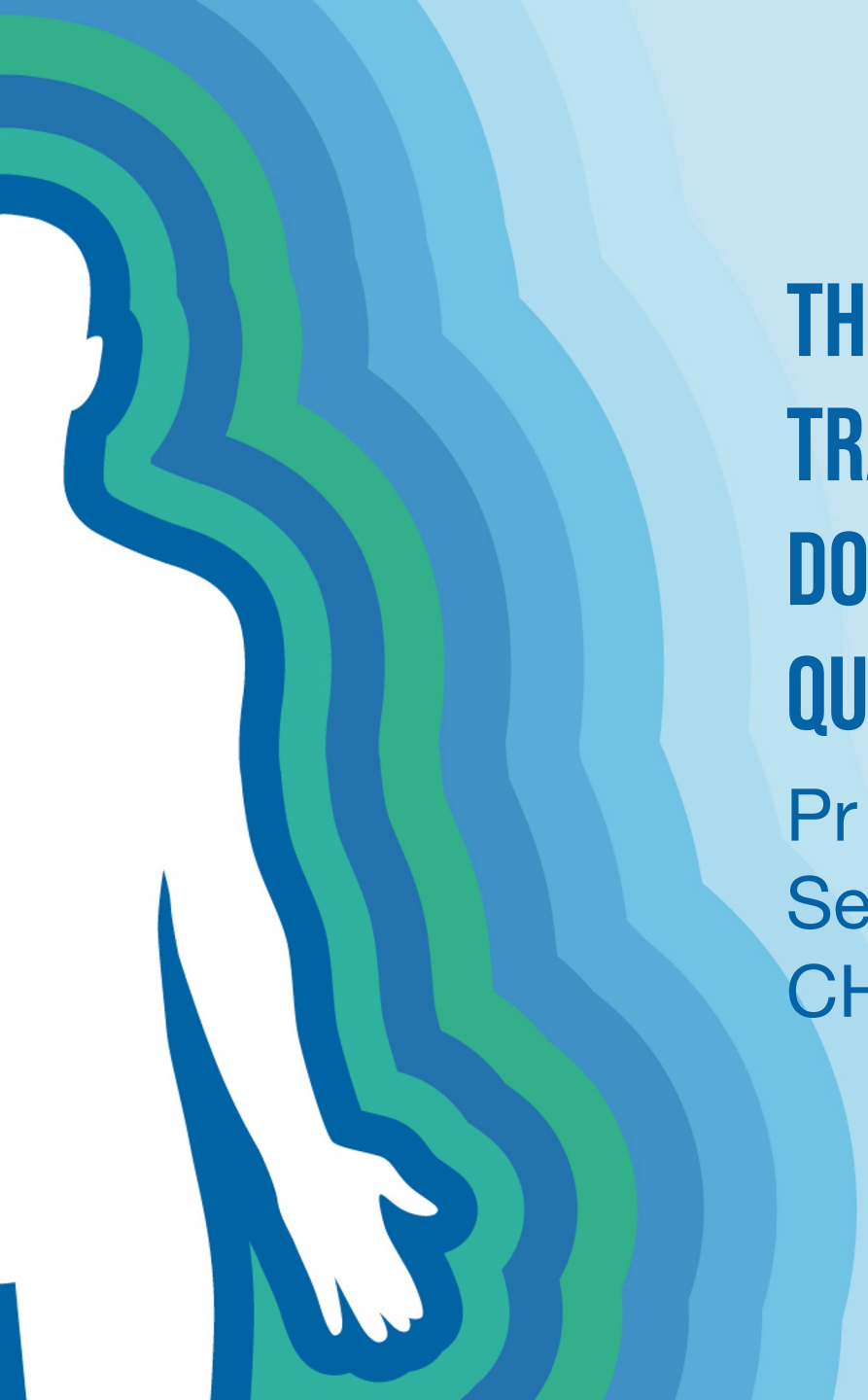

THÉRAPIES COGNITIVES ET COMPORTEMENTALES ET TRAITEMENTS MÉDICAMENTEUX: AMIS OU ENNEMIS? DONNÉES DE LA LITTÉRATURE ET EXPÉRIENCE DU QUOTIDIEN

Pr CAPDEVIELLE Delphine
Service Universitaire de Psychiatrie Adulte
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51ème CONGRÈS AF TCC

Conflits d’intérêts

Invitation: Laboratoires Lundbeck, Otsuka, Janssen
Expertise: Laboratoires Lundbeck, Otsuka
Investigateur: Laboratoire Boehringer

Une présentation en 2 temps

Données de la littérature: Pr Delphine Capdevielle

Expériences Pratiques du Quotidien- Table ronde
Modérateur :
Pr Delphine Capdevielle
Discutants:
Dr Soufiane Carde: Psychiatre libéral, Montpellier
Dr Hélène Denis: Pédopsychiatrie, CHU Montpellier
Mme Emily Karsinti , Psychologue clinicienne, Paris
Pr Stéphane Raffard, Psychologue clinicien, CHU Montpelier

Une question complexe (1)

- Selon les troubles?
- Selon les traitements pharmacologiques?
- Et surtout selon le patient
  - Son âge
  - Son lieu de soin
  - Son lieu de vie
  - Son choix

Quelles données dans la littérature ?

Une question complexe (2)

- Très peu d'études de comparaisons directes
- Des méta-analyses portant sur des données indirectes
- Question des associations TCC/traitements pharmacologiques
- Questions médico-économiques: quelles implications pour les décideurs

Quelles données dans la littérature?

Pourquoi se poser cette question?

European Psychiatry

www.cambridge.org/epa

Review/Meta-analysis

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Does the use of pharmacotherapy interact with the effects of psychotherapy? A meta-analytic review

Pim Cuijpers[1,2], Clara Miguel[1], Mathias Harrer[3,4], Marketa Ciharova[1] and Eirini Karyotaki[1]

[1]Department of Clinical, Neuro and Developmental Psychology, Amsterdam Public Health Research Institute, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands; [2]International Institute for Psychotherapy, Babeş-Bolyai University, Cluj-Napoca, Romania; [3]Psychology & Digital Mental Health Care, Department of Health Sciences, Technical University Munich, Munich, Germany and [4]Department of Clinical Psychology & Psychotherapy, Friedrich-Alexander-University Erlangen-Nuremberg, Erlangen, Germany

3 hypothèses (1)

1) Aucune interaction: leurs effets sont indépendants

2) Les médicaments peuvent réduire les effets de la psychothérapie

3) Les médicaments peuvent augmenter les effets de la psychothérapie

3 hypothèses (2)

Etudes randomisées à 4 bras

Troubles anxieux: 11 RCT
- effets combinés versus placebo g= 0,74 → sommes des effets de la psychothérapie(g=0,37) et pharmacothérapie (g=0,35)
→ Intervalles de confiance très larges

Dépression? Méta-analyse

Méthodologie

Etudes contrôlées et randomisées:
- Traitements psychologiques de la dépression sont comparés avec un groupe contrôle inactif (liste d'attente, traitement habituel, placebo, autre) et proportion de participants sous ATD est rapportée
- études sur combinaisons

300 études inclues comprenant 353 comparaisons dont 175 avec TCC

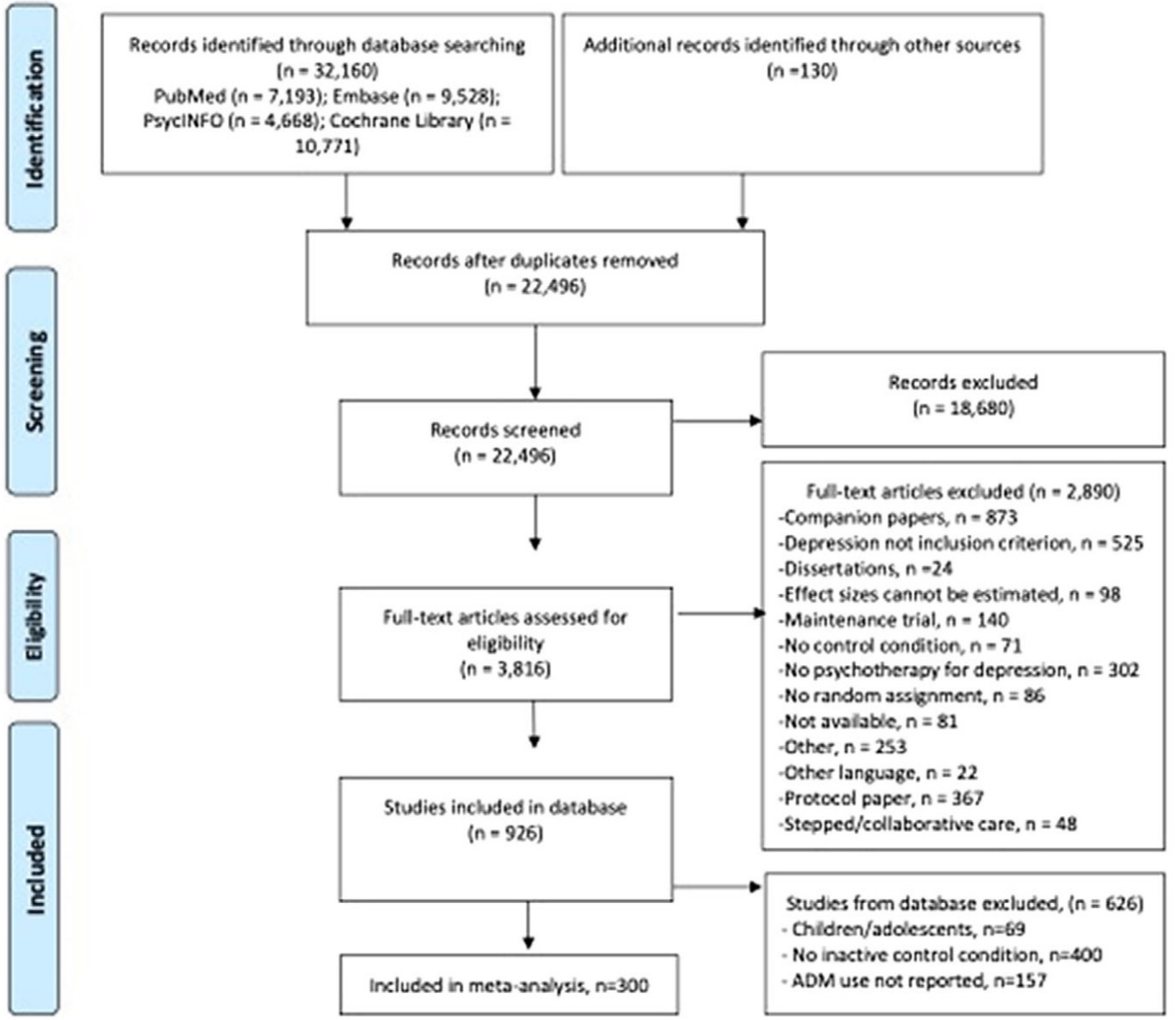


Figure 1. Flowchart of the inclusion of studies.

Effets des psychothérapies

Table 2. Pooled effects of psychotherapies for adult depression

	k	*g*	95% CI	I^2	95% CI	95% PI	NNT
All comparisons (combined)	353	0.71	0.64; 0.79	82	80; 84	−0.48; 1.91	4.26
One ES/study (lowest)	300	0.63	0.55; 0.71	82	80; 84	−0.53; 1.78	4.95
One ES/study (highest)	300	0.72	0.64; 0.80	83	81; 84	−0.49; 1.93	4.2
Outliers removed	248	0.62	0.58; 0.65	23	9; 35	0.39; 0.84	5.04
Influence analysis	343	0.62	0.56; 0.68	74	72; 77	−0.22; 1.45	5.05
Only risk of bias > 3	115	0.45	0.36; 0.54	73	68; 78	−0.3; 1.20	7.31
Three-level model (CHE)	410	0.68	0.61; 0.76	88	–	−0.51; 1.88	4.49
Publication bias correction							
– Trim-and-fill method	457	0.38	0.29; 0.48	88	87; 89	−1.45; 2.21	8.82
– Limit meta-analysis	353	0.25	0.14; 0.36	93	–	−0.95; 1.45	14.23
– Selection model[l]	353	0.58	0.47; 0.70	88	–	−0.88; 2.05	5.38

Abbreviations: CHE, "correlated and hierarchical effects" model; CI, confidence interval; ES, effect size; *g*, Hedges' *g*; I^2, level of heterogeneity; *k*, number of comparisons; NNT, number-needed-to-treat; PI, prediction interval.

Association entre l'utilisation des antidépresseurs et les effets de la psychothérapie

Analyses avec méta-régression univariée

→Il n'est pas retrouvé d'association significative quand la proportion d'utilisation d'antidépresseurs est rentrée comme facteur prédictif de la réponse aux psychothérapies (p=0,7)
→Ce résultat ce maintien même en entrant d'autres facteurs dans le modèle

Discussion

- **Large méta-analyse ne retrouve pas que l'utilisation d'ATD est associée aux effets des psychothérapies**
- **1ère hypothèse: l'utilisation d'antidépresseurs n'interfère pas avec les effets des psychothérapies**
- **Bonne nouvelle d'un point de vue clinique?**
- **Mais:**
  - **Pas de données sur quel type d'ATD**
  - **Pas de données sur la qualité de la pharmacothérapie**
  - **Pas de données sur la temporalité des traitements**
  - **Pas de données sur les autres traitements (BZD)**

EPISODE DEPRESSIF et TROUBLES ANXIEUX

RESEARCH REPORT

The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: a meta-analysis of direct comparisons

Pim Cuijpers[1-3], Marit Sijbrandij[1,2], Sander L. Koole[1,2], Gerhard Andersson[4,5], Aartjan T. Beekman[2,6], Charles F. Reynolds III[7]

[1]Department of Clinical Psychology, VU University Amsterdam, Van der Boechorststraat 1, 1081 BT Amsterdam, The Netherlands; [2]EMGO Institute for Health and Care Research, VU University and VU University Medical Center, Amsterdam, The Netherlands; [3]Leuphana University, Lünebrug, Germany; [4]Department of Behavioural Sciences and Learning, Swedish Institute for Disability Research, University of Linköping, Sweden; [5]Department of Clinical Neuroscience, Psychiatry Section, Karolinska Institutet, Stockholm, Sweden; [6]Department of Psychiatry, VU University Medical Center, Amsterdam, The Netherlands; [7]Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, PA, USA

Although psychotherapy and antidepressant medication are efficacious in the treatment of depressive and anxiety disorders, it is not known whether they are equally efficacious for all types of disorders, and whether all types of psychotherapy and antidepressants are equally efficacious for each disorder. We conducted a meta-analysis of studies in which psychotherapy and antidepressant medication were directly compared in the treatment of depressive and anxiety disorders. Systematic searches in bibliographical databases resulted in 67 randomized trials, including 5,993 patients that met inclusion criteria, 40 studies focusing on depressive disorders and 27 focusing on anxiety disorders. The overall effect size indicating the difference between psychotherapy and pharmacotherapy after treatment in all disorders was g=0.02 (95% CI: −0.07 to 0.10), which was not statistically significant. Pharmacotherapy was significantly more efficacious than psychotherapy in dysthymia (g=0.30), and psychotherapy was significantly more efficacious than pharmacotherapy in obsessive-compulsive disorder (g=0.64). Furthermore, pharmacotherapy was significantly more efficacious than non-directive counseling (g=0.33), and psychotherapy was significantly more efficacious than pharmacotherapy with tricyclic antidepressants (g=0.21). These results remained significant when we controlled for other characteristics of the studies in multivariate meta-regression analysis, except for the differential effects in dysthymia, which were no longer statistically significant.

Key words: Psychotherapy, antidepressant medication, depressive disorders, anxiety disorders, dysthymia, obsessive-compulsive disorder, meta-analysis

(World Psychiatry 2013;12:137–148)

	Depression	GAD	SAD	Panic	OCD/PTSD	Total
21,729 references identified by literature search						
Pubmed	3320	547	296	849	91	5103
Cochrane	2988	1309	752	1436	128	6613
PsycInfo	2710	337	246	424	32	3749
Embase	4389	372	661	764	78	6264
Total	13407	2565	1955	3473	329	21729
⇓						
After removal of duplicates	9860	1562	1228	2032	221	14903
⇓						
Earlier meta-analyses checked for references	42	7	14	26	27	116
⇓						
Full-text papers retrieved	1344	136	247	493	58	2278
⇓						
Reasons for exclusion						
No correct comparison	235	49	83	169	27	563
Duplicate study	306	32	24	52	5	419
No diagnosis	165	32	52	112	2	363
No control group	167	7	39	33	3	249
No psychotherapy	151	7	1	76	3	238
Other reason	280	8	41	40	10	379
Total	1304	135	240	482	50	2211
⇓						
Included in meta-analysis	40	1	7	11	OCD: 6 PTSD: 2	67

GAD – generalized anxiety disorder, SAD – social anxiety disorder, OCD – obsessive-compulsive disorder, PTSD – post-traumatic stress disorder

Figure 1 Selection and inclusion of studies

67 études → **5 993** patients inclus (3 143 psychothérapies et 2 851 pharmacothérapies)

Dépression : 40 études

Anxiété: 27 études

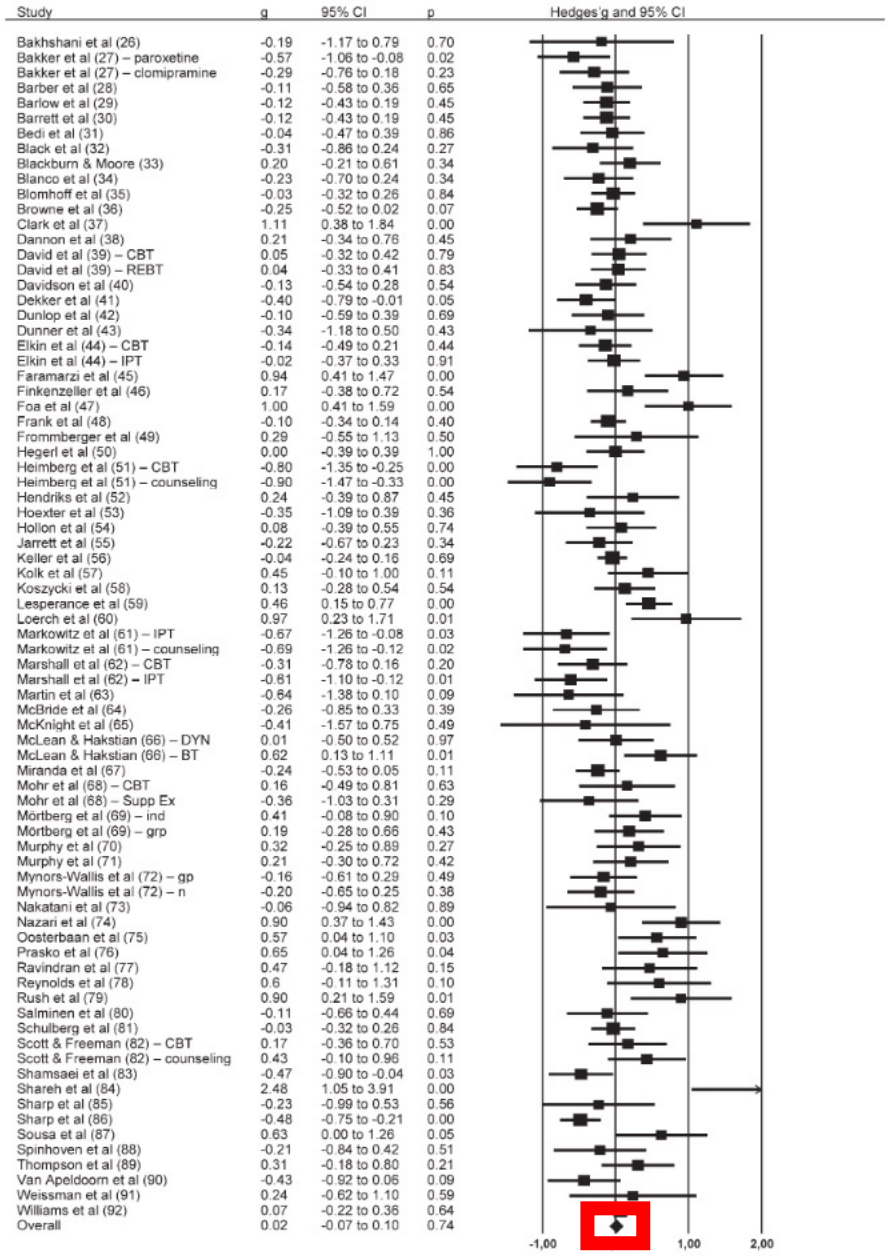
Psychothérapie: 49/78 TCC

Psychothérapie en individuel: 62, nombre de session entre 6 à 20

Antidépresseurs: ISRS (37), ATC (20), IRSNA (2), IMAO (7)

Psychothérapie versus Pharmacothérapie

Pas de différence significative
Hétérogénéité modérée à élevée entre les 2 groupes



CBT – cognitive-behavioral therapy, REBT – rationale emotive behavior therapy, IPT – interpersonal psychotherapy, DYN – psychodynamic therapy, BT – behavior therapy, Supp Ex – supportive-expressive therapy, ind – individual format, grp – group format, gp – delivered by a general practitioner, n – delivered by a nurse

Figure 2 Differential effects of psychotherapy and pharmacotherapy (Hedges' g)

Psychothérapie versus Pharmacothérapie

Taille de l'effet associée au type de trouble

Pharmaco > Psychothérapie dans la **dysthymie**

Pharmaco < Psychothérapie dans le **TOC**

ATC < psychothérapie

Pharmaco > thérapie de soutien non guidée

Table 2 Comparative effects of psychotherapy and pharmacotherapy: subgroup analyses

		N	g	95% CI	I^2	95% CI	p
All studies		78	0.02	−0.07 to 0.10	62	52 to 70	
Possible outliers removed		68	−0.07	−0.14 to 0.01	41	21 to 56	
One effect size per study (highest)		67	0.06	−0.03 to 0.15	62	51 to 71	
One effect size per study (lowest)		67	0.03	−0.07 to 0.12	62	51 to 71	
Mood disorders							
	Any mood disorder	48	−0.03	−0.14 to 0.08	52	0 to 47	**0.01**
	Major depression	39	0.02	−0.10 to 0.13	46	22 to 63	
	Dysthymia	5	**−0.30**	−0.60 to −0.00	55	0 to 83	
	Mixed mood disorders	4	−0.14	−0.45 to 0.17	64	0 to 88	
Anxiety disorders							
	Any anxiety disorder	30	0.10	−0.05 to 0.25	71	59 to 80	
	Panic disorder	12	0.00	−0.28 to 0.28	62	28 to 79	
	SAD	9	−0.03	−0.34 to 0.28	74	50 to 87	
	OCD	6	**0.64**	0.20 to 1.08	72	36 to 88	
	Other	3	0.24	−0.39 to 0.86	0	0 to 90	
Psychotherapy type							
	Cognitive-behavioral therapy	49	0.09	−0.03 to 0.20	60	46 to 71	0.12
	Interpersonal psychotherapy	11	−0.09	−0.31to 0.14	65	33 to 82	
	Problem-solving therapy	5	−0.04	−0.36 to 0.27	0	0 to 79	
	Counseling	6	**−0.33**	−0.64 to −0.02	69	27 to 87	
	Other	7	0.07	−0.21 to 0.34	67	27 to 85	
Treatment format							
	Individual	62	0.02	−0.08 to 0.12	61	48 to 70	0.89
	Group	14	0.03	−0.18 to 0.25	71	50 to 83	
Pharmacotherapy							
	SSRI	37	0.01	−0.12 to 0.13	58	40 to 71	**0.02**
	TCA	20	**0.21**	0.04 to 0.39	52	19 to 71	
	MAOI	7	−0.05	−0.34 to 0.25	83	65 to 91	
	Mixed/protocol/other	14	−0.19	−0.37 to 0.00	49	5 to 72	
Recruitment							
	Only clinical samples	36	0.07	−0.06 to 0.20	55	34 to 69	0.52
	Also community recruitment	35	−0.03	−0.16 to 0.10	65	50 to 76	
	Other recruitment method	7	−0.04	−0.34 to 0.25	76	49 to 89	
Country							
	USA	31	−0.07	−0.21 to 0.07	52	28 to 68	0.17
	Europe	29	0.03	−0.11 to 0.17	56	34 to 71	
	Other	18	0.15	−0.04 to 0.34	76	62 to 85	
Quality							
	Score 0–1	31	0.10	−0.06 to 0.25	69	56 to 79	0.44
	Score 2–3	23	−0.03	−0.19 to 0.13	65	46 to 78	
	Score 4	24	−0.02	−0.17 to 0.12	38	0 to 62	

All subgroup analyses were conducted with the random effects model; a positive effect size indicates superior effects of psychotherapy; the p values indicate whether the effect sizes in the subgroups differ significantly from each other; significant values are highlighted in bold

SAD – social anxiety disorder, OCD – obsessive-compulsive disorder, SSRI – selective serotonin reuptake inhibitor, TCA – tricyclic antidepressant, MAOI – monoamine oxidase inhibitor

Discussion

Limites:

- nombreux troubles et nombreux traitements
- qualité non optimale de plusieurs études
- pas de données sur le long terme
- effets secondaires?

Effets comparables dans l'EDC et les troubles anxieux à l'exception de la dysthymie et du TOC

RESEARCH REPORT

Adding psychotherapy to antidepressant medication in depression and anxiety disorders: a meta-analysis

Pim Cuijpers[1-3], Marit Sijbrandij[1,2], Sander L. Koole[1,2], Gerhard Andersson[4,5], Aartjan T. Beekman[2,6], Charles F. Reynolds III[7]

[1]Department of Clinical Psychology, VU University Amsterdam, The Netherlands; [2]EMGO Institute for Health and Care Research, VU University and VU University Medical Center Amsterdam, The Netherlands; [3]Leuphana University, Lünebrug, Germany; [4]Department of Behavioural Sciences and Learning, Swedish Institute for Disability Research, University of Linköping, Sweden; [5]Department of Clinical Neuroscience, Psychiatry Section, Karolinska Institutet, Stockholm, Sweden; [6]Department of Psychiatry, VU University Medical Center Amsterdam, The Netherlands; [7]Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, PA, USA

We conducted a meta-analysis of randomized trials in which the effects of treatment with antidepressant medication were compared to the effects of combined pharmacotherapy and psychotherapy in adults with a diagnosed depressive or anxiety disorder. A total of 52 studies (with 3,623 patients) met inclusion criteria, 32 on depressive disorders and 21 on anxiety disorders (one on both depressive and anxiety disorders). The overall difference between pharmacotherapy and combined treatment was Hedges' g = 0.43 (95% CI: 0.31-0.56), indicating a moderately large effect and clinically meaningful difference in favor of combined treatment, which corresponds to a number needed to treat (NNT) of 4.20. There was sufficient evidence that combined treatment is superior for major depression, panic disorder, and obsessive-compulsive disorder (OCD). The effects of combined treatment compared with placebo only were about twice as large as those of pharmacotherapy compared with placebo only, underscoring the clinical advantage of combined treatment. The results also suggest that the effects of pharmacotherapy and those of psychotherapy are largely independent from each other, with both contributing about equally to the effects of combined treatment. We conclude that combined treatment appears to be more effective than treatment with antidepressant medication alone in major depression, panic disorder, and OCD. These effects remain strong and significant up to two years after treatment. Monotherapy with psychotropic medication may not constitute optimal care for common mental disorders.

Key words: Combined treatment, psychotherapy, antidepressant medication, depressive disorders, anxiety disorders, dysthymia, obsessive-compulsive disorder, meta-analysis

(World Psychiatry 2014;13:56–67)

	Depression	GAD	SAD	Panic	OCD / PTSD	Total
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No control group	167	7	39	33	3	249
No psychotherapy	151	7	1	76	3	238
Other reason	280	8	41	40	10	379
Total	1312	135	243	483	52	2226
⇓						
Included in meta-analysis	32	1	4	10	OCD: 4 PTSD: 2	52

52 études → **3 623** patients inclus (1 767 traitements combinés et 1 856 pharmacothérapies)

Dépression : 32 études

Anxiété: 21 études

Psychothérapie: 33 TCC

nombre de session entre 5 à 56

Antidépresseurs: ISRS (22), ATC (13), IRSNA (3), IMAO (4)

Pharmacothérapie Versus Pharmacothérapie + Psychothérapie

Taille d'effet à 0,43 (95% IC: 0,31-0,56) pour le traitement combiné

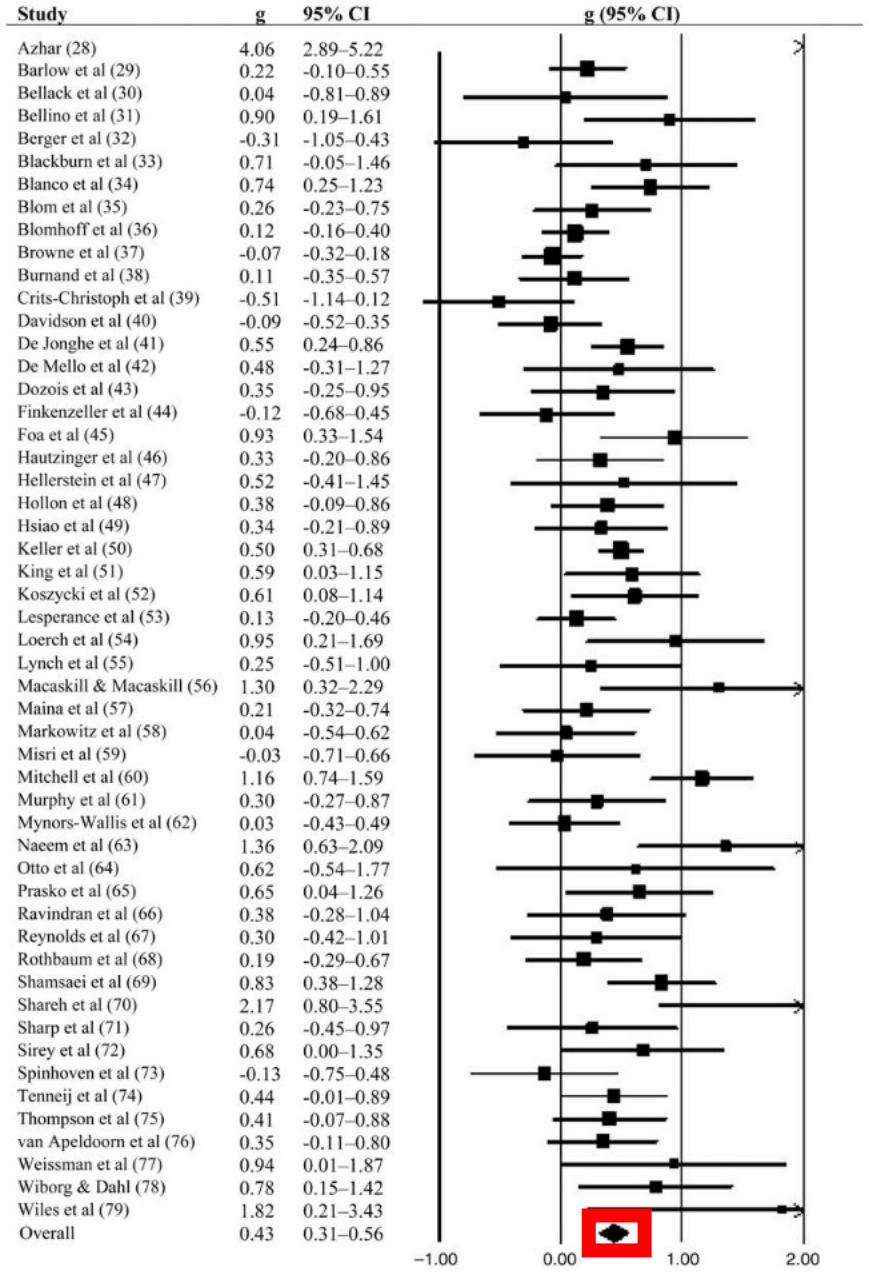

Figure 2 Effects of pharmacotherapy compared to combined treatment with pharmacotherapy and psychotherapy (Hedges' g)

Pharmacothérapie Versus Pharmacothérapie + Psychothérapie

Traitement combiné > pharmacothérapie :

- EDC
- TOC
- TP

Sorties d'étude: identique dans les 2 groupes

Pas de différence selon les traitements

Table 2 Effects of combined therapy for adult depressive and anxiety disorders compared with antidepressant medication only

		Ncomp	g	95% CI	I^2	95% CI	p	NNT
Depressive and anxiety disorders		52	0.43	0.31-0.56	64	52-73	0.81	4.20
Possible outliers excluded (g > 1.5)		49	0.37	0.27-0.47	48	28-63		4.85
Depressive disorders		32	0.41	0.28-0.54	50	25-67	0.17	4.39
Major depression		23	0.43	0.29-0.57	30	0-58		4.20
Dysthymia		5	0.20	−0.21-0.60	0	0-79		8.93
Mixed depressive disorders		5	0.56	0.12-0.99	73	32-89		3.25
Anxiety disorders		21	0.47	0.23-0.71	75	61-84	0.66	3.85
Panic disorder		10	0.54	0.25-0.82	82	68-90		3.36
OCD		4	0.70	0.14-1.25	67	5-89		2.63
SAD		4	0.32	−0.01-0.71	65	0-88		5.56
PTSD		2	0.31	−0.39-1.00	0	-		5.75
GAD		1	−0.51	−1.42-0.40	-	-		(3.55)
Subgroup analyses								
Medication	SSRI	22	0.34	0.15-0.53	76	63-84	0.45	5.26
	TCA	13	0.46	0.22-0.71	9	0-47		3.91
	Other/protocol	17	0.51	0.31-0.72	41	0-67		3.55
Recruitment	Clinical samples	32	0.49	0.34-0.64	63	46-75	0.09	3.68
	Community	16	0.28	0.08-0.47	45	2-70		6.41
Target group	Adult in general	43	0.44	0.30-0.57	65	51-74	0.89	4.10
	Specific group	9	0.41	0.12-0.71	64	27-83		4.39
Type of therapy	CBT	33	0.51	0.35-0.66	70	58-79	0.20	3.55
	IPT	9	0.24	−0.05-0.53	32	0-69		7.46
	Other	10	0.37	0.09-0.64	10	0-50		4.85
Number of sessions	5-9	11	0.67	0.40-0.93	86	76-91	0.10	2.75
	10-12	16	0.24	0.03-0.46	48	8-71		7.46
	13-18	18	0.47	0.26-0.67	4	0-52		3.85
	>19	7	0.41	0.06-0.76	33	0-72		4.39
Treatment format	Individual	42	0.46	0.32-0.59	68	55-76	0.35	3.91
	Group	9	0.29	−0.02-0.60	40	0-73		6.17
Quality score	<3	32	0.49	0.33-0.66	62	44-74	0.23	3.68
	3 or 4	20	0.35	0.16-0.54	67	47-79		5.10

CBT – cognitive behavior therapy, GAD – generalized anxiety disorder, IPT – interpersonal psychotherapy, Ncomp – number of comparisons, NNT – number needed to treat, OCD – obsessive-compulsive disorder, PTSD – post-traumatic stress disorder, SAD – social anxiety disorder, SNRI – serotonin-norepinephrine reuptake inhibitor, SSRI – selective serotonin reuptake inhibitor, TCA – tricyclic antidepressant

Pharmacothérapie + Psychothérapie versus Placebo

Traitement combiné > placebo : large taille d'effet

Effets des psychothérapies et des traitements pharmacologiques sont largement indépendants

Table 3 Direct comparisons between psychotherapy, pharmacotherapy, combined psychotherapy and pharmacotherapy, and placebo in anxiety and depressive disorders (Hedges' g)

	Ncomp	g	95% CI	I^2	95% CI	NNT
Combined vs. placebo	11	0.74	0.48-1.01	65	33-82	2.50
Pharmacotherapy vs. combined	11	0.37	0.12-0.63	43	0-72	4.85
Pharmacotherapy vs. placebo	11	0.35	0.21-0.49	0	0-60	5.10
Psychotherapy vs. combined	11	0.38	0.16-0.59	53	8-76	4.72
Psychotherapy vs. placebo	11	0.37	0.11-0.64	68	41-83	4.85

Discussion

Effets des psychothérapies et de la pharmacothérapie: indépendants et additifs, n'interférant pas l'un avec l'autre et les 2 contribuant également aux effets du traitement combiné

Dans quels cas mettre un traitement combiné?

Cognitive behavior therapy vs. control conditions, other psychotherapies, pharmacotherapies and combined treatment for depression: a comprehensive meta-analysis including 409 trials with 52,702 patients

Pim Cuijpers[1-3], Clara Miguel[1], Mathias Harrer[4,5], Constantin Yves Plessen[1,6], Marketa Ciharova[1], David Ebert[4], Eirini Karyotaki[1]

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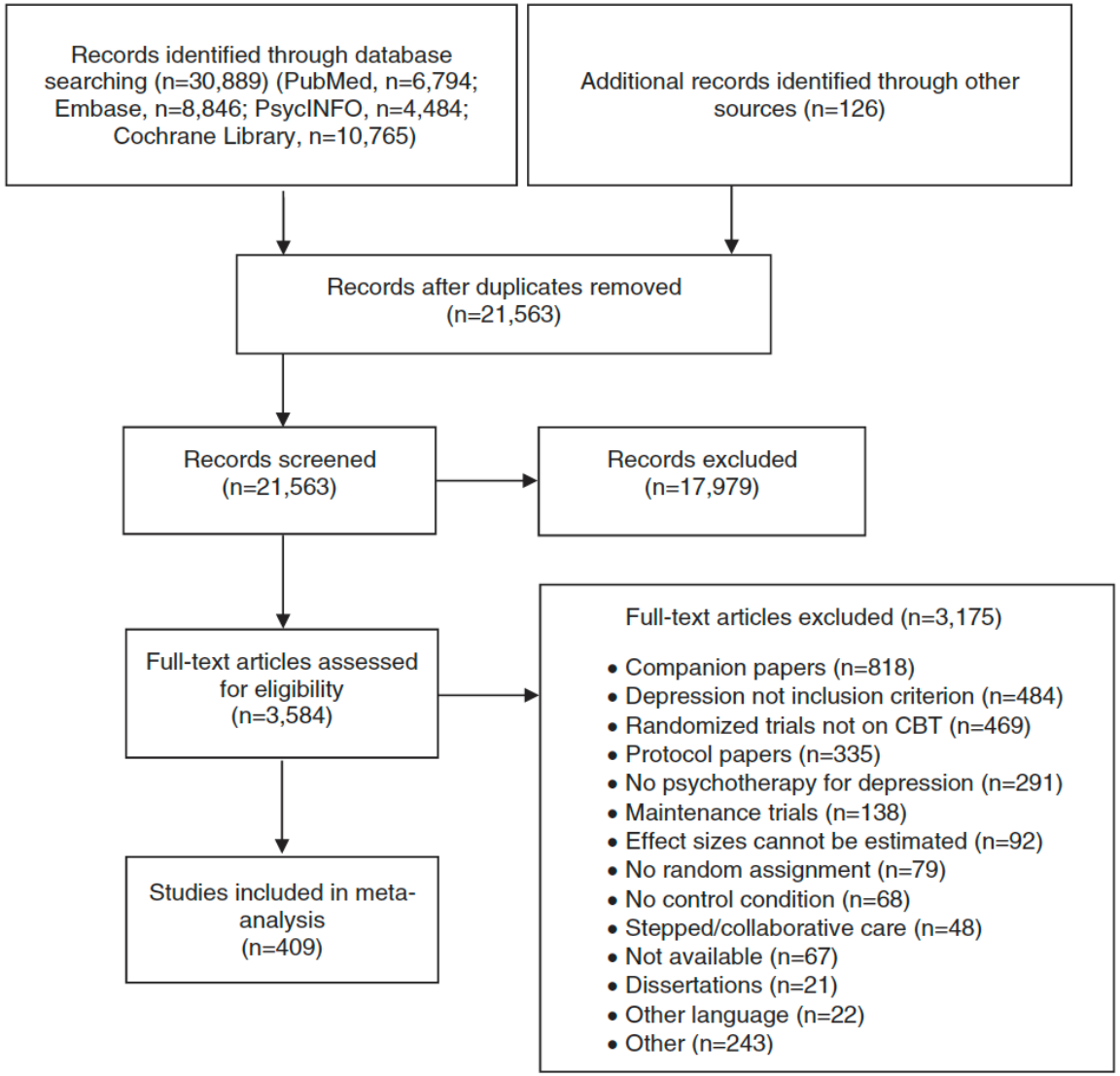
Cognitive behavior therapy (CBT) is by far the most examined type of psychological treatment for depression and is recommended in most treatment guidelines. However, no recent meta-analysis has integrated the results of randomized trials examining its effects, and its efficacy in comparison with other psychotherapies, pharmacotherapies and combined treatment for depression remains uncertain. We searched PubMed, PsycINFO, Embase and the Cochrane Library to identify studies on CBT, and separated included trials into several subsets to conduct random-effects meta-analyses. We included 409 trials (518 comparisons) with 52,702 patients, thus conducting the largest meta-analysis ever of a specific type of psychotherapy for a mental disorder. The quality of the trials was found to have increased significantly over time (with increasing numbers of trials with low risk of bias, less waitlist control groups, and larger sample sizes). CBT had moderate to large effects compared to control conditions such as care as usual and waitlist (g=0.79; 95% CI: 0.70-0.89), which remained similar in sensitivity analyses and were still significant at 6-12 month follow-up. There was no reduction of the effect size of CBT according to the publication year (<2001 vs. 2001-2010 vs. >2011). CBT was significantly more effective than other psychotherapies, but the difference was small (g=0.06; 95% CI: 0-0.12) and became non-significant in most sensitivity analyses. The effects of CBT did not differ significantly from those of pharmacotherapies at the short term, but were significantly larger at 6-12 month follow-up (g=0.34; 95% CI: 0.09-0.58), although the number of trials was small, and the difference was not significant in all sensitivity analyses. Combined treatment was more effective than pharmacotherapies alone at the short (g=0.51; 95% CI: 0.19-0.84) and long term (g=0.32; 95% CI: 0.09-0.55), but it was not more effective than CBT alone at either time point. CBT was also effective as unguided self-help intervention (g=0.45; 95% CI: 0.31-0.60), in institutional settings (g=0.65; 95% CI: 0.21-1.08), and in children and adolescents (g=0.41; 95% CI: 0.25-0.57). We can conclude that the efficacy of CBT in depression is documented across different formats, ages, target groups, and settings. However, the superiority of CBT over other psychotherapies for depression does not emerge clearly from this meta-analysis. CBT appears to be as effective as pharmacotherapies at the short term, but more effective at the longer term.

Key words: Depression, cognitive behavior therapy, psychotherapies, Internet-based interventions, meta-analysis, antidepressants, combined treatment

(World Psychiatry 2023;22:105–115)



409 études → **52 702** patients inclus (27 000 TCC et 25 702 groupes contrôles), âge moyen 40 ans, 69% de femmes

Dépression périnatale: 10%

Enfants et adolescents: 9%

Critères diagnostics de dépression: score ou entretien

TCC individuel: 39,8%

TCC groupe: 27,2%

Guided Self help: 16,2%

Unguided Self Help: 7,5%

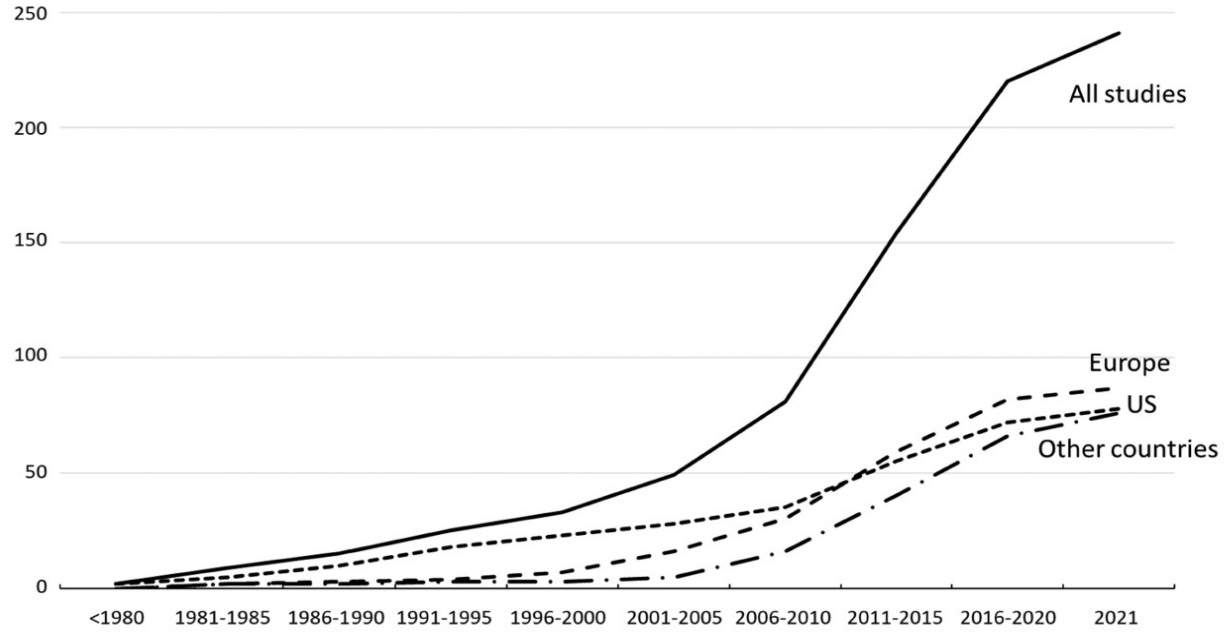


Figure 2 Randomized trials comparing cognitive behavior therapy (CBT) with control conditions: cumulation over time

↗ des études sur **dépression périnatale**

↗ des études sur **dépression et conditions médicale**

↘ des études avec **liste d'attente**

↗ des études **niveau bas de biais**

↗ du nombre de **participants par étude**

↘ du nombre de **sessions de TCC**

TCC versus conditions contrôles

Taux de réponse:
TCC: 0,42 (0,39-0,45)
Contrôle: 0,19 (0,18-0,21)
→NNT 4,7
Taux de rémission:
TCC: 0,36 (0,31-0,42)
Contrôle: 0,15 (0,12-0,18)
→NNT 3,6

Table 2 Cognitive behavior therapy (CBT) vs. control conditions: main analyses

	n	g (95% CI)	I^2 (95% CI)	PI	NNT
Post-test					
All comparisons	271	0.79 (0.70-0.89)	85 (83-86)	–0.45 to 2.04	3.8
Outliers removed	194	0.70 (0.65-0.74)	26 (11-39)	0.49 to 0.90	4.4
Only low risk of bias	90	0.60 (0.49-0.71)	77 (72-81)	–0.22 to 1.42	5.2
Three-level model	460	0.81 (0.72-0.90)	90 (-)	–0.56 to 2.17	3.7
Publication bias correction	349	0.47 (0.35-0.59)	90 (89-91)	–1.52 to 2.46	7.0
6-9 month follow-up					
All comparisons	78	0.74 (0.36-1.11)	91 (89-92)	–1.90 to 3.37	4.1
Outliers removed	65	0.42 (0.33-0.50)	63 (51-72)	–0.10 to 0.93	8.0
Only low risk of bias	29	0.91 (0.46-1.36)	94 (92-95)	–1.46 to 3.28	3.2
Three-level model	119	0.74 (0.40-1.08)	98 (-)	–2.17 to 3.65	4.1
Publication bias correction	93	0.30 (–0.23 to 0.83)	94 (93-95)	–4.31 to 4.91	11.4
10-12 month follow-up					
All comparisons	22	0.49 (0.01-0.98)	91 (88-93)	–1.68 to 2.67	6.5
Outliers removed	20	0.22 (0.10-0.35)	74 (59-83)	–0.25 to 0.70	16.0
Only low risk of bias	4	0.28 (–0.25 to 0.82)	87 (68-94)	–1.29 to 1.86	12.3
Three-level model	30	0.50 (0.03-0.96)	97 (-)	–1.65 to 2.64	6.5
Publication bias correction	22	0.49 (0.01-0.98)	91 (88-93)	–1.68 to 2.67	6.5
13-24 month follow-up					
All comparisons	8	0.22 (–0.12 to 0.56)	86 (75-93)	–0.77 to 1.21	16.2
Outliers removed	7	0.09 (–0.10 to 0.27)	11 (0-74)	–0.24 to 0.42	42.9
Only low risk of bias	3	–0.01 (–0.17 to 0.16)	0 (0-90)	–1.20 to 1.18	416.3
Three-level model	13	0.22 (–0.14 to 0.59)	80 (-)	–0.68 to 1.13	16.0
Publication bias correction	11	0.44 (0.09-0.80)	89 (83-93)	–0.71 to 1.60	7.4

PI – prediction interval, NNT – number needed to treat. The reported publication bias correction is that using the trim and fill procedure.

TCC
versus
autres thérapies

Table 4 Cognitive behavior therapy (CBT) vs. other active treatments

	n	g (95% CI)	I^2 (95% CI)	NNT
CBT vs. other psychotherapies				
All studies	87	0.06 (0-0.12)	31 (10-47)	63
Outliers removed	81	0.04 (–0.01 to 0.09)	1 (0-27)	93.9
Only low risk of bias	24	0.02 (–0.05 to 0.09)	0 (0-45)	200.4
Publication bias correction	92	0.04 (–0.03 to 0.11)	44 (28-56)	93.4
Long-term effect (at 6-9 months)	18	–0.03 (–0.14 to 0.07)	0 (0-50)	117.2
Long-term effect (at 9-12 months)	14	–0.09 (–0.19 to 0.01)	12 (0-50)	47.7
Compared to supportive therapy	22	0.12 (–0.07 to 0.31)	54 (26-72)	31.2
Compared to interpersonal therapy	9	0.00 (–0.12 to 0.12)	0 (0-65)	18.0
Compared to psychodynamic therapy	7	0.21 (–0.10 to 0.52)	47 (0-78)	17.1
Compared to behavioral activation	10	0.02 (–0.17 to 0.20)	28 (0-66)	196.6
Compared to 3rd wave therapies	2	–0.05 (–1.21 to 1.11)	0 (-)	81.0
Compared to problem-solving therapy	2	0.12 (–0.21 to 0.44)	0 (-)	31.2
Compared to other psychotherapies	35	0.05 (–0.04 to 0.14)	23 (0-49)	77.2

TCC
versus
Pharmacothérapie
versus
Traitements combinés

Table 4 Cognitive behavior therapy (CBT) vs. other active treatments

	n	g (95% CI)	I^2 (95% CI)	NNT
CBT vs. pharmacotherapies				
All studies	38	0.08 (–0.07 to 0.24)	66 (52-76)	46.1
Outliers removed	32	–0.03 (–0.13 to 0.07)	34 (0-57)	135.0
Only low risk of bias	8	–0.06 (–0.38 to 0.27)	66 (29-84)	70.6
Publication bias correction	44	–0.05 (–0.25 to 0.15)	76 (68-82)	81.7
Long-term effect (at 6-12 months)	12	0.34 (0.09-0.58)	53 (10-76)	10.2
Combined treatment vs. pharmacotherapy alone				
All studies	18	0.51 (0.19-0.84)	71 (53-82)	6.3
Outliers removed	16	0.41 (0.23-0.60)	49 (8-71)	8.1
Only low risk of bias	5	0.27 (–0.42 to 0.96)	77 (43-90)	13.1
Publication bias correction	21	0.34 (–0.08 to 0.76)	79 (68-86)	10.1
Long-term effect (at 6-12 months)	6	0.32 (0.09-0.55)	29 (0-71)	10.6
Combined treatment vs. CBT alone				
All studies	15	0.19 (–0.11 to 0.50)	68 (45-81)	22.4
Outliers removed	13	0.19 (–0.01 to 0.39)	18 (0-56)	22.8
Only low risk of bias	2	–0.24 (–12.73 to 12.25)	94 (82-98)	14.7
Publication bias correction	18	0.37 (0.03-0.72)	77 (63-85)	12.8
Long-term effect (at 6-12 months)	5	0.11 (–0.38 to 0.60)	25 (0-70)	34.8

NNT – number needed to treat. The reported publication bias correction is that using the trim and fill procedure.

TCC
versus
Autres comparaisons

Table 5 Other comparisons between cognitive behavior therapy (CBT) and control conditions

	n	g (95% CI)	I^2 (95% CI)	NNT
Unguided self-help CBT				
All comparisons	39	0.45 (0.31-0.60)	78 (71-84)	7.2
Outliers removed	34	0.43 (0.34-0.52)	51 (28-67)	7.7
Only low risk of bias	18	0.40 (0.27-0.52)	59 (32-76)	8.4
Publication bias correction	53	0.25 (0.07-0.43)	84 (80-88)	14.2
CBT in institutional settings				
All comparisons	11	0.65 (0.21-1.08)	70 (45-84)	4.8
Outliers removed	10	0.49 (0.15-0.83)	52 (2-77)	6.6
Publication bias correction	13	0.41 (–0.14 to 0.96)	81 (68-88)	8.2
CBT in children and adolescents				
All comparisons	39	0.41 (0.25-0.57)	78 (70-84)	8.1
Outliers removed	32	0.33 (0.23-0.43)	24 (0-51)	10.3
Only low risk of bias	8	0.17 (–0.10 to 0.45)	78 (57-89)	21
Publication bias correction	55	0.10 (–0.09 to 0.30)	86 (82-899	36.8

NNT – number needed to treat. The reported publication bias correction is that using the trim and fill procedure.

Etudes avec liste d'attente: large taille d'effet
Etudes en Europe: plus faible taille d'effet
Etudes après 2011: taille d'effet plus importante

Discussion

TCC sont efficaces dans le traitement de la dépression avec une taille d'effet modérée à large et qui dure 12 mois

TCC **aussi efficace** que le traitement pharmacologique **à court terme** mais **plus efficace sur le long terme.**

TCC + Pharmacothérapie:

- Supérieur à pharmacothérapie seule
- Pas plus efficace que TCC seule

Comparative efficacy and acceptability of antidepressants, psychotherapies, and their combination for acute treatment of children and adolescents with depressive disorder: a systematic review and network meta-analysis

Xinyu Zhou, Teng Teng*, Yuqing Zhang*, Cinzia Del Giovane, Toshi A Furukawa, John R Weisz, Xuemei Li, Pim Cuijpers, David Coghill, Yajie Xiang, Sarah E Hetrick, Stefan Leucht, Mengchang Qin, Jürgen Barth, Arun V Ravindran, Lining Yang, John Curry, Li Fan, Susan G Silva, Andrea Ciprianiٹ, Peng Xieٹ*

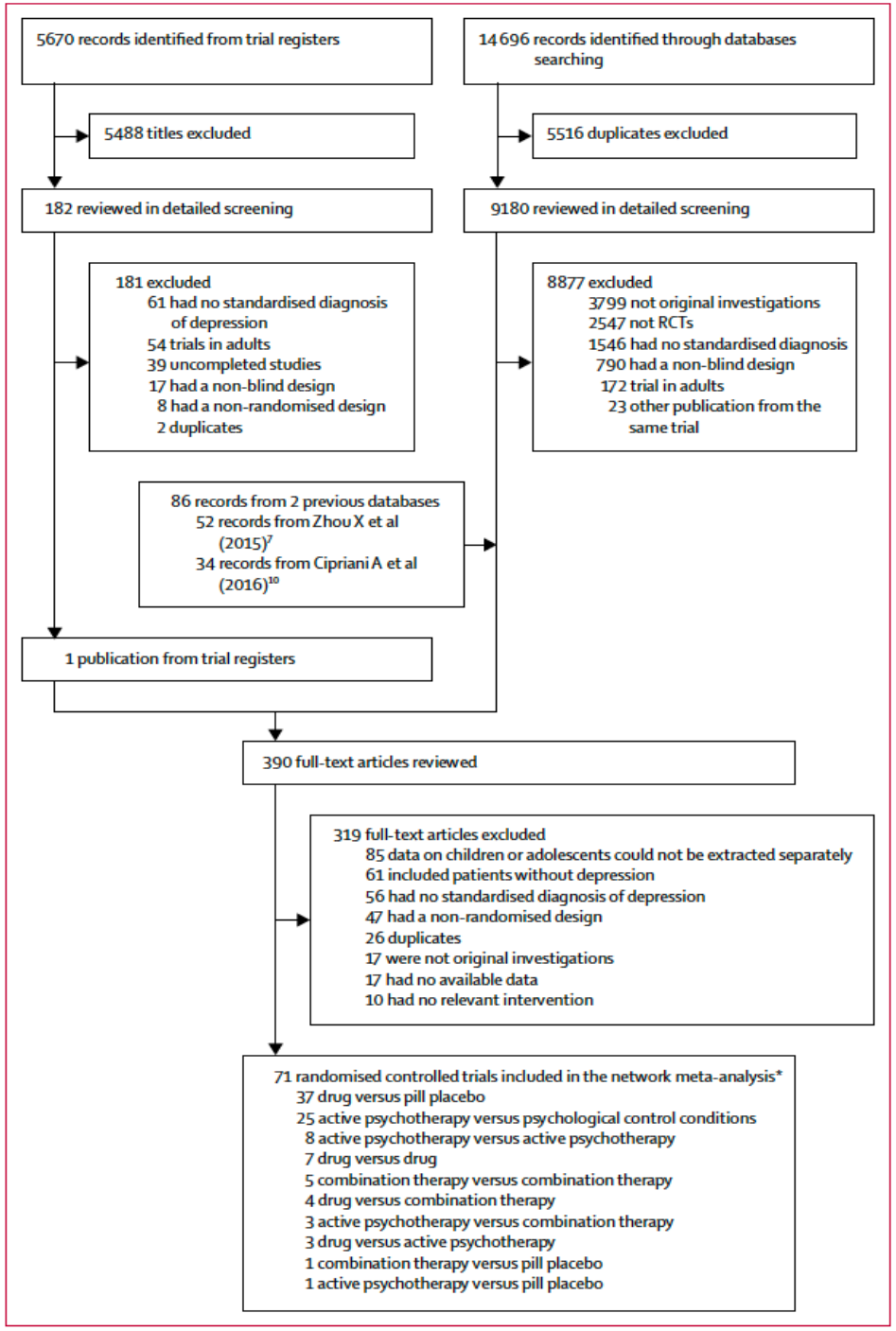
Summary

Background Depressive disorders are common in children and adolescents. Antidepressants, psychotherapies, and their combination are often used in routine clinical practice; however, available evidence on the comparative efficacy and safety of these interventions is inconclusive. Therefore, we sought to compare and rank all available treatment interventions for the acute treatment of depressive disorders in children and adolescents.

Lancet Psychiatry 2020; 7: 581–601

See Comment page 562

*These authors contributed equally



71 études → **9 510** patients inclus

4081 avec antidépresseurs, 1575 avec psychothérapie, 553 avec une combinaison

16 antidépresseurs

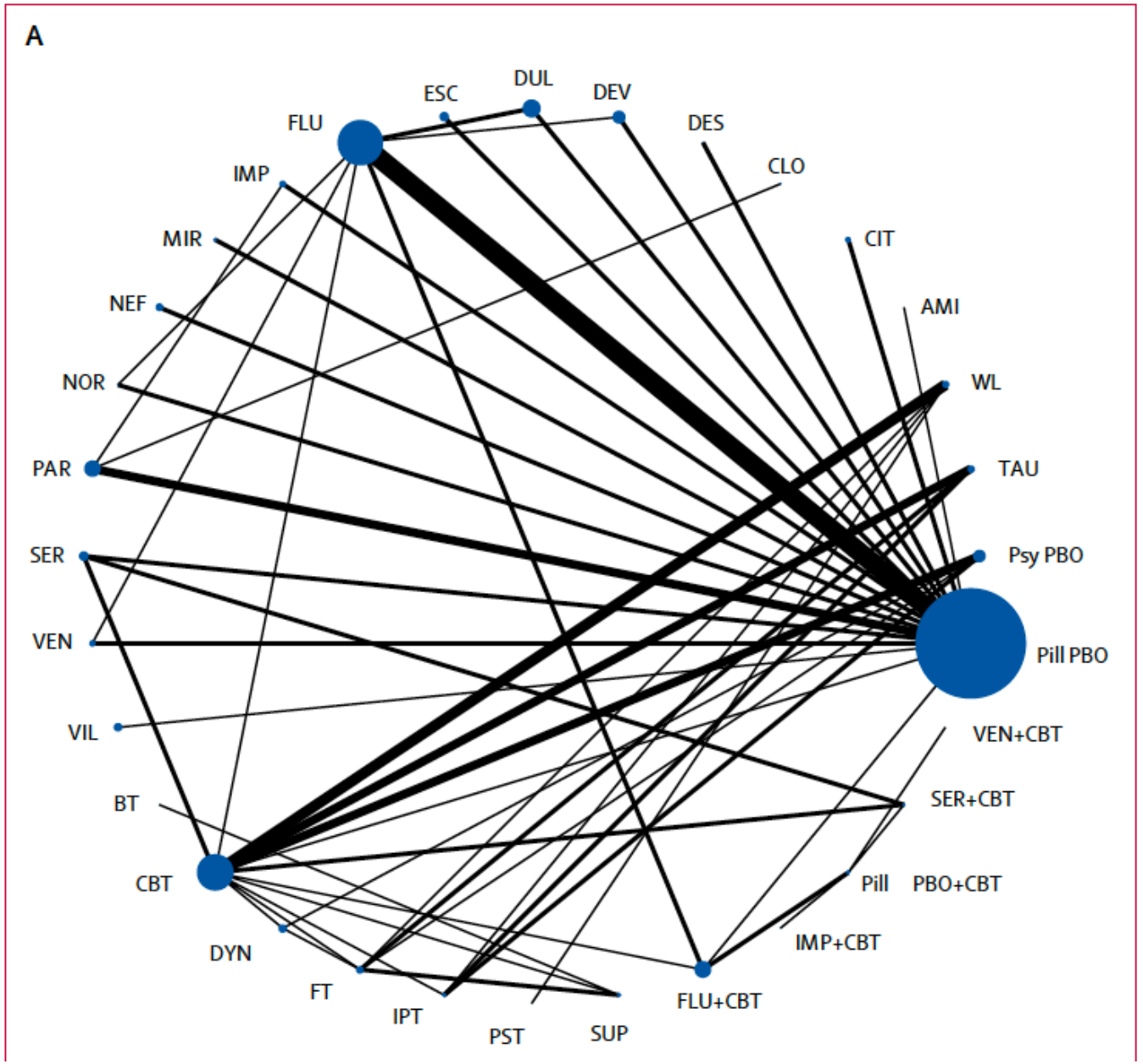
7 psychothérapies

5 combinaisons

Âge moyen de 14 ans (3 à 20 ans)

Durée de traitement: 8 semaines

EFFICACITE:
70 études → **8 906** patients



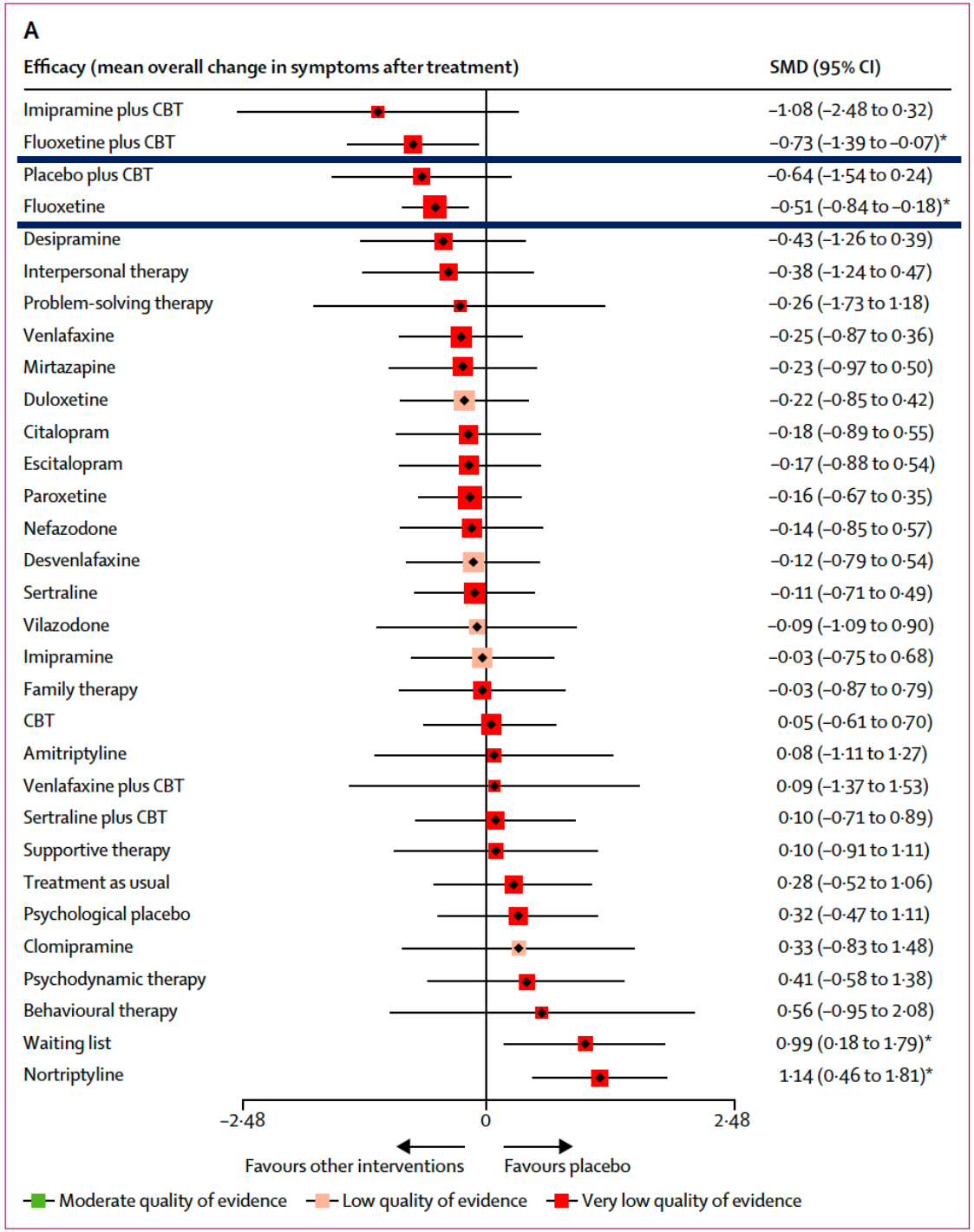
EFFICACITE:

70 études → **8 906** patients

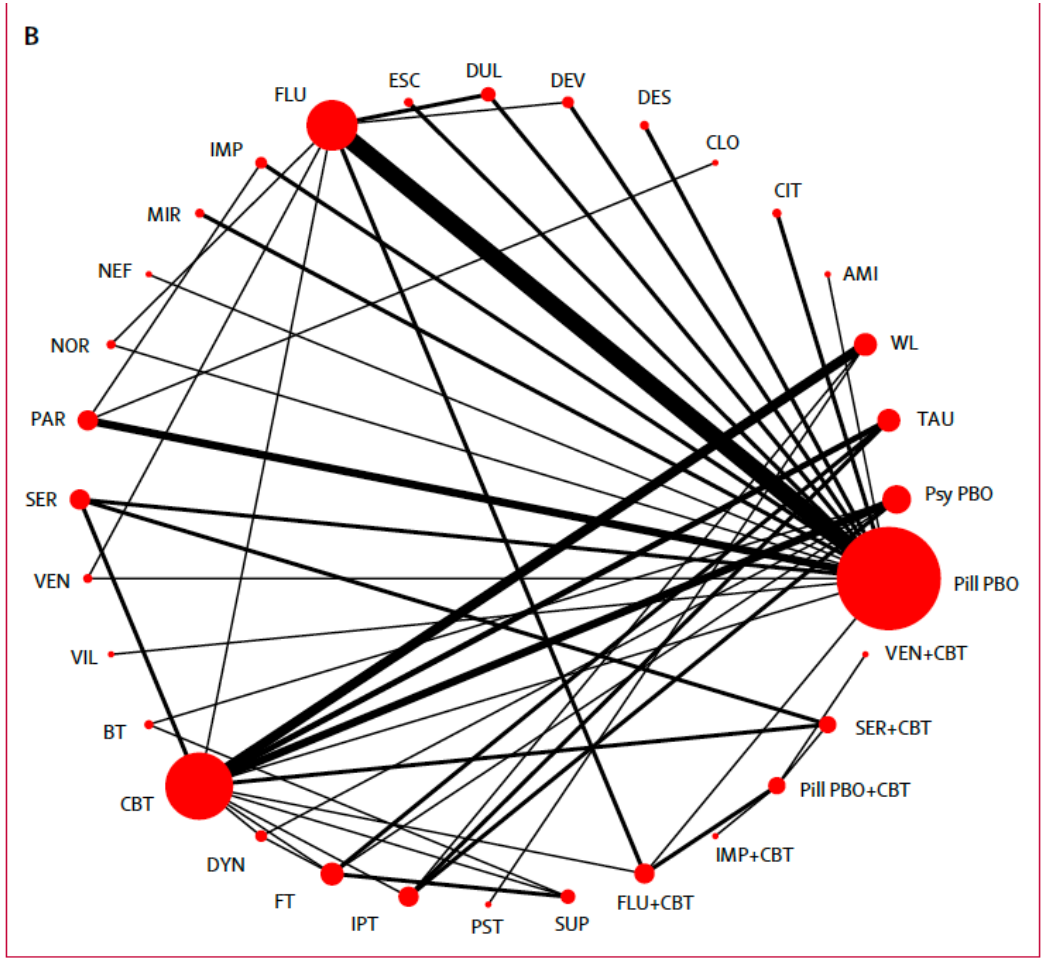
Fluoxétine + TCC et fluoxétine seule > placebo ou psychothérapie contrôle

Fluoxétine + TCC > TCC

(SMDs -0,78,95% CrI -1,55 à -0,01)



ACCEPTABILITE:
66 études → **9 075** patients

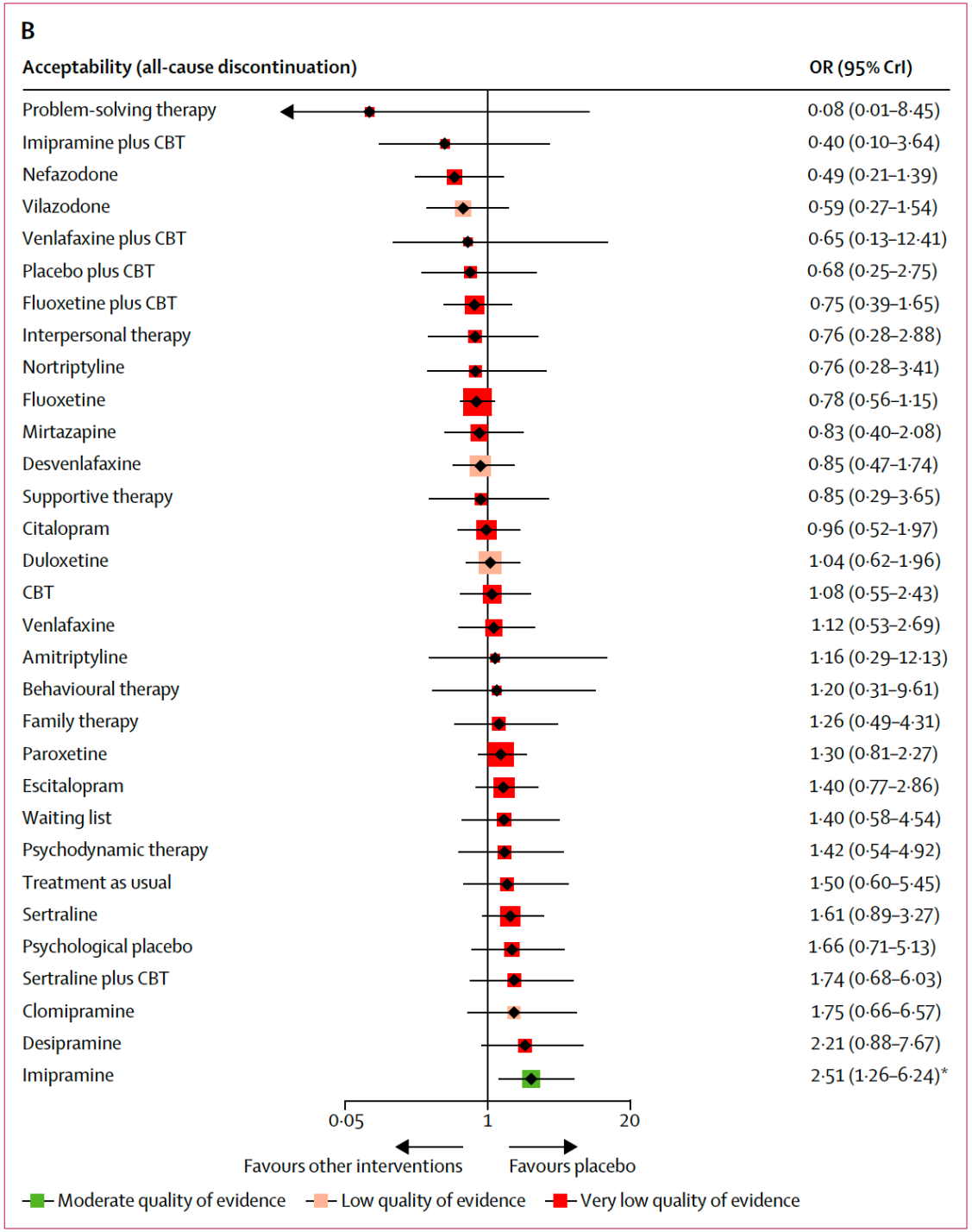


ACCEPTABILITE:

70 études → **8 906** patients

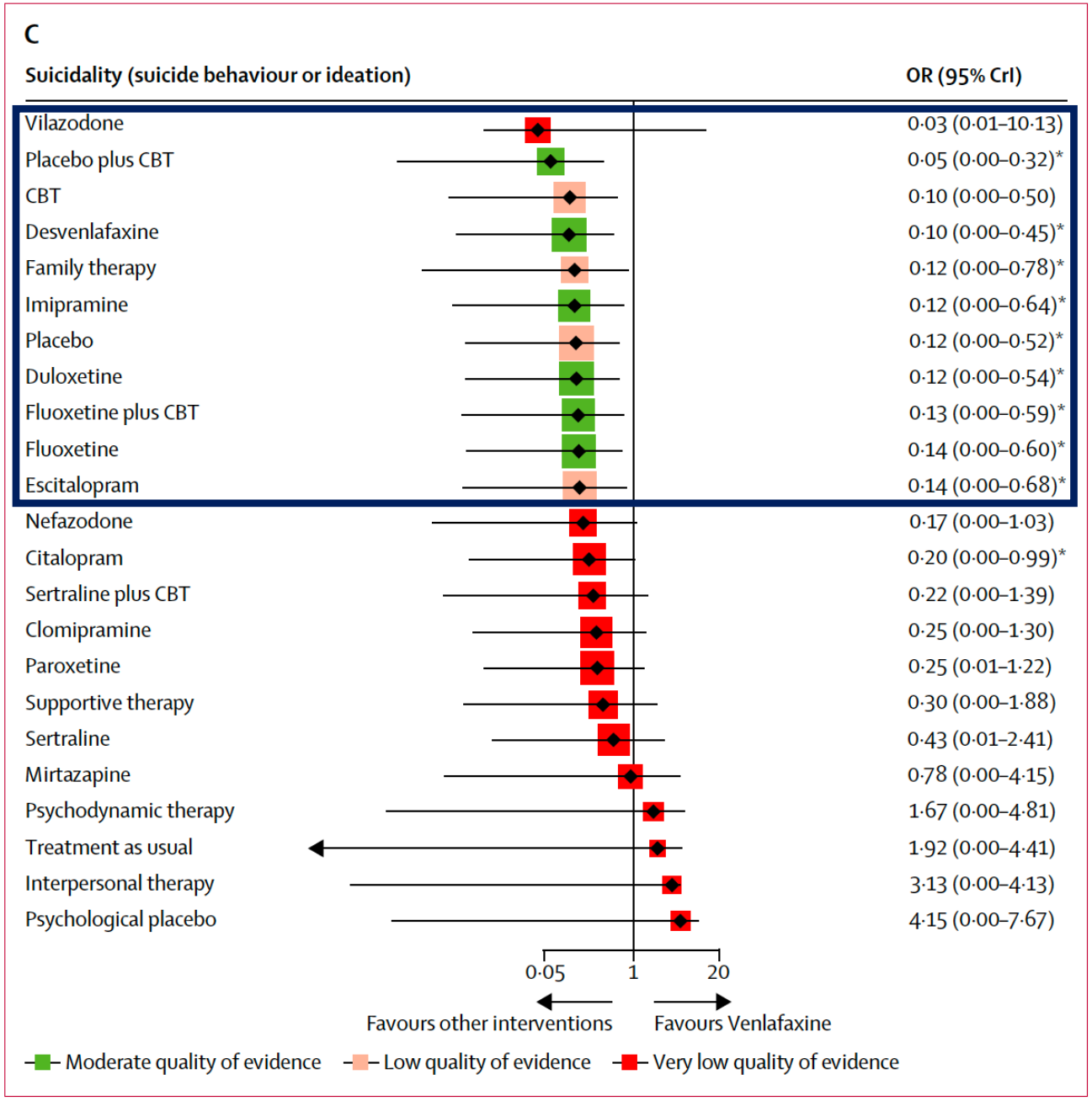
Fluoxétine et Nefazone > sertraline/imipramine/desipramine

Imipramine < placebo, fluoxetine+CBT



RISQUE SUICIDAIRE

Venlafaxine: risque suicidaire augmenté par rapport à 10 autres interventions



Discussion (1)

Résultats chez l'enfant différents de chez l'adulte

Hypothèses:

1) **Mécanismes neurodéveloppementaux et modifications hormonales**
2) **Faible nombre d'études et faible nombre de patients**
3) **Différences méthodologiques dans les études peuvent augmenter l'effet placebo**
4) **Thérapies pas assez spécifiques**

Discussion (2)

Risque suicidaire → risque augmenté avec la Venlafaxine

Nécessité d'évaluer++ risque suicidaire

EPISODE DEPRESSIF et TROUBLES ANXIEUX CONCLUSIONS

Chez l'adulte

- TCC efficace à court et long terme
- Pharmacothérapie efficace à court terme
- Traitements combinés > pharmacothérapie

Chez les mineurs

- Résultats différents avec Fluoxétine et Fluoxétine+ TCC qui seules ressortent.

ETAT DE STRESS POST TRAUMATIQUE

PLOS MEDICINE

RESEARCH ARTICLE

Psychological and pharmacological interventions for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network meta-analysis

Peter A. Coventry[1,2]*, Nick Meader[1], Hollie Melton[1], Melanie Temple[3], Holly Dale[4], Kath Wright[1], Marylène Cloitre[5,6], Thanos Karatzias[7], Jonathan Bisson[8], Neil P. Roberts[8,9], Jennifer V. E. Brown[1,2], Corrado Barbui[10], Rachel Churchill[1], Karina Lovell[11], Dean McMillan[2,12], Simon Gilbody[2,12]

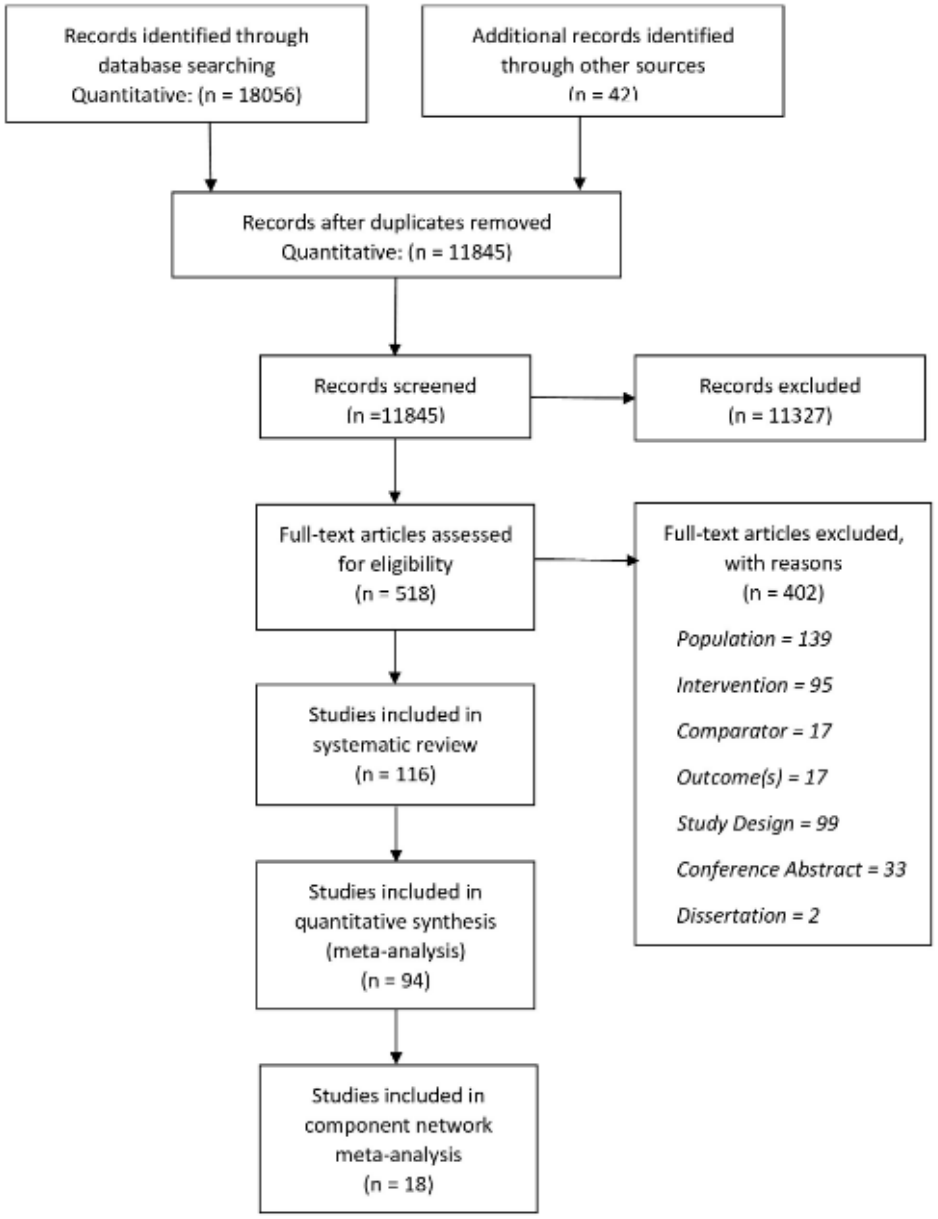


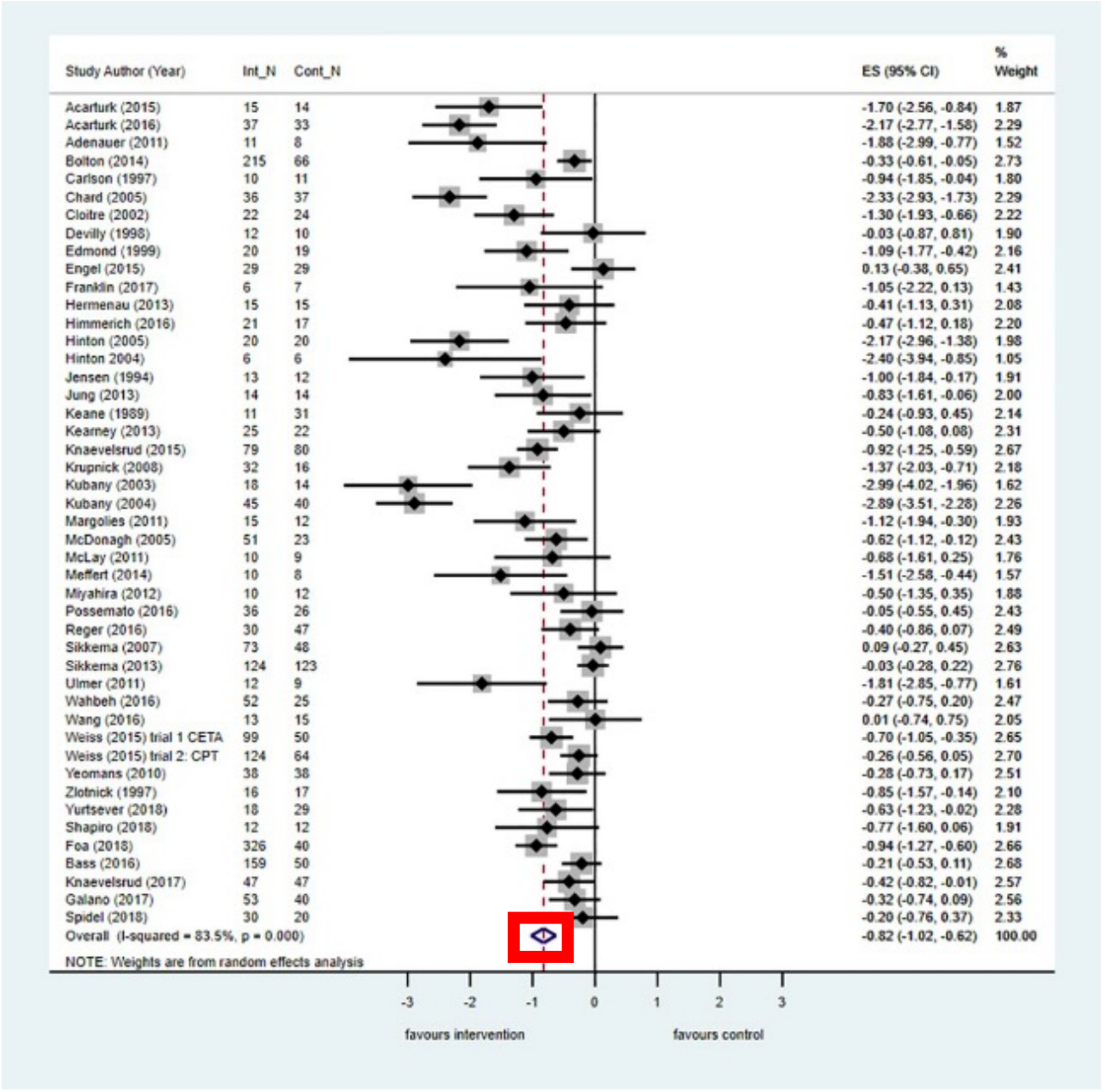
Fig 1. PRISMA flow diagram.

94 études dans méta-analyses → **6 158** patients **trauma**: combat de guerre (vétéran ou non), abus sexuel dans l'enfance, réfugiés, violences domestiques

Âge moyen: 42,6 ans, 42% d'hommes

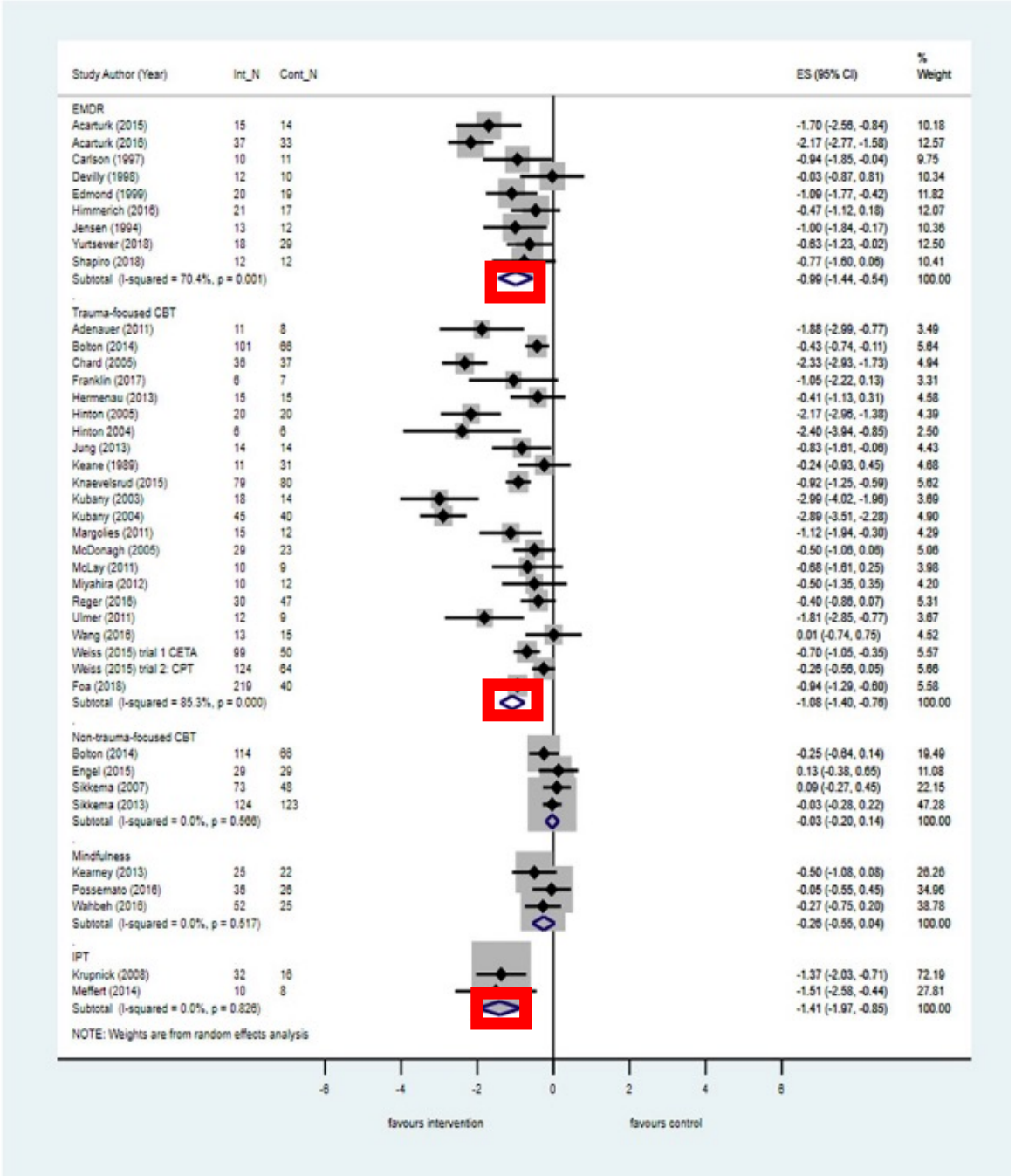
Psychothérapie versus Groupe contrôle

Symptômes de l'ESPT
Psychothérapie > groupe contrôle
Taille d'effet: -0,82 (-1,02, -0,62)



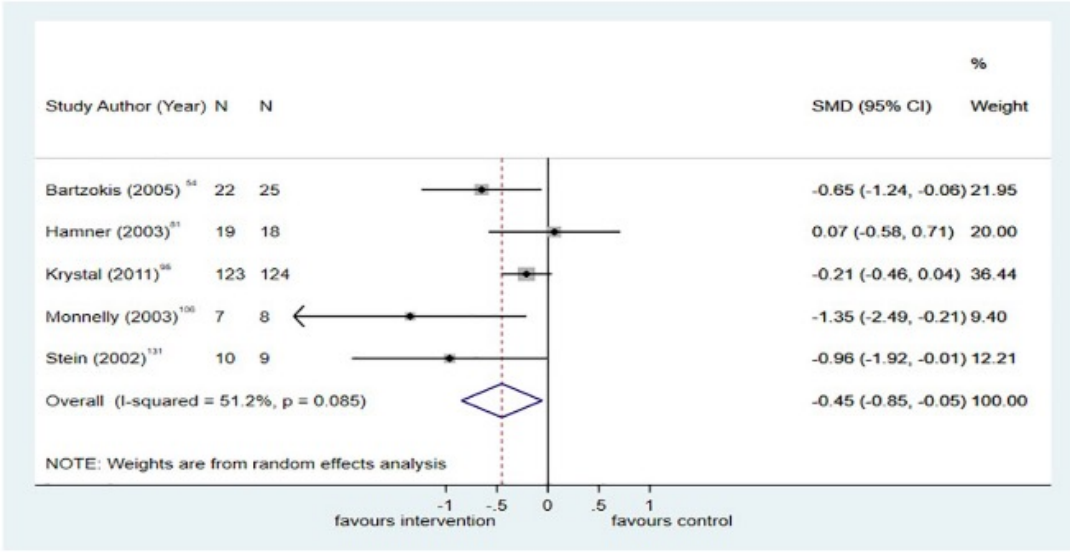
Psychothérapie versus Groupe contrôle

Symptômes de l'ESPT
EMDR, TF-CBT et IPT > groupe contrôle

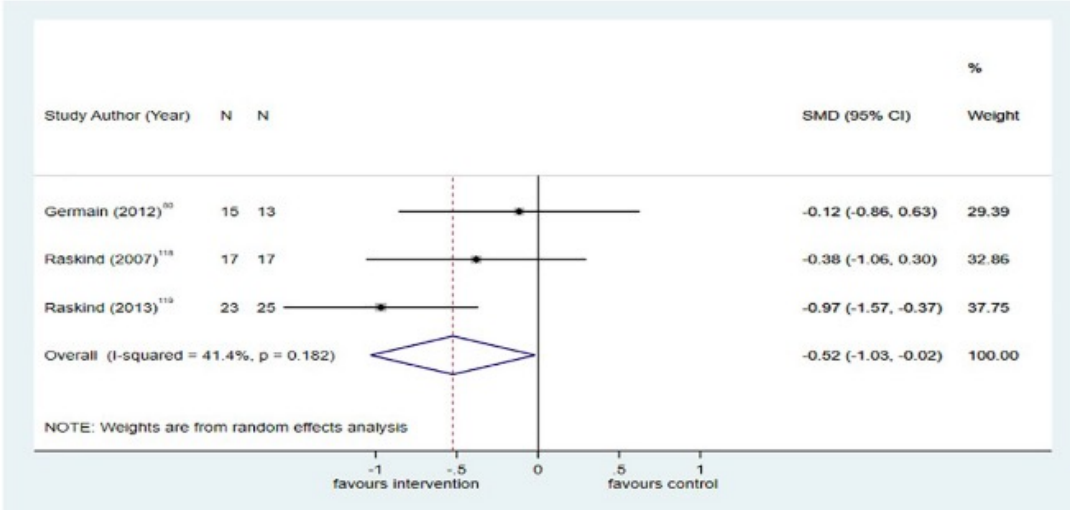


Traitement médicamenteux versus Groupe contrôle

Symptômes de l'ESPT
Seuls ressortent les antipsychotiques et prazosine



Antipsychotiques



Prazosine

Discussion

Les psychothérapies sont efficaces dans l'ESPT pour le traitement des symptômes de l'ESPT mais aussi des troubles psychologiques comorbides, notamment le sommeil.

JAMA Psychiatry | Original Investigation

Comparative Efficacy and Acceptability of Pharmacological, Psychotherapeutic, and Combination Treatments in Adults With Posttraumatic Stress Disorder

A Network Meta-analysis

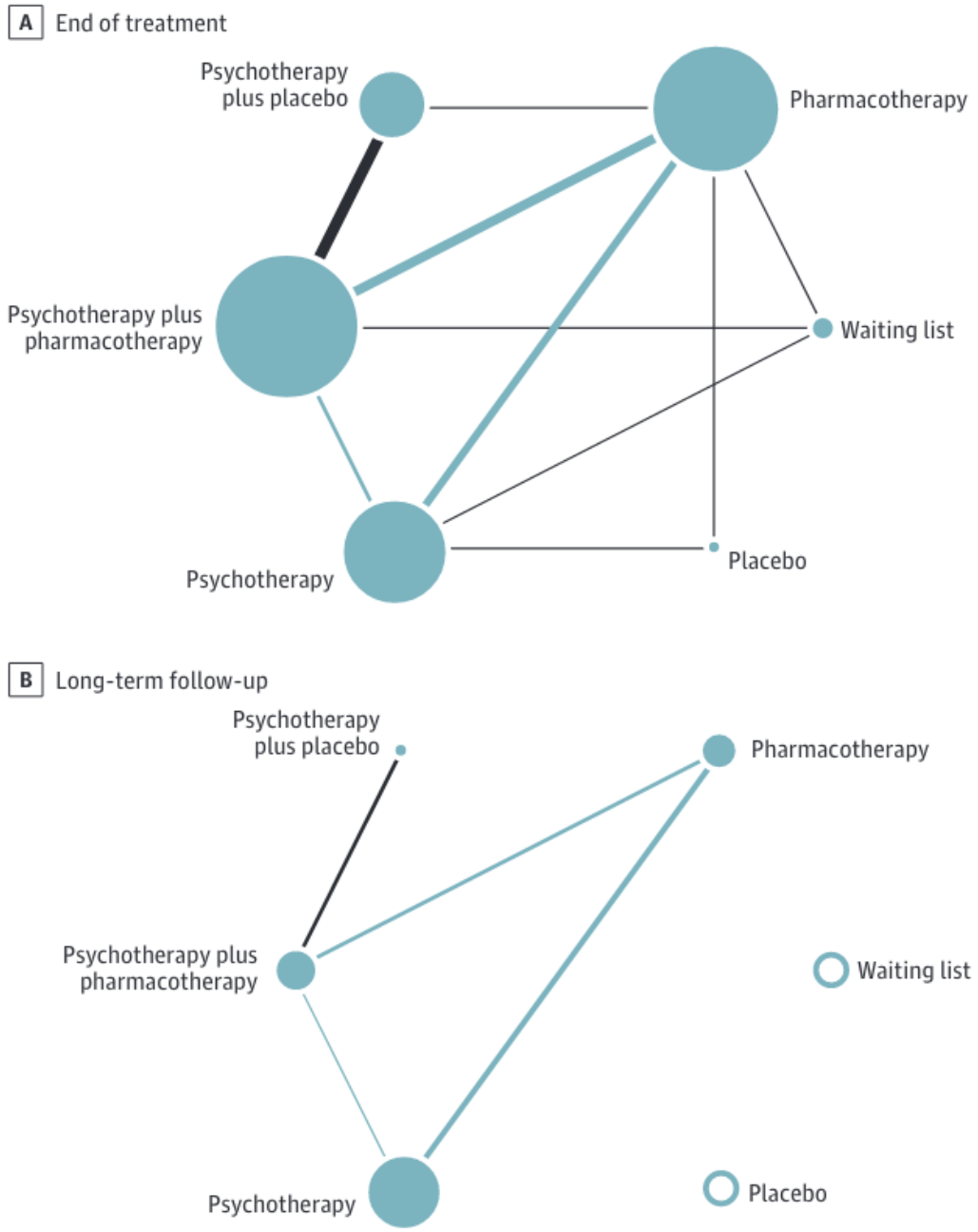
Jasmin Merz, MSc; Guido Schwarzer, PhD; Heike Gerger, PhD

Méthodologie

Etudes contrôlées et randomisées comparant psychothérapie et traitement pharmacologique ou une combinaison des deux sur la réduction de la sévérité des symptômes de l'EPST

12 Etudes inclues soit 922 patients
Analyse en réseau: 12 études avec 23 comparaisons et 6 études ont donné des résultats à long terme

Figure 1. Network of Included Comparisons at the End of Treatment and Follow-up



Résultats

Figure 2. Comparative Outcomes and Acceptability

A Short-term severity

Combination	-0.18 (-0.45 to 0.08) (N = 2; I^2 = 0%)	-0.07 (-0.26 to 0.13) (N = 5; I^2 = 0%)
-0.09 (-0.36 to 0.19) (N = 12; I^2 = 19.8%)	Psychotherapy	-0.05 (-0.31 to 0.21) (N = 4; I^2 = 14%)
0.12 (-0.34 to 0.11) (N = 12; I^2 = 19.8%)	-0.03 (-0.28 to 0.23) (N = 12; I^2 = 19.8%)	Pharmacotherapy

B Long-term severity

Combination	0.06 (-0.31 to 0.42) (N = 1; I^2 = NA[a])	-1.02 (-2.77 to 0.72) (N = 2; I^2 = 88%)
-0.13 (-1.13 to 0.87) (N = 6; I^2 = 70.8%)	Psychotherapy	-0.63 (-1.18 to -0.09) (N = 3; I^2 = 53%)
-0.96 (-1.88 to -0.04) (N = 6; I^2 = 70.8%)	-0.83 (-1.59 to -0.07) (N = 6; I^2 = 70.8%)	Pharmacotherapy

C Treatment dropout

Combination	2.00 (0.43 to 9.33) (N = 2; I^2 = 86%)	1.67 (0.80 to 3.47) (N = 5; I^2 = 48%)
2.43 (1.00 to 5.94) (N = 12; I^2 = 52%)	Psychotherapy	0.57 (0.19 to 2.34) (N = 4; I^2 = 79%)
-1.81 (0.87 to 3.77) (N = 12; I^2 = 52%)	0.74 (0.33 to 1.66) (N = 12; I^2 = 52%)	Pharmacotherapy

A la fin du traitement: aucune supériorité significative

A long terme: Psychothérapie > pharmacothérapie
Combinaison > pharmacothérapie

Discussion

Psychothérapie en 1ère intention
Importance d'inclure du long terme dans toutes les analyses

ETAT DE STRESS POST TRAUMATIQUE
CONCLUSION

- **Psychothérapie en 1ère intention**
  - EMDR
  - TF-TCC
  - IPT
- **Traitements médicamenteux: efficacité? Lesquels?**

INSOMNIE

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Comparative efficacy and acceptability of psychotherapies, pharmacotherapies, and their combination for the treatment of adult insomnia: A systematic review and network meta-analysis

Ye Zhang [a], Rong Ren [a, **], Linghui Yang [a], Haipeng Zhang [a], Yuan Shi [a], Jie Shi [b], Larry D. Sanford [c], Lin Lu [b], Michael V. Vitiello [d], Xiangdong Tang [a, *]

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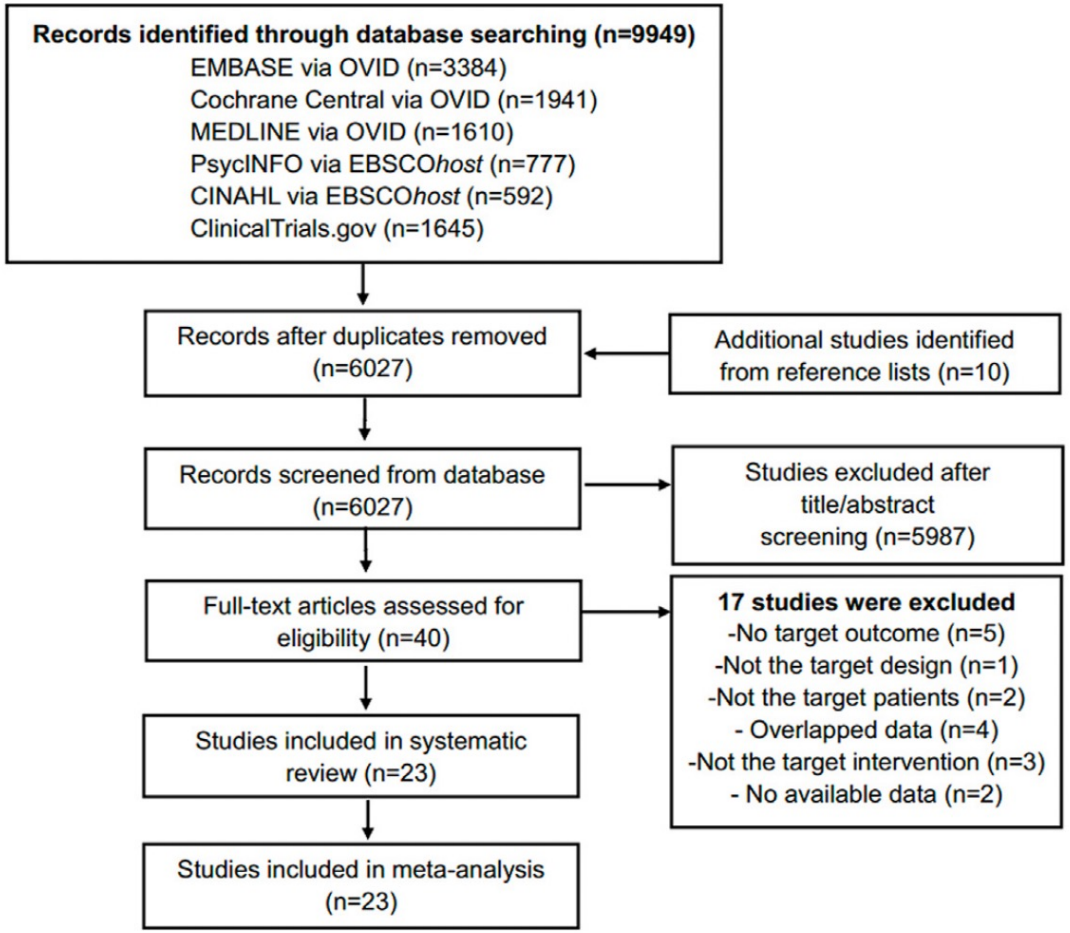

Fig. 1. Flow chart used for the identification of eligible studies.

23 études → **1 334** patients inclus
440 avec pharmacothérapie, 454 avec psychothérapie, 440 avec une combinaison
Âge moyen de 32,5 ans à 64,4 ans
Durée de traitement: 2 à 16 semaines
Nombre de séances de psychothérapie: 2 à 16

NETWORK META-ANALYSIS (1)

Efficacité Subjective du sommeil

Psychothérapie > Pharmacothérapie *(SMD= 0.39, 95% CI: 0.02 to 0.75)*

Traitement combiné > Pharmacothérapie *(SMD= 0.54, 95% CI: 0.88 to 0.19)*

Latence subjective du sommeil et en polysomnographie, éveil après endormissement

Traitement combiné > Pharmacothérapie *(SMD= 0.51, 95% CI: 0.06 to 0.95), (SMD= 0.57, 95% CI: 0.11 to 1.04)(SMD= 0.31, 95% CI: 0.02 to 0.60)*

NETWORK META-ANALYSIS (2)

Efficacité Subjective du sommeil

TCC > pharmacothérapie (SMD= 0.49, 95% CI: 0.03 to 0.95)

TCC+ Pharmacothérapie > Pharmacothérapie (SMD= 0.66, 95% CI: 1.06 to 0.25)

Eveil après endormissement

TCC > Pharmacothérapie (SMD= 0.47, 95% CI: 0.83 to 0.11)

TCC+ Pharmacothérapie > Pharmacothérapie (SMD= 0.54, 95% CI: 0.23 to 0.84)

Latence de sommeil subjective et polysomnographie

TCC+ Pharmacothérapie > Pharmacothérapie (SMD= 0.81, 95% CI: 0.20 to 1.43) SMD= 0.57, 95% CI: 0.11 to 1.04),

NETWORK META-ANALYSIS (3)
EFFICACITE A LONG TERME (9 RCT)

TCC > Pharmacothérapie à 1 et 3 mois pour items d'Efficacité Subjective du sommeil, et efficacité sur Polysomnographie
Pharmacothérapie < traitement combiné

Résultats identique de 4 à 12 mois de suivi

Traitement combiné n'est jamais supérieur à TCC seule

Discussion

TCC: gold standard dans les troubles du sommeil, insomnie chronique → doit être proposé avant les traitements hypnotiques
Traitement combiné: choix intéressant → intérêt pour arrêt des hypnotiques?
Résultats surtout sur variables subjectives → troubles du sommeil: une évaluation subjective

TROUBLE OBSESSIONNEL COMPULSIF

Clinical Psychology Review 40 (2015) 156–169

Contents lists available at ScienceDirect

Clinical Psychology Review

Cognitive behavioral treatments of obsessive–compulsive disorder. A systematic review and meta-analysis of studies published 1993–2014

Lars-Göran Öst [a,b,c,d,*], Audun Havnen [c,d], Bjarne Hansen [c,d], Gerd Kvale [c,d]

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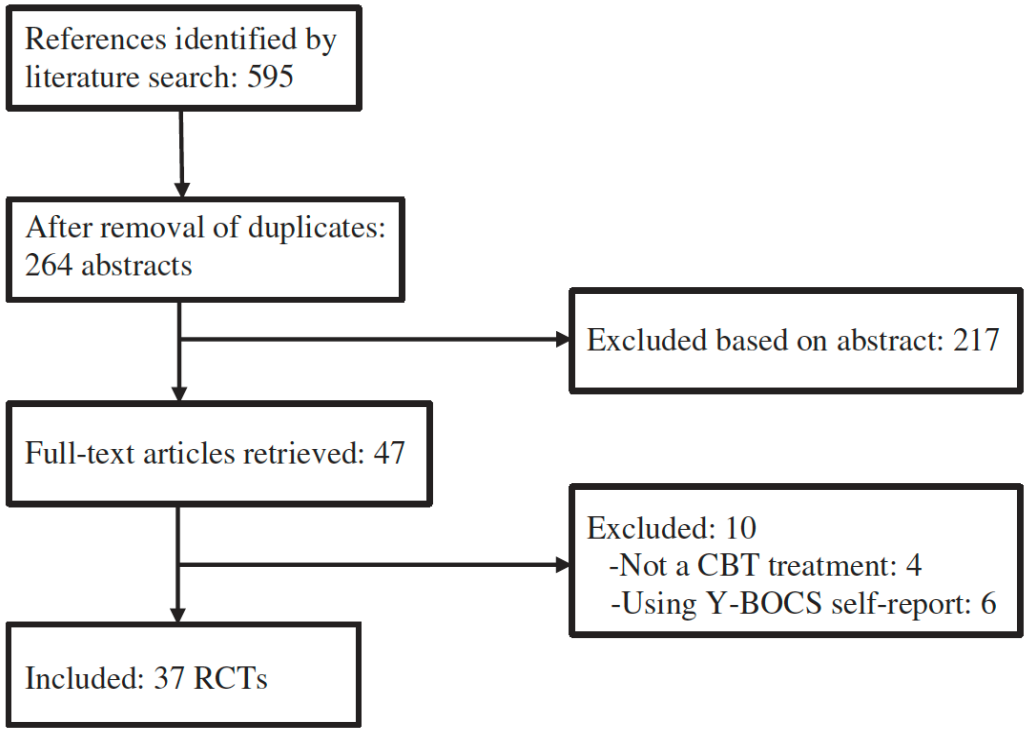


Fig. 1. Flowchart of the inclusion of studies.

37 études → **2 414** patients inclus
Âge moyen de **34,7 ans**
57,9% de femmes
Durée des troubles: **15,2 ans**
42,2% des patients ont aussi un traitement pharmacologique
Thérapies:
- EPR sans thérapie cognitive dans 23 études
- Thérapie cognitive sans EPR dans 7 études
- combinaison dans 13 études
Durée thérapie: **12,7 semaines**, moy **14 séances**

Table 1
Attrition in the OCD-studies.

Condition	*k*	Dropout	95% CI	*z*-Value	Q-value	I^2
ERP	28	19.1%	16.1–22.7%	13.22[b]	27.7	2.6
CT	8	11.4%	7.4–17.0%	8.55[b]	6.9	0
CBT	19	15.5%	12.5–19.2%	12.92[b]	22.8	21.0
Antidepressants	4	30.3%	23.5–38.3%	4.62[b]	9.0[a]	66.8
ERP/CBT + ADM	7	32.0%	24.2–40.9%	3.83[b]	14.5[a]	57.1
Placebo	6	16.8%	9.3–28.6%	4.58[b]	3.8	0
WLC	8	13.7%	7.9–22.6%	5.88[b]	4.9	0

[a] $p < .05$.
[b] $p < .0001$.

Sorties d'essai ATD et EPR+ ATD > TC, TCC, EPR, placebo et liste d'attente

META-ANALYSE:

Post traitement:

TCC > liste d'attente, placebo, psychothérapie placebo → taille d'effet large

EPR/TCC > ATD

Suivi à long terme (15 mois)

Perte des effets

Table 2

Effect sizes (Hedges' *g*) on Y-BOCS for all OCD RCTs and divided on comparison conditions for post-treatment assessments.

Comparison	*k*	*g*-Value	95% CI	*z*-Value	Q-value	I^2
All studies	62	0.57	0.39–0.75	6.20[c]	305.4[c]	80
CBT vs. WLC	15	1.31	1.08–1.55	10.85[c]	22.3	37
CBT vs. placebo: all	8	1.33	0.91–1.76	6.18[c]	24.7[b]	72
CBT vs. placebo: psychological	6	1.29	0.76–1.81	4.81[c]	21.3[b]	77
CBT vs. all active Tx	37	0.09	−0.05–0.22	1.19	70.5[b]	49
Individual vs. Group Tx	6	0.17	−0.06–0.40	1.45	2.6	0
ERP vs. CT	7	0.07	−0.15–0.30	0.64	5.5	0
ERP/CBT vs. Medication	4	0.55	0.05–1.04	2.17[a]	9.7[a]	69
ERP/ERP + Pla. vs. ERP + Med	6	−0.25	−0.46–0.03	1.71	5.1	0

Note: *k* = number of comparisons. A positive *g*-value means that the first treatment in the comparison is better and a negative *g*-value means that the second treatment is better.

Table 3

Effect sizes (Hedges' *g*) on Y-BOCS for all OCD RCTs and divided on comparison conditions for follow-up assessments.

Comparison	*k*	*g*-Value	95% CI	*z*-Value	Q-value	I^2
All studies	27	0.06	−0.13–0.24	0.60	55.4[b]	53
CBT vs. active Tx	25	0.04	−0.16–0.24	0.41	54.3[c]	56
Individual vs. Group Tx	6	0.21	−0.03–0.45	1.75	1.7	0
ERP vs. CT	4	0.07	−0.27–0.41	0.39	3.7	20
ERP/CBT vs. Medication	2	0.38	−0.81–1.57	0.62	6.1[a]	84
ERP/ERP + Pla. vs. ERP + Med	3	−0.06	−0.66–0.55	0.18	3.3	39

Note: *k* = number of comparisons. A positive *g*-value means that the first treatment in the comparison is better and a negative *g*-value means that the second treatment is better.

[a] $p < 0.05$.

[b] $p < 0.001$.

[c] $p < 0.0001$.

META-ANALYSE:

Taux de réponse très proches pour EPR/TC/EPR+TC (62 à 68%)

Même résultat pour le « changement clinique significatif »

Table 6
Proportions of response and clinically significant change (CSC) at post-treatment.

Comparison	Measure	*k*	Proportion	95% CI	*z*-Value*	Q-value	I^2
ERP	Resp.	15	65.0%	59.3–70.2%	5.02[d]	12.1	0
	CSC	13	50.0%	44.0–56.0%	0.01	7.3	0
CT	Resp.	5	67.7%	52.0–80.2%	2.20[a]	9.4	57
	CSC	4	51.6%	27.8–74.8%	0.13	17.5[c]	83
ERP + CT	Resp.	13	62.4%	51.3–72.3%	2.18[a]	46.0[d]	74
	CSC	13	43.4%	34.5–42.8%	−1.38	34.0[c]	65
Antidepressants	Resp.	4	32.9%	25.8–40.9%	−4.06[d]	2.6	0
	CSC	1	14.0%	5.2–32.6%	−3.27[c]		
ERP/CT + ADM	Resp.	2	79.5%	56.0–92.2%	2.38[a]	2.0	51
	CSC	1	43.0%	23.3–56.2%	−0.61		
Placebo	Resp.	3	26.8%	2.5–84.1%	−0.74	10.3[b]	81
	CSC	3	12.0%	1.4–56.7%	−1.73	15.2[c]	87

Note: k = number of comparisons.
[a] $p < 0.05$.
[b] $p < 0.01$.
[c] $p < 0.001$.
[d] $p < 0.0001$.
* Test if significantly different from 50%.

Discussion

- **Peu d’intérêt à combiner EPR et TC**
- **TCC a un effet supérieur aux ATD**
- **Combinaison TCC + ATD a un effet supérieur à ATD seul**
- **Ajouter ATD à TCC ne montre pas une efficacité supérieur à TCC seule**

Pharmacological and psychotherapeutic interventions for management of obsessive-compulsive disorder in adults: a systematic review and network meta-analysis

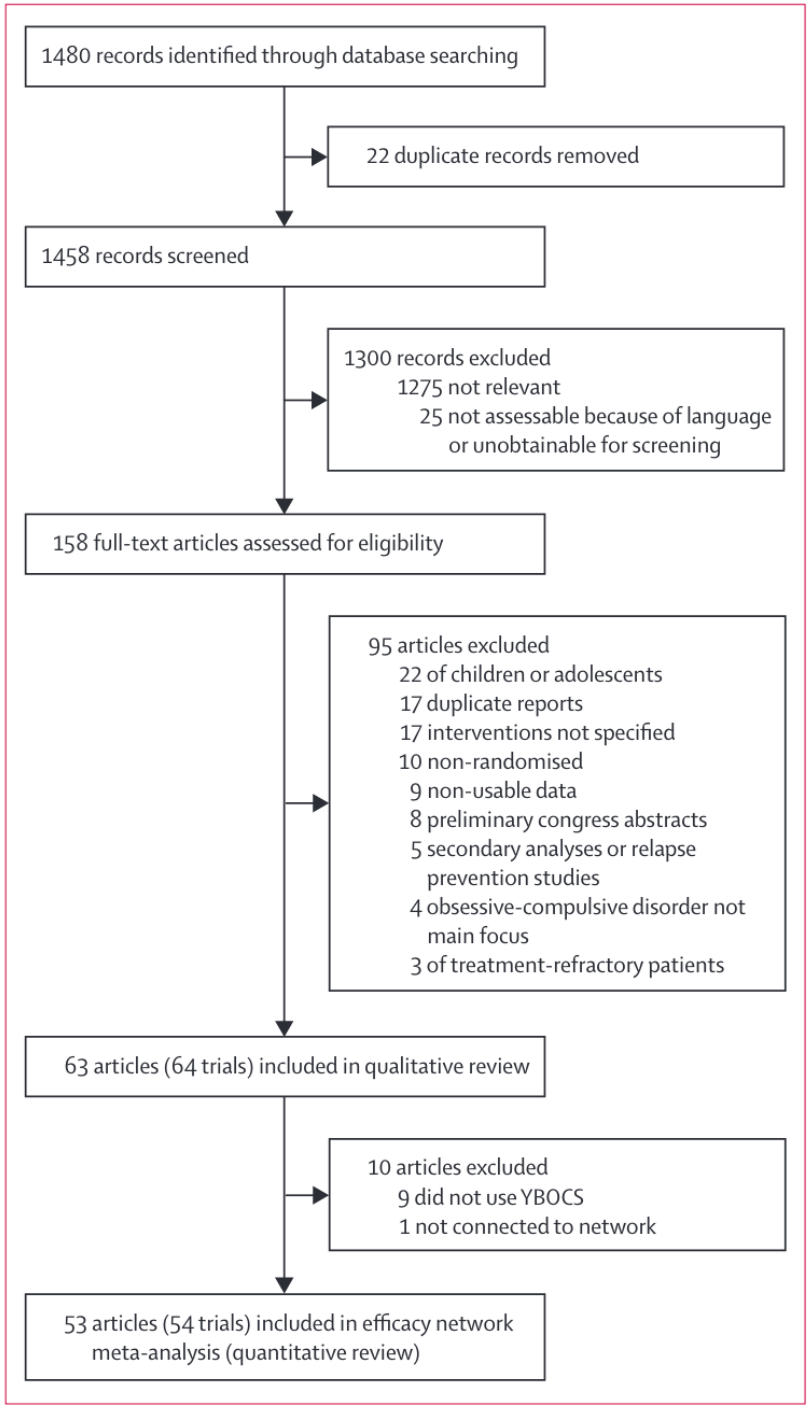
Petros Skapinakis, Deborah M Caldwell, William Hollingworth, Peter Bryden, Naomi A Fineberg, Paul Salkovskis, Nicky J Welton, Helen Baxter, David Kessler, Rachel Churchill, Glyn Lewis

Lancet Psychiatry 2016; 3: 730–39

Published Online

Summary

Background Several interventions are available for management of obsessive-compulsive disorder in adults, but few studies have compared their relative efficacy in a single analysis. We aimed to simultaneously compare all available treatments using both direct and indirect data.



54 études → **6 652** patients inclus

17 traitements en 12 classes

Âge moyen de 36 ans

17 traitements en 12 classes
27% des études sont des comparaisons avec bras actif
liste d'attente 11%

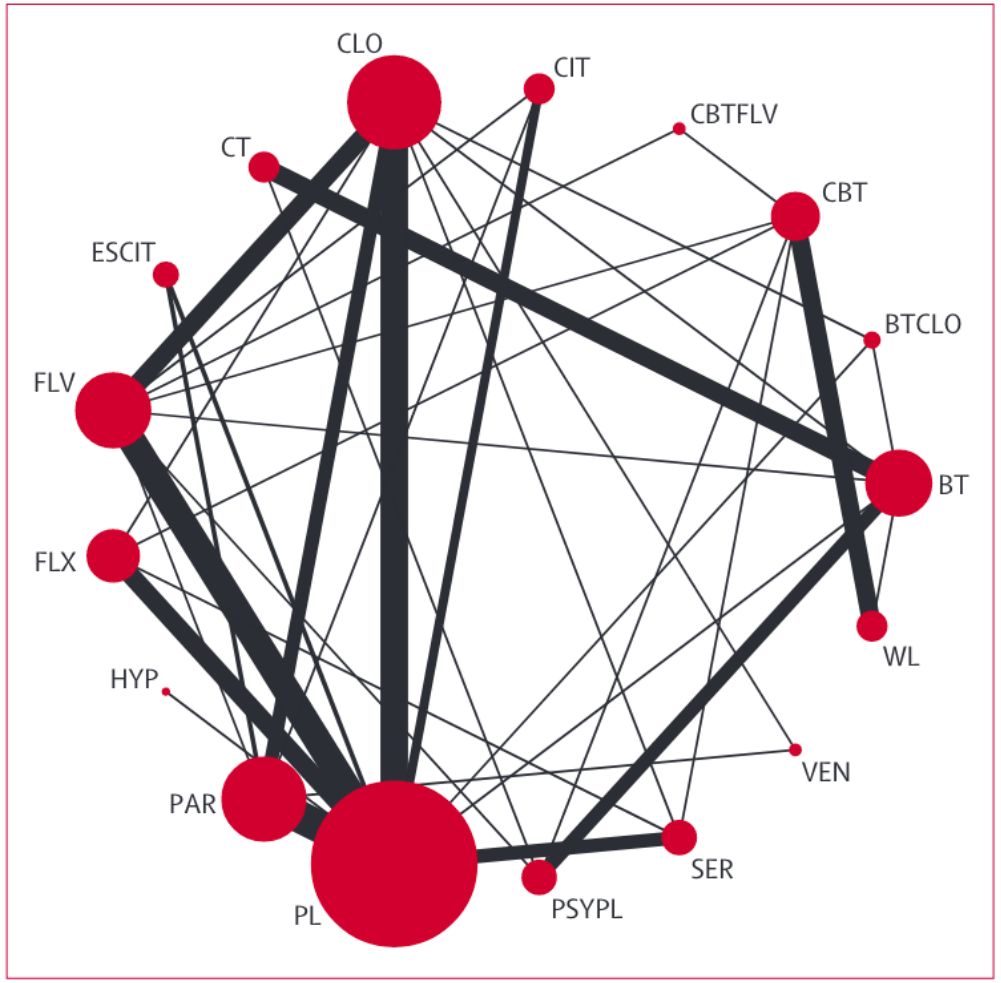


Figure 2: **Network diagram for efficacy analysis representing direct comparisons between individual treatments**
The size of each circle is proportional to the number of randomly allocated participants and the width of each line is proportional to the number of trials in each direct comparison. BT=behavioural therapy. CBT=cognitive behavioural therapy. CT=cognitive therapy. BTCLO=behavioural therapy and clomipramine. CBTFLV=cognitive behavioural therapy and fluvoxamine. CIT=citalopram. CLO=clomipramine. ESCIT=escitalopram. FLV=fluvoxamine. FLX=fluoxetine. HYP=hypericum. PAR=paroxetine. PL=placebo. PSYPL=psychological placebo. SER=sertraline. VEN=venlafaxine. WL=waiting list.

EFFICACITE versus PLACEBO

La plupart des interventions ont une efficacité significative (↘ YBOCS) par rapport au placebo sauf venlafaxine

Liste d'attente: ↗ YBOCS

	Number of trials (n=54)*	Number of patients (n=6652)*	Mean YBOCS difference	
			Full network (n=54)	Excluding waiting list controlled trials (n=48)
Drug placebo	23	1515	Reference	Reference
Waiting list	6	97	5·62 (0·91 to 10·26)	NA
Psychological placebo†	6	196	−4·15 (−8·65 to 0·49)	−1·90 (−5·62 to 1·91)
SSRIs (class effect)	37	3158	−3·49 (−5·12 to −1·81)	−3·62 (−4·89 to −2·34)
Fluoxetine	6	633	−3·46 (−5·27 to −1·58)	−3·67 (−5·13 to −2·26)
Fluvoxamine	13	521	−3·60 (−5·29 to −1·95)	−3·66 (−4·96 to −2·37)
Paroxetine	8	902	−3·42 (−5·10 to −1·61)	−3·51 (−4·81 to −2·14)
Sertraline	7	565	−3·50 (−5·30 to −1·63)	−3·68 (−5·14 to −2·30)
Citalopram	2	311	−3·49 (−5·62 to −1·31)	−3·60 (−5·25 to −1·91)
Escitalopram	1	226	−3·48 (−5·61 to −1·23)	−3·59 (−5·25 to −1·86)
Venlafaxine	2	98	−3·22 (−8·26 to 1·88)	−3·21 (−7·01 to 0·69)
Clomipramine	13	831	−4·72 (−6·85 to −2·60)	−4·66 (−6·26 to −3·05)
BT†	11	287	−14·48 (−18·61 to −10·23)	−10·41 (−14·04 to −6·77)
CBT†	9	231	−5·37 (−9·10 to −1·63)	−7·98 (−11·02 to −4·93)
Cognitive therapy†	6	172	−13·36 (−18·40 to −8·21)	−9·45 (−13·76 to −5·19)
Hypericum	1	30	−0·15 (−7·46 to 7·12)	−0·13 (−5·93 to 5·68)
CBT and fluvoxamine	1	6	−7·50 (−13·89 to −1·17)	−8·81 (−13·75 to −3·88)
BT and clomipramine	1	31	−12·97 (−19·18 to −6·74)	−11·68 (−16·73 to −6·65)

Data in parentheses are 95% credible intervals. YBOCS=Yale-Brown Obsessive Compulsive Scale. BT=behavioural therapy. CBT=cognitive behavioural therapy. NA=not applicable. *Individual trials could be included in more than one treatment category. †Several patients randomly allocated into these psychotherapeutic interventions were allowed to take stable doses of antidepressants and remain on the same dose without further adjustments.

Table 2: **Treatment efficacy compared with drug placebo**

EFFICACITE versus ISRS

Pas de différence pour la Clomipramine

Thérapie cognitive et thérapie comportementale > ISRS

Même résultats si comparaison à la Clomipramine

	Mean YBOCS difference in full network (n=54)	Mean YBOCS difference excluding waiting list controlled trials (n=48)
SSRIs (class effect)	Reference	Reference
Clomipramine	−1·23 (−3·41 to 0·94)	−1·05 (−2·73 to 0·63)
BT*	−10·99 (−15·14 to −6·75)	−6·79 (−10·44 to −3·11)
CBT*	−1·88 (−5·52 to 1·76)	−4·36 (−7·34 to −1·40)
Cognitive therapy*	−9·87 (−14·91 to −4·74)	−5·83 (−10·17 to −1·51)
CBT and fluvoxamine	−4·03 (−10·36 to 2·21)	−5·19 (−10·09 to −0·33)
BT and clomipramine	−9·48 (−15·78 to −3·14)	−8·01 (−13·18 to −2·95)

Data in parentheses are 95% credible intervals. YBOCS=Yale-Brown Obsessive Compulsive Scale. BT=behavioural therapy. CBT=cognitive behavioural therapy. *Several patients randomly allocated into these psychotherapeutic interventions were allowed to take stable doses of antidepressants and remain on the same dose without further adjustments.

Table 3: **Efficacy of psychological and pharmacological interventions compared with SSRIs**

Discussion

- **Les traitements sont efficaces / placebo**
- **Pas de différence entre les ISRS**
- **TCC ≠ Thérapie cognitive ou thérapie comportementale?**
- **Thérapies > médications**

Journal of Psychiatric Research 148 (2022) 95–102

Contents lists available at ScienceDirect

Journal of Psychiatric Research

journal homepage: www.elsevier.com/locate/jpsychires

Comparing the efficacy of pharmacological and psychological treatment, alone and in combination, in children and adolescents with obsessive-compulsive disorder: A network meta-analysis

Yuanmei Tao [a], Hancong Li [b], Lu Li [c], Hang Zhang [a], Hanmei Xu [a], Hong Zhang [a], Shoukang Zou [a], Fang Deng [a], Lijuan Huang [a], Yanping Wang [a], Xiaolan Wang [a], Xiaowei Tang [a], Xia Fu [a], Li Yin [a,d,e,*]

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[e] *Sichuan Clinical Medical Research Center for Mental Disorders, Chengdu, Sichuan, 610041, China*

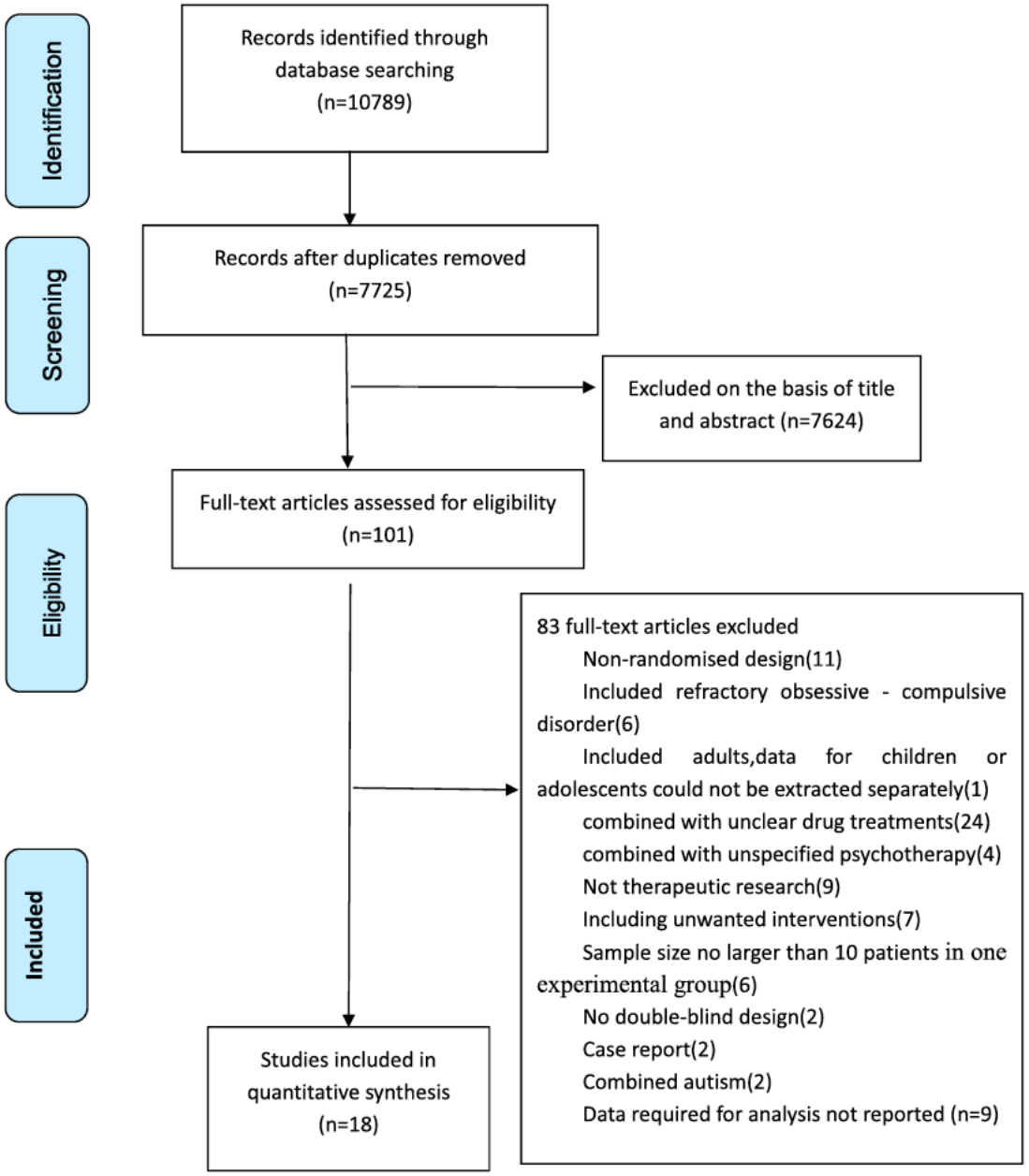


Fig. 1. PRISMA flow diagram of study selection and inclusion.

18 études → **1 353** patients inclus
12 méthodes de traitement
Âge moyen de 13 ans
45% de femmes
Durée des traitements: entre 8 à 12 semaines

RESEAU de COMPARAISON et analyse

Tous les traitements pharmacologiques et psychothérapeutiques sont plus efficaces que le placebo
TCC+ATD > ATD
TCC > ATD
ESC > CLO/FLV/PAR/SER mais de différence avec FLO

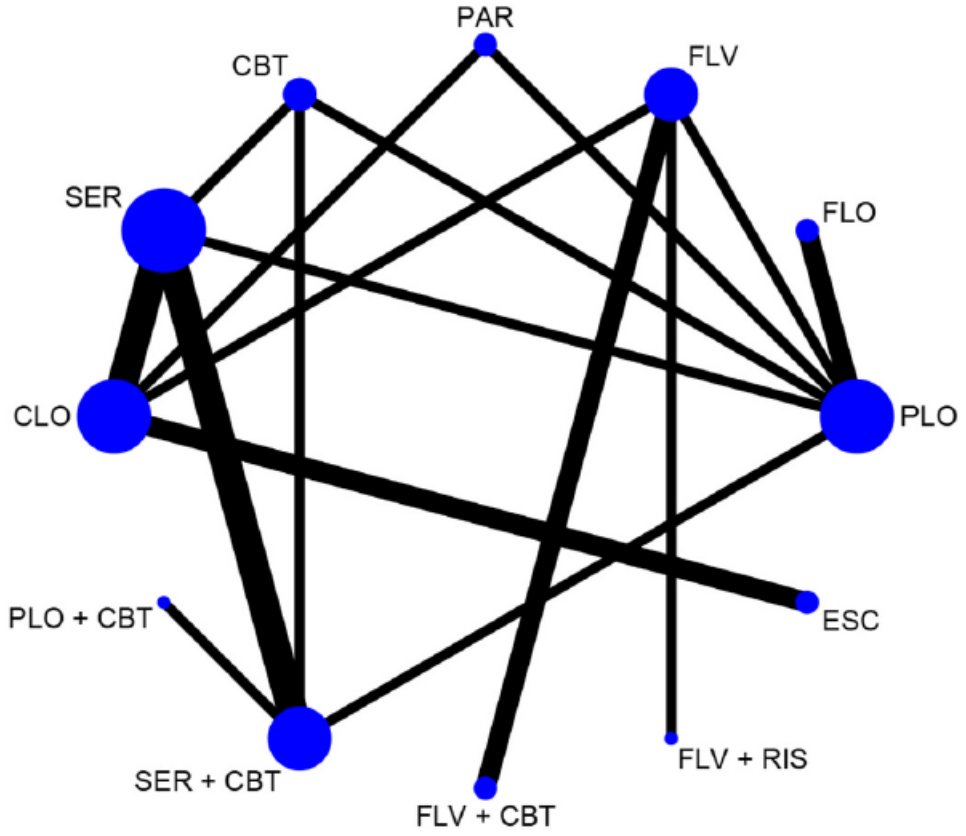


Fig. 2. Network plot of 12 treatments in 18 included clinical trials. Abbreviations: CBT = cognitive behavioral therapy, CLO = clomipramine, ESC = escitalopram, FLO = fluoxetine, FLV = fluvoxamine, FLV + CBT = fluvoxamine and cognitive behavioral therapy, FLV + RIS = fluvoxamine and risperidone, SER + CBT = sertraline and cognitive behavioral therapy, PLO + CBT = placebo and cognitive behavioral therapy, PAR = paroxetine, PLO = placebo, SER = sertraline.

Discussion

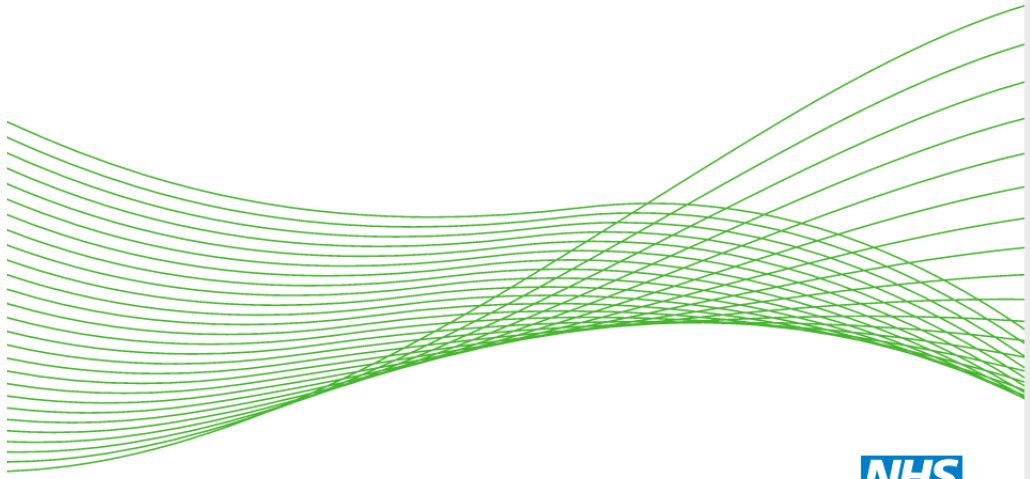
- **Tous les traitements sont efficaces**
- **TCC+ ATD > ATD**
- **TCC > ATD**
- **Recommandation de TCC comme le meilleur choix pour cas légers à modérés**

HEALTH TECHNOLOGY ASSESSMENT

VOLUME 20 ISSUE 43 JUNE 2016
ISSN 1366-5278

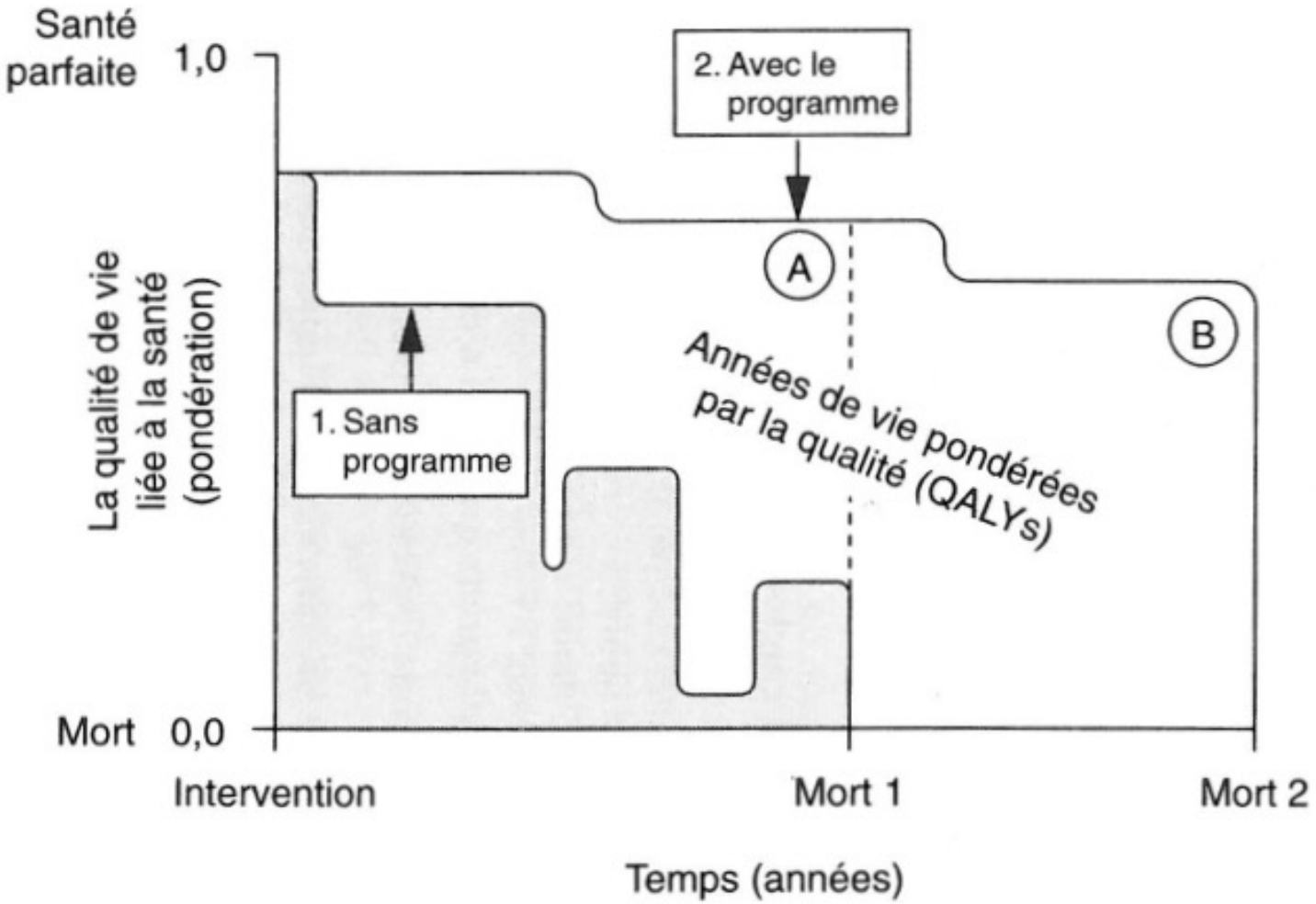
A systematic review of the clinical effectiveness and cost-effectiveness of pharmacological and psychological interventions for the management of obsessive–compulsive disorder in children/adolescents and adults

Petros Skapinakis, Deborah Caldwell, William Hollingworth, Peter Bryden, Naomi Fineberg, Paul Salkovskis, Nicky Welton, Helen Baxter, David Kessler, Rachel Churchill and Glyn Lewis



DOI 10.3310/hta20430

NHS
National Institute for Health Research

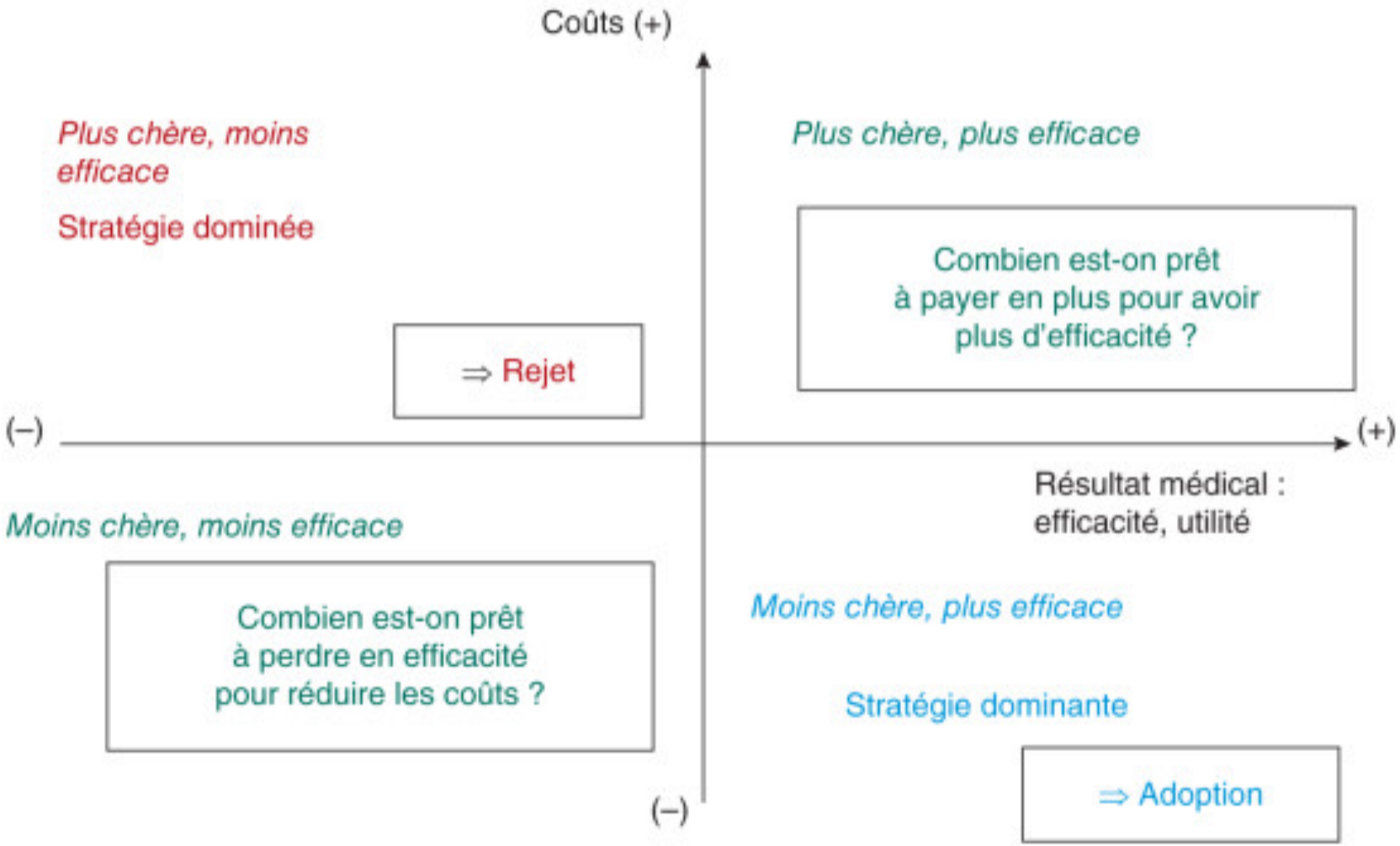


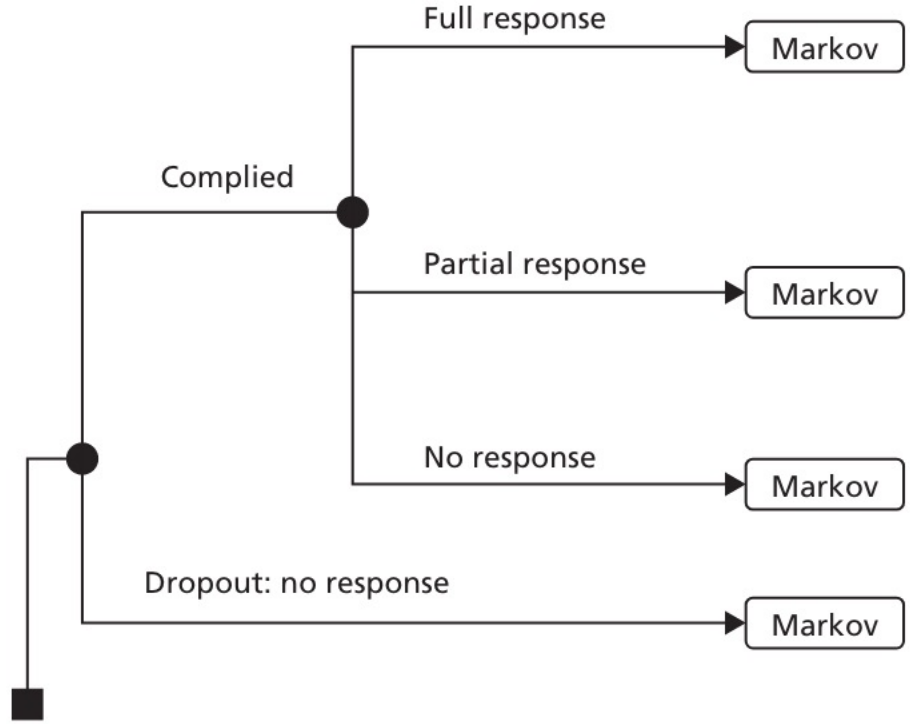
HAS 2020: analyse de type cout-utilité car la qualité de vie est liée à l'état de santé de ces patients,

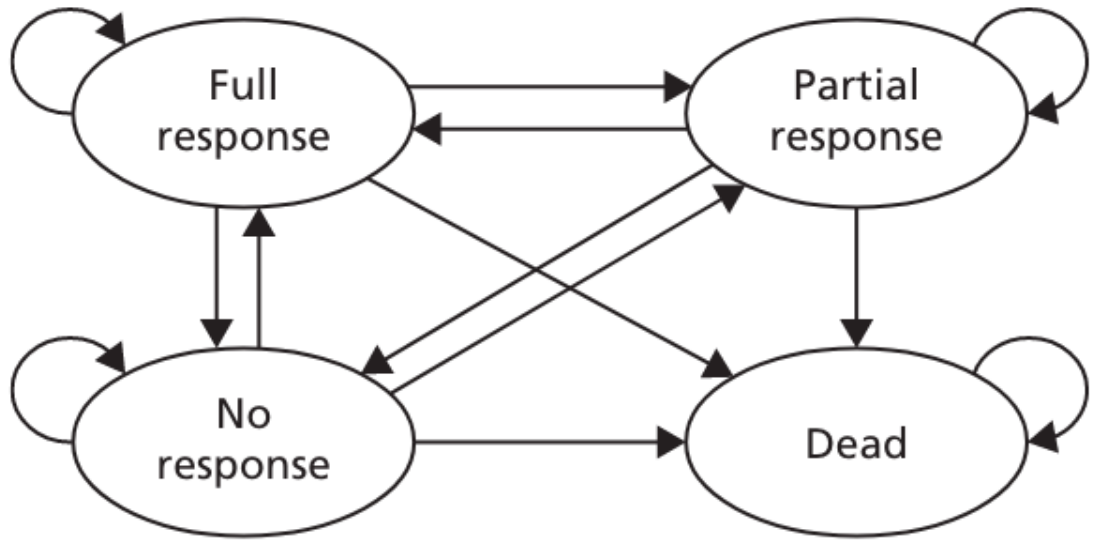
Le critère de résultat sera la durée de vie pondérée par des scores de préférences (QALY).

Les scores de préférences seront dérivés de l'EQ-5D-5L validé en France.

Comparaison par rapport à la référence




Full response
Markov
Complied
Partial response
Markov
No response
Markov
Dropout: no response
Markov


Full response
Partial response
No response
Dead

Thérapies les plus efficaces sont les plus chères
Thérapies cognitives et comportementales sont celles qui ont la probabilité la plus élevée d'être « coût-efficace » (£20,000 to £30,000 per QALY NICE)

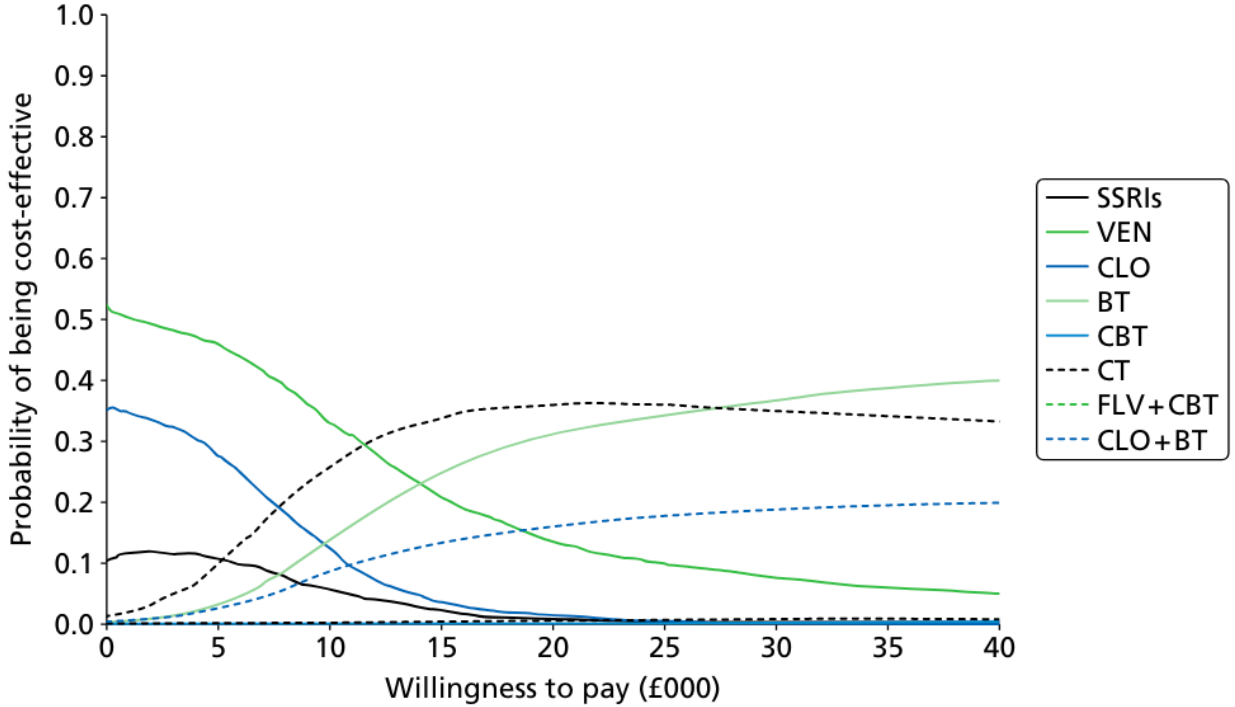


FIGURE 14 Cost-effectiveness acceptability curve: adults, primary analysis. CLO, clomipramine; FLV, fluvoxamine; VEN, venlafaxine.

TROUBLE OBSESSIONNEL COMPULSIF
CONCLUSION

- TCC > ATD
- TCC moins efficace que thérapie cognitive ou EPR?
- traitements combinés > ATD seuls
-TCC: traitement le plus « coût-efficace »

Une question complexe → les réponses?

- Selon les troubles: **TCC > ATD notamment à long terme**
- Selon les traitements pharmacologiques:
  - **Résultats assez identiques sauf venlafaxine dans le TOC et risque suicidaire**
  - **La Clomipramine ne ressort pas comme supérieur aux ISRS dans les dernières études sur le TOC**
- Et surtout selon le patient
  - Son âge: **dans la dépression enfant/ado Traitement combiné > traitement seul dans la dépression**
  - Son lieu de soin: **peu de données mais identique en intra et extra hospitalier**
  - Son lieu de vie: **pas de données**
  - Son choix: **pas de données**

Une question complexe → les réponses?

- limites:
  - **dans la majorité des études, dans les groupes thérapies les patients ont un traitement pharmacologique stable quid si arrêt?**
  - **Délai d'accès aux soins non relevé dans toutes les études**
  - **Traitement pharmacologique: dose, adaptation?**
  - **comorbidités**
- Comment répondre à cela:
  - **Données en « vie quotidienne »**
  - **Études de cas unique**

Je vous remercie pour votre attention

Et maintenant la table ronde