randomised controlled trials have evaluated the efficacy of CBT in anorexic patients and highlight the improved compliance of anorexic patients to CBT compared to other treatments. They were not however able to establish the benefit of this type of treatment. The most recent controlled trial was the first empirical evaluation of the efficacy of CBT as a post-hospitalisation treatment for anorexia nervosa in adults. Following weight regain, the relapse rate and treatment discontinuation rate were lower and the overall clinical results were better in the group which received CBT compared to the comparator group.

Four meta-analyses have been published in the treatment of bulimia, combining between 7 and 35 randomised controlled treatment trials (usually women) with a diagnosis of bulimia (occasionally also binge eating disorder or non-specific bulimic eating disorder). All four meta-analyses concluded that CBT was effective in the short term in reducing symptoms of bulimia (often assessed from the frequency of attacks and of vomiting) and in the associated dysfunctional attitudes and distortions (in the fewer studies which included these measurements). Comparisons were performed pre and post-treatment or by comparing CBT to the control conditions. The reported effect sizes ranged from 0.55 to 0.74 in the intragroup comparisons (pre- versus post- treatment) and from 0.23 to 0.67 in the intergroup comparisons (CBT versus control). The long term data are either insufficient or less encouraging than in the short term: in addition, the wide range of follow up periods and measurements used to calculate the long term effect size limits the interpretation of present results. One of the meta-analyses compared randomised controlled trials of drug treatment (9 trials) to controlled trials of CBT or behavioural therapy (26 trials). In the short term, CBT produced effect sizes which were greater than for drug therapy for all of the variables examined. Combination of these two treatments was significantly more effective than drug treatment alone for the frequency of attacks and vomiting, and more effective than CBT alone for the frequency of attacks, but not for the frequency of vomiting. The general conclusions drawn were that existing research in favour of CBT being effective in bulimia is convincing despite considerable interindividual variability in the magnitude and stability of the response to treatment.

CBT has also been studied in the treatment of binge eating disorder or BED. This syndrome, which has recently been identified as a specific eating disorder, is in fact closer to bulimia

than to obesity without binge eating disorder. Because of this, the first research into the treatment of BED concentrated on investigating the efficacy of methods which have already been proven for the treatment of bulimia (CBT and interpersonal psychotherapy). Six controlled trials demonstrated CBT in various forms (individual or group, self-administered or under the supervision of a therapist) to be effective, demonstrated by good compliance with treatment, which is unusual in eating disorders. Addition of physical exercise to CBT and extending the treatment period (one trial) improved the results and helped to produce a greater reduction in the frequency of bulimic attacks and rise in BMI (Body Mass Index). The positive effects of CBT in obese subjects with BED included a reduction in weight (although this was less that in obese patients without BED) and also a significant improvement in subjective perception of state of health and associated quality of life (one trial). Only one trial included a follow up period (12 months). The frequency of attacks increased slightly during the follow up period although remained less than the pre-treatment.

Levels of proof of CBT

Proven efficacy: established by one or more meta-analyses or consistent high statistical power randomised trials.

- agoraphobia; panic attacks; social phobias; generalised anxiety; post traumatic stress; obsessive compulsive disorder
- mild or moderate depressive states; acute depressive states; prevention of relapses and recurrences of outpatient depression; hospitalised depression
- schizophrenia for psychosocial rehabilitation
- borderline personality in women; alcohol dependent people
- bulimia

Presumed efficacy: established by meta-analyses, randomised controlled trials, cohort studies, reviews: some of these studies may be contradictory and require confirmation.

- specific phobias
- avoidant personality; antisocial personality
- schizophrenia in the acute phase (combined with neuroleptics)
- bipolar disorder (treated with mood regulating drugs)
- moderate depressive disorders in children and adolescents
- anxiety disorders in children and adolescents

The efficacy of CBT in the treatment of depression has been evaluated in children and adolescents in two meta-analyses, the results of which were consistent and indicate that CBT provides significant symptomatic improvement. However, the trials included in these meta-analyses were limited in number, mediocre in quality and they used samples of patients recruited from the general population rather than those requesting care, and therefore people who were less severely affected. More recent but isolated controlled trials suggest that the response to CBT is better in younger people and in those in whom the consequences of the disorders are less severe, that the parents involvement in the treatment does not improve results, and that a rapid response to treatment predicts better long term outcome. We can refer to the CBT as being of presumed efficacy in moderate depressive disorders in children and adolescents, although the CBT cannot currently be recommended as monotherapy in cases of severe depression in young people.

Proof of the efficacy of the CBT in anxiety disorders in children and adolescents is still limited. Although many studies which examine specific phobias exist, most are old and are of more experimental than therapeutic interest, as they were performed on subjects who were not recruited in a clinical context. The more recent studies have used different CBT

techniques (systematic desensitisation in an imaginary situation or *in vivo*, filmed model technique or *in vivo* model technique, participation modelling, contingency reinforcement management, training in self-control, restructuring of distorted cognition), which have been shown to be effective compared to other treatments or to a waiting list.

In the treatment of fears and phobias, proof of efficacy exists from several consistent randomised trials for two CBT techniques: participation modelling and contingency reinforcement management; presumed efficacy exists for desensitisation in the imaginary or *in vivo* situation, the *in vivo* model technique and the filmed model technique.

Two randomised controlled trials have been published in school phobia, one demonstrating CBT to be superior to a waiting list and the other concluding that CBT but also psychoeducational support, introduced initially as a control condition, were both effective. Only one recent controlled trial in social phobia has shown that treatment called *"social effectiveness therapy for children"* which combines group training with social skills, individual exposure and household tasks was more effective than non-specific psychotherapy centred on performance anxiety, and that the benefits were maintained at 6 months.

Presumed efficacy exists for a set of anxiety disorders grouped together in the same trials: hyperanxiety, separation anxiety and childhood avoidant disorder, from 4 controlled trials which demonstrated that an individual treatment programme with CBT was superior to no treatment and from 2 controlled trials demonstrating group CBT to be superior to a waiting list. In addition, an open trial of group CBT combining parents and children in the treatment of separation anxiety (in some cases associated with another anxiety disorder) in pre-adolescents, demonstrated a higher recovery rate after 3 years than at the end of treatment.

In obsessive compulsive disorder in children and adolescents, presumed efficacy only exists for a CBT programme based on exposure with response prevention (manual-based programme). A single low power, randomised trial and 9 open trials are consistent, demonstrating that this treatment is effective on obsessional and compulsive symptoms both in the short term (between 25% and 79% of subjects were improved) and in the long term (6 trials, included follow up periods ranging from 3 months to 14 years). Huge multi-centre randomised controlled trials on the efficacy of CBT, either alone or in association with pharmacological therapy are currently underway. These should provide more clearly defined proof of the efficacy of CBT in this indication.

Many cognitive-behavioural techniques are used in the psychosocial intervention programmes designed for the treatment of invasive developmental disorders, particularly autism and externalised disorders, i.e. hyperactivity with attention deficit and conduct disorders, in children and adolescents. As these programmes usually include active participation of the parents, proof supporting the efficacy of CBT in these indications is reported in the context of family therapies.

What are the results obtained with family and couple therapy techniques?

Reviews which analysed the initial trials, published between 1972 and 1983, highlighted the absence or inadequate nature of the control groups, the unreliability of the evaluation methods, the absence of a sufficient period before follow up assessment and the poorly defined nature of the theoretical bases used in the comparisons. Since the 1980s, authors have proposed more detailed indications based on comparisons with individual therapies, comparisons between theoretical orientations, differences between these orientations depending on the problems treated and the effects of essential moderators and methodological choices on the evaluation of results. Work is now examining the actual

scientific proof of the effectiveness of couple and family therapies in major disorders and problems in adults (schizophrenia, mood disorders, drug addiction etc.) and in children and adolescents (autism, anorexia, conduct disorders etc.).

The largest number of evaluation studies has been performed in schizophrenia. A single robust criterion for efficacy of treatment is often used in the studies: this is the percentage relapse rate observed in a group during a given time period (relapses being defined for example as psychiatric hospitalisation). The results are consistent and it can be stated with a high level of proof that family interventions reduce the percentage relapse rate in these types of disorders.

Long term family interventions are significantly better efficacy compared to brief family interventions. Beyond this, the large diversity of the types of intervention (hospital, outpatient, home) the trials examined describe interventions which were usually based on the expressed emotion theory. This theory considers schizophrenia to be a brain disease for which the families are not responsible and refers to behavioural and cognitive principles: understanding and management of stressful situations, recognition of disorders and information about therapeutic methods and family adjustment to the consequences of the disorders and impacts of treatments. Four meta-analyses and three systematic reviews describe the efficacy of behavioural and cognitive-inspired family therapies.

One controlled trial demonstrated that multi-family behavioural and cognitive interventions appear to produce better results than single family interventions on prevention of relapse with hospitalisation. This does not mean that all families will benefit from multi-family therapy, particularly as some are not ready for it.

Information for schizophrenic patients and their families about the current state of knowledge available to professionals about the disorders and the types of treatment and therapeutic approaches available appears to have a clear therapeutic component in a large number of cases. This lies within a global psychosocial treatment, which may involve learning social skills and management of critical situations and an accompanying approach to social-occupational rehabilitation processes, when these can be envisaged.

In addition, increasingly diverse forms of family therapies exist which are still difficult to evaluate in the current state of methods used to assess therapeutic efficacy, particularly as they are continually evolving. These various practices do not involve standardised family follow up. It is not clear which family follow up therapeutic technique is most effective, with which type of patients, and with which types of family. There is, therefore, a considerable gap between research into families of schizophrenic patients over the last thirty years and the application of this knowledge to everyday clinical practice.

Two controlled trials compared different forms of family intervention in a wide range of mood disorders. One of these demonstrated the benefit of multi-family therapies. Conversely, the use of intensive couple therapy for women with unipolar depression appears to be less relevant than the use of drug therapy combined with supportive therapy, either individually or with the partner.

In the case of bipolar disorders, 2 controlled trials have shown that family-focused therapy with information about the nature of the problems, and involving the partners, reduces the number of relapses, increases the periods before relapses and markedly improves depressive symptoms (according to one of these trials the question of manic symptoms remains controversial).

In forms of major depression with a “critical partner” one controlled trial has shown that systemic interactive marital therapy produces an improvement in symptoms, both at the end of treatment and 2 years later.

In anorexia nervosa, family therapy appears to produce better results at the start of the disorder in young adolescents. It does not produce savings in hospitalisation in some severe, life-threatening forms of the disease. Published studies consider family interventions, either during a hospitalisation or during outpatient treatments. Five controlled trials have demonstrated various family therapies (psychodynamic, cognitive, systemic, psychoeducation) to have a positive effect on weight recovery. In addition, taking the family dynamic into consideration in the treatment plan appears to have a specific effect on overall improvement, not only on weight gain. One systematic review, however, states that in types of the illness in which serious discord exists within the family it may be preferable to consider psychotherapy in parallel for the anorexic patient and accompanying support, information and assistance work for the parents. Depending on the case, direct face to face meeting between the patient and his/her parents may have a maturing value, or may be destructive. The therapist's clinical judgement on an individual case basis appears to be essential. One systematic review found no clear advantages associated with any particular theoretical orientation or type of therapist for the family therapy of bulimia. The best results appear to be obtained with more sustainable intensely programmed groups, with the addition of external components (for example individual work).

In alcohol-dependency, the trials (grouped in 2 meta-analyses and 2 systematic reviews) have demonstrated proof of the utility of including family members in the three phases of treatment: initiation; primary treatment; post cure rehabilitation. Proof has accumulated over time on the efficacy of behavioural couple therapies in terms of abstinence, resolution of problems associated with alcohol, quality of relationships and reductions in separations and divorces when compared to individual treatments. Some projects, such as the CALM *(counselling for alcoholics marriages)* had significant effects on domestic violence and on reducing hospitalisations and imprisonment. In all cases it seems advisable to consider multiple treatment methods tailored to each specific situation. The individual approach to the alcohol-dependent patient and the partner, the marital and family approach, multi-marital and multi-family approach, or community reinforcement approach may be added, depending on the factors making up the personality of the patients and their close relatives, the family situation, the type of alcohol misuse, possible co-morbidities and levels of motivation and commitment to the treatment project. Although at present, results for the efficacy of the adjustment process are uncertain and new hypotheses need to be constructed in order to establish how the variables relating to severity of psychiatric disorders, level of independence, level of support with abstinence and degree of investment in social relationships can guide towards the most relevant type of therapy. It would be interesting, for example, to test the effects of interaction between the theory of the treatment and the features of a patient.

Effects of family therapies depending on disorder

Disease	Trials considered	Main results
Schizophrenias	4 meta-analyses 6 controlled trials	Significant benefit of behavioural and cognitive family therapies and family psychoeducation in reducing relapses and rehospitalisations.
Anorexia	5 controlled trials 1 systematic review	Significant benefit of behavioural and cognitive family therapies and family psychoeducation and ecosystem therapies for patients with anorexia nervosa which had developed less than 3 years previously.
Mood disorders	5 controlled trials	Significant benefit of behavioural and cognitive orientated ecosystem couple and family therapies for bipolar disorder and major depression.
Alcohol dependency	2 meta-analyses	Significant benefit of including family members in the

	2 systematic reviews	treatment of the alcohol dependent person; significant benefit of behavioural couple therapies.
Childhood autism	7 controlled trials	Significant benefit of behavioural and psychoeducation programmes with parental training in improvement in IQ, educational performance and social conduct of children with early autism.
Hyperactivity	3 controlled trials 2 prospective controlled trials	Significant benefit of behavioural training of parents and combined treatment including medical drugs and intensive management of the child with parents and school.
Conduct disorders	8 controlled trials	Significant benefit of parental learning and training in problem resolution skills.
Anxiety disorders in children	1 controlled trial	Significant benefit of family "management" associated with cognitive and behavioural therapy in disappearance of symptoms.

Other trials examined childhood diseases such as anxiety disorders, hyperactivity, conduct disorders and autism. One controlled trial demonstrated behavioural and cognitive family therapy to be effective in childhood anxiety disorders. The informed participation of parents as co-therapists appears to represent a considerable advance in psychotherapies for children with separation anxiety, hyperanxiety or social phobia.

Attention deficit disorder with hyperactivity has received considerable attention in both pharmacological and psychotherapeutic research. Behavioural training of parents, involving teaching them to adopt a contingency reinforcement management system with their hyperactive child has been shown to be effective on many occasions compared to waiting list conditions. Training in social skills and problem resolution has been shown to be effective when it forms an integral part of intensive multi-modal treatment programmes (5 controlled trials). Combined treatment associating drug therapy and intensive management including the parents, children and school has been shown to be significantly superior to behavioural therapy alone in three fields: opposal and aggressive behaviour scored by the parents, internalised symptoms and reading performance. The presence of a co-morbid anxiety disorder (34% of subjects) also tends to lend an advantage to combined treatment. In addition, combined treatment could help to reduce doses of drugs.

Conduct disorders in children and adolescents cause raise serious problems for the family, school and overall society. These include a wide range of behaviours which range from simple opposal or aggression provocation conduct to those as serious as murder. Minor problems in young children often represent the premonitoring developmental signs of serious aggression in adolescents or in adulthood, making their treatment both desirable and justified. The proposed treatments may be orientated towards the parents, the subject him/herself or his/her environment (for example school); the approaches are often different depending on whether the children involved are prepubertal or adolescents, and several treatments may be combined. Therapy with parental learning (explaining the principles of social learning and behaviour modification, rewarding desired conduct and removing parental attention or privileges in situations of undesirable conduct) is more effective than no treatment (waiting list) or even to alternative therapies. In addition, this type of treatment, designed to reduce antisocial behaviour in the person initially referred for care, can also reduce the risk of analogous behaviour developing in the siblings. Another method proposed to treat disruptive conduct in children and adolescents is training in problem resolution skills. This is based on the idea that antisocial conduct is at least in part linked to cognitive processes such as a tendency to attribute hostility inappropriately to other people and a poor capacity to understand social situations and resolve interpersonal problems.

Combined therapy with parental learning and problem resolution training appears to provide additional advantage (8 controlled trials).

Seven controlled trials had been dedicated to intensive educational and behavioural programmes in autistic children, conducted to a large extent by the parents. The first systematic evaluation of an early intervention programme for autism dates from 1987 (UCLA, *University of California)*. The treatment lasted for 2 years, began at home and involved an intensive intervention of at least 40 hours per week with a therapist face to face with the child. The effectiveness of this programme had a key influence on subsequent works.

Therapies for autism are based to a large extent on the operant behaviour and conditioning principle (Loovas method) and on psychoeducational and behavioural approaches centred on cognitive and developmental acquisition of competencies (TEACCH method). Both methods are used with a view to educational or social normalisation.

Studies which have applied these two approaches have shown substantial gains in cognitive development (IQ) and in the language of children suffering from autism or other invasive developmental problems (IDP). Starting treatment at an early age appears to be a necessary condition for these interventions to be effective.

Regardless of the place where these programmes are conducted (at home or in specialist centres) close co-operation between the parents and professionals over a long period is a prerequisite for success. The gains obtained are generally maintained after treatment is stopped. According to one of the trials, 42% of children who received intensive behavioural treatment (Loovas method) could no longer be distinguished from other children 6 years after the end of treatment.

Nevertheless, despite intensive interventions, the authors found a lack of progress in some children, whereas those who progressed most had the best cognitive competencies at the start. Studies which were dedicated to childhood autism therefore appear to confirm that autism does not represent a homogeneous group of diseases and/or handicaps and that there is a very wide range of responses between children and families to intensive therapeutic approaches.

In conclusion, we found that the current forms of family therapy share a number of common points:

- modest expectation in the objectives for change in demanding and severe pathological situations;
- not accusing the family and respecting individuals, their lifestyles, beliefs and knowledge systems;
- sharing relevant information between the patients, families and professionals;
- calming anxiety-generating or stressful situations;
- accompanying the patients and their families over a sufficiently long time if needed;
- acceptance of differentiation and diversification of intervention methods.

Levels of proof for family therapy

Proven efficacy: established by one or more meta-analyses and consistent, high statistical power randomised controlled trials	
Schizophrenia	Family therapy by psychoeducation for the prevention of relapses and rehospitalisations
Alcohol dependency	Couple behavioural therapy
Autism (child)	Intensive educational and behavioural programme

	administered early
Hyperactivity (child)	Intensive multi-modal treatment including parental behavioural training
Conduct disorders (Child)	Treatment with parental learning
Presumed efficacy: established by meta-analyses, randomised controlled trials, cohort studies, reviews: some of these may be contradictory and require confirmation.	
Bipolar disorder	Couple and family therapy with psychoeducation
Anorexia nervosa	Family therapy, any orientation (cognitive-behavioural, psychoeducation ecosystem)

Schizophrenias and alcohol-dependency in the adult, conduct disorders and drug addictions in the adolescent and hyperactivity and autism in children clearly benefit from a combination of therapies, amongst which the family therapies appear to be important. It would be desirable to see research undertaken to evaluate the many forms of family therapy which are based on personal and interactive individuality and which are tailored in order to relieve distress and give back reasons for living to patients with major life-threatening problems. It is also important to stress that after being in existence for fifty years, the family therapies movement continues to experience rapid change in practice, continuously adapting to the constraints of individual clinical situations depending on the wide diversity of methods and techniques which have been used and formalised to date.

What data are available on the comparative assessment of the different therapies?

In recent decades, the field of research into comparison of different forms of psychotherapy has advanced considerably and has led to many therapeutic recommendations in various countries. Nevertheless, making comparisons between the different approaches is a difficult process when evaluating the psychotherapies.

In this section, only those trials aiming directly to modify the diagnostic criteria for a disorder, the symptoms or various aspects of patient functioning are analysed. These trials include meta-analyses and randomised controlled trials which have made direct comparisons between two types of therapy and those which have compared the efficacy of different psychotherapies compared to a control group within the same trial. The control group can be made up of people who have not received any active treatment (for example a waiting list group) or patients who have received "standard" supportive psychotherapy[8]. Comparison with a supportive therapy allows the specific effects of a given treatment to be identified beyond the expected benefits of positive regular contacts with other people.

Firstly considering the overall effects, all diseases combined, 5 meta-analyses were found based on almost 700 trials, conducted over 60 years. These trials were very varied in methodology and mostly involved people suffering from anxiety and depressive disorders. Their findings indicate that psychotherapy (all forms analysed together) is more effective than no treatment. The average result in treated patients was 70% to 80% better than in untreated patients. This difference was statistically significant in all five meta-analyses. However, the overall positive effects of psychotherapies do not mean that all forms of psychotherapy are effective in the same way, or that the psychotherapies are effective when considered on an individual level. The meta-analyses which demonstrated positive effects of psychotherapy also showed that the positive results were usually associated with cognitive-

[8] These therapies are known by various names (general psychotherapy, supportive psychotherapy, non-directive therapy etc.). Some humanist approaches, including the Rogerian therapy, are also considered to be supportive therapies as they consider empathy and the support from therapists as being fundamental mechanisms for change.

behavioural therapy divided into two categories: those in which the CBT emerged in leading position in an effect size classification and those (the more frequent) which were obtained from direct comparisons between different forms of psychotherapy. Beyond these results, the five meta-analyses were not able to classify the other psychotherapies in terms of general efficacy.

Whilst it may be useful to be aware that psychotherapy is effective, good patient management in general is based on an evaluation of efficacy in the specific types of mental disorder.

One analysis demonstrated that the CBT approach was more effective than "verbal" therapies (psychodynamic approaches and gestalt[9] combined) in various anxiety syndromes analysed together, and than supportive therapy. One randomised control trial compared the psychodynamic approach to supportive therapy in a sample of patients suffering from various anxiety disorders (and some depressive disorders) and found no significant difference in efficacy.

In generalised anxiety disorder (GAD) one meta-analysis found that CBT was more effective than psychodynamic therapy at the end of treatment and after 6 months' follow up (no family therapy studies were included in this meta-analysis). Of the seven randomised controlled trials found in GAD, three compared CBT to psychodynamic therapy and concluded that CBT was more effective. In the four trials which compared CBT with supportive therapy, three found CBT to be superior and one found no difference.

In other trials which compared supportive therapy with CBT, CBT was found to be superior in the treatment of social phobia (3 trials), panic disorder (3 trials) and post-traumatic stress state (2 trials). The literature does not contain trials which compared pharmacodynamic or family approaches to supportive therapy in these disorders and no randomised controlled trials were found for the specific phobias. For patients with post-traumatic stress state, one randomised controlled trial, which compared psychodynamic therapy with CBT, did not find any significant difference between the two therapies, both of which produced superior results to those in untreated subjects.

All of the trials which have included a patient follow up period have shown that the therapeutic gains, regardless of therapy, are generally stable over time in most patients treated for anxiety disorder. The same applies to all of the disorders examined in this review. In addition, the trials do not report symptom substitution with any of the therapies studied (including CBT) in the months or years of the follow up after treatment.

Depression is a heterogeneous syndrome involving various aetiological factors and may be managed with different types of therapy. Nine meta-analyses or systematic reviews have compared different forms of psychotherapy in adults or in the elderly. In four of these trials, CBT was compared to several other forms of therapy, analysed under the single category of "other therapies": interpersonal therapies, psychodynamic therapy and supportive therapy.

All of these concluded that CBT was more effective at the end of treatment. In addition, one meta-analysis reported CBT to be superior after a follow up period of one to twelve months, with no fall in the effect size which was obtained initially. Two meta-analyses which compared psychodynamic psychotherapy with CBT produced different results. One, which directly compared brief psychodynamic psychotherapy with CBT, found no significant difference, although CBT but not psychodynamic therapy was statistically different to no treatment. The other meta-analysis also found no significant difference between

[9] An existential phenomenon therapy of F Perls (1940) based on gaining awareness of acts and emotions, and on beliefs and self-acceptance and self-esteem.

psychodynamic therapy and CBT, although both treatments were more effective than supportive therapy.

Two systematic reviews have compared different forms of psychotherapy in depressive disorders. The first examined 9 trials comparing the psychodynamic approach with CBT: 5 found both approaches to produce equivalent results and 4 found that CBT was superior. In the other comparisons CBT, was equivalent to interpersonal therapy in one trial and equivalent to supportive therapy in four others. The only trial which compared psychodynamic therapy with supportive therapy found no difference. In the second systematic review, of depression in the elderly, 3 trials compared psychodynamic therapy with CBT and found no difference between the two therapies at the end of treatment, although two of the three trials found greater improvement and improved maintenance of gains on follow up in patients treated with CBT.

Fifteen recent randomised controlled trials have directly compared the psychodynamic approach with CBT in the treatment of depression. Most of these have included a patient follow up period ranging from between 3 and 18 months after the end of treatment. Almost all involved brief forms of psychotherapy (between 8 and 20 sessions). Most of the trials found that psychodynamic therapy and CBT were associated with improvement in the depression. Eleven trials found CBT to be more effective, either at the end of treatment or in the follow up period, and no trials found psychodynamic therapy to be more effective. The trials which concluded that CBT was superior only on follow up or in which the magnitude of result was greater on follow up than at the end of treatment suggest an "incubation" effect, indicating that the benefits of CBT are not restricted to the active treatment period.

Two of four trials in depressed patients demonstrated CBT to be more effective than supportive therapy, whereas two found no difference. The only trial which compared psychodynamic therapy to supportive therapy found no difference. In the United States *National Institute of Mental Health* (NIMH) collaborative programme for the treatment of depression, two trials demonstrated that interpersonal therapy and CBT were effective in the management of depression, although found no significant difference between these two approaches.

Results of comparative evaluations of different approaches (PT, CBT, ET)

Diseases	Trials considered	Main results
Anxiety disorders		
Generalised anxiety disorder	PT/CBT: 1 meta-analysis 3 controlled trials	CBT more effective
	CBT/ST: 1 meta-analysis 4 controlled trials	CBT more effective
Panic disorder	CBT/ST: 3 controlled trials	CBT more effective
Social phobia	CBT/ST: 3 controlled trials	CBT more effective
Post-traumatic stress	PT/CBT: 1 controlled trial	No difference in efficacy between the two therapies
	CBT/ST: 2 controlled trials	CBT more effective
Mood disorders		
Depression in adults or the elderly	PT/CBT: 2 meta-analyses 2 reviews, 15 controlled trials	Results of meta-analyses inconsistent: no difference found (50% of trials) or CBT superior (50% of trials). Results of trials analysed in the reviews: CBT superior in the majority (73%) of the controlled trials.
	CBT/"others" 4 meta-analyses	CBT superior to "other" therapies
	CBT/ST: 1 meta-analysis: 4 controlled trials	CBT more effective in the meta-analysis and in half of the controlled trials.
	CBT/IT: 2 controlled trials	No difference in efficacy between the two therapies.
	PT/ST: 1 controlled trial	No difference in efficacy between the two therapies.
Major depression in adolescents	CBT/FT: 2 controlled trials	Inconsistent results
	CBT/ST: 3 controlled trials	CBT more effective
	FT/ST: 2 controlled trials	Inconsistent results
	CBT/IP: 1 controlled trial	No difference in efficacy between the two therapies
Schizophrenia		
Schizophrenia (non-acute period)	PT/CBT/FT: 2 meta-analyses	No difference in efficacy between FT (psychoeducation) and CBT. CBT and FT superior to PT
	PT/CBT: 1 controlled trial	CBT more effective
	FT/ST: 1 controlled trial	Psychodynamic therapy more beneficial on functioning of the ego and cognition, less beneficial for relapses.
	CBT/SR: 1 controlled trial	Family therapy more effective on improvement of residual symptoms.
Schizophrenia (acute period)	CBT/SRT: 1 controlled study	CBT more effective
	CBT/ST: 1 controlled study	CBT more effective
	CBT/ST psychoeducation: 1 controlled trial	Difference not significant: trend towards fewer relapses with CBT.
Eating disorders		
Bulimia	PT/CBT/FT: 1 meta-analysis 1 controlled trial	No significant difference between the therapies
	PT/CBT: 3 controlled trials	Little difference between the therapies or inconsistent results
	PT/FT/ST: 2 controlled trials	Little difference between the therapies
	CBT/MT: 2 controlled trials	No difference between the therapies or inconsistent results
	CBT/IT: 2 controlled trials	Little difference between the therapies or inconsistent results
Anorexia	PT/CBT: 2 controlled trials	Little difference between the therapies or inconsistent results
	PT/FT/ST: 1 controlled trial	Little difference between the therapies or inconsistent results, although improved efficacy of family therapy for recent anorexia.

CBT: cognitive-behavioural therapy; PT: psychodynamic therapy; ST: supportive therapy; IT: interpersonal therapy; FT: family therapy; SRT: standard recreation therapy; "others" PT, ST, IT analysed in a single category; MT: motivational therapy.

Schizophrenia is characterised by psychotic symptoms (such as hallucinations or delusions) present during the active phase and frequently by persistent deficits in the area of social or occupational functioning in the residual phase. The different psychotherapies have been evaluated in this disorder as a supplement to standard medical treatments. The two comparative meta-analyses on the subject examined more than 100 trials, including various forms of psychotherapy in the treatment of schizophrenia (symptoms in the acute or residual phase, relapse rates). Both found that family therapies (psychoeducation) had the greatest effects at the end of treatment: the effects of CBT were equivalent or slightly inferior to those of the family approach. Psychoanalytical or psychodynamic treatments were the least effective. However, few if any specific comparisons were performed between therapies (two by two). Six randomised controlled trials of different psychotherapies in schizophrenia were examined: four compared CBT to other psychotherapeutic approaches, with follow up for 9 to 24 months. CBT was found to be more effective than psychodynamic therapy (1 trial), recreation therapy (1 trial) and supportive therapy (2 trials). In one trial which examined the efficacy of psychodynamic therapy compared to so-called "reality adaptation/supportive" therapy with a follow up period of 2 years, the authors found little differences in efficacy. Finally, a comparison between "personal" therapy (a coping approach or adaptation strategy centred on stress reactivity), family therapy and supportive therapy conducted over a period of 3 years found none of the therapies to be superior overall to the others, although different gains were found depending on the patient's home conditions (whether the patient lived alone or in a family setting).

The trials have shown several forms of psychotherapy to be effective in eating disorders. The only meta-analysis which examined bulimia did not find any significant difference between the various therapies tested (psychodynamic therapy, CBT, family therapy, standard support). Various forms of psychotherapy (psychodynamic, CBT, family therapy, interpersonal therapy, supportive therapy) were compared in 9 randomised controlled trials on bulimia conducted after 1992 (the date of the meta-analysis described above). Although significant differences were found, the results of the trials were inconsistent and no general conclusion can be drawn as to the superiority of one approach over another. The literature is far more limited for the treatment of anorexia (3 controlled trials) and does not demonstrate any significant difference in efficacy between the therapies: psychodynamic, CBT, family therapy, or supportive therapy.

Similarly, there is insufficient literature on the other disorders in adults, notably alcohol dependency and personality disorders, to allow the different psychotherapies considered in this review to be compared.

Finally for disorders in children and adolescents, the meta-analyses show that at the end of psychotherapy a significantly larger number of children treated are improved compared to untreated control subjects, and that the mean effect sizes of psychotherapy are similar to those reported for adults. In addition, the effects of psychotherapies are generally superior for CBT compared to non-CBT treatments (psychodynamic therapy and supportive therapy) and slightly superior for family or supportive therapies compared to psychodynamic treatments. Considering the findings by specific disorder, there are relatively few comparisons between approaches except for those on depression and anxiety disorders. For these syndromes the comparative trials in children and adolescents have tended to demonstrate similar results to those described for adults. For example, the four recent trials of good methodological quality on depression, with follow up of to 2 years, mostly found CBT to be generally equivalent to interpersonal therapy and to be more effective compared to the other approaches. Family therapy was more effective than other therapies in one of these trials, particularly for family problems and parent-children relationships. No trials have included the psychodynamic (psychoanalytical) therapies. Overall, and despite some

similarities with the results obtained in adults, the smaller number of trials in children and adolescents and their methodological weaknesses make it impossible to identify the differences in efficacy between the different forms of psychotherapy as clearly.

Levels of proof in adults demonstrating superior efficacy between the three approaches studied, established by comparative trials

	Superior efficacy proven
Generalised anxiety disorder	CBT *versus* psychodynamic therapy
Major depression	CBT *versus* psychodynamic therapy
	Superior efficacy presumed
Schizophrenia	Psychoeducational family therapy *versus* psychodynamic therapy
	CBT *versus* psychodynamic therapy

Levels of proof in adults demonstrating superior efficacy of one therapy compared to supportive therapy

	Superior efficacy proven
Generalised anxiety disorder	CBT
Panic disorder	CBT
Social phobia	CBT
Post-traumatic stress	CBT
Major depression	CBT
	Superior efficacy presumed
Schizophrenia	Psychoeducational family therapy CBT

What factors can be assessed to determine which therapy is suitable for which disorder?

For each of the three types of approaches examined in this review – psychodynamic (psychoanalytical therapy), CBT and family therapy - we have reviewed the trials which have assessed their efficacy compared to a control group. The results of trials comparing the efficacy of these therapies are also described. Finally, these analyses allow us to describe those therapies which are liable to bring patients benefit in their care for each of the disorders.

Published findings on patients suffering from acute phase or hospitalised schizophrenia have established the efficacy of family therapies combined with antipsychotic agents on the 2 year relapse rate (1 meta-analysis), the presumed short term efficacy of cognitive therapies combined with antipsychotic agents (1 meta-analysis) and the lack of effect of psychodynamic therapies alone or combined with drug treatment (1 good quality meta-analysis, which only however used data from 3 old trials, in the absence of other usable published data).

Diseases	Trials considered	Main results
Schizophrenia	3 meta-analyses, CBT	CBT moderately effective on the 2 year relapse rate in schizophrenic patients in the acute or hospitalised phase, combined with antipsychotic agents. CBT effective in stabilised patients followed

	on an outpatient basis, combined with antipsychotic agents.
1 meta-analysis, CBT and FT (PE 1 meta-analysis, PE	Family therapies effective on the 2 year relapse rate in acute phase or hospitalised schizophrenics combined with antipsychotic agents.
3 meta-analyses, FT (of which 2 with PE)	Psychoeducational approach effective (family or patient centred) in stabilised patients followed up on an outpatient basis, combined with antipsychotic agents.
1 meta-analysis, PT 1 systematic review, PT	No efficacy demonstrated for PT on clinical course of schizophrenic patients.

CBT: cognitive-behavioural therapy; FT: family therapy; PE: psychoeducational approach; PT: psychodynamic therapy.

For stabilised schizophrenic patients followed on an outpatient basis, 3 meta-analyses have established the efficacy of the cognitive-behavioural approach in combination with drug therapy on social skills acquisition or improvement in emotion management, with a mean follow up period of 5 months. The psychoeducational approach combined with drug therapy has also been proven to be effective on the 1 and 2 year relapse rates when the family approach is used (2 meta-analyses) and on the 18 month relapse rate when it is patient-centred (1 meta-analysis). The psychodynamic approach has not been established to be effective on patients' clinical course of (1 meta-analysis and 1 review) even when combined with antipsychotic agents. Direct comparisons between the various psychotherapeutic approaches themselves have established that cognitive-behavioural therapies and the psychoeducational approach are more effective.

For the mood disorders, the information available on bipolar disorder only relates to the psychoeducational approach, which was shown to be effective in combination with drug therapy on global functioning and compliance with treatment when the psychotherapy was family-based (marital) (1 controlled trial) and on the time to development of relapses of mania (but not depression) at 18 months when it was only patient-based (1 controlled trial). Notably, no comparisons have been performed between the psychotherapies designed for the treatment of bipolar disorder.

It has been established for depressive disorders in hospitalised patients that cognitive-behavioural therapies combined with antidepressants have effects on depressive symptoms (1 meta-analysis). Family psychoeducation has short term effects on global patient functioning (1 controlled trial) and psychodynamic therapies have effects on social adaptation and the length of the patient's hospitalisation (1 controlled trial). The level of proof of efficacy in this indication is greater for the CBT, and the controlled trials which compared psychodynamic and cognitive-behavioural approaches have concluded that the cognitive-behavioural approaches are superior.

For mild or moderate depressive disorders treated on an outpatient basis, cognitive therapies have been proven to be more effective than antidepressant treatments (2 meta-analyses). Interpersonal therapies are similar in efficacy to cognitive therapies (1 meta-analysis). There are little data on the psychodynamic therapies. In contrast to the interpersonal therapies, these have not been shown to be similar in efficacy to the CBT (1 meta-analysis). Couple therapies also appear to be effective for people living with a critical partner (1 controlled trial).

The cognitive-behavioural therapies have been studied by far the most in anxiety disorders. Their efficacy is best established in panic disorder, whether or not associated with antidepressants (2 meta-analyses), in general anxiety disorder, whether or not associated with medical drug treatments (1 meta-analysis), in the post-traumatic stress disorder (2

meta-analyses, 1 examining EMDR) in obsessive compulsive disorders (3 meta-analyses), in social phobias (3 meta-analyses) and in various specific phobias (6 controlled trials).

Diseases	Trials considered	Main results
Mood disorders		
Bipolar disorder	2 controlled trials, PE (one of which involving FT)	Efficacy of the family psychoeducational or individual approach, in combination with medical drug treatment.
Depressive disorders in hospitalised patients	1 meta-analysis, CBT	Efficacy of CBT on depressive symptoms
	1 controlled trial, PE (FT)	Efficacy of short term family psychoeducation on global functioning in combination with medical drug treatment.
	1 controlled trial, PT	Efficacy of PT on social adaptation and length of hospitalisation, in combination with medical drug treatment
Mild or moderate depressive disorders	2 meta-analyses, CBT	Efficacy of CBT and IT
	1 meta-analysis, CBT and IT	
	1 meta-analysis, CBT and VT	Efficacy of verbal therapies, including possibly PT
	1 meta-analysis, CBT and PT in the elderly	Efficacy of CBT in the depressed elderly
Major depressive disorders	1 controlled trial, FT (couple)	Efficacy of FT (couple) in subjects living with a critical partner

PE: psychoeducational approach; FT: family therapy; CBT: cognitive-behavioural therapy; PT: psychodynamic therapy; IT: interpersonal therapy; VT: verbal therapy

The brief psychodynamic therapies are effective when used in combination with antidepressant treatment in preventing relapses of panic disorder, 9 months after the antidepressant treatment has been stopped (1 controlled trial) although with a lower level of proof than the CBT. They also are of presumed efficacy in the post-traumatic stress state (1 controlled trial) but have not to date been studied in other anxiety disorders. Comparisons between the different approaches (including comparative meta-analyses) have also shown the CBT to be the most effective therapies for all of the anxiety disorders.

Diseases	Trials considered	Main results
Anxiety disorders		
Panic disorder	1 meta-analysis, CBT	Efficacy of CBT in prevention of relapses
	1 controlled trial, BPT	Efficacy of CBT in prevention of relapses
Generalised anxiety disorder	1 meta-analysis, CBT	Efficacy of CBT
Post-traumatic stress	2 meta-analyses, CBT	Efficacy of CBT and PT
	1 controlled trial, PT	
Obsessive compulsive disorder	3 meta-analyses, CBT	Efficacy of CBT
Social phobia	3 meta-analyses, CBT	Efficacy of CBT
Specific phobia	6 controlled trials, CBT	Efficacy of CBT

CBT: cognitive-behavioural therapy; BPT: brief psychodynamic therapy; PT: psychodynamic therapy

Cognitive-behavioural therapies, whether or not combined with drug therapy, have been shown to be effective in bulimia nervosa (6 meta-analyses) as have the interpersonal therapies (1 meta-analysis, 1 controlled trial).

In anorexia nervosa, family therapies have been proven to be effective, but only in young patients in whom the disorder has been present for less than 3 years for up to 5 years' follow up (3 controlled trials, 1 non-meta-analysis systematic review). The cognitive-behavioural

approach has not been shown to be effective on symptoms (disparate results in one non-meta-analytical systematic review and 2 controlled trials) although has presumed efficacy in preventing relapses (1 controlled trial).

Diseases	Trials considered	Main results
Eating disorders		
Bulimia nervosa	6 meta-analyses, CBT	Efficacy of CBT clearly established, efficacy of IT established in prevention of relapses
	1 meta-analysis, IT	Possible efficacy of the PE approach
	1 controlled trial, IT	
	1 systematic review, EP	
Anorexia nervosa	5 controlled trials, FT	Efficacy of FT established in young patients
	1 systematic review, FT (CBT)	Efficacy of CBT not demonstrated
	1 systematic review, CBT	(except in the form of FT)

CBT: cognitive-behavioural therapy; IT: interpersonal therapy; PT: psychodynamic therapy; PE: psychoeducational approach; FT: family therapy

Borderline personality has been the most studied of the personality disorders; psychodynamic therapies (1 meta-analysis and 1 controlled trial) have been shown to be effective from 18 months' to 4 years' follow up. The cognitive-behavioural therapies have also been shown to be effective at 1 year follow up (1 meta-analysis and 5 controlled trials).

The psychodynamic (psychoanalytical) therapies and cognitive-behavioural therapies appear to be effective at 7 months' follow up for antisocial personality when the people concerned are also depressed (1 controlled trial) and at 6 months' follow up in certain personality disorders (1 meta-analysis and 1 controlled trial).

As for eating disorders, no controlled trials have yet established any one therapy to be more effective than another in personality disorders.

In problems relating to alcohol dependency or abuse, family therapies (2 meta-analyses, 1 systematic review and 1 systematic trial) and cognitive-behavioural therapies (1 meta-analysis and 1 controlled CBT trial) have shown the family therapies still to have presumed efficacy. Psychoanalysis-derived therapies have not been studied in this situation.

The comparisons between psychotherapies performed to date have concluded that the motivational therapies are as effective as the cognitive-behavioural therapies for problems associated with alcohol abuse or dependency (1 controlled trial).

Diseases	Trials considered	Main results
Personality disorders	1 meta-analysis, PT and CBT	Efficacy of PT and CBT for personality disorders
	1 controlled trial, PT, CBT	(particularly borderline and antisocial types if
	5 controlled trials, CBT	associated with depression)
	2 controlled trials, PT	
Alcohol dependency	2 meta-analyses and 1 systematic review, FT	Efficacy of FT in maintaining abstinence
	1 meta-analysis and 1 controlled trial, CBT	Efficacy of CBT in maintaining abstinence
	1 controlled trial (MT, CBT)	Comparable efficacy of MT and CBT

CBT: cognitive-behavioural therapy; PT: psychodynamic therapy; FT: family therapy; MT: motivational therapy

Finally, no evidence of short or long term symptom substitution or displacement was found in the trials evaluated for any therapy or disorder considered by this expert review.

Levels of proof of efficacy of three psychotherapeutic approaches examined in the adult*

	Efficacy Proven (1) or Presumed(2)

Schizophrenia (acute phase) with medical drugs	Family psychoeducational therapy on 2 year relapse rates (1) CBT approach (2)
Schizophrenia (stabilised, followed upon outpatient basis) with medical drugs	Family psychoeducational approach (1) CBT approach (social skills acquisition, emotion management) (1)
Depression, hospitalised on antidepressants	CBT approach (1)
Bipolar disorder with medical drugs	Family psychoeducation approach (marital) and CBT approach (2)
Moderate depression	CBT approach (1)
Panic disorder	CBT approach (1) Brief psychodynamic approach with antidepressants (2)
Post-traumatic stress	CBT approach (of which EMDR) (1) Brief psychodynamic approach (2)
Anxiety disorders (GAD, OCD, phobias)	CBT approach (1)
Bulimia	CBT approach (1)
Anorexia	Family therapies in young patients (2) CBT approach for prevention of relapses (2)
Personality disorders	Psychodynamic approach (1) CBT approach (1)
Alcohol dependency	Family therapy and CBT approach in maintenance of abstinence (1)

CBT: cognitive-behavioural therapy; EMDR: Eye movement desensitisation and reprocessing

* See previous tables for levels of proof of the therapies applied to children

In conclusion, the literature review conducted in this expert evaluation has enabled us to produce a summary of the trials which have examined evaluations of psychodynamic (psychoanalytical) therapy, cognitive-behavioural therapy and family and couple therapy consistent with current recognised scientific criteria.

The objective of this report is to assist decision-making in public health. It is based on the results of controlled trials conducted in the clinical population which are appropriate for this purpose, and without ignoring the methodological limits of such an exercise which are discussed at the beginning of the review. The major criterion used to evaluate the efficacy of therapies is improvement in clinical symptoms. Other criteria such as improvement in functioning of the person, the person's quality of life and social adjustment have also been taken into account in some of the analyses. The review conducted in this expert evaluation allows the efficacy of each of the three approaches to be assessed, when used alone compared to no treatment (placebo or waiting list) and depending on the disorders in question. Depending on the disorder, some approaches appear to be more effective than others (see table above).

The conclusions which follow from this analysis and from the review of the evaluation studies contained in the literature represents an information source of use to professionals and users. Whilst the individual relationship between the person who is suffering and the therapist remains a key factor in the choice and execution of a therapy, informing of users and training of therapists must be consistent with the available scientific proof. These are two major factors in improving the health care offered and the networking of different healthcare workers.