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Editoriale

Caro lettore/lettrice,

chi ha seguito le pubblicazioni della nostra rivista fin dall'inizio, saprà che una componente della politica editoriale di *Psychomed,* nonché una delle sua finalità fondanti, è quello di rendere disponibile in modo sintetico la letteratura scientifica nel nostro campo. Ad esempio, è in base a questo elemento che ci siamo ispirati per proporre il nostro concetto di "sintesi" nella comunicazione scientifica, non nel senso di aver inventato la sintesi, ovviamente, ma indicando con questo termine un documento intermedio tra il riassunto (*abstract* per chi ama l'inglese), di solito di 2-300 parole, e l'articolo su rivista scientifica (il *paper*), abitualmente tra un minimo di 5-6 e massimo di 12-20 cartelle.

Un esempio di comunicazione di sintesi è invece il *poster*, il lavoro scientifico che viene comunicato sotto forma di manifesto, esposto in verticale, per lo più durante i congressi, e perciò da leggere di solito in piedi e quindi con meno agio della lettura di una rivista scientifica, che si può sfogliare alla scrivania o scorrere sullo schermo di un computer comodamente seduti. Per questo, i poster ben fatti contengono mediamente una quantità di testo senz'altro inferiore a quella degli articoli, e contengono invece una quantità maggiore di grafica, che attira l'occhio (e stimola la curiosità) molto più del testo. Forse proprio per la sua fruizione effimera, però, il poster ha purtroppo finito per essere percepito come una forma di comunicazione scientifica di second'ordine, da relegare in un angolo dei congressi e atta ad accogliere meglio i lavori dei colleghi più giovani e quindi meno adusi a parlare in pubblico; sembra confermare questa percezione il fatto che i *poster* normalmente non vengono pubblicati.

Questa concezione dei *poster* come lavori di serie B, tuttavia, contrasta con l'esperienza mia e di molti colleghi che proprio nei *poster* si trovano spesso lavori più originali, idee più innovative, studi condotti molto meglio di quelli delle presentazioni orali (spesso concordate da colleghi più titolati con gli organizzatori dei convegni). E' per questo motivo quindi che ci chiedemmo già due anni fa se *Psychomed* non potesse ospitare proprio dei *poster:* così si fece, chiedendo ai relatori del 6° Congresso Internazionale di Psicoterapia Cognitiva tenutosi a Roma dal 19 al 22 giugno 2008 di spedirci i poster presentati a quel Convegno. La risposta fu molto positiva: ricevemmo molte proposte, per cui potemmo pubblicare 25 poster sul 2° numero del 2008.

Anche in questo numero di *Psychomed* troverai un buon numero di poster, presentati in un convegno internazionale. I poster inclusi in questo numero della rivista provengono dal Congresso della Associazione Europea di Terapia Comportamentale e Cognitiva (*EABCT*)

tenutosi a Dubrovnik (Croazia) nel settembre 2009, proposti da ricercatori di numerosi paesi sia europei che extraeuropei. Questi poster sono stati da noi sollecitati e selezionati, in qualche caso "curati" in modo che gli Autori potessero renderli più leggibili e ridurli al formato di una pagina. Altri *poster* sono stati invece scartati, quando ritenuti insoddisfacenti per contenuto (rilevanza, accuratezza o altro), leggibilità o impostazione grafica.

Vi troverete senz'altro argomenti originali, quali metodiche di analisi innovative del processo psicoterapico, nuove proposte di metodi psicoterapici o un uso originale in psicoterapia di tecniche già note, nuovi strumenti di *assessment*, nuove proposte di modelli psicopatologici; tutto ciò in una gamma di condizioni psicopatologiche che vanno dagli OCD alla depressione, dai disturbi attenzionali a quelli alimentari, senza dimenticare ambiti di ricerca specificamente psicologica, quali l'adattamento dell'adolescente alla gravidanza, la soddisfazione nel rapporto di coppia, le strategie di soppressione dei ricordi, effetti dello stress sulla memoria di parole, etc.

Date le finalità che ho ricordato, quindi, è più che naturale che *Psyhomed* ospiti dei *poster*, ma vorrei lasciarvi con una ultima notazione: la tecnologia che ci consente ora di leggere anche i *poster* con lo stesso agio di un articolo non dovrebbe farci dimenticare che in ogni *poster* c'è mediamente molto più lavoro di quanto non ci sia in una pagina di rivista.

Quindi, buona lettura e visione.

Lucio Sibilia

Evaluation of an Inference-Based Approach to Treating Body Dysmorphic Disorder: Preliminary Results

Annie Taillon[1-2], Kieron O'Connor[1-3-4], Gilles Dupuis[2] & Anick Laverdure[1-4]

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Introduction

Body dysmorphic disorder (BDD) is characterized by an excessive preoccupation with an imagined or very slight defect in physical appearance that causes clinically significant distress or impairment in important areas of everyday functioning.

BDD is usually characterized by high levels of overvalued ideation (OVI), which refers to the strength of a particular belief along a continuum from rational thought to delusional belief.

High levels of OVI have been shown to be predictive of poorer response to cognitive-behavioural treatment in patients with BDD (Neziroglu et al., 2001).

BDD is generally referred to as an obsessive-compulsive spectrum disorder because of its similarities with obsessive-compulsive disorder (OCD) in phenomenology, epidemiology, comorbidity, familial aggregation and response to treatment (Hollander, 1993).

Recent research has shown that a cognitive treatment specifically designed for OCD with strong obsessional beliefs, the Inference-Based Approach (IBA; O'Connor et al., 2005), was equally effective in people with OCD with high and low OVI (Provencher et al., in press).

Objective

Given the many similarities between BDD and OCD and the high levels of OVI commonly found in those with BDD, the purpose of this preliminary study is to evaluate the efficacy of IBA in a BDD sample.

Method

Participants

The total sample consisted of 4 participants (3 females and 1 male). The average age for the group was 34,25 years (SD=6,5; range 28-43). Location of perceived defects were: eyelids (participant 1); ears (participant 2); and skin (participants 3 and 4).

Participants were first screened by telephone and then diagnosed by a trained independent psychologist. They received BDD-YBOCS and OVIS interviews and completed several questionnaires before and after therapy.

Written informed consent approved by local ethics committee was obtained from all participants.

Treatment

The Inference Based Approach (IBA) is a 20-week cognitive therapy that was first designed for OCD, but whose focus on beliefs can also apply to a BDD population. IBA conceptualizes BDD obsessions as inferences arrived at through inductive reasoning processes and the treatment focuses on addressing the faulty inferences that lead to appraisals. IBA is purely cognitive and does not include systematic exposure and response prevention.

Treatment was administered weekly by a licensed psychologist.

Instruments

The Overvalued Ideas Scale (OVIS) is an 11-item clinician-administered scale assessing the severity of OVI.

The Yale-Brown Obsessive-Compulsive Scale Modified for BDD (BDD-YBOCS) is a 12-item semi-structured interview which assesses frequency, interference, distress, resistance and control over BDD obsessions and compulsions. Mean pre-treatment score on the BDD-YBOCS for the 4 participants was 27,75 (SD = 1,71).

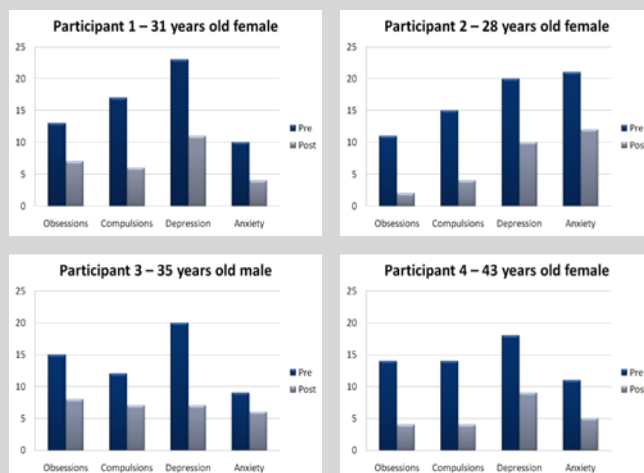
The Beck Anxiety Inventory (BAI) and the Beck Depression Inventory (BDI-II) are 21-item checklists respectively rating anxiety and depressive symptom intensity for the last week.

Analyses

Using a multiple case-study design, we looked at change in scores on clinical questionnaires for all 4 participants.

The average percentage change in scores from pre- to post-treatment on clinical measures and on the OVIS were also computed.

Results



As shown in the graphs above, every participant improved on all clinical measures from pre- to post-treatment.

	Obsessions	Compulsions	Depression	Anxiety
Mean percentage decrease in scores	62%	63%	54%	48%

The level of OVI also decreased from pre- to post-treatment, as suggests a mean 55% decrease in scores on the OVIS.

Conclusion, limits & recommendations

The severity of BDD obsessions and compulsions decreased of at least 44% (mean = 62%) in all 4 participants, thus suggesting a clinically significant improvement.

The decrease in scores on all clinical questionnaires as well as on the OVIS suggests that IBA impacts on both BDD symptoms per se and associated symptomatology.

These preliminary results suggest that IBA is a promising psychological treatment option for BDD despite the high level of overvalued ideation commonly found in people with this disorder.

It will be important to see if improvement is maintained at follow-up on all 4 participants.

The present preliminary study was an open trial and clearly a controlled trial with existing cognitive-behavioural treatments would give more information on the specificity of IBA.

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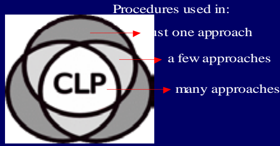
IRSC CIHR

Project for a Common Language for Psychotherapy (CLP) Procedures

Common Language for Psychotherapy procedures: Update

www.commonlanguagepsychotherapy.org



CLP Task Force

Set up by EABCT & ABCT to develop a **Common Language for Psychotherapy Procedures** to encourage therapists to use the same terms for similar clinical procedures

Entries describe **procedures**, not theory – **what** therapists **do** *(fly on the wall)*, not why they do it

CLP now sponsored by 10 organisations

Task Force members

EABCT: Stefania BORGO, Pim CUIJPERS, Miquel Angel FULLANA (deputy co-ordinator), Isaac MARKS (co-ordinator), Lucio SIBILIA, Mehmet SUNGUR

ABCT: Marvin GOLDFRIED, Michelle NEWMAN, George STRICKER

Australian Psychological Society: Kate MOORE

Psychodynamic Editor: Jeremy HOLMES

Website: **www.commonlanguagepsychotherapy.org**
Designer: Marco BENARD
Manager: Lorena FERNÁNDEZ DE LA CRUZ

The Problem: therapists often

1. give similar therapy procedures different names
   e.g. to ↓ grief: a. *guided mourning*, b. *exposure*, and c. *working through* are done similarly

2. give different therapy procedures similar names
   e.g. *diary keeping* may be of: relaxation exercises without exposure, particular thoughts, or live-exposure homework tasks

Lack of a common language for therapy procedures leads to:

-misunderstandings among therapists, clients & researchers

-slowing of psychotherapy's maturing into a science

CLP aims to:

-have therapists across the world from diverse orientations describe therapy **procedure/s** in a plain common language, each entry with a brief real Case Illustration

-get international use of a common language for all procedures by a broad range of therapists

CLP work so far

Steadily-growing CLP website now has 68 accepted entries for procedures from diverse orientations *(ACT, behavioural, buddhist, cognitive, gestalt, interpersonal, psychodynamic, other)*

entries **highlight author's name**

84 authors from 13 countries *(Australia, Canada, France, Germany, Greece, Israel, Italy, Japan, Netherlands, Sweden, Switzerland, UK, USA)*

Classification of procedures in progress

68 entries for procedures accepted so far

-acceptance; -anger management; -applied relaxation; -assertiveness training; -attention training; -behavioral activation; -CAVE (computer-aided vicarious exposure); -cognitive defusion; -cognitive restructuring; community reinforcement approach; -coping cat; -countertransference, use of; -danger ideation reduction therapy (DIRT); -decisional balance; -dialectical behaviour therapy (DBT); -dream interpretation; -evoked response arousal plus sensitization; -experiment; -exposure, interoceptive (to internal cues); -exposure, live (in-vivo, live desensitization); -expressive writing therapy; -family work for schizophrenia; -fixed-role therapy; -guided mourning; -habit reversal; -harm reduction; -imago relationship therapy; -internalized other interviewing; -inflated responsibility, reduction of; -internet-based therapy; -interpersonal therapy (IPT); -life review therapy (integrative reminiscence therapy); -linking current, past and transference relationships (triangle of person); -mentalizing, promoting; -metacognitive therapy; -metaphor, use of; -method of levels; -mindfulness training; -morita therapy; -motivational enhancement therapy; -motivational interviewing; -narrative exposure; -nidotherapy; -problem solving therapy; -prolonged exposure counterconditioning; -prolonged-grief therapy; -promoting resilience (social/emotional competence) in children; -puppet play to prepare children for surgery; -reciprocal role procedures, describing and changing; -repairing rupture; -repertory grid technique; -ritual (response) prevention; -schema-focused emotive behaviour therapy; -self as context; -self-praise training; -sibling fighting-reduction training; -skills-directed therapy; -solution-focused questioning brief therapy; -speech restructuring therapy; -stimulus control of worry; -task concentration training; -time-boundary setting and interpreting; -time-in management; -token economy; -transference interpretation; -Triple-P parenting program; two-chair dialogue; -validation of feelings; -values exploration and construction; -well-being therapy

Classifying therapy procedures *1*

-500 years ago Europe's voyages of discovery collected a host of new species for scientific attention and led to great advances with later classification of species

-today's clp too is a voyage of discovery: collecting and comparing entries reveals abundant ingenious practices hidden under diverse names and often known to only a minority of therapists.

-therapists from diverse orientations often use similar procedure

-as entries increase, website visitors need a signposting index to see procedures they're interested in and domains grouping those

i.e. an empirical classification

Classifying therapy procedures *2*

some (overlapping) domains & procedures in them

activity/homework *tasks encouraged e.g. do things usually avoided, practise skills, challenge beliefs by experiments*
behavioral activation; community reinforcement approach; diary keeping; experiment; exposure (most forms); expressive writing therapy; goal setting; homework; imago relationship therapy; interpersonal therapy; morita therapy; programmed practice; rehearsal

attention focussing breathing control; compassionate mind training; danger ideation reduction therapy; mindfulness & other meditation; relaxation; task concentration

nidotherapy *environmental change to alter behaviour, initiated externally or by self*
community reinforcement approach; contingency management; family work for schizophrenia; evoked response arousal plus sensitization;

skills training anger management; assertiveness, communication & social skills training; interpersonal therapy; psychodrama; rehearsal; role play

ANY THERAPIST CAN CONTRIBUTE TO www.commonlanguagepsychotherapy.org

1. suggest a term for a new procedure-entry to **isaac.marks@kcl.ac.uk** & **mafr@copc.es**
2. if term is still open for a clp entry, therapist submits a 1st draft in the clp format
3. draft entry is edited into clp format until author & editor agree final entry
4. accepted entry for the procedure is published on the clp website with **author's name highlighted**

Relation between negative beliefs about worry and thought suppression

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Keywords: **Negative beliefs about worry, Thought suppression, Meta-cognition**

Abstract

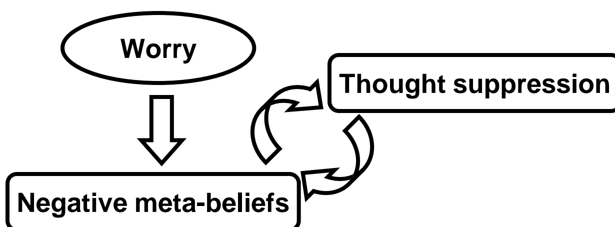
This study examine whether negative beliefs about worry predict thought suppression and thought suppression predict negative beliefs. Such a reciprocal relation between negative beliefs about worry and thought suppression was investigated. A two-time point assessment was conducted with an interval of four weeks. Sixty-nine university students completed two-time point assessment. They completed White Beer Suppression Inventory (WBSI) and Metacognitive Beliefs about Worry Questionnaire. Synchronous effects model was used in analysis. This model showed that thought suppression predicted negative beliefs about worry. This result indicated that there may not be reciprocal relation between negative beliefs and thought suppression but only thought suppression may reinforce negative beliefs.

Introduction

Worry has been determined to be a central factor in generalized anxiety disorder (GAD) and has been associated with other several psychopathological conditions. Negative metacognitive beliefs about worry (like 'worry is uncontrollable) is one of the core factor in the metacognitive model of GAD.

People may often attempt not to think unpleasant thoughts that may trigger worrying. Unfortunately, a simple attempt to suppress a certain thought is often counterproductive; this is considered to be the paradoxical effect of thought suppression. Moreover, the failure of thought suppression may reinforce the belief in uncontrollability. Wells (1995) suggested the relation between negative meta-cognition and thought control in GAD.

In the present study, the relation between negative metacognitive beliefs and thought suppression in normal subjects was investigated.



Method

Instruments

1.Metacognitive Beliefs about Worry Questionnaire (Kanetsuki, Ito, & Nedate,2007).

This instrument consists of two subscales: positive meta-beliefs, negative meta-beliefs. In this study, negative meta-beliefs only was used (In the resent study (Kanetsuki et al., 2007), the α level for negative meta-beliefs was taken at .95)

2.White Bear Suppression Inventory (WBSI) (Wegner & Zanakos, 1994).

The WBSI is a self-report measure of thought suppression. This measure is a widely used instrument and has proven to be a reliable and valid measure in a series of studies.

Participants

A total of 113 university students (88 men and 25 women) completed a two time-point assessment after an interval of four weeks. Their mean age was 19.22 years.

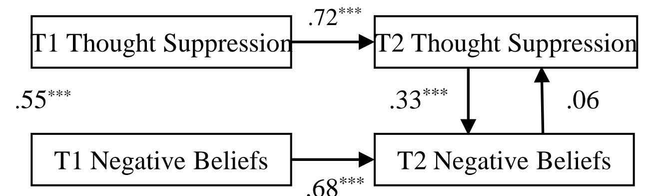
Model Construction

***Synchronous effects model* (Finkel, 1995)**

This model shows contemporary reciprocal effects between two variables at a given time point.

Results

The path from thought suppression to negative beliefs=.31(p<.001)
The path from negative beliefs to thought suppression=.06($n.s$)



***p<.001
$\chi^2(1)$=.35,p=.56, GFI=.99, AGFI=.97, RMSEA=.00

Figure. Synchronous effects model

Discussion

This result indicated that there may not be reciprocal relation between negative beliefs and thought suppression but only thought suppression may reinforce negative beliefs.

Wells(1995) suggested negative meta-cognition (meta-worry) and thought control reinforce each other. But, in this study it wasn't maintained.

Individual differences in the effect of acute stress on words memory

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Previous studies have reported on the effects of acute stress on memory, namely, that while acute stress impairs memory of neutral words, it does not impair or enhance memory of emotional words. Although many studies have examined memory and acute stress, few have investigated the individual differences in the effect of acute stress. This study tested the individual differences in memory of words after exposure to acute stress. Fifty-two undergraduate students were assigned to two groups, stress group (*n* = 26) and control group (*n* = 26). After answering Zung's Self-rating Depression Scale (SDS), participants were exposed to either the Trier Social Stress Test (TSST) or a non-stressful task. They then learned neutral, positive, and negative word lists of 10 words each, followed by a memory test after the filler task. The result showed impaired recognition performance in the stress group, only for neutral words. However, there were no individual differences between the two groups.

Introduction

●Previous studies reported that the effect of acute stress on memory of words depends on the word valence.

・ Acute stress impaired recall of neutral words, but enhanced recall of emotional words (Jelicic et al., 2004).

・ Neutral recall performance was impaired in the stress group, but there were no differences between the two groups with regard to positive and negative words (Smeets et al., 2006).

●Previous studies have never reported individual differences in the effect of acute stress on memory of words

(eg. the negative bias in depressive people).

★This study tested the effect of acute stress on neutral, positive, and negative two-compound kanji words, and the individual differences with the depression scale.

Methods

・ ***Participants*** 52 students (18 women and 34 men) with mean age of 19.17 years (*SD* = 1.16)

・ ***Procedure***

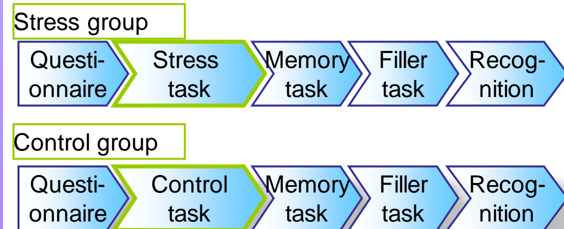

Fig 1. Procedure of this study

不安 成功 今後 満足 数字 貧困

Fig 2. Examples of two-compound kanji words

・ ***Stress Task*** Trier Social Stress Test (TSST) (Kirschbaum et al., 1993)

・ 3-min speech after 5-min preparation time and 3-min mental arithmetic task (1022-13) in front of a video camera and microphone

・ Participants were informed that the visual and audio recordings would be appraised by 3 people

・ ***Control task*** a nonverbal figure task

・ ***Memory task*** Visual Verbal Learning Test (VVLT) (Riedel, 1999)

・ 10 positive, 10 negative, 10 neutral two-compound kanji words from Gto and Oshima's (2001) list

・ 2 learning (random presentation→recall) trials

・ ***Recognition task*** 60 words (30 presented and 30 non-presented), 2-alternative forced choice

・***Questionnaire*** Self-rating Depression Scale (SDS)(Zung,1965), 20 items, 4-point scale

Results & Discussion

◆Effect of acute stress on 2 two-compound kanji words◆

2(stress) × 3(valence) ANOVA

Main effects of VALENCE [$F(2,100) = 7.07$, $p < .001$]

STRESS ×VALENCE interaction [$F(2,100) = 2.47$, $p < .10$]

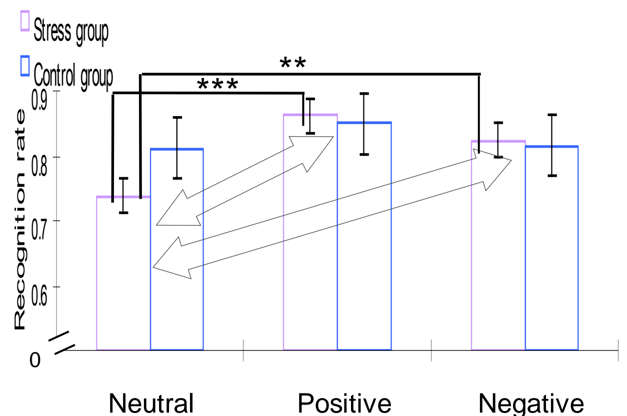

Fig 3. Results of 2(group) × 3(valence) ANOVA . This recognition rate showed correct recognition (hit rate – false alarm rate).

** $p < .01$, *** $p < .001$

●Bonferroni corrected post hoc tests

Positive words ＞ Neutral words ($p < .001$)

Negative words ＞ Neutral words ($p < .01$)

in the STRESS group

★The results showed a different effect of acute stress that depends on word valence even when the stimulus was two-compound kanji words.

↑Main effect of STRESS was not significant. We should improve the stress task.

◆Individual differences (depression)◆

2(depression) × 2(stress) × 3(valence) ANOVA

No main effects of VALENCE, STRESS ×VALENCE interaction.

…There were no effects of DEPRESSION.

★There were no individual differences.

↑However, the effect of depression depends on the memory task, and we need to test the effect using another task and stimulus.

Temporal stability and strategies for Memory suppression

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EABCT 2009

Introduction

Anderson & Green (2001)

Using the Think/No-Think task (TNT) task, they showed that **people could suppress their wanted memory**.

Hertel & Calcaterra (2005)

They found that a thought-substitution strategy was effective for memory suppression.

However, there were **some problems**.

(1) The members of the control group could not suppress their memory.

(2) The thought-substitution strategy induced retrieval-induced forgetting (RIF).

Therefore, it was unclear if suppression was induced by the TNT task or some other effect.

Thinking of a different thought instead of the target.

Purpose

We reconsidered the effectiveness of a distraction strategy for memory suppression.

Thought suppression researches have found that a distraction strategy is effective for thought suppression.

The hypothesis

A distraction strategy is useful for memory suppression.

It was assumed that the distraction strategy group would demonstrate more suppression than the control group.

In addition to the strategy, we also examined the temporal stability of memory suppression.

If it exists, the ecological validity of memory suppression increases.

Design

(1) Strategy: Control & Distraction (Between)

(2) Condition: Baseline, Respond, & Suppress (With-in)

(3) Delay: Day 1 & Day 2 (With-in)

Procedure

We conducted a two-day experiment.

On day 1, the participants were given the TNT task.

It consisted of three phases: (1) Learning, (2) Condition, and (3) Test.

(1) Learning phase

The participants learned thirty-six Japanese noun pairs.

Next, they were given a cue-recall test until their memory performance exceeded 50%.

+
Cue- target

Examples.
門 - ゴルフ (gate-golf)
炎 - バレエ (fire-ballet)
港-カンゴフ (port-nurse)

(2) Condition phase

The thirty-six learned noun pairs were divided into three conditions: Baseline, Respond, and Suppress.

We presented each cue only in this phase.

The following were the participants' responses to the cues.

Respond (Red cue): Participants recalled a target paired with a cue.

Suppress(Green cue): Participants suppressed a target.

Baseline: Baseline items were not presented in this phase.

+ fire — ballet

+ gate — golf

Baseline
"port" was not presented.

Only the distraction strategy group was asked to memorize the nonverbal image (*see below*) and were asked to think of it during suppression.

(3) Test phase

After the participants had answered a questionnaire to measure the effort and difficulty during suppression, they took a cue-recall test for all noun pairs.

On day 2, the participants took only the cue-recall test again.

Result & Discussion

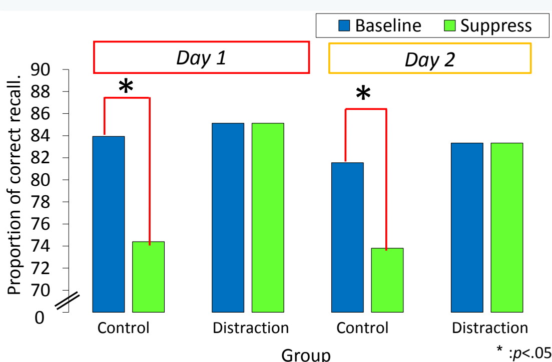

Figure 1. Proportion of correct recall in each group for 2 days.

Table 1. Questionnaire score in each group

Group	Effort	Difficulty
Control	6.00	4.00
Distraction	5.92	5.07 *

Note: Seven-point scale. * : $p < .05$

A higher score indicates that the participants had to put in more efforts for suppression or found it more difficult.

Cued-recall (Figure 1)

The control group recalled a significantly fewer number of suppressed targets than baseline targets.

The distraction group recalled a significantly higher number of response targets than baseline targets, but they recalled a significantly fewer number of suppressed targets than baseline; in addition, the interaction between a strategy, condition, and delay was not significant.

The control group demonstrated suppression, but the distraction group did not, and that memory suppression in control group last.

Questionnaire Score (Table1)

The distraction group found suppression significantly more difficult than the control group.

The result suggests that

a distraction strategy was ineffective for memory suppression, and that memory suppression has temporal stability.

This suggests that our hypothesis was not supported.

In future research

Thinking of a related thought and suppressing the target.

Most of the participants in the control group used an interference strategy.

It appears that the interference strategy facilitates memory suppression.

In future research, one needs to consider the effects of the strategy; moreover, examine its application in the suppression of negative materials.

Participants & Materials

Participants

Thirty-four undergraduate students were randomly assigned to each combination of strategy group(control or distraction).

Questionnaire

We composed a questionnaire to measure the effort and level of difficulty experienced during suppression (7 point). Only the control group was questioned using strategies.

Stimuli

We used thirty-six Japanese noun pairs from Matsuda (2006).

In addition, we selected nonverbal image form International Affective Picture System(Lang et al., 2005) for the distraction strategy.

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BODY CHECKING AND AVOIDANCE IN OVERWEIGHT SUBJECTS WITH AND WITHOUT BINGE EATING DISORDER

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Background

Diagnostic criteria for Binge Eating Disorder (BED) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR; APA, 2000) do not include "self evaluation unduly influenced by body shape and weight" as a central diagnostic feature. However, research has documented the importance of this feature among overweight individuals diagnosed with BED (Masheb & Grilo, 2000; Wilfley, Schwartz, Spurrell, & Fairburn, 2000; Reas, Grilo, Masheb & Wilson, 2005). This overvaluation of shape and weight, used in determining self-worth, has been conceptualized in cognitive-behavioral models as the core aspect of eating disorder psychopathology, from which various hallmark eating disorder symptoms stem (Fairbum, Cooper, & .Shafran, 2003).

Recently, repetitive body checking and body avoidance have been shown to be behavioral manifestation of the overvaluation of shape and weight among under-weight and normal-weight eating disorder patients (Shafran, Fairburn, Robinson & Lask, 2003)

Clinical lore holds that overweight patients with BED frequently engage in avoidance behaviors, but are believed to do less checking than normal-weight eating disorder patients. Reas, Grilo, Masheb & Wilson (2005), documented clinically significant levels of checking and avoidance behaviors in overweight men and women diagnosed with Binge Eating Disorder.

Aim

The purpose of the current study was twofold. First, our goal was to examine the presence of select body checking and avoidance behaviors in an overweight sample of Italian men and women diagnosed with and without Binge Eating Disorder (DSM-IV TR; American Psychiatric Association, 2000).

Second, we examined the relationship between checking and avoidance behaviors in association with the following variables: age, Body Mass Index (BMI), Binge Eating and dietary restraint.

Such an examination would improve the understanding of the roles of checking and avoidance in the maintenance of eating disorders, and extend our understanding of these concepts to overweight subjects with and without BED

Method

PARTICIPANTS

Participants were a consecutively evaluated series of 32 treatment seeking overweight italian adults and 12 no treatment seeking, BMI ≥ 25. 30 subjects met DSM IV-TR (APA, 2000) criteria for Binge Eating Disorder, 14 subjects were not BED. Participants' mean age was 44,14 years (SD = 12,40). Mean BMI (Kg/m²) was 38,10 (SD = 8,66; range 25,2 – 61,0).

Written informed consent was obtained.

PROCEDURES AND MEASURES

Participants completed a battery of self-report measures described below.

The Body Checking Questionnaire (BCQ). The BCQ (Reas, Whisenohunt, Netemeyer & Williamson, 2002) is a 23-item self-report measure of the global construct of body checking, with 3 correlated subfactors related to overall appearance, specific body parts, and idiosyncratic checking behaviors.

The Three-Factor Eating Questionnaire (TFEQ). The TFEQ (Stunkard & Messik, 1985) is a 51 item self-report questionnaire with three subscales reflecting three eating-related domains: Cognitive Restraint, Disinhibition and Hunger

The Body Image Avoidance Questionnaire (BIAQ). The BIAQ (Rosen, Srebnik, Saltzberg & Wendt, 1991) is a 19 item self-report measure of the avoiding behaviours of situations that might increase the preoccupation about body shape and weight.

Results

As shown in Table 1, in overweight subjects Body Checking and Avoidance are both positively and significantly correlated with Eating Restraint. In the group with BED the Eating Restraint is significantly correlated with Body Checking and Avoidance Behavior; in the group without BED Eating Restraint is significantly correlated with Avoidance Behavior but not with Body Checking.

The subscales correlated with BMI indicating – in the subjects without BED - the presence of a significant association between weight status and some Body Avoidance behaviors frequency, like body clothing and social activities; otherwise, there is not any significant association between weight status and Body Checking.

The t-Test analysis, that compares the group of subjects with BED with the group Not BED, shows the statistically significant differences about two variables: Body Clothing and Grooming and Weighing.

Indipendent Samples t-test

		Mean	SD	t_{42}	p
Body Clothing	Subject with BED	21.73	8.86	-2.12	.04
	Subject without BED	15.86	7.81		
Grooming and Weighing	Subject with BED	5.27	2.19	3.28	.002
	Subject without BED	7.57	2.10		

Table 2. Independent Samples t-test

Table 1.

Total Overweight Subjects (n=44)	AGE	BMI	Overall Appearance	Specific Body Parts	Idiosyncratic Checking	BCQ Total Score	Body Clothing	Social Activities	Eating Restraint	Grooming and Weighing	BIAQ TotalScore
AGE	1	.253	-.164	-.025	.275	-.014	.172	.010	-.186	-.035	.076
BMI	.253	1	-.106	.035	.106	.014	**.473****	**.345***	-.078	-.357	**.361***
BCQ Total Score	-.014	.014	**.841****	**.916****	**.643****	1	.230	.130	**.420****	**.322***	**.352***
BIAQ Total Score	.076	**.361***	.260	**.314***	**.363***	**.352***	**.932****	**.774****	**.496****	-.072	1

Overweight Subjects With BED (n=30)	AGE	BMI	Overall Appearance	Specific Body Parts	Idiosyncratic Checking	BCQ Total Score	Body Clothing	Social Activities	Eating Restraint	Grooming and Weighing	BIAQ Total Score
AGE	1	.197	-.213	-.032	.170	-.081	.060	-.019	-.254	.146	.004
BMI	.197	1	-.203	-.151	-.592	-.190	.268	.166	-.248	**-.455***	.111
BCQ Total Score	-.081	-.190	**.855****	**.898****	.717	1	.166	.161	**.512****	.357	.350
BIAQ Total Score	.004	.111	.315	.293	.264	.350	**.925****	**.838****	**.445***	-.239	1

Overweight Subjects Without BED (n=14)	AGE	BMI	Overall Appearance	Specific Body Parts	Idiosyncratic Checking	BCQ Total Score	Body Clothing	Social Activities	Eating Restraint	Grooming and Weighing	BIAQ Total Score
AGE	1	.192	-.097	.018	.470	.111	.246	-.080	-.051	-.100	.096
BMI	.192	1	.055	.458	.465	.432	**.754****	**.585***	.293	.260	**.743****
BCQ Total Score	.111	.432	**.835****	**.962****	**.535***	1	.409	.050	.192	.413	.368
BIAQ Total Score	.096	**.743****	.079	.409	**.563***	.368	**.960****	**.594***	**.651***	**.625***	1

Table 1. Pearson Correlation Matrix for the variables AGE, BMI, BCQ total score, BIAQ total score (* $p< 0.05$; ** $p< 0.01$)

Opinions

The current study examined aspects of body checking and body avoidance in overweight patients diagnosed with and without BED.

Our findings indicate that clinically significant levels of checking and avoidance behaviors occur in the group with BED. Consistent with findings by Shafran et al. (2003), our results support the view that Body Checking and Body Avoidance represent behavioral manifestations of the core eating disorder pathology. These findings also provide preliminary support for the potential role of checking and avoidance in the maintenance of this eating disorder category.

Consistent with earlier findings, with normal weight eating disorder samples, the positive association between checking and avoiding indicated these behaviors are not mutually exclusive; they may co-occur or alternate in the time (Shafran et al., 2003).

Consistent with earlier studies (Wilfley et al., 2000; Reas, Grilo, Masheb e Wilson, 2005), in subjects with BED we note the absence of a significant correlation between weight status and frequency of body checking and avoidance.

This finding echoes previous reports that shape and weight concerns in patients with BED do not vary significantly across levels of BMI (Wilfley et al., 2000).

Thus, it appears that degree of overweight does not substantially impact eating disorder pathology within treatment-seeking patients with BED.

In overweight subjects without BED we observe the presence of a significant correlation between weight status and frequency of Avoidance Behaviours, but not for Body Checking

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Acquisition of Fear and Attention Bias in Children, an Eye Tracking Study

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Introduction

- In Rachman's theory (Rachman, 1977) information is one of the pathways to fear: one can learn fear of a stimulus by receiving negative information about it.
- Information can indeed induce fear of a neutral stimulus: children acquire fear of a novel animal by listening to some negative information about it (e.g., Field, A. P., & Lawson, J. 2003).
- Such a fear induction leads to acquiring attention bias: in a dot-probe task, children detect a dot-probe behind the newly feared animal faster than the dot-probe behind an animal about which they have received no negative information (Field, 2006).
- Eye tracking methodology can yield worthwhile information about the visual attention patterns involved in anxiety, fear and phobia.
- As an example, a pattern of fast orientation-fast avoidance has been found in spider phobics when attending to images of spiders using this methodology (e.g., Pflugshaupt et al, 2005).

Aim

To examine whether attention bias which is resulted from fear induction is reflected in visual scan-paths, when searching actively in a naturalistic scene.

Method

49 primary school children aged between 6-10 (M=7.38, SD=1.34) participated in the study.

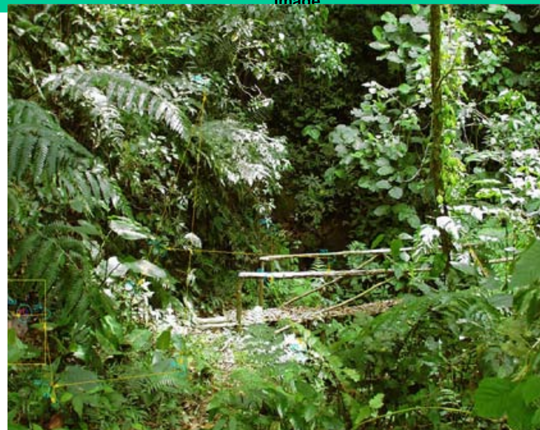
Fear Belief Paradigm. In this part of the experiment, first, children's baseline fear of two Australian marsupials, cuscus and quokka, was measured by Fear Belief Questionnaire (FBQ) which consists of 8 questions about each animal, such as:

Do you think this animal would hurt you?
a. No, not at all b. No, not really c. Don't know/neither d. Yes, probably e. Yes, definitely

Then, they listened to some negative information about one of the animals, and at the end, their fear of both animals was post-tested.

Visual Search Task. In this part, participants were asked to search in jungle images (two blocks of 54 images) for a cuscus or a quokka, and indicate by pressing a button whether they see the animal. Their eye movements ware recorded throughout the task.

Figure 1. examples of visual scan-paths and RT button response in a target present image

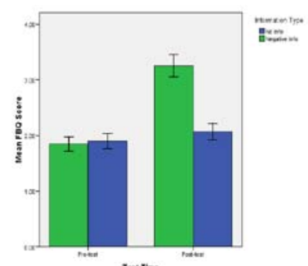


Results

Fear Belief Paradigm. After listening to negative information, children's fear beliefs scores significantly increased from pre-test (M=1.85, SD=0.76) to post-test (M=3.255, SD=0.80), t (48)= -10.89, p<.001.

For no information condition, no significant difference between baseline (M=1.90, SD=0.83) and post-test fear belief scores (M=2.07, SD=0.82) was found, t (48)= -1.74. p>.05

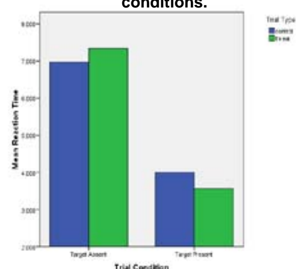
Figure3. Mean FBQ scores for negative information and no information animals in the baseline and post-test measurements.



Visual Search Task

Reaction Time Data. Multilevel regression analysis using bootstrap method revealed a significant effect of receiving negative information on detecting the threat-related animal. In target present trials, participants' RT when detecting the threat related animal (M=3569.03ms SD=3265.73) comparing with the neutral animal (M=3999.86, SD=3471.24) was significantly faster (Beta= -560.05, SE= 183.45, Chi. sq (1)=9.32, p<.01).

Figure 4. Mean reaction times for negative information and no information animals in target present and target absent conditions.



Eye Movement Data. A summary of means and multilevel regression results for some of the eye movement indices:

Eye Movement Index	Type of animal	Mean	SD	Beta	SE	Chi sq.	Sig.
Interest Area (IA) Dwell Time	Threat	1104.07	1278.07	-167.05	78.86	8.814	p<.01
	Neutral	1235.97	939.77				
IA Fixation Count	Threat	2.38	1.76	-0.35	.156	5.158	p<.05
	Neutral	2.67	2.41				
Trial Dwell Time	Threat	3172.85	2790.20	-393.21	149.8	6.89	p<.01
	Neutral	3466.63	2748.59				
Trial Fixation Count	Threat	10.4	9.16	-1.39	0.493	7.91	p<.01
	Neutral	11.46	8.93				

In the table above, all chi squares have a d.f. =1, and Beta represents share of the type of the animal being searched (i.e. whether it is a threat or neutral) in the eye movement measure.

No significant effect was found for other important IA indices, such as First Fixation Time, First Fixation Duration, Run Count, and Pupil Size.

Conclusion

- In accordance with reaction time results, IA dwell time, IA fixation count, trial dwell time and trial fixation count, are significantly lower for threat stimulus as compared to neutral stimulus. These data indicate that making a decision about whether a stimulus is present in the scene is significantly quicker if the stimulus is related to threat.
- Since trials terminate after button press response, lower IA dwell time and fixation count on threat stimuli can not be concluded as a fear- avoidance pattern.
- The difference between IA first fixation time in feared and neutral animals is not significant, therefore an overt attention hyper-vigilance is not supported.

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A FUNCTIONAL ANALYTIC X-RAY OF THE THERAPEUTIC PROCESS

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OBJECTIVE

To present a therapists' clinical performance model based on the distribution of the potential functions of psychologists' verbal behaviour in the different phases of the therapeutic process.

INTRODUCTION

- Processes research focused on the analysis of what occurs in the clinical setting
- The therapist-client interaction as a process of discrimination and reinforcement: shaping of the client's verbal behaviour (Hamilton, 1998; Rosenfarb, 1992)
- Functional-analytic tradition related to the study of verbal behaviour and learning processes in psychotherapy (Follette, Naugle & Callaghan, 1996; Kohlenberg & Tsai, 1991; Wilson & Blackledge, 2000)
- Verbal behaviour as the main object of research to understand the therapeutic process (speech is the most important activity in therapy)
- Topographic analysis: a preliminary step to study the functions of verbal behaviour. Analyses of potential functions.
- Focus on the therapist's verbal behaviour in the early stages of the research (future directions: client's verbal behaviour and therapist-client interaction)

METHOD

PHASE 1: A CASE STUDY

SAMPLE: 10 clinical sessions recordings. Case of a 32-year old woman seeking couple therapy. Private clinic and intervention behaviourally oriented.

VARIABLES: In session therapist's verbal behaviour

INSTRUMENTS: *The Observer XT* software and the *Therapists' Verbal Behaviour Category System* (TVB-CS) (Froján et al., 2008) :

CODES	BRIEF DEFINITIONS
DISCRIMINATIVE FUNCTION (DF)	Verbalization prompting client behaviour that will be followed by the presentation of reinforcing or punishing stimuli by the therapist.
EVOCATIVE FUNCTION (EF)	Verbalization that elicits an overt emotional response with eventual accompanying verbalizations in the client
REINFORCEMENT FUNCTION (RF)	Verbalization denoting agreement, approval or acceptance of client's behaviour
PUNISHMENT FUNCTION (PF)	Verbalization denoting disapproval, refusal or lack of acceptance of client's behaviour (including the interruption of client's behaviour with no sign of approval, agreement or acceptance)
INSTRUCTIONAL FUNCTION (ItF)	Verbalization prompting client behaviour change outside the clinical setting (e.g., description of clinical strategies, steps to follow for a given performance)
MOTIVATIONAL FUNCTION (MF)	Verbalization anticipating the positive or negative effect of a client's behaviour towards a clinical goal
INFORMATIVE FUNCTION (IfF)	Therapist verbalization conveying technical or clinical information in a plain-language format
OTHER (O)	Therapist's verbalization not included in the categories above

PROCEDURE: A trained observer coded TVB-CS categories aided by The Observer XT. Inter-rater agreement was obtained by randomly selecting four recordings also coded by a secondary observer (K=.64-.67). Intra-rater agreement was studied as well (k = .67-.76).

PHASE 2: MULTIVARIATE ANALYSES

SAMPLE: 97 clinical sessions recordings from 20 cases. 8 behaviour therapists. Private individual adulthood interventions.

VARIABLES: 8 quantitative variables referred to the percentage of each category of the TVB-CS in each registered session.

1 qualitative variable to select sessions: *therapeutic phase* with 5 categories (*Assessment, Functional analysis and treatment proposal explanation, Treatment (I), Treatment (II), Treatment (III)).*

INSTRUMENTS: *Therapists' Verbal Behaviour Category System* (TVB-CS) (Froján et al., 2008) and *The Observer XT* software

PROCEDURE: (1) Obtaining and preparation of recordings; (2) cases division into therapeutic phases (1 trained observer); (3) observation and register (1 trained observer); (4) periodical revision of inter and intra-rater agreement (k > .60); (5) cluster analysis followed by discriminant analysis.

RESULTS

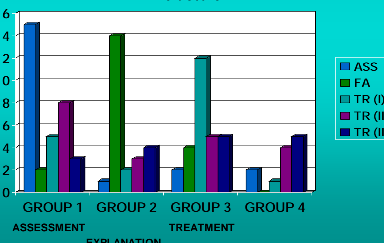
CASE STUDY

Therapist's verbal behaviour determined by the clinically relevant activity that is being carried out:

CLINICALLY RELEVANT ACTIVITY	THERAPIST'S VERBAL BEHAVIOUR
ASSESSMENT	DF + DF +...RF
EXPLANATION	IfF, MF
TASKS	ItF
DEBATE (Cognitive restructuring)	PF + DF + DF + + IfF ... + RF / MF / ItF

HIERARCHICAL CLUSTER ANALYSIS

- Ward's method of cluster analysis
- Measure of similarity: squared Euclidean distance
- Number of registers of each phase included in the clusters:



DISCRIMINANT ANALYSIS

- All variables related to the therapist' verbal behaviour were included (simultaneous estimation)

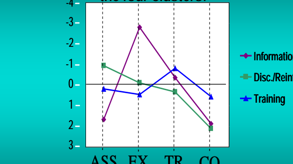
Statistical significance of the functions to discriminate between clusters:

	λ	$\chi^2_{(gl)}$	*p*
Complete model	0,[illegible]	$\chi^2_{(21)}$=219,78	<0,00
Functions 2 and 3	[illegible]	$\chi^2_{(12)}$=83,26	<0,00
Function 3	[illegible]	$\chi^2_{(5)}$=24,15	<0,00

Structure matrix:

	Function 1	Function 2	Function 3
D	-0.07	0,85	0.43
R	0.13	0,95	0.19
E	0.05	-0.11	0.003
P	-0.04	0.03	-0.77
I	-0,92	0.20	0.23
F M	-0.11	0.07	0.21
I	0.01	0.09	0,18
T O	-0.13	-0.08	0.80
	Information	Discr.-reinforc.	Training

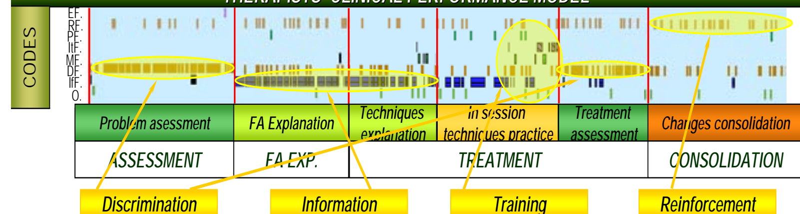
Means of the three discriminant functions in the four clusters:



Validation of the model:

Hit ratio (classification matrix)	91,8 %
Cross-validation (*k* - 1)	83,5 %

THERAPISTS' CLINICAL PERFORMANCE MODEL



CONCLUSIONS

The proposed model was theoretically consistent with the idea of underlying learning mechanisms (basically discrimination, reinforcement, and punishment) that operate during the therapist-client interaction and explain the behavioural change observed in clinical settings. From a practical point of view, the development of a model like this could be really useful to train inexperienced therapists and to propose more efficient psychological interventions.

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THERAPIST- CLIENT INTERACTION ANALYSIS BY A SINGLE CASE STUDY

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INTRODUCTION

TO FULLY UNDERSTAND THE THERAPEUTIC PHENOMENON, IT IS NECESARY TO STUDY NOT ONLY WHAT IS *DONE*; BUT ALSO WHAT IS *SAID* IN SESSION WHEN THERAPIST- CLIENT INTERACTION OCCURS.

OBJETIVE

THROUGH THE STUDY OF A SINGLE CASE WE TRY TO MAKE A FIRST INTENSIVE ANALYSIS OF THE THERAPEUTIC PROCESS AND TO FORMULATE HYPOTHESIS IN ORDER TO GUIDE FUTURE CLINICAL STUDIES.

OUR PROPOSAL

- •FUNCTIONAL-ANALYTIC APPROACH FOCUSED ON VERBAL BEHAVIOUR AND LEARNING RESEARCH IN CLINICAL SETTINGS
- •RESEARCH FOCUSED ON THE ANALYSIS OF WHAT OCCURRES IN SESSION: Therapist-client relationship constitutes a social context where problematic behaviours can be evoked and modified.
- •TOPOGRAPHIC ANALYSIS: THE PRELIMINARY STEP TO STUDY FUNCTIONS OF VERBAL BEHAVIOUR
- •SINGLE CASE IS A FUNDAMENTAL METHODOLOGY IN CLINICAL RESEARCH. It makes possible an individualistic analysis. Moreover, it allows to plan hypothesis in order to carry out future and more complex research.

METHOD

SAMPLE

- ➢10 clinical sessions recordings from 1 case treated in a private centre.
- ➢1 behavioural therapist with 15 years of clinical experience.
- ➢The client was a 32 years old woman attending for relationship problems with partner.

VARIABLES

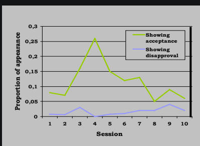
•Therapist's verbal behaviour, comprised of 8 levels based on the basic behavioural operations. Registering was made using an observational code elaborated by the authors (Froján *et al.*, 2008).

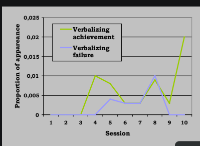
Category	*Brief description*
Providing with information	Verbalization used by the client to try to provide the therapist with information for the assessment and/or the treatment.
Asking for information	Client's question, comment and/or information request to the therapist.
Showing acceptance	Client's verbalization showing agreement, acceptance and/or admiration in relation to the therapist's verbalizations.
Showing disapproval	Client's verbalization showing disagreement, disapproval and/or rejection in relation to the therapist's verbalizations.
Verbalizing negative emotion	Expression of negative emotions as a complaint related to the client's suffering as a consequence of his problematic behaviours.
Verbalizing positive emotions	Expression of positive emotions as a related to the client's well- being.
Verbalizing achievement	Expression of positive emotions related to the achievement of the therapeutic goals
Verbalizing failure	Expression of negative emotions related to the failure of the therapeutic goals
Following instructions	Client's verbal behavior involving a partial or total following of instructions.
No following instructions	Client´s verbal behaviour involving a partial or total don´t following of instructions.

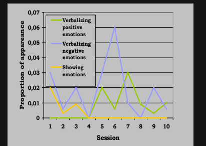
INSTRUMENTS

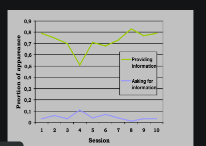
Software to code, register and analyse observational data: *The Observer XT*

PRELIMINARY RESULTS





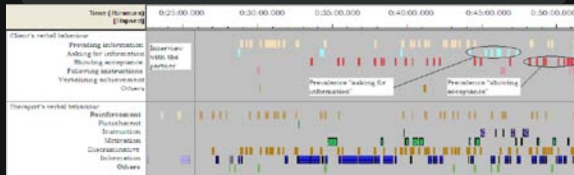




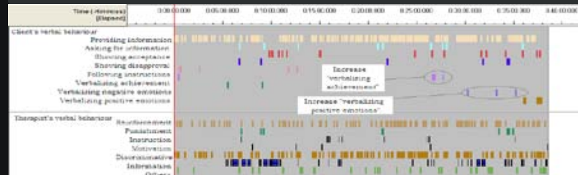
PHASE OF ASSESSMENT- SESSION 3

PHASE OF TREATMENT- SESSION 6

PHASE OF FUNCTIONAL ANALYSIS EXPLANATION- SESSION 4



PHASE OF CLINICAL CHANGES AND CONSOLIDATION- SESSION 10



CONCLUSIONS

- ➢This new methodology has been demostrated to be useful to analyze the therapist- client interaction.
- ➢Client´s verbal behaviour changes as psychoterapy progresses. As the therapist´s behaviour changes, the client´s also does and her behaviour gets more adaptative as sessions more forwars.
- ➢To describe possible patterns of the therapist-client interaction is a first step to identify the learning mechanisms underlying clinical change.

FUTURE IMPROVEMENTS

- ➢The study of the therapist- client interaction must be completed with the analysis of non verbal behaviour and quantitative analysis in order to get a fully comprehension of psychoterapeutic phenomenon
- ➢We must to refine the initial observational code system. We expect to develop a more systematic and effective instrument.

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CODING SYSTEM FOR THE STUDY OF CLIENT-THERAPIST INTERACTION: APPLICATION TO THE COGNITIVE RESTRUCTURING TECHNIQUE

39th EABCT Annual Congress

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RESEARCH QUESTIONS

• Is it possible to develop a scientifically acceptable coding system to analyze therapist's and client's verbal behaviour during the application of the cognitive restructuring technique as a complement of previously developed general therapist's coding system (SISC-CVT; Froján et al., 2008)?

• Would it be possible to study interaction between therapist and client in order to understand the processes that explain change during the application of this technique?

OBJECTIVE

To present a coding system for the study of therapist's and client's verbal behaviour during the application of the cognitive restructuring technique.

METHOD

SAMPLE

28 recordings of fragments of cognitive-restructuring technique from 11 different cases

4 behavioural therapists from private clinical centres in Madrid (Spain)

INSTRUMENTS

Closed-circuit video camera system to capture the sessions.

Software to code, register and analyze observational data: *The Observer XT* (Noldus Information Technology ®) versions 6.0 and 7.0

PROCEDURE

3 PHASES:

Categories' initial proposal: 5 psychologists expert in Behavior Modification proposed some initial categories for the therapist's and the client's verbal behaviour (16 categories for the therapist and 8 for the client)

Pilot observations: 4 independent judges analized 3 transcripts of sessions with cognitive restructuring tecnique to test the initial categories and to propose some preliminary coding criteria.

Refinement and definitive proposal of the category system: 4 judges observed and registered new 25 clinical sessions with *The Observer XT* 6.0 and their registers were compared. Inter-rater agreement was periodically obtained.

RESULTS

THERAPIST'S CATEGORY SUBSYSTEM (SISC-CVT-RC)

• ***DISCRIMINATIVE FUNCTION***: Therapist's verbalization that occasions a client's behaviour (verbal or non verbal) that is usually followed by reinforcement or punishment.

POSSIBLE VARIANTS: without showing the desired direction of the response, showing the desired direction of the response, conversational discriminative function, unsuccessful discriminative function, "others" discriminative function.

• ***ELICITATION FUNCTION***: Verbalization by the therapist that elicits an observable emotional response with a verbalization referring to its appearance by the client or only this verbalization.

• ***REINFORCEMENT FUNCTION:*** Therapist's verbalization that shows agreement with, acceptance of and/or approval with the behaviour shown by the client.

POSSIBLE VARIANTS: conversational reinforcement function, low, medium, high.

• ***PUNISHMENT FUNCTION:*** Therapist's verbalization that indicate disagreement with, disapproval of and/or rejection of the behaviour shown by the client.

POSSIBLE VARIANTS: low, medium, high.

• ***PREPARATION FUNCTION:*** Therapist's verbalization that facilitates the emission of a certain response by the client.

POSSIBLE VARIANTS: preparation of discriminative, informative, motivational.

• ***INSTRUCTIONAL FUNCTION:*** Verbalization by the therapist to promote a given behaviour in the client inside or outside the clinical context. The consequences do not have to be explicitly mentioned, but the steps to be followed by the client must be described.

•***OTHERS:*** Any therapist's verbalization that could not be included in any of the above categories.

CLIENT'S CATEGORY SUBSYSTEM (SISC-CVC-RC)

• ***PROVIDING WITH INFORMATION***: Verbalization used by the client to try to provide the therapist with information for the assessment and/or the treatment.

• ***ASKING FOR INFORMATION***: Client's question, comment and/or information request to the therapist.

• ***SHOWING ACCEPTANCE:*** Client's verbalization showing agreement, acceptance and/or admiration in relation to the therapist's verbalizations.

• ***SHOWING DISAPPROVAL:*** Client's verbalization showing disagreement, disapproval and/or rejection in relation to the therapist's verbalizations.

• ***VERBALIZING NEGATIVE EMOTIONS:*** Expression of negative emotions as a complaint related to the client's suffering as a consequence of his problematic behaviours. Also verbalizations by means of which the client shows he is reluctant to accomplish the proposed home tasks as they would make him suffer.

• ***VERBALIZING POSITIVE EMOTIONS:*** Expression of positive emotions related to the achievement of the therapeutic goals or to the situation that the client is living or will live as a consequence of the achievement of the therapeutic goals or any other circumstance.

• ***FOLLOWING INSTRUCTIONS:*** Client's verbal behaviour involving a partial or total following of instructions given immediately before by the therapist.

• ***OTHERS:*** Any client's verbalization that could not be included in the previous categories.

INTER-RATER AGREEMENT

SISC-CVT-RC

	Observer 1 and 2		
	PA	*k*	*p*
Fragment 1	70%	0,64	< 0,01
Fragment 2	59%	0,51	< 0,01
Fragment 3	78%	0,74	< 0,01

SISC-CVC-RC

	Observer 1 and 2		
	PA	*k*	*p*
Fragment 1	85%	0,73	< 0,01
Fragment 2	86%	0,75	< 0,01
Fragment 3	68%	0,51	< 0,01

PA = Percentage of agreement; k = Cohen's kappa coefficient

DISCUSSION

✓ The obtained levels of inter-rater agreement were at least reasonable (Bakeman, 2000).

✓ As for the study of validity, two studies were carried out (Calero-Elvira, 2009) so we can conclude that the categories cover the range of issues to observe and there were differences in verbal behaviour between sessions and groups that were theoretically and clinically coherent.

✓It is possible to study interaction with this system to try to understand the underlying processes.

✓Future lines of research: trying to improve inter-rater agreement, more studies on validity, studies to identify the factors related with a higher effectiveness in the application of the technique.

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Development and initial validation of an adolescent version of Tylka's *Intuitive Eating Scale*

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The Positive Pole of Eating Behaviours

Instruments that assess eating behaviours (EBs) have traditionally focused on pathology. However, it has been shown that measures of *Intuitive Eating*, i.e., eating behaviour based on physiological hunger and satiety cues rather than situational and emotional cues, were predictors of well-being measures independent of eating disorder symptomatology (Tylka & Wilcox, 2006).

Development of the IES-A

Content and wording of the IES are not fully suitable for administration to adolescents. Starting from the Italian adaptation of the IES (Chiorri, in press), an adolescent version of the IES (IES-A) was developed.

1. I try to avoid certain foods high in fat, carbohydrates, or calories.
2. I stop eating when I feel full (not overstuffed).
3. I find myself eating when I'm feeling emotional (e.g., anxious, depressed, sad), even when I'm not physically hungry.
4. If I am craving a certain food, I allow myself to have it.
5. I follow a specific diet that dictate what, when, and/or how much to eat.
6. I find myself eating when I am bored, even when I'm not physically hungry.
7. I can tell when I'm slightly full.
8. I can tell when I'm slightly hungry.

9a. I can't eat something unhealthy (e.g. fat foods).

9b. I commit myself not to eat something unhealthy (e.g. fat foods).

10. I find myself eating when I am lonely, even when I'm not physically hungry.
11. It is my body that tells me when to eat.
12. It is my body that tells me what to eat.
13. It is my body that tells me how much to eat.
14. I have forbidden foods that I don't allow myself to eat.
15. When I'm eating, I can tell when I am getting full.
16. I use food to help me soothe my negative emotions.
17. I find myself eating when I am stressed out, even when I'm not physically hungry.
18. I feel guilty if I eat a certain food that is high in calories, fat, or carbohydrates.
19. I think of a certain food as "good"or "bad" depending on its nutritional content.
20. I am not sure I can resist eating tasty but fat foods.
21. I wish my mother did not keep in my house because I think that I may lose control and eat them.

Note: Bolded items are those modified from the original version; the original IES-A is in Italian, this English version is for explantory purposes only

Method

The IES-A was administered to 717 adolescents (70% females, mean age 15.25 ±0.71, range 13-19) together with a socio-demographical questionnaire about EBs, attitudes toward food, physical appearance and activity, and a brief battery of other measures (Rosenberg's Self-Esteem Scale [RSES], the OBQ Perfectionism Scale [OBQ-P] and General Self-Efficacy, [GSE]). To cross-validate results, the total sample was randomly splitted into two subsamples. To cross-validate results, the total sample was randomly splitted into two subsamples.

Measuring Intuitive Eating

Tylka (2006) developed a 21-item instrument, the *Intuitive Eating Scale* (IES), which assesses the three core components of intuitive eating: (a) *Unconditional Permission to Eat* (UPE, 9 items; e.g., "If I am craving a certain food, I allow myself to have it"), (b) *Eating for Physical Rather Than Emotional Reasons* (EPR, 6 items; e.g., "I stop eating when I feel full [not overstuffed]"), and (c) *Reliance on Internal Hunger / Satiety Cues* (RIH/SC, 6 items; e.g., "I trust my body to tell me how much to eat").

Results

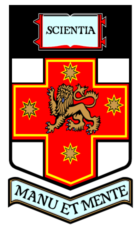
Exploratory factor analyses on subsample-1 data showed that either a three- or a four-factor measurement model could be considered adequate. Confirmatory factor analyses on subsample-2 showed that the four-correlated-factor measurement model showed substantially higher fit indices. The correlations of IES-A scales with socio-demographical variables and the other psychometric measures supported the criterion and construct validity of the new instrument.

	EPR	*UPC*	*RIH*	*SC*	*α*
Items	3, 6, 10, 16, 17, 20	1, 4(R), 5, 9a, 9b, 14	11, 12, 13	2, 7, 8, 15	
EPR	–	.16	–.12	–.17	*.83*
UPE		–	**–.20**	–.14	*.80*
RIH			–	**.35**	*.63*
SC				–	*.74*
Gender*	.17	–.08	.18	**.23**	
Age	.00	.03	.05	–.09	
corrected BMI	–.19	.08	.09	–.06	
RSES	**.26**	.18	–0.1	–.12	*.84*
OBQ–P	–.07	**–.23**	.09	.11	*.83*
GSE	**.28**	.09	–.09	–.16	*.84*

* F=0, M=1; Bolded coefficients are those >|.20|, suggesting a substantial association

Conclusions

The IES-A appears to be a valid and reliable tool for assessing intuitive eating in adolescents, while retaining the sound psychometric properties of its original version. Further research is needed to provide more support to IES-A construct and criterion validity and to investigate its test-retest reliability and sensitivity to change.



Does Parenting Matter for Conduct Problems in Children with Callous-Unemotional Traits?

Dave Pasalich[1], Mark Dadds[1], David Hawes[2], John Brennan[1] and Anthony Kokin[1]

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Background

Negative styles of parenting and parent-child interaction are considered key mechanisms in the development of child aggression and persistent defiance (i.e., conduct problems) (e.g., Patterson, 1982).

Contrary to this traditional view, it has recently been argued that there is considerable genetic influence on the development of conduct problems in children with callous-unemotional (CU) traits (e.g., lack of guilt and empathy) (Viding, Frick & Plomin, 2007), and that parenting does not significantly matter:

- Parent and adolescent reports of ineffective parenting (e.g., poor supervision, harsh and inconsistent parenting) are not related to the elevated rates of conduct problems in high CU children and adolescents (e.g., Wootton, Frick, Shelton, & Silverthorn, 1997)
- High CU children show a poorer response to behavioural parent training intervention (Hawes & Dadds, 2005)

However, these studies have only considered parenting from a behavioural (i.e., social learning/operant theory) perspective, and have mostly relied on 'paper and pencil' reports of parenting.

Attachment theory places emphasis on parents' warmth and sensitive responding to their child, for the development of a secure parent-child attachment. There is reason to suspect that affective and attachment-based measures of parenting may be more important in explaining the development and/or maintenance of conduct problems in high CU children:

- CU traits drop over time with more child-reported parental warmth (Pardini et al., 2007)
- Parents' amount of love and support is related to conduct problems in young adolescents, regardless of the level of the child's emotional empathy (de Kemp et al., 2007)
- Attachment security predicts conscience development in fearless children (Kochanska, 1995) (a temperament style thought to underpin CU traits; Frick & Ellis,1998)

Considering that CU conduct problems are purportedly under significant genetic influence, it is also possible that there are unique intrinsic risk factors in parents of high CU children, that are either directly or indirectly associated with their child's conduct problems. Previous research has found that parents' level of psychopathology and antisocial traits covary with child conduct problems (e.g., Nigg & Hinshaw, 1998).

Aims

(i) To examine whether affective and attachment-based measures of parenting are related to conduct problems in high CU children, and (ii) to investigate whether there are specific risk factors for conduct problems in the parents of these children.

Hypotheses

1) Parental warmth/responsiveness and parents' affective attitude towards their child, would independently predict conduct problems in children high and low on CU traits

2) Parental antisocial traits and/or parental psychopathology would uniquely demonstrate a stronger link with conduct problems in high CU children

Method

Participants

- 78 clinic-referred boys aged 3 to 16 years (mean = 8 yrs)
- Externalising problems (i.e., Oppositional Defiant Disorder or Conduct Disorder and/or Attention Deficit Hyperactivity Disorder)

Measures

CU Traits and conduct problems:

Pooled items from; *Antisocial Process Screening Device* (Frick & Hare, 2002), *Strengths and Difficulties Questionnaire* (Goodman, 1997)

- – aggregated parent, teacher and youth report; where high CU traits = top 25%
- – aggregated parent and teacher report

Parenting:

Maternal warmth/responsiveness (e.g., positive verbal/non-verbal behaviour; sensitive, child-directed responding) was coded during semi-structured family observations using the *Family Observation Schedule – 6th Edition* (Pasalich & Dadds, 2009).

Mothers' positive and negative affective attitudes toward their child were coded during five-minute speech samples using the *Family Affective Attitude Rating Scale* (Bullock et al., 2003).

Parental risk factors:

Antisocial traits; *Millon Clinical Multiaxial Inventory-III* (Millon, 1994)

Psychopathology; *Brief Symptom Inventory – Global Severity* (Derogatis & Melisaratos, 1983)

Results

In the prediction of conduct problems:

- *Hypothesis 1:* CU traits significantly interacted with warmth/responsiveness (see Fig. 1) and there was a significant main effect for negative affective attitude (see Table 2)
- *Hypothesis 2:* Neither of the parental risk factors accounted for unique variance within the context of the model

Table 1. *Order of entry of predictors into the hierarchical stepwise regression*

The overall model accounted for 27% of the variance in conduct problems ($F_{4,73} = 8.24$; $p < .01$).

Step 1	Step 2 (Main Effects)	Step 3 (Interactions)
Age Mother's education Number of siblings in observation	CU traits Warmth/responsiveness Positive affective attitude Negative affective attitude Parental antisocial traits Parental psychopathology	CU traits x main effects

Table 2. *Overall regression model predicting conduct problems*

	B (SE)	β	*ΔR²*
Step 1			.15**
Age	.11 (.03)	.39**	
Step 2			.09*
CU traits	.01 (.00)	.21*	
NAA	.02 (.01)	.22*	
Step 3			.08**
CU traits x warmth/resp	-.01 (.00)	-.28**	

Note: NAA = Negative Affective Attitude. Regression coefficients for Age, CU traits and NAA were significant in step 3.

* p<.05, ** p<.01

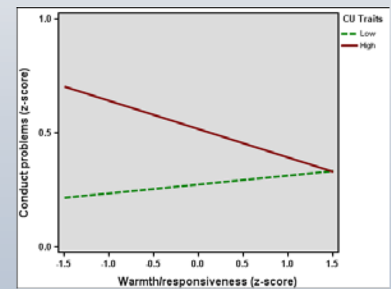

Figure 1. *Prediction of conduct problems from interaction between CU traits and parental warmth/responsiveness*

Discussion

- Increased parental warmth/responsiveness predicted decreased rates of conduct problems in high CU children, but not in low CU children. Moreover, consistent with this study's hypothesis, parents' negative affective attitude toward their child, was positively related to elevated levels of conduct problems; independent of CU traits.
- Against prediction, there was no evidence for parental antisocial traits/psychopathology being specific risk factors for conduct problems in high CU children. These intrinsic parental factors did not account for unique variance in conduct problems when controlling for the other predictors in the model.
- Overall, despite needing longitudinal replication, the results of this study provide tentative support for the suggestion that there are significant psychosocial risk factors implicated in the development and/or maintenance of conduct problems in high CU children. This study argues that parenting may be one of them.

Clinical Implications

How should we treat conduct problems in high CU children?

The present results suggest that parent training may still be effective in treating conduct problems in high CU children. However, current behavioural parent training interventions should be adapted to include parenting strategies informed by attachment theory. It may be necessary to target parents' lack of warm responding within the context of the parent-child relationship. In addition, treatment should focus on parents' implicit attitude toward their child (e.g., using schema-focused therapy with parents).

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Psychological Adaptations to the Adolescent Pregnancy: Influence Contexts

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INTRODUCTION

Social changes in the last century have contributed to a view of adolescent pregnancy as an unexpected event, neither acceptable nor even socially desirable; In the last decades a decline in the incidence of adolescent pregnancy and maternity rates in Portugal has been reported– even though Portugal heads the EU as the countries with the higher rates of pregnancy in adolescence. It is, therefore, most relevant to identify vulnerability and protection factors for pregnancy in adolescence.

Social support emerges as one of the variables in the social and relational contexts that may have a protective action against the risks associated with pregnancy (*e.g.* Shapiro & Mangelsdorf, 1994; Sommer et al., 2000; Whitman, Borkowski, Keogh & Weed, 2001). It promotes the physical and psychological well-being of adolescents (*e.g.* Turner, Grindstaff & Philips, 1990), and has implications for adaptation to changes resulting from pregnancy to the construction of the parental role and for more appropriate maternal behaviours (*e.g.* Borkowski, 2001; Jongenelen, 1988; Soares et al., 2001). Social support has also an impact on the educational background and financial status of the adolescent (*e.g.* Anderson, 1999; Coley & Unger, 1991).

OBJECTIVES

The purpose of this study is to compare Portuguese high-school adolescents who are pregnant with those, who are not or have never been pregnant, in terms of perception of social support as provided by significant others in their social support networks, and also to examine the relational antecedent variables associated with teenage pregnancy.

METHODS

Perception of Social Support Received and Parenting Educational Practices of Portuguese pregnant adolescents and Portuguese teenagers (n = 363) were assessed by a clinical interview (clinical and psychological information); by medical, obstetric and social grids and by a self-reported questionnaire: *EMBU – Inventory for Assessing Memories of Parental Rearing Behaviour* (C. Perris, L Jacobson, H. Lindstorm, L.. von Knorring & H. Perris, 1980).

Table 1: Description of demographic and social characteristics of the sample

	Portuguese Pregnant Teenagers (n=191)		Portuguese Teenagers (n=172)		
	N	(%)	N	(%)	Comparative Tests
Age					
< 15 years	41	21,5	48	27,9	
> 15 years	150	78,5	124	72,1	
	Min = 12 Max = 19 (M=16,32; DP=1,23		Min = 12 Max = 19 (M=16,34; DP =1,61)		t(361)= -.122 p>.001
Marital Status					
Single	111	58,1	171	99,4	
Cohabitating	64	33,5	1	0,6	
Married (by church)	10	5,2	0	0	
Married (by civil)	6	3,1	0	0	χ^2 (3) 89,07 p<.001
Parents Marital Status					
Married/Cohabitating	106	56,7	132	77,6	
Separated	42	22,5	11	6,5	
Divorced	18	9,6	17	10	
Widow	21	11,2	10	5,9	χ^2 (3) 24,15 p<.001
Socioeconomic Status					
Low	173	91,5	101	59,1	
Middle	16	8,5	48	28,1	
Upper	0	0	22	12,9	χ^2 (2) 56,16 p<.001

RESULTS

• *Perception of Social Support Received*

1) SIGNIFICANT OTHERS

Table 2: Univariate analysis of covariance (SES and Marital Status controlled)

		Teenage Pregnant		*Control Group*		
		M	DP	M	DP	
Social Support	Mother	4,17	1,27	4,11	1,15	F1,343=.120, p>.05
	Father	3,43	1,76	3,37	1,51	F1,325=.488, p>.05
	Boyfriend	4,35	1,29	2,79	2,21	F1,309=26,931, p<.01
	Boyfriend`s Family	3,82	1,61	2,12	1,9	F1,299=29,499, p<.01

2) INSTITUTIONS

Table 3: Univariate analysis of covariance (SES and Marital Status controlled)

		Teenage Pregnant		*Control Group*		
		M	DP	M	DP	
Social Suppor	School	3,42	1,69	3,61	0,93	F1,253=.080, p>.05
	Medical Services	4,32	0,86	3,20	1,08	F1,350=83,556, p<.01
	Health Professionals	4,43	0,79	3,38	1,03	F1,349=77,70, p<.01

• *EMBU - Parenting Educational Practices*

Table 4: Multivariate analysis of variance

	Teenage Pregnant		Control Group			
	M	DP	M	DP	F(1,264)	p
Father						
Emotional Support	17,2	6,00	20,2	5,25	5,98	.01
Overprotection	9,87	2,75	10,0	3,00	4,07	.46
Rejection	12,7	2,92	14,1	3,26	.55	.04
	Teenage Pregnant		Control Group			
	M	DP	M	DP		
Mother						
Emotional Support	18,7	5,71	21,9	4,48	9,08	.00
Overprotection	10,7	2,62	11,6	3,45	21,1	.00
Rejection	12,5	2,79	14,4	3,06	7,66	.00

DISCUSSION

Most studies on adolescent pregnancy focuses on the demographic, social and structural characteristics of families. Literature review suggests that social and relational domains are important in identifying vulnerability and protection factors for pregnancy in adolescence.

The key findings of this study also reinforce the importance of social support and family as an important risk and / or protection factor that should be taken into account, specifically:

1) Results point out that adolescents coming from a low socio-economic background and monoparental structure are a group-risk for pregnancy in this stage of the cycle of life.

2) Data from EMBU indicates that the Emotional Support by parents may be a protective factor for adolescent pregnancy so that, conversely, less parental supervision may trigger the occurrence of pregnancies in this period of development

Overall this study attempts to identify sociodemographic and psychological factors associated with teenage pregnancy in Continental Portugal. In doing so, it puts in evidence risk contexts that frame the occurrence and course of teenage pregnancy as well as protective social and relational contexts that promote the adjustment of the adolescent when facing a non-expected pregnancy

Relações, Desenvolvimento & Saúde

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The role of general practitioner in suicide prevention - Using the Hopelessness Scale in primary care

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Abstract

Studies by the WHO showed that 40% - 60% of people who committed suicide had seen a physician, usually a general practitioner, in the month prior to suicide. For people with suicidal thoughts and intentions often go to see their GP, our intention was to assess the potential suicide risk amongst them.
Depression and some psychosocial risk factors have been found in several studies to be correlated with suicidal intent. The level of stress are mediated by the subjective appraisal of the hopelessness of these situations. In a 2002' study the prevalence of depression was 28% in the Hungarian population.
Based on these studies, we assumed the rate of depression to be about 30 % among patients waiting at the GP and that there would be suicidal patients too.
Results showed a more serious picture than expected: people visiting the GP in special with physical health problems, were significantly more depressed, hopeless and anxious than controls, and one third of them proved to be at high suicide risk.

Introduction

Hungary still has one of the highest suicide rates in the world.
In the course of identifying the risk factors of suicide, a lot of examinations confirmed that depression is the most frequent psychiatric diagnosis linked to suicide. According to results of domestic examinations, the proportion of those patients who did not ask for medical help, or rather the under diagnosis of depression is a notable factor in suicide mortality in Hungary.
A more accurate analysis of suicide recognized that a significant number of those who commit and almost everyone who attempt suicide communicate their intention to the surroundings in some way („cry for help" syndrome).
Although much attention is focused on suicide prevention by psychiatric services, the role of the general practitioner in the prevention of suicidal behaviour is also important.
The results of cognitive psychology researches provide an important basis to recognize the suicidal intent, since hopelessness as a negative cognitive pattern can be indentified as a strong predictor of suicide and can be modified by an appropriate supportive intervention.
This research is based on a survey carried out among the patients visiting the GP, since according to previous surveys they are at a high risk of depression and suicidal predisposition.

Methodology

Sample

138 patients and were assessed in different GP's practice in Budapest. Age: 18-70. Random allocation (Patient group).
The Control group consisted of 91 volunteers.
The two samples were matched with regard to gender, age, qualification and marital status.

Measures

- Beck Depression Inventory (BDI), Beck, A.T., Ward, C. H.,Mendelsohn, M., Mock, J., Erbaugh, J., 1961
- Beck Anxiety Inventory (BAI), Beck, A.T., 1976
- Beck Hopelessness Scale (BHS), Beck, A.T., Weissmann, A., Lester, D.,Trexler L., 1974
- Life Event Scale (LES), Paykel, 1991

Hypothesis

1. Depression, anxiety and hopelessness rate will be significantly higher among the patients waiting at the GP than among the control persons.
2. Based on previous surveys, the rate of depression in Patient group will be expected appr. 30%.
3. Since hopelessness proved to be a valid predictor of suicidality, we wanted to identify suicidal patients characterized by high BHS score.

Demographic characteristics of the 138 patients and 91 control persons

		Patient group (n= 138)		Control group (n=91)	
Age p<0,049	Average	40,6		37,3	
	St. deviation	12,79		11,48	
Gender p<0,505	Males	45	32,4%	33	36,7%
	Females	93	67,6%	58	63,3%
Marital status p<0,845	Married	76	55,2%	57	63,6%
	Divorced	34	24%	9	10%
	Single	28	20,8%	25	26,7%
Education p<0,746	University graduation	54	38,8%	31	34,4%
	High school graduation	84	61,2%	60	64,4%

RESULTS

Depressive symptomatology (BDI scores) in the Patient group and Control group

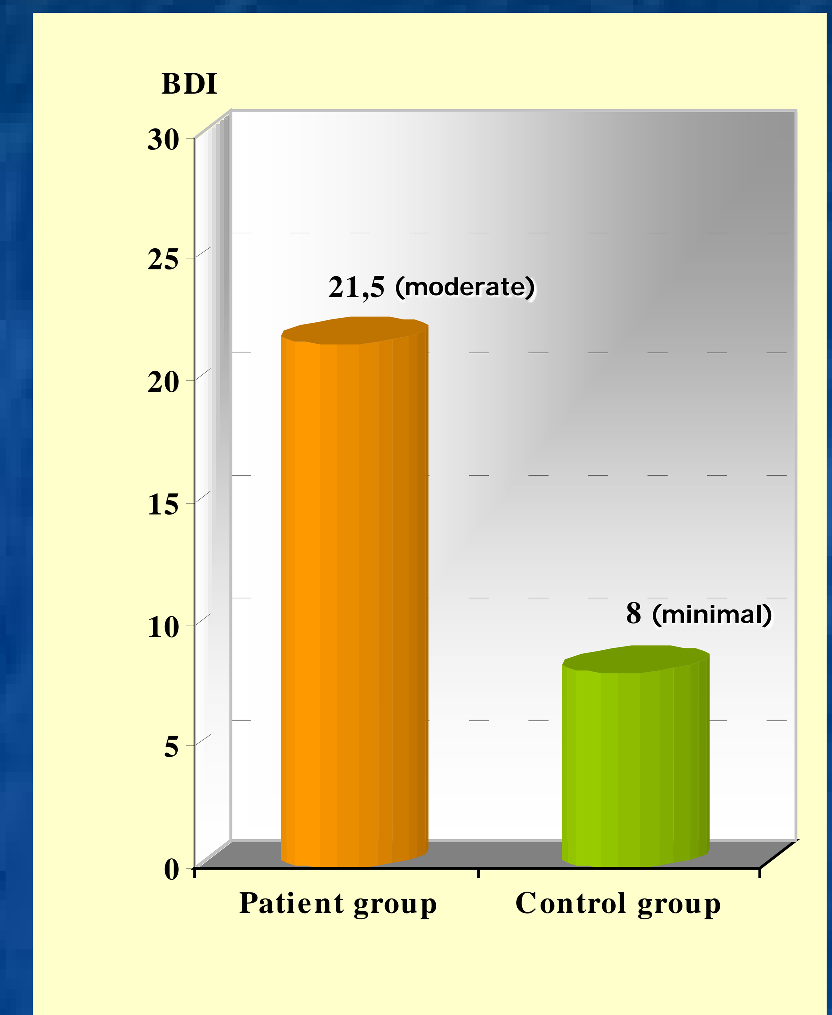
	BDI severity categories				
	Minimal (0-9)	Mild (10-18)	Moderate (19-25)	Severe (26-	
Patient group	14	47	26	51	N=138
	10,1%	34,1%	**18,8%**	**37%**	100%
Control group	71	13	4	2	N=91
	78,9%	14,4%	**4,4%**	**2,2%**	100%

Hopelessness symptomatology (HS scores) in the Group P and Group C

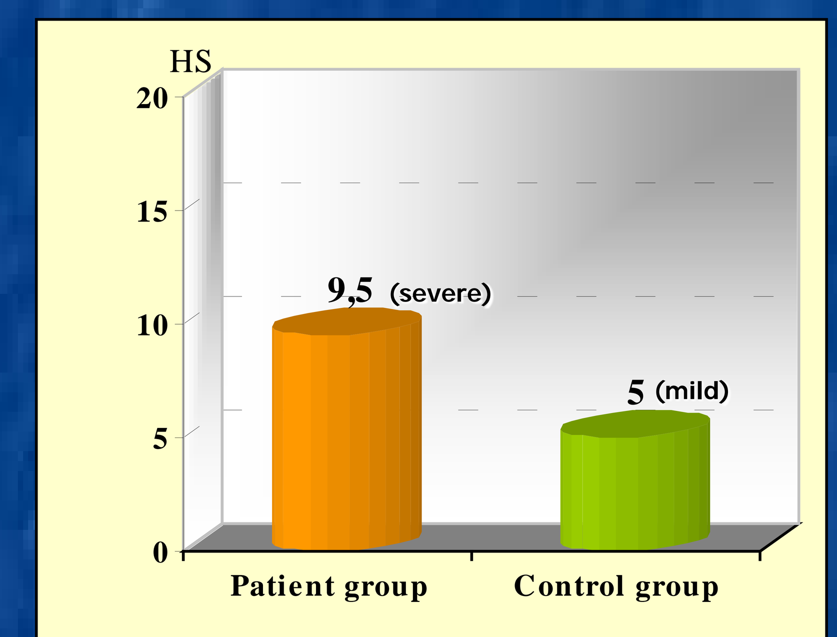
	HS severity categories		
	Mild (0-9)	Severe (9-20)	
Patient group	77	61	138
	55,7%	**44,2%**	100%
Control group	81	10	91
	89%	**11%**	100%

Depressive and hopelessness symptomatology (BDI and HS scores) in the Patient group

HS severity categories	BDI severity categories			
	Normal (0-9)	Mild (10-18)	Moderate (19-25)	Severe (26-)
Mild (0-9)	13	29	10	11
	9,42%	21,01%	7,24%	7,97%
Severe (9-20)	2	15	15	42
	1,44%	10,86%	**10,86%**	**30,43%**



Depressive symptomatology (BDI scores) in the Patient group and Control group (p<0,001)



Hopelessness symptomatology (HS scores) in the Patient group and Control group (p<0,001)

Results

1. 37% of the Patient group showed serious depression instead of the expected 30%, and symptoms of moderate depression occurred in 18%.
2. Patient group showed significantly more severe depression symptoms, hopelessness and anxiety than the Control group.
3. Moreover, a high risk group was identified in the Patient group: those individuals who are characterized by intense hopelessness and with moderate or severe depression.

Conclusion

1. Early identification and appropriate treatment of mental illness is an important strategy for preventing suicide and the general practitioner is often the most appropriate person from whom to seek help.
2. It is a basic step of prevention to influence the modifiable factors as the negative way of thinking or feeling of hopelessness. It is of a capital importance to have quickly applicable and reliable means and questionnaries available.
3. The short versions of the BDI or the BHS can be successfully applied in the Hungarian population as well.
4. Using of BDI and BHS are highly recommended in GP's offices to assess suicide risks when suicidal intent is not explicitly expressed.

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Emotion regulation, negative affectivity, and dysphoria: Moderated mediation

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Objectives. Previous research has shown that two emotion regulation strategies, experiential avoidance (a tendency to have negative reactions toward own internal experiences) and depression-related ruminative style, are related to dysphoria (Hayes, Strosahl, Wilson, Bissett, Pistorello, Toramino et al., 2004; Lyubomirsky & Nolen-Hoeksema, 1993). Also, thought suppression can make, ironically the thoughts more accessible and lead subsequently to rumination (Wenzlaff & Luxton, 2003). However, it remains unclear to what extent avoidance of internal experiences other then thoughts might lead to rumination. Additionally, the role of a general tendency to experience negative affect in the avoidance-rumination-dysphoria link is unclear. The proposed conceptual model that was tested in this study is depicted in Figure 1.

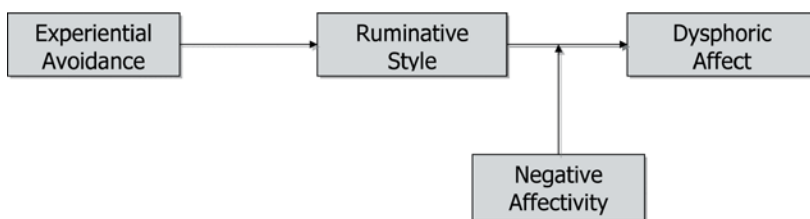
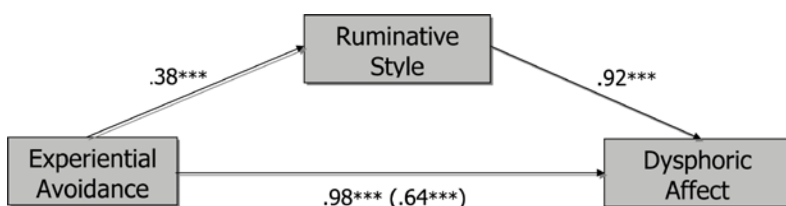


Figure 1. The proposed conceptual model

Methods. 223 Serbian undergraduates completed in a counterbalanced order: the Acceptance and Action Questionnaire II (Bond, Hayes, Baer, Carpenter, Orcutt, & Zettle, personal communication, January 15, 2008), the Response Style Questionnaire-SF (Nolen-Hoeksema, Parker, & Larson, 1994), the Positive and Negative Affect Schedule-SF (Watson, Clark, & Tellegen, 1988) and the Self-rating Dysphoria Scale (Novovic, Biro, & Nedimovic, 2007).

Results. A test of mediation, depicted in Figure 2, suggested that the link between experiential avoidance and dysphoria was partly mediated through depression-related ruminative style (Sobel z = .36, p < .001; 95% PB CI = .20 - .54, p <.001). This indirect effect was moderated by a propensity to experience negative affect (NA). For High NA individuals (+1SD), the effect of rumination on dysphoria was larger (boot IE = .25, p < .01) compared to Low NA individuals (- 1SD) (boot IE = .12, p < .05).



Note: N = 223. Unstandardized regression coefficients reported. *** p <.001

Figure 2: Regression Results for Simple Mediation

Conclusions. Ruminative style acted as a partial mediator in the relation between experiential avoidance and dysphoria. This finding extends the previous research on thought suppression suggesting that avoidance of other internal experiences (emotions, impulses) can also lead to rumination, which, in turn, promotes dysphoria. The detrimental effects of rumination were particularly pronounced in High NA individuals. Noteworthy, experiential avoidance still explained a significant portion of the variance in dysphoria when the mediator was taken into account, suggesting that both emotional regulation strategies are important in understanding vulnerability to dysphoria. Clients, particularly those high on NA, might benefit from intervention programs aimed at enhancing acceptance and psychological flexibility.

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Relation between cognitive and psychiatric constructs of vulnerability to depression

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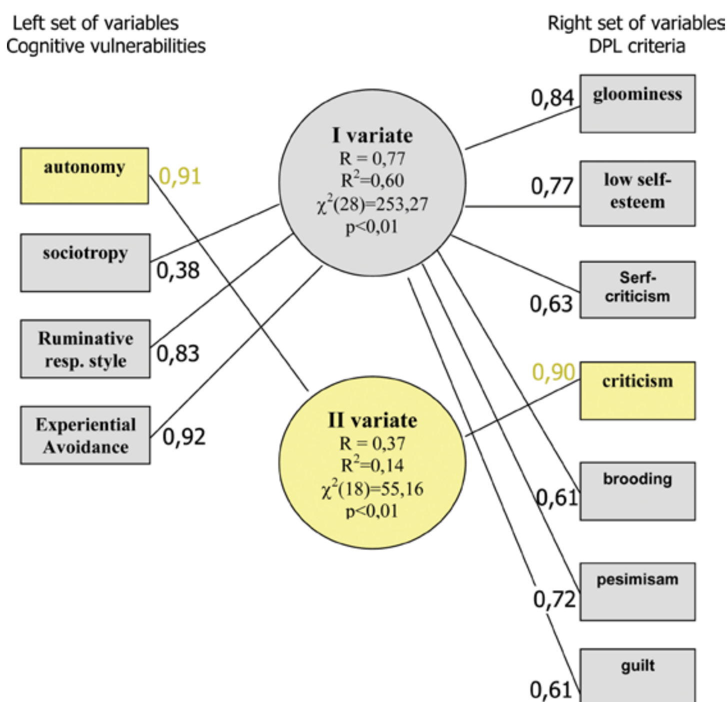
Introduction. The cognitive theories of depression have suggested several constructs of vulnerability to depression based on the diathesis-stress models of psychopathology. On the other hand, in the history of psychiatry several authors have described depressive personality as potential vulnerability factor for the affective disorders. This construct served as a basis for the diagnosis of depressive personality disorder (DPD), as defined in Appendix B of the DSM-IV classification.

The objective of this study is to explore the relations among the cognitive constructs of depressive vulnerability: Sociotropy, Autonomy (Beck, 1983), Depression-related Ruminative Responsive Style (RRS; Nolan-Hoeksema, 2000), and Experiential Avoidance (EA) (Hayes et al., 1996), on the one hand, and, the DSM-IV criteria for DPD, on the other.

Figure 1: Factor structure of the canonical roots



Methods. 225 undergraduates completed the cognitive measures of depressive vulnerability: 1) Personal Style Inventory (Robins et al, 1994), 2) Response Style Questionnaire-SF (Gonzales et al, 2003), 3) Acceptance and Action Questionnaire II (Hayes et al, 2004), 4) 7 DSM-IV criteria for DPD - a self-report instrument tapping DPD criteria using 4-point Likert scale.

Results. To address the research question, a canonical correlation analysis was conducted to examine the multivariate relations among the cognitive measures of depressive vulnerability (left set) and 7 criteria for DPD based on the DSM-IV appendix B (right set). Four variants were extracted, but only two functions were significant that explained more than 10% of variance (figure 1)

Discussion and conclusions. The relation between the cognitive vulnerability to depression and the DSM-IV criteria for DPD can be described by two latent functions:

1. EA turned out to be the strongest predictor of the majority of the depressive personality criteria, followed by RRS and Sociotropy. It appears that the first canonical variate is made up largely of a general cognitive vulnerability, on the one side, and the majority of criteria for DPD, on the other.
2. The second pair of canonical variables connected Beck's Autonomy with one of the DPD criteria - negativism, criticism, and judgmentalness toward others.

Successful psychotherapies based on the cognitive constructs can be recommended for persons with DPD. Therapies targeting EA can be especially potent. Psychological and psychiatric concepts of depressive vulnerability are interrelated but not redundant, suggesting both concurrent and construct validity of the DSM construct of depressive personality.

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Irrational beliefs and goal importance in predicting dysfunctional mood states: an experimental study

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Introduction. Rational Emotive Behavioral Therapy is well established therapy practice in a large family of CBT. However, some of REBT theoretical assumptions have received insufficient empirical support. In this research, REBT ABC model of emotion formation was reformulated and element G (goal) was added, according to recent Ellis conceptualizations (Ellis, 1994).

Experimental study was designed to test how irrational beliefs (B) and goal importance (value of potential award - G) affected dysfunctional mood states (general, anxiety, depression and anger – C), after receiving a negative feedback (A).

Method and Design. Non-clinical sample of 62 undergraduates in experimental condition reported irrational beliefs and mood states before and after the negative feedback induction, while 35 undergraduates in control condition reported irrational beliefs and mood states before and after reading a neutral text.

Measures: - General attitudes and beliefs scale (GABS), short and modified version (Marić, 2002),
- Profile of Mood States (POMS; McNair, Lorr & Droppleman, 1971); anxiety, anger and depression subscales were used.

Results. Results suggested that both rational and irrational beliefs were related to general negative mood state, as well as with anxious, depressive and angry mood. Relations between rational beliefs and mood states proved to be mediated by the effect of irrational beliefs (see Table 1).

Table 1: partial correlations beliefs with mood states

variables	POMS	ANX	DEP	ANG
RU°	- .13	- .08	- .18	- .06
IU§	.40***	.31***	.32***	.40***

° controlling for IU; § controlling for RU; *** p< .001; ** p< .01; * p< .05

Results further revealed significant interaction of activating event (A) and irrational beliefs (B) in predicting general dysfunctional emotional state and anger, but not anxiety and depression. Triple interaction AxBxG found to be statistically significant in predicting POMS ($F(2, 54)=6.41$, $p<.01$), as well as anger ($F(2, 54)=5.07$, $p<.01$). "Highly irrational" respondents, who found potential award very important scored higher on both POMS and anger after receiving negative feedback, comparing to all other subgroups.

Finally, contrary to original REBT model, results of the regression analysis revealed that irrational beliefs of self–depreciation, and not absolutistic demands, was the strongest predictor of negative mood.

Conclusions and Implications. Results partially supported Ellis' ABCG model of emotion formation and questioned the assumption of absolutistic demands as a principal irrational mechanism (see also Dryden, 2003). Goal importance acted as a moderator in relation between negative feedback, irrational beliefs and mood states.

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Relation between depression symptoms, perfectionism and self-concept

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1. Introduction

A dual process model of perfectionism is based on reinforcement theory and the authors of this model proposed two types of perfectionism - positive and negative (Slade & Owens, 1998). Positive perfectionists are people who set for themselves high but realistic and achievable goals which are adjusted to situation, they are motivated by the wish for success, and their sense of self-worth is independent of their performance. Negative perfectionists set for themselves non-realistic and unachievable goals, they are extremely rigid, motivated by the fear of failure, focused on avoiding mistakes, and extremely self-critical at failure. There are researches that confirm correlation between depression symptoms and maladaptive perfectionism (Lauri-Korajlija, 2004; Ashby, Rice & Martin, 2006). Depression symptoms are also correlated with low self-esteem (Mickelson & Williams, 2008) and actual-self/ideal-self discrepancy (Higgins, 1987) but it is still unclear what is the particular contribution of these variables in predicting

2. Aim

The aim of this study was to examine relation of positive and negative perfectionism, self-esteem and actual-self/ ideal-self discrepancy with depression

3. Sample

205 undergraduate students of University of Zagreb (26% boys and 74% girls) participated in this study. Average age of students in the sample was M=20,73;

4. Procedure and Analysis

Positive and Negative Perfectionism Scale (PANPS; Terry-Short et al., 1995) Self-Liking/Self-Competence Scale (SLCS; Tafarodi & Swann, 1995), Self Concept Questionnaire - Conventional Construct Version (SCQ-CC; Watson, 2001) and Beck Depression Inventory (BDI-II; 1996) were applied. The order of questionnaires was rotated.

Linear regression analysis was conducted with positive and negative self-oriented perfectionism, positive and negative socially prescribed perfectionism, self-liking and self-competence, and actual-self/ideal-self discrepancy as predictor variables and depression symptoms as criterion variable.

5. Results

Table 1. Model summary of hierarchical regression analysis with depression symptoms as criterion variable (N=205)

Model	R	R^2	Adjusted R^2	R^2 Change	F Change	Sig. F Change
1 (gender, age)	0,154	0,024	0,013	0,024	2,161	p>0,05
2 (PERFECTIONISM: positive self-oriented, positive socially prescribed, negative self-oriented, negative socially prescribed)	**0,625**	**0,390**	**0,369**	**0,367**	**26,009**	**p<0,01**
3 (self-liking, self-competence)	0,632	0,399	0,371	0,009	1,283	p>0,05
4 (actual-self/ideal-self discrepancy)	**0,671**	**0,450**	**0,420**	**0,050**	**15,498**	**p<0,01**

Table 2. Coefficients of hierarchical regression analysis with depression symptoms as criterion variable (N=205)

Model		Standardized β	t	Sig.	Correlations	
					Partial	Part
1	gender	**0,160**	**2,070**	**p<0,05**	**0,154**	**0,154**
	age	-0,032	-0,408	p>0,05	-0,031	-0,030
2	gender	0,076	1,211	p>0,05	0,092	0,072
	age	-0,026	-0,416	p>0,05	-0,032	-0,025
	positive self-oriented perfectionism	-0,067	-0,860	p>0,05	-0,065	-0,051
	positive socially prescribed perfectionism	**-0,203**	**-2,465**	**p<0,05**	**-0,184**	**-0,146**
	negative self-oriented perfectionism	**0,476**	**5,752**	**p<0,01**	**0,401**	**0,341**
	negative socially prescribed perfectionism	**0,200**	**2,304**	**p<0,05**	**0,173**	**0,137**
3	gender	0,073	1,153	p>0,05	0,088	0,068
	age	-0,028	-0,451	p>0,05	-0,035	-0,027
	positive self-oriented perfectionism	-0,065	-0,831	p>0,05	-0,063	-0,049
	positive socially prescribed perfectionism	**-0,203**	**-2,458**	**p<0,05**	**-0,185**	**-0,146**
	negative self-oriented perfectionism	**0,454**	**5,418**	**p<0,01**	**0,383**	**0,321**
	negative socially prescribed perfectionism	**0,182**	**2,073**	**p<0,05**	**0,157**	**0,123**
	self-liking	0,042	0,648	p>0,05	0,050	0,038
	self-competence	0,082	1,282	p>0,05	0,098	0,076
4	gender	0,108	1,748	p>0,05	0,133	0,099
	age	-0,025	-0,410	p>0,05	-0,031	-0,023
	positive self-oriented perfectionism	-0,005	-0,064	p>0,05	-0,005	-0,004
	positive socially prescribed perfectionism	**-0,192**	**-2,415**	**p<0,05**	**-0,182**	**-0,137**
	negative self-oriented perfectionism	**0,392**	**4,776**	**p<0,01**	**0,344**	**0,272**
	negative socially prescribed perfectionism	0,161	1,917	p>0,05	0,145	0,109
	self-liking	0,022	0,354	p>0,05	0,027	0,020
	self-competence	0,065	1,052	p>0,05	0,080	0,060
	actual-self/ideal-self discrepancy	**0,247**	**3,937**	**p<0,01**	**0,289**	**0,224**

6. Conclusion

Results of hierarchical regression analysis have shown that included four blocks of variables explain 42% of depression symptoms variance. Most of the variance is explained by perfectionism. The best predictor of depression symptoms is **negative self-oriented perfectionism**. Also significant predictors are discrepancy between students' actual-self and ideal-self and positive socially prescribed perfectionism. Results indicate that students' too high expectations of them-self and belief that they wouldn't meet that expectations is related with depression symptoms.

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MONITORING GROUP COHESION IN CBT EDUCATIONAL GROUPS - A PROSPECTIVE STUDY

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BACKGROUND: The Association for Cognitive Behavioral Psychotherapy in Macedonia works as an educational centre for CBT since 2006, and has a total number of 55 members, of which 45 are students in training program. Until now three groups are already in CBT basic course training and have completed the Personal Development Program (PDP), based on the standards for personal therapy/development under EABCT.

AIM: We are interested in how the CBT training program affects the intergroup relations and group cohesion level of groups as they progress in CBT training. We plan to conduct a 3 year prospective study based on our primary findings of the mean scores for each of the two groups in the initial testing with the Group Cohesion Scale - Revised (V. Veeraraghavan et al., 1999).

SAMPLE:

(i) The first group has 19 (2 male, 17 female)

(ii) The second group has 13 members (1 male, 12 female)

The groups are comprised mostly of psychiatrists, psychologists and counselors in different mental health areas. The first group had weekend workshops (2 daysX8h) once a month at irregular intervals and the second group had the same workshops every month (regular interval), during the business year (except national holydays and semester vacations).

PROCEDURE: For this task we have measured the level of group cohesion with the GCS-R in two groups of students at the end of the first year of the training course (after they have finished the PDP). We intend to monitor the group's cohesion level of both groups at the following intervals: two years and at the end of CBT course.

We also intend to include future comparison measures of the Relational Satisfaction Scale (RSS, Anderson M.C. et al., 2001) at the end of the second year and the end of the course, and also add a third group with comparison measures since 3 months of training.

INITIAL RESULTS and EXPECTATIONS: The mean scores on the GCS-R in the initial testing were 53 and 79 for the first and second group, respectively, which show large difference in the level of group cohesion. We expect to find further evidence as the monitoring of group development goes along.

We expect that the smaller group will have greater group cohesion than the larger one and that the time spent on group work and intensity of educational sessions to be a positive influence on cohesiveness. We also expect that cohesion and relational satisfaction should relate in a positive manner.

GROUP COHESION

Forsyth (1999) regarded cohesion as the strength of the bonds linking group members to the group. He observed that cohesive groups share some common characteristics:
(a) enjoyment and satisfaction,
(b) a cooperative and friendly atmosphere,
(c) exchange of praise for accomplishments,
(d) higher self-esteem and less anxiety among group members, and
(e) greater member retention.

Frank (1997) claimed that group cohesion is important in therapy groups because it enables members not only to risk change but also to maintain the change.

GROUP COHESION SCALE-REVISED

The GCS-R is used to assess cohesion among group members in terms of the diverse dimensions, such as interaction and communication (including domination and subordination), member retention, decision making, vulnerability among group members, and consistency between group and individual goals. It should be regarded as a state, as opposed to a trait, instrument, and thus, it can be appropriately used to assess fluctuations in cohesion within a group's development.

GSC-R (V. Veeraraghavan et al., 2001) showed acceptably high reliability for use in research (α=0.84).

Therapists can use the GCS-R as a barometer to assess cohesiveness at different stages of group development.

RELATIONAL SATISFACTION

Communication satisfaction can be defined as a perception about the quality of group life that exists (Pavitt & Curtis, 1998). Satisfaction with intragroup relations is generally accepted as a maintenance dimension of group work.

Relational satisfaction as a concept presents building and maintaining of member relationships during communicative processes and practices throughout the life span of the group.

Pavitt and Curtis (1998) suggested that once group members build levels of cohesiveness, it can be viewed as an input variable that influences the group's discussions and recursively may even affect itself.

RELATIONAL SATISFACTION SCALE

The RSS is designed to measure people's perceptions of the social fabric of group experiences. Participants are instructed to "think of their latest work-related group" in responding to the Likert-type items on a range from "Strongly Agree" (5) to "Strongly Disagree" (1).

The RSS may prove useful for testing motives for communicating in groups and would also be a useful tool in testing models addressing the relational side of groups.

The scale results from a single factor, that is taken as a unidimensional measure (Anderson M.C. et al., 2001) and the reliability for the RSS is α=0.89.

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A NEW TECHNIQUE, CINEMATHERAPY: CLINICAL PRACTICE

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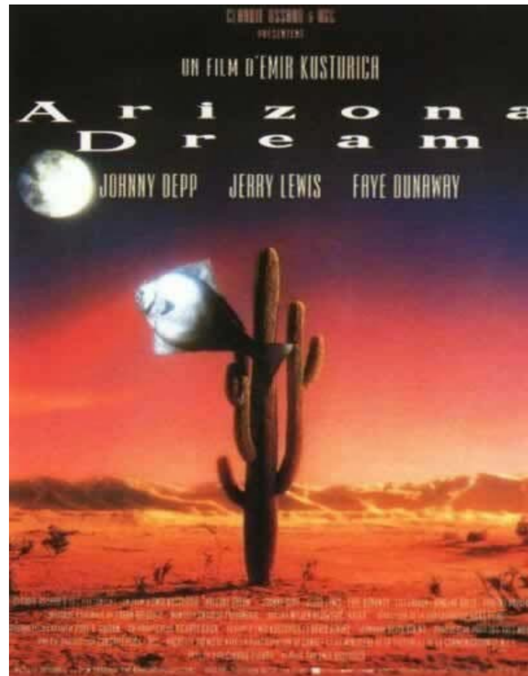
The purpose of this study is to report, through one case, a new technique: cinematherapy that works into CBT. In other words, this study is conducted in order to determine the therapeutic effect of cinematherapy technique of Cognitive-Behavioral Therapy in-sessions. One of the uses of this technique is to deal with unwanted negative emotions such as shame and guilt. In general, this technique motivates patients to realise their repressed emotions and focuses on their self-awareness.

This case study is about a 27 years-old female doctorate student –to -be had lost her parents from cancer when a child herself.

Indications:
•Fear of abondenment
•A pattern of unstable and intense interpersonal relationships (idealization-devaluation)
•Affective instability
•Chronic feelings of emptiness, shame, guilt
•Inappropriate, intense anger or difficulty controlling anger
•Depressive symptoms and suicide ideation

Cinematherapy technique is combined with CBT in total of 49 psychotherapy sessions weekly for approximately two years



The patient shows a pervasive pattern of instability in interpersonal relationships, self-image and emotions. The data is derived from records and transcription of psychotherapy sessions conducted by the researcher herself and homework assignments done by the patient. In addition to these materials, self-report scales are assessed for psychopathological symptoms. The selected films which display more contributions in improvement for psychological problems were: Arizona Dream (1993), The Sea Inside (Mar adentro-2004), and Vicky Christina Barcelona (2008).

"Arizona Dream"is mentioned to be the best film identified with, is dealing with feelings of "worthlessness" and "emptiness".

"The Sea Inside" is considered to be about "loss", "fear of dying" , and "choices we make".

According to her, "Vicky Christina Barcelona" is projection of conflicts between actual and ideal self as well as feelings of being victimized by matrimony.

Assignment Questions:
Tell me about the characters in the movie. What was the character thinking/feeling? What did the character see as his or her main problem? How did the character resolve his or her issues? What other solutions might the character have used? What was his or her relationship to other characters? Who did you like/not like? Who did you identify with? Why?

Consequently, the patient confronts her repressed negative emotions and accept her psychological problems. Feelings of anger, unhappiness, shame and guilt are recognized, distinguished and construed while she gains insight about her distorted perceptions, negative automatic thoughts and irrational beliefs. Along with depressive symptoms, affective instability, impulsivity and, interpersonal issues improved as well. As a result, the cinematherapy technique is proved to be a useful tool for confronting unwanted emotions such as anger, shame and guilt, in addition to support cognitive-behavioral therapy.

The Preliminary Psychometric Properties of the Center for Epidemiologic Studies-Depression Scale (CES-D) in a Turkish sample

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Introduction

In Turkey a reliable measure of depressive symptoms is needed for use in research to determine the incidence, prevalence, and risk factors associated with depression in several populations. The Center for Epidemiologic Studies-Depression Scale (CES-D; Radloff, 1977) was chosen for this study over other depression inventories because it was developed for use in the community rather than a psychiatric population, and the wording of the CES-D is more concise than other available instruments. While the CES-D has been used extensively in other populations to screen for depression, there has been no reported psychometric testing or use in Turkish population, including a wide range of age groups. The aim of the present study was to investigate the psychometric properties of the CES-D in a Turkish community sample.

Method

Subjects. Three-hundred and twenty six subjects comprised of 175 (53.8%) females and 150 (46.2%) males, with one case not indicating his/her gender, participated in the study. The age of the total sample ranged from 18 to 52 years with a mean of 22.02 (SD = 4.01).

Instruments. Along with the CES-D, Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979), Brief Symptom Inventory (BSI; Derogatis, 1992), Positive Affect Negative Affect Scale (PANAS; Watson, Clark, & Tellegen, 1988), and Reassurance Seeking

Scale (RASS; it is one of four components of the Depressive Interpersonal Relationships Inventory; Coyne, 1976) were administered.

Procedure. The CES-D was translated into Turkish using the two-way translation procedure. Following the participants' informed consent, the instruments were administered in a randomized order to eliminate the effect of sequencing.

Results

Descriptive Statistics. Gender differences for the measures of the study were examined with independent samples *t*-tests and the differences between men and women on the total scores of the measures of the study did not emerge as significant.

Factor Structure. Scores obtained from the CES-D were subjected to exploratory factor analysis using principal components factoring. The Kaiser-Meyer-Olkin measure of sampling adequacy was found to be .92 and Bartlett's test of sphericity was significant (df = 190, $p < .001$). Scree plot and Eigen values indicated four factors with eigenvalues of 7.56, 1.53, 1.19, and 1.01 for extraction. These factors together were explained 56.48 percent of the variance. However, when these factors were subjected to four, three and two factor solutions with varimax rotation (and also with oblique and promax rotations), items were not loaded under their respective factors as supported by previous studies. In these analyses, the lower limit for a salient factor loading was set at .32 (Tabachnick & Fidell, 2001). As a result, a single-factor solution accounting for 37.81 percent of the total variance by itself seemed to be more appropriately fit the data. The loadings of the items on this single factor were ranged from 0.34 to 0.82.

Reliability. The corrected item-total coefficients for the total CES-D ranged from .29 to .77, indicating that all items are associated with the whole CES-D. Cronbach's alpha coefficient for the whole scale was found to be .91, supporting high reliability for the scale corresponding with the relevant literature. The Guttman split-half reliability for the whole

CES-D was .91, where the Cronbach's alpha coefficient for the first half composed of 10 items was .84, it was .82 for the second half which consisted of 10 items.

Convergent Validity. Supporting the convergent validity, the CES-D showed significant positive correlations with the BDI, BSI, PANAS-NA, and RASS (see Table 2). As expected, there was a significant negative correlation between CES-D and PANAS-PA.

Conclusion

The findings of the present study indicated that the CES-D had adequate psychometric properties in a Turkish community sample. In particular, the results revealed preliminary evidence for the cross-cultural utility of the CES-D in epidemiological studies. Consistent with the present results, there is still no complete consensus concerning the factorial structure of the CES-D. Although most researchers point out a four-factor solution, there are variations among the factor structure, the item content and hierarchy of items loading on the factors in the literature. Future research investigating the cross-cultural aspects of depressive symptomatology is strongly encouraged.

Table 1. Descriptive statistics (means with standard deviations in parentheses) for the study variables

	Total (N = 326)	Men (N = 150)	Women (N = 175)	t value
1. CES-D	15.92 (10.86)	16.10 (10.89)	15.70 (10.86)	0.33
2. BDI	11.68 (8.38)	12.22 (9.21)	11.21 (7.62)	1.08
3. BSI	105.17 (34.87)	102.79 (34.25)	107.29 (35.44)	-1.16
4. Panas-NA	20.21 (7.16)	20.28 (7.02)	20.14 (7.32)	0.18
5. Panas-PA	30.21 (7.26)	30.35 (6.99)	30.04 (7.49)	0.38
6. RASS	11.87 (4.95)	11.69 (4.99)	12.03 (4.93)	-0.61

Note. CES-D = Center for Epidemiologic Studies-Depression Scale, BDI = Beck Depression Inventory, BSI = Brief Symptom Inventory PANAS-NA = Negative Affect Scale, PANAS-PA = Positive Affect Sale, RASS = Reassurance Seeking Scale.

Table 2. Correlations among the CES-D, BDI, BSI, PANAS, and RASS (N = 326)

	BDI	BSI	PANAS-NA	PANAS-PA	RASS
CES-D	0.70**	0.73**	0.74**	-0.51**	0.38**
BDI		0.75**	0.68**	-0.46**	0.36**
BSI			0.74**	-0.34**	0.46**
PANAS-NA				-0.36**	0.35**
PANAS-PA					-0.13*

Note. CES-D = Center for Epidemiologic Studies-Depression Scale, BDI = Beck Depression Inventory, BSI = Brief Symptom Inventory PANAS-NA = Negative Affect Scale, PANAS-PA = Positive Affect Sale, RASS = Reassurance Seeking Scale. *$p < .05$, **$p < .01$

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PREDICTION OF THERAPEUTIC RESPONSE TO CBT IN PATIENTS SUFERING WITH OBSESSIVE COMPULSIVE DISORDER RESISTANT TO THE TREATMENT WITH PSYCHOPHARMACS

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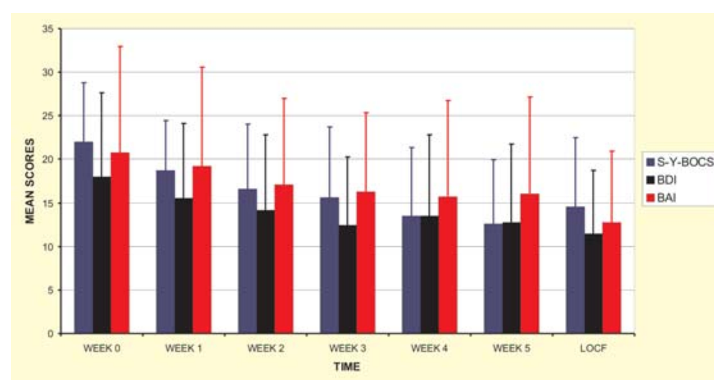
INTRODUCTION

- No consistent predictors of outcome have been identified for the treatment of the obsessive-compulsive disorder (OCD).
- The purpose of the present study is to examine the effectiveness of CBT on a sample of no selected, pharmacologically treatment-resistant OCD patients and to find the predictors of successful treatment in these conditions.
- The therapy was conducted in a naturalistic setting and systematic CBT steps were adapted to each patient.
- Pharmacologic treatment underwent no or minimal changes during the trial period.
- Outcome measures included the Yale-Brown Obsessive Compulsive Scale, subjective version, the Clinical Global Impressions-Severity of Illness scale, Beck Depression Inventory, Beck Anxiety Inventory, Somatoform Dissociation Questionaire, Dissociative Experience Scale.
- The primary outcome measure for response was a rating of 25% improvement in Y-BOCS. There was border for remission -12 points or less on the same scale, and 1-2 points in CGI-S.

Figure 1: Clinical rating scales during the treatment



Y-BOCS: ANOVA week 0 to 5: $p < 0.0001$; t-test week 0 a LOCF: $p<0.0001$
BDI: ANOVA week 0 to 5: $p<0.05$; t-test week 0 and LOCF: $p<0.0001$
BAI: ANOVA week 0 až 5: ns; t-test week 0 and LOCF: $p<0.0001$

RESULTS

- 47 patients completed the trial (19 male and 28 female). One patient refused the protocol.
- All patients finished minimum of 5 weeks of CBT and showed statistically significant improvement on all outcome measures.
- At the end of therapy:
  - 64.1% of patients were improved as measured by the 25% decreasing in Y-BOCS.
  - 50% of patients reach remission according Y-BOCS
  - and 40.4% according CGI.
- The main predictors of good therapeutic outcome were lower scores in Y-BOCS, good insight, high resistance against symptoms, low level of dissociation, and aggressive character of obsessions.
- The negative predictors were control/symmetry obsession and compulsions, and obsessive slowness and ambivalence

Table: Demographic and clinical data before therapy

Age	32.2 + 9.3 let
Gender 19 males and 28 females	
Years of education	14.0 ± 3.1 let
Age of OCD onset	15.3 + 7.7 let
Years of OCD symptoms	16.8 + 9.7 let
Treatment delay	10.5 + 7.3 let
S-Y-BOCS	
total	22.97 + 6.83
obsessions	11.15 ± 3.04
compulzions	10.95 ± 4.32
SDQ-20	23.67 ± 4.86
DES	
total	12.86 + 11.15
depersonalization	43.33 ± 63.66
disociativní amnézie	50.50 ± 65.55
imaginal concern	158.3 ± 140.4
CGI	4.43 + 1.06
BAI	20.81 ± 12.14
BDI	18.00 ± 9.61
Doses of antidepressants (eqvivalent of paroxetine)	39.57 + 30,80
Adjuvant medication (n of patients):	
antipsychotics	17 (36,2%)
antikonvulsiva	3 (6,4%)
without medikation	4 (8,5%)
Comorbidity axis I	20 (42,6%)
Comorbidity axis II	30 (62,8%)

RESULTS

- There were significant decreases of the mean scores in outcome measures during the treatment.

Table: Mean scores during the treatment

Measurements	WEEK 0	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6	LOCF
Y-BOCS	21.97 + 6.83	18.73 + 5.72	16.58 + 7.50	15.64 + 8.06	13.46 + 7.91	12.56 + 7.42	16.63 + 7.06	14.59+ 7.87
CGI	4.43 + 1.06							2.83 + 1.19
BDI	18.00 ± 9.61	15.53 ± 8.62	14.11 ± 8.69	12.44 ± 7.82	13.51 ± 9.29	12.74 ± 8.98	13.02 ± 8.98	11.47 + 7.28
BAI	20.81 ± 12.14	19.19 ±11.42	17.11±9.89	16.29 ±9.05	15.67 ±11.04	16.00 ±11.19	15.34 ±10.37	12.77 + 8.19

CONCLUSIONS

- CBT could be effectively used for medication-resistant OCD patients.
- There are some factors, like intensity of OCD symptoms, level of insight, resistance against symptoms, and level of dissociation, which could predict outcome of the therapy. It is important in future to find new therapeutic strategies to influence these negative predictors.

This work was supported by.CNS

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STIGMATIZATION IN OCD AND DELAY OF TREATMENT

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STIGMA-PROCESS

- The stigma process sets of by recognizing and labeling a difference between a person and other people
- The next step involves the linking of the labeled person with the negative stereotypes that predominate in society about this group of people
- The stigma process culminates in that the person concerned is exposed to different forms of discrimination and the negative social consequences resulting from this

DIFFERENT COMPONENTS OF STIGMA

1) labeling
2) stereotyping
3) separating
4) status loss and discrimination

SELF - STIGMA

- Public prejudice and self-stigma may provide equally large barriers to achieving and relishing life opportunities

Self-stigmatization affects individual's daily life:

- reduction of life opportunities
- limitation of social contacts
- reduces self-esteem
- overall reduced quality of life

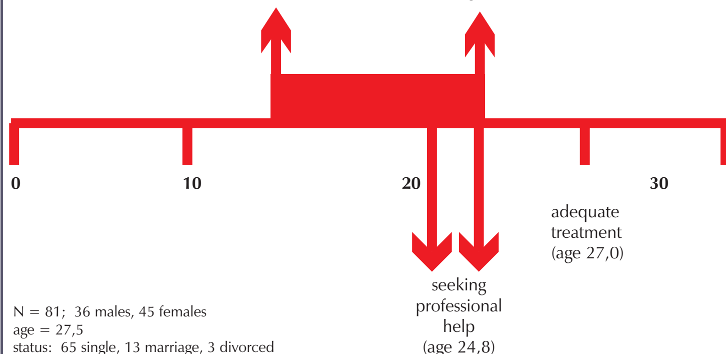
Regarding the course of illness:

- the stigma may lead to a higher threshold for help-seeking behavior,
- implication a treatment delay lead in to a more severe first manifestation of the disorder

IMPACT OF SELF-STIGMATIZATION IN ANXIETY DISORDERS

- person suffering with anxiety disorder adopts the stereotypes prevailing in society about people with psychiatric illness
- the process of self-stigmatization has great impact to treatment - people with anxiety disorders want to believe, that their symptoms are due to the somatic disorder:
  - they avoid psychological or psychiatric treatment
  - in most cases use enormous laboratory investigations, somatic health services and unhelpful somatic treatment
- The lack of early diagnosis of the anxiety disorder lead to long term suffering and chronic conditions

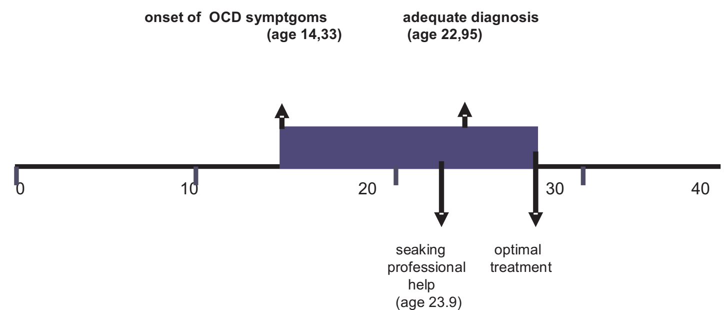
DELAY OF ADEQUATE TREATMENT IN OUR SOCIAL PHOBIA STUDY (n = 81)



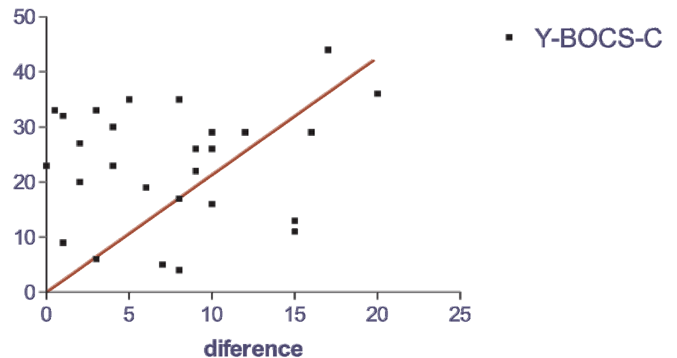
N = 81; 36 males, 45 females
age = 27,5
status: 65 single, 13 marriage, 3 divorced
education: 10 university, 57 secondary school, 10 basic education only
age of social phobia onset: 14,8
Seeking professional help from 24,8
age of treatment onset: 25,4
age of adequate treatment onset: 27,0
comorbidity: 59%

Praško et al. 2005

DELAY OF ADEQUATE TREATMENT IN OUR OCD STUDY (n = 33)



LINEAR REGRESSION – DELAY OF THE TREATMENT x Y-BOCS



DEMOGRAPHIC CHARACTERISTICS A ASSESSMENT OF PSYCHOPATHOLOGY – RELATION TO THE TREATMENT DELAY

Category	Average	SD	Correlation – delay of the treatment and characteristic
N	33		
Age	28,06	+ 7,103	
Gender M:F	13:20		n.s.
Education Bas:HightS:Univ	1:16:16		n.s.
Years of education	15,9	+2,72	n.s.
Marriage S:M:D	28:3:2		n.s.
Age of OCD onset	14,33	+5,956	n.s.
Age of first treatment	22,95	+5,319	n.s.
Psychiatric treatment delay	8,621	+5,749	Perfect line
Adequate treatmenta	23,91	+ 6,212	n.s.
HAMA	12,68	+4,962	n.s.
Y-BOCS	23,41	+10,54	n.s.
Y-BOCS – subjective	21,71	+8,524	Pearson r: 3241; p < 0.05
BAI	17,1	+12,34	n.s.
BDI	15,03	+10,96	n.s.

SUMMARY

- **We found 9,5 years treatment delay from symptoms onset among patients with OCD and more than 12 in patients suffering with social phobia.**
- **There was a correlation beween delay of treatment onset and severity of OCD**

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PERSONALITY DISORDER INFLUENCE THE TREATMENT OF SOCIAL PHOBIA

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INTRODUCTION

The efficacy of the treatment of personality disorder was repeatedly been reported as less successful than the therapy of patients without personality disorder. Most clinicians tend to believe that the occurrence of the anxiety disorder in tandem with a personality disorder often leads to longer treatment, worsens the prognosis, and thus increasing treatment costs.

Our study is designed to compare the short-term effectiveness of combination of cognitive behavioral therapy and pharmacotherapy in patient suffering with social phobia with and without personality disorder.

METHOD

The aim of the study was to asses the efficacy of the 6 week therapeutic program designed for social phobia (SSRIs and CBT) in patients suffering with social phobia and comorbid personality disorder (17 patients) and social phobia without comorbid personality disorder (18 patients). Diagnosis was done according to the ICD-10 research diagnostic criteria confirmed with MINI. Patients were treated with CBT and antidepressants. They were regularly assessed in week 0, 2, 4, and 6 on the CGI (Clinical Global Improvement) for severity, LSAS (Liebowitz Social Anxiety Scale), and in self-assessments BAI (Beck Anxiety Inventory) and BDI (Beck Depression Inventory).

Table 1: Time table – assessment and measurement methods

Method	Week 0	Week 2	Week 4	Week 6
ICD -10 diagnostic criteria	X			
MINI	X			
CGI-severity	X	X	X	X
BAI	X	X	X	X
BDI	X	X	X	X
LSAS	X	X	X	X

ICD - 10: International classification of the disorders – 10. revision; MINI: Mini international neuropsychiatric interview; CGI: Clinical global impression; BAI: Beck anxiety inventory; BDI: Beck depressive inventory; LSAS: Liebowitz social anxiety scale

Table 2: Description of the patients

	Personality disorder	No personality disorder	chi[2] or Fischer's test
age	29.06 ± 2.625	32.17 ± 2.401	n.s.
Gender: male : female	7 : 10	9:9	n.s.
Marital status (Single: Married: Divorced/Widowed)	14 : 2 : 1	12 : 4 : 2	n.s.
Education basal: secondary school: university	4:13:0	2 : 10 : 6	P<0.005
Employment: yes: no	10 : 7	13 : 5	n.s.
Personality Disorder	17	0	
• Histrionic	2		
• Narcissistic	3		
• Avoidant	5		
• Dependent	1		
• Borderline	5		
• Schizoid	3		
• Anakastic	1		
• Paranoid	1		
Comorbidity – current disorder	13 (76 %)	8 (44 %)	P<0.05
• Dysthymia	1 (6 %)	0	
• Panic disorder/agoraphobia	2 (11 %)	3 (16 %)	
• GAD	2 (11 %)	2 (11 %)	
• Depressive disorder	2 (11 %)	0	
• Obsessive compulsive disorder	1 (6 %)	1 (5 %)	
• Adaptation disorder	1 (6 %)	0	
• Alcohol misuse	2 (11 %)	0	
• Somatoform disorder	2 (11 %)	0	
• Gambling	0	1 (5 %)	
• Balbuties	0	1 (5 %)	
With medication: without medication	12 : 5	10 : 8	n.s.

RESULTS

Patients of both two groups improved in most of assessment instruments. A combination of CBT and pharmacotherapy proved to be the effective treatment of patients suffering with social phobia with or without comorbid personality disorder. The treatment efficacy in the patients with social phobia without personality disorder had been showed significantly better compared with the group with social phobia comorbid with personality disorder in CGI and specific inventory for social phobia – LSAS. Also the scores in subjective depression inventory BDI showed significantly higher degrease during the treatment in the group without personality disorder. But the treatment effect between groups did not differ in subjective general anxiety scales BAI.

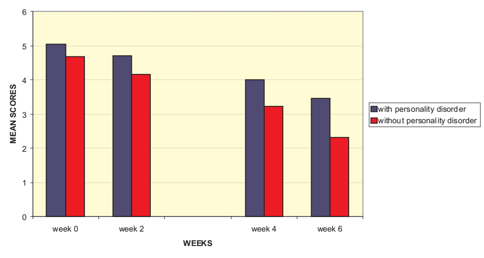
Table 3: Changes of psychopathology during the treatment

		With personality disorder (n=17)		Without personality disorder (n=18)		Statistics un-pair t-test
scale	time	mean	SD	mean	SD	p value
CGI	Week 0	5,059	0,1348	4,722	0,1577	ns
	Week 2	4,706	0,1872	4,167	0,1457	P<0.05
	Week 4	4	0,1917	3,222	0,1292	P<0.005
	Week 6	3,471	0,2121	2,333	0,14	P<0.0001
pair t-test	p value	P<0.0001		P<0.0001		
one-way ANOVA	p value	P<0.0001		P<0.0001		
BAI	Week 0	20,24	2,524	18,94	1,794	ns
	Week 2	24,41	2,135	22,56	2,505	ns
	Week 4	21,76	2,379	16,89	2,229	ns
	Week 6	18,76	2,431	14,33	1,597	ns
pair t-test	p value	ns		ns		
one-way ANOVA	p value	ns		P<0.005		
BDI	Week 0	23,65	2,049	14,72	1,521	P<0.005
	Week 2	22,47	2,243	14,33	2,353	P<0.05
	Week 4	20,59	2,592	11	1,43	P<0.005
	Week 6	18,47	2,223	8,5	1,415	P<0.001
pair t-test	p value	ns		P<0.001		
one-way ANOVA	p value	P<0.005		P<0.001		
LSAS-Anxiety	Week 0	41,12	2,613	37,61	3,033	ns
	Week 2	35,94	3,009	33,39	2,899	ns
	Week 4	32	2,761	27,67	2,661	ns
	Week 6	32,41	2,801	21,78	2,422	P<0.01
pair t-test	p value	P<0.05		P<0.001		
one-way ANOVA	p value	P<0.001		P<0.001		
LSAS-avoidance	Week 0	34,53	3,571	35,39	3,184	ns
	Week 2	32,12	3,421	29	3,226	ns
	Week 4	29,59	3,55	23,72	3,057	ns
	Week 6	25,65	3,866	18,61	2,311	ns
pair t-test	p value	ns		P<0.001		
one-way ANOVA	p value	P<0.005		P<0.001		
LSAS-total score	Week 0	75,65	6,000	73,61	6,073	ns
	Week 2	69,24	6,384	62,94	5,964	ns
	Week 4	62,76	6,201	51,94	5,628	ns
	Week 6	58,71	6,481	40,61	4,506	P<0.05
pair t-test	p value	ns		P<0.0001		
one-way ANOVA	p value	P<0.005		P<0.0001		

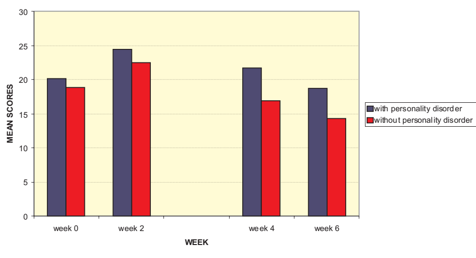
CONCLUSIONS

Our study showed that, patients suffering with social phobia and comorbid personality disorder showed a smaller decrease of specific social phobia symptomatology during the treatment compared with the patients with social phobia without personality disorders. Nevertheless, a significant decrease in symptomatology occurs in personality disorder patients as well.

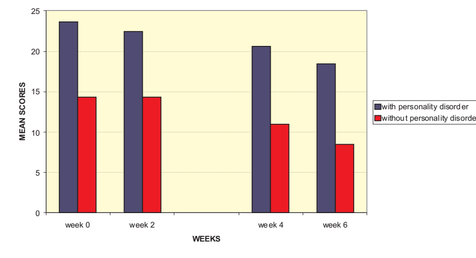
CGI-SEVERITY



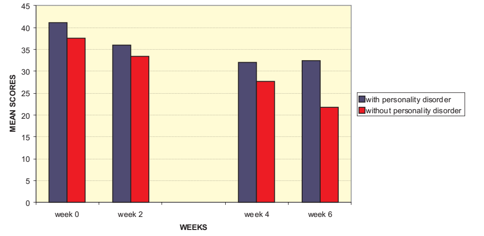
Beck Anxiety Inventory



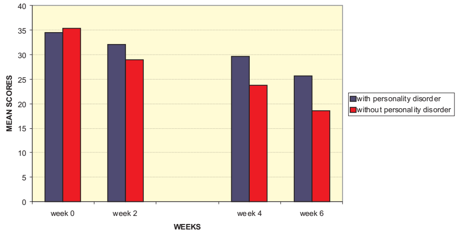
Beck Depression Inventory



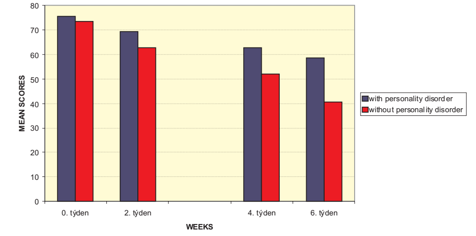
LSAS-ANXIETY



LSAS-AVOIDANCE



LSAS-TOTAL SCORE



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INFLUENCE OF PERSONALITY DISORDER ON THE TREATMENT OF PANIC DISORDER – COMPARISON STUDY

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INTRODUCTION

Most clinicians tend to believe that the occurrence of the anxiety disorder in tandem with a personality disorder often leads to longer treatment, worsens the prognosis, and thus increasing treatment costs. The study is designed to compare the short-term effectiveness of combination of cognitive behavioral therapy and pharmacotherapy in patient suffering with panic disorder with and without personality disorder.

METHOD

We compare the efficacy of 6th week therapeutic program and 6th week follow up in patients suffering with panic disorder and/or agoraphobia and comorbid personality disorder (29 patients) and panic disorder and/or agoraphobia without comorbid personality disorder (31 patients). Diagnosis was done according to the ICD-10 research diagnostic criteria confirmed with MINI and support with psychological methods: IPDE, MCMI-III and TCI. Patients were treated with CBT and psychopharmacs. They were regularly assessed in week 0, 2, 4, 6 and 12 by an independent reviewer on the CGI (Clinical Global Improvement) for severity and change, PDSS (Panic Disorder Severity Scale), HAMA (Hamilton Anxiety Rating Scale), SDS (Sheehan Disability Scale), HDRS (Hamilton Depression Rating Scale), and in self-assessments BAI (Beck Anxiety Inventory) and BDI (Beck Depression Inventory).

PATIENT GROUP

60 patients who met the following admission criteria have been included into the study (31 with panic disorders without comorbid personality disorders and 29 with panic disorders and comorbid personality disorders):

(a) research criteria ICD-10 (1996) for panic disorder or panic disorder with agoraphobia (as diagnosed by a struc-tured MINI interview, Lecrubier et al. 1997);
(b) age 18-45 years;
(c) signed informed consent of the study.

The exclusion criteria were following: a) the presence of a major depressive episode (ICD-10 criteria for a depressive episode, BDI ≥ 20 or HDRS ≥ 18; dysthymia and minor depressive episodes were not reasons for exclusion from the study); b) organic mental disorder; c) psychotic disorder in the person's history; e) drug addiction; f) serious somatic illness; g) pregnancy and lactation in women; h) suicidality.

The inclusion and exclusion criteria of the study were confirmed by two independent experts. The study was approved by a joint ethical committee of the Prague Psychiatric Centre and the Psychiatric Hospital in Bohnice.

Table: **Description of the patients**

	Panic Disorder with Personality Disorder	Panic Disorder without Personaliy Disorder	Statistics
Number	29	31	
Age	33,10 + 7,77	35,39 + 9,61	t-test: n.s.
Sex (Male:Female)	7 : 22	7 : 24	chi$_2$: n.s.
Marital Status			
(Single:Married:Divorced/Widowed)	11 : 13 : 5	14 : 16 : 1	chi^2: n.s.
Personality Disorder	100 %	0	
· Histrionic	8 (27,6 %)		
· Narcissistic	4 (13,8 %)		
· Avoidant	3 (10,3 %)		
· Dependent	12 (41,4 %)		
Borderline	2 (6,9 %)		
Comorbidity – current disorders	17 (58,6 %)	14 (45,2 %)	chi^2: n.s.
· Dysthymia/mixed anxiety and depressive disorder	3 (10,3 %)	0	
· Social Phobia	6 (20,7 %)	8 (25,8 %)	
· GAD	8 (27,6 %)	5 (16,1 %)	
· Eating Disorder	1 (3,5 %)	1 (3,2 %)	
· Somatization Disorder/neurasthenia	3 (10,3 %)	0	
Claustrophobia	0	2 (6,5 %)	

TREATMENT APPROACHES

Patients were treated with SSRI and cognitive-behavioural therapy.

The medication of the first choice was paroxetine in doses of 10 mg during the first week and 20 mg during the second week. In the fourth week there was a possibility to double the dose in case of insufficient effectiveness. If no results occurred by the end of the fourth week, paroxetine was replaced by another SSRI.

The cognitive-behavioural therapy was performed in a group format. This is a short CBT programme focusing on managing panic and agoraphobia; it is not aimed at treatment of personality disorders.

Table: **Average dose of medication according to the equivalent of an antidepressant, anxiolytic and antipsychotic**

	Panic Disorder with Personality Disorder	Panic Disorder without Personaliy Disorder	Statistics
Patients with medication: patients without medication	26 : 3	19 : 12	chi2: P < 0,05
Antidepressants, patients without: patients with	3:29	12: 19	chi2: P < 0,05
Anxiolytics: patients without: patients with	10 : 19	5 : 26	chi2: n.s.
Average equivalent dose of antidepressant (paroxetine) in the group of all patients	30,34 + 10,57	19,35 + 15,59	t-test: P < 0,05
Average equivalent dose of antidepressant (paroxetine) of one medicated patient	33,84 + 10,24	31,59 + 12,02	t-test: n.s.
Average equivalent dose of anxiolytic (alprazolam) in the group of all patients	0,52 + 0,75	0,13 + 0,22	t-test: P = n.s.
Average equivalent dose of anxiolytic (alprazolam) of one medicated patient	1,51 + 0,99	0,83 + 0,58	t-test: n.s.

ASSESSMENT

After study enrolment, patients were assessed during the first two days of attendance at the day-care clinic before the beginning of treatment. The assessment focused on psychopathology and was carried out by psychiatric rating scales in the second, fourth and sixth week, and in a brief follow up six weeks after the end of treatment

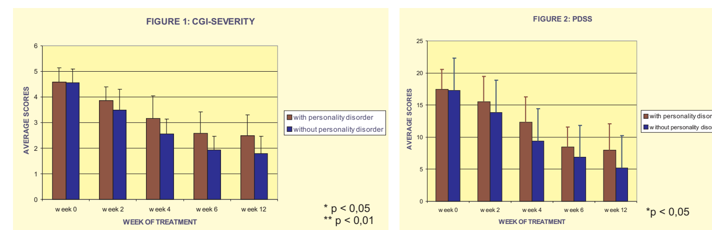
Table: **Timetable of the rating scales administration**

Assessment tool	week 0	week 2	week 4	week 6	week 12
ICD-10	X				
MINI interview	X				
CGI-severity	X	X	X	X	X
CGI – improvement		X	X	X	X
PDSS	X	X	X	X	X
HAMA	X	X	X	X	X
SDS	X				X
HRSD	X				X
BAI	X	X	X	X	X
BDI	X				X
MCM-III	X				
IPDE	X				

IPDE: International Personality Disorder Examination, TCI: Temperament and Character Inventory
MCMI-III: Millon Clinical Multiaxial Inventory – III, ICD-10: International Classification of Diseases, tenth revision, M.I.N.I.: MINI International Neuropsychiatric Interview, CGI: Clinical Global Impression, PDSS: Panic Disorder Severity Scale, HAMA: Hamilton Anxiety Rating Scale, SDS: Sheehan Disability Scale, HAMD: Hamilton Depression Rating Scale, BAI: Beck Anxiety Inventory, BDI: Beck Depression Inventory

Table: **Changes of psychopathology during the treatment**

		Panic Disorder with Personality Disorder (n=29)	Panic Disorder without Personaliy Disorder (n=31)	Statistics (Mann-Whitney test)
CGI – severity	0.week	4,59 + 0,55	4,55 + 0,55	n.s.
	2.week	3,86 + 0,53	3,48 + 0,83	n.s.
	4.week	3,17 + 0,87	2,55 + 0,6	**p< 0.05**
	6.week	2,59 + 0,83	1,94 + 0,53	**p< 0.05**
	12.week	2,48 + 0,82	1,78 + 0,68	**p< 0.01**
PDSS	0.week	17,45 + 3,11	17,29 + 2,93	n.s.
	2.week	15,48 + 4,02	13,87 + 3,65	n.s.
	4.week	12,34 + 3,97	9,42 + 3,52	**p< 0.05**
	6.week	8,48 + 3,12	6,84 + 2,64	n.s.
	12.week	8,0 + 4.07	5,23 + 2,82	**p< 0.05**
HAMA	0.week	23,72 + 4,12	24,65 + 5,06	n.s.
	2.week	20,79 + 5,61	19,39 + 6,03	n.s.
	4.week	16,52 + 6,25	14,45 + 5,86	n.s.
	6.week	12,48 + 4,65	10,19 + 4,31	n.s.
	12.week	11,41 + 5,34	9,94 + 4,55	n.s.
SDS	0. week	7,41 + 1,86	6,29 + 1,77	**p< 0.05**
· work		5 + 2,13	4 + 2,97	n.s.
· social activities		4,94 + 1,94	2,97 + 1,22	n.s.
· family				
SDS	12.week	3,9 + 1,82	2,32 + 0,92	**p< 0.01**
· work		3,14 + 1,64	2,39 + 1,15	n.s.
· social activities				
· family				
HDRS	0. week	14,14 + 3,89	14 + 4,31	n.s.
	12.week	10,59 + 4,37	6,61 + 3,16	**p< 0.05**
BAI	0.week	22,93 + 6,39	26,1 + 8,67	n.s.
	2.week	20,62 + 6,29	20,81 + 9,93	n.s.
	4.week	18,52 + 6,82	17,19 + 7,48	n.s.
	6.week	15,83 + 6,22	16,84 + 7,31	n.s.
	12.week	15,83 + 6,21	14,68 + 6,57	n.s.
BDI	0.week	15,41 + 6,21	13,26 + 6,1	n.s.
	12.week	12,72 + 6,14	6,48 + 3,67	**p< 0.05**



RESULTS

A combination of CBT and pharmacotherapy proved to be the effective treatment of patients suffering with panic disorder and/or agoraphobia with or without comorbid personality disorder. The 12th week treatment efficacy in the patients with panic disorder without personality disorder had been showed significantly better compared with the group with panic disorder comorbid with personality disorder in CGI and specific inventory for panic disorder – PDSS. Also the scores in depression inventories HDRS and BDI showed significantly higher decrease during the treatment comparing with group without personality disorder. But the treatment effect between groups did not differ in objective anxiety scale HAMA, and subjective anxiety scale BAI.

CONCLUSIONS

Our study showed that, personality disorder in panic disorder patients is related to a smaller decrease of specific panic and agoraphobic symptomatology during treatment than in patients without personality disorders. Nevertheless, a significant decrease in symptomatology occurs in personality disorder patients as well. And a large proportion of them is with significant overall improvement. However, they are less able to continue with improvements after the end of the treatment and improvement in their self-confidence to manage their work situation is not the same as for patients without personality disorders

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