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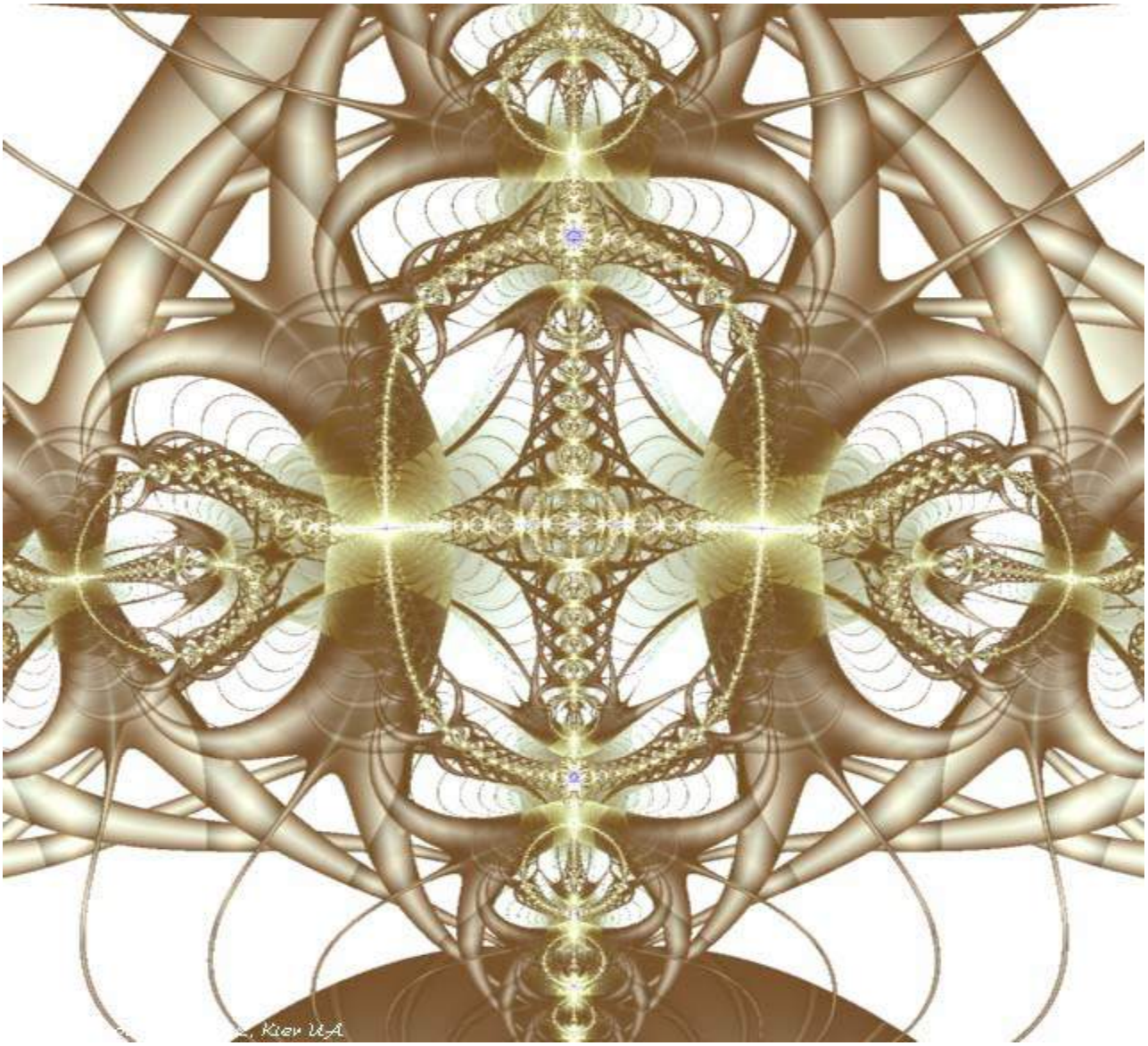

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INDICE

Editoriale *pag. 9*

Emotional Schemas and Cognitive Therapy
di Robert L. Leahy, Ph.D.American Institute for Cognitive Therapy, NYC *pag. 10*

Psicopatologia

Vukosavljevic – Gvozden T., Maric Z., Mirovic T.
The mediating role of negative self-rating in the relationship between early maladaptive schemas and symptoms of depression and anxiety
tanja_vukosavljevic@hotmail.com Serbia *pag, 13*

Peulic A., Maric Z., Vukosavljevic – Gvozden T.
Cognitive characteristics of substance abusers
tanja_vukosavljevic@hotmail.com Serbia *pag,14*

Dethier M., Sojic B., Blairy S.
Emotional facial expressions decoding in siblings of children with autism
marie.dethier@ulg.ac.be Belgium *pag. 15*

Costa J.e Pinto-Gouveia J.
The mediation effect of experiential avoidance between coping and psychopathology in chronic pain
joanascosta@hotmail.com Portugal *pag. 16*

Schreiber F., Stangier U., Steil R.
The applicability of Clark and Wells' cognitive model of social phobia (1995) in socially anxious adolescents
schreiber@psych.uni-frankfurt.de Germany *pag. 17*

Santacana M., Soler A., Fernández-de-la-Cruz L., Ramos I., Guillamat R.
Perfectionism and self-esteem in patients with obsessive compulsive personality disorder
m.santacana@cst.cat Spain *pag. 18*

Fernández-Moltalvo J., López – Goñi J.J., Arteaga A.
Prevalence of pathological gambling in treatment - seeking addicted patients
fernandez.montalvo@unavarra.es Spain *pag. 19*

Dozois A.J.A., Martin R.A., Faulkner B.
Early maladaptive schemas, styles of humor and aggression
ddozois@uwo.ca Canada *pag. 20*

Lin M., Tanno Y.
The order in which subjected acute stress affect memory of words
mlin@beck.c.u-tokyo.ac.jp Japan *pag. 21*

Koizumi H., Hashimoto R.
Functional magnetic resonance imaging study of neuronal activation during cognitive tasks related to frontal lobe functions in patients with obsessive-compulsive disorder
hkoizumi@kanazawa-med.ac.jp Japan *pag. 22*

Koboyashi M., Tanno Y.
What strategy can enhance memory suppression to negative word memory?
koboyashi@beck.c.u-tokyo.ac.jp Japan *pag. 23*

Austin S., Mors O., Morsà L., Hagen R., Secher G., Nordentoft M.
Metacognition and schizophrenia: an investigation of metacognitive beliefs and psychopathology within the OPUS cohort at 10 years follow up
stepaust@rm.dk Denmark *pag. 24*

Ortiz N., Meylan J., Alberque C.
Eating disorders inpatient care: a multidimensional clinical assessment
nadia.ortiz@hcuge.ch Svizzera *pag. 25*

Iijima Y., Tanno Y.
Rebound effects of thought suppression about worry
iijima@beck.c.u-tokyo.ac.jp Japan *pag. 26*

Bohn C., Schreiber F., Al-Dalati T.
Revealing implicit attitudes via the affect misattribution procedure: words versus pictures as stimuli in high versus low socially anxious students
bohn@psych.uni-frankfurt.de Germany *pag. 27*

Sirri L., Tossani E., Grandi S.
Psychological status of long-term heart transplant survivors: a comparison with the general population
laurasirri@libero.it Italy *pag. 28*

Sirri L., Grandi S.
The assessment of alexithymia in heart trasplanted patients: the integration of different instruments
laurasirri@libero.it Italy *pag. 29*

Grandi S., Sirri L., Tossani E., Fava G.A.
Demoralization in heart transplanted patients: relationships with major depressive disorder and dimensional measures of psychological well-being and distress
laurasirri@libero.it Italy *pag. 30*

Caprin C., Tagini A., Morbe E., Piuri E., Mazza E., Corsale B.
Peer interaction at school: anxiety and depression in refused children
claudia.caprin@unimib.it Italy *pag. 31*

Caprin C., Tagini A., Bislenghi L., Messineo S., Ciaccia D.
The validation of the social phobia and anxiety inventory for children in the italian population
claudia.caprin@unimib.it Italy *pag. 32*

Relazione Terapeutica
Ruíz Sancho E., Álvarez Inglesias I.A., Froján Parga M.X.
Analysis of instructions following in the therapeutics interaction in a study case
ana.calero@uam.es Spain *pag. 33*

Calero A., Linares F., Froján M.X.
Descriptive Study of the psychologist's and the client's verbal behavior during the application of the

therapeutic procedures within cognitive restructuring technique
ana.calero@uam.es Spain *pag. 34*

Vargas de la Cruz I., Alpañes-Freitag M., Ruiz-Sancho A., Calero-Elvira A., Froján Parga M.X.
Study of the definition of rule applied to therapy
ana.calero@uam.es Spain *pag. 35*

Vargas de la Cruz I., Pardo Cebrián R., Froján Parga M.X.
Analysis of the rules emitted by the therapist in a case study
ana.calero@uam.es Spain *pag. 36*

Strumenti

Heeren A., Douilliez C., Peschard V., Philippot P.
Cross cultural consisteny of the Five Facets Mindfulness Questionnaire: adaptation and validation in a french sample
Alexandre.Heeren@uclouvain.be Belgium *pag. 37*

Deane F.P., Oades L., Crowe T., Kelly P., Clarke S.
Therapeutic homework and goal attainment amongst people with persistent and recurring mental illness: A pilot study
fdeane@uow.edu.au Australia *pag. 38*

Trattamento/Intervento

Heeren A., Philippot P.
A single-case study of attention training in Social Phobia: from lab to practise
Alexandre.Heeren@uclouvain.be Belgium *pag. 39*

Buizza C., Pioli R., Saviotti F.A., Benvenuti C., Napoli M.F., Caldera M.T., Crosatti B., Il Chiaro del Bosco *Onlus*
Family and school as laboratory of prevention: an experimental project targeted to build well being
buizza@med.unibs.it Italy *pag. 40*

Teismann T., Von Brachel R., hanning S., Grillenberger M., Hebermehl L., Willutzki U.
Rumination-Focused CBT group treatment for residual depression
tobias.teismann@rub.de Germany *pag. 41*

Teismann T., Willutzki U.
Resource Focused Cognitive Behavioural therapy for depression
tobias.teismann@rub.de Germany *pag. 42*

Manchisi D.K., Piegari D., Fioritti A., for the Eqolise Group
The EQOLISE study: enhancing the quality of life and independence of persons disabled by severe mental illness through supported employment
d.manchisi@libero.it Italy *pag. 43*

Sütcü S.T., Aci A.A., Sorias O., Bildik T.
Evaluating the Fear Hunter Program: an individual cognitive behavioural therapy program for children with anxiety
seraptekinsav@hotmail.com Turkey *pag. 44*

Aci A.A., Sütcü S.T.,
Parental involvement in cognitive behavioural therapy for children with social anxiety
arzuguay@hotmail.com Turkey *pag. 45*

Crocetti A., Cimbro C., Colombo F.
Are self esteem development and stress management trainings effective in subjective well being increasing?
a_crocetti@tiscali.it Italy *pag. 46*

Herbette G., Guilmot P., Heeren A.
Horses and Mindfulness: how meditation and relationship with horses can enhance well-being and coping with stress and emotions
gwenola.herbette@gmail.com Belgium *pag. 47*

Ceccarini M., Glionna E.
A cognitive-behavioural group therapy for public mental care patients with various anxiety disorders
dr.ssa.ceccarini@libero.it Italy *pag. 48*

Colombo P., Perini S.,
Learning math facts with "*Leggere Scrivere Far di Conto*" (Reading, Writing, Counting): fluency paths in the classroom
petra.colombo@gmail.com Italy *pag. 49*

Isomura K., Nakao T., Sanematsu H., Yoshiura T., Yoshioka K., Tomita M., Masuda Y., Nakagawa A.
The effect of behaviour therapy on brain function in patients with Obsessive Compulsive Disorder A comparison study using fMRI
kais71@gf7.so-net.ne.jp Japan *pag. 50*

Life Style

Ambrosi-Randić N., Pokrajac-Bulian A., Ružić A.
Psysical activity in overweight and obese patients with cardiovascular problems
nambrosi@uni.pu.hr Croatia *pag. 51*

Lebedina-Manzoni M., Lotar M.
Student's self perception as a predictor of their depression symptoms and satisfaction with academic achievement
martina.lotar@gmail.com Croatia *pag. 52*

Miklosi M., Ribiczey N., Forintos D.P.
Cognitive emotion regulation strategies of mothers and their relation to parental self-efficacy
miklosi.monika@gmail.com Hungary *pag. 53*

Ceccarini M., Glionna E.
A study of assertive behaviour in two different samples: italian citizens and foreigners living in Italy
drssa.ceccarini@libero.it Italy *pag. 54*

Shams M., Zafferri V., Polimeni S., Grosso D., Vascon F., Galtarossa N., Padovan m., Pastorelli D., Giacobbo M.

Progetto Atmosfera
valeria.zafferi@ioveneto.it Italy *pag. 55*

Qualità di vita tra normalità e patologia negli adolescenti.

Maria Paola Macrì[1], Elena Canicattì[1], Silvia Duetti[1], Susanna Pizzo[1], Luca Filipponi[3], Aldo Galeazzi[2]
(1)Miller Institute, Genoa; (2) Faculty of Psychology, Padua University; (3) Department of Biomedical Sciences, Chieti University *pag. 56*

Le risorse di fronteggiamento dell'insufficienza renale cronica: una ricerca sperimentale in un centro di dialisi.
Federica Mancusi (psicologa) *pag. 61*

Il ruolo dei fattori psicosociali nel Morbo di Crohn. Un'indagine sperimentale
Maria Pina Costanza (psicologa) *pag. 66*

Novità editoriale *pag. 70*
Congressi *pag. 72*

EDITORIALE

Cari lettori,

questo numero di Psychomed, così come quello dell'inizio dell'annata 2010, la quinta, vuole raccogliere una serie di contributi presentati ad un Convegno internazionale: questa volta si tratta del 40° Congresso della *European Association of Behavior and Cogntive Therapy* (EABCT), tenutosi a Milano dal 7 al 10 ottobre 2010.

I contributi sono quasi tutti sotto forma di posters, per una precisa scelta editoriale, che segue la nostra rivista fin dall'inizio, di privilegiare lavori sintetici, che rendano agevole l'aggiornamento, e di premiare gli sforzi di giovani ricercatori. Noi constatiamo spesso, infatti, che i poster, lungi dal rappresentare contributi scientifici di serie B, sono spesso molto più innovativi di presentazioni di autori già noti, almeno agli organizzatori dei convegni. Sono infatti spesso prodotti da autori più giovani, che, non essendo ancora ben conosciuti, vengono relegati in un settore del convegno ritenuto a torto meno importante, oppure da autori che, anche per la loro età, non sentono di avere ancora abbastanza esperienza per parlare in pubblico ad una platea di colleghi, spesso in una lingua non ben padroneggiata. Tutto ciò ha poco a che vedere con la qualità scientifica dei contenuti, che possono anche essere più interessanti di quelli delle relazioni orali. Inoltre, la leggibilità dei poster è spesso superiore a quella degli articoli: dovendo essere letti in piedi, quindi in poco tempo, vi è contenuto uno sforzo di sintetizzare i contenuti scientifici, e dovendo competere per l'attenzione con altri poster nella stessa sessione, sono ricchi di grafica, che aiuta a memorizzarne i contenuti stessi.

Naturalmente, non tutti i poster sono ugualmente leggibili, sintetici, informativi e graficamente ben impostati, ma questo è un giudizio che lasciamo ai lettori. Noi della redazione ci siamo limitati a verificare che fossero pertinenti agli argomenti della rivista, che sono quelli dell'interfaccia medicina-psicologia, e che fossero metodologicamente e scientificamente corretti.

Con un appello diffuso a tutti i partecipanti autori di poster del Convegno EABCT di quest'anno, abbiamo raccolto così 44 lavori, provenienti da Autori di 15 Paesi nel mondo. Ci siamo trovati per la prima volta a non dover scartare alcuna proposta, talché sono stati pubblicati tutti; un fatto notevole, a mio avviso, che ci conferma come la qualità scientifica non sia certo meno rappresentata nei poster rispetto alle presentazioni orali.

Una buona parte di questi lavori è rivolta alla psicopatologia, per lo più indagata con strumenti e

concetti di tipo cognitivista (es.: "schemi", "metacognizione", "soppressione di pensieri"), ma non mancano quelli che usano costrutti tipicamente comportamentali (es.: "evitamento esperienziale", "stili di comportamento") o riferibili allo studio delle emozioni (es.: "decodifica delle espressioni facciali", "benessere psicologico", "stress"). Un'altra ampia sezione riguarda invece gli interventi, sia terapeutici che preventivi, rivolti ad una varietà di problemi. Anzitutto il trattamento di condizioni cliniche come la fobia sociale, la depressione, il disturbo ossessivo-compulsivo e l'ansia infantile; vi sono anche programmi di intervento per l'adattamento a disturbi psichiatrici gravi, per il potenziamento del benessere, nonché per il superamento di disturbi spefici dell'apprendimento. C'è anche una interessante sezione sulla relazione teapeutica, con alcuni poster prodotti da una sola autrice, Ana Calero. Ciò mostra ancora una volta, se ce ne fosse bisogno, che la relazione terapeutica è un argomento ancora poco frequentato dai ricercatori in ambito cognitivo e comportamentale, nonostante possa evidentemente essere studiata con metodi empirici, come mostrano anche i lavori qui pubblicati, e vi si attribuisca almeno una parte del successo terapeutico delle psicoterapie di ogni orientamento (nonché il successo degli interventi placebo).

A questa carrellata di poster si aggiungono alcuni altri lavori, che, sebbene in formato più tradizionale di articoli, si riferiscono sempre allo stesso Convegno e si segnalano per il particolare interesse verso l'argomento del benessere emotivo: l'articolo di R. Leahy sul ruolo dell'accettazione dell'emotività nella genesi della salute mentale e l'adattamento, e l'articolo di M.P. Macrì e Coll., sul ruolo del *coping* e dell'autostima quali componenti del benessere e qualità della vita in età adolescenziale.

Sperando che anche questo numero incontri l'interesse suscitato dai precedenti, vi auguriamo buona lettura,

Lucio Sibilia

EMOTIONAL SCHEMAS AND COGNITIVE THERAPY

Robert L. Leahy, Ph.D. American Institute for Cognitive Therapy, NYC

Throughout the history of Western Culture a single dialectic has repeated itself. This is the apparent conflict between rationality and emotion. Plato describes the "Charioteer" who attempts to control the two horses who pull in different directions. This metaphor represents the "need" for rational control (the Charioteer) over the emotional forces represented by the horses. But if Plato gives privilege or superiority to the controlling Charioteer, we are reminded that no one goes anywhere without the horse. Emotions are essential. Indeed, the emphasis on the "superiority" of rationality has continued over the last 2,400 years, from Plato to the Stoics (Epictetus, Seneca, Cicero), down through the Enlightenment (Bentham), to more recent 20th century British Analytic Philosophy and Logical Positivism. In contrast to the emphasis on rationality there is an equally important tradition that emphasizes emotion, the tragic, and the transcendent. This is reflected by the work in Greek tragedy (Aeschylus, Sophocles, Euripides), Shakespeare, Sentimentalism, Romanticism, and in Existential and Continental Philosophy. The dialectic rationality vs. emotion continues in cognitive behavioral therapy, with the emphasis on "constructivism", rationality, evidence and thinking logically "using the facts". Often cognitive-behavioral therapy is criticized for being overly rational, even cold-blooded, leaving out the human element.

It is my view that we, in the cognitive tradition, can learn from these criticisms and meet the challenge. I would like to suggest that although emotions may have a universal, biological and even evolutionary quality, there is also a strong social constructivism in emotion. We only have to look at the history over the last 500 years in Western Europe and America to recognize that rules for emotional control and display have dramatically changed. Indeed, as feudalism declined and the warrior knights were brought into the regal courts of France (and throughout Europe) there emerged new rules of conduct, new rules for emotional control. The court could not allow warriors to fight and challenge one another, so new rules of "courtesy" and "etiquette" emerged, leading to the internalization of emotion. New rules for shame, for display, for showing deference and respect became widespread first, among the aristocracy and then, later, among those who would become "safe-made men". Indeed, John Adams, the second President of the United States, represented this "self-made man". Knowing that he needed to socialize with more "respectable" aristocrats, he practiced controlling his face and bodily movements in order to keep from reflecting his true feelings. Indeed, Lord Chesterfield's "Letters to his Son", written from 1737 on, was published and became a best-seller in England and America. Chesterfield, a social mannerism Machiavellian, urged his son not to show emotion, never laugh, and always hold your cards close to your chest. The internalization of emotion continued into the Victorian period in England, with its emphasis on the two "spheres" of life home and the outside commercial world, where home could be the venue for intimacy and tenderness, while the outside world was one of competition and impersonality. Home was the "feminized" world of women while the outside commercial world was for "manly competition". This led to the further division of the expression of emotion in woman's place and the suppression of emotion in man's place. These two spheres marked the gendering of emotion.

If emotions are socially constructed and rules for appropriate emotions change, then it would be of interest to know what our patients believe about emotion. I have been developing a model that I refer to as "emotional schema therapy" which stresses this individual, socially constructed view of emotion. Each individual holds a theory about his or her emotions and those of others. I have identified fourteen dimensions on which one can think about emotions or respond to them. For example, let's imagine Anthony whose girlfriend has just broken up with him. Anthony grew up with parents who invalidated him, told him that boys don't cry, and that emotions are a sign of weakness. Now, upset over the breakup, he is overwhelmed with feelings of sadness, anxiety, loneliness and confusion. Anthony believes that his emotions will last forever, will drive him

insane, are a sign of his weakness, and that others would never understand the way he feels. He believes his emotions don't make sense, that others don't share these experiences, and that having mixed feelings makes no sense at all. In order to cope with these emotions, Anthony blames either himself or his ex-girlfriend, he drinks excessively, he tries to escape into the world of pornography, and he ruminates and worries. His beliefs and strategies (which I call "emotional schemas") are negative and result in problematic coping.

In contrast, Arturo has grown up in a family where people talked about their feelings and mother and father comforted Arturo when he was upset as a boy. He had safe attachments, strong connections, and expression was encouraged and validated. Now, as a coincidence, Arturo is also going through a breakup but his emotional schemas are much more positive, more adaptive. He has all the feelings of sadness, anger, anxiety and confusion that Anthony had, but he also believes that breakups naturally lead to these emotions, others would have similar responses and there is nothing to be ashamed of. He believes that emotions come and go, nothing is permanent, and infact there is even the possibility for growth. He has friends with whom he shares these feelings, they talk about the meaning of the experience, and his emotions make sense. As a result, he feels little need to binge drink or escape into other acting-out behavior and he is able to tolerate and grow.

Our research has confirmed that emotional schemas are related to psychopathology. We have developed the Leahy Emotional Schema Scale (LESS), comprised of 14 dimensions, and have administered this to over 1600 patients at our Institute in New York City. To summarize, we found that negative emotional schemas are related to depression, anxiety, worry, experiential avoidance, dispositional mindfulness, PTSD, substance abuse, and marital conflict. Moreover, an interesting pattern of results has emerged for personality disorders and emotional schemas. Patients scoring higher on borderline, avoidant or dependent personality have negative beliefs about emotions. But, perhaps of even more interest, patients scoring higher on narcissistic and histrionic personality have *overly positive views* of emotion. We view these data as suggesting that personality disorders are not only characterized by the content of personal schemas as Beck, Freeman and Young have suggested, but that these disorders are also characterized by specific beliefs and strategies about emotion.

We are currently looking at beliefs about the emotions of other people. We are testing out a questionnaire that we give couples to determine what their beliefs are about the emotions of their partner. For example, when your partner is upset, do you believe that her emotions will go on forever, her emotions don't make sense, and that you have to get her to stop feeling so badly? Or do you believe that you need to provide the time, space and tolerance to encourage her to express her emotions, explore them, make sense of them, and even link them to values that are important? We also are interested in how therapists think about the emotions of their patients. For example, as a therapist do you believe that emotions get in the way of "efficient" or "practical" problem-solving and that the goal of therapy is simply to get the patient to stop feeling down? Do you think that the patient's crying is a sign of "losing control"? Or, do you have more positive views of emotional expression and believe that sometimes emotional expression can uncover deeper and more meaningful experiences, that life is sometimes tragic and difficult and that the patient's expression of emotion is a sign of trust in you? I have suggested that there may often be a "schematic-mismatch" between patient and therapist, with some patients who have a negative view of emotions working with therapists who also have a negative view of emotion. This results in both "collaborating" to suppress emotion expression and exploration and further confirms the patient's belief that "My emotions are a sign of my weakness and no one really cares about them".

As Michael Mahoney once said, "Some patients come to therapy to be put back together. Others come to be able to fall apart".

We need to be ready to take care of both of these people.

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The mediating role of negative self-rating in the relationship between early maladaptive schemas and symptoms of depression and anxiety

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Introduction

Following cognitive models of psychopathology, Young (1990) argued that symptoms arise from the formation and maintenance of Early Maladaptive Schemas (EMS), which he defined as pervasive themes that develop during childhood and continue to serve as templates for the processing of later experience. Different studies have demonstrated strong connection between individual EMS and symptoms of depression and anxiety (e.g., McGinn et al., 2005, Harris & Curtin, 2002). Results obtained on Serbian sample showed significant correlation (p<.000) between all EMS and symptoms of depression and anxiety (Mirovic, 2010).

Another factor that predisposes people to feel depressed or anxious is negative self-rating that could be measured through levels of self-esteem and unconditional self acceptance (e.g. Chamberlain, Haaga, 2001). Self-esteem is defined as a positive or negative orientation toward oneself; an overall evaluation of one's worth or value (Rosenberg, 1989). Low self-esteem is typically considered dysfunctional, yet REBT holds that the very presence of any level of self-esteem reflects occurrence of a dysfunctional self-rating process, an evaluating of one's global worth as a person. Ellis introduces the concept of unconditional self-acceptance (USA) meaning that "the individual fully and unconditionally accepts himself whether or not he behaves intelligently, correctly, or competently and whether or not other people approve, respect, or love him" (Ellis, 1977, p.101). The hypothesis that USA is associated with mental health has been part of REBT theory for decades but it has been tested less often than the hypothesized connection between self-esteem and mental health.

Aims of the Study

Being that both EMS and negative self-rating contribute to symptoms of depression and anxiety this study aims to examine the relationship between these factors. Our clinical experience suggests that negative self-rating could be a mediator between EMS and symptoms of psychopathology. This study therefore explores whether self-esteem and unconditional self-acceptance serve as mediators in the relationship between Young's EMS and symptoms of depression and anxiety in adolescent sample.

Method

Sample and Procedure

The sample consisted of 300 adolescents (150 male and 150 female) students at Belgrade University. Their age ranged from 18 to 25 (M=21.58, SD=2.69). The sample included two groups – a group withclinically relevant symptoms of anxiety and depression (N=200) and a comparative non-clinical group without either symptoms (N=100). All participants were volonteers and received no extra course credit for their contribution to the project.

Measures

Early maladaptive schemas were assessed with Young Schema Questionnaire short form (YSQ; Young, 1998), negative self-rating was assessed with Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1989) and Unconditional Self-Acceptance Questionnaire (USAQ; Chamberlain & Haaga, 2001). Beck Depression Inventory (BDI; Beck, Rush, Shaw & Emery, 1979) was used to assess symptoms of depression, State and Trait Anxiety Inventory (STAI-Y; Spielberger, 1983) was used to assess symptoms of anxiety. All measures had good reliability coefficients (α raging from .88 to .95), except for USAQ (α=.75).

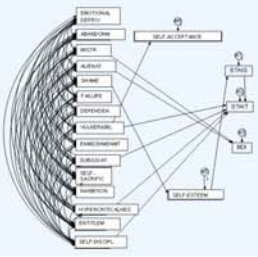
Results

Structural Equation Modeling (Path Analysis) was used to test self-esteem and unconditional self-acceptance as mediator variables in relationship between EMS and symptoms of depression and anxiety in both groups.

The mediating role of unconditional self-acceptance was not significant in either sample.

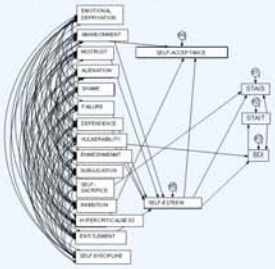
Noncinical sample

The model which fits data in non-clinical sample (Chi-square 29.469, df 32, p .595) demonstrates that several EMS (Mistrust/Abuse, Social Isolation, Vulnerability to harm, Subjugation, Unrelenting Standards and Insufficient Self-Control) have direct influence on symptoms of depression and anxiety without the mediating role of self-esteem and unconditional self-acceptance.



Clinical sample

The model which fits data in clinical sample (Chi-square 42.653, df 35, p .175) demonstrates that self-esteem serves as mediator in the relationship between several EMS (Abandonment, Mistrust/Abuse, Failure, Dependence, Vulnerability to harm, Entitlement) and symptoms of depression and anxiety. Only two EMS (Self-sacrifice and Vulnerability to harm) have direct effect on symptoms.



Disscussion

The most important finding show that negative self-rating serves as the mediator between EMS and symptoms of depression and anxiety when it is measured by Rosenberg Self-Esteem Scale in clinical sample.

In the nonclinical sample EMS have direct effect on trait anxiety and depression, creating a tendency toward these reactions to an extent which is not clinically relevant. In the clinical sample, schemas have negative effect on self-esteem, which produces clinically relevant levels of state anxiety and depression. Stronger connection with state than trait anxiety could imply that a relevant negative activating event, triggers global negative evaluation of the self, which consequently produces clinically relevant symptoms of anxiety and depression. This is in accordance with REBT theory that in a specific situation, global negative evaluation of the self (along with other irrational evaluations) is generating psychological problems such as anxiety and depression.

Still, contrary to our prediction REBT concept of Unconditional Self-acceptance was not significant mediator in either sample. Possible explanations for this result are better psychometric properties of Rosenberg's Self-esteem Scale coupled with the overlap between this scale and Unconditional Self-Acceptance Questionnaire (Chamberlain & Haaga, 2001). Future studies could examine the effect of USA, while controlling for self-esteem.

The findings suggest that in treating cases with symptoms of depression and anxiety it is useful to consider not only EMS but also their relationship with negative self-rating.

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Cognitive characteristics of substance abusers

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Introduction

REBT asserts that addict's inability to stop using psychoactive substances (PAS) is connected with irrational beliefs which maintain addictive behavior (Ellis et al., 1988). REBT authors have tested the efficiency of various methods in working with substance abusers. Bishop (2000) offered specific methods which facilitate therapeutic work with substance abusers, while Horvath (2000) introduced SMART model (Self Management And Recovery Training) which represents cognitive-behavioral extrapolation of research findings on the treatment of addictive disorders. Both models emphasize the importance of core irrational believes, such as low frustration tolerance, self-downing and automatic thoughts.

Aims of the Study

The study aimed to examine whether irrational beliefs (Ellis, 1994) and automatic thoughts (Beck et al, 1979) play a significant role in the maintenance of substance addiction, and if so, which of these two types of cognitions is better in explaining the variance of addiction.

The additional goals were to examine: a. which dimension of irrationality contributes to the maintenance of substance addiction the most; b. whether the low level of rational beliefs significantly contributes to the maintenance of substance addiction; c. is this problem influenced more by the presence of negative automatic thoughts or by the absence of positive automatic thoughts.

Method

Sample and Procedure

The sample consisted of 102 respondents, ages 17 to 33 (M=22.82 SD=4.56). The first group consisted of 52 patients treated for substance abuse problems at the Institute for substance dependence. Control group consisted of 50 students at the University of Belgrade.

Measures

In this study, irrational beliefs were operationalized through the modified version (Maric, 2003) of General Attitude and Belief Scale (Bernard, 1998), negative automatic thoughts through the Automatic Thought Questionnaire-N (Hollon & Kendall, 1980), and positive automatic thoughts through the Automatic Thought Questionnaire-P (Ingram & Wisnicki, 1988). Affective variables were operationalized through the Mood and Anxiety Symptom Questionnaire, i.e., through its subscales of general distress and anhedonia (Clark & Watson, 1991). All measures had good reliability coefficients (α raging from .92 to .96).

Results

Factor analysis of modified version of General Attitude and Belief Scale produced 5 factors, which explain 53% of variance. Multivariate analysis of covariance (MANCOVA) was used to test the hypothesis that cognitions have an affect on the maintenance of substance addictions independently from respondents' affective states. In the model, cognitive variables (five factors from modified version of General Attitude and Belief Scale, negative automatic thoughts and positive automatic thoughts) served as the set of dependent variables. Demographic variables (sex, age and the level of education) and affective variables (general distress and positive affect) served as covariates in the model. The results demonstrated that there were not significant differences between the two groups in relation to the dependent variables.

However, we conducted univariate ANOVA (Table 1) in order to explore possible relevance of some of the cognitive dimensions. ANOVA demonstrated that the two groups were significantly different in respect to the factor which we called "the need for love and acceptance".

The group of patients has significantly higher ($p<.001$) scores on "the need for love and acceptance" factor.

Table 1. The results of ANOVA

		Sum of squares	df	mean of sum of squares	F	sig.
Self-downing and low frustration tolerance (I factor)	contrast	,512	1	,512	,703	,404
	error	68,493	94	,729		
Putting others down (II factor)	contrast	,202	1	,202	,236	,628
	error	80,500	94	,856		
The need for love and acceptance (III factor)	contrast	4,159	1	4,159	7,464	,008
	error	52,372	94	,557		
Demandigness toward one's self and others (IV factor)	contrast	5,354E-04	1	5,354E-04	,001	,981
	error	90,510	94	,963		
Flexibility (V factor)	contrast	1,147E-02	1	1,147E-02	,012	,914
	error	92,607	94	,985		
Scale of negative automatic thoughts	contrast	612,765	1	612,765	2,422	,123
	error	23781,341	94	252,993		
Scale of positive automatic thoughts	contrast	23,881	1	23,881	,065	,800

Discussion

The results revealed that irrational beliefs related to "the need for love and acceptance" could be the only stable cognitive variable that significantly discriminated the abusers from non-abusers. This factor is consisted of the items which reflect absolutistic demand for love and acceptance, as well as extremely negative evaluations of the loss of love. Persons who hold this kind of irrational beliefs develop an extreme interpersonal vulnerability, an extreme sensitivity to rejection, to an ending of friendships/love relationships or to conflicts (Ellis, 1994).

The hypotheses on significant differences on the measures of positive and negative automatic thoughts, independently of affective state, were not corroborated. These results suggest that the presence of positive automatic thoughts and the absence of negative automatic thoughts represent a product of the current mood and, therefore, do not necessarily have to be a stable specificity of the problem of substance abusers.

This study has several limitations. Sample of substance abusers was small and some of them had great problems in filling the questionnaires. Future researches could test the role of irrational beliefs and automatic thoughts in maintenance of substance addiction in a better conditions.

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Emotional facial expressions decoding in siblings of children with autism

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INTRODUCTION

The ability to identify other individual's emotions, including their emotional facial expression (EFE), is fundamental to many social processes. Individuals with autism spectrum disorders (ASD) show deficits in several empathy-related processes, including EFE decoding (e.g., Ashwin et al., 2007). The object of this study was to investigate the capacity to decode accurately EFE in siblings of children with ASD in relation to their propensity to present autistic characteristics'. Indeed, autism is considered to be substantially influenced by genetic factors and relatives of ASD individuals present different type of deficits including the domains of language, theory of mind, and executive functioning (e.g., Fombonne et al., 1997).

Hypotheses:

- **Compared to siblings of healthy children, siblings of children with ASD will be lower in an EFE decoding task. The previous results on that topic are contradictory (Bölte & Poustka, 2003; Dorris et al., 2004, Palermo et al., 2006)**
- **As reported previously by Bishop et al. (2004), the siblings of children with ASD will present more autistic characteristics'.**
- **The propensity to present autistic characteristics' will be correlated to the accuracy in an EFE decoding task.**

METHODS

Participants
Experimental Group: 18 children (7 to 15 years old; four girls and 14 boys) siblings of children with ASD .
Control Group: 18 children matched with the children from the experimental group in function of age and sex. All children from the control group had brother(s) and/or sister(s)

Emotional Facial Expression Decoding Task
The children had to associate a photograph of an EFE of 50% intensity (the photographs come from the material of Matsumoto & Ekman, 1988) with a sentence describing a situation of the everyday life in which a person is susceptible to feel an emotion of an average intensity. The task comprised two sets (one of men, one of women) of seven photographs of EFE (anger, joy, surprise, sadness, disgust, contempt, and fear). The two sets (one set at a row) were presented in front of the child who had to read the seven sentences (one for each emotion) and matched each photograph with a the accurate sentence.

Example: She gets into the kitchen and sees a huge spider on the table.

Autism-Spectrum Quotient (AQ: Auyeung et al., 2007; Baron-Cohen et al., 2006)
One parent of the child answered to a French version of the AQ. This quotient aims to evaluate the degree to which an individual presents some autistic characteristics'. The AQ comprises three versions (Adults -16 years and older, Adolescents -12 to 15 years old, Children –4 to 11 years old). Because the computation of the scores are different for each version, we used only the score of the participants that were assessed with the children version. The AQ is a 50-items questionnaire that assess five domains of competence: social skills, communication skills, imagination, attention to detail; and attention switching/tolerance of change .

RESULTS

❖Is the control group better than the experimental group to find the accurate association between an EFE and an emotional story?
Group effect: $F(1,34) = 1.2, p = .28$

NO

❖Does the control group differ from the experimental group in their propensity to be accurate in function of the emotion display by the stimulus?
Emotion x Group : $F(6,204) = 1.41, p = .21$
Emotion x Sex x Group : $F(6,204) = .51, p = .80$

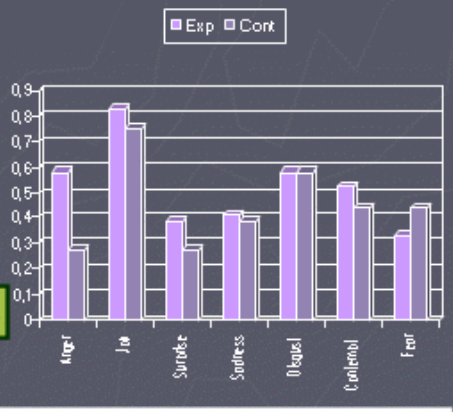
NO

❖Does the experimental group have an higher AQ than the control group?
The difference between the two groups does not reach a statistical level of significance, t (26) = 1.08, p = .29 (Exp: M = 54.83; Cont: M = 50.11)

NO

❖Is there an association between the AQ and the propensity to associate accurately an EFE with an emotional story?
Because the two groups do not differ significantly for both variables, we regroup them together. The lower the child's level of AQ was, the more he/she associated accurately EFEs and emotional stories, $r(28) = -.47, p = .01$

YES



CONCLUSIONS

Contrary to our hypothesis, but consistent with the results of Bölte, & Poustka (2003), the capacity of EFE decoding and the comprehension of brief emotional stories seem to be preserved in siblings of ASD. Further, contrary to the results of Bishop et al. (2004), they do not seem to present more autistic traits than children from the control group. Both autistic measures evaluated in this study fail to show any difference between the two groups. However, these results must be taken cautiously in reason of the small sample size of this study.

An interesting finding is the high negative correlation between the AQ and the accuracy in the EFE decoding task. This result suggests that some components of the empathy deficit of children with ASD could be extended to individuals that present some autistic traits. The clinician must be vigilant to this personality characteristics' in reason of their relation with poor interpersonal relationship quality.

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The Mediation Effect of Experiential Avoidance between Coping and Psychopathology in Chronic Pain.

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1. GOALS

-Explore the associations between coping, experiential avoidance and psychopathology (depression, anxiety and stress);

- Examine the mediational function of experiential avoidance in the relation between coping and psychopathology.

2. METHOD

Sample: 70 adults with diagnosis of rheumatoid arthritis (7 males; 63 females), with a mean age of 61.00 years old (*SD* = 16.81), for males and 58.66 years old (*SD* = 14.68), for females.

Measures:

- Acceptance and Action Questionnaire-II (AAQ-II: Hayes, Strosahl, Wilson, Bissett, Pistorello, Toarmino, et al., 2004; Pinto-Gouveia & Gregório, unpublished data);

-Coping Styles Questionnaire-3 (CSQ-3: Roger, 1996; Pinto-Gouveia & Dinis, unpublished data);

-Depression, Anxiety and Stress Scales (DASS-42 Lovibond & Lovibond, 1995; Pais-Ribeiro, Honorato & Leal, 2004a).

3. RESULTS

Pearson Correlations

- Coping and Psychopathology:

The rational coping was moderately and negatively correlated with depression (r= -0.396; p< 0.01), anxiety (r=-0.301; p< 0.05) and stress (r= -0.439; p < 0.001). Detached/ Emotional coping was negatively correlated with depression (r= -0.278; p< 0.05) and stress (r= -0.737; p< 0.01).

-Experiential Avoidance and Psychopathology:

Experiential Avoidance was highly and positively correlated with depression (r= 0.671; p< 0.001) and stress (r= 0.693; p< 0.001), and moderately but also positively correlated with anxiety (r= 0.314; p<0.05).

Mediation Analyses:

- Coping and Depression

I.V.	β	t	p	F	p	Adjusted R^2	ΔR^2
Rational Coping	-.396	-.3280	.002				
				10.755	.002	.142	.142
Rational Coping	-.289	-2.313	.024				
				5.359	.024	.068	
Rational Coping	-.261	-2.612	.012				
Experential Avoidance	.596	5.959	.000				
				27.980	.000	.495	.353
Avoidance Coping	-.150	-1.155	.253				
				1.333	.253	.006	.006
Avoidant Coping	-.168	-1.313	.194				
				1.724	.194	.012	-
Avoidance Coping	-	-	-				
Experential Avoidance	-	-	-				
				-	-	-	-
Detached / Emotional Coping	-.278	-2.169	.034				
				4.703	.034	.061	.061
Detached/ Emotional Coping	-.452	-3.821	.000				
				14.600	.000	.190	
Detached/ Emotional Coping	-.203	-1.813	.076				
Experential Avoidance	.587	5.257	.000				
				24.869	.000	.474	.413

- Coping and Anxiety

I.V.	β	t	p	F	p	Adjusted R^2	ΔR^2
Rational Coping	-.301	-2.560	.013				
				6.556	.013	.077	.077
Rational Coping	-.289	-2.313	.024				
				5.359	.024	.068	
Rational Coping	.249	1.933	.53				
Experential Avoidance	.243	1.933	.58				
				5.365	.007	.127	.05
Avoidance Coping	-.033	-.268	.789				
				.072	.789	-.014	-
Avoidant Coping	-.168	-1.313	.194				
				1.724	.194	.012	-
Avoidance Coping	-	-	-				
Experential Avoidance	-	-	-				
				-	-	-	-
Detached/ Emotional Coping	-.030	-.395	.694				
				.156	.694	-.013	-.013
Detached/ Emotional Coping	-.452	-3.821	.000				
				14.600	.000	.190	
Detached/ Emotional Coping	.078	.538	.59				
Experential Avoidance	.313	2.233	.030	4.035	.023	.095	.082

- Coping and Stress

I.V.	β	t	p	F	p	Adjusted R^2	ΔR^2
Rational Coping	-.439	-3.815	.000				
				14.553	.000	.179	.179
Rational Coping	-.289	-2.313	.024				
				5.359	.024	.068	
Rational Coping	-.254	-2.042	.005				
Experential Avoidance	.635	6.819	.000				
				35.680	.000	.558	.379
Avoidance Coping	-.041	-.323	.748				
				.104	.748	-.015	-
Avoidant Coping	-.168	-1.313	.194				
				1.724	.194	.012	-
Avoidance Coping							
Experential Avoidance	-	-	-				
				-	-	-	-
Detached / Emotional Coping	-.373	-3.091	.003				
				9.555	.003	.125	.125
Detached/ Emotional Coping	-.452	-3.821	.000				
				14.600	.000	.190	
Detached/ Emotional Coping	-.180	-1.638	.107				
Experential Avoidance	.611	5.568	.000				
				26.754	.000	.488	.363

4. DISCUSSION

Mediation Analyse Results

-Experiential avoidance partially mediate the effects of rational coping on depression (z= -2.16; p= 0.003); Experiential avoidance fully mediate the relationship between detached/ emotional coping and depression (z= -3.08; p= 0.00)

-Experiential avoidance partially mediate the effects of rational coping on stress (z= -1.089; p= 0.28).

Main Conclusions

-Low use of adaptive coping was associated with more psychopathology via differences in psychological (in)flexibility as a general characteristic;

-Findings suggest that psychopathology is not a necessary direct product of coping, and other processes, such as experiential avoidance, are likely involved;

-Patients with chronic pain disease may achieve better psychosocial outcomes if they reduce their avoidance and other attempts to control pain, accept it, and direct their effects toward valued goals.

THE APPLICABILITY OF CLARK & WELLS' COGNITIVE MODEL OF SOCIAL PHOBIA (1995) IN SOCIALLY ANXIOUS ADOLESCENTS

FRANZISKA SCHREIBER, ULRICH STANGIER & REGINA STEIL

Introduction

There is empirical evidence that the cognitive model of social phobia (Clark & Wells, 1995; see Fig. 1) can be applied to socially phobic adults. Effect sizes from treatment studies for cognitive therapy according to the model are high (e.g. Clark et al., 2006). Using a questionnaire-design, Hodson et al. (2008) showed that the model could also be successfully assigned to socially anxious youths (N=171, age 11-14). The actual study aims to replicate the results of Hodson et al. in an analogue and clinical sample of socially phobic adolescents. Additionally, the role of self-imagery concerning the process of self-focused attention is going to be explored. Moreover, the psychometric qualities of all questionnaires are going to be obtained in order to test their use in adolescent populations.

Hypotheses:

1. The "high" social anxiety group will score significantly higher than the "middle" and "low" social anxiety group on all measures of the Clark and Wells´ cognitive model variables. These are: negative social cognitions, social attitudes, self-focused attention, safety behaviors, self-imagery, and pre- and post-event processing.
2. The models´ variables will predict a significant amount of the variance in social anxiety even when controlled for depression.

Method

Sample: ***N*=567, representative by type of school and grade**

- adolescents recruited through schools in Frankfurt city and a rural area in Hessen, Germany
- age: 14-20 years, M=16.48, SD=1.67; 8th-13th grade, gender: 44.8% male, 28 school classes
- return rate: 99.99%

Design: school-based cross-sectional study

Hypothesis 1: Multivariate group comparisons via quartile split → 3 groups

Hypothesis 2: Multiple and sequential regression

with complete sample

Measures: German versions of:

- Social Phobia and Anxiety Inventory (SPAI) - Beidel et al. (1989); Cronbachs α=.96
- Social Behaviour Questionnaire (SBQ) - Clark (1995); Cronbachs α=.77
- Social Cognitions Questionnaire (SCQ) - Wells et al. (1993); Cronbachs α=.88
- Social Attitudes Questionnaire (SAQ) - Clark (1995); Cronbachs α=.92
- Social Phobia Weekly Summary Scale - Clark et al. (2003)
- Focus of Attention Questionnaire (FAQ) - Woody (1996); Cronbachs α=.79
- Post-Event Processing Questionnaire (PEPQ) - adapted Fehm et al. (2008); Cronbachs α=.92
- Imagery Questionnaire - Schreiber, Stangier & Steil (2009)
- Depression Inventory for Children and Adolescents - Stiensmeier-Pelster et al. (2000)

Procedure: anonymous questionnaire assessments in classes during regular school time

Social Anxiety (SA):

SPAI score: complete sample M=1.71, SD=0.79

Cut-off (SPAI ≥ 2.6): 12.7%

Low-SA	1st quartile (25%) SPAI ≤ 1.16 n=143
Middle-SA	2nd + 3rd quartile (25-75%) n=281
High-SA	4th quartile (75%) SPAI ≥ 2.23 n=147

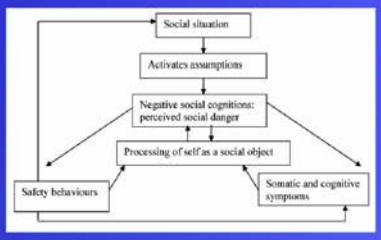
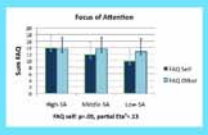


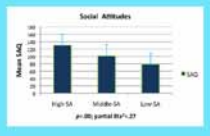
Figure 1. Cognitive model of social phobia by Clark and Wells (1995)

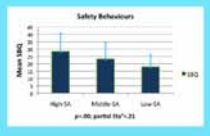
Results

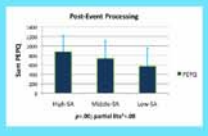
Hypothesis 1:

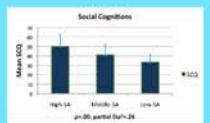
- The high, middle and low socially anxious adolescents differ significantly in the variables safety behaviours, negative social cognitions, social phobic attitudes, pre- and post-event processing, frequency of images and self-focused attention (Wilks λ=.66, F=15.59, p=.00, partial Eta²=.95).

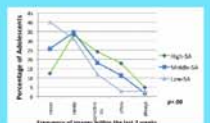


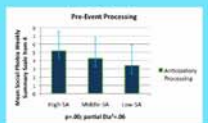












Hypothesis 2:

- Multiple regression: DV „social anxiety" R^2=.46 ($p \leq .001$)
- Sequential regression controlling for depression:

→ R^2=.18 for step 1; R^2=.45 for step 2 ($p \leq .001$)

Table 1 *Summary of sequential regression analysis for variables predicting social anxiety*

Variable	*B*	*SE (B)*	β	sr^2
Step 1				.14**
Depression	.04	.01	.37**	
Step 2				.31**
Depression	.00	.01	.03	
Safety Behaviours	.02	.01	.21**	
Negative Social Cognitions	.02	.00	.26**	
Social Attitudes	.01	.00	.27**	
Post-Event Processing	-2.47	.00	-.01	
Self-Focused Attention	-.00	.01	-.02	
Pre-Event Processing	-.01	.01	-.02	
Frequency of Images	.08	.01	.02***	

** p <.001
*** p<.010

Discussion

Results are in line with those of Hodson et al. (2008) and confirm the applicability of the cognitive model of social p… youths. This indicates that Clark and Wells´ cognitive model can be used to develop an effective treatment protocol for adolescents with social anxiety. The current study extends the findings of Hodson et al. (2008) in showing that the frequency of mental imagery is an independent and significant predictor of social anxiety. This highlights the role of mental imagery in the maintenance of social anxiety. A replication of the present study with a clinical sample of socially phobic youths is currently in progress.

Literature:
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Stangier, U., Heidenreich, T., Peitz, M., Lauterbach, W., & Clark, D.M. (2003). Cognitive Therapy for Social Phobia: individual versus group treatment. *Behaviour Research & Therapy, 41* (9), 991-1007.

CST: Consorci Sanitari de Terrassa
CST: Fundació Joan Costa Roma

PERFECTIONISM AND SELF-ESTEEM IN PATIENTS WITH OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

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INTRODUCTION

According to some authors, the prevalence of obsessive-compulsive personality disorder (OCPD) in mental health services ranges from 3% to 10%. Considering this situation, continued research on this disorder is being carried out in our unit. In the context of this wider research, the specific aim of our study was to analyze the relationship between different dimensions of perfectionism and self-esteem in patients with OCPD.

METHODS

Sixty-seven patients diagnosed with OCPD agreed to take part in the study. All participants were assessed using the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II). Among other psychometric instruments, the Frost Multidimensional Perfectionism Scale (FMPS) and the Rosenberg Self-Esteem Scale (RSE) were administered. Pearson correlations were used to explore the possible relationships between different dimensions of perfectionism and self-esteem in patients with OCPD.

RESULTS

Negative and statistically significant correlations were found between four dimensions of perfectionism and self-esteem (concern about mistakes, personal standards, parental criticism, doubts about actions). The other two dimensions of perfectionism (parental expectations and organization) did not show significant correlations with self-esteem.

Correlations between perfectionism dimensions and self-esteem	RSE
FMPS	
Concern over mistakes	**-0,645****
Personal standards	**-0,374****
Parental expectations	-0,142
Parental criticism	**-0,286***
Doubts about actions	**-0,602****
Organization	-0,01

N=67, **p < 0.01, *p < 0.05

CONCLUSIONS

Our findings suggest that high scores on several subscales of the FMPS are associated with a low self-esteem, while on the other hand some dimensions of perfectionism are not associated with self-esteem. These results are consistent with previous research that has shown that only some dimensions of perfectionism are associated with maladjustment and psychopathology.

Antony, M. M., Purdon, C. L., Huta, V., & Swinson, R. P. (1998). Dimensions of perfectionism across the anxiety disorders. *Behaviour Research and Therapy, 36*, 1143-1154.
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PREVALENCE OF PATHOLOGICAL GAMBLING IN TREATMENT-SEEKING ADDICTED PATIENTS

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INTRODUCTION

In recent years, there has been a growing interest in the study of comorbid disorders in addictive behaviours. To date, only a few studies have been carried out on the prevalence of pathological gambling among drug abusers, most of them in the field of alcoholism. The aim of this research was to obtain the prevalence rate of pathological gambling in a clinical sample of treatment-seeking patients with substance addiction.

METHOD

Participants

The sample consisted of 112 treatment seeking patients with substance addiction (81 alcoholics and 31 cocaine dependents), who sought outpatient treatment at the Addiction Treatment Program in Pamplona, Spain. This is a cognitive-behavioural intervention on an outpatient basis, aimed at abstinence.

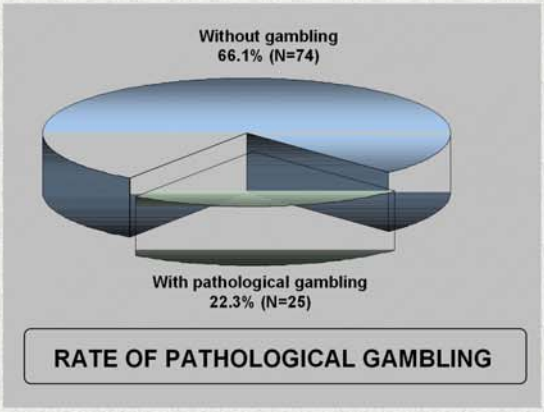
Sociodemographic characteristics:

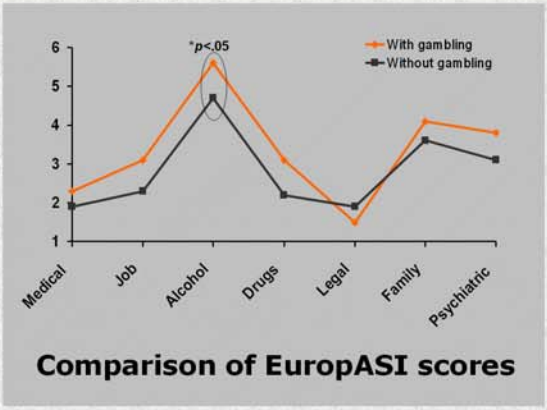
Mean age: 43.9 (SD=11.6). Sex: 99 male; 13 female.
Social class: middle to lower-middle.

Assessment measures

- DSM-IV-TR diagnostic criteria for pathological gambling
- Spanish version (Echeburua *et al.*, 1994) of the South Oaks Gambling Screen (SOGS) (Lesieur & Blume, 1987)
- *EuropASI* (Kokkevi & Hartgers, 1995). European version of the *Addiction Severity Index (ASI)* (McLellan et al., 1980)
- Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1992)
- Millon Clinical Multiaxial Inventory (MCMI-II) (Millon, 1997)

RESULTS





Comparisons in SCL-90-R scores

	With gambling N=25		Without gambling N=87		t	Total sample N=112	
	Mean	(SD)	Mean	(SD)		Mean	(SD)
GSI	1.1	(.6)	1.2	(4.7)	.1	1.8	(4.1)
PSDI	3.1	(5.7)	1.7	(.6)	1.1	1.9	(2.7)
PST	51.1	(19.8)	35.6	(18.6)	**3.6***	39.1	(19.8)
Somatisation	.9	(.8)	.6	(.6)	**2.1***	.6	(.6)
Obsessive-compulsive	1.3	(.8)	.8	(.7)	**2.9***	.9	(.7)
Interpersonal sensitivity	1.4	(.7)	.8	(.7)	**4.1***	.9	(.7)
Depression	1.4	(.7)	.9	(.7)	**2.9***	1.1	(.7)
Anxiety	.9	(.7)	.7	(.8)	1.3	.7	(.7)
Hostility	.7	(.7)	.6	(.7)	.8	.6	(.7)
Phobic anxiety	.6	(.6)	.3	(.4)	**3.1***	.3	(.4)
Paranoid ideation	1.3	(.7)	.8	(.6)	**3.6***	.8	(.6)
Psychoticism	.9	(.6)	.5	(.6)	**2.5***	.6	(.6)

Comparisons in MCMI scores

	With gambling (N=25)		Without gambling (N=87)		t	Total (N=112)	
	Mean	(SD)	Mean	(SD)		Mean	(SD)
Schizoid	64.1	24.9	59.3	35.1	.6	60.3	33.1
Phobic	65.1	23.5	45.5	27.8	**3.5***	49.8	28.1
Dependence	63.2	18.6	61.9	24.5	.2	62.2	23.2
Histrionic	56.1	21.5	52.1	19.9	.9	52.8	20.2
Narcissistic	52.1	23.1	50.8	24.8	.2	51.1	24.3
Antisocial	65.8	21.9	48.3	26.4	**3.1***	52.1	26.4
Aggressive-sadistic	61.6	18.6	50.1	26.1	**2.5***	52.5	24.9
Compulsive	48.2	22.7	61.9	18.9	**3.1***	58.8	20.5
Passive-aggressive	57.7	32.1	40.2	31.2	**2.4***	44.1	32.1
Self-destructive	60.9	17.1	46.4	24.1	**3.4***	49.6	23.4
Schizotypal	54.1	20.9	40.2	25.1	**2.8***	43.2	27.5
Borderline	55.9	16.8	35.9	28.5	**4.4***	40.3	27.5
Paranoid	60.4	15.3	56.4	18.3	1.1	57.3	17.6

CONCLUSIONS

1. This research contributes further evidence of an elevated prevalence rate of pathological gambling among addicted patients. This high prevalence is worrying, because most of the standard programs for clinical intervention with addicted patients do not include an assessment of pathological gambling. However, the results of this study show a need to take into account problems related to gambling, both in the clinical evaluation of addictions and in the development of specific treatment programs. Otherwise, the gambling problem could remain hidden or overlapped with the drug dependence and hinder therapeutic intervention.

2. Comparisons between substance-addicted patients with and without pathological gambling showed significant differences in alcohol severity (assessed by the *EuropASI*), psychopathological symptoms (assessed by the *SCL-90-R*) and personality variables (assessed by the *MCMI-II*). In all cases, scores were significantly higher in gamblers than in non-gamblers. Therefore, a greater severity was observed in addicted patients with pathological gambling.

Early Maladaptive Schemas, Styles of Humor and Aggression

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ABSTRACT

The relationship between early maladaptive schemas (EMS) and psychopathology is thought to be mediated by the use of maladaptive compensatory coping and deficits in adaptive coping. One form of coping that might be affected by EMS is an individual's style of humor, which can be adaptive or maladaptive. This study examined the relationships among EMS domains, styles of humor and aggression. The EMS domain of Impaired Limits was most consistently related to aggression. In addition, an aggressive style of humor mediated the relationship between Impaired Limits and various aspects of aggression (i.e., verbal, physical, and hostility). Self-defeating humor mediated the respective relationships between hostility and EMS domains of Impaired Limits, Disconnection and Impaired Autonomy

INTRODUCTION

Considerable research has documented that one's underlying belief system (e.g., hostile attribution biases) may influence dispositions toward hostility and aggression. Much of this work is based on the conceptualization of early maladaptive schemas (EMS; e.g., Young et al., 2003).

EMS are believed to originate in childhood, because of unmet or inadequately met needs, and form a template upon which subsequent relationships are perceived. Particular EMS appear to relate to the constructs of anger and aggression.

According to Young et al. (2003), individuals with EMS also tend to display maladaptive compensatory or other coping strategies that may perpetuate their schemas. However, a paucity of research has investigated the relationship between compensatory or coping styles and EMS in the context of aggression.

One method of coping interpersonally involves an individual's use of humor. Martin et al. (2003) argued that certain styles of humor (affiliative and self-enhancing) may be adaptive in that they enhance well-being. In contrast, other styles of humor (self-defeating and aggressive) may be maladaptive in that they are detrimental to well-being.

We have argued previously that aggressive and self-defeating humor styles may be maladaptive ways of coping with activated schemas, which may serve to perpetuate and maintain the schema-related negative beliefs (e.g., aggressive humor may serve as an overcompensation strategy to enhance oneself at the expense of one's relationships with others; Dozois et al., 2009).

The objective of this study was to determine whether particular EMS are associated with certain forms of humor and to assess whether aggressive humor mediates the relationship between EMS and self-reported aggression. Our prediction was that impaired limits (comprised of insufficient self-control and entitlement) would be the EMS domain most strongly correlated with aggression and that an aggressive style of humor would mediate the relationships between this EMS and self-reported aggression.

METHOD

PARTICIPANTS

- N = 208 undergraduate students (70% female); Mean age = 18.46 (*SD* = 1.73); 69% Caucasian, 25% Asian, 2% African-Canadian, 1% Hispanic; 3% other

MEASURES

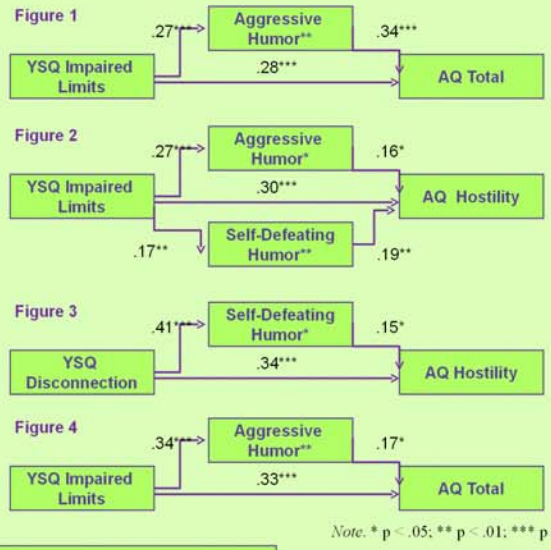
Young Schema Questionnaire – Short Form: 75 items that measure core beliefs presumed to be related to internalizing and externalizing psychopathology. We focuses on the four domains supported in a recent confirmatory factor analysis (Hoffart et al., 2005): Disconnection, Impaired Autonomy, Impaired Limits, Exaggerated Standards.

Humor Styles Questionnaire (HSQ: **Martin et al., 2003**): 32-items measure affiliative, self-enhancing, aggressive and self-defeating forms of humor. Previous research supports the reliability and validity of this instrument.

Aggression Questionnaire (AQ; Buss and Perry, 1992): 29 items assess physical aggression, verbal aggression, anger and hostility.

RESULTS

To test for potential mediating effects of several humor styles simultaneously, we used the recently developed bootstrap sampling procedure described by Preacher and Hays (2008).



Note. * p < .05; ** p < .01; *** p < .001

DISCUSSION

Aggressive humor consistently mediated the relationship between the EMS of Impaired Limits and aggression (cf. Figure 1). This finding replicated across subtypes of aggression (verbal, physical, hostility) and was quite specific to aggressive humor. The only other humor style that mediated the relationship between EMS and aggression was self-defeating humor, and this was specific to hostility.

In all analyses of hostility, self-defeating humor was a particularly strong mediator. It may be that this use of humor represents a response to a lack of intimacy in one's relationships. Another possibility is that the use of this style of humor is an example of an overcompensation strategy. Attending excessively to the needs of others and becoming overly controlled (possibly manifested as self-disparaging humor) are examples of overcompensation associated with Impaired Limits (see Young et al., 2003). Although speculative, it is possible that self-defeating humor mediates the relationship between Impaired Limits and hostility because of overcompensation.

The net effect of using self-defeating humor to cope with activated core beliefs of disconnection and impaired autonomy is that these individuals feel hostility rather than the more externalizing forms of verbal or physical aggression. These individuals may be trying to connect with others by using a maladaptive style of humor (humor at one's own expense) that may ultimately lead to resentment.

This study demonstrated that cognitive risk factors for aggression may be mediated by maladaptive uses of humor in coping. Additional research is needed to examine the specific mechanisms by which EMS and humor styles confer risk to verbal or physical aggression, violence, and other manifestations of externalizing pathology.

The order in which subjected acute stress affect memory of words

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Introduction

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

- Acute stress impairs the recall for neutral words, but enhances the recall for emotional words (Jelicic et al., 2004).
- In the stress group, emotional recall performance was enhanced as compared with neutral recall (Smeets et al., 2008).

●However, previous studies did not refer to the order procedure of the learning task and stress task. For example, Jelicic et al. (2004) used a pre-learning stress procedure, but Smeets et al. (2008) used a post-learning stress procedure.

● The purpose of this study was to investigate the order procedure—whether acute stress exposure before, after, or during the learning task affected memory performance.

Results & Discussion

●A 4 (Group) × 3 (Valence) ANOVA yielded a significant effect of Valence [F (2,118)=8.92, p< .001] and Group × Valence interaction [F (6,118)=2.21, p<. 05]. No other main effect was detected.

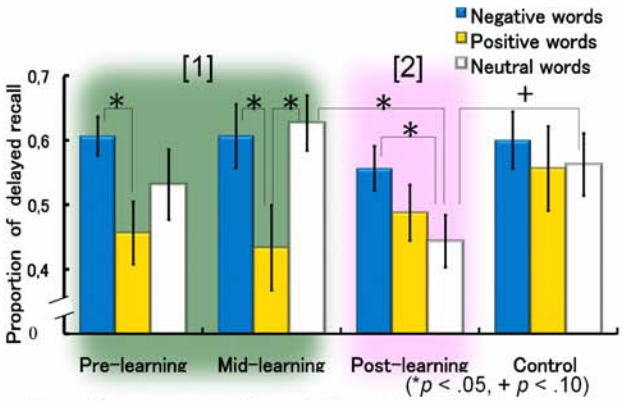

Figure 2 Mean proportion of delayed recall in each groups. Error bar represent the standard error of mean.

[1] Pre-learning stress group & Mid-learning Stress group
Impairment of positive recall as compared with negative words and neutral recall

→Mood congruency effect?

[2] Post-learning stress group
- Impairment of the performance of neutral words as compared with that of negative words in the post-learning stress group and impairment of neutral words in post-learning compared with mid-learning and control groups
- No significant difference between negative words and positive words in this group

→The result showed impaired memory performance for neutral words compared with emotional words, which previous studies reported, only when we subjected the acute stress at post-learning order. We also have to examine this effect with kinds of acute stress other than white noise.

Method

●***Participants*** Sixty-three undergraduate students (33 women and 30 men) with a mean age of 19.06 (SD = 0.83)
●***Stress task*** White noise, 85 dB, 5 min
[1] *Fixation task* Fixate on the fixation cross presented on the computer screen, 5 min
[2] *Learning task* Visual Verbal Learning Test (VVLT) (Riedel, 1999) 5 min
- 10 positive, 10 negative, 10 neutral two-compound kanji words from Goto and Ota's (2001) list, randomly presented two times.

[3] *Filler task* Nonverbal figure task, 10 min
[4] *Delayed recall* Free recall

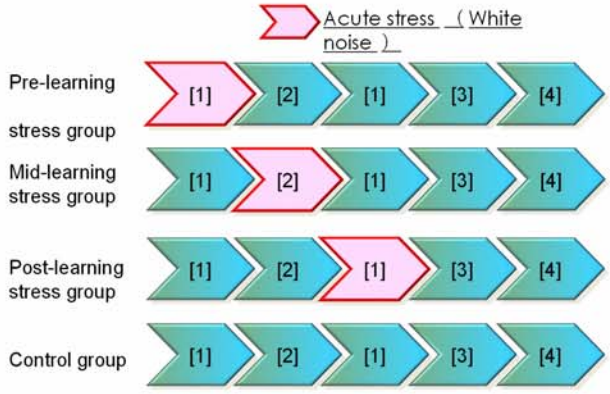

Figure 1 Procedure ([number] see the explanation on the left)

Functional Magnetic Resonance Imaging Study of Neuronal Activation during Cognitive Tasks Related to Frontal Lobe Functions in Patients with OCD

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Introduction

- Previous neuropsychological studies in patients with Obsessive-Compulsive Disorder (OCD) suggest that OCD may be related to dysfunctions in the frontal lobe, such as impairments of fluencies, executive functions, attentional functions and memories.
- In addition, brain activation studies using functional magnetic resonance imaging (f-MRI) show evidence of abnormalities in the frontostriatal pathway of OCD patients. However, no f-MRI study had used cognitive tasks reflecting fluency of ideas and memory related to frontal lobe functions.

Purpose

- To assess the cognitive functions of patients with Obsessive-Compulsive Disorder (OCD) based on neuropsychological examinations reflecting frontal lobe functions
- To examine the neuronal activation of OCD patients during cognitive tasks, including the generation of ideas and remembrance of words

Method

- Subjects : 22 right-handed persons consisting of 11 outpatients who had received a diagnosis of OCD based on DMS-IV and age- and sex-matched 11 healthy controls (Table 1)
- Assessment: Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), Wechsler Adult Intelligence Scale-3rd edition (WAIS-III), Wisconsin Card Sorting Test (WCST), Modified Stroop Test (MST), Verbal Fluency Test (VFT), Idea Fluency Test (IFT), and Rey-Auditory Verbal Learning Test (RAVLT)
- Procedure : All OCD patients and healthy controls were assessed by the neuropsychological examinations. The brain activities were measured with f-MRI during three cognitive tasks: Tsk1: idea generation (IFT), Task 2: word generation (VFT), and Task3: remembrance of words (RAVLT). During the f-MRI examination, the subjects were supine with earphones on their ears, and their eyes were masked. Trials consisted of five 1-min periods in which rest and activation were alternated.
- Cognitive tasks :
  Task1 (IFT): To generate ideas of how to use a given object in as many ways as they could without overtly pronouncing the ideas
  Task2 (VFT): To generate as many words as possible that began with a given letter without uttering
  Task3 (RAVLT): To remember phonologically given 15 words and recall as many words as they could during the scanning time
- Statistical Methods: paired t-test and Pearson correlation; z-test by statistical parametrical mapping （SPM）

Result

- The neuropsychological examinations revealed significant differences in the numbers of categories achieved and total errors in WCST, times of Part I in MST, scores of VFT and IFT, and the results of RAVLT between the OCD patients and healthy controls (Table 2)
- Noticeable activation was found in the superior/ middle/ inferior frontal gyrus and the front cingulate gyrus during all tasks in both the OCD and control groups (Table 3)
- The comparison between the two groups showed that the OCD patients had significantly more activation in the front cingulate gyrus and less activation in the middle frontal gyrus than normal controls during Task 1 (IFT) (Table 3 & Figure 1)
- The OCD patients tended to show more activation in the left inferior frontal gyrus and less activation in the bilateral front cingulate gyrus during Task 2 (VFT), but no significant difference was found between the two groups. (Table 3 & Figure 2)
- During Task 3 (RAVLT), the OCD patients had significantly less activation in the middle frontal gyrus and a tendency to more activities in the right front cingulate gyrus. (Table 3 & Figure 3)
- The Y-BOCS scores assessing the syndrome severity were significantly associated with the results of neuropsychological examinations reflecting the frontal lobe functions and the brain activities of the front cingulate gyrus and the middle frontal gyrus ($p < .05$).

Discussion

- It was suggested that the severity of the obsessive-compulsive symptoms, the decrease of the frontal lobe functions suggested by the neuropsychological findings, and biological abnormalities in the middle frontal gyrus and/or the front cingulate gyrus were all associated with each other in terms of forming the psychopathology in the OCD patients.
- These findings could provide some implications to understanding the etiology of OCD.

Conclusion

- The neuropsychological examinations of OCD patients and their brain activities during cognitive tasks related to the frontal lobe functions were investigated in this study.
- The findings could contribute to understanding the overall conditions of patients having OCD.

Table 1 Demographic and Clinical Characteristics

	OCD patients (N = 11)	Healthy Control (N = 11)
Sex, Male	5	5
Female	6	6
Age, M (SD)	31.2 (12.2)	30.4 (11.7)

Table 2 The results of neuropsychological tests

	OCD patients (N = 11)	Healthy Controls (N = 11)	
Y-BOCS			
Obsessions	12.18 (3.12)	2.45 (1.75)	***
Compulsions	12.81 (2.48)	1.18 (1.89)	***
Total scores	25.00 (4.96)	3.64 (2.98)	***
WAIS			
VIQ	98.73 (13.99)	111.90 (16.29)	
PIQ	96.45 (18.69)	100.00 (11.89)	
FIQ	97.36 (15.91)	106 .36 (13.91)	
WCST			
CA	3.36 (1.63)	5.00 (1.18)	*
PEN	4.64 (4.25)	2.64 (3.38)	
DMS	1.09 (1.64)	0.73 (1.10)	
TE	20.50 (6.89)	14.30 (4.15)	*
MST			
PartI	14.25 (3.44)	11.28 (1.63)	*
PartII	23.52 (7.54)	18.31 (5.34)	
PartII-PartI	9.27 (5.88)	7.02 (3.99)	
VFT			
Word Fluency	25.64 (9.93)	44.36 (9.67)	**
Category Fluency	38.18 (6.87)	53.91 (9.13)	***
IFT			
Total number	4.36 (1.43)	8.09 (2.07)	***
RAVLT			
List A 1st trial	4.45 (1.37)	5.91 (1.45)	*
List A 5th trial	10.27 (2.65)	13.00 (2.93)	*
List B	4.91 (2.26)	6.64 (2.06)	
Later Recall	9.64 (3.04)	12.73 (2.97)	*

* $p < .05$ ** $p < .01$ *** $p < .001$

Table3 The number of voxel (case) reflecting the brain activation during cognitive tasks

		OCD patients N = 11)			Healthy controls N = 11)		
		Task 1	Task 2	Task 3	Task 1	Task 2	Task 3
Superior frontal gyrus	Left	8 (5)	4 (3)	2 (2)	2 (2)	4 (3)	2 (2)
	Right	1 (1)	0 (0)	2 (2)	1 (1)	3 (2)	2 (1)
Middle frontal gyrus	Left	3 (3)	5 (5)	2* (1)	9 (6)	6 (4)	11* (6)
	Right	1▲ (1)	4 (4)	0* (0)	7▲ (4)	3 (2)	14* (6)
Frontal cingulate gyrus	Left	12* (7)	2▲ (2)	7 (4)	8* (4)	7▲ (5)	2 (1)
	Right	4 (4)	0▲ (0)	4▲ (3)	2 (2)	6▲ (2)	0▲ (0)
Inferior frontal gyrus	Left	8 (5)	16 (6)	8 (5)	5 (3)	13 (5)	7 (5)
	Right	1 (1)	1 (1)	1 (1)	1 (1)	0 (0)	2 (2)
Gyrus precentralis	Left	0 (0)	4 (2)	0 (0)	0 (0)	1 (1)	0 (0)
	Right	0 (0)	2 (1)	0 (0)	0 (0)	0 (0)	0 (0)
Superior temporal gyrus	Left	0 (0)	0 (0)	5 (2)	0 (0)	0 (0)	1 (1)
	Right	0 (0)	0 (0)	1 (1)	0 (0)	0 (0)	0 (0)
Middle temporal gyrus	Left	0 (0)	0 (0)	3 (1)	0 (0)	0 (0)	0 (0)
	Right	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Inferior temporal gyrus	Left	0 (0)	0 (0)	2 (1)	0 (0)	0 (0)	0 (0)
	Right	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Frontal lobe base	Left	0 (0)	0 (0)	7 (1)	0 (0)	0 (0)	0 (0)
	Right	0 (0)	0 (0)	3 (1)	0 (0)	0 (0)	0 (0)

*: $p < .05$ ▲: $.05 < p < .10$

Figure 1: The functional brain image by f-MRI during Task 1 (IFT)

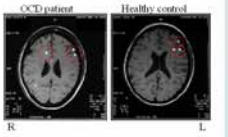

Figure 2: The functional brain image by f-MRI during Task 2 (VFT)

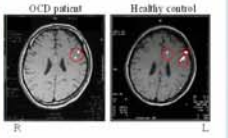

Figure 3: The functional brain image by f-MRI during Task 3 (RAVLT)

This study was supported by Grants-in-Aid for Scientific Research of Ministry of Education, Culture, Sports, Science and Technology (MEXT)

What strategy can enhance memory suppression of negative word memory?

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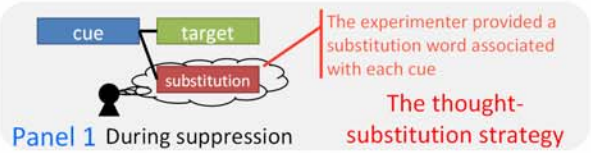
The University of Tokyo

Introduction

While suppressing memory intentionally using think/no-think tasks (Anderson & Green, 2001), a thought-substitution strategy (see panel 1), enhances suppression (Hertel & Calcatterra, 2005).



However, in real situations, it may be difficult for another person to provide a thought that is related to an unwanted memory as a thought-substitution while confronting a reminder (cue).

This study

Thus, this present study investigated the effectiveness of an interference strategy in the intentional suppression of negative word memory (see panel 2).

Furthermore, we investigated the factor (see below) of the interference strategy, which contributed to memory suppression.

Factor 1: Associative blocking

Reducing the level of experimental association between a cue and a target caused suppression, which reflects a cued recall performance.

Factor 2: Inhibition

Reducing the activation level of a target itself caused suppression, which reflects a speeded recognition performance.

Design

1. Strategy: Control vs. Interference strategy (between factors)
2. Condition: Baseline vs. No-think vs. Think (within factors)

Result & Discussion

Result: Memory performances in the cued recall test and the speeded recognition test were both submitted to ANOVA. Further, we compared the memory suppression effect (memory performance in the baseline condition subtracted from that in no-think condition).

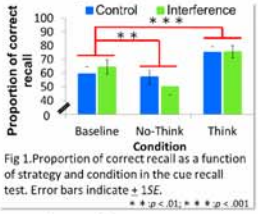


Fig 1.Proportion of correct recall as a function of strategy and condition in the cue recall test. Error bars indicate ± 1*SE*.

Cued recall (Fig.1)
Participants significantly recalled lower recall rate in no-think condition and higher recall rate in think condition than they did in the baseline condition.
No group difference.

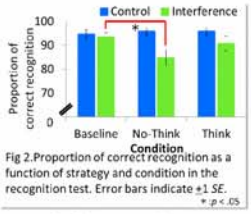


Fig 2.Proportion of correct recognition as a function of strategy and condition in the recognition test. Error bars indicate ±1 *SE*.

Speeded recognition (Fig.2)
Only participants in the interference strategy group showed lower recognition rate than those in the control group.

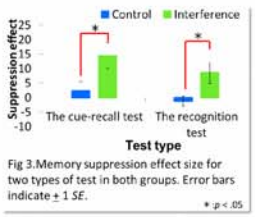


Fig 3.Memory suppression effect size for two types of test in both groups. Error bars indicate ± 1 *SE*.

Memory suppression effect (Fig.3)
In both test, participants in the interference strategy group showed higher memory suppression effect than those in the control group.

Discussion

Participants in both groups showed memory suppression in the cued recall test.

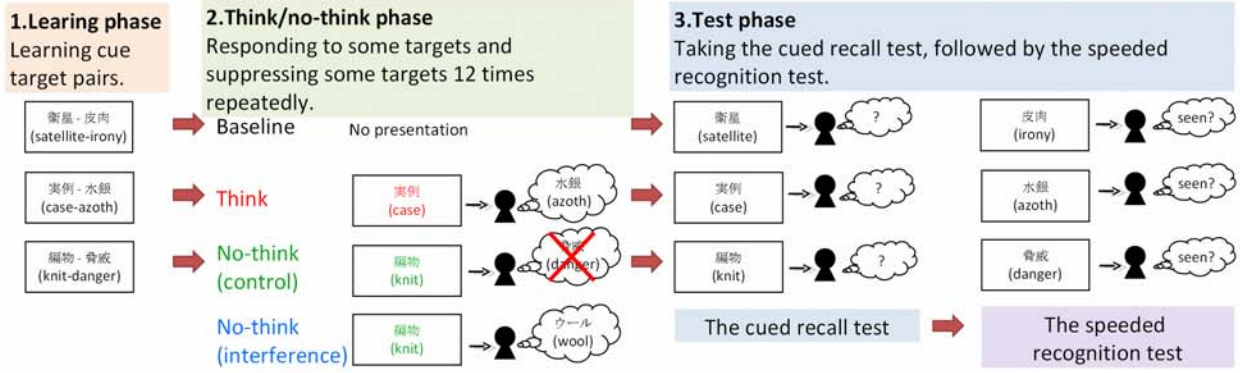
Further, participants in the interference strategy group showed memory suppression only in the speeded recognition test while displaying more suppression effect than those in the control group.

The results indicate that the interference strategy enhances memory suppression and that inhibition contributes to the enhancement.

Further researches need to study the application of the interference strategy on depressed people.

Method

Procedure: The procedure consisted of three phases: 1. learning, 2. think/no-think, and 3. test.



Participants: Totally, 46 healthy university students participated in this study. Half of them were assigned in the control group and the other half were assigned in the interference group. For some reason, 6 participants were omitted from the analysis, leaving a final samples of 40 (N = 21, the control group and N = 19, the interference strategy group).

Materials: We used 24 Japanese cue-target noun pairs selected from Goto & Ota (2001). The pairs consisted of a neutral noun cue and a negative noun target. Furthermore, we used 24 negative additional nouns as fillers in the speeded recognition test.

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Metacognition and schizophrenia: An investigation of metacognitive beliefs and psychopathology within the OPUS cohort at 10 year follow up.

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(3) Reseach Unit, Psychiatric Center Bispebjerg, Copenhagen

Introduction

Metacognition has been defined as beliefs and attitudes held about cognition or "cognition about cognition". The modulation of positive symptoms in schizophrenia has been implicated with cognitive disturbances, which may originate due to structural problems (bottom up processes) or strategies for appraising and controlling thoughts: (top down processes). The Self-Regulatory Executive Function model (S-REF) (Fig 1) postulates that metacognitive beliefs specify the execution of thought processing, guide attention and the interpretation or controlling of cognitive events. The result of cognitive strategies such as threat monitoring, worrying, ruminative processing and maladaptive self-regulatory behaviours can be psychological and emotional distress (1). Numerous scientific studies have supported the central tenets of the S-REF model and found that elevated levels of positive & negative metacognitive beliefs are associated with psychological disorders.

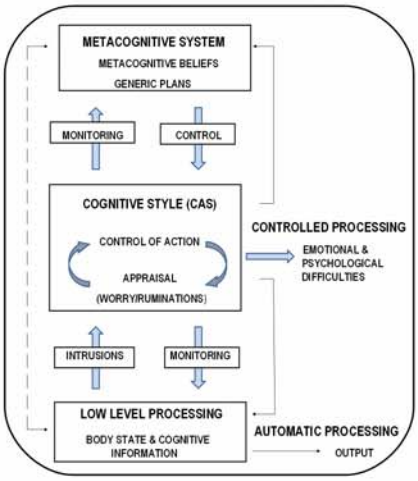

Figure 1. S-REF Model (Wells & Matthews 1996

Metacognitive beliefs and schizophrenia

Studies investigating metacognition within schizophrenia have found those with psychosis often experience elevated levels of metacognitive beliefs compared to healthy controls. Metacognitive beliefs can lie on a continuum ranging from "healthy" to "at risk" to "psychotic" and may be implicated in the vulnerability, transition and maintenance of psychotic symptoms (2). Disturbances in metacognition have been linked to deficits in executive functioning, although further research is required. Researchers have shown that clinical interventions can modify metacognitive biases which can result in the reduction of psychological and emotional distress. (3)

Study design and measures

The study is a randomized clinical trial with previous multiple points of assessment (baseline, 1yr, 2yr & 5yr). A sample of 547 patients included in the original OPUS trial (1998-2000) will be invited to participate in the 10 year follow-up. All participants received a first time diagnosis within the schizophrenia spectrum. Diagnosis and levels of psychopathology will be determined by Schedules for Clinical Assessment in Neuropsychiatry (SCAN) and Schedules for Positive and Negative Symptoms (SAPS/SANS) . Functional outcomes will be assessed using the Personal and Social Performance Scale (PSP) and Global Assessment of Functioning (GAF). Metacognitions will be examined using Metacognitive Beliefs Questionnaire (MCQ-30). Previous executive and pre-morbid functioning were estimated by Trailmaking A & B and DART collected at 5 year follow-up. Current neurocognitive functioning will be assessed by Brief Assessment of Cognition in Schizophrenia (BACS).

Hypotheses

1. The OPUS cohort will show significantly elevated metacognitive beliefs compared to the general population.
2. Metacognitive beliefs will lie on a continuum and vary as a function of type/severity of psychopathology.
3. Deficits in cognitive functioning and elevated metacognitive beliefs will predict psychopathology and distress.

Perspectives

This study will help clarify the relationship between metacognitive beliefs, symptoms and neurocognitive deficits. The identification of specific metacognitive beliefs in relation to different types and levels of severity in psychotic symptoms can have implications for the development of clinical interventions that could alter these metacognitive beliefs and potentially reduce psychological and emotional distress.

1) Wells, A & Matthews, G (1996) Modelling cognition in emotional disorder: The S-REF model. *Behaviour, Research & Therapy*. 34:881-888
2) Morrison, AP, French, P, Wells, A (2007) Meta-cognitive beliefs across the continuum of psychosis: Comparisons between patients with psychotic disorders, patients at ultra high risk and non-patients. *Behaviour Research & Therapy* 45:2241-2246
3) Solem, S, Håland, A, Vogel, P, Hansen, B & Wells, A (2009) Change in meta-cognitions predict in obsessive-compulsive disorder patients undergoing treatment with exposure and response prevention. *Behaviour Research & Therapy 47:301-307*

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EATING DISORDERS INPATIENT CARE: A MULTIDIMENSIONAL CLINICAL ASSESSMENT

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SUMMARY

We evaluated with a multidimensional assessment clinical changes in eating disorder inpatients. Our study highlights an improvement on several subscales linked to the focus of cognitive behavioural interventions.

I INTRODUCTION

- In occidental countries eating disorders (ED) increase, requiring specialised care services
- Since 2007, in Geneva University Hospitals inpatients with ED are treated in a medical-psychiatric unit located in the district general hospital
- A multidisciplinary team is in charge of the patients and different psychotherapeutic approaches cohabit with cognitive behavioural therapy
- This diversity contrasts with ED specialised units in which a cognitive behavioural framework exists in the overall unit milieu.
- **In this context**
  Cognitive behavioural interventions are merely focused on cognitions towards shape and weight, emotion identification and regulation, self-esteem and interpersonal problems.

II STUDY

Aim

- To evaluate clinical changes in ED inpatients with a multidimensional assessment

Participants

- Twenty-five ED disorders patients with somatic complications requiring an inpatient care

Assessment

- Eating Disorder Inventory 2 (EDI-2) (Garner, D.M., 1991) self-report, multiscale measure designed for the assessment of psychological and behavioural traits common in anorexia nervosa and bulimia
- 11 independent sub-scales (6 points: never-always):

1) Drive for Thinness
2) Bulimia
3) Body Dissatisfaction
4) Ineffectiveness
5) Perfectionism
6) Interpersonal Distrust
7) Interoceptive Awareness
8) Maturity Fears
9) Asceticism
10) Impulse Regulation
11) Social Insecurity.

Procedure

- Assessment at admission and at discharge with the French version of the questionnaire.

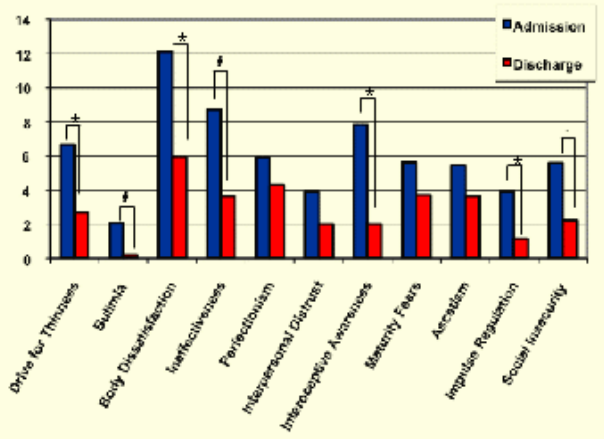
III RESULTS

Participants

Length of stay, median		86 days (min. 26; max. 302)
Mean age (SD)		22.7 (7.5) years
Sex		96,5% women
Mean BMI (SD)	admission	14 (1.9)
	discharge	17.6 (1.8)

EDI-2

Mean Subscale Scores



Wilcoxon signed-Ranks Tests: *= significant effect at p ≤.005; #= significant effect at p ≤.01

IV CONCLUSION

- Change observed in all dimensions with significant improvement for drive for thinness, bulimia, body dissatisfaction, ineffectiveness, interoceptive awareness, impulse regulation and social insecurity.
- Changes can be linked with the focus of cognitive behavioural interventions.
- Clinical impact is important on patients at discharge.

V REFERENCES

Garner DM. (1991).The EDI-2 - Professional Manual. *Odessa, FL: Psychological Assessment Resources.*

Rebound effect of thought suppression about worry

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Keywords: Negative beliefs about worry, Thought suppression

Summary

The present study examines whether the negative meta-cognitive beliefs about worry can affect the rebound effect of thought suppression. A total of 38 university students participated in a thought sampling experiment. In the suppression period, they had less worrisome thoughts than they did in the baseline. However, they had an increased number of thoughts after the suppression period than they did in the baseline. Thus, the rebound effect of thought suppression was confirmed. However, there was no effect due to negative meta-cognition and no effect significant interactions. These results suggest that the suppression of worrisome thoughts increases these thoughts.

Introduction

People who have negative meta-cognitive beliefs about worry (such as uncontrollability) cause their worry to become excessive. They often attempt not to think unpleasant thoughts that may trigger worry. Unfortunately, a simple attempt to suppress a certain thought is often counterproductive. Because thought suppression will lead to a rebound effect, wherein the suppressed thought increases after suppression.

The present study examines whether the negative meta-cognitive beliefs about worry can affect the paradoxical effect of thought suppression.

Method

Participants

Thirty-eight undergraduates participated in the experiment (19 females, 19 males; the mean age was 19.3 years old, *SD* = .9). Participants were divided into groups having high and low negative meta-beliefs.

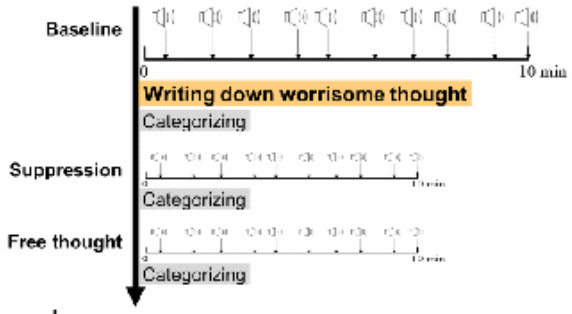

Figure 1. Time table

Procedure

- When the bell was rung, Ss reported on mental content for 10 min at approximately one min intervals (40 sec–80 sec) without any additional instruction in the first period (Baseline period).
- Subsequently, they wrote down their main worry.
- For the next 10 min, they tried to suppress their main worry and reported for 10 min (Suppression period).
- After the suppression period, they were free to think about any topic that came to their minds and report for 10 min (Free thought period).
- After each period, they categorized their mental contents into four categories.

(a) Main worry (b) Other worry or unpleasant thought

(c) Neutral or pleasant thought (d) Nothing

Measures

Meta-cognitions Questionnaire (Cartwright-Hatton & Wells, 1997). In this study, only negative beliefs about the controllability of thoughts and corresponding danger were used (α = .86; Sugiura, 2007)

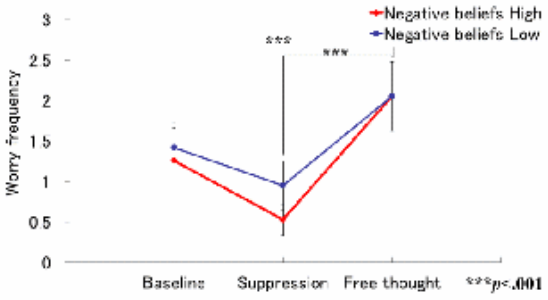

Figure 2. Frequency of worrisome thoughts

Results and Discussion

The frequency of worrisome thoughts was entered into an ANOVA, with one between Ss factors (negative meta-cognition: high and low) and one within Ss factors (periods: baseline, suppression, and free thought).

- Ss had an increased number of reported worrisome thoughts in the free thought period than they did in the control and suppression periods ($F(2,72) = 8.31$, $p < .01$).

Thus, the rebound effect of thought suppression was confirmed.

- However, there was no effect due to negative meta-cognition and no effect significant interactions.

These results suggest that suppression of worrisome thoughts increases these thoughts, even in people who do not have negative beliefs about worry.

Revealing implicit attitudes via the affect misattribution procedure: words versus pictures as stimuli in high versus low socially anxious students

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Regina Steil, Ulrich Stangier

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INTRODUCTION

Implicit attitudes are spontaneously displayed evaluative responses that are evoked automatically and without a person's awareness. It is suggested that implicit processes partially influence other behavioral, emotional and cognitive aspects than explicit attitudes. The affect misattribution procedure (AMP, Payne et al., 2005) is a reliable and valid measure of implicit attitudes that uses the tendency of people to misattribute affective reactions from one stimuli to another under ambiguous conditions. Participants are instructed to judge the valence of Chinese pictographs and to ignore earlier presented positive, negative, neutral or social stimuli. However, the affective reaction to the prime is supposed to influence the rating of the Chinese pictograph.

HYPOTHESES

Hypothesis 1: Participants with a high level of social anxiety show more automatic negative reactions on the AMP after social primes compared to positive and neutral primes.

Hypothesis 2: Participants with a high level of social anxiety show significantly more negative automatic reactions after social primes compared to participants with a low level of social anxiety.

Hypothesis 3: The number of negative automatic reactions after social primes correlates high with the Social Attitudes Questionnaire (SAQ) and the Social Phobia and Anxiety Inventory (SPAI).

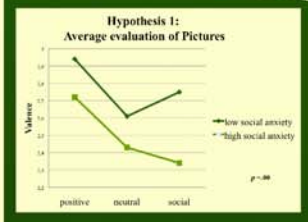
METHOD

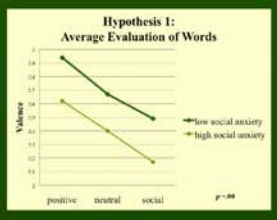
AMP:
Primes: 15 x positive, negative, social & neutral
2 trials: 60 Chinese characters each → randomised sequence: 120 trials

Sample:
N = 69 students
CG: N = 34; age M = 24.22 SD = 4.07; 51.4% female; SPAI: M = 0.86 SD = 0.50
EG: N = 35; age M = 23.83 SD = 3,65; 88.6% female; SPAI: M = 3,07 SD = 0,32

Explicit Measures:
SPAI (Fydrich, 2002)
SAQ (Clark, 1995)
II (Beck, 1996)

RESULTS





Hypothesis 3:
Correlation between AMP and explicit measures

		SAQ[1]	SPAI[2]
Reaction to social pictures (AMP)	r	-.344**	-.424**
	p	.003	.000
Reaction to social words (AMP)	r	-.181	-.291*
	p	.131	.013
	N	69	69

DISCUSSION

In line with the first hypothesis, participants in the experimental group evaluated social pictures as well as social words significantly more negative than positive or neutral stimuli. The second hypothesis was partly confirmed. Participants with high social anxiety evaluated social pictures significantly more negative than participants with low social anxiety. No differences bewteen the groups were found for words as stimuli. The third hypothesis was also partly confirmed. The reaction to social pictures was significantly correlated with the SAQ and SPAI scores. However, for words as stimuli only the correlation with the SPAI scores revealed a significant results. The results indicate that pictures might be more appropriate stimuli in order to investigate implicit attitudes in social phobic subjects. The current study supports the viability of the AMP to assess automatically activated affective reaction and might therefore be considered a good alternative for the implicit association test regarding social phobia as well as other disorders.

Literature:
Payne, B.K., Cheng, C. M., Govorun, O., & Stewart, B. (2005). An inkblot for attitudes: Affect misattribution as implicit measurement. *Journal of Personality and Social Psychology, 89*, 277-293.
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Erfert, N., Heidenreich, T., Bohn, C., Kröner, T., Hehlemann, C., & Stangier, U. (in preparation). Standardization of pictorial stimuli for social phobia research: The social phobia picture system.

PSYCHOLOGICAL STATUS OF LONG-TERM HEART TRANSPLANT SURVIVORS: A COMPARISON WITH THE GENERAL POPULATION

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INTRODUCTION

The literature on cardiac recipients' psychological status is focused mainly on the first years after heart transplantation, despite a steadily increasing survival duration. Little is known about long-term heart transplant survivors' quality of life and psychological adjustment.

OBJECTIVES

To examine whether long-term heart transplant survivors' psychological distress, quality of life, psychological well-being and perceived social support (1) equal that of the general population and (2) are affected by the distance from transplantation.

METHODS

Subjects

- Sixty six heart transplanted patients (79% males, mean age 62 ± 9.1 years) at 10.2 ± 3.3 years (range 6.0-19.6 years) from operation.
- Sixty six controls, matched for demographic variables (sex and age in decades), recruited in the general population.

Psychometric assessment

- World Health Organization Quality of Life-Brief (WHOQOL-Brief): physical, psychological, social, environmental quality of life.
- C. Ryff's Psychological Well-Being Scales (PWB): autonomy, enwironmental mastery, personal growth, purpose in life, positive relationships, self-acceptance.
- R. Kellner's Symptom Questionnaire (SQ): depression, anxiety, somatization, hostility.
- Interpersonal Support Evaluation List (ISEL) by S. Cohen, R. Mermelstein, T. Kamarck & H.M. Hoberman. It assesses the total level and four functions of perceived social support: appraisal, belonging, tangible, self-esteem.

Statistical methods

- A series of univariate ANOVAs was performed to compare cardiac recipients and non-clinical controls according to WHOQOL-Brief, PWB, SQ and ISEL scores.
- Then, the clinical sample was divided according to the mean distance from operation into two subgroups that were compared according to the aforementioned psychological variables with a series of univariate ANOVAs.
- The association between the psychological scales and the distance from transplantation was also examined with Pearson correlation test.
- A p value less than or equal to 0.05 was considered to be significant.

RESULTS

(1) Comparison between heart transplanted patients and controls

- Cardiac recipients had significantly lower levels of psychological and social quality of life (WHOQOL-Brief), autonomy, environmental mastery, personal growth, purpose in life and self-acceptance (PWB). Patients were significantly more anxious (SQ), but also more satisfied for their supportive resources at the ISEL "appraisal" subscale.

(2) Associations between psychological status and distance from transplantation

- No significant associations were found between the psychological variables and the distance from operation, neither when the subgroups were compared nor at the Pearson correlation test.

CONCLUSIONS

- Several quality of life and psychological well-being dimensions seem impaired at long-term after transplantation. Specific psychotherapeutic interventions may be necessary to improve them.
- The risk of acute rejection and immunosuppressive-related complications may explain the higher level of anxiety in cardiac recipients compared to the controls.
- Better perception of social support in patients may reflect their caregivers' continuous provision of support.

THE ASSESSMENT OF ALEXITHYMIA IN HEART TRANSPLANTED PATIENTS: THE INTEGRATION OF DIFFERENT INSTRUMENTS

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INTRODUCTION

• Alexithymia is defined as the difficulty in identifying and describing feelings associated with an impoverished fantasy life. It was found in the setting of both psychiatric and medical disorders and its assessment is controversial.

• The Toronto Alexithymia Scale-20 (TAS-20), the most used instrument, is criticized. Furthermore, an integration between self-rating and observer-based instruments may be necessary.

OBJECTIVE

To compare different self-rating and observer-based instruments for the assessment of alexithymic features in a population where a high prevalence of alexithymia was proven.

METHODS

SUBJECTS: 95 heart transplanted patients (83% males, mean age 56 ± 10.1 years) at a mean of 4.4 (± 3.2) years from transplantation.

PSYCHOMETRIC INSTRUMENTS:

• the section pertaining to alexithymia of the Structured Interview for Diagnostic Criteria for Psychosomatic Research (DCPR-A);

• the Toronto Alexithymia Scale-20 (TAS-20) by G.J. Taylor, R.M. Bagby and J.D.A. Parker: Difficulties in Identifying Feelings, Difficulties in Describing Feelings, Externally Oriented Thinking;

• the Emotional Inhibition Scale (EIS) by R. Kellner. It was developed for the assessment of four alexithymia-related features: Verbal inhibition, Timidity, Disguise of feelings, Self-control. It also yields a total score of emotional inhibition.

RESULTS

PREVALENCE OF ALEXITHYMIA ACCORDING TO DCPR-A AND TAS-20

• Alexithymia was found in 17 (18%) and 21 (22%) subjects according to DCPR-A and TAS-20 (total score ≥61), respectively.

• These percentages did not significantly differ each other.

OVERLAP BETWEEN DCPR-A AND TAS-20

• The concordance rate between DCPR-A and TAS-20 was 66%.

ASSOCIATIONS BETWEEN INSTRUMENTS

• DCPR-A was significantly associated with neither the TAS-20 nor the EIS scores.

• Both EIS total score and EIS Timidity significantly correlated with TAS-20 total score and TAS-20 subscales pertaining to Difficulties in Identifying Feelings and Difficulties in Describing Feelings ($p<0.001$).

• EIS Verbal inhibition was significantly associated with all the TAS-20 scores ($p<0.001$).

• EIS Disguise of feelings significantly correlated with TAS-20 Difficulties in Describing Feelings ($p<0.001$).

CONCLUSIONS

• The integration of DCPR-A and TAS-20 seems to be mandatory because the two instruments are only partially overlapping and may identify different facets of alexithymia.

• The addition of the EIS may lead to a better characterization of some alexithymia-related features neglected by traditional instruments for alexithymia.

DEMORALIZATION IN HEART TRANSPLANTED PATIENTS: RELATIONSHIPS WITH MAJOR DEPRESSIVE DISORDER AND DIMENSIONAL MEASURES OF PSYCHOLOGICAL WELL-BEING AND DISTRESS

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OBJECTIVES

To examine: (a) the overlap rates between demoralization and depression, (b) the associations of demoralization with psychological well-being and distress and (c) whether they differ according to the addition of major depressive disorder.

METHODS

SUBJECTS. Ninety-five heart transplanted patients (83% males, mean age 56 ± 10.1 years, 80% married or living as married) at 4.4 ± 3.2 years from transplantation. We chose heart transplanted patients, as they are a population where both demoralization and major depressive disorder were previously found to be fairly frequent.

PSYCHOMETRIC ASSESSMENT

Interviewer-based instruments

- Structured Clinical Interview for DSM-IV, leading to the identification of major depressive disorder.
- The section regarding Demoralization of the Structured Interview for the Diagnostic Criteria for Psychosomatic Research (DCPR).

Self-rated questionnaires

- Ryff's Psychological Well-Being scales (PWB): autonomy, environmental mastery, personal growth, purpose in life, positive relationships, self-acceptance.
- Kellner's Symptom Questionnaire (SQ): anxiety, depression, somatization, hostility.

RESULTS

Prevalence of major depressive disorder and demoralization

- Demoralization according to DCPR and DSM-IV major depressive disorder were found in 31 (32.6%) and 14 (14.8%) patients, respectively.

Overlap rates between demoralization and depression

- Among depressed subjects, 35.7% (n=5) were not demoralized.
- Seventy one percent (n=22) of those with demoralization did not satisfy the criteria for major depressive disorder.

Associations of demoralization with psychological well-being and distress

- Demoralization was significantly related to impairments in several psychological well-being dimensions (PWB): autonomy ($p<0.05$), environmental mastery ($p<0.001$), positive relationships ($p<0.05$), purpose in life ($p<0.05$), self-acceptance ($p<0.001$).
- Demoralization was also significantly associated with higher scores in all the SQ scales: anxiety ($p<0.001$), depression ($p<0.001$), somatization ($p<0.001$) and hostility ($p<0.05$).
- The co-occurrence of a major depressive episode did not significantly alter this pattern of associations.

CONCLUSIONS

- Major depressive disorder and demoralization are not linked by a hierarchical relationship.
- Demoralization, as defined by DCPR, is characterized by several phenomenological manifestations of psychological distress and impaired well-being independently from major depressive disorder.
- Demoralized patients may require psychotherapeutic strategies, such as the Well-Being Therapy, aimed at the promotion of the sense of mastery and amelioration of self-acceptance.

PEER INTERACTION AT SCHOOL: ANXIETY AND DEPRESSION IN REFUSED CHILDREN

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Children's peer relations provide unique and essential contributions to social and emotional development. Children and adolescents identified with problematic peer relations are at risk for later adjustment problems, with respect to social and emotional functioning (Hecht et al. 1998). In fact, negative peer status in childhood is predictive of a variety of maladaptive outcomes in adolescence and adulthood (Coie et al., 1992). Studies found an association between rejected children and externalizing problems, and these children manifest higher levels of aggression (Newcom et al., 1993). Research suggests that rejected and neglected children report greater depressive symptomatology than their peers (Cole & Carpentieri, 1990; Malik & Furman, 1993; Hecht et al., 1998).

AIMS

To investigate differences concerning anxious and depressive symptoms with respect to classroom social status.

METHOD

Participants

This study took place at primary and secondary schools in Milan (Italy). Participants were 683 children (males 350 females=333) ranging in age from 7,67 to 13.78 years (Mean=10.37 sd=1.12).

Instruments and Procedure

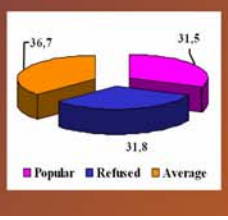
Children's social status was assessed through the use of a sociometric nomination measure. Children were asked to indicate three children with whom they wished to spend a weekend together and three with whom they would not like to do so. Sociometric nomination is a measure of social likeability, which reflects the extent to which children are liked or disliked by peers. Moreover, the degree of Peer Interaction Problems was assessed by means of the "Social Problems" Scale of the CRS-R ("Conners' Rating Scale-Revised" - Conners, 2001) , compiled by parents (CPRS-R) and teachers (CTRS-R).

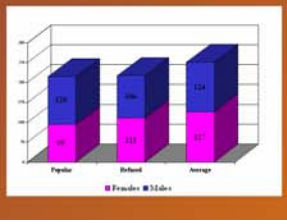
Children's anxious and depressive symptoms were assessed by the TAD questionnaire ("Depression and Anxiety Youth Scale" - Newcomer, Barenbaum, & Bryant, 1995). The questionnaires were completed by the children, their parents and teachers.

RESULTS

Sociometric Status

Sociometric Status was identified by using "Walsh's Classroom Sociometrics" software, which yields five status categories: POPULAR (P), AVERAGE (A), NEGLECTED (N), REJECTED (R) and CONTROVERSIAL (C). We grouped children with negative status (N, R, C) in a REFUSED category.





The analysis of the CRS-R scores of "Social Problems" Scale confirmed that parents and teachers consider REFUSED children to be more problematic (Table 1).

CRS - R		GROUPS						Kruskal - Wallis		
		POPULAR		AVERAGE		REFUSED				
		Mean	SD	Mean	SD	Mean	SD	χ^2	df	p
P	SOCIAL PROBLEMS	46.07	6.917	47.62	7.273	51.01	12.722	19.101	2	<0.001
T	SOCIAL PROBLEMS	50.04	10.422	51.38	11.342	55.08	13.623	17.909	2	<0.001

Internalizing Symptoms

Analyses showed differences among the three groups in the TAD Scores concerning Anxiety and Depression (Table 2)

TAD		GROUPS						Kruskal - Wallis Test		
		POPULAR		AVERAGE		REFUSED				
		Mean	SD	Mean	SD	Mean	SD	χ^2	df	p
C	ANXIETY	20,11	4,719	18,74	3,174	21,49	6,304	16,330	2	<0,01
	DEPRESSION	16,13	4,014	16,17	4,488	17,56	5,928	8,134	2	<0,05
P	ANXIETY	1,67	1,392	1,90	1,745	2,12	1,854	6,888	2	<0,05
	DEPRESSION	0,83	1,285	0,87	1,261	1,11	1,488	5,959	2	<0,055
T	ANXIETY	0,93	1,183	1,45	1,487	2,14	1,867	77,093	2	<0,001
	DEPRESSION	2,02	2,646	2,37	2,537	3,39	3,121	28,310	2	<0,001

Mann-Whitney Tests of children's self-evalutations (TAD-C) showed that the REFUSED differed from the POPULAR for Anxiety (U=20274 p=.025) and Depression (U=19940 p=.025), and also from the AVERAGE (Anxiety U=22740 p=.025; Depression U=23856 p=.025). No differences were found between the AVERAGE and POPULAR.

Concerning parent evaluations (TAD-P), analyses indicated that the REFUSED differed from the POPULAR for Anxiety (U=19458 p=.01) and Depression (U=20288 p=.03), and from the AVERAGE for Depression (U=24024 p=.039). Again, no differences were found between the AVERAGE and POPULAR.

Concerning teacher's evaluations (TAD-T), analyses showed significant differences in all the comparisons among the 3 groups: REFUSED vs POPULAR (Depression U=16317 p<.001; Anxiety U=13804 p<.001) REFUSED vs AVERAGE (Depression U=20656 p<.001; Anxiety U=22460 p<.001) POPULAR vs AVERAGE (Depression U=19866 p<.001; Anxiety U=21295 p<.001).

DISCUSSION AND CONCLUSION

The analyses showed sociometric group differences on Anxiety and Depression scores, as measured by the TAD. These differences concerned both self-evaluations and other-evaluations (parents and teachers). Although more anxious and depressive symptoms, asssociated with peer rejection, may result from the status, the symptoms could also cause the peer rejection (Rubin, 1983).

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THE VALIDATION OF THE SOCIAL PHOBIA AND ANXIETY INVENTORY FOR CHILDREN IN THE ITALIAN POPULATION

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Social Phobia (SP) is described as a fear of humiliation, embarrassment and distress in social situations, which may lead to significant avoidance. The age of onset is thought to be teenage, with an earlier onset in males than females. More recent studies suggest it may arise even earlier. The literature reports Prevalence rates for SP in children and adolescent ranging from 5-10%.

The "Social Phobia and Anxiety Inventory for Children" (SPAI-C, Beidel, Turner, Morris, 2000) is an empirically derived self-report questionnaire, developed specifically to assess social phobia in childhood and early adolescence. It contains 26 items, some of which require multiple responses, and uses a Likert scale format that allows an assessment of the frequency with which each symptom is experienced (i.e., hardly ever, sometimes, etc.).

AIMS

The study evaluated the psychometric properties of the Italian version of the SPAI-C. Thus, data relative to the "Factorial Analysis"; "Normative data"; "Reliability"; "Concurrent and Discriminant Validity" shall be discussed.

METHOD

Participants

The study took place at primary and secondary schools in Milan (Italy). Participants were 479 children (males 242; females=237) ranging in age from 9 to 13 years (Mean=10.75 s.d.=.941), their parents and teachers.

Instruments and Procedure

CHILDREN completed the SPAI-C and the TAD-C "Depression and Anxiety Youth Scale" children's version (Newcomer, Barenbaum, & Bryant, 1995).

PARENTS completed the TAD-P, CPRS-R:L ("Conners' Rating Scale-Revised" - Conners, 2001); and the CBCL (Child Behavior Checklist; Achenbach, 1991)

TEACHERS completed the TAD-T and CTRS-R:L for teachers.

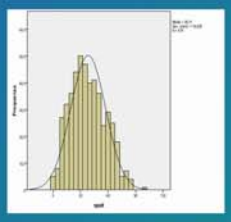
RESULTS

FACTOR ANALYSIS

Beidel et al. (1995) using a principal components analysis with a Varimax rotation found 3 factors: Assertiveness/Conversation (48%); Traditional Social Encounters (6.2%); Public Performance (5.4%). The analysis of data of our 163 children (M=88 F=75 AGE: 9-14 mean=11.99 sd=1.69), confirmed a 3 factor structure, which in part differed from the original study. We labelled the factors: Assertiveness/ Conversation (35.6%); Social Situations Adversity (6.73%); Public Performance (5.92%).

NORMATIVE DATA

The scores ranged from 0 to 99 (mean=38.31; s.d.=19.028), the asimmetry value was ".325" (ESM=.112), the curtosis value was "-.482" (ESM=.223). The distribution of scores approximated a Normal one (Kolmogorov-Smirnov test, p=.156). Analyses showed significant negative correlations between age and factors and total scores (Pearson's coefficient F1 r=-.177 p<.001; F2 r=-.181 p<.001; F3=-.099 p=.030; total r=-.250 p<.001). As a consequence, age was controlled in all the analyses. Moreover, significantly higher scores were found for females (Beidel et al. 2000, Gauer et al., 2005).



GENDER DIFFERENCES: T-TEST ANALYSIS

		MALES M	MALES SD	FEMALES M	FEMALES SD	t	df	p
SPAI-C	F I	14.7	8.1	18.3	9.9	-4.3	482	.003
	F II	12.2	7.4	14.2	7.6	-3.1	481.5	.344
	F III	6.9	3.9	8.3	4.2	-3.7	479.8	.181
	Total	35.0	18.7	41.7	18.7	-3.9	482	.938

RELIABILITY

Internal Consistency: Cronbach's alpha was calculated to determine the internal consistency of the SPAI-C (alpha=.939). *Test-Retest Reliability*: two weeks after the initial administration, the SPAI-C was readministered. Using a partial correlation (controlling for age) the test-retest reliability coefficient was r=.775 p<.001.

CONCURRENT AND DISCRIMINANT VALIDITY

Correlations between the SPAI-C factorial and total scores and the TAD, CBCL and CRS-R Scales were calculated. A good concurrent and discriminant validity was found. Only some results are reported in this paper.

PARTIAL CORRELATIONS BETWEEN MEASURES OF THE SPAI-C AND TAD (CONTROLLING AGE)

			SPAI-C Factor I	SPAI-C Factor II	SPAI-C Factor III	SPAI-C Total Score
TAD	C	ANXIETY	.478 .001	.540 .001	.414 .001	.229 .001
	P	ANXIETY	.111 .018	.181 .001	.164 .001	.059 .209
		SOCIAL MALADJUSTMENT	.170 .001	.132 .005	.122 .009	.033 .482
	T	ANXIETY	.081 .083	.101 .038	.041 .379	.037 .432

PARTIAL CORRELATIONS BETWEEN MEASURES OF THE SPAI-C AND CBCL

		SPAI-C Factor I	SPAI-C Factor II	SPAI-C Factor III	SPAI-C Total score
CBCL	ANXIETY DEPRESSION	.160 .001	.200 .001	.161 .001	.093 .044
	SOCIAL WITHDRAWAL	.059 .202	.096 .037	.019 .676	.052 .259
	INTERNALIZING SCALE	.126 .006	.179 .001	.135 .003	.072 .122
	EXTERNALIZING SCALE	.051 .274	.107 .021	.058 .213	.025 .595

PARTIAL CORRELATIONS BETWEEN MEASURES OF THE SPAI-C AND CRS-R

			SPAI-C Factor I	SPAI-C Factor II	SPAI-C Factor III	SPAI-C Total Score
CRS-R	P	ANXIETY - SHYNESS	.141 .004	.177 .001	.146 .003	.099 .073
		EMOTIONAL INSTABILITY	.069 .164	.106 .031	.090 .068	.015 .759
	T	ANXIETY - SHYNESS	.201 .001	.140 .005	.058 .106	.099 .045
		EMOTIONAL INSTABILITY	.036 .462	.023 .642	-.027 .587	.007 .883

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ANALYSIS OF INSTRUCTIONS FOLLOWING IN THE THERAPEUTICS INTERACTION IN A STUDY CASE

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1. Introduction

This work is part of a research line aimed to clarify the mechanisms underlying change in therapy from an analytic-functional perspective. The aim of this specific study is to complete this work with an analysis of the instructions given by the therapist, as well as the effect produced by these on the client´s behavior.

❖ **Objectives**:

1. To perform a first description of the use of the therapist's instructions.
2. To analyze the relationship between the therapist's instructions, the associated motivating and informative verbalizations and the positive or negative execution of the given instructions.

2. Method

Sample:

❖ 10 video recordings of a clinical case treated at The Therapeutic Institute of Madrid (ITEMA, Spain).

❖ A cognitive-behavioural therapist with 15 years experience in clinical practice.

❖ A case of a 32 years old woman with marital distress.

Instruments:

❖ Two validated category system (analysis of inter rater reliability) :

SISC-CVT (Therapist´s Cathegory subsystem)
SISC-CVC (Client´s Category Subsystem)

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

Procedure:

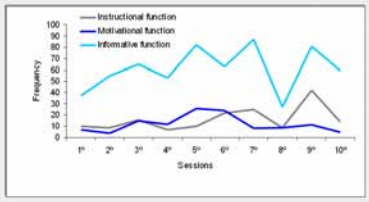
❖ Review of video recordings of the complete therapy (evaluation and treatment): 10 clinical sessions.

❖ Systematic observation of each therapist's instruction and the five previous and subsequent verbalizations issued by the therapist.

❖ Observation of the client's instructional following.

3. Results

Evolution of the therapist´s categories frequency



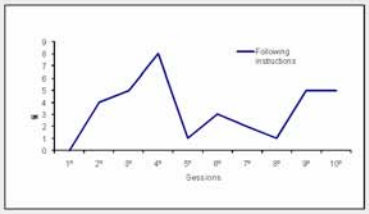
❖ **Instructional function:** Verbalization by the therapist to promote a given behaviour in the client inside or outside the clinical context. The consequences do not have to be explicitly mentioned, but the steps to be followed by the client must be described.

❖ **Motivational function**: Verbalization anticipating the positive or negative effect of a client's behaviour towards a clinical goal.

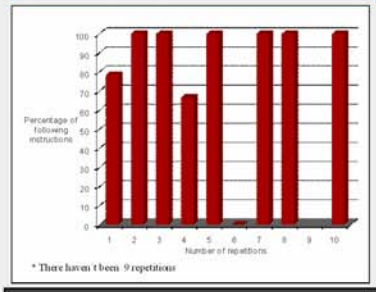
❖ **Informative function**: Therapist verbalization conveying technical or clinical information in a plain-language format.

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

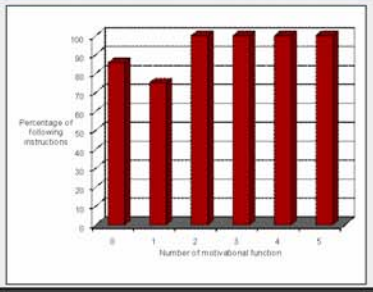
Client´s instructional following



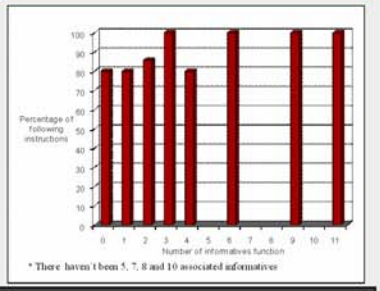
Number of repetitions of each instruction



Number of motivational function associated with each instruction



Number of informative function associated with each instruction



4. Conclusions

❖ There is a correlation between the number of informative and instructional functions. Additionally, the number of instructions that were successfully followed is higher in the first half of the treatment.

❖ As the number of motivational or informative functions associated with an instruction increases, there is a higher probability of successfully following this instruction. However, there is no effect in case that what increases is the number of repetitions of an instruction.

❖ As a continuation of this work, we propose to perform a multivariant-analysis over an extended sample in order to study the relationships between the diverse functions and their effect on the instructional following.

❖ In the same line, we propose to include a larger set of SISC-CVC categories for the client related to the instructional following.

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DESCRIPTIVE STUDY OF PSYCHOLOGIST'S AND CLIENT'S VERBAL BEHAVIOR DURING THE APPLICATION OF THE THERAPEUTIC PROCEDURES WITHIN COGNITIVE RESTRUCTURING TECHNIQUE

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OBJECTIVES

- This work is part of the so-called *processes research*: it is a preliminary approach to the analysis of the therapeutic processes taking place during the application of the *cognitive restructuring technique*.
- Cognitive restructuring is widely used among clinicians (PracticeNet Survey, APA, 2003), but little is known about it in terms of the underlying mechanisms of change.
- The aim of this study: to conduct a descriptive analysis of psychologist's and client's verbal behavior during the application of the therapeutic procedures within cognitive restructuring technique and to analyze the differences between them.
- In a previous study we found that the therapeutic components were: explanation about the technique, Socratic method, proposal of home tasks and checking home tasks (Calero-Elvira, 2009; Froján-Parga, Calero-Elvira and Montano-Fidalgo, 2009, in press).

METHOD

PARTICIPANTS

- 153 fragments of recordings of clinical sessions in which cognitive restructuring technique was applied. These fragments were selected from 87 sessions that involved 22 different cases.
- 4 cognitive-behavioral therapists with more than 3 years of professional experience at the Therapeutic Institute of Madrid (ITEMA, Spain).

INSTRUMENTS

- SISC-INTER-RC coding system (Calero-Elvira, 2009; Froján-Parga, Montaño-Fidalgo, Calero-Elvira, García-Soler, Garzón-Fernández y Ruiz-Sancho, 2008).
- Software The Observer XT 6.0 and 7.0
- SPSS 15.0
- Closed-circuit video camera system to capture the sessions.

VARIABLES

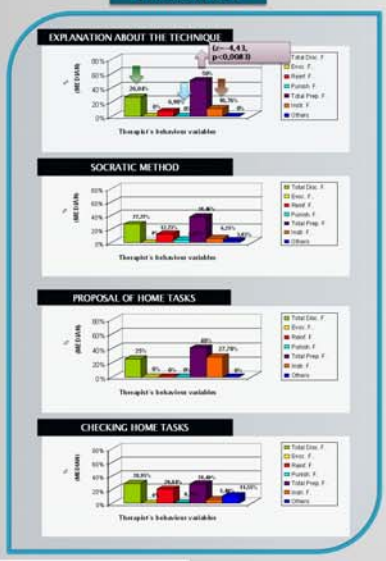
- Psychologist's verbal behavior coded according to SISC-INTER-RC :
  - Discriminative function not indicating the desired direction of the client's response
  - Discriminative function Indicating the desired direction of the client's response
  - Conversational discriminative function
  - Failed discriminative function
  - Discriminative function "other"
  - Evocative function
  - Conversational reinforcement function
  - Low reinforcement function
  - Medium reinforcement function
  - High reinforcement function
  - Low punishment function
  - Medium punishment function
  - High punishment function
  - Preparation for the discriminative function
  - (Preparation) informative function
  - (Preparation) motivating function
  - Instructional function
  - Others
- Client´s verbal behavior coded according to SISC-INTER-RC:
  - Providing information
  - Asking for information
  - Showing acceptance
  - Showing disapproval
  - Express negative emotions
  - Express positive emotions
  - Following instructions
  - Others

PROCEDURE

- An observer expert in behavior therapy identified the moments in which cognitive restructuring was applied and also identified the kind of therapeutic procedure used.
- The observer registered and coded the therapist's and the client's verbal behavior using The Observer XT software.
- To maintain an adequate level of reliability in observations, inter- and intra-judge concordance levels were computed periodically. The minimum level was set at Kappa = 0.50 (the values were always higher than 0.50).

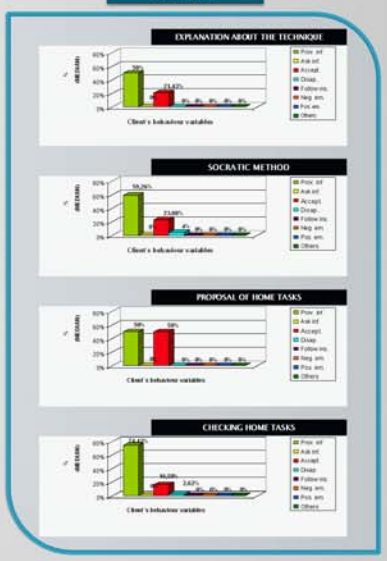
RESULTS

THERAPIST



DISTRIBUTION OF VARIABLES OF THERAPIST´S AND CLIENT´S VERBAL BEHAVIOUR

CLIENT



DISCUSSION

WE KNOW SOMETHING MORE ABOUT COGNITIVE RESTRUCTURING

REGARDING THERAPIST'S VERBAL BEHAVIOR

- EXPLANATION ABOUT THE TECHNIQUE: PROVIDES THE CLIENT WITH INFORMATION ABOUT THE TECHNIQUE AND USES MORE VERBALIZATIONS TRYING TO MOTIVATE CLINICAL CHANGE.
- SOCRATIC METHOD: SHOWS DISAPPROVAL WITH PREVIOUS CLIENT´S BEHAVIORS.
- PROPOSAL OF HOME TASKS: THE FREQUENCY OF THE INSTRUCTIONAL FUNCTION IS REMARKABLE.
- CHECKING HOME TASKS: SHOWS ACCEPTANCE WITH CLIENT´S BEHAVIORS THAT TOOK PLACE OUT OF SESSION.

REGARDING CLIENT´S VERBAL BEHAVIOR

IT CAN BE GROUPED IN 3 CATEGORIES:

- PROVIDING INFORMATION ABOUT THE AREAS COVERED IN EACH SESSION.
- SHOWING DISAPPROVAL WITH THE PSYCHOLOGIST'S VERBALIZATIONS.
- SHOWING ACCEPTANCE WITH THE PSYCHOLOGIST'S VERBALIZATIONS.

CONTRIBUTIONS

- THE PROPOSED CATEGORIES COVERED THE RANGE OF POSSIBLE BEHAVIORS BY THE THERAPIST AND CLIENT WHEN THIS TECHNIQUE IS APPLIED AND OBSERVERS ARE ABLE TO CODE THEM WITH AN ADEQUATE LEVEL OF INTRA- AND INTER- JUDGE AGREEMENT. FURTHERMORE, THE RESULTS FOUND HAD USEFUL PSYCHOLOGICAL MEANING IN RELATION TO THE DESCRIPTION OF EACH COGNITIVE RESTRUCTURING THERAPEUTIC PROCEDURE AND IN RELATION TO THE DIFFERENT COMPARISONS BETWEEN GROUPS.
- WE CAN STATE THAT THIS STUDY IS NOT ONLY A PRELIMINARY APPROACH TO THE ANALYSIS OF THE THERAPEUTIC PROCEDURE WITHIN THE COGNITIVE RESTRUCTURING TECHNIQUE, BUT ALSO IT IS A FIRST STEP IN THE VALIDATION OF THE MEASURING INSTRUMENTS USED, THE SISC-INTER-RC CODING SYSTEM.

LIMITATIONS

- IN THE FUTURE IT WILL BE NECESSARY TO STUDY MOMENT BY MOMENT THE THERAPEUTIC PROCEDURE TO IDENTIFY THE MECHANISMS OF CHANGE THAT MAY BE RELATED TO A GREATER EFFECTIVENESS IN THE USE OF THIS TECHNIQUE.

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Study of the definition of rule applied to therapy

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OBJECTVE: To develop a definition of rule applied to the therapeutic process.

THEORICAL BASES

- Knowledge "by familiarity" or "by description" (Rusell, 1912).
- "Knowing how" and "knowing that..." (Ryle, 1949).
- RULE as a **"Stimuli specifying contingencies"** (Skinner, 1969).

CRITICISM

- The listener's behavior is verbal, too (Cerutti, 1989; Ribes, 1990; Schlinger, 1993; Vaughan, 1989; Zettle & Hayes, 1982).
- A rule is not just a discriminative stimuli (Cerutti, 1989; Ribes, 1990; Schlinger, 1993; Vaughan, 1989; Zettle & Hayes, 1982).
- A rule is also under the control of contingencies (Ribes, 1990).
- A verbal stimuli is not just the product of verbal behavior (Hayes & Hayes, 1989).

EXPERIMENTAL BASES

- In the late 50's the first studies emerged that noticed the instructional control in the subject's behavior.
- In the 60's and 70's the instructions were not studied directly, but it was clear that:

(1) Instructions favored executions with fewer mistakes (Ader & Tatum, 1961; Ayllon & Azrin, 1964; Kaufman, Baron, & Kopp, 1966)
(2) Instructions allowed faster acquisition, but they may also decrease the strengthening programs (Lipman & Mayer, 1967; Weiner, 1970)
(3) The more precise an instruction was, the better results it produced (Baron et al., 1969).

- There were no theoretical concerns (Hayes et al., 1989).
- Rule following was "synonymous" of instruction following.

DEFINITION PROPOSALS

- **Functional definition:** A verbal stimuli only makes sense if there are **verbal stimulus functions and a listener,** as listener behaving verbally (Vaughan, 1989; Hayes & Hayes, 1989). They define a rule as behavior controlled by antecedent verbal stimuli (Zettle & Hayes, 1982).
- **Formal definition:** We should be able to identify the rules **independently of the behavior they controlled** (Glenn, 1989).
- **Functional and formal definition:** We must distinguish between a verbal discriminative stimulus and a rule that is a **function altering stimulus** when some formal requirements are complied (Schlinger & Blakely, 1987).

CONTEMPORARY RESEARCH

RULES

- They suggest control of a **wide variety of circumstances.**
- They describe a **generality** or **regularity.**
- They refer to described **contingencies formulated through the experience.**

INSTRUCTIONS

- They suggest **situational limits** (Cerutti, 1989)
- They describe a **specific situation** (Ribes, Moreno, & Martínez, 1998)
- They refers to described contingencies **formulated without the experience** (Martínez y Tamayo, 2005).

IN THE CLINICAL CONTEXT

Several studies from the 90´s point to the importance of studying rule governed behavior in order to improve:

(1) the understanding of different psychological problems (Hayes et al., 1999; Sturmey et al., 2005; Torneke, Luciano, & Salas, 2008)
(2) the development of therapeutic procedures (Lappalainen & Tuomisto, 1999; Rhem & Rokke, 1988).
(3) the understanding of clinical change (Martin & Pear, 2007; Plaud & Newberry, 1996; Poppen, 1989).

On the other hand, there is a lack of processes research about the effect of the therapist's rules during therapy. Furthermore, nowadays the terms "rule" and "instruction" are still considered synonymous.

OUR DEFINITION: Rule as the expression of the contingencies derived from the therapist's experience and knowledge included in a principle that can be associated with a great variability in behaviors and with non- immediate subsequent responses.

CONCLUSIONS

- The proposed definition can help delimiting a part of therapist's verbal behavior with the aim of studying its role on the therapeutic process at a functional level.
- In future research we will try to study how therapist's rules interact with the client's verbalizations until the client achieves the desirable change.
- In the long term this work will make possible a better understanding of what happens in the therapeutic process and, as a consequence, a better effectiveness in the clinic practice.

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ANALYSIS OF RULES EMITTED BY THE THERAPIST IN A CASE STUDY

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INTRODUCTION

The general line of research in which this study is framed aims to clarify the mechanisms of change taking place during the therapeutic process from a functional analytic perspective.

In this part of the research, we achieved a specific study of "rules" expressed by the therapist during the clinical sessions in a descriptive and non-explanatory level of analysis.

Our definition of the concept of rule applied to the clinical context is proposed as follows: ***"the expression of the contingencies derived from the therapist's experience and knowledge included in a principle that can be associated with a great variability in behaviors and with non- immediate subsequent responses".***

METHOD

Observational methodology

OBJECTIVE

To analyze therapist's rules and their distribution along the treatment of a clinical case.

SAMPLE

10 video recorded sessions (approx. one hour each) from a clinical case corresponding to a 32-year-old woman with marital distress.

The psychological intervention was carried out by an expert cognitive-behavioral therapist (more than 15 years of practice) from the Therapeutic Institute of Madrid (ITEMA, Spain).

MATERIALS

Software "**The Observer XT 6.0**"

The "**SISC-CVT**" category sistem

Category	Brief description
Communication stimulus (Ec)	Verbalizations that commented a client's behavior (verbal or non- verbal) followed by reinforcement or punishment (operant conditioning) by the therapist. (Event-event category)
Elicitation (El)	Verbalizations by the therapist that elicited an observable emotional response in a client's verbalizations referring to a current emotional response. (Event-event category)
Reinforcement (R)	Verbalizations that showed agreement with, acceptance of, and/or admiration for the client's behavior. (Event-event category)
Punishment (P)	Verbalizations that indicated disagreement with, disapproval of, and/or rejection of the client's behavior. (Event-event category)
Information (IT)	Verbalization by the therapist that transmitted his or her theoretical and/or clinical knowledge to the client. (State-event category)
Motivation (Mt)	Verbalization by the therapist that highlighted the benefits of the client's behavior or the costs of maintaining a dysfunctional behavior. (State-event category)
Instruction (IT)	Guidelines offered by the therapist with the aim of promoting a certain behavior outside of the clinical context. (State-event category)
Other (O)	Verbalizations that could not be included in any of the above categories. (Event-event category)

VARIABLES

SISC-REGLAS category system

PROCEDURE

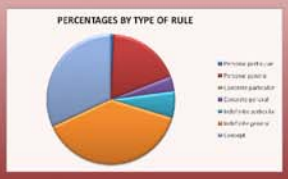
In the first stage, the clinical sessions recordings were observed and coded with the system *Therapists' verbal behavior category system* (SISC-CVT) (Froján Parga, M.X. et al., 2008), with an adequate level of reliability.

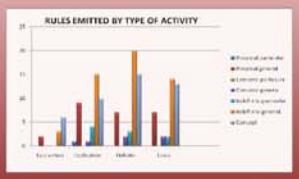
The verbalizations categorized as "Informative function" according to this system were selected as the sample for the second stage of the research. In this stage we developed *The therapists' rule category system* (SISC-RULES) to classify the rules emitted by the therapist. This system allows specifying the type of rule considering the type of agent and the type of context. *The Observer XT* software was used to code and register data.

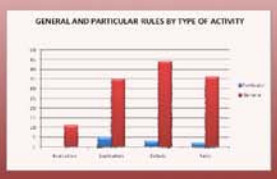
RESULTS

Percentage of intra observer agreement : 91%

Percentage of inter observer agreement :77 %







CONCLUSIONS

- During sessions the therapist emits more "general rules", specifically, there is a predominance of the type of rule "indefinite general".
- Throughout the different activities carried out within session, most of the rules were emitted during debate; during evaluation the frequency of rules was very low.
- The data could indicate that the therapist uses rules as a tool for discussion rather than a tool to explain.
- In future research it would be interesting to compare rules emitted in therapy by experts and non-expert therapists. Another objective could be to discover whether there is a change in client's rules and which are the processes involved in such change.
- Our study is just an approach to understand the role of rules during the therapeutic process. However, we believe that the classification proposed in this work would contribute to reach our final goal: the understanding of change in therapy that in the long term would lead to more effective therapeutic interventions.

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Consultations Psychologiques Spécialisées
Troubles émotionnels

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Cross-cultural consistency of the Five Facets Mindfulness Questionnaire: Adaptation and validation in a French sample

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The authors are thankful to Ruth A. Baer for her permission in the development of the French version of the FFMQ.

1. Introduction

Several studies have observed that mindfulness training improves mental health and psychological functioning (e.g., Baer, 2003). Until recently, however, methods for assessing mindfulness have received little empirical attention. Recently, five self-reported questionnaires have been validated and proposed for assessing mindfulness skills. They include the *Mindful Attention Awareness Scale* (Brown & Ryan, 2003), the *Freiburg Mindfulness Inventory* (Buchheld et al., 2001), the *Kentucky Inventory of Mindfulness Skills* (Baer et al., 2004), the *Cognitive and Affective Mindfulness Scale* (Feldman et al., 2004) and the *Mindfulness Questionnaire* (Chadwick et al., 2005). Although all of these measures assess a general tendency to be mindful in daily life and have shown potentially good psychometric properties, differences in their content and structural construct clearly indicate a lack of consensus about the conceptualization of mindfulness.

To overcome this limitation, Baer et al. (2006) conducted exploratory factor analysis in a sample of students who had completed all of the five mindfulness self-reports described above. This approach integrated items from different questionnaires into structural factors, providing an empirical integration of previous independent attempts to operationalize mindfulness. This procedure resulted in a 39-item questionnaire, called the Five Facet Mindfulness Questionnaire and organized in a five-factor solution labeled: (1) *Observing*, (2) *Describing*, (3) *Acting with awareness*, (4) *Nonjudging of inner experience*, and (5) *Nonreactivity to inner experience*. In a second nonmeditating sample, confirmatory factor analysis corroborated the five factors solution. Further, hierarchical confirmatory factor analysis suggested that the facets were found to be clear indicators of an overarching mindfulness construct. For each subscale, good internal consistencies were observed.

→ The main goal of this study was to adapt and validate this scale into French

2. Method

Transaltion

In line with the International Test Commission guidelines for test adaptation (Hambleton, 2001), items were first translated into French and then back-translated into English. Three fully bilingual experts translated the original English scale into French using a committee approach. This version was then translated back into English and re-evaluated by two other bilingual experts. The whole translation back-translation process was supervised by the first author. Items with problematic back-translation were thoroughly discussed and appropriately amended. Most discrepancies were minor, involving the choice between two synonyms. Then, following the recommendation of Hambleton et al. (2005) concerning the use of an appropriate format for the items, four participants were instructed to comment on the overall presentation of the instrument and the precision of the items. No remarks were made.

Participants

- 214 participants (131 women) aged between 18 and 81 years olrs (M = 35.39, SD= 13.55) with at least a secondary school degree and were predominantly university graduates. They have never practiced mindfulness training.

Measures

- French version of the Five Facets Mindfulness Questionnaire (FFMQ; Baer et al., 2008)
- Beck Depression Inventory (BDI-II; Beck, Steer, and Brown, 1994)
- State and Trait Anxiety Inventory (STAI; Spielberger, 1983)

Results

Descriptive statistics and internal consistency

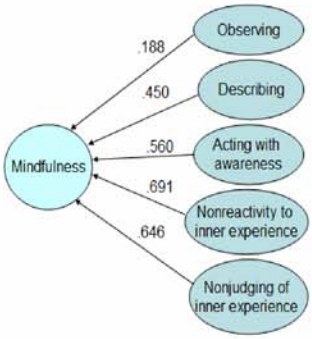
	Observing	*Describing*	*Acting with awareness*	*Nonreactivity to inner experience*	*Nonjudging of inner experience*	*Mindfulness (global scale)*
α	.77	.89	.88	.77	.88	.88
M	25.06	25.62	26.66	18.98	26.97	123
SD	5.47	6.43	6.359	4.401	6.63	17.99
Nunber of items	8	8	8	7	8	39

Concurrent validity (Pearson'r coefficient)

	Observing	*Describing*	*Acting with awareness*	*Nonreactivity to inner experience*	*Nonjudging of inner experience*	*Mindfulness (global scale)*
STAI-state	-.011	-.159	-.408**	-.369**	-.452**	-.482**
STAI-trait	-.042	-.250**	-.198**	-.447**	-.297**	-.425**
BDI-II	-.042	-.086	-.467**	-.241**	-.281**	-.355**

** $p < .01$

Confirmatory factor analysis



Due to a non-multinormal distribution of the data (Mardia's coefficient = 158.713), structural equation modeling was base on « ***Unweighted Least Squares*** » estimation (Browne, 1982).

Fit Indices:

GFI = .891
AGFI = .879
PGFI = .797
PRATIO = .941

→ Non rejection of the model

Note. GFI is for Goodness of Fit Index; AGFI is for Ajusted Goodness of Fit Index; PGFI is for Parsimony-based Goodness of Fit Index; PRATIO is for Parsimony Ratio. For GFI and AGFI, as suggested by Cole (1987), a value of .80 has usually been considered as a minimum for model acceptance. For PGFI and PRATIO, values larger than .60 are generally considered satisfying (Blunch, 2008)

Conclusion

In accordance with the observation of Baer et al. (2006), the present data support a hierarchical model with the five facets of mindfulness as latent variables and mindfulness as a second-order factor. In addition, with a value of Cronbach's alpha higher than .70 for all factors (Nunally, 1978), the scale and each subscale have good internal consistencies. These results suggest that the French version of the FFMQ may be used either as a unidimensional scale, using a global score of mindfulness, either as a multidimensional scale, via the specific score of each subscale. However, the observing facet did not really fit this model and was associated with a lower factor loading. Regarding this facet, Baer et al. (2006) have found similar results. More recently, Baer et al. (2008) have observed that this effect interacted with the type of sample used. Indeed, confirmatory factor analysis, conducted on a sample of individuals who have already practiced mindfulness, clearly support a five-factor solution which are indicators of an overarching mindfulness construct, while the observing factor did not fit among a nonmeditating sample.
At a clinical level, significant negative correlations were observed between the FFMQ and measures of depression and anxiety. At an applied level, as suggested by Baer et al. (2008, p. 330), such assessment is necessary for examining whether individuals who practise mindfulness become more mindful over time and whether these changes effectively mediate the effects of mindfulness training on psychological health.

Therapeutic homework and goal attainment amongst people with persistent and recurring mental illness: A pilot study

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Homework Use and Outcome

➢Homework (HW) refers to between-session activities that are tied to therapeutic goals (Deane et al., 2005)

➢There is an increasing body of literature recommending the use of HW for individuals diagnosed with psychotic disorders (Glaser, et al., 2000; Luboshitzky & Gaber, 2000).

➢For example, HW is included in cognitive therapy for psychosis (Turkington, et al., 2004), social skills training (Wixted, Morrison, & Bellack, 1988) and family therapy (Barrowclough & Tarrier, 1992).

➢Individuals diagnosed with psychotic disorders are primarily treated within multi-disciplinary case management teams.

➢Previous surveys indicate that 93% of case managers use HW with individuals diagnosed with psychotic disorders (Kelly et al., 2006).

➢Research has not previously examined the relationship between HW use and Goal Attainment in this population

HW Administration Procedures

➢To improve HW completion rates, it has been suggested that clinicians use a systematic approach to HW administration (Shelton & Levy, 1981).

➢This approach includes providing a written copy of the HW assignment for the individual to take away describing when, where, how often and how long the task should take (e.g. see Figure 1.).

➢Monitoring of HW performance occurs through ratings of quantity (how much) and quality (how well) of HW completion at subsequent sessions

Homework and Goal Attainment

➢ Goal Attainment Scaling (GAS, Kiresuk & Sherman, 1968) generally requires identification of client's goals, identifying different levels of outcome achievement for each goal and then quantifying each level to obtain a goal attainment score for a specified period of time.

➢Usually only low to moderate correlations are found between GAS scores and other outcome measures (e.g., Cytrynbaum et al., 1979).

➢Although HW has been related to other outcome measures, and other outcome measures have been found to be modestly related to goal attainment, HW has not been related to goal attainment.

Project Overview

➢As part of a national project evaluating a recovery-orientated case management approach (Oades et al., 2005), case managers were trained to collaboratively negotiate and develop goals and HW with clients and to help achieve those goals.

Aims and Hypotheses

➢ Examine the relationship between HW use and goal achievement. It was hypothesised that HW would be positively related to goal achievement after 3 months.

Method

Participants

➢A convenience sample of 24 service users and 21 case managers recruited from non-Government and public sector mental health services in Australia

Service users

➢Average age was 40 years (range 18-69),70% were single, 15% married and most were female (62.5%).

➢71% (17 of 24) had a diagnosis of schizophrenia or schizoaffective disorder and the remainder had bipolar disorder or depression with psychotic features (29%).

➢Most had received their diagnosis in excess of 5 years (65%)

Case Managers (CM)

➢Average age was 47 years (range 26-60), with most being nurses by profession (67%), female (75%) and working fulltime (62%)

➢83% were from public sector mental health services and mostly working in rehabilitation settings (62%) followed by community mental health settings (38%).

➢62% were trained in Australia, 29% in the UK and 9% NZ

➢All had tertiary level education with 63% TAFE/Polytechnic, 21% undergraduate degree and 16% postgraduate university degree

Procedures

➢Case Managers participated in a 2-day training course in the Collaborative Recovery Model (CRM; Oades et al., 2005).

➢Training included skills on development of a goal plan and systematic implementation of HW with clients to facilitate progress toward these goals

➢Specifically related to HW they were instructed to:

(1) use the HW assignment pad whenever they assigned HW.
(2) administer HW on at least a fortnightly basis.
(3) link the HW to the individuals recovery goals.
(4) provide a copy of the completed HW sheet to the client.
(5) review the HW assignment at the following HW session by completing the HRS items on the HW assignment sheet.

➢Goal plans were established at baseline and reviewed at 3 months

➢Clinician and client measures were completed independently at baseline and 3-months.

Measures

➢**Kessler-10** (Andrews & Kessler, 2004). 10-item client completed self report measure of psychological symptom distress. Rated from 1 = None of the time to 5 = All of the time.

Homework

➢**Homework Assignment Pad**. Based on the empirical recommendations of Shelton & Levy (Shelton & Levy, 1981). The first 3 items of the HRS were included on the sheet to rate "how much" & "how well" homework was completed (see figure 1.). Both clients and therapists provided independent ratings of HW completion at the following session. The mean of client and clinician ratings of "how much", "how often" and "how difficult" were taken across all HW assignments for each client over the 3 month period.

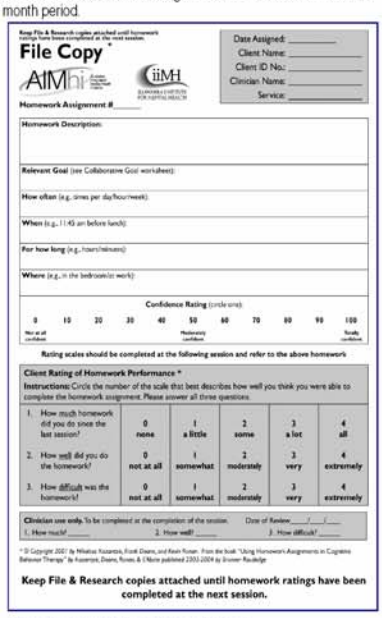

Figure 1. Homework Assignment Sheet

Goal Attainment

➢The Collaborative Goal Technology form (Clarke et al., 2006) was used as the goal planning form in services. In addition to specifying the content of goals, it utilises a modified form of Goal Attainment Scaling.

➢Each goal is assigned a level of perceived importance (totalling up to 10 points across all goals e.g., 2 goals could receive 6 and 4 points each to total 10)

➢Within each goal three levels of achievement are specified and allocated a weighting, the target level of attainment (1) and a higher (2) and lower level (0).

➢Goal attainment scores involve endorsing the level of achievement (0,1,2) and then multiplying this by the perceived importance of the goal (1-10).

➢Scores can range between 0 and 20 with a score of 10 representing the targeted goal achievement

Results

Homework Use, Quantity and Quality of Completion

➢An average of 8.45 (SD=6.06) HW sheets were administered to each client (range 1 to 20) over the 3 month period

➢HW was mostly behavioural in nature, focusing on conducting tasks of daily living and engaging in social or physical activities.

➢There were no significant differences between client or therapist ratings of quantity or quality of HW completed. However, therapists did rate the difficulty of the homework significantly higher (M = 1.78, SD = .86) than did service users (M = 1.34, SD = .70), t(18) = 2.92, p < .01.

Homework and Goal Attainment

➢ The mean Goal attainment score was 7.08 (SD = 4.83) and 42% (10/24) achieved their target goals over the 3 months period.

➢The number of HW assignments was not related to Goal attainment (See Table 1)

➢ Client average ratings of how much HW assignments were completed was significantly positively related to Goal Attainment

➢Clinician ratings of both quantity and quality of HW completion were positively related to goal attainment but these relationships only approached significance (both p = .06).

➢HW difficulty was not related to Goal attainment but was significantly associated with lower level symptom improvement (K10 change) over the 3 month period

Table 1. Correlations between Homework variables, Goal Attainment and Symptom Change

	Goal Attainment			Symptom change		
	r	n	p	r	n	p
Total number of HW assignments	.12	24	.28	- 03	17	.46
Client ratings						
How much done	.38*	24	.04	.31	17	.11
How well done	.26	24	.11	.16	17	.27
How difficult	- 02	24	.46	- 51*	17	.02
Therapist ratings						
How much done	.33	23	.06	.42*	16	.05
How well done	.34	23	.06	.42*	16	.05
How difficult	- 16	23	.24	- 03	16	.46

Conclusions

➢The number of HW assignments was not related to goal attainment and suggests that simply "giving more assignments" will not necessarily result in better goal achievement

➢The amount of HW completed and to some extent how well they are done are related to better goal attainment.

➢Clinicians should focus on supporting clients to complete as much as they can and as well as they can within each assignment. This would be facilitated by systematic monitoring and contingent reinforcement of efforts toward such task completion.

➢There is support from theory and empirical research that suggests HW completion leads to better outcomes. Our results suggest this extends to goal attainment in people with psychotic disorders

➢A major limitation of the study was the very small sample. This prevented the ability to look at multiple HW predictors and to specify what types of HW might best match to particular goals

➢Future research is required to further explore these relationships over time periods beyond 3 months

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A single-case study of attention training in Social Phobia: From lab to clinical practice

Preliminary results

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Introduction

Attention capture for threatening stimuli and difficulties to disengage from these stimuli have been identified as core components in Social Phobia (e.g. Amir et al, 2003). Further, cognitive models of Social Phobia state that attention biases for threatening information contribute to the installation and maintenance of this disorder (e.g., Clark, 2001; Rapee & Heimberg, 1997). As a consequence, some studies have demonstrated that training social phobics to attend to non-threatening stimuli is related to short-term (Amir et al., 2008) as well as long term emotional changes (e.g., Schmidt et al., 2009). However, to date, no studies have examined the adaptation of an attention training approach within a single-case design. The present study aims at directly assessing this question.

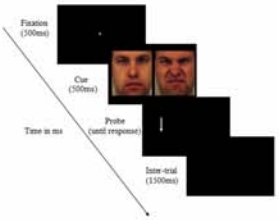
Rationale and predictions

Using an attention training procedure based on a dot-probe task, the present, **ABA-designed with a 2-month follow-up period**, experiment examined whether such procedure

→ enabled a social phobic client to reduce attentional biases

→ and to transfer this rehabilitation to daily functionning.

Attention training program



The attention biases induction: a modified version of the dot-probe task designed to train the client to disengage from disgust faces and attend to neutral faces.

At this end, the probe appeared in the position of the neutral faces on 95% of the trials.

During each session, the client saw 560 trials.

The faces used were selected from the Montreal Set of Facial Displays of Emotion (Beaupré, Cheung, & Hess, 2000)

Case report

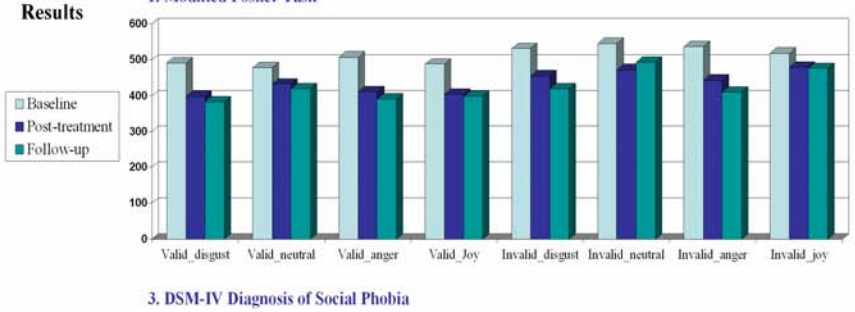
BJ is a 64-year-old right-handed woman working as voluntary with mentally handicapped person. BJ showed no deficits in general cognitive functioning examined with the Mini Mental State Examination (Crum et al., 1993). She also reported good attention processes, examined with the Attention Self-Assessment; Coyette et al., 1999). BJ showed no significant level of depression (using Beck Depression Inventory, Beck & Steer, 1987), no significant level of trait-anxiety (using STAI-Trait; Spielberger et al., 1983) as well as no significant level of general psychopathology (using the global score index of the Symptom Check-List-90-R; Derogatis, 1977). Nevertheless, a clear DSM-IV diagnosis of Generalized Social Phobia was apparent in the Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987), based on Heimberg et al.'s criterion (1999), as well as in the Mini International Neuropsychiatric Interview (MINI; Lecrubier et al., 1994), a semi-structured interview diagnosing specific DSM-IV (American Psychiatric Association, 1994) axis I disorders. Her demand was to cope with her fear to negative evaluation during speech performance (e.g., in front of friend, at work).

Design and measures

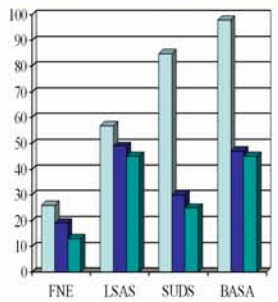
PROCEDURE	*Baseline*	2 weeks of attention training program	*Post-training*	2-month follow-up interval	*Follow-up*
MEASURES	- Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987) - Fear of Negative Evaluation questionnaire (FNE; Watson & Friend, 1969) - Behavioral Assessment of Speech Anxiety (BASA; Mulac & Sherman, 1974). - Subjective Units of Discomfort Scale (SUDS; Wolpe, 1958) : rate her level of situational anxiety, from 0 (not anxious) to 100 (extremely anxious) during speech performance - Mini International Neuropsychiatric Interview (MINI; Lecrubier et al, 1994) assessing specific DSM-IV axis I disorders. - Modified Posner Task (e.g., Amir et al., 2003). Participants saw 576 trials. 2/3 were validly cued 1/6 were invalidly cued and 1/6 were uncued. Each type of trial were equally subdivided into four emotions: Disugst, Joy, Anger, and Neutral. Trials were presented in a different random order.	The program was administrated each day. During each session, the client saw 560 trials.	- LSAS - FNE - BASA - SUDS - MINI - Modified Posner task		- LSAS - FNE - BASA - SUDS - MINI - Modified Posner task

Results

1. Modified Posner Task



2. Clinical Symptoms of Social Phobia



3. DSM-IV Diagnosis of Social Phobia

Regarding criterion of Social Phobia, the MINI semi-structured interview revealed the absence of DSM-IV diagnosis of Generalized Social Phobia only at follow-up.

Conclusion

The present findings revealed that the attention training program decreased self-reports assessment of social anxiety, subjective evaluation of anxiety and behavioural anxiety during a speech. These benefits were maintained at 2-month follow-up. Further, the data also revealed the absence of DSM-IV diagnosis of Generalized Social Phobia only at follow-up. At a processual level, the use of an independent attention bias assessment suggests the effective change in attention bias. Indeed, data suggest a decrease of facilitation biases (i.e., valid trials) for disgust and anger faces as well as of disengagement biases (i..e., invalid trials) for disgust and anger faces. However, the absence of non social phobics control group appears as a severe limitation. These data are still in collection and should permit to overcome this limitation. At a clinical level, these data are consistent with recent development in developments in cognitive bias modification (e.g., MacLeod, Koster, & Fox, 2009) demonstrating that the attention bias for threatening stimuli can be changed and that this change is related to short-term as well as long term emotional benefits. At a fundamental level, the present data are consistent with cognitive models of Social Phobia suggesting that attention biases for socially threatening stimuli may play a role in the development of social anxiety (e.g., Clark, 2001).

FAMILY AND SCHOOL AS LABORATORY OF PREVENTION: AN EXPERIMENTAL PROJECT TARGETED TO BUILD WELL-BEING

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BACKGROUND

The school represents an important setting where carry out actions to promote health. For this reason we created a project aimed at students, parents and teachers of some classes of a middle and high school of Brescia. Aims of this project were to improve the level of psychological health of the students involved and to give at teachers and families some tools, in order to recognize and to manage situations of adolescent uneasiness.

METHODOLOGY

Students, parents and teachers participated at three information/sensitization meetings, using experiential and interactive techniques. To evaluate the effectiveness of the project, we used instruments created *ad hoc* for students, parents and teachers. Were also administered questionnaires to assess the satisfaction for the project.

RESULTS

34 teachers, 20 parents and 429 students were involved.

The STUDENTS showed a good level of motivation and involvement towards the topics of the meetings.

The TEACHERS appeared motivated to exchange, with mental health professionals, resources to learn new teaching strategies.

We collected a greater involvement by PARENTS of middle school students: they eagerly responded at the educational meetings, urging both the need to create a space where to confront with other people and the possibilities that similar initiatives are realized more frequently in the school.

CONCLUSION

We think that the innovative aspects of this project are to extend an approach aimed at health promotion based on the living environment and to promote an integrated intervention based on the coordination of public policies on health. We hope that school and families always become more adequate to interact with social and health sectors, as well as to answer at the psychological needs of children and adolescents with whom they interact.

RUB Ruhr-University Bochum

Rumination-focused CBT group treatment for residual depression

Teismann, T., von Brachel, R., Hanning, S., Grillenberger, M., Hebermehl, L. & Willutzki, U.

Background

Rumination has been identified as a key factor in the onset and maintenance of depression (Nolen-Hoeksema et al., 2008). Moreover, rumination is associated with a delayed response to cognitive-behavioural therapy (e.g. Jones et al., 2008). Still, treatment manuals with an explicit focus on reducing rumination are rare. In a randomised controlled trial a cognitive-behavioural group treatment focusing on rumination (RFCBT) is currently under evaluation. The treatment manual comprises metacognitive (Wells, 2009) and behavioral (Martell et al., 2001) strategies (i.e. socialization, attention training, detached mindfulness, modifying positive and negative metacognitive beliefs, acceptance and activity, alternatives to rumination).

Method

Participants

By now, 47 depressed outpatients (15 ♂, 32 ♀) were randomly assigned to either 11 group sessions of RFCBT (n = 26) or a wait-list control group (WLC; n = 21), with the WLC-group receiving treatment three months later. Inclusion criteria were diagnoses of residual depression, dysthmia and minor depression as well as a score of ≥ 9 on the BDI.

Measures

- Beck Depression Inventory (BDI; Beck & Steer, 1987)
- Perseverative Thinking Questionnaire (PTQ; Ehring et al., submitted)
- Positive beliefs about rumination (PBRS; Wells & Papgeorgiou , 2001)
- Negative beliefs about rumination (NBRS; Papageorgiou & Wells, 2002)

Results

Treatment effects

Patients` level of self-rated depression, perseverative thinking and positive metacognitions significantly improved under treatment, $F(1,25) \geq 28.1$, $p<.001$. Negative metacognitive beliefs only improved slightly, $F(1,25) = 5.5$, $p<.05$ – yet, there was a significant increase in control over rumination (Item 9 of the NBRS), $F(1,25) = 59.1$, $p<.001$. There were no significant changes during the waiting period, $F(1,20) \leq 3.4$, *ns*. Effect sizes are displayed in figure 1.

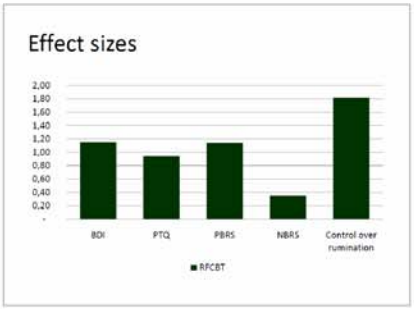

Figure 1: Effect sizes

Satisfaction with treatment

Satisfaction with treatment overall (see figure 2) and with single sessions, (see figure 3) was adaequate.

Response rate

53.8 % responded (50% reduction in BDI-scores) and 50% achieved full remission.

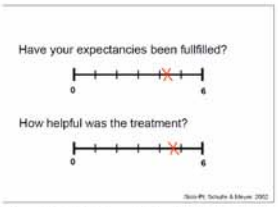

Figure 2: Satisfaction with treatment

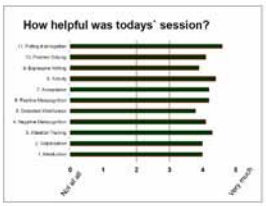

Figure 3: Satisfaction with sessions

Conclusion

The results of this ongoing study suggest that interventions targeting rumination are associated with improvements in depressive symptoms – which is consistent with the hypothesis that rumination plays a central role in maintaining depression. While future analyses on the long-term effect of the treatment have to be awaited, RFCBT group treatment seems to provide an effective approach for treating residual and subsyndromal depression (cf. Watkins et al. 2007; Wells et al., 2009).

This study is founded by the German Research Society (Deutsche Forschungsgemeinschaft, DFG)

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Resource-oriented CBT for depression

Teismann, T. & Willutzki, U.

Background

The importance of activating and utilising patients` strengths and resources within psychotherapy has been emphasised in recent years. In line, resource-activating interventions have been found to be associated with improved therapy outcome in correlational process-outcome studies (Grawe, 2006). Yet, explicit manuals for working with patients` resources as well as controlled studies on the efficacy of these interventions are lacking. Therefore, a randomized-controlled trial on treating unipolar depression with an integrative resource-oriented cognitive behavioural treatment (R-CBT) – incorporating solution- (de Shazer, 1994) and strength-focused (Kuyken et al., 2008) interventions – was conducted.

Method

Participants

70 depressed outpatients were randomly assigned to either 24 individual sessions of classical CBT (Hautzinger, 2000) or resource-focused CBT. Inclusion criteria were diagnoses of unipolar depression (single or recurrent) or dysthmia and a score of ≥ 20 on the BDI.

Measures

- Beck Depression Inventory (BDI; Beck & Steer, 1987)
- Hamilton Depression Scale (HAMD; Hamilton, 1986)
- Brief Symptom Inventory (BSI; Derogatis & Melisoratos, 1983)
- Response Styles Questionnaire (RSQ; Nolen-Hoeksema & Morrow, 1991)
- Dysfunctional Attitude Scale (DAS; Weissman & Beck, 1978
- Rosenberg Scale (RS; Rosenberg, 1965)

Results

Dropouts

One patient in CBT (2,9%) and six patients in R-CBT(16,7%) were classified as dropouts (see figure 1), with Fischer`s Exact Test ($p \leq .05$) indicating a significant difference in dropout rates.

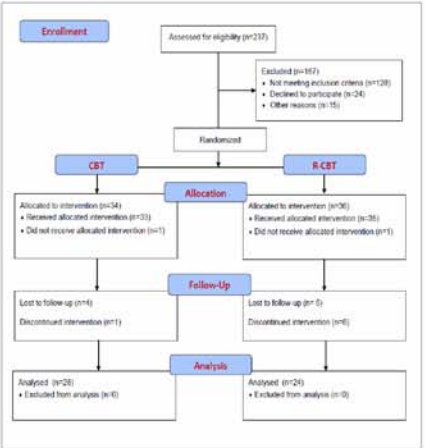

Figure 1: Flow chart

Treatment effects

Patients` level of self- and observer rated depression, general symptomatology, rumination, dysfunctional attitudes and self-esteem significantly improved in both therapy groups, $F(1,50) \geq 20.7$, $p<.001$. Yet, treatments did not differ in efficacy, $F(1,50) \leq 2.7$.
See figure 2 for effect sizes

Responder rates

Twelve patients in CBT (42%) and eight patients in R-CBT (33%) were classified as responders: BDI ≤ 8 (Frank et al., 1991). Treatments did not differ in responder rates, $Chi^2= 0.49$, df=1, *ns*.

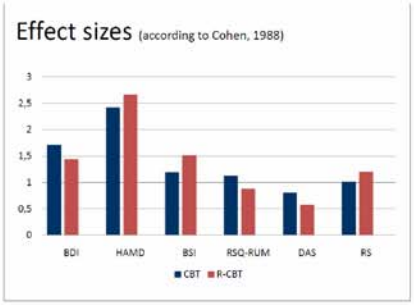

Figure 2: Effect sizes

Conclusion

R-CBT is an effective treatment for depression – yet, it does not outperform classic CBT. The study adds to a growing body of evidence suggesting that there are no large differences in efficacy between different types of "bona fide" therapies in the treatment of acute depression (e.g. Cuijpers et al., 2008). Still, the pattern of results points to the possibility that even in the face of severe depression patients are open and responsive to interventions explicitly focusing on their strengths and resources.

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The EQOLISE Study :

Enhancing the Quality Of Life and Independence of persons disabled by severe mental illness through Supported Employment

Denise Kerstin Manchisi ª, Donato Piegari ª, Angelo Fioritti*, for the Eqolise Group
ª Azienda Usl Rimini, *Azienda Usl Bologna

Introduction

Around five million people of working age are living with Severe Mental Illness in the European Union and member states (Eurostat, 2004). These people necessitate high levels of public expenditure. The long-term of the study was to enhance the quality of life and independence of persons with severe mental illness by increasing their access to competitive employment. To achieve this, we conducted a randomised controlled trial (RCT) of the effectiveness of a clearly defined model of supported employment, Individual Placement and Support (IPS), compared to usual good quality rehabilitation and vocational services for people with severe mental illness

Design, method and objectives

The design of the study was a randomised controlled trial conducted in six European centres: London, Germany, Italy, Switzerland, Netherlands and Bulgaria. Clients (n=312) had severe mental illness (psychotic illness, including bipolar disorder), were aged between 18 and local retirement age, had been ill and had major role dysfunction for at least 2 years. They were followed up for 18 months, with interviews at baseline (T0), 6 months (T1), 12 months (T2) and 18 months (T3). Part of the immediate objectives were: to assess the effectiveness of the IPS model of "supported employment" over usual vocational services in terms of : Employment outcomes, clinical and social functioning and to explore the impact of work on clients' lives.

Research Instruments

The ***Lancashire Quality of Life Profile - European Version*** (LQoLP-EU- from Oliver et al, 1997) measures objective and subjective measures of quality of life, usual living situation, employment and income, service receipt and medication profile.
The ***Groningen Social Disability Schedule*** (GSDS) (Wiersma et al, 1988, 1990) measures the social functioning of psychiatric clients.
The ***Positive and Negative Syndrome Scale*** (PANSS) (Kay et al, 1987) evaluates the severity of positive and negative symptoms.
The ***Global Assessment of Functioning*** (GAF) is a simple 1-100 scale, rating the severity of symptoms and disability (Endicott et al, 1976).
The ***Hospital Anxiety and Depression Scale*** (HADS) (Zigmond & Snaith, 1983) is a self-report questionnaire developed to detect adverse anxiety and depressive states.

Results

Table . 1 Difference between IPS and Vocational Services – Vocational and hospitalisation outcomes – All

Outcome	IPS	Vocational	Difference*	95% CI*	p-value
Worked for one day at least	85 (54.5%)	43 (27.6%)	26.9%	(16.4%, 37.4%)	<.001
Number of hours worked *	428.8 (706.77)	119.1 (311.94)	308.7	(189.22, 434.17)	
Number of hours worked *	428.8 (706.77)	119.1 (311.94)	308.7	(189.22, 434.17)	
Number of days employed *	130.3 (174.12)	30.5 (80.07)	99.8	(70.71, 129.27)	
Job tenure (days) *	213.6 (159.42)	108.4 (111.95)	104.9	(56.03, 155.04)	
Drop-out from service	20 (12.8%)	70 (44.9%)	-32.1%	(-41.5%, -22.7%)	<.001
Hospitalized	28 (20.1%)	42 (31.3%)	-11.2%	(-21.5%, -.90%)	.034
Percentage of time spent in hospital*	4.6 (13.56)	8.9 (20.08)	-4.3	(-8.40, -.59)	

PANSS, Positive and Negative Symptoms Scale, HADS, Hospital Anxiety and Depression Scale, LQoLP, Lancashire Quality of Life Profile, GSDS, Groningen Social Disability Schedule. Positive: occurrence of delusions, hallucination etc, negative: occurrence of apathy, alogia, anhedonia etc, general: overall psychopathology Total score computed as the sum of the GSDS subscales scores excluding "parent."

Table 2. Clinical and Social Functioning Outcomes at T3, by IPS/Control—Mean (SD)

Outcome	Subscales	IPS (n = 132)	Control (n = 120)	Difference (95% CI)
GAF-S (0–100)		57.4 (11.90)	58.3 (10.76)	-1.23 (-3.75 to 1.28)
GAF-D (0–100)		57.6 (11.94)	56.6 (10.45)	1.48 (-1.03 to 4.00)
PANSS	Positive (7–49)	12.7 (4.84)	12.6 (4.40)	0.028 (-0.928 to 0.983)
	Negative (7–49)	13.3 (5.13)	13.5 (5.47)	0.084 (-0.983 to 1.15)
	General (16–112)	29.3 (7.82)	28.9 (7.87)	0.455 (-1.11 to 2.02)
HADS	Anxiety (0–21)	6.5 (4.53)	6.4 (4.30)	-0.221 (-1.07 to 0.632)
	Depression (0–21)	6.1 (4.24)	6.2 (4.56)	-0.302 (-1.21 to 0.606)
GSDS Total	(0–21)	8.1 (3.38)	8.2 (4.11)	-0.289 (1.1 to 0.487)
LQoLP	Overall subjective quality of life (1–7)	4.7 (0.758)	4.7 (0.861)	0.032 (-0.137 to 0.201)
		n (%)	n (%)	OR (95% CI)
Hospitalized in final 6 mo	Yes	11 (8.3)	22 (18.3)	2.16 (0.972 to 4.79)
	No	121 (91.7)	98 (81.7)	
Remission	Yes	50 (39.7)	48 (42.1)	1.23 (0.687 to 2.20)
	No	76 (60.3)	66 (57.9)	

a Bootstrapped estimates of difference between means and bias corrected and accelerated 95% confidence intervals presented.

Figure 1: Effect of risk of benefit trap on event rate

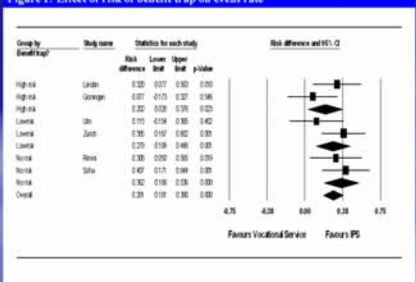

Table 3. Clinical and Social Functioning Outcomes at T3, by Worked/Not Worked, Days Worked, and Job Tenure

		Worked/Not Worked			Days Worked	Job Tenure
Outcome	Subscales	Worked (n = 113), Mean (SD)	Not worked (n = 139), Mean (SD)	Difference (95% CI)	B (95% CI)	B (95% CI)
GAF-S (0-100)		61.1 (12.20)	55.1 (9.91)	-5.86 (-8.28 to -3.44)	0.016 (0.008 to 0.025)	0.004 (-0.010 to 0.018)
GAF-D (0-100)		60.5 (12.53)	54.3 (9.20)	-7.31 (-9.68 to -4.94)	0.029 (0.021 to 0.037)	0.022 (0.008 to 0.036)
PANSS	Positive (7–49)	12.6 (5.00)	12.6 (4.35)	0.487 (-0.474 to 1.45)	0.002 (-0.006 to 0.001)	0.002 (-0.007 to 0.004)
	Negative (7–49)	12.1 (4.76)	14.4 (5.48)	1.85 (0.802 to 2.90)	0.005 (-0.008 to -0.001)	0.002 (-0.003 to
0.006)						
	General (16–112)	27.9 (7.92)	30.0 (7.65)	1.77 (0.212 to 3.34)	0.007 (-0.012 to -0.001)	0.002 (-0.010 to 0.006)
HADS	Anxiety (0–21)	6.3 (4.54)	6.5 (4.32)	0.507 (-0.347 to 1.35)	0.002 (-0.005 to 0.001)	0.002 (-0.007 to 0.003)
	Depression (0–21)	6.1 (4.51)	6.2 (4.29)	0.607 (-0.305 to 1.52)	-0.002 (-0.005 to 0.001)	-0.001 (-0.006 to 0.004)
GSDS	Total (0 21)	7.1 (3.37)	8.9 (3.83)	1.75 (0.999 to 2.50)	-0.006 (-0.008 to -0.003)	-0.002 (-0.005 to
0.002)						
LQoLP	Overall subjective quality of life (0–7)	4.6 (0.847)	4.7 (0.775)	-0.050 (-0.220 to 0.120)	0.000 (0.000 to 0.001)	0.000 (-0.001 to 0.001)
		n (%)	n (%)	OR (95% CI)	OR (95% CI)	OR (95% CI)
Hospitalized in final 6 mo	Yes	11 (9.7)	22 (15.8)	0.632 (0.285 to 1.40)	0.998 (0.995 to 1.000)	0.999 (0.996 to 1.002)
	No	102 (90.3)	117 (84.2)			
Remission *	Yes	54 (50.0)	44 (33.3)	1.75 (0.979 to 3.14)	1.001 (0.999 to 1.003)	0.999 (0.996 to 1.003)
	No	54 (50.0)	88 (66.7)			

Note: Abbreviations are explained in the first footnote to table 1.

Outcomes/Conclusions

Table 1 Vocational and hospitalisation outcomes:

All the vocational outcomes showed statistically significant differences in favour of IPS. Just over half the IPS clients (54.5%) worked for at least a day compared to only just over a quarter of the Vocational Service clients (27.6%).

Table 2 Differences in clinical and social functioning between the IPS and Vocational Service Groups:

There were no significant differences between patients who received IPS and those who received the vocational services at the final follow-up (T3) in terms of clinical and social functioning outcomes. This result shows also that there are no risks for psychiatric patients to worse their clinical conditions by trying to achieve a competitive employment. The vocational service patients were twice as likely as the IPS patients to have been hospitalized in the last 6 months of the study.

Table 3. Associations Between Working and Clinical and Social Functioning Outcomes at Final Follow-up. Associations Between Having Worked and Outcomes.

Patients who worked during the 18-month study period had significantly better global functioning in terms of symptoms and disability, fewer negative and general symptoms, and less social disability at T3 than those who had not worked. To explore the differences in social disability, the 8 subscales of the GSDS were analyzed separately. There were statistically significant differences between the 2 groups on the "family," "citizen," "social," and "occupation" subscales, all of a small magnitude with the greatest being a difference of 0.7 points (out of 4) on the "occupation" subscale, all in favor of those who had worked.

Figure 1. Effect of risk of benefit trap on risk difference

The forest plot, Figure 1, displays the effect sizes of the centres, grouped by the risk of benefit trap variable. Centres where benefits were likely to be higher than salary (a 'benefit trap') moved the risk difference (indicating effectiveness of IPS) closer to being non-significant.

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Evaluating the Fear Hunter Program:
An Individual Cognitive Behavioral Therapy Program for Children with Anxiety

Serap Tekinsav Sütcü[1], Arzu Aydin Acı[2], Oya Sorias[1], Tezan Bildik[3]

Introduction

Anxiety difficulties in children and adolescents are very common problems (Bernstein & Borchardt, 1991). Researches indicate that anxious children show impairment in peer relations, self-esteem, attention, school performance, and social behavior (e.g., Strauss, Frame & Forehand, 1987).

There are only a few structural psychotherapy programs and psychotherapy effectiveness studies for anxious children in Turkey. One of the limited number of programs is the Fear Hunter program (Sorias et al, 2009). The Fear Hunter (Korku Avcısı) Program is a structural cognitive behavioral therapy program for Turkish children with anxiety disorders. The program comprises 13 individual child sessions and 3 parent sessions. Child sessions include the techniques such as psycho-education, relaxation training, cognitive restructuring, problem solving training and exposure. In the program workbook there is a fictional cartoon character who guides the children through the program. Additionally, crosswords, pictures and examples were used in the program to make the therapy fun. The uncontrolled pilot study of the program indicated that anxiety symptoms and cognitive error scores of anxious children decreased from pretest to posttest.

THE FEAR HUNTER PROGRAM

Objective

The objective of the study is to evaluate the effectiveness of the Fear Hunter program on anxiety symptoms and cognitive errors compared to drug treatment.

Method

Sample:

The participants consisted of Turkish children aged between 9-15 years who referred to the mental health services because of anxiety symptoms.

Materials:

Data was collected by State Trait Anxiety Inventory for children, The Screen for Child Anxiety Related Emotional Disorders (SCARED) self report and parent report, Children Negative Cognitive Error Questionnaire, and Child Depression Inventory.

Therapists:

Therapists were clinical psychology master students and child psychiatry assistants. Each therapist worked with one ore two children. They applied the therapy under supervision according to the guidebook of the program.

Procedure:

Children with anxiety problems and their parents who reported that participation of every session is impossible were assigned to the standard drug treatment condition. Others who accepted to participate in every session were received took place in the Fear Hunter program.

Results

Independent samples t-tests revealed no significant group differences on any of the measures, providing some evidence of pre-treatment equivalence.

In order to determine whether the Fear Hunter Program influenced the children's anxiety symptoms and cognitive error levels, a series of 2 (group: treatment and control) X 2 (time: pretest and posttest) Repeated Measures ANOVAs were conducted.

Analysis yielded significant Group X Time interactions for trait anxiety score (*Wilk's* λ=.742, $F(1,24) = 8,35$, $p<.01$, $\eta^2=.26$), self-report SCARED total anxiety score (*Wilk's* λ=.808, $F(1,24) = 5,72$, $p<.05$, $\eta^2=.19$) parent-report SCARED total anxiety score (*Wilk's* λ=.819, $F(1,24) = 5,29$, $p<.05$, $\eta^2=.18$) and CNCEQ selective abstraction score (*Wilk's* λ=.798, $F(1,24) = 6,07$, $p<.05$, $\eta^2=.20$).

	Fear Hunter Treatment (N=14)				Drug Treatment (N=12)			
	Pretest		Posttest		Pretest		Posttest	
	X	S	X	S	X	S	X	S
CDI	13.82	4.61	11.85	3.93	13.93	4.61	13.08	4.64
STAI-Trait anxiety	38.57	8.22	31.50	6.05	36.08	5.81	34.25	6.52
SCARED- self report	32.21	16.64	20.86	11.90	29.58	11.30	31.50	13.85
SCARED- parent report	28.28	14.08	18.71	14.85	22.42	14.42	20.38	13.43
CNCEQ- catastrophizing	17.50	7.88	14.85	8.68	22.83	6.45	22.92	4.71
CNCEQ- selective abstraction	16.93	7.36	13.00	9.31	20.92	6.58	21.83	5.29
CNCEQ- personalization	19.14	7.72	13.86	8.79	21.66	5.81	22.58	4.63
CNCEQ- overgeneralization	18.93	6.88	13.85	8.61	23.67	4.89	23.00	4.04
CNCEQ- total	72.50	14.66	61.57	34.83	89.08	11.30	91.58	13.85

The means and standard deviations of the scores obtained on pre-test and post-test of the therapy and control groups are presented in Table 1.

As shown in Table 1, the mean scores of trait anxiety, self- report SCARED parent-report SCARED and selective abstraction in CBT group decreased from pretest to posttest while the scores of the control group didn't decrease.

There were no significant Group X Time interaction for catastrophizing, personalization, overgeneralization scores and total scores of CNCEQ. When we examine Table 1, we see that the catastrophizing, personalization, overgeneralization scores and total score of CNCEQ decreased slightly from pretest to post test although this change was not statistically significant.

Discussion and Conclusion

The results demonstrated that the Fear Hunter program is more effective than drug treatment in reducing trait anxiety and anxiety symptoms as rated by children. Results also showed that the program is more effective than drug treatment in the reduction of anxiety symptoms as rated by parent. Through these findings, it can be concluded that the change derived from the Fear Hunter program is not only based on subjective experience but can also be observed by others as it is reflected on behavior.

Cognitive restructuring is the one of the main components of the Fear Hunter program. The aim of the technique is to reduce anxiety and unhealthy behaviors by changing cognitive distortions and cognitive errors. So, according to cognitive theory, our hypothesis was that there would be a decrease on cognitive error scores after the program. However the analysis showed that there were no statistically significant decreases on cognitive errors from pretest to posttest (except selective abstraction). The results were unexpected. There are some possible explanations for the results. One of them is, children participating in the Fear Hunter program benefited from the other techniques such as psycho-education, relaxation training, exposure etc. Because the children (at least some of them) couldn't apply the cognitive restructuring technique, their cognitive errors couldn't be decreased.

Another explanation may be related to small sample size. There were decreases on cognitive errors from pretest to posttest but they (except selective abstraction) weren't statistically significant. Accordingly, if the sample size increases, significant differences between groups can be found.

Actually some studies such as Durlak and colleagues' (1991) meta-analysis of cognitive behavior therapy showed that changes in cognitions, a primary proposed mechanism of change, had minimal association with outcome.

There are several limitations of the study. First limitation of the study is small sample size as stated above. Nonrandom assignment of children to conditions is another limitation. The third limitation of the study is the lack of follow-up data, which makes evaluation of the long-term effects of the findings impossible.

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Parental Involvement in Cognitive-Behavioral Therapy for Children with Social Anxiety

Arzu Aydın-Acı[1], Serap Tekinsav-Sütçü[2]

WHY Involve Parents?

The involvement of parents in cognitive-behavioral therapy for their social anxious children is important for a number of reasons: First, parents can help their children to practice the skills thought them in CBT treatment and generalize learning to other contexts. Second, parent's beliefs and attitudes, their own skills to cope with the social problems, and the safety of the world, may impede progress. Third, changes in their children may threaten parents because the child's new-found independence may provoke fear or uncertainty in them (Siqueland & Diamond, 1998). According to Braswell (1991) there are three general rationales for parental involvement: (1) Parents play a role in defining the child's problem; (2) Parents and family may cause, exacerbate, or moderate the problem for which the child is to be treated; and (3) Parents, regardless of their involvement to the cause of the child's difficulties, have a role to play in generalization, skills transfer, and maintenance of therapeutic change.

Two cognitive-behavioral treatment programs specifically targeting childhood or adolescent SAD (social anxiety disorder) have been developed: (1) cognitive-behavioral group therapy (CBGT) (Albano, Marten, Holt, Heimberg & Barlow, 1995; Hayward et al., 2000; Spence, Donovan, & Brechman-Toussaint, 2000) and (2) social-effectiveness therapy (SET) (Beidel, Turner, & Morris, 2000b). In addition, "coping cat" child behavior therapy program (Flannery-Schroeder & Kendall, 2000; Kendall, 1990; Kendall, 1994), "FRIENDS" a cognitive behavioral group treatment for anxious children and their parents (Shortt, Barrett & Fox, 2001) and "fear hunter" child cognitive-behavioral therapy program for Turkish children with anxiety disorders (Soriac, Bildik, Tekinsav-Sütçü & Aydin, 2009) were designed to target anxiety disorders among children in general, but not SAD specifically. The CBGT and SET programs are both modeled after established adult protocols and are typically conducted in a group format. "FRIENDS" is also developed in a group format but not SAD specifically. The "coping cat" and "fear hunter" program are typically implemented in an individual format. All programs which are mentioned above have a treatment manual.

Interventions Specifically Targeting Social Anxiety Disorder:

CBGT has two overall components; skill building and behavioral exposure. Authors developed CBGT for adolescents with structured and limited parental involvement. In this program parents can attend sessions 1, 2, 8 and the penultimate session with their adolescents. Parents can be invited to attend first and second treatment sessions or alternatively, therapist can hold a parents-only session to provide psychoeducational information and address parental concerns. Session 8 emphasizes adolescents and their support networks and outlines the behavioral exposure sessions. Parents can be invited to attend this session or a parent session can be held at this point to provide information concerning the upcoming exposure phase of treatment. (Albano & DiBartolo 2007).

Social Effectiveness Therapy for Children (SET-C) is a 12 week, multicomponent program developed specifically to treat children diagnosed with social anxiety. Components of SET-C include parent education, social skills training (SST), peer generalization, and graduated in vivo exposure (Morris, 2004). Beidel and Turner (1998), emphasized the necessity for parental involvement in the assessment and treatment process. Parental cooperation is a crucial aspect of the success of the exposure tasks. In some cases, only minimal parental involvement is required. However, other assignments, such as having a friend over to play, inviting a friend to a movie or eating in a fast food restaurant, required the parent to play an active role in facilitating successful completion of the assignment.

Interventions Not Specifically Designed for Social Anxiety Disorder

Kendall's (1994) program called the "coping cat" includes 16 sessions for the treatment of anxiety disorders, specifically generalized anxiety disorder, social phobia and separation anxiety disorder in children and young adolescents. The 16 session program is divided into two parts: The first eight sessions are training part and the other eight sessions are the practice (exposure) part. In addition, two sessions between therapist and the parent(s) are scheduled at session 4 and session 9. The goals of the first meeting with parents are (1) provide additional information about treatment, (2) provide parents an opportunity to discuss their concerns, (3) learn more about the situations in which the child becomes anxious, (4) offer specific ways the parents can be involved in the program. The second meeting with parents also includes for purposes: (1) provide additional information about the exposure tasks, (2) provide parents an opportunity to discuss their concerns, (3) learn more about the situations in which the child becomes anxious, (4) offer specific ways the parents can be involved in the second part of treatment. The program was adapted for Australian and Chinese child population, renaming "coping koala" and "coping bear" (Barrett, Dadds & Rapee, 1996; Lau, Chan, Li, & Au, in press)

FRIENDS is a family based group cognitive-behavioral treatment for anxious children, consists of 10 weekly sessions and 2 booster sessions, which are conducted 1 month and 3 months following completion of treatment. This program incorporates a family-skills component, which includes cognitive restructuring for parents and partner-support training and encourages families to build supportive social networks. Parents and children are also encouraged to practice the skills learned in FRIENDS as a family, on a daily basis. FRIENDS program emphasizes peer support and peer learning. Children are encouraged to make friends and to build their social networks. Parents are encouraged to facilitate children's friendships (Shortt, Barrett, Fox & 2001).

"Fear Hunter" program which is developed for Turkish children with anxiety disorders, includes 13 sessions with child and 3 sessions with parents (Soriac, Bildik, Tekinsav-Sütçü & Aydin, 2009). The authors describe educating the parents about the disorder, providing information about treatment, involving them in establishing the anxiety hierarchy, and implementing in vivo. In addition, the authors also suggest that following each of the child session (especially working with young children), the parents should be invited for 5-10 minutes to discuss the child's task and how to help their children. Then, the therapist is required to get in touch with parent(s) after every child sessions during course of the therapy, especially when working with young children.

The efficacy of the programs is examined in several studies. Table I presents the studies' designs, sample sizes, and the participants' characteristics.

Table 1: *Study characteristics*

Program	Authors/year	Age	Parental involvement	Control	Follow-up
CBGT-A	Albano et al. (1995)	[illegible]	[illegible]	[illegible]	[illegible]
SET-C	Beidel, Turner & Morris (2000)	[illegible]	[illegible]	Study skills and test taking strategy program	[illegible]
SET-C (modified)	Baer & Garland (2005)	[illegible]	[illegible]	wait-list	[illegible]
Coping Cat	Dadds et al. (1997)	[illegible]	[illegible]	no treatment	[illegible]
Coping Cat	Silverman et al. (1999)	[illegible]	[illegible]	wait-list	[illegible]
Coping Cat	Flannery-Schroeder & Kendall (2000)	[illegible]	[illegible]	wait-list Group CBT	[illegible]
Coping Bear	Lau et al. (in press)	[illegible]	[illegible]	wait-list	[illegible]
FRIENDS	Shortt et al. (2001)	[illegible]	[illegible]	wait-list	[illegible]

DISCUSSION

There are a small but growing number of studies examining the impact of incorporating parents in the therapeutic processes. Involving parents may be important because the factors such as high parental control, parental own pathology (especially anxiety), and parental reinforcement of avoidant behavior have been implicated in the maintenance of social anxiety in children (Barrett, Rapee, Dadds, & Ryan, 1996; Cobham, Dadds, & Spence, 1998). The purpose of this study was to describe parental involvement in manualized cognitive-behavioral therapy programs for social anxious children. Some of the programs are directed at social anxiety, while the others, such as "coping cat", "FRIENDS" and "Fear Hunter" are not. The programs involved parents shared some common purposes: educating the parents about the disorder, providing information about treatment procedure, especially for exposure tasks, and asking their support. The empirical studies indicated that anxious children who completed cognitive-behavioral treatment with parental involvement showed more improvement than wait list and alternative controls. In addition there was evidence that these improvements were maintained at follow-ups (e.g., Albano et al. 1995, Beidel, Turner & Morris, 2000, Baer & Garland, 2005, Shortt et al., 2001).

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ARE SELF ESTEEM DEVELOPMENT AND STRESS MANAGEMENT TRAININGS EFFECTIVE IN SUBJECTIVE WELL BEING INCREASING?

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Abstract

One of the ways tried by people searching for better quality of life consists in courses organized by private or public institutions. In the city of Milan we can find many of these courses, regarding general themes, health specifically. This study is about two courses: "Stress management training" and "Self-esteem development"; specifically, our experience shows how some people participate in order to get a therapeutic goal, having a wrong expectancy about the training; someone, instead, want to recover a higher subjective well being level and some others simply try to find a good way to spend their time.

The aim of this study is to find out if these trainings are able to change subjective well being, more than to supply a gain in terms of culture.

We have administered Psychap Inventory to participants of both courses, to Subjective Well Being Training and to a group set in waiting list, comparing differences pre and post courses in participants, and differences at the same time distance in waiting list group.

In this study we want to measure if, among benefits reported by pupils, there is an improvement about subjective well being. This is a first approach to look at what kind of gain these people could recover from cited experience.

These courses are useful in stimulating a better quality of life and life style, but could be more efficacious in developing subjective well being, adding this further gain.

A stimulus here to think about how to enrich programs with exercises aimed to develop 14 Fordyce variables: we will be able then to observe if we can give better tools for these kind of development.

Introduction

Many people search for personal well being development, often trying different ways selected with imprecise criteria: friends suggesting, internet, information randomly perceived. Among these, many are courses purposed to the public, where people with unsatisfying quality of life or sometimes with psychological diseases come. This could give confounding expectation, thinking to recover the solution for subjective psychological problems through methods not proposed to it.

Here, we want to measure subjective quality of life improvement of people attending a course of self esteem development (SED) and a course of stress management (SM), compare the gain after these experience to the one obtained after a Subjective Well Being Training (SWBT) and to the values of a waiting list group.

Material and methods

We have recruited:

n.20 subjects for the course of self esteem development

n.20 subjects about stress management training

n. 12 subjects attending specifically subjective well being training

n.20 subjects in a waiting list.

The variable considered is the "subjective well being", measured with Psychap Inventory, standardized for the Italian population. This tool consisted in 80 items, giving a value for global level of happiness and sub-variables: happiness achieved, happy personality, happy attitudes, happy life style.

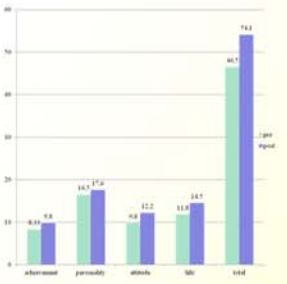
The questionnaire was administered before and after courses. Time span of self esteem development and stress management training was 13 weeks, subjective well being training was 8 weeks. For the waiting list, questionnaire was administered at a time distance of 13 weeks.

Difference about pre-post subjective well being levels are calculated with SPSS 13.0.

Results

Groups, after Chi Square analysis, are similar for gender, marital status, years of school attended and typology of jobs. Also comparing pres test situations of groups, we discover no significant differences among groups.

SWBT group has a mean age of 41 years and it is composed by 75% of female.
Subjects of this group attended school for 16 years.
After the experience, we can observe an improvement in all the variables measured by the questionnaire. Significance has been obtained about variables *total happiness*, *life style* and *attitude*.

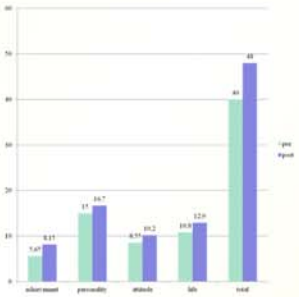


Graph. 1Pre post SWBT values of variables measured by Psychap Inventory.

a Based on negative ranks.

Tab. 1 Pre post SWBT statistic significances

SM group is composed by 70% of women, with a mean age of 44 years old.
Years of school: 14.
Here we have obtained an improvement, quietly comparable to the one calculated about SWBT.
Significance has been obtained in all variables measured by the questionnaire.

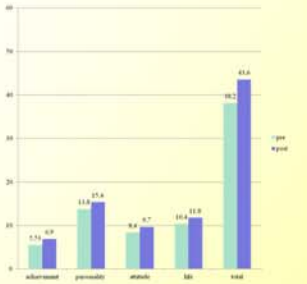


Graph. 2Pre post SM values of variables measured by Psychap Inventory.

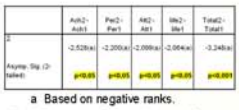
a Based on negative ranks.

Tab. 2 Pre post SM statistic significances

Also in SED training we have measured an improvement, even if particularly in SED differences are less noticeable, as clearly show the total happiness value.
Significance, as in the previous group was found in all variables, showing a general improvement about subjective well being training.
This group sees 60% of women, mean age 40.
They attended school for 13 years.



Graph. 3Pre post SED values of variables measured by Psychap Inventory.



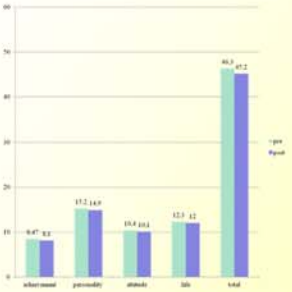
a Based on negative ranks.

Tab. 3 Pre post SED statistic significances

Looking at measures about group not attending to any experience, but only in a waiting list, we observe a general stability of variables, precisely a little worsening, even if not statistically significant. This group, in other words, show a stability.
In this control group, 55% were women, and totally these subjects has a mean age of 39, with 13 years of school.

a Based on negative ranks.

Tab. 4 Pre post CONTROL statistic significances



Graph. 4 Pre post waiting list group values of variables measured by Psychap Inventory.

Conclusions

Our experience shows how many the modalities through which people search for a better quality of life are, not always getting to the right experience. Our work would be a contribution to understand how people can obtain the best result. Furthermore, indications could be deduced about programs to teach to these kind of people.
Generally, SWBT gives a good improvement of subjective well being such as the other trainings, but considering also that its program consists in 8 meetings, compared to the 13 of SM and SED.
Part of the program of SM is aimed to cognitive theory, automatic negative thoughts, and training about changing negative thoughts into positive ones. This part, in common with the program of SWBT, could explain the bigger similarity among results of SWBT and SM.
Possible developments are to add a specific measure for each group aim: self esteem, stress levels. Then to compare the contribution of each group for every measure planned and if the best contribution obtains the goal the training is placed for.

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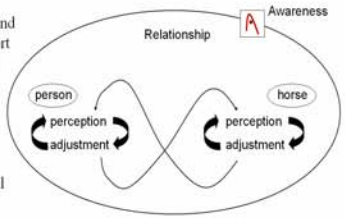
1. Introduction

Mindfulness is defined as a specific state of mind, resulting of "paying attention on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 1994). Mindfulness programs (MBCT or MBSR) train attentional capacities by the means of several formal practices (body scan, yoga, sitting and walking meditations) and lead to a greater ability to cope with stress and emotions (for an empirical review, see Baer, 2003; Grossman et al., 2004). In parallel, our work based on the relationship with horses focuses on the interaction between the person and the animal, and on the awareness development of the continuous adjustments in such relational situations. The contact with horses stimulates a greater attention to the present moment. Training attention in such a relational context supports the development of a deeper emotional and physical sensitivity (e.g. Bronkhorst, 2006; Massie, 2005). This process can support a greater congruence in people's different aspects of experience (sensations, emotions, cognitions and behaviors) and a greater care for their feelings.

	Mindfulness	Horse relationship
Pursued goal => why?	Attention training	Sensitivity training
Process, mean => how?	To focus attention and bring it back when it wonders	Perception ⇄ Adjustment (Cf. figure)
Practice => what?	Ex. Body scan,mindful stretching/yoga, sitting meditation,walking meditation	Ex. Discovering a horse when blindfold; walking with a horse; riding a horse; being with the herd; lunging a horse; ...
Context => when?	Anything, anytime	Relation with horses

The interaction with the horse and its necessary adjustments support the person to be fully present to what is going on. Our work aims at promoting in the person a specific awareness to this process in order to support the development of a greater physical and emotional sensitivity.



2. Hypotheses and Predictions

The study was designed to compare effects of a MBSR program with a 10-week program combining a mindfulness training with horses relationship (H&M) on participants' well-being.

→ Compared to the pre intervention, participants in both groups would report a decrease in depression and anxiety levels, an increased self-esteem, and a decreased psychological distress after the program.

→ These effects would be stronger in the H&M group than in the MBSR group, considering the adding effect of the work with horses to the mindfulness training.

3. Method

27 participants signed-up for the MBSR program and 22 participants signed up for the weekly H&M program, based on the MBSR protocol* (each session lasted 3h00: 45' formal meditation and inquiry; introduction of a new discussion theme related to coping with stress; time period with horses and inquiry). In each group, participants committed themselves to informal meditation practice and to 45' daily formal practice.

** There were no differences between groups at baseline on BDI-II, STAI-trait, Self-Esteem, and GSI.*

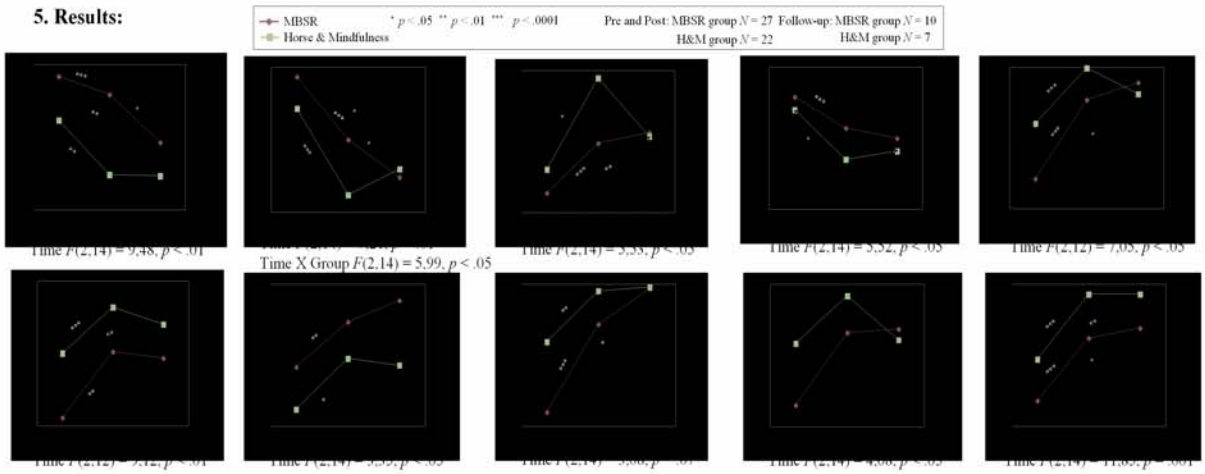
4. Measures

Questionnaires completed before and after the weekly program, and at a 6-month follow-up:

- FFMQ* (Baer et al. 2006):
  - Observation of experience
  - Description of experience
  - Act with awareness
  - Non-judge
  - Non-react
  - Total score
- BDI-II (Beck, 1979)
- STAI-Trait (Spielberger, 1983)
- Self-Esteem (Rosenberg, 1965)
- GSI (SCL-90R) (Derogatis, 1977)

** Five Facets of Mindfulness Questionnaire*

5. Results:



6. Conclusion

In accordance to our predictions, these preliminary results show in both programs (MBSR and H&M) a significant reduction in depression, anxiety, and psychological distress, and a significant increase in self-esteem, as well as in mindfulness, confirming that mindfulness capacities were trained in both groups. Yet, contrary to our predictions, effects in MBSR and in H&M groups did not significantly differ from each other. In addition, at a 6-month follow-up, MBSR participants maintain benefits of the program or even keep on improving (on depression and anxiety). However, in the H&M group, participants generally loose benefits of the program over time.

We know that 7 out of 10 MBSR participants who completed follow-up questionnaires keep on meeting together once a month. This could explain the observed difference between both groups at follow-up time. Yet, considering the little number of subjects, we cannot draw final conclusions (collection in progress). In addition, data on a control group (horse riders) need to be collected.

Positive outcomes of the combined program support us to keep on exploring the specific contribution of the work with horses (by selecting new measures assessing emotional intelligence, physical sensitivity awareness, acceptance and ability to let go), beyond giving access to "horse people" to mindfulness and its benefits.

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AIAMC Members (Italian Association for Behaviour Analysis & Modification and for Cognitive-Behavioural Psychotherapies); Scuola ASIPSE, Milan, Italy (Psicoterapia Cognitivo-Comportamentale); Centro Psico-Sociale 19 II °(Azienda Ospedaliera Fatebenefratelli) Milan, Italy

A Cognitive-Behavioural Group therapy for public mental care patients with various anxiety disorders.

ABSTRACT - Objectives: a preliminary evaluation of a CBT group to treat patients with various anxiety disorders in the same group with a specifically designed 10-week protocol. **Method**: 10 subjects were selected from a public mental care centre in Milan, Italy. Before entering the group, they were administered a clinical interview to identify those with major anxiety disorders. 3 subjects dropped out and 2 did not fit diagnostic criteria hence the sample had just 5 subjects, some of them had more than a current anxiety diagnosis. Those with active substance abuse/dependency, with psychosis or cognitive impairment were excluded. The CBA 2.0 test was administered before and after treatment, and will be assessed again 6 months after. **Results**: there are significant changes in 3 of the CBA 2.0 scales measuring trait anxiety (STAIX-2), the fear of calamity/threat to self and the anxiety level at the end of the test. Such improvements should also be present in 6 months time. **Conclusions**: A short-term heterogeneous CBT group can make an effective treatment for anxiety. Thus, further research addressing the nature and the effectiveness of mixed-disorders protocols for the treatment of anxiety disorders is needed.

INTRODUCTION

From 5% to 8% of Italians suffer of an anxiety disease (Alonso et al., 2004). Treatment protocols for anxiety disorders are usually based on contents regarding a specific diagnosis and can thus be employed efficiently in a few sessions. In many mental health public services, it is not possible to implement CBT groups based on a single diagnosis as it is difficult to reach a good number of patients who suffer from the same anxiety disease, require psychological treatment and are available at the same time. A CBT mixed group protocol for those suffering from various anxiety diseases could represent a more effective intervention in the public context. A heterogeneous group focused on shared common features underlying anxiety disorders could be much suitable in a public service as it must be considered that patients often suffer of more than one anxiety disease (Brown et al., 2001). Hence, this study aims at evaluating the efficacy of a CBT treatment group protocol for patients suffering from different anxiety diseases, partially replicating previous studies in such field (Norton and Hope, 2005; Erickson et al., 2007). Before using such treatment on a large-scale, it is necessary to carry out more empirical research investigating the nature of the protocols, their effects for each anxiety disorder and the inclusion/exclusion criteria of heterogeneous treatment groups.

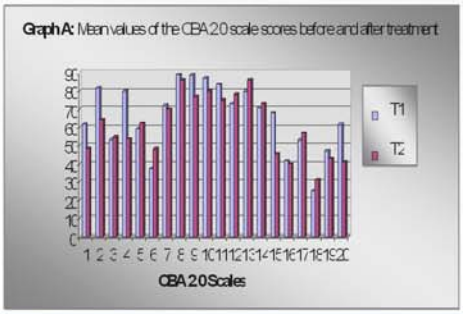
RESULTS

Paired Samples T-Test: Differences between T1 and T2

	CBA 2.0 Scale	CBA 2.0 Scale	Mean	Std. Dev.	Std. Err. Mean
PAIR 1	STAIX1	State anxiety T1	81,6	35,04	15,6704
	STAIX1	State anxiety T2	40,5	20,5852	9,206
PAIR 2	STAIX2	Trait anxiety T1	82	9,7468	4,3589
	STAIX2	Trait anxiety T2	64	12,9422	5,7879
PAIR 3	EPQ/R-E	Introversion-extroversion T1	53,6	34,3755	15,3732
	EPQ/R-E	Introversion-extroversion T2	54,8	43,8101	19,5925
PAIR 4	EPQ/R-N	Neuroticism T1	80,1	19,0735	8,5299
	EPQ/R-N	Neuroticism T2	54	24,5967	11
PAIR 5	EPQ/R-P	Psychoticism T1	59,4	19,4756	8,7098
	EPQ/R-P	Psychoticism T2	62,5	16,9558	7,5829
PAIR 6	EPQ/R-L	LIE T1	37,5	31,4245	14,0535
	EPQ/R-L	LIE T2	48	36,3742	16,2673
PAIR 7	QPF/R	Psychophysiological disorders T1	71,8	17,6522	7,8937
	QPF/R	Psychophysiological disorders T2	70	15,8114	7,0711
PAIR 8	FSS/R	Fears and phobias T1	89	6,5192	2,9155
	FSS/R	Fears and phobias T2	86	7,4162	3,3166
PAIR 9	FSS/max	Max Response to Fears and phobias T1	88,8	7,0498	3,1528
	FSS/max	Max Response to Fears and phobias T2	77	21,6795	9,6954
PAIR 10	FSS 1	Calamity/Personal Threats T1	87	12,5499	5,6125
	FSS 1	Calamity/ Personal Threats T2	80	11,726	5,244
PAIR 11	FSS 2	Social Anxiety T1	83,6	16,6373	7,4404
	FSS 2	Social Anxiety T2	74,8	24,7528	11,0698
PAIR 12	FSS 3	Animals T1	73	14,4049	6,442
	FSS 3	Animals T2	70	9,7468	4,3589
PAIR 13	FSS 4	Travelling/departure T1	79,8	26,7432	11,9599
	FSS 4	Travelling/departure T2	86,1	14,2934	6,3922
PAIR 14	FSS 5	Cuts/Blood T1	71	12,0675	5,3962
	FSS 5	Cuts/Blood T2	73,5	13,6473	6,1033
PAIR 15	QD	Depressive Behaviours T1	68	27,5227	12,3085
	QD	Depressive Behaviours T2	45,3	29,0444	12,989
PAIR 16	MOCQ/R	Obsessions/compulsions T1	41,5	25,5318	11,4182
	MOCQ/R	Obsessions/compulsions T2	40	18,2859	8,1777
PAIR 17	MOCQ/R1	Checking T1	53	19,6373	8,7821
	MOCQ/R1	Checking T2	57	21,169	9,467
PAIR 18	MOCQ/R2	Cleaning T1	25	24,5506	10,9829
	MOCQ/R2	Cleaning T2	31,3	29,4695	13,1792
PAIR 19	MOCQ/R3	Doubting and Ruminating T1	47	31,7411	14,1951
	MOCQ/R3	Doubting and Ruminating T2	43	15,6525	7
PAIR 20	STAIX-3	Anxiety at the end of the testT1	61,5	27,8164	12,4399
	STAIX-3	Anxiety at the end of the testT2	41,1	29,9758	13,4056

There's a significant difference between **trait anxiety** before and after treatment (△1 Mean = 82, d.s + 9,75; △2 Mean = 64, d.s + 12,94 with a p-value = 0,018. Moreover, there's a statistically significant difference between T1 and T2 in in the scale measuring the **fear of calamity and threat to self** (△1 Mean = 87, d.s + 12,55; △2 Mean = 80, d.s + 11,73, with a p-value = 0,025) and between T1 and T2 in the **anxiety levels at the end of the CBA 2.0 test** (△1 Mean = 61,5 d.s + 27,82; △2 Mean = 41,1; d.s + 29,97; p = 0, 08).

Graph A: Mean values of the CBA 2.0 scale scores before and after treatment



10 -week treatment protocol for a cognitive behavioral group therapy for patients with various anxiety disorders (2 hours per session)

Session I	1) Short presentation of the treatment protocol; 2) Aims of treatment description; 3) Participants and group leaders presentation; 4) Group member's expectations , motivation and needs analysis ; 5) Psycho-education on anxiety (what is anxiety, how does anxiety manifest itself, why does it occur, symptoms; CBA 2.0 first take)
Session II	PSYCHO-EDUCATION ON ANXIETY 1) Learning about anxiety disoders and what they imply; 2) 'Flight Vs. fight' anxiety model, Clark's panic model, Well's GAD model; 3) Cognitive behavioral treatment for anxiety disorders; 4) Pharmacotherapy;
Session III	COGNITIVE RESTRUCTURING 1 1) Identifying metacognitions; 2) Thoughts register; 3) Functional cognitive and behavioural analysis; 4) Cognitive biases; 5) Homework: thoughts register;
Session IV	COGNITIVE RESTRUCTURING 2 1) What are negative automatic thoughts; 2) Disfunctional beliefs; 3) Automatic disfunctional thoughs restructuring; 4) Homework: thought register;
Session V	COGNITIVE RESTRUCTURING 3 1) Analysis and restructuring of fears and worries; 2) Disfunctional beliefs restructuring; 3) Homework evaluation; 4) Homework: thoughts register;
Session VI	COGNITIVE RESTRUCTURING 4 1) Contrasting anxious thoughts; 2) Maladaptive schemes; 3) Downward Arrow techinques; 4) Thoughts register with alternative functional thoughts; 5) Homework: thoughts register;
Session VII	COPING STRATEGIES FOR ANXIETY 1 1) Worry control and thought stopping; 2) Distraction and flash cards; 3) Delay in response; 4) Homework: behavioural experiments and thought stopping;
Session VIII	COPING STRATEGIES FOR ANXIETY 2 1) Coping strategies monitoring; 2) Homework evaluation; 3) Diaphragmatic Breathing; 4) Homework: thoughts register;
Session IX	COPING STRATEGIES FOR ANXIETY 3 1) Coping strategies monitoring; 2) Behavioural techniques evaluation; 3) Body Scan; 4) Homework: thoughts register;
Session X	COPING STRATEGIES FOR ANXIETY 4 1) Monitoring the Relaxation technique; 2) Relapse prevention; 3) CBA 2.0 re-test; 4) Closing the CBT gruoup;

DISCUSSION AND CONCLUSIONS

- The t-tests show statistically significant improvements in 3 scales of the CBA 2.0 between T1 and T2: fear of calamity and threat to self, the anxiety level at the end of the test and in the STAIX-2 scores measuring trait anxiety.
- Our treatment protocol proved to be efficient as it made the fear concerning uncontrollable aspects of life such as calamity and threats to self decrease, suggesting that subjects had better coping skills when dealing with anxiety connected to external events.
- Pearson correlations proved that age and the amount of time subjects had been suffering from the anxiety disorder do not have an effect on changes between T1 and T2. Spearman correlations proved that sex, profession, psychological diagnosis (one or more anxiety diseases), pharmacotherapy and psychosomatic disorders did not have an impact on the improvements in the 3 CBA 2.0 scales.
- The subjects' civil status seems to have an effect on the decrease of trait anxiety after the treatment: married subjects had higher improvements than those who were not married. The scholar level was found to influence trait anxiety differences between T1 and T2 as those who had a lower education improved more than those who had a higher education.
- Overall, results support the use of a heterogeneous CBT group treatment for patients suffering from various anxiety diseases, particularly in the public mental health context. Nonetheless, this study reveals several limitations such as the extremely small sample and the experimental design, hence it could not fully replicate previous studies in such field. All in all, our data suggest the need for further empirical research addressing the efficiency of heterogeneous CBT group interventions to investigate whether it would be possible to successfully treat anxiety disorders considering them as a unitary psychopathology.

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Learning math facts with "Leggere Scrivere Far di Conto" (Reading, Writing, Counting): fluency paths in the classroom.

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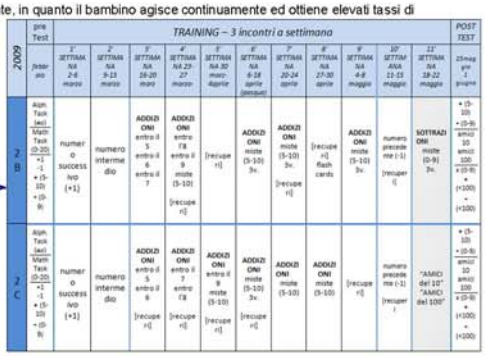
Il metodo

La metodologia attraverso la quale si intende implementare l'intervento sulle abilità accademiche in oggetto è il ***Precision Teaching*** (PT), finalizzato al raggiungimento di ***Fluenza*** dei contenuti appresi: essendo la fluenza strettamente correlata alla capacità attentiva del bambino, i dati di ricerca dimostrano come tale metodo abbia dirette conseguenze sia a livello metacognitivo (motivazione, autostima) che a livello comportamentale.

Le principali caratteristiche di tale metodologia sono:

- Il tempo richiesto per l'apprendimento è minimo: al bambino è richiesto di rispondere ad alta velocità e in pochi minuti .
- L'altissimo numero di esercizi utilizzati in ogni seduta consente di ottenere un grado di generalizzazione decisamente più elevato rispetto alle procedure tradizionali.
- La padronanza in situazioni di ansia, come le interrogazioni è decisamente alta: il bambino impara a rispondere in modo così automatico che in condizioni stressanti si mostra comunque competente.
- Il controllo da parte della famiglia e degli insegnanti è immediato e reale: viene registrato il grado di apprendimento di ogni allievo, seduta dopo seduta e diventa possibile basarsi su valutazioni obiettive e precise
- Il training è di per sé motivante, in quanto il bambino agisce continuamente ed ottiene elevati tassi di successo.



Le fasi del progetto

- ottobre-novembre 2008: incontri di Formazione per le Insegnanti: 24 partecipanti
- marzo-maggio 2009: Laboratori in 5 classi (3 prime e 2 seconde)
- giugno 2009: incontro di Restituzione

SOGGETTI

Classi e numero alunni coinvolti

- 2 classi seconde [tot. 42 alunni]
  - 2 B Cercagnano: 22 alunni
  - 2 C Albertesi: 20 alunni
- 1 classe *gruppo di controllo*

Percorso potenziamento ABILITÀ MATEMATICHE

Disegno sperimentale

quasi esperimento 3x2: una variabile è between ed è rappresentata dal diverso tipo di training somministrato ai gruppi (2 con training differenziati su addizioni e sottrazioni, 1 controllo), mentre l'altra variabile è within ed indica i due momenti della ricerca: valutazione pre e post-test effettuata con test criteriali e di application (es. nelle moltiplicazioni).

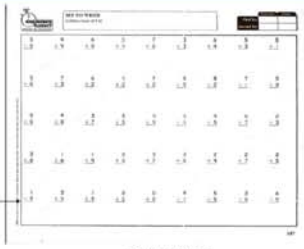
La conquista della conoscenza numerica costituisce senza dubbio uno dei processi più affascinanti e complessi dello sviluppo infantile. Capire come si evolvano le abilità di conteggio è, da sempre, oggetto di interesse della psicologia anche se, in letteratura, esistono pochi dati riguardo tale processo. Le ricerche elaborate in ambito cognitivista mettono in luce alcuni aspetti fondamentali tra cui la gradualità e la sequenzialità delle competenze (per cui un bambino apprende prima i tool skill per poi passare all'apprendimento di abilità più complesse) e l'importanza dell'automatismo nelle conoscenze acquisite (McCloskey, Caramazza e Basili, 1985; Siegler, Mitchell, 1982; Ashcraft; 1982). Considerando le abilità di calcolo come risultato di un processo di apprendimento e di acquisizione di competenze dipendenti dalla pratica, le ricerche condotte in ambito comportamentista evidenziano gli stessi indicatori di mastery. I teorici del Precision Teaching si sono occupati di valutare gli effetti della fluenza nelle operazioni matematiche di base in soggetti con ritardo in rapporto all'acquisizione di compiti più complessi e problemi (DuVall, McLaughlin e Sederstrom, 2003; Chiesa e Robertson, 2000; Linsdey, 1990; Mortenson, 2001). I dati in letteratura confermano miglioramenti altamente significativi nelle performance dei soggetti rispetto a:

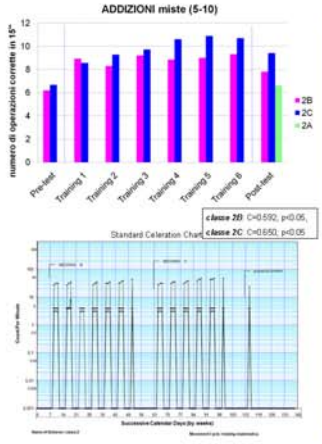
- riconoscimento di numeri
- lettura di numeri
- scrittura di numeri
- velocità di risoluzione di addizioni, sottrazioni e moltiplicazioni.

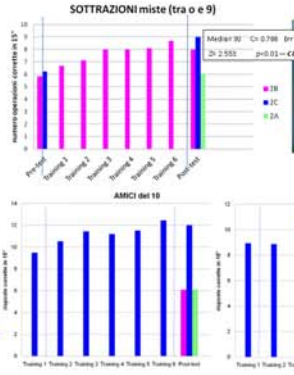
I dati dimostrano inoltre che i soggetti che raggiungono fluenza nei *tool skill* della matematica (ad esempio riconoscimento di numeri) svolgono in modo più accurato e veloce compiti più complessi (ad esempio addizioni semplici).

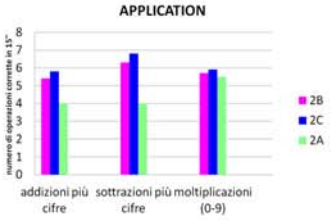
Il lavoro che esponiamo vuole essere un'esemplificazione dell'efficacia del metodo Precision Teaching nell'apprendimento delle abilità di calcolo sul gruppo classe.

Materiale: per i curricula di matematica abbiamo utilizzato il programma "Practicing Basic Skill in Math" (Beck, Conrad e Anderson; 2007). Tale programma è strutturato secondo un principio di Task Analysis e prevede compiti di complessità crescente che vanno da denominazione di numeri a moltiplicazioni complesse. Nel nostro caso abbiamo utilizzato le schede operative relative alle addizioni senza riporto, che rappresenta un *tool skill* per le operazioni più complesse. Ogni scheda contiene 60 operazioni.
Modalità: il training veniva svolto da ogni bambino in modo individuale ma all'interno della classe.
Istruzioni: ai bambini veniva detto risolvere le operazioni sul foglio nel modo più accurato e veloce possibile fino al segnale di stop. Al termine di ogni sessione ogni soggetto riceveva un feedback informativo sulla propria prestazione.
Tempi: il training si è svolto per circa 2 mesi (marzo-maggio), ha previsto 3 incontri settimanali durante i quali i soggetti svolgevano in media 3 sessioni di esercizio della durata di 15 secondi l'una.
Totale tempo training: 20 minuti circa.









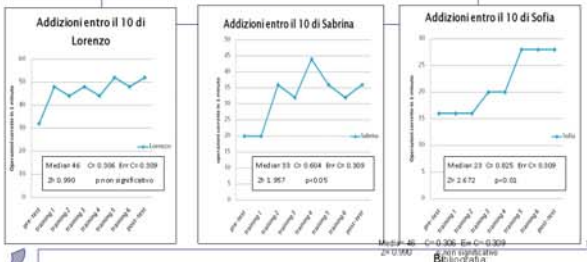
CONCLUSIONI

I gruppi sperimentali mostrano un trend di miglioramento significativo sia nelle abilità oggetto di training comune che nelle competenze del training differenziato. Dal confronto tra gruppi emergono risultati significativamente più positivi nei gruppi sperimentali rispetto al gruppo di controllo. I dati sembrano anche suggerire che il training seguito dalla sezione C (training specifico sulle "coppie di numeri la cui somma è 10 o 100") sia più funzionale come supporto al compito di soluzione di addizioni nel quadro di un potenziamento delle abilità di calcolo.

Si può affermare, in conclusione, che ciascun training PT sia efficace nel promuovere lo sviluppo e potenziare le abilità di calcolo; ulteriori indagini circa la differenziazione dei training e gli effetti della fluenza sul singolo all'interno del gruppo sono auspicabili.

Considerazioni sul rendimento dei singoli soggetti
il training ha incrementato il rendimento di ciascuno dei tre soggetti, ma in particolar modo sembrano aver beneficiato dell'intervento i soggetti con rendimento medio-basso ($p<0.05$ e $p<0.01$), mentre per il soggetto con livello di partenza alto l'incremento risulta non significativo. Questo perché, si ipotizza, essendo già molto vicino all'aim finale desiderato, il dislivello e quindi la pendenza del trend sono ovviamente ridotti – l'indicazione potrebbe essere quella di predisporre schede di lavoro più complesse per tali soggetti.

EFFETTI DEL TRAINING DI FLUENZA SUL SINGOLO



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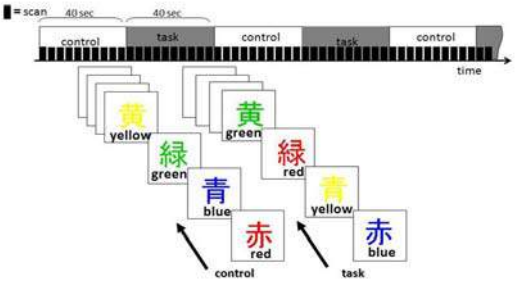
The effect of behaviour therapy on brain function in patients with Obsessive Compulsive Disorder
- A comparison study using fMRI-

Isomura K[1], Nakao T[2], Sanematsu H[2], Yoshiura T[3], Yoshioka K[4], Tomita M[5], Masuda Y[5], Nakagawa A[2,6]

Introduction

Although there have been ample evidences showing the effectiveness of behaviour therapy (BT) for Obsessive Compulsive Disorder (OCD) , few studies have elucidated how BT changes brain function compared with other treatments including SRIs.

We, therefore, investigated the differences of brain change among patients treated with BT, fluvoxamine (FLV), and placebo treatment using Stroop test assessing inhibition processes that might be related with OCD symptoms.

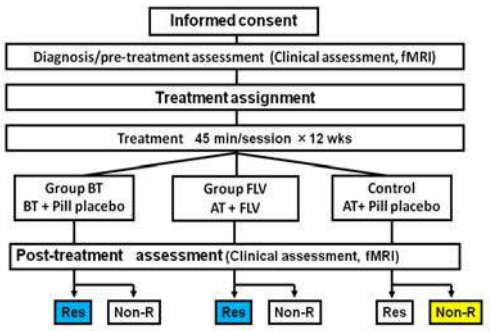


Stroop task during fMRI scanning

Characters were displayed one by one on a video screen at the participant's feet and changed every 2 sec with no interval. The patients viewed the characters through prismatic glasses and read the color silently. In the control condition, each character was printed in the same color as its meaning. In the task condition, each character was printed in a different color from its meaning.

To investigate the differences of changes of patients' brain activation while performing the Stroop test before and after treatment in the three treatment groups, two-way ANOVA by SPM8 was performed with a random-effects model.

Study design



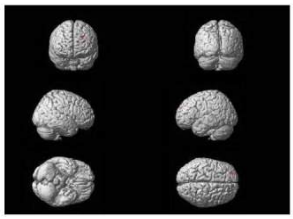
Res: Responder Non-R: Non-responder

De…nts

	Group BT※ (N=11)			Group FLV Responder¶ (N=5)			Group FLV Non-responder (N=9)			Control Group※ (N=7)		
Age (y)	32.4±10.6			32.2±11.1			31.9±6.9			34.7±7.3		
Sex (m/f)	4/7			3/2			3/6			3/4		
Age of onset (y)	22±9.3			27.6±12.6			19.8±9.6			14.4±7.4		
Duration (y)	10.7±7.0			4.5±2.3			12.3±9.4			20.4±9.4		
	pre	post	p§	pre	post	p§	pre	post	p§	pre	post	p§
YBOCS	29.7±3.0	12.4±4.9	**	26.8±1.8	11.8±5.9	**	30.2±3.4	26±4.6	**	30.7±3.4	27.3±4.2	**
GAF	45.9±3.8	60.9±7.0	**	47±5.7	58±4.5	**	42.8±5.1	46.7±7.1	**	45±4.1	46.4±5.6	
HD	9.3±4.6	7.7±5.8		9.6±4.5	2.4±1.3	**	10.1±4.3	5.8±3.1	**	5.9±4.8	5.0±3.4	
CGI-I post treatment	5.4±0.5			5.2±0.4			3.4±0.7			3.3±0.5		**

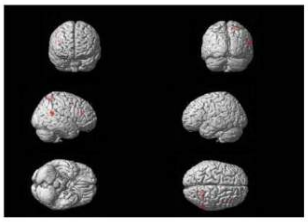
• ※ : All subjects of Group BT were responders, all controls were non-responders.
• ¶ : Responders definition; the reduction of the YBOCS total score ≧35% + the CGI-I score ≧5
• § : paired t-test, **p values<0.05

Brain Regions displaying significant differences of pre post changes of activation between Responder Group FLV and Control



Region		BA	Coordinates X	y	z	Z score
L	Dorsolateral Prefrontal Cortex	9	-26	56	32	3.76

Brain Regions displaying significant differences of pre post changes of activation between Group BT and Control



Region		BA	Coordinates X	y	z	Z score
R	Supramarginal Gyrus	40	64	-48	22	4.38
R	Dorsolateral Prefrontal Cortex	46	40	30	24	4.37
L	Middle Frontal Gyrus	6	-22	-6	42	4.17
R	Putamen		18	6	-2	4.01
R	Superior Parietal Lobule	7	18	-58	62	3.87

Conclusion

As the results show, there were several regions in which significantly different changes in brain activity were detected between patients treated successfully with BT or FLV and those receiving placebo treatment. More detected regions were found in the subjects with BT than FLV.

Only the Dorsolateral Prefrontal Cortex was detected in analysis comparing the patients treated with FLV to placebo treatment group. The region was also found in the analysis between BT and control group. The brain roci has been suggested as one of the regions related to the pathophysiology of OCD, especially in planning aspects of executive function.

Future studies with larger number of subjects and with other neuropsychological and provocation tasks are warranted to elucidate how each treatment changes brain function.

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Physical activity in overweight and obese patients with cardiovascular problems

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Alen Ružić, Thalassotherapy Opatija, Croatia

Introduction

Figure 1: Stages of change

The Transtheoretical Model (TTM) has been extensively used to guide behaviour change for health promotion (Plummer et al., 2001). The TTM offers a theoretical framework to guide the design, content, implementation, and evaluation of population-based interventions for exercise, physical activity, and diet change (Prochaska et al., 1998). The model comprises the construct of *stages of change* (*Figure 1*).

Objectives

Objectives in this research were to determine the frequency of exercising of obese patients with cardiovascular problems, related to their motivation for practicing physical activities, and to examine the relationship of motivational readiness to change body weight and to change the frequency of exercising. It is interesting to examine weather these two types of motivation overlap, or maybe one precedes the other, or weather their developmental trajectories are completely independent.

Sample

The sample consisted in 105 overweight and obese patients (84 men and 21 woman), with the age range from 32 to 72 years (M=55.15; SD=7.28), and the average body mass index (BMI) of 31.59 (SD=2.81), ranging from 26.37 to 42.25. Patients were hospitalised at the Department of Cardiological Rehabilitation. All of them experienced a major cardiovascular event: acute myocardial infarction or aortocoronary revascularization surgery.

Results

The obese patients with higher BMI in comparison with those with lover BMI exercise significantly less (*Table 1*).

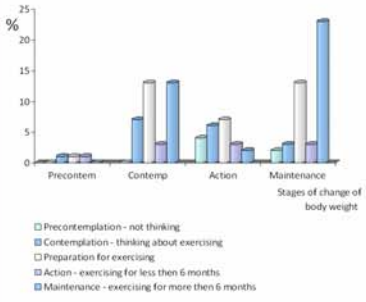
Table 1: Physical activity of obese patients with different BMI

		Overweight	Obesity level I	Obesity level II & III	F
		N = 29	*N =28*	*N = 14*	
The average time spent in everyday activities	M SD	7.20 3.91	6.03 3.90	5.86 3.87	0.99
The average time spent in sedentary activities	M SD	5.95 3.98	6.64 3.37	7.29 4.03	0.70
The average time spent in exercising	M SD	1.49 1.78	1.67 1.40	0.61 0.63	**3.07***

*$p < .05$

A high percentage of obese and very obese patients are at the level of *preparation* and *maintenance* of physical activity practicing compared with the overweight patients. A significant percentage of patients are at the level of *maintenance* of body weight (*Figure 2*), and the majority of them regularly practice some type of physical activity (mostly walking) for more than six months.

Figure 2: Motivational readiness to change physical activity in relation to stages of change of body weight



Discussion

Results show that motivation for changing body weight and frequency of physical activity act as two relatively independent processes. From the therapeutically point of view, these findings suggest the need of simultaneous encouragement for changing body weight and frequency of physical activity. Differentiating between levels of change the patients are at, gives the possibility for interventions directed towards his/her specific needs at every particular level. It also helps therapists to act proactively towards the target groups of patients that are not yet involved in programmes of physical activity (e.g. patients who contemplate and are preparing themselves for change). Knowing the individual readiness for change is a predictor of success in acquisition and long-term maintenance of physical activity.

F. Botero

Student's self-perception as a predictor of their depression symptoms and satisfaction with academic achievement

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University of Zagreb, Croatia

1. Introduction

If we want to empower students´ development as competent practitioners, it is important to explore what kind of problems they are dealing with during their study. This paper emphasizes problems with **self-perception** (self-esteem), **setting personal goals** (perfectionism), and **achievement of their goals** and their relation with **depression symptoms**. We took a global self esteem as a construct that consists of two dimensions (Tafarodi & Swann, 1995): a sense of social worth (*self-liking*) and a sense of personal efficacy (*self-competence*). Perfectionism is personal style which characterize wish to be the best in any circumstances, without mistakes, with extremely high achievement accompanying with tendency to be very critical to that achievement (Flett & Hewitt, 2002).

Slade & Owens (1998) find dual process model of perfectionism. Positive (adaptive) perfectionism characterized 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 (non-adaptive) 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.

2. Aim

The aim of this research is to determine **relation between student's depression symptoms and satisfaction with their academic achievement on one side and their self-esteem and perfectionism on the other side.**

Our presumption is that self-esteem and perfectionism will be significant predictors of depression symptoms as well as student's satisfaction with academic achievement.

Another presumption is that satisfaction with academic achievement will be in positive correlation with self-esteem and in negative correlation with perfectionism.

3. Method

The sample were 151 female undergraduate students and first year graduate students of University of Zagreb, age 19 to 32 (M=20,93; SD=1,900).

Self-esteem was measured with the Self-Liking / Self-Competence Scale (SLSC; Tafarodi & Swann, 1995); for the measuring of perfectionism was used the Positive and Negative Perfectionism Scale (PANPS, Terry-Short et al., 1995) and for depression symptoms it was applied Beck's Depression Inventory (BDI-II). Students were asked to evaluate their satisfaction with their achievement on 10 point scale.

Regression analysis was conducted, with the depression symptoms and students' satisfaction in academic achievement as criterion variables and self-esteem and perfectionism as predictor variables.

4. Results

Table 1. Regression analysis with **Depression** symptoms as criterion variable

Predictor variable	β	Partial correlation	t	sig.
Self-liking	**-0,471**	**-0,398**	**-5,122**	**0,00**
Self-competence	-0,170	-0,153	-1,824	0,07
Positive perfectionism	-0,030	-0,035	-0,418	0,68
Negative perfectionism	0,164	0,144	1,710	0,09

included predictors explain 51% of **depression symptoms** variance (R^2=0,515).
g as aspect of self-esteem and it is significant predictor of depression in student
les is negative. According to our results perfectionism (positive and negative) is

academic achievement as criterion variable

Predictor variable	β	Partial correlation	t	sig.
Self-liking	0,168	0,132	1,601	0,11
Self-competence	**0,559**	**0,397**	**5,214**	**0,00**
Positive perfectionism	**-0,214**	**-0,210**	**-2,593**	**0,01**
Negative perfectionism	0,150	0,113	1,372	0,17

at included predictors explain 32% of students' satisfaction with academic
hievement in study is significant and positive correlated with **self-competence**
lation with positive perfectionism.

5. Conclusion

Results of this study have shown that positive evaluation of self is very importan for different life aspects. On one side positive self-evaluation is connected with satisfaction in everyday life (without depression) and on the other side with students' satisfaction in academic achievement and it is the best predictor of those aspects.

Congress of EABCT, Milano 2010

COGNITIVE EMOTION REGULATION STRATEGIES OF MOTHERS AND THEIR RELATION TO PARENTAL SELF-EFFICACY

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Objective: Parental self-efficacy (PSE) – the caregiver's beliefs in their ability to parent successfully – play an important role in parent and child adjustment (Coleman & Carraker, 1997; Jones & Prinz, 2005). There is little research to determine the cognitive factors underlying PSE. This study investigated the relationships between parental self-efficacy and cognitive emotion regulation strategies.

Method: Mothers of 101 non-clinical children aged between 7 and 10 completed the Parenting Sense of Competence Scale (PSOC), as a measure of PSE, the shortened version of the Child Behavior Checklist (S-CBCL) and the Cognitive Emotion Regulation Questionnaire (CERQ) with a special instruction directing mothers' attention to problem situations related to child's behavior and parenting.

PARTICIPANTS	MEAN AGE	SD	RANGE
Mothers	36.4	4.2	27-52
Children	8.7	1.1	7-10

N=101; mothers of 51 boys and 49 girls (1 missing)

A hierarchical regression was conducted using the PSOC total score as the dependent variable. Child's and mother's age (Step 1) and S-CBCL total score (Step 2) were entered. At step 3, we entered the nine CERQ subscales.

Results: Child's and mother's age (Step 1) had no significant effect on the dependent variable (adjusted R^2=-.001). At step 2, S-CBCL total score accounted for 9.9% of the variance (ß=-.33, p<.001). At step 3, the nine CERQ subscales accounted for an additional 20.3% of the variance. In the final model, which accounted for 30.1% of the variance, four cognitive coping strategies – Self-blame (ß=-.44), Acceptance (ß=.20), Planning (ß=.26) and Catastrophizing (ß=-.40) – remained significant (p<.05).

Conclusions: Specific cognitive coping strategies are strongly related to parental self-efficacy. Targeting these cognitive factors may play an important role in parent interventions.

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INSTRUMENTS

Parenting Sense of Competence Scale (Johnston & Mash, 1989)

Child Behavior Checklist, Shortened (Achenbach, 1991; Rózsa et al. 1999)

Cognitive Emotion Regulation Questionnaire (Garnefski et al., 2001)

The Cognitive Emotion Regulation Questionnaire measures nine cognitive coping strategies people use after having experienced a negative life event to regulate negative emotions:

Self-blame: „I feel that I am the one to blame for it"
Acceptance: „I think that I have to accept the situation"
Rumination: „I dwell upon the feelings the situation has evoked in me"
Positive Refocusing: „I think of nicer things than what I have experienced"
Refocus on Planning: „I think of what I can do best"
Positive Reappraisal: „I look for the positive sides to the matter"
Putting into Perspective: „I think that it all could have been much worse"
Catastrophizing: „I continually think how horrible the situation has been"
Other-blame: „I feel that basically the cause lies with others"

HIERARCHICAL REGRESSION ANALYSIS FOR THE SCORES OF THE PARENTING SENSE OF COMPETENCE SCALE

	ß	R^2 - Change
STEP 1		-.001
Age (child)	-.08	
Age (mother)	-.11	
STEP 2		**.099*** **
Child Behavior Checklist	-.11	
STEP 3		**.203*** **
Self-blame	**-.44*** **
Acceptance	**.20***
Rumination	-.05
Positive Refocusing	.04
Refocus on Planning	**.26***
Positive Reappraisal	.10
Putting into Perspective	.10
Catastrophizing	**-.40*** **
Other-blame	.17

N=101; R^2 =.39; adjusted R^2=.30; F(12,88)=4.59 p<.001
ß: standardized regression coefficients from the final model
* p<.05; ** p<.01 ; *** p<.001 SPSS 17.0

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A study of assertive behaviour in two different samples: Italian citizens and foreigners living in Italy.

ABSTRACT - Objectives: to investigate whether assertive or unassertive behaviour is distinguishable in different cultures and to identify if specific cultural backgrounds and beliefs may mediate differences in displaying assertive behaviour from individuals coming from different countries. **Method**: the paper examines assertiveness in 108 Italian citizens randomly recruited and 108 foreigners from the city of Milan (Italy) and surroundings matched for age, sex religion and scholar level. In the foreigners group, only those who spoke Italian fluently were included. The two samples, for a total of 216 participants were assessed once using the Gambrill and Richey Assertion Inventory (1975). **Results**: we hypothesized that assertiveness is strictly correlated to social competence and integration with the surrounding environment, hence that the Italian sample would be more assertive than foreigners. The data gathered demonstrated that we were right as the differences we found suggest that foreigners are less assertive than Italians overall. Moreover, we found some cultural differences in the results of the Gambrill and Richey Assertion Inventory scores depending on nationality. **Conclusions**: According to our research assertiveness is somehow culturally-specific though more in depth research addressing assertiveness should be carried out, since up to date there are not many studies regarding this matter.

INTRODUCTION

The term 'assertiveness' means 'to state', and it is associated with terms like positive and successful. Within this concept two meanings coexist: expressing your own opinion and attitudes and having the tendency to positively solve problems (Anchisi and Gambotto Dessy, 1995). Individuals, as part of a social network, are often confronted with the need to mediate between their own needs and those of others. Social interactions are affected by people's self-esteem, beliefs, cohort, social, political, philosophical and religious conditioning. Facing difficult situations assertively requires a good level of self-esteem and self-efficacy (Bandura, 2000). Assertiveness is the ability to keep your rights up respecting those of others and to communicate something clearly, directly and coherently, both verbally and non-verbally. Being assertive implies the ability to defend your own rights, to start or continue social interactions feeling at ease, to express feelings or show initiative and to be independent (Boldorini and Giannantonio 2007). Assertiveness often coincides with the most competent behaviour for a specific situation, considering both the self and others (Bonenti and Meneghelli, 1992). Since it is very dynamic, this concept may be influenced by cultural background and beliefs. This study wants to investigate whether those who are more eradicated in their territory are more assertive than those who come from other geographical areas and it intends to evaluate if individuals who are more adapted to their own environment are able to recognise their own strengths and weaknesses relating to others accordingly without feeling inferior, superior or envious, hence behaving assertively.

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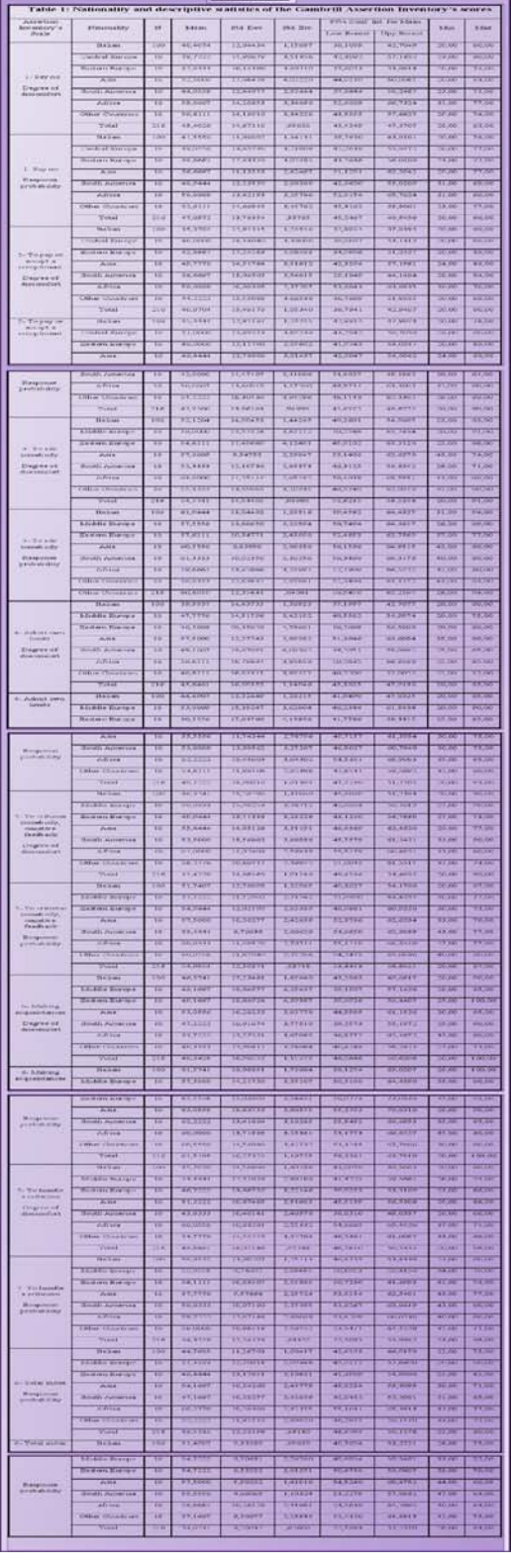
RESULTS

Table 1: Nationality and descriptive statistics of the Gambrill Assertion Inventory's scores



RESULTS

The ANOVA between groups/within groups analysis demonstrated that there are statistical differences in the following:

ANOVA - Nationality

Assertion Inventory's Scale		Sum of Squares	df	Mean Square	F	Sig.
1- Say no Degree of discomfort	Between Groups	8124,051	6	1354,008	7,415	,000
	Within Groups	38165,907	209	182,612		
	Total	46289,958	215			
1- Say no Response probability	Between Groups	8264,347	6	1377,391	8,835	,000
	Within Groups	32582,611	209	155,898		
	Total	40846,958	215			
2- To pay or accept a compliment Degree of discomfort	Between Groups	11591,185	6	1931,864	10,109	,000
	Within Groups	39941,185	209	191,106		
	Total	51532,370	215			
2- To pay or accept a compliment Response probability	Between Groups	3554,278	6	592,380	3,228	,005
	Within Groups	38356,222	209	183,523		
	Total	41910,500	215			
3- To ask somebody Degree of discomfort	Between Groups	2759,324	6	459,887	2,250	,040
	Within Groups	42719,491	209	204,399		
	Total	45478,815	215			
3- To ask somebody Response probability	Between Groups	604,426	6	100,738	,654	,687
	Within Groups	32211,333	209	154,121		
	Total	32815,759	215			
4- Admit own limits Degree of discomfort	Between Groups	9527,546	6	1587,924	6,403	,000
	Within Groups	51831,713	209	247,999		
	Total	61359,259	215			
4- Admit own limits Response probability	Between Groups	7290,509	6	1215,085	6,279	,000
	Within Groups	40442,824	209	193,506		
	Total	47733,333	215			
5- To criticise somebody, negative feedback Degree of discomfort	Between Groups	3526,671	6	587,779	2,793	,012
	Within Groups	43985,657	209	210,458		
	Total	47512,329	215			
5- To criticise somebody, negative feedback Response probability	Between Groups	2679,310	6	446,552	3,125	,006
	Within Groups	29867,685	209	142,908		
	Total	32546,995	215			
6- Making acquaintances Degree of discomfort	Between Groups	1505,574	6	250,929	,866	,520
	Within Groups	60525,074	209	289,594		
	Total	62030,648	215			
6- Making acquaintances Response probability	Between Groups	710,296	6	118,383	,440	,851
	Within Groups	56225,630	209	269,022		
	Total	56935,926	215			
7- To handle a criticism Degree of discomfort	Between Groups	4717,435	6	786,239	4,341	,000
	Within Groups	37853,824	209	181,119		
	Total	42571,259	215			
7- To handle a criticism Response probability	Between Groups	2792,546	6	465,424	3,303	,004
	Within Groups	29448,713	209	140,903		
	Total	32241,259	215			
8- Total index Degree of discomfort	Between Groups	5004,546	6	834,091	6,430	,000
	Within Groups	27111,380	209	129,720		
	Total	32115,926	215			
8- Total index Response probability	Between Groups	1721,227	6	286,871	3,639	,002
	Within Groups	16477,657	209	78,840		
	Total	18198,884	215			

CONCLUSIONS

1. Italians generally have a low degree of discomfort and a medium global probability of engaging in assertive behaviour.
2. From the descriptive statistics of the Assertion Inventory scores, it is possible to notice that foreigners generally have a medium degree of discomfort and a medium/high global probability of engaging in assertive behaviour.
3. This demonstrates that they are a little more anxious than Italians and are therefore slightly less socially able.
4. All in all, Italians seem to be little more assertive than the foreign sample.
5. The results of the study suggest that assertiveness is somehow related to social adaptation and cultural background.

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Progetto Atmosfera

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1. BACKGROUND

A diagnosis of cancer forces a man or a woman to leave a familiar and safe environment to enter a world made of hospitals, specialists and treatments. This involves the loss of one's role in the family and in the working place. At the same time they become someone who, independently from the actual condition, is sick and needy. Adding to this, there is the fear of what the therapy involves and of the unknown future.
Therefore, the treatment of a patient should imply the improvement of both the physical and the psychological condition, dealing with the negative emotions that always accompany the diagnosis, such as fear, anxiety and anger. The use of complementary therapies to enhance the psychological well-being may contribute to a better acceptance and tolerance of the illness and its treatment.
The project aims to promote a global approach to the patients, stimulating a process of humanization of the treatment procedures with the assumption that the creation of welcoming places and the presence of welcoming people can evoke positive emotions and convey an idea of acceptance and continuity of life.

2. OBJECTIVES

The aims of this project are the improvement of the patients' experience when starting chemotherapy and the assessment of the positive impact of a pleasant and relaxing environment on psychological well-being and psychosomatic side-effects of the treatment (such as antic patory nausea and vomiting, anxiety, fear and/or depression).
The study aims to demonstrate that the implementation of three complementary therapies, used together, improves the quality of life of cancer patients, lessens their anxiety and pain and reduces chemotherapy-induced side effects in cancer patients.

3. DESIGN OF THE STUDY

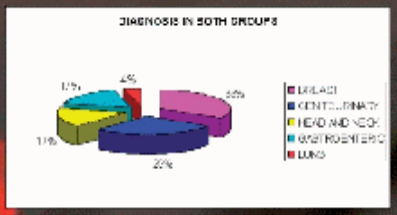
This is a randomized, pilot, stratified trial whose purpose is to survey patients regarding their perceived anxiety and quality of life during the period they receive chemotherapy. Patients treated in a dedicated room in which are used complementary therapies (from here on called Atmosphere Room) are compared to patients treated in any other Day Hospital room.

Material and Methods

The Atmosphere Room has been developed to offer a more welcoming environment. Walls and furniture are in the tones of yellow, orange and red to shape a warmer setting. For the same reason people working in the Room don't wear a uniform but coloured shirts. Beside the nurse, a psychologist is always present in the Room to offer support modulated on the patients' needs.
A combination of three complementary therapies are used to enhance the emotional closeness and the sense of acceptance perceived by the patients:

- Aromatherapy, an holistic practice that influences somatic and psychological processes through essential oils, that can have relaxing and balancing features;
- Music therapy, as a way of non verbal communication that increases the patients' well-being, reduces both anxiety and nausea and also draws attention away from pain;
- "Touch therapy", meant as a global way to take care of the patients, considering their physical, emotional and mental distress.

On the first encounter with the patient information is acquired on their age, education level, employment and marital status, and diagnosis.
To measure the impact of the environment on patients' Quality of life and side effects of chemotherapy we interview the patients every time they access the day Hospital using EORTC QLQ-C30 questionnaire.
Moreover we evaluated the level of anxiety experienced at the beginning and at the ending of the treatment through the STAY Y state version. Also, the first and last day of therapy the trait anxiety is assessed to establish a baseline.
Each day of treatment two blood samples are collected, one at the beginning and one at the end, and examined to measure the serotonin level.
The experimental group is also surveyed at the end of their experience in the Atmosphere Room with a questionnaire that we designed to have a qualitative feedback on what aspects of the environment we created was more appreciated by the patients.



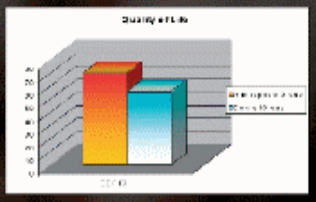
Sample

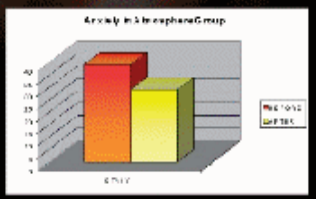
A total of 140 patients are going to be recruited for the research.
All patients aged 18 to 75 are contacted on their first access to our Oncologic Day Hospital and the research is proposed to them. On this occasion all potential participants are screened for cognitive impairment and excluded from the study if they receive a score lower than 19 at the MMSE. If they accept to participate and sign an informed consent they are randomly divided in two groups.

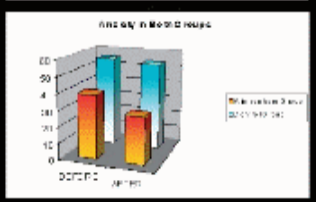
Statistical Analysis

The difference between the two treatment groups will be investigated using analysis of variance test or the nonparametric Kruskall-Wallis test where the distribution of the variable under investigation is far from normal.

The primary endpoints (anxiety and quality of life) will be explored with survival curves that consider as event the exceeding of preset thresholds of response variables and the time of occurrence of this event. The comparison between the curves of the two groups will be made by log-rank test. Statistical significance will be set at 5%.







4. RESULTS

At present the research is still ongoing. Therefore the results here presented are still partial.

So far 75 patients have been recruited, 30% of which have finished the trial, considering both groups.

A preliminary analysis has been conducted on the questionnaire scores of these subjects, comparing the mean results of the two groups.

The mean level of anxiety in the experimental group is 20 percentile points lower than the average result in the control group. Moreover, during the permanence in the Day Hospital the anxiety level of the experimental group decreased of 10%, whereas the anxiety level of the control group did not change significantly (1%).

The perception of the quality of life is about 15% higher in the experimental group.

On the contrary, the serotonin level showed no difference between the two groups and remained generally unchanged between the pre and post therapy measurement.

An interesting finding of this study is that patients that receive chemotherapy in the Atmosphere Room express profound satisfaction with the service of the Institute, as evaluated through the qualitative questionnaire. In particular they are pleased with the humanity of the treatment and the emotional closeness with the nurses and the psychologists.

5. DISCUSSION

The results obtained so far, even if partial, look very promising. We expect that the final results will be similar to these. All the patients that have received treatment in the Atmosphere Room have expressed great satisfaction with the project and the attitude of closeness they perceive. People working in the room feel that the environment increases the empathy towards the patients. Moreover, this experience helps tightening the bond between workers with different roles.
We hope that this positive experience could become common practice.

Computer Graphics Marinella Rizzo

QUALITÀ DI VITA TRA NORMALITÀ E PATOLOGIA NEGLI ADOLESCENTI

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Abstract

Questo lavoro intende portare un contributo allo studio della qualità della vita negli adolescenti. Si propone di analizzare preliminarmente eventuali analogie e differenze nel comportamento di risposta di soggetti adolescenti, clinici e non clinici, in aree quali autostima, tratti depressivi e strategie di coping. Si intende considerare la relazione di queste variabili con la qualità della vita dei soggetti, intesa come benessere psicologico percepito, derivante dalla soddisfazione in determinati ambiti di vita ritenuti rilevanti dal soggetto stesso (Goldbeck, Schmitz, Besier, Herschbach & Henrich, 2007) e la relazione tra tutte le variabili considerate e la variabile indipendente età. Si vuole, infine, indagare quali tipi di relazioni si evidenzino nei soggetti esaminati, tra autostima, tratti depressivi e abilità di coping e verificare quali fattori specifici, relativi all'autostima e al coping, siano più strettamente correlati al benessere psicologico (Erickson & Feldstein, 2007).

Introduzione

L'adolescenza è considerato un periodo di transizione, non lineare, caratterizzato da aspetti conflittuali, contraddizioni, incongruenze, profondi cambiamenti sia in ambito biologico, fisico, psicologico, cognitivo e sociale che la rendono una fase ricca di opportunità e allo stesso tempo di rischi (Goldbeck et al., 2007).

Secondo Horstmanshof, Punch e Creed (2008) l'autonomia, la crescita personale, l'autoaccettazione, l'opportunità di avere contatti interpersonali, il supporto sociale e familiare, l'amicizia e le relazioni positive con l'ambiente esterno, sono elementi importanti del benessere psicologico soggettivo e sono ritenuti fondamentali anche dalla Psicologia Positiva (Park & Peterson, 2008).

Un obiettivo rilevante in adolescenza è quello di creare e mantenere un'identità stabile, accrescendo la propria indipendenza, attraverso un processo di separazione-individuazione. Questo sembra spiegare perché gli adolescenti ricerchino maggiormente il gruppo dei pari (Goldbeck et al., 2007) e quanto questo possa incidere sul loro sviluppo. Antaramian, Huebner e Valois (2008) evidenziano come le relazioni familiari (sostegno familiare, coinvolgimento familiare e rapporti positivi tra genitori e figli) abbiano un ruolo determinante rispetto alla scuola, al gruppo dei pari e alla comunità in cui vivono per il benessere soggettivo percepito, a tal punto da essere un fattore protettivo rispetto all'utilizzo di sostanze.

L'autostima è uno dei più chiari segnali di benessere psicologico; una buona o cattiva autostima ha ripercussioni molto importanti sull'umore, risultando un fattore centrale di buon adattamento socio emozionale in quanto il soggetto considera realisticamente i propri pregi e difetti e non li valuta in modo ipercritico. Analizzando i giudizi di valore personale di un individuo, relativamente ad ambiti di vita specifici, possiamo rilevare una consistente presenza di fattori relativi all'autostima e alla vulnerabilità.

Considerata la molteplicità delle aree che appaiono rilevanti nella vita di ogni adolescente, nel presente studio, si fa riferimento al modello gerarchico multidimensionale dell'autostima (Bracken, 1993) secondo cui l'autostima globale, intesa come autovalutazione integrata di tutte le componenti del sé, si esplicita in sei ambiti: relazioni interpersonali, competenza di controllo sull'ambiente, emozionalità, successo scolastico, vita familiare e vissuto corporeo.

Tale costrutto è presente e in evoluzione già dalla prima infanzia, per poi maturare e consolidarsi con le nuove informazioni acquisite nel corso dello sviluppo, risultando l'adolescenza un momento

critico e nodale anche per l'eccessiva fiducia o dipendenza dalle fonti sociali di valutazione.

Le strategie di coping, nella nostra ricerca, sono considerate come l'insieme degli sforzi cognitivi, comportamentali, emotivi e sociali messi in atto per fronteggiare situazioni percepite soggettivamente come stressanti, ambigue e imprevedibili, unitamente alla mobilitazione delle risorse e dei mezzi individuali disponibili (Lazarus & Folkman, 1984). La multidimensionalità delle strategie di fronteggiamento si esprimerebbe, quindi, nei più svariati ambiti di vita del soggetto (Patterson & McCubbin, 1987).

Metodo e Partecipanti

La ricerca è stata condotta in Toscana. Hanno partecipato alla ricerca 76 adolescenti di età compresa tra i 14 e i 19 anni ed età media pari a 16.62 con una deviazione standard di 1.54, di cui 27 maschi e 49 femmine, cosi suddivisi: 42 soggetti, studenti di liceo Classico e 34 pazienti presso alcuni centri clinici per disturbi del comportamento.

A tutti i soggetti è stata somministrata una batteria di test self report quali: Test Multidimensionale dell'Autostima (TMA), Adolescent Coping Orientation for Problem Experience (A-COPE) e Children Depression Scale (CDS) nella forma per adolescenti

Strumenti

Il Test Multidimensionale dell'Autostima (TMA, Bracken, 1993) è un questionario, composto da 150 item, con risposta su scala Likert a 4 punti, che valuta l'autostima globale e al suo interno sei ambiti specifici: relazioni interpersonali, competenza di controllo dell'ambiente, emotività, successo scolastico, vita familiare e vissuto corporeo.

Il Children Depression Scale (CDS, Lang, Tisher, 1978; Gori-Savellini & Morino-Abbele, 1984) è composto da 55 item, con risposta su scala Likert a 5 punti, e comprende due fattori (Cioffi, 2000).

Il primo è il senso di Inadeguatezza che raccoglie item che esprimono bassa stima di sé, incapacità di comunicare, visione pessimistica della realtà, autopunizioni, solitudine, disagio sociale, non accettazione di sé e identità disturbata. Il secondo fattore è relativo al senso di Colpa espresso da item che indicano disagio nell'ambiente familiare, sensi di colpa, paura di non gratificare i genitori, percezione di essere punito eccessivamente, pessimismo, timore di non dare amore e desiderio di essere punito. Vi è, infine, una scala totale data dalla somma dei due fattori precedenti.

L'Adolescent Coping Orientation for Problem Experience (A-COPE, Patterson & McCubbin, 1983; Galeazzi & Moretti, 2000) elaborato al fine di valutare lo sforzo attivo di adattamento in ambito individuale, familiare e sociale, è costituito da 54 item, con modalità di risposta su scala Lickert a 5 punti, che afferiscono a 10 fattori: ricerca di sostegno sociale, sostegno familiare, fiducia in sé/autostima, ricerca di diversivi, impegno in attività scolastiche, ottimismo e ridefinizione cognitiva, evitamento mediante l'uso di sostanze, esternazione di sentimenti negativi, ricerca di un sostegno spirituale, hobby.

Analisi dei dati

Le analisi dei dati sono state condotte con il pacchetto statistico SPSS ver. 17.0, per rilevare principalmente l'eventuale relazione fra i costrutti osservati mediante correlazioni lineari e studi di confronto. Le ANOVA hanno, invece, permesso di approfondire e confrontare il comportamento di risposta di soggetti normali e soggetti clinici nelle dimensioni esaminate dai tre strumenti. Oltre all'appartenenza al gruppo clinico o meno, è stata presa in esame anche la variabile indipendente età. Il nostro attuale contributo di ricerca si basa soprattutto su analisi di tipo correlazionale, del cui limitato valore euristico siamo consapevoli e pertanto possiamo considerare solo come utili indicazioni di tendenze di risposta.

Risultati

La clinicità del campione sembra una variabile determinante ai fini del comportamento di risposta; i profili ottenuti ai test, infatti, sono stati esaminati mediante un confronto tra medie dei

soggetti normali e patologici. Evidenziamo alcuni risultati emersi all'analisi del TMA. Un primo dato inatteso riguarda il controllo emozionale che risulta significativamente più elevato nei soggetti clinici rispetto ai normali (scala "Emozionale": $M_{normali}$=62.3 d.s.=6.1, $M_{clinici}$=65.6 d.s.=6.9; $F_{1,74}$=4.9 p=0.029). Più adeguati appaiono invece i dati relativi all'autostima in riferimento alla vita familiare con valori medi significativamente più elevati nei soggetti normali rispetto ai clinici ($M_{normali}$=69.1 d.s.=4.6, $M_{clinici}$=65.5 d.s.=4.9; $F_{1,74}$=8.1 p=0.009). Quindi il gruppo dei soggetti normali mostra una percezione più positiva della vita familiare. Analoghe considerazioni si possono fare relativamente all'autostima circa l'area "Corporea": i soggetti normali mostrano un punteggio medio più elevato dei clinici ($M_{normali}$=63.1 d.s.=4.6, $M_{clinici}$=60.5 d.s.=4.6; $F_{1,74}$=6.2 p=0.015), indicando che in condizioni di normalità l'apprezzamento corporeo personale risulta decisamente più positivo.

Significative differenze si evidenziano tra i due gruppi in riferimento alle tendenze depressive. Infatti al CDS la differenza delle medie tra i due gruppi risulta decisamente marcata; i soggetti normali mostrano punteggi nettamente inferiori ($M_{normali}$=48.8 d.s.=18.9, $M_{clinici}$=61.7 d.s.=19.4; $F_{1,74}$=8.37 p=0.001). Tale dato viene confermato dal confronto dei punteggi totali del CDS in cui si evidenziano differenze statisticamente significative ($M_{normali}$=145.5 d.s.=21.7, $M_{clinici}$=155 d.s.=21.4; $F_{1,74}$=6 p=0.017).

Differenze nelle abilità di coping si evidenziano in alcune aree importanti. Alla scala "Ricerca di sostegno sociale" dell'A-Cope i soggetti clinici presentano una minore tendenza all'uso di questa importante risorsa ($M_{normali}$=29.1 d.s.=5.8, $M_{clinici}$=25.1 d.s.=5.9; $F_{1,74}$=8.6 p=0.005).

Analogamente alla scala "Ottimismo e ridefinizione cognitiva", i clinici evidenziano un punteggio medio decisamente più basso rispetto ai normali ($M_{normali}$=16.1 d.s.=3.7, $M_{clinici}$=11.3 d.s.=4.1; $F_{1,74}$=27.3 p<0.001); il gruppo clinico appare decisamente più fragile anche in termini di ottimismo, umorismo e orientamento positivo. Il ricorso agli "Hobby", risulta meno utilizzato dai soggetti clinici rispetto all'altro gruppo ($M_{normali}$=4.9 d.s.=2.1, $M_{clinici}$=3.9 d.s.=1.6; $F_{1,74}$=5.2 p=0.026).

Infine, il confronto su la scala A-COPE TOT conferma un generale ricorso alle abilità di coping decisamente inferiore dei soggetti clinici rispetto ai normali ($M_{normali}$=115.6 d.s.=12.8, $M_{clinici}$=102.5 d.s.=17.9; $F_{1,74}$=13.7 p<0.001), per cui si può affermare che il fatto che il gruppo clinico presenti maggiori livelli di criticità e di stress è reso più grave dalla carenza di adeguate strategie di coping.

Come affermano Horstmanshof, Punch e Creed (2008) l'autonomia, l'opportunità di avere contatti interpersonali, il supporto familiare, l'amicizia e le relazioni positive con l'ambiente esterno, sono elementi importanti del benessere psicologico soggettivo e, dunque, dovrebbero costituire una importante discriminazione tra normalità e patologia. Tale differenziazione non è emersa in modo completo e coerente nei nostri soggetti. E' stata confermata, come vedremo, solo per alcune scale mentre non sono emerse differenze significative in altre importanti scale, quali "Fiducia in sé" e "Competenza di controllo sull'ambiente", "Impegno scolastico" e "Successo scolastico", "Sostegno familiare" e soprattutto nelle "Relazioni interpersonali". Sembra pertanto che in alcune aree e, per lo meno, in certe fasi dell'adolescenza, non esistano differenze nelle risposte di soggetti normali e clinici. E' un dato che potrebbe essere attribuito alle caratteristiche di instabilità di questo periodo dello sviluppo caratterizzato da profonde contraddizioni e incongruenze (Goldbeck et al., 2007).

Non si può escludere che l'apparente normalità di numerose risposte potrebbe mascherare un rischio per lo sviluppo di sintomi depressivi soprattutto nei soggetti che non abbiano sviluppato adeguate strategie di fronteggiamento di situazioni problematiche.

I punteggi di tutti i test, quindi di tutti i soggetti senza distinzione tra normali e clinici, sono stati messi in relazione anche con la variabile età del soggetto. Le correlazioni statisticamente significative tra le scale e la variabile età sono risultate due: età e "Sostegno spirituale" del A-COPE

(r= -0.23 p=0.045) e tra età e “Uso di sostanze” della A-COPE (r= 0.25 p=0.026). Tali correlazioni sembrano indicare che con l’aumentare dell’età c’è una leggera tendenza alla diminuzione della ricerca del sostegno spirituale e un incremento nell’utilizzo di sostanze come strategie di coping. Tuttavia è necessario tenere conto del valore limitato e relativo di questi dati.

Esaminando il TMA in relazione all’A-COPE si evidenziano correlazioni di segno diverso (v. tab.1). Quella tra TMA Emozionale e Sostegno Familiare sembra indicare che al crescere dell’autostima circa il controllo emozionale diminuisca il ricorso al sostegno familiare, così la percezione di positività della vita familiare correla positivamente con la ricerca del sostegno familiare e si configura come fattore protettivo circa il ricorso all’uso di sostanze.

Risulta invece una relazione di significato diverso tra Competenza di controllo dell’ambiente, Sentimenti negativi e Uso di sostanze. Sembrerebbe dunque che alcuni aspetti dell’autostima influenzino positivamente modalità adattive di fronteggiamento dello stress mentre altre appaiono rafforzare reazioni di segno negativo dal punto di vista emotivo e cognitivo.

In relazione al CDS si evidenzia una correlazione positiva tra Senso di inadeguatezza e Sentimenti negativi del A-COPE (r= 0.305 p=0.003). L’analisi delle correlazioni effettuate in modo separato per normali e clinici ha evidenziato alcune criticità del gruppo clinico già emerse nelle analisi precedenti ed ha confermato anche aspetti di disagio e problematicità in quello dei normali.

Conclusioni

Dal presente studio emergono, tra gli studenti, più alto livello di autostima, minor distress, strategie di coping più adattive e maggior senso di adeguatezza; necessita, tuttavia, di ulteriori approfondimenti la relazione tra autostima e benessere psicologico.

Si intende incrementare la numerosità del campione clinico e normale diversificandolo ulteriormente per patologia e per tipologia di istruzione scolastica considerata la specificità dell’indirizzo di studio oggetto della presente ricerca.

Tra gli adolescenti appartenenti al gruppo normale le relazioni vissute in ambito familiare, e il sostegno percepito in essa risultano fattori rilevanti per la qualità della vita inteso in senso, anche se non esaustivo, di benessere psicologico, rivelandosi fattore protettivo nell’uso di sostanze.

Nei soggetti frequentanti centri clinici per disturbi psicologici si è evidenziata una relazione tra presenza di comportamenti problematici, percezione di bassa competenza sociale, senso di inadeguatezza, qualità della vita e strategie di coping utilizzate; il campione clinico appare decisamente più fragile in termini di ottimismo, umorismo, e orientamento positivo, non solo in termini emotivi ma anche di organizzazione cognitiva.

La clinicità del campione sembra una variabile determinante ai fini della risposta comportamentale.

Relativamente alla variabile età, si può affermare che con il suo aumentare, si evidenzi una crescita delle strategie di coping piu adattive (ridefinizione cognitiva, ottimismo) ma anche di quelle orientate all’evitamento (uso di sostanze).

Sentimenti negativi quali accusare gli altri di ciò che va male, dire cose cattive agli altri, essere sarcastici, sfogarsi, lamentarsi con i familiari, arrabbiarsi e gridare agli altri, sfogarsi e lamentarsi con gli amici sembra che possano essere strategie impiegate dagli adolescenti per sentirsi maggiormente capaci di determinare gli eventi, raggiungere obiettivi di varia natura, percepirsi più autonomi e con maggior libertà di autodeterminazione.

In conclusione ci sembra importante rammentare che le contraddizioni, le apparenti incongruenze delle risposte degli adolescenti non sempre sono l’espressione di caratteristiche negative quanto piuttosto del desiderio di autorealizzazione in forma ancora indistinta tra normalità e patologia.

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LE RISORSE DI FRONTEGGIAMENTO DELL'INSUFFICIENZA RENALE CRONICA: UNA RICERCA SPERIMENTALE IN UN CENTRO DI DIALISI.

Federica Mancusi

Introduzione

L'uomo nel corso della sua vita si trova ad affrontare situazioni più o meno complesse, piacevoli e spiacevoli che chiamano in causa e mettono alla prova le sue capacità e le sue risorse. L'insorgenza di una malattia è uno tra gli eventi di vita che può modificare il corso della stessa, momentaneamente nel caso di una malattia curabile; in modo permanente nel caso di una malattia cronica. L'insufficienza renale cronica è una condizione di malattia cronica caratterizzata, a livello fisico, da un'importante depressione delle capacità di filtrazione glomerulare dei reni con una conseguente menomazione dell'efficienza con la quale questi organi preservano l'omeostasi dell'organismo. La mancata azione di depurazione del sangue viene pertanto svolta dalla macchina per la dialisi che, diviene parte integrante della vita del paziente (Colombo, 1993, 652).

La modalità con cui le persone affrontano la malattia e le conseguenze di quest'ultima sulla vita quotidiana sono tra i temi più discussi e rilevanti nell'ambito della psicologia della salute.

I comportamenti e le convinzioni di un individuo di fronte a una diagnosi, agli effetti collaterali di un trattamento, alle limitazioni imposte da una malattia cronica o da una disabilità sono cruciali nel determinare il suo adattamento, o disadattamento, alla nuova condizione nel tempo e quindi nel fronteggiamento dello stress che ne segue (Della Fave – Bassi, 2007, 31).

Il rapporto tra stress e malattia non è unidirezionale. La produzione scientifica riguardante i rapporti tra stress e malattia può essere classificata in tre assunti:

1. lo stress provoca malattia
2. le malattie provocano stress;
3. riducendo lo stress si riduce il rischio di esacerbazioni di malattie esistenti.

(Majani, 1999, 83).

La seconda proposizione, è quella che si è scelto di tenere in considerazione in questa ricerca. È ipotizzabile che l'IRC provochi forte stress poiché modifica il sistema di credenze, forza verso revisioni di sé, delle proprie abilità, del proprio valore familiare e sociale (Majani, 2001, 83-84).

Nel caso di una malattia cronica come l'IRC un'area comune che permette al "mondo" della psicologia e della medicina di interfacciarsi e di parlarsi è quella relativa all abilità di *coping* che il paziente ha o non ha, mette o non mette in atto nel confrontarsi con lo stress che gli deriva dalla malattia e dalle terapie che il medico ha da offrirgli.

Partendo da questi assunti offerti dalla letteratura in merito alla malattia cronica ed alle risorse di *coping*, si è scelto di andare ad indagare il rapporto esistente tra strategie di *coping* interne, quali l'autoefficacia percepita e l'autoefficacia nella gestione della malattia, ed esterne, quali il sostegno sociale e la relazione paziente-personale sanitario, ipotizzando che esse possano risultare come fattori moderatori dello relazione stress - malattia cronica determinato dall'IRC.

Metodologia e campione di riferimento

Le ipotesi che sono state verificate sono le seguenti:

Prima ipotesi

I pazienti dializzati rispetto ai soggetti sani presentano punteggi più elevati nell'indice di stress clinico, più bassi nell'autoefficacia percepita, più elevati nel sostegno sociale.

Seconda ipotesi

Coloro che tra i pazienti dializzati presentano punteggi più elevati nell'autoefficacia generalizzata, nell'autogestione della malattia, nella comunicazione con il personale sanitario e nel sostegno

sociale percepito, presentano punteggi più bassi nell'indice di stress clinico.

Il campione

Il campione utilizzato per la ricerca è costituito da 105 persone di cui 75 costituiscono il gruppo sperimentale, all'interno del quale vi sono 21 donne e 54 uomini, e 30 il gruppo di controllo, costituito da 14 donne e 16 uomini. I 75 soggetti del gruppo sperimentale hanno una forma di insufficienza renale cronica e pertanto si sottopongono a trattamento dialitico, con tre sedute settimanali, presso l'Ospedale San Carlo di Potenza. Il gruppo di controllo è invece costituito da soggetti fisicamente sani, non aventi alcuna forma di malattia fisica.

Nello specifico il campione è così composto:

1. relativamente alla variabile età il 56% del campione ha un'età compresa tra i 20 ed i 60 anni, il rimanente 49% di esso, ha un'età che va dai 61 agli 88 anni;

- relativamente allo stato civile, l'80% del campione è costituito da coniugati, il 12% da vedovi, il 7% da celibi/nubili, infine l'1% del campione è costituito da separati;
- relativamente al titolo di studio, il 36% del campione ha completato le scuole elementari, il 30% le scuole medie superiori, il 23% le scuole medie inferiori, il 5% non ha nessun titolo di studio, infine il 6% ha conseguito la laurea;
- relativamente alla professione il 56% del campione è costituito da persone in pensione, il 21% da impiegati, l'11% da casalinghe, il 5% da liberi professionisti, un altro 5% da artigiani, il rimanente 1% da studenti.

Strumenti

Per la misurazione delle variabili in oggetto, sono stati utilizzati i seguenti strumenti:

- indice di stress clinico
- scala dell'autoefficacia generalizzata
- scala dell'autoefficacia nella gestione della malattia
- scala del livello di comunicazione
- scala del sostegno sociale

Di questi strumenti, quelli relativi allo stress, all'autoefficacia generalizzata ed al sostegno sociale erano già esistenti, gli altri sono stati elaborati appositamente per la verifica delle ipotesi. Per assicurare la validità dei dati emersi dall'utilizzo di questi strumenti è stata verificata la loro affidabilità, attraverso l'analisi della coerenza di ogni scala, rappresentata dal coefficiente Alfa di Cronbach.

Rispetto ai test creati appositamente per la ricerca, la loro comprensibilità, è stata realizzata somministrando ogni test ad un gruppo di dieci persone, aventi differenti livelli di istruzione.

Risultati

L'analisi complessiva dei dati del campione utilizzato, quindi età, sesso, stato civile, titolo di studio, professione, religiosità o non religiosità, non ha messo in luce particolari correlazioni tra questi stessi dati e le variabili oggetto di studio.

Dall'analisi dei dati, relativi alle differenze tra gruppo di controllo e gruppo sperimentale, sono emersi i seguenti risultati:

1. il livello di stress nei due gruppi non presenta differenze significative: la media corrispondente a questa variabile nel gruppo di controllo è pari a 82,00, nel gruppo sperimentale è invece pari a 75,47. La significatività p>248, non permette di ritenere la differenza come statisticamente significativa;
2. l'autoefficacia percepita risulta invece maggiore nel gruppo costituito da persone sane,

con una media corrispondente a 30,40, rispetto al gruppo costituito da persone in dialisi, con una media pari a 26,94. La significatività di tale differenze ha un valore statisticamente significativo, pari a p<0,013;

3. il sostegno sociale percepito risulta maggiore nel gruppo sperimentale, con una media pari a 38, 4, rispetto al gruppo di controllo con una media pari a 33,3. La differenza tra queste medie ha un valore statisticamente significativo con un valore pari p<0,000.

4.

Tab. 1. Significatività della differenza delle medie tra gruppi

		Somma dei quadrati	Df	Media dei quadrati	F	Sig.
Indice di Stress Clinico	Fra gruppi	914,667	1	914,667	**1,351**	**,248**
	Entro gruppi	69747,467	103	677,160		
	Totale	70662,133	104			
Autoefficacia	Fra gruppi	255,547	1	255,547	**6,431**	**,013**
	Entro gruppi	4092,987	103	39,738		
	Totale	4348,533	104			
Sostegno sociale percepito	Fra gruppi	570,549	1	570,549	**12,929**	**,000**
	Entro gruppi	4545,413	103	44,130		
	Totale	5115,962	104			

La seconda ipotesi è invece indirizzata a rilevare una correlazione inversa tra indice di stress clinico e senso di autoefficacia generalizzata, senso di autoefficacia nella gestione della malattia, livello di comunicazione con il personale sanitario, percezione di sostegno sociale; il risultato delle indagini va nella direzione della conferma dell'ipotesi.

Tab. 2. Correlazioni di Pearson tra variabili

		Correlazione di Pearson	Sig. (2-code)	N
Indice di Stress Clinico	Autoefficacia	-,572(**)	**,000**	105
	Autoefficacia nella gestione malattia	-,306(**)	**,008**	75
	Comunicazione col personale sanitario	-,074	**,527**	75
	Sostegno sociale percepito	-,192(*)	**,049**	105
Autoefficacia	Autoefficacia nella gestione malattia	,602(**)	**,000**	75
	Comunicazione col personale sanitario	,176	**,130**	75
	Sostegno sociale percepito	,272(**)	**,005**	105
Autoefficacia nella gestione malattia	Comunicazione col personale sanitario	,398(**)	**,000**	75

	Sostegno sociale percepito	,602(**)	**,000**	75
Comunicazione col personale sanitario	Sostegno sociale percepito	,359(**)	**,002**	75

Dall'analisi dei dati, presentati nella tabella, è emerso che:

all'aumentare del senso di autoefficacia diminuisce lo stress clinico, avendo la correlazione di *Pearson* un valore pari a -,572(**), con un indice di significatività p<,000

all'aumentare dell'autoefficacia nella gestione della malattia diminuisce lo stress clinico, con una correlazione di *Pearson* pari a -,306(**), con un indice di significatività p<,008

all'aumentare del livello di comunicazione con il personale sanitario non vi è una significativa diminuzione dello stress clinico, con una correlazione di *Pearson* pari a -,074, con un indice di significatività p<527

all'aumentare del sostegno sociale percepito diminuisce lo stress clinico, con una correlazione di *Pearson* pari a -,192(*), con una significatività pari a p<,005.

Oltre alla correlazione inversa tra stress clinico e le altre variabili, sono emerse altre correlazioni di tipo diretto tra le singole variabili:

- la percezione di autoefficacia è positivamente correlata all'autoefficacia nella gestione della malattia, con un valore di *Pearson* pari a 0,602(**), e p<,00; ed alla percezione di sostegno sociale, con un valore di *Pearson* pari a 0,272(**), e p<,005;
- l'autoefficacia nella gestione della malattia è positivamente correlata alla percezione di autoefficacia, alla comunicazione con il personale sanitario, con un valore di *Pearson* pari a 0,398(**), e p<,000; ed al sostegno sociale percepito, con un valore *Pearson* pari a 0,602(**) e p<,000;
- la comunicazione col personale sanitario è positivamente correlata con l'autoefficacia generalizzata, l'autoefficacia nella gestione della malattia e con il sostegno sociale percepito, con un valore pari a 0,359(**), e con p<,002.
- il sostegno sociale percepito è a sua volta direttamente correlato con autoefficacia generalizzata, autoefficacia nella gestione della malattia, comunicazione con il personale sanitario.

Questi dati stanno ad indicare come vi siano delle correlazioni anche tra le singole variabili, e come vi sia dunque la possibilità di modificare una di loro andando ad agire su quella correlata.

E' stata inoltre realizzata l'analisi fattoriale, procedimento statistico che determina un accorpamento delle variabili che mostrano una maggiore dipendenza l'una dall'altra. Da tale analisi è emersa la formazione di due gruppi naturali:

- indice di stress clinico e percezione di autoefficacia da una parte;
- autoefficacia nella gestione della malattia, sostegno sociale percepito e comunicazione con il personale sanitario dall'altra

Questo dato assume importanza poiché mettendo in luce la stretta correlazione tra le singole variabili fa ipotizzare che un cambiamento in una di esse determini un cambiamento nelle altre, ovvero al diminuire di una di esse può corrispondere il diminuire delle altre. Rispetto ai risvolti operativi, questa informazione può essere usata in funzione protettiva andando ad agire per il potenziamento delle altre variabili qualora una che compone il gruppo risulti inficiata.

Conclusioni

La ricerca condotta ha messo in luce la validità delle due ipotesi di partenza.

In primo luogo, è emersa la differenza tra il gruppo di controllo costituito da soggetti sani, ed il gruppo sperimentale costituito da soggetti dializzati che, mostrano una minore percezione del senso di autoefficacia ed una maggiore percezione di sostegno da parte di parenti ed amici.

Rispetto alla seconda ipotesi, per cui il possesso di risorse di fronteggiamento della malattia, quali l'autoefficacia generalizzata, l'autoefficacia nella gestione della malattia, la comunicazione con il personale sanitario e il sostegno sociale percepito, risulta correlato ad un minor indice di stress clinico personale, i dati emersi ne hanno rivelato la veridicità mettendo in luce la correlazione inversa esistente tra stress clinico e le risorse di fronteggiamento. Questi risultati hanno grande valore in vista della pianificazione di progetti di prevenzione poiché danno importanti informazioni sulle risorse da incrementare affinché sia possibile una gestione dello stress conseguente la malattia. Nello specifico, si potrebbe intervenire, oltre che sull'autoefficacia del paziente, sugli aspetti che più direttamente riguardano la relazione tra personale sanitario e paziente, ad esempio andando a migliorare la comunicazione tra le due parti, formando in modo specifico il personale sanitario alla gestione della relazione con questi pazienti.

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L RUOLO DEI FATTORI PSICOSOCIALI NEL MORBO DI CROHN. UN'INDAGINE SPERIMENTALE

Maria Pina Costanza

Introduzione e descrizione della ricerca

Fino a qualche decennio fa si riteneva che il sistema immunitario fosse un sistema di autoregolazione autonomo ed indipendente, geneticamente determinato, e che la risposta immunitaria fosse del tutto autogena, senza alcun controllo endocrino o nervoso.

Negli ultimi trent'anni è stato dimostrato come sia possibile modificare tale risposta, e soprattutto, come l'attività del sistema immunitario subisca consistentemente l'interferenza di eventi stressanti e di emozioni spiacevoli (Lanza, 1998, 124-126).

Le MICI (Malattie Infiammatorie Croniche Intestinali) sono patologie serie e invalidanti ad eziologia ignota per le quali non esiste una terapia definitiva. Fanno parte di questa categoria il Morbo di Crohn (MDC) e la Rettocolite Ulcerosa (RCU); si tratta di malattie croniche, immunitarie, contrassegnate da fasi di riacutizzazione e di remissione di durata variabile, ma comunque imprevedibile. Sono ben conosciute le manifestazioni e le lesioni tipiche di tali malattie: dolori addominali, proctorragie, artrite, infezioni urinarie, ulcere aftose, polipi infiammatori, deformazione del viscere con perdita della normale morfologia, scarsa distendibilità delle pareti, sub stenosi (Corazza – Tinozzi, 2000, 9).

La presente ricerca mira a verificare quanto alcuni fattori quali stress percepito, senso di coerenza, (Antonovsky, 1987, 47) e alessitimia(Taylor, 1993, 74-75), possano contribuire all'insorgenza e allo sviluppo del MDC e della RCU.

Considerando la letteratura sulle MICI, la triplice ipotesi che si intende avvalorare è la seguente:

I pazienti affetti da MDC e RCU presentano, prima dell'insorgenza della malattia:

Elevati livelli di stress;

Basso senso di coerenza;

Un' alessitimia di tratto

Tutto ciò potrebbe influire sulla nascita e sullo sviluppo della malattia stessa.

Metodologia e campione di riferimento

Come detto precedentemente la ricerca mira a verificare specificatamente come le tre variabili possano intervenire sull'insorgenza e lo sviluppo del MDC e della RCU.

Il campione indagato è costituito da 165 soggetti, dei quali 135 facenti parte del gruppo sperimentale (GS), e 35 del gruppo di controllo (GC).

Il campione è stato suddiviso per età e per sesso (cfr. Tab. 1). Esso si compone di 87 soggetti maschi e 78 femmine, di una fascia di età compresa tra i 20 e gli 80 anni circa. Il GS, caratterizzato da soggetti affetti da MDC e RCU, è stato reclutato da un forum virtuale, in cui sono iscritti soggetti affetti da MICI provenienti da tutta l'Italia, e dall'Associazione delle malattie infiammatorie croniche intestinali (A:M.I.C.I.) del Lazio. Nella ricerca sono stati esaminati soggetti con MDC e RCU senza distinzione, in quanto, le due malattie sono entrambe di origine ignota, si presentano allo stesso modo e subiscono entrambe un importante influsso dei fattori psicosociali.

Il GC, invece, è costituito da soggetti fisicamente sani rappresentati da studenti, lavoratori, religiosi, pensionati, casalinghe, persone che conducono una vita normale e vivono, perciò, situazioni stressanti tipiche della quotidianità.

Tab. 1 : Suddivisione per sesso e età

	GRUPPO			SESSO		CLASSI di ETA'		
	TOTALE rispondenti	Schizofrenici	Controllo	M	F	20-40 anni	41-60 anni	61-80 anni
T O T A L I	165	135	30	87	78	76	67	22
Maschi	87	73	14	87	0	41	34	12
Femmine	78	62	16	0	78	35	33	10

Strumenti di lavoro

Per esaminare la correlazione tra le variabili ed il MDC sono stati utilizzati tre test:

L' Index of clinical stress (ICS), il Sense of Coherence (SOC) e la Toronto Alexithymia Scale (TAS 20). Oltre a tali strumenti è stato richiesto, ad ognuno dei soggetti, di compilare una griglia contenente alcuni dati anagrafici, come il sesso, l'età e la professione. Ai soggetti facenti parte del GS è stato chiesto, nella consegna di ogni test, di compilare il medesimo ripensando alla propria situazione prima dell'insorgenza della malattia; perciò i risultati ottenuti fanno riferimento alle condizioni personali antecedenti ad essa.

Risultati della ricerca e analisi dei dati

I dati ottenuti sono stati inizialmente analizzati evidenziando la differenza tra il GS e il GC (cfr. Tab. 2). Nella tabella sottostante vengono presentate le variabili esaminate, ossia lo stress, il senso di coerenza e l'alessitimia e le differenze tra il GS e il GC. Dai risultati ottenuti possiamo notare una significativa differenza in entrambi i gruppi ed in tutte le variabili esaminate. Nella prima variabile, ossia lo stress, l'indice di significatività è di 0,001; ciò significa che la differenza tra i due gruppi è significativa; i soggetti affetti da MDC e RCU possiedono un livello di stress maggiore rispetto ai soggetti fisicamente sani; i soggetti si sentono maggiormente tesi, nervosi e molto irritabili; spesso in panico o addirittura sull'orlo di un collasso totale.

Per quanto concerne il senso di coerenza, anche qui appare significata la differenza tra GS e GC, in quanto si registra un punteggio pari a 0.05; ciò significa che i soggetti affetti da MDC e RCU riportano punteggi significativamente inferiori sulla scala in oggetto rispetto ai soggetti fisicamente sani. Presentano una difficoltà nell'affrontare e gestire le situazioni della vita, in particolare quelle stressanti; essi, di fronte ad una situazione difficile, sono più propensi a vederla come una sconfitta, piuttosto che come un'opportunità di crescita. A questo ne consegue, perciò, una maggior difficoltà nella gestione delle situazioni di vita, e di conseguenza un maggior livello di stress.

I soggetti del GS presentano inoltre un' alessitimia di tratto manifestando una notevole difficoltà nella gestione, espressione e descrizione delle proprie emozioni e di quelle altrui.

Tab. 2 : Confronto delle variabili nel GS e nel GC

1=SPERIM. 2=CONTROLLO

VARIABILE	N	MEDIA	SIGMA	g.lib.	F	P
STRESS	135	3.29	.95	1/ 163	15.97	.001
	30	2.56	.70			
COERENZA	135	4.26	.92	1/ 163	5.00	.050
	30	4.67	.86			
DIFFICOLTA' IDENTIFICARE SENTIMENTI	135	2.66	.94	1/ 163	12.98	.001
	30	2.00	.77			
DIFFICOLTA' DESCRIVERE SENTIMENTI	135	2.73	.90	1/ 163	4.11	.050
	30	2.37	.87			
PENSIERO ORIENTATO VERSO l'ESTERNO	135	2.33	.66	1/ 163	6.40	.020
	30	2.00	.61			

I dati ottenuti sono stati anche analizzati sia per la categoria sesso che per quella età; per quando concerne il sesso non emerge significativa differenza tra maschi e femmine in nessuna delle tre variabili; solamente il fattore pensiero orientato verso l'esterno presenza una differenza significativa tra i due sessi (cfr. Tab. 3). I soggetti maschi tendono maggiormente ad avere un pensiero orientato verso l'esterno, rispetto alle femmine.

Tab. 3: Confronto delle variabili nella differenza di sesso

1=M 2=F

VARIABILE	N	MEDIA	SIGMA	g.lib.	F	P
STRESS	87	3.04	.97	1/ 163	2.85	.100
	78	3.29	.92			
COERENZA	87	4.42	.90	1/ 163	1.48	n.s.
	78	4.25	.93			
DIFFICOLTA' IDENTIFICARE SENTIMENTI	87	2.49	.91	1/ 163	.40	n.s.
	78	2.59	.98			
DIFFICOLTA' DESCRIVERE SENTIMENTI	87	2.77	.90	1/ 163	2.29	n.s.
	78	2.55	.90			
PENSIERO ORIENTATO VERSO l'ESTERNO	87	2.44	.59	1/ 163	12.70	.001
	78	2.08	.70			

Per quanto concerne l'età, invece, non vi è nessuna differenza significativa tra i tre gruppi con differenza di età relativamente alla variabile stress. Compare, invece, una differenza significativa

per quanto riguarda il senso di coerenza; emerge un indice abbastanza relativo nel confronto tra il secondo ed il terzo gruppo (P=0.007). Tale valore sta ad indicare che i soggetti di età compresa tra i 61 e gli 80 anni possiedono un senso di coerenza maggiore rispetto ai soggetti di età compresa tra i 41 e i 60 anni; di fronte a situazioni di vita particolarmente stressanti, hanno maggiori capacità di poterle gestire e affrontare. Il secondo gruppo (41-60 anni) oltre ad avere un basso senso di coerenza, dimostra di avere anche difficoltà ad identificare i sentimenti rispetto ai soggetti di 20-40 anni, ai quali invece viene più facile. Sempre questo gruppo presenta più facilità nel descrivere i propri sentimenti agli altri, a differenza dei soggetti del terzo gruppo (61-80 anni) che dimostrano una maggiore difficoltà. Infine, la capacità di sapersi orientare verso l'esterno si evidenzia in misura maggiore nei soggetti con un'età compresa tra 61 e gli 80 anni, a differenza degli altri sue gruppi (20-40/41-60) che tendono ad orientare il pensiero verso la propria interiorità.

Conclusione

La ricerca, seppur con il limite della retrospettività, ha permesso di verificare l'ipotesi secondo la quale elevati livelli di stress, alessitimia e carente senso di coerenza possono contribuire all'insorgenza e allo sviluppo del MDC e della RCU. Certamente tali variabili non possono essere considerate cause effettive della malattia, bensì fattori di rischio importanti. Ogni soggetto ha una situazione a sé, una propria storia personale, con fattori ereditari, infettivi e immunologici differenti che possono rendere più o meno vulnerabile l'organismo di fronte alla malattia. I fattori psicosociali come lo stress, il senso di coerenza e l'alessitimia possono essere influenti nei soggetti particolarmente vulnerabili, esponendoli maggiormente alla patologia.

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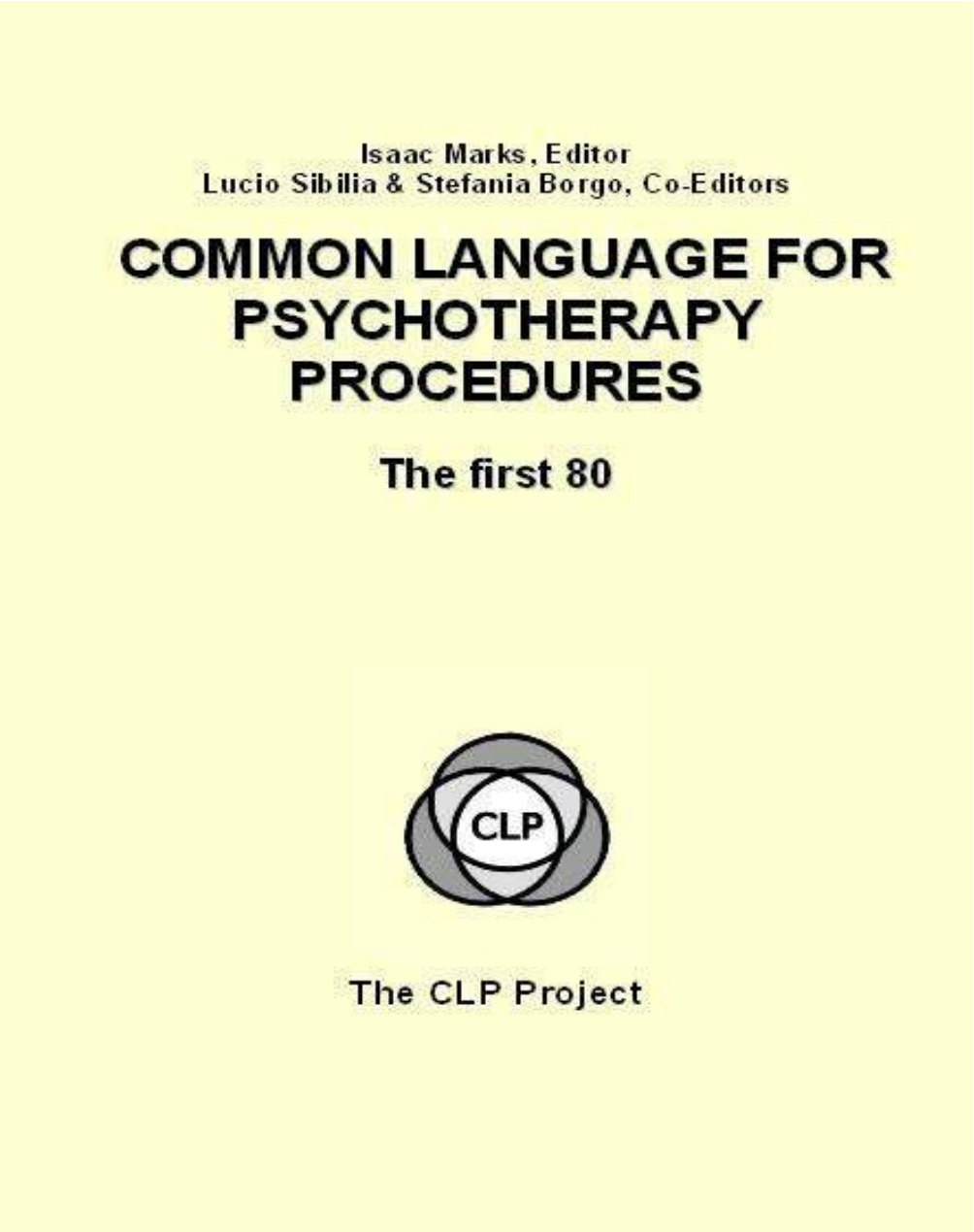

CLP

Marks I., (Ed.), Sibilia L.& Borgo S., (Co-ed.), (2010) Common Language For Psychotherapy Procedures, the first 80. Roma: CRP.

The clp project is creating a general lexicon of psychotherapy procedures in its website: www.commonlanguagepsychotherapy.org. Therapists from round the world describe operationally what they do with clients. They show overlaps and differences across procedures used in varying approaches. Clp entries are practical descriptions of therapists' procedures - what they do, not why they do it - though procedure and theory can be hard to unravel. Each entry briefly describes one of a broad range of psychotherapy procedures in plain language, and includes a short Case Illustration.

The growing A-Z website already includes procedures from many therapy approaches, with entries coming so far from Australia, Canada, France, Germany, Greece, Israel, Italy, Japan, Netherlands, Sweden, Switzerland, UK, and USA. This volume shows the first 80 entries.

Il progetto CLP (Common Language for Psychotherapy procedures) mira a costituire un lessico ampiamente riconosciuto delle procedure usate in psicoterapia, attraverso il sito web www.commonlanguagepsychotherapy.org. Terapeuti di tutto il mondo descrivono operativamente ciò fanno con i pazienti. Si evidenziano così sovrapposizioni e differenze tra le procedure dei vari approcci. Le voci del CLP sono descrizioni pratiche dei metodi dei terapeuti, cioè di quanto viene fatto e non perché venga fatto, sebbene la teoria possa talvolta esser difficile da distinguere dalla pratica. Ogni voce descrive brevemente ed in linguaggio corrente una singola procedura, dell'ampia gamma oggi esistente, ivi includendo uno o due Casi Clinici di esempio. Il sito già comprende procedure di molti approcci terapeutici, con voci fornite da Autori in Australia, Canada, Francia, Germania, Grecia, Israele, Italia, Giappone, Paesi Bassi, Svezia, Svizzera, Regno Unito e Stati Uniti. Nel 2010 è uscito anche il primo libro prodotto dal Progetto, contenente le prime ottanta voci.

In Colombia dal 10 al 12 febbraio 2011 il Centro per la Ricerca in Psicoterapia (CRP), l'Associazione Italiana di Psicologia Preventiva (AIPRE), la Società Italiana di Medicina Psicosociale (SIMPS) e ALETEIA - Istituto Superiore per le Scienze Cognitive , in collaborazione con gli ordini degli psichiatri e degli psicologi Colombiani organizzano il primo Congresso di orientamento cognitivo-comportamentale, sul tema "*Il Modello Bio-Psico-Sociale nella salute e nella malattia. L'approccio Cognitivo-Comportamentale nella valutazione e trattamento delle sindromi psichiatriche, nella gestione dello stress, nella promozione della salute.*" In un Paese la cui cultura psichiatrica e psicologica era dominata dalla psichiatria biologica e dalla psicoanalisi, contiamo di portare qualcosa di nuovo; non sappiamo se questo Congresso costituirà in Colombia l'inizio di un cambiamento culturale nella psicoterapia, nella prassi psichiatrica e della medicina preventiva, ma certamente questi Paesi sudamericani adesso guardano a noi Europei e non più agli USA! Link: http://www.congresointernacionalarmenia.com/

First International Conference of Metacognitive Therapy
11-13 May 2011
Manchester, UK
http://www.registration.no/mct2011/

7th International Congress of Cognitive Psychotherapy
2-5 June 2011
Istanbul, Turkey
http://www.iccp2011.com/invitation.php

41st Eabct Annual Congress
31 August - 3 September 2011
Reykjavik, Icelan
http://www.congress.is/eabct/