

Neurofeedback en psychiatrie : une technique du présent ? [Neurofeedback: one of today's techniques in psychiatry?]

Martijn Arns, Jean-Marie Batail, Stéphanie Bioulac, Marco Congedo, Christophe Daudet, Dominique Drapier, Thomas Fovet, Renaud Jardri, Le Van Quyen, Fabien Lotte, et al.

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1 Neurofeedback: one of today's techniques in psychiatry?

2 Neurofeedback en psychiatrie: Une technique du présent ?

3
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1 **Résumé**

2 **Introduction**

3 Le neurofeedback consiste à mesurer, chez un sujet, une activité cérébrale et à traiter le signal
4 au moyen d'une interface technique afin d'en extraire un paramètre d'intérêt qui sera présenté
5 en temps réel au participant sous la forme d'une information visuelle ou auditive. L'objectif
6 est d'apprendre au sujet à modifier ce paramètre et donc à moduler son activité cérébrale et
7 cognitive. Cependant, l'utilisation du neurofeedback en pratique clinique pour la prise en
8 charge des troubles psychiatriques reste controversée.

9 **Méthode**

10 Cet article présente une synthèse de la 1^{ère} journée nationale sur le neurofeedback organisé par
11 la section NExT (*Neurofeedback Evaluation & Training*) de l'Association française de
12 psychiatrie biologique et de neuropharmacologie (AFPBN). Un état des lieux de l'utilisation
13 du neurofeedback en électroencéphalographie (EEG) et en imagerie par résonance
14 magnétique fonctionnelle (IRMf) est proposé. Pour intégrer l'arsenal thérapeutique, cette
15 technique doit en effet répondre aux exigences de *l'evidence based medicine*.

16 **Résultats**

17 Les études montrent une efficacité probable du neurofeedback en EEG pour le trouble du
18 déficit de l'attention / hyperactivité (TDAH) chez les enfants. Pour les autres troubles
19 psychiatriques, le nombre d'études est encore trop limité pour se positionner. En ce qui
20 concerne le neurofeedback en IRMf, le niveau de preuve reste, pour l'heure, trop faible pour
21 justifier une utilisation clinique. Les modalités d'emploi du neurofeedback, notamment en ce
22 qui concerne les indications médicales, les protocoles d'utilisation (activité(s) cérébrale(s)
23 ciblée(s), caractéristiques d'apprentissage) et les outils de mesure employés (EEG, IRMf,
24 mode de traitement du signal) restent donc à clarifier.

25 **Conclusion**

26 Le vaste champ de recherche du neurofeedback implique à la fois des psychiatres, des
27 neurophysiologistes et des chercheurs du domaine des interfaces cerveaux-ordinateurs. Les
28 futurs travaux devront s'attacher à déterminer les critères permettant d'optimiser les séances
29 de neurofeedback afin de mieux comprendre ses effets, le tout dans l'optique d'une utilisation
30 en pratique clinique dans certaines indications. L'étude des processus d'apprentissage
31 constitue un élément clé autour duquel les futures recherches devront se focaliser.

32 **Mots clefs**

33 Neurofeedback ; Électroencéphalographie ; imagerie fonctionnelle par résonance magnétique
34 en temps réel ; Troubles psychiatriques

1 **Abstract**

2 **Objectives**

3 Neurofeedback is a technique that aims to teach a subject to regulate a brain parameter
4 measured by a technical interface to modulate his/her related brain and cognitive activities.
5 However, the use of neurofeedback as a therapeutic tool for psychiatric disorders remains
6 controversial. The aim of this review is to summarize and to comment the level of evidence of
7 electroencephalogram (EEG) neurofeedback and real-time functional magnetic resonance
8 imaging (fMRI) neurofeedback for therapeutic application in psychiatry.

9 **Method**

10 Literature on neurofeedback and mental disorders but also on Brain Computer Interfaces
11 (BCI) used in the field of neurocognitive science has been considered by the group of expert
12 of the NExT (Neurofeedback Evaluation & Training) section of the French Association of
13 Biological Psychiatry and Neuropsychopharmacology (AFPBN).

14 **Results**

15 Results show a potential efficacy of EEG-neurofeedback in the treatment of attentional-
16 deficit/hyperactivity disorder (ADHD) in children, even if this is still debated. For other
17 mental disorders, there is too limited research to warrant the use of EEG-neurofeedback in
18 clinical practice. Regarding fMRI-neurofeedback, the level of evidence remains too weak, for
19 now, to justify clinical use. The literature review highlights various unclear points, such as
20 indications (psychiatric disorders, pathophysiologic rationale), protocols (brain signals
21 targeted, learning characteristics), and techniques (EEG, fMRI, signal processing).

22 **Conclusion**

23 The field of neurofeedback involves psychiatrists, neurophysiologists and researchers in the
24 field of brain-computer-interfaces. Future studies should determine the criteria for optimizing
25 neurofeedback sessions. A better understanding of the learning processes underpinning
26 neurofeedback could be a key element to develop the use of this technique in clinical practice.

27

28 **Keywords**

29 Neurofeedback; EEG; real-time fMRI; psychiatric disorder

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1 **1 Introduction**

2 Neurofeedback can be considered as a biofeedback technique (*i.e.* a technique which consists
3 in measuring a physiological activity using a technical interface to extract a parameter of
4 interest; this parameter is then presented in real-time to the participant, typically *via* visual or
5 auditory feedback [1]; the goal is to teach the subject to modify the parameter). When the
6 physiological activity is a brain activity, biofeedback is called neurofeedback. Thus,
7 neurofeedback allows the subject to voluntarily modulate his/her related brain and cognitive
8 activities [1, 2](see **Figure 1**).

9 The first observation of neurofeedback, was based on the classical conditioning principles
10 applied to the electroencephalogram (EEG). Classical conditioning involves learning new
11 behaviors through the process of association. Neurofeedback originates from the 1930s based
12 on the work of Gustave Durup and Alfred Fessard, who were two emblematic figures of
13 psychophysiology and neurophysiology in France. They observed that brain activity (alpha
14 blocking response) could be modified according to the classical conditioning principles (*i.e.*
15 to develop an association between an EEG activity (alpha blocking response), a behavior and
16 cognitive response, and a signal of feedback [3]. In 1941, Jasper & Shagass published the first
17 systematic study that investigated classical conditioning of EEG [4]. Subsequent studies in the
18 1960s confirmed that alpha blocking could indeed be conditioned and related to some specific
19 cognitive activities of the trained subject [5].

20 After a serious decline during the 1980s and 1990s, mainly due to the poor reliability of
21 methods used for recording brain activity, the technique gained ground again in the early
22 2000s with a renewed interest both in scientific and societal terms [6]. Thanks to the principle
23 on which it is based and to the fertile dynamic nature of ongoing research in a range of
24 clinical, therapeutic and fundamental topics, neurofeedback can be considered a technology of
25 today [6, 7]. However, despite great interest in neurofeedback research [8-10], significant
26 controversy exists, particularly in psychiatry and neurology [7, 11]. With regard to the
27 efficacy of neurofeedback in brain disorders, opinions within the scientific community appear
28 to be rather sharply divided [7, 9, 12] comprising an optimistic group who consider
29 neurofeedback to be effective and a skeptical group who do neither assign scientific or
30 therapeutic value to neurofeedback training. This article aims to review the evidence of EEG
31 neurofeedback (EEG NF) and real-time functional magnetic resonance imaging
32 neurofeedback (fMRI NF) in psychiatric disorders. The advantages and pitfalls for each of
33 both neurofeedback techniques are discussed, and new perspectives are highlighted. Lastly,

1 research on the learning process through the link between neurofeedback and brain computer
2 interfaces (BCIs) is discussed.

3 **2 Electroencephalographic neurofeedback (EEG-NF)**

4 **2.1 Level of Evidence**

5 Most trials on the efficacy of EEG neurofeedback in psychiatric disorders have significant
6 methodological weaknesses (in particular: size of the population studied, none randomized or
7 none blinded protocol, inadequate control group, low quality of the EEG neurofeedback
8 session) [13]. This point could explain the skepticism of many researchers and clinicians
9 concerning the effectiveness of EEG neurofeedback to treat psychiatric disorders [12].
10 However, a number of studies have presented good methodological criteria (studies designed
11 with controlled, randomized, and open or blind protocols, a primary endpoint related to the
12 treated disorder and assessed using standardized measurement tools, and an identifiable EEG
13 neurophysiological target) particularly in the field of attentional-deficit/hyperactivity disorder
14 (ADHD) [9, 12, 14].

15 **2.1.1 Attentional-Deficit/Hyperactivity Disorder, the emblematic disorder**

16 Four meta-analyses discussed the therapeutic interest of EEG neurofeedback in ADHD [15-
17 18]. Computed effect size (ES) in the meta-analyses can be considered as small between 0.2
18 and 0.5, medium between 0.5 and 0.8 and large above 0.8. The first meta-analysis conducted
19 by Arns et al. (2009) found an effect size (ES) that was more larger for the domain of
20 inattention (ES=0.81, 95% CI=0.39-1.23) than for the domain of hyperactivity (ES=0.39,
21 95% CI=0.05-0.75) in ADHD [16]. The second meta-analysis of Sonuga-Barke et al. (2013)
22 found a significant ES using parent ratings in randomized controlled trials (RCTs) (ES=0.59,
23 95% CI=0.31-0.87), but this result was no longer significant (ES=0.29, 95% CI=-0.02-0.61,
24 though trend, p=0.07) when looking at “probably blinded” teacher ratings [17]. The third
25 meta-analysis of Micoulaud-Franchi et al. (2014) found an ES that was significantly higher
26 than in the control group on “probably blinded” teacher ratings for the inattention dimension
27 of ADHD in RCTs (ES=0.30, 95% CI=0.03-0.58) [18]. The fourth meta-analysis of Cortese et
28 al (2016) is the updated Sonuga-Barke et al. meta-analysis and reported similar results
29 (ADHD total symptoms, ES=0.35, 95% CI=0.11-0.59; inattention, ES= 0.36, 95% CI= 0.09-
30 0.63; hyperactivity/impulsivity, ES=0.26, 95% CI=0.08-0.43 for parent ratings, but non
31 significant ES for “probably blinded” teacher ratings) [15]. However, a sub-analysis in this
32 meta-analysis focused on standard neurofeedback protocols (based on the Arns et al. criteria

1 [12]), and for this sub-analysis a significant ES for probably blinded ratings was found
2 (ADHD total symptoms ES=0.35, 95% CI=0.04-0.69) [12]. RCTs that have compared EEG
3 neurofeedback with medication found that methylphenidate was not superior to EEG
4 neurofeedback training [19, 20]. In the study of Meisel et al. (2013), significant pre-post
5 academic performance improvements were obtained only in the neurofeedback group [19].
6 However, studies that added EEG neurofeedback to methylphenidate treatment did not report
7 ‘add-on’ improvements on clinical symptoms [21, 22] or cognitive function [23].

8 **2.1.2 Other psychiatric disorders**

9 There has been too limited research (i.e. lack of RCTs and independent replications) on the
10 following indications to warrant its use in clinical practice: Depression [24], Addictions [25,
11 26], Anxiety disorders [27, 28].

12 **2.2 Advantages and pitfalls of EEG neurofeedback**

13 Despite the meta-analyses presented before, the effectiveness of EEG neurofeedback in
14 treating ADHD remains debated because of the studies that were included [12, 29-34]. These
15 choices warrant some explanations. For example, in the meta-analysis of Micoulaud-Franchi
16 et al. (2014), the well-controlled, randomized and blinded study conducted by Arnold et al.
17 (2013) [35] was not included because the EEG neurofeedback protocol was not based on the
18 basic learning theory used in standard EEG neurofeedback protocols (particularly because of
19 the type of reinforcement chosen) [1]. Moreover, the EEG recording was carried out using an
20 unconventional setup, with electrodes placed on the forehead, a region known to be
21 problematic for recording because of muscular artefacts. The study by Arnold et al. thus
22 highlights the need to avoid some pitfalls regarding technical issues of electrophysiology [36]
23 and technical issues of learning [1, 37] when a study on neurofeedback is conducted. In
24 further support of this notion is the above reported result from the Cortese et al. (2016) meta-
25 analysis, who reported that when focusing on ‘standard neurofeedback protocols’ significant
26 effects are found for both parent as well as teacher rated symptoms. Further emphasizing the
27 need to evaluate neurofeedback not as a singular phenomenon (neurofeedback as an umbrella
28 term i.e. medication) but evaluate it based on the specific protocol used (specific protocol i.e.
29 antidepressant, psychostimulant) [15]. These aspects are too rarely discussed in the debate of
30 EEG neurofeedback efficacy. Considering the absence of a current consensus [12, 38-40],
31 these points will be crucial in the next years to gradually improve the practice of EEG
32 neurofeedback in psychiatry [41].

1 Two groups of technical issues can be identified in EEG neurofeedback protocols: i)
2 electrophysiology because the practice of EEG neurofeedback requires high quality
3 recordings of EEG signal [9, 36]; ii) learning because the practice of EEG neurofeedback
4 requires attention to some important technical aspects as described below and in **Table 1**.
5 The number of sessions is the first technical aspect, which is usually between 20 and 30, one
6 to three times per week, but the ideal number and the optimum inter-session duration have not
7 been defined yet [42]. It should be noted that efficacy with regards to the inattention
8 dimension in ADHD is proportional to the number of neurofeedback sessions [16] and
9 seemed to be maintained over time [43].
10 Second is the choice of the threshold of reward, which is essential. Adjusting a threshold (and
11 a given occupation time) determines the number of positive reinforcements required to
12 strengthen the subject in a type of neurocognitive strategy. The threshold may be set
13 automatically or manually. When the threshold is determined automatically there is a
14 continuous updating of a threshold in order to give positive reinforcement to the subject for a
15 given percentage of occupation time below or above the threshold. The threshold is
16 continuously calculated according to signal just before. When the threshold is determined
17 manually, the professional determines the threshold based on a baseline recorded before the
18 neurofeedback session. If the number of positive reinforcement is too high or too low during
19 the session, the professional can adjust the threshold. The manual threshold seems to lead to
20 better learning [1, 42]. Indeed, if the subject is being asked to increase the amplitude of a
21 given brain activity and the threshold is calculated automatically, he will always be getting a
22 percentage of feedback even if the amplitudes are decreased across time. However, the
23 manual threshold requires performing a baseline measurement before each session and the
24 adjustment during the session by the professional complicates the standardization of
25 neurofeedback protocol.
26 Third is the type of positive reinforcement. This can be visual or auditory, proportioned
27 (graduated) or binary (present or absent), immediate or delayed, simple or complex, and
28 frequent or rare. Visual feedback, which is proportionate, immediate and simple, seems to
29 allow for better learning [42]. The number of reinforcements must be sufficient to maintain
30 the motivation of the subject. However, if the number of reinforcement is too high the
31 learning process can be altered [39, 42]. Note that positive reinforcement incorporated in an
32 entertaining interface (such as video games) may increase the motivation of the subject but
33 could impair learning according to some authors [1, 14].

1 Fourth is the evaluation of the training parameter during one session (evolution of the
2 performance), and the evaluation of the learning curve across the sessions (evolution of the
3 training parameter) that should be determined to ensure that a learning process occurs during
4 neurofeedback treatment. Lastly, the “transfer sessions” allow for the generalization of skills
5 learned in daily life [12, 14, 40].

6 **2.3 EEG neurofeedback and the vigilance system**

7 Neurophysiological targets for EEG neurofeedback in ADHD are underpinned by
8 pathophysiological relevance related to the vigilance system. EEG neurofeedback
9 traditionally records a limited amount of information provided by a single electrode placed on
10 the scalp. This information concerns the EEG power in certain spectral bands: the beta band
11 (12-21 Hz) and the theta band (4-8 Hz) [44, 45]. In a simple manner, an increase in the central
12 frontal beta band can be related to an increase in vigilance [46], and an increase in central
13 frontal theta band is related to a decrease in vigilance with subjective diurnal sleepiness and
14 possibly entering the first stage of sleep [45, 47]. Interestingly, an increase in theta power and
15 a decrease in beta power were observed in a subgroup of ADHD patients (greater theta/beta
16 (TBR) ratio) [48]. These EEG patterns suggest a link between the vigilance system, sleep
17 problems and ADHD (particularly in the subgroup with the greater TBR ratio) [49]. As a
18 result, decreasing TBR can be a potentially interesting target for EEG neurofeedback [50-52].
19 Indeed, it was shown that TBR neurofeedback is more effective in the subgroup of patients
20 with the greater TBR ratio [53].

21 Several studies have also demonstrated that sensori-motor rhythm neurofeedback (SMR), a
22 frequency that overlaps with to the TBR protocol, results in increased sleep spindle density
23 during sleep [54, 55], decreased sleep latency [54] and increased total sleep time [54, 56].
24 More specifically, it was recently demonstrated that SMR neurofeedback in ADHD resulted
25 in reduced inattention, hyperactivity and impulsivity, and these effects were mediated by
26 reduced sleep onset latency [50], further demonstrating a causal link between delayed sleep
27 onset latency and ADHD symptoms, specifically inattention. The TBR neurofeedback
28 overlaps with the SMR protocol, with clinical effects on ADHD indistinguishable from SMR
29 neurofeedback. However, the effect of TBR neurofeedback was not be mediated via sleep
30 onset latency normalization [50]. The effect of TBR neurofeedback could be mediated via a
31 reduction in diurnal sleepiness [49], but further research is needed to investigate the exact
32 working mechanism of TBR neurofeedback in ADHD [14].

1 **2.4 *EEG neurofeedback and new target methods***

2 The major limitation of “traditional” neurofeedback resides in the limited information
3 provided by a single electrode placed on the scalp, which is a differentially measured
4 potential with respect to a reference electrode. It is known that the EEG signal reflects mainly
5 the superposition of the electric potential created by ionic charge oscillation (due to
6 postsynaptic potentials) around the pyramidal cells found in the neocortex [57]. The potential
7 generated from a large population of neurons beneath the electrode are superimposed to create
8 the measurable EEG. Put differently, the response of the electrode is highly spatially
9 unspecific. It has been suggested that this lack of spatial specificity may impede the ability of
10 subjects to acquire control over the region of interest (ROI), i.e., the brain structures to be
11 trained [58]. Another limitation of traditional neurofeedback is the filtering resulting from the
12 choice of the reference electrode placement; depending on the position of the active and
13 reference electrode on the scalp, the measurement is sensitive to current flowing in the ROI
14 along one direction only. Therefore, a considerable improvement in the neurofeedback
15 technique can be obtained considering spatial-specific brain activity, solving implicitly the
16 issue of the chosen reference. Two possible improvements in this sense have been proposed,
17 namely, basing the neurofeedback not on the signal captured by the two scalp electrodes but
18 on EEG inverse solutions or on EEG blind source separation. Both methods require the use of
19 multiple electrodes (a minimum of eight); it is indeed the spatial information contained in
20 such a multivariate EEG recording that allow for better estimates of the ROI’s current.

21 **2.4.1 EEG neurofeedback based on inverse solutions**

22 An EEG inverse solution is a mathematical method used to estimate the intracranial current
23 generated in the observed scalp potential. Once the current is estimated in the ROI, its density
24 (energy) provides an appropriate feedback signal. By acquiring data from 19 electrodes,
25 Congedo, Lubar and Joffe (2004) demonstrated learned control of the cognitive division of
26 the anterior cingulate cortex using the inverse solution known as *low resolution*
27 *electromagnetic tomography* (LORETA) [59, 60]. Subsequent studies confirmed the viability
28 and further explored the correlates of LORETA-neurofeedback of the anterior cingulate
29 cortex [61, 62]. This preliminary work was replicated and reiterated later by several other
30 research groups using other inverse solutions in proof-of-concept studies [63, 64].

1 **2.4.2 EEG neurofeedback based on BSS/ICA**

2 Over the past 20 years, research on blind source separation (BSS) has developed into a
3 burgeoning signal processing method with applications across a wide variety of fields. It has
4 since been proven valuable in identifying cortical sources of brain activity associated with
5 cognitive task performance [65]. Such a spatial filtering technique may provide an ideal way
6 to train specific brain regions or networks in a neurofeedback setting. In fact, a blind source
7 separation filter can estimate both the location and the direction of current, thus yielding a
8 sharper filter compared to an inverse solution [66]. Further advantages of such spatial filters
9 are that they are computationally inexpensive (important for ‘real-time’ feedback) and
10 potentially more robust in the presence of artefacts. The viability of BSS neurofeedback has
11 been explored in two studies; the first aimed to suppress excessive theta in deep frontal
12 medial regions for the treatment of obsessive-compulsive disorder [67], the second aimed to
13 enhance theta activity on a source localized into deep medial-temporal regions associated
14 with spatial-navigation abilities [68].

15 **2.4.3 EEG neurofeedback based on stereotactic EEG**

16 As early as the 1960s, the important work by Fetz (1969) on primates showed the operant
17 conditioning of single cell spike trains in the motor cortex [69]. The motor cortex is probably
18 the most obvious place to search for cortical signals directly associated with volitional
19 movement [70]. This may be one of the reasons why a substantial part of invasive
20 neurofeedback research has been conducted on paralyzed or lock-in patients, recognizing the
21 need of people with disabilities and aiming to restore their communicative or motor functions.
22 In this context, brain-computer interfaces (BCIs) were tested in amyotrophic lateral sclerosis,
23 brain stem stroke and spinal cord lesions using cortical neuronal activity recorded by
24 implanted electrodes [71]. Nevertheless, conscious control has also been shown to be possible
25 at the cellular level in human temporal lobe structures [72]. The successful cases in these
26 applications encouraged the usage of invasive neurofeedback for other neurological and
27 neuropsychiatric conditions. Such a technique has been called BrainTV [73]. The technique
28 enables to combine the spatial resolution of fMRI neurofeedback and the temporal resolution
29 of scalp-level EEG neurofeedback [74]. Thus, despite the invasive nature of BrainTV, these
30 protocols could be a response to some limitations of neurofeedback protocols in the future.
31 In this context, neurofeedback can indeed be performed in patients with drug resistant
32 epilepsy undergoing long-term monitoring, where depth electrodes are implanted for clinical
33 diagnostics. The effects of self-induced intracortical oscillatory activity (4-8 Hz) were studied

1 in several neurosurgical patients. It was found that subjects learned to robustly and
2 specifically induce oscillations in the target frequency, confirmed by increased oscillatory
3 event density [75]. As controls improved during learning, induced oscillatory activity at the
4 target electrode became functionally decoupled from distant sites, which predicted the
5 individual session-to-session performance variability. Furthermore, in another study [75],
6 patients were trained to up-regulate the relative proportion of the gamma rhythm at different
7 fronto-temporal cortical locations. In line with previous findings, on monkeys using direct
8 cortical recordings [76], it was found that most subjects learned to specifically increase local
9 cortical gamma power. These findings suggest that the effects of voluntary control of
10 intracortical oscillations can be exploited to specifically target plasticity processes to
11 reconfigure network activity, with a particular relevance for memory function or skill
12 acquisition [77]. In particular, abnormalities in gamma oscillations exist in a number of
13 neurologic and psychiatric diseases [78]. Thus, the specific rectification of gamma
14 oscillations could ameliorate some of the deficits caused by these pathological conditions
15 [77].

16 **3 Functional magnetic resonance imagery and neurofeedback**

17 Real-time functional magnetic resonance imaging neurofeedback (fMRI neurofeedback) is a
18 rather recent development for providing neurofeedback training based on blood oxygenation
19 contrasts (blood-oxygen level dependent, BOLD) [79]. fMRI neurofeedback training can
20 overcome some limitations of more traditional forms of neurofeedback, such as EEG-
21 neurofeedback, because of its better spatial resolution and whole brain coverage. In particular,
22 the whole brain coverage makes fMRI neurofeedback a promising technique for non-invasive
23 psychiatric rehabilitation because it allows for training patients in self-regulating subcortical
24 brain areas [80]. Depending on the disease model of interest, patients can be either trained to
25 increase or decrease the activity of relevant brain areas [10].

26 **3.1 Level of Evidence**

27 Due to the novelty of the technique, the studies that have so far provided evidence for the
28 clinical use of fMRI neurofeedback are limited. This section will focus on recent
29 developments in the field and on clinical and translational applications. A more
30 comprehensive review on relevant designs and training paradigms can be found elsewhere
31 [10].

1 **3.1.1 Major Depressive Disorder, the emblematic disorder**

2 The psychiatric disorder most studied in the context of fMRI neurofeedback is major
3 depressive disorder. The use of fMRI neurofeedback in treating depression is based on the
4 pathophysiological model of emotional dysfunction during a depressive episode [81, 82].
5 Therefore, published studies have so far mainly focused on the up-regulation of brain areas or
6 even on specific structures that are involved in emotions, including parts of the limbic system
7 (e.g., the amygdala) and the ventral prefrontal cortex [83]. To date, no randomized control
8 trials (RCTs) have been published, and the current literature consists exclusively of open label
9 and pilot studies [84-86]. These studies have demonstrated the feasibility of the technique and
10 suggested that patients are able to self-regulate their brain activity in target areas. Further,
11 improvements in mood were only found in the group that received fMRI neurofeedback
12 training but not in a control group, suggesting a link between neurofeedback success, positive
13 emotions (as accessed by self-reports in autobiographic memory recall and happiness ratings)
14 and clinical improvement (e.g., HDRS-17). To rule out the unspecific effects (e.g., regression
15 to the mean) of these pilot findings, RCTs are needed that are based on larger samples and
16 appropriate clinical control conditions, including randomization and blinded assessments.
17 Two ongoing (Young, [clinicaltrials.gov: NCT02709161](https://clinicaltrials.gov/ct2/show/study/NCT02709161); Moll et al., NCT01920490), one
18 completed single blind (Linden et al., NCT01544205), and one completed double blind
19 (Young et al., NCT02079610) RCTs are currently listed.

20 **3.1.2 Other psychiatric disorders**

21 For other psychiatric conditions, such as schizophrenia, addiction, obsessive compulsive
22 disorder and eating disorder, the feasibility of fMRI neurofeedback training has been
23 investigated in pilot studies with small sample sizes (for review [10]). These studies used
24 different target areas such as the insula in schizophrenia (based on a facial emotion
25 recognition paradigm) and in psychopathic personality disorder (regulation of fear circuitry)
26 and the anterior cingulate cortex in controlling cravings in nicotine addiction. The
27 Collaborative Research Project BRAINTRAIN is a European consortium that focuses on the
28 improvement and translation of real-time fMRI neurofeedback protocols for clinical
29 applications (braintrainproject.eu). Current registered RCTs investigate therapeutic effects of
30 fMRI neurofeedback in alcohol addiction (Linden et al., NCT02486900), Anxiety in
31 adolescents (Cohen-Kadosh et al., NCT02440451) and autism spectrum disorder (Castelo-
32 Branco et al., NCT02440451). Finally, an independent RCT is focusing on training the

1 functional connectivity between reward- and impulse-related brain areas in eating disorders
2 (Hallschmid et al., NCT02148770).

3 **3.2 Advantages and pitfalls of fMRI neurofeedback**

4 The gold standard for evaluating a therapeutic technique requires assessing its efficacy in a
5 double-blind randomized and placebo-controlled trial. However, some of these requirements
6 can pose a challenge for the evaluation of fMRI neurofeedback training. First, implementing a
7 double-blind design can be limited because most current training protocols require (at least in
8 the early learning phase) that patients engage in specific conscious processes in the form of
9 explicit mental strategies.

10 Second, designing an appropriate placebo-controlled condition for neurofeedback protocols
11 requires careful consideration depending on the study type. Three main types of controls have
12 been proposed and tested so far:

- 13 • Transfer runs, during which patients are instructed to engage in the same cognitive
14 strategies in or outside the scanner but without being provided with neurofeedback.
- 15 • “Sham” neurofeedback, which entails either random or yoked feedback based on some
16 other patient’s brain activity. However, sham feedback bears the risk that patients
17 notice the non-contingency of the feedback [10].
- 18 • An active control group that receives veridical feedback from target areas of another
19 functional system that is neither involved in the pathophysiology of the respective
20 condition nor in the task (i.e., cognitive strategy) of interest. However, a recent study
21 has demonstrated that neurofeedback training itself involves various brain regions
22 besides the individual target areas, including structures of reward circuitry (basal
23 ganglia, striatum) and parts of the prefrontal cortex [87]. Further, such a control group
24 cannot control for potential unspecific effects due to the high-tech laboratory setting.
25 Including a third treatment as a usual control group that receives standard therapy
26 could address this problem at the expense of increased trial costs.

27 Third, it remains to be tested how to optimize neurofeedback protocols for psychiatric
28 conditions. This includes:

- 29 • Defining effective target areas or the networks for a particular psychiatric condition
30 based on a pathophysiological model. Target areas can either be chosen a priori based
31 on anatomical landmarks, or they can be functionally defined using a so-called
32 “localizer” task (e.g., presenting emotionally valenced visual stimuli in a
33 neurofeedback protocol for depression [86]). Similarly, target areas for functional

1 connectivity-based neurofeedback are determined by the correlation of activity among
2 brain areas that belong to a network of interest.

- 3 • Determining efficient study designs with regard to the duration and number of
4 sessions to exploit regarding the learning capacities of patients who have cognitive
5 impairments (e.g., attention and memory deficits).
- 6 • The nature of task instructions for patients, either given explicit strategies at hand
7 (e.g., imaging positive autobiographical memories) or task instructions that rather
8 focus on the goal to achieve a certain target level in the feedback while patients learn
9 implicitly the effect of various strategies [88].
- 10 • The design of the interface, such as the modality of feedback (e.g., visual, auditory or
11 tactile), the mode of feedback presentation (e.g., continuous or intermittent) and the
12 complexity of the presented feedback (e.g., for visual feedback, a thermometer display
13 or more complex scenes based on virtual reality)

14 **3.3 *fMRI neurofeedback and new target method***

15 As previously described, different strategies exist to optimally define the brain target, or the
16 region(s) of interest (ROI), in fMRI neurofeedback protocols [10]. This ROI can be localized
17 using structural information but can also be functionally defined. In the latter, the patient is
18 asked to perform a specific task in the scanner, and the highlighted areas can be used as the
19 ROI for the fMRI-neurofeedback in a second step (e.g., in [86]).

20 For fMRI neurofeedback with a therapeutic purpose, both of these methods rely on our a
21 priori knowledge of the underlying neural mechanisms of the disorder/symptom we want to
22 relieve. Such strategies appear very relevant for disorders with persistent (or tonic) symptoms,
23 i.e., symptoms that do not change much over time (e.g., depressive mood) but pose special
24 challenges for more acute symptoms, characterized by intrusiveness and phasic activity (e.g.,
25 hallucinations in schizophrenia or obsessions in obsessive compulsive disorder). For the latter
26 symptoms, which are associated with transitory brain-states, strategies using pre-defined
27 anatomical targets appear poorly appropriate. On the contrary, training patients to self-
28 regulate the activity of brain regions that re-activate during the occurrence of subjective
29 symptoms could be an interesting alternative.

30 To address this issue, a first method could be to induce symptoms while scanning to localize
31 functional activations associated with the targeted subjective experience that can then be used
32 as the ROI for fMRI neurofeedback. However, in some cases (such as hallucinations [89]),

1 symptom provocation may not be possible, and another method to detect the onset of
2 symptoms together with the associated brain activation patterns is needed.

3 Machine-learning, and particularly the recent development for fMRI analysis of linear support
4 vector machines (LSVMs), offers several advantages in this context. Such techniques classify
5 functional or anatomical patterns using a multivariate strategy and thus allow for decoding
6 and capturing the fine-grained spatial pattern of BOLD activity to predict future mental states,
7 such as perception or free choices [90]. In the same way, it is now possible to develop
8 classifiers able to quickly detect the emergence of subjective symptoms by detecting specific
9 patterns of brain activity identified during symptomatic periods [91, 92]. Such fine-grained
10 activity patterns can be used as the signal that is fed back to the patient during neurofeedback
11 protocols. However, to be eligible for this strategy, the patient's symptoms must exhibit some
12 specific features, such as frequent occurrence (i.e., the symptom must occur several times
13 during the fMRI session) [93].

14 Combining LSVM (or other advanced machine learning classifiers) and fMRI neurofeedback
15 could constitute a promising way to develop fMRI neurofeedback for the treatment of phasic
16 psychiatric symptoms. However, considering the potential cost necessary to implement fMRI
17 neurofeedback, proof-of-concept studies are urgently required.

18 **4 Human learning and neurofeedback**

19 The learning process is crucial in neurofeedback and requires models to understand the
20 mechanism of feedback learning [94]. A good practice guide is also of critical importance for
21 the evaluation of these interventions and to reach higher standards in clinical practice [9].
22 Learning during neurofeedback can be either explicit or implicit [94]. In the explicit learning
23 process, the user observes a feedback signal, which is a direct correlate of the neurosignal to
24 be regulated. In the implicit learning process, the signal is not explicitly presented to the
25 subject but instead changes some detail(s) of the experimental conditions. For example, a
26 person using a videogame whose content (e.g., changing levels of difficulty or access to
27 bonus items) evolves depending upon his frontal alpha rhythm is receiving implicit feedback;
28 he/she does not know directly that his brainwaves have changed, but he/she experiences
29 indirect effects of this physiological change.

30 **4.1 Theory of human learning**

31 From the perspective of the experimenter, operant conditioning has historically been the
32 dominant interpretation of neurofeedback mechanisms; in this case the feedback is modeled

1 as an implicit infra-cognitive reinforcement learning (RL) signal [1]. Such an approach is
2 indeed supported by animal studies: for example, prefrontal cortical neurons can be controlled
3 by rhesus monkeys through an operant conditioning paradigm [95]. The problem lies with the
4 definition of the reward: the interpretation of the biosignal depends upon the motivational
5 state of the subject. Furthermore, RL has two possible mechanisms [96]:

- 6 • either the subject is in a goal-directed setup and supports his learning from an internal
7 model, in which case learning is termed as model-based RL;
- 8 • or the subject has no model of the outside events and learning arises from simple
9 associations, termed as model-free RL.

10 The two issues associated with operant conditioning are therefore to determine the reward
11 mechanisms and the type of RL.

12 From the perspective of the subject, neurofeedback relies on two specific biofeedback skills
13 [97]:

- 14 • discrimination, which is the aptitude to achieve an inner perception of the biological
15 variable,
- 16 • and self-maintenance, which is the ability to affect the biological variable and to
17 effectively change it in the intended direction.

18 The acquisition of these skills could be either explicit or implicit, depending on the type of
19 neurofeedback.

20 During an implicit neurofeedback procedure, learning is more likely to follow a model-free
21 RL mechanism. The subject scans the different percepts available to him/her at a given time.
22 Several levels of salience filters attribute weights to both external and internal percepts based
23 on their physical, temporal, motivational, and emotional properties [98]. The resulting neural
24 representations then go through a competitive selection process to determine which
25 information enters working memory (WM). This filtering layer is referred to as bottom-up
26 attention and will, for example, allow a loud, unexpected sound to enter almost anyone's WM
27 (in addition to triggering subcortical responses).

28 During an explicit neurofeedback procedure, a model-based RL is triggered: the subject seeks
29 to reach a goal (regulating the feedback signal). Top-down signals may therefore alter the
30 bottom-up selection process by modifying the behavior of salience filters (e.g., emotional
31 regulation) or by enhancing or inhibiting a neural representation that has already entered WM
32 and has gained or lost salience through high-level processing (voluntary attention and percept
33 inhibition, respectively). The subjects will then manipulate their different neural
34 representations to determine if a correlation between the feedback and the neural

1 representation can be established with the feedback, which is a typical set-shifting task. Set-
2 shifting indeed refers to the ability to switch between different high-level neural
3 representations of a percept on the basis of a feedback [99]. Sustained attention is another top-
4 down component of attention and refers to the ability to maintain neural representations in
5 WM over time [100], which is necessary for long-lasting neurofeedback sessions.

6 The interaction between these top-down and bottom-up processes lead to the dual-process
7 theory for neurofeedback mechanisms [101] (**Figure 2**), a theory that categorizes the
8 cognitive functions supporting neurofeedback into two main types of processing:

- 9 • more automatic and capacity-free processes
- 10 • vs. more controlled and capacity-limited processes.

11 These two processes lead to opposing perspectives on proper feedback designs:

- 12 • one based on bottom-up operant conditioning strategies [102];
- 13 • and another based on a top-down cognitive paradigm where higher cognitive functions
14 percolate down from large-scale oscillations to small-scale and single-neuronal
15 activities [77].

16 Recent models of explicit neurofeedback learning are based on a top-down skill learning
17 paradigm [42]. Skill learning is a paradigm that describes the mechanisms involved in the
18 acquisition of complex perceptual, cognitive, or motor skills. One can identify two significant
19 properties of a motor action [103]:

- 20 • its performance, i.e., the quality of the subject's own movement (how to do the
21 action);
- 22 • and its result, i.e., the success or failure of the action (what shall be performed).

23 The subject can learn about these two properties either by himself or with external help.
24 When the subject has direct access to these two observables, it is termed “intrinsic feedback.”
25 When the information comes from an external source (for example, a sports coach or a
26 device), it is termed “external feedback.” Extrinsic feedback helps to accelerate and facilitate
27 the learning process [104], especially when it is not redundant with internal feedback. It has
28 informational functions and motivational properties with important influences on learning
29 [105]. Successful feedback learning is an adaptation of internal feedback in a way that
30 incorporates the external feedback [106]. Neurofeedback provides scaffolding for the subject,
31 helping him/her to acquire or improve task-related discrimination and self-maintenance skills.

32 A possible resolution of the apparent contradiction between top-down and bottom-up models
33 would be to postulate the existence of interactions between these two types of processing.
34 Model-free RL and model-based RL form two cooperative systems with model-free RL

1 driving online behavior and model-based RL working offline in the background to
2 continuously adjust model-free RL. Once the subject becomes proficient with the task, model-
3 free RL progressively dominates with time. As a consequence, early explicit neurofeedback
4 learning can become implicit with time, and there is a continuum between the two learning
5 mechanisms [1].

6 **4.2 Human learning and Brain Computer Interface**

7 A brain-computer interface (BCI) can be defined as a system that translates the brain activity
8 patterns of a user into messages or commands for an interactive application, this activity
9 being measured and processed by the system [107]. With a BCI, the user's brain activity is
10 usually measured via EEG and processed by the system. For instance, a BCI can enable a user
11 to move a cursor to the left or to the right of a computer screen by imagining left or right hand
12 movements, respectively. Because they make computer control possible without any physical
13 activity, EEG-based BCIs have revolutionized many applications areas, notably enabling
14 severely motor-impaired users to control assistive technologies, e.g., to control text input
15 systems or wheelchairs, as a rehabilitation device for stroke patients, or as new gaming input
16 device, for example [108-110].

17 Such BCI-based systems are used for communication and control applications in which the
18 user voluntarily sends mental commands to the application. These types of BCIs are known
19 either as active BCI (or explicit), when the user performs mental tasks (e.g., imagining
20 movement), or as reactive BCI, when the users have to attend to stimuli (e.g., flickering visual
21 images) [111, 112]. There is yet another category of BCI: passive BCI (or implicit), for which
22 the mental state of the user is passively estimated, without any voluntary mental command
23 from the user, to adapt the application in real-time to this mental state [111, 112].

24 BCIs, similarly to neurofeedback, thus rely on a closed loop that exploits brain activity in real
25 time, specifically by acquiring EEG signals, preprocessing them (filtering), extracting
26 relevant features describing the user's state or intent and translating them into feedback to
27 close the loop. Although both BCIs and neurofeedback share similar technological tools, their
28 original purposes were very different: BCIs enable users to control an external object, such as
29 a computer or an orthosis, whereas neurofeedback enables their users to acquire control of
30 themselves. Although some BCIs, e.g., BCIs based on mental imagery tasks, involve a
31 learning process, and thus require the user to perform self-regulation, self-regulation is not the
32 final objective [113]. As such, it can be said that neurofeedback is used to train users to learn
33 how to control a BCI.

1 It should be noted though that the boundaries between BCI and neurofeedback remain blurry
2 and are a subject of debate (see [114] for more detailed discussions). For instance, recently,
3 active BCI systems that can detect imagined movements of the hands have been used to
4 perform stroke rehabilitation by guiding users to self-regulate their brain activity in motor
5 brain areas damaged by stroke [115], similar to neurofeedback. Passive BCIs can also be used
6 to give feedback to a user regarding his own high-level mental states, such as mental stress or
7 attention, to implicitly help him/her to self-regulate those states [115], again, similar to
8 neurofeedback.

9 In these examples above, there are nonetheless differences between BCIs and neurofeedback.
10 Indeed, contrary to classical neurofeedback approaches, BCIs usually heavily rely on machine
11 learning tools to estimate some specific mental states [116]. BCIs typically use a set of
12 example of EEG data that are recorded while the target user is in the mental state to be
13 detected. Such data are used to calibrate a classifier to recognize this mental state using
14 machine learning. Most neurofeedback approaches do not use a data-driven approach or
15 machine learning to provide feedback to the user. Nevertheless, there is no fundamental
16 constraint preventing neurofeedback from using machine learning as BCIs do, and future
17 neurofeedback approaches could benefit from machine learning algorithms initially developed
18 for BCI to provide more specific and robust feedback.

19 Overall, BCIs (both active/explicit and passive/implicit) and neurofeedback are clearly related
20 approaches and technologies. Although they are primarily studied separately, they could both
21 benefit from one another, notably in terms of EEG signal processing, feedback design and
22 user training. In the future, it is not unlikely that BCI and neurofeedback share similar
23 research paths.

24 **5 Conclusion**

25 This review highlights the growing body of evidence for use of neurofeedback in the field of
26 psychiatry. Neurofeedback remains a very promising technique thanks to the progress of i)
27 the techniques used (such as multivariate EEG recording for a better ROI localization, or
28 coupled EEG-fMRI neurofeedback protocols), ii) signal processing (such as EEG-low
29 resolution electromagnetic tomography or linear support vector machines in fMRI for phasic
30 psychiatric disorders), and iii) understanding of the learning skills (both model-free and
31 model-based reinforcement learning).

32 Thus, neurofeedback is a today's technique that is largely inspired by the original works of
33 Durup and Fessard. However, it remains to be clarified whether the therapeutic effect of

1 neurofeedback is clinically meaningful and how to optimally perform neurofeedback in a
2 clinical setting. The respective place of neurofeedback techniques in the clinical
3 armamentarium has to be defined. The field of neurofeedback involves psychiatrists,
4 neurophysiologists and researchers in the field of brain-computer-interfaces. Future studies
5 should determine the criteria for optimizing neurofeedback sessions. A better understanding
6 of the learning processes underpinning neurofeedback could be a key element to develop the
7 use of this technique in clinical practice.

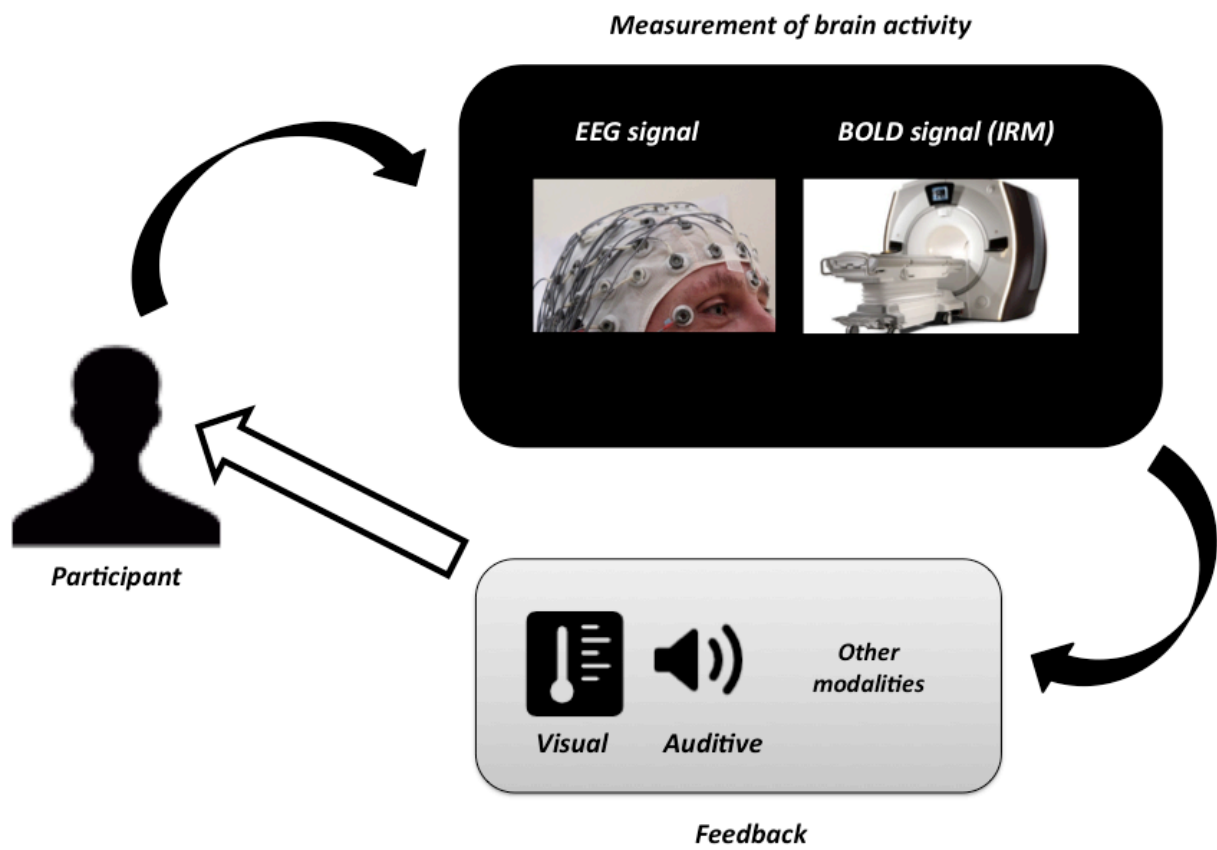
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- 1 **Figure 1**
- 2 Principle of neurofeedback
- 3

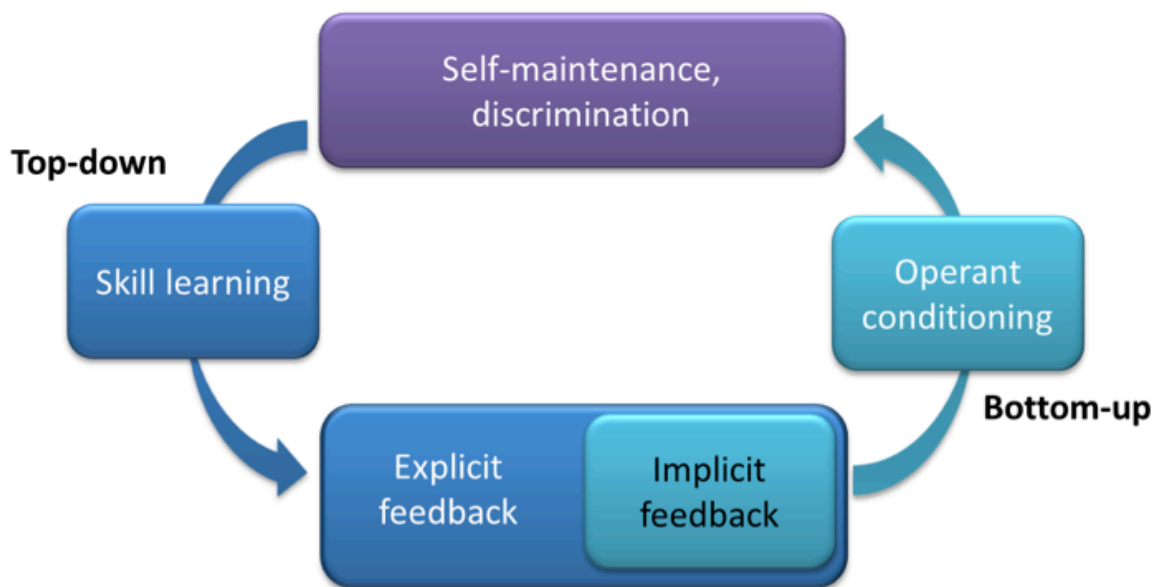


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1 **Figure 2**

2 Dual process theory of neurofeedback. Bottom-up operant conditioning and top-down skill
3 learning processes improve self-maintenance and discrimination skills. Implicit feedbacks
4 interact mostly with the bottom-up system, whereas explicit feedbacks first interact with the
5 top-down system, before becoming progressively integrated as the subject becomes
6 independent from the feedback, which becomes then mostly a bottom-up reinforcement
7 signal, migrating towards the operant conditioning mechanism.

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1 **Table 1**

2 Principles and technical aspects of learning during neurofeedback

3

| Aim of the learning during neurofeedback | |
|--|---|
| Learnability | The parameters of interest can be regulated by the learner |
| Perceptibility | The parameter of interest can be perceived by the learner without exceeding his/her perception capabilities |
| Mastery | The learner gains progressively control over the sessions |
| Motivation | The learner should be preserved from boredom and not experience disengagement from the task |
| Autonomy | The learner achieves progressive independence from the feedback and can self-regulate the brain signal of interest without feedback |
| Technical aspects related to the learning | |
| Quality of signal recording | Quality of the signal-to-noise ratio / Method to avoid artefact |
| Signal processing | Signal processing method to compute the parameter of interest |
| Occupation time | Time above or below a threshold until a reward is given |
| Threshold | Automatically adapted or manually |
| Number of positive reinforcements | Number of positive reinforcements above or below a certain number until the threshold is modified |
| Perceptual modality of feedback | Type of cue used to provide feedback (e.g. visual, auditory or tactile) |
| Mode of feedback presentation | Continuous or intermittent |
| Complexity of the feedback | e.g., for visual feedback, a thermometer display or more complex scenes based on virtual reality |
| Number of sessions | Number of session to obtain a learning |
| Duration of a session | Duration of a session and number of block per session |
| Inter session duration | Duration between two sessions |
| Training curve | Evaluation of the training parameter during the session |
| Learning curve | Evolution of the training across the sessions |
| Role of the professional | Task instructions and motivation given to the subject before, during and after the session |
| Transfer sessions | Generalization of learned skills to activities of daily living i.e. in an ecologically relevant setting |

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