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Direttore responsabile: Stefania Borgo
Condirettore: Lucio Sibilia

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EDITORIAL

First in the landscape of National scientific journals in the field of CBT, Behavioural Medicine, Health Psychology and Psychosocial Intervention, *Psychomed* has dared to publish posters, and has continued so far, taking advantage of the technical possibilities offered by the Internet and the "public document format" or pdf. The idea was to allow to poster presenters to disseminate their scientific work to a wider audience and in a less ephimeral way than the short-lived poster exhibition during the Conferences, and to readers to examine posters in a far more comfortable way on their computer screens than standing in a Conference hall.

At first, in the issue of December 2008 of *Psychomed*, a selection of posters was gathered from the 6th International Congress of Cognitive Psychotherapy, which took place in June in Rome; a second issue presented 25 posters from the EABCT Conference hold in Dubrovnik (Croatia) in September 2009, a third issue published 46 posters form the 40th EABCT Conference, hold in Milan, Italy, in October 2010; then on a fourth issue 39 posters were published from the 7th International Conference of Cognitive Psychotherapy "Clinical Science" (ICCP 2011) hold in Istanbul, Turkey, and, finally, 27 posters were published from the 12th International Conference of Behavioral Medicine (ISBM) hold in Budapest, Hungary, in 2012. The current new issue of *Psychomed* follows again the same path as the previous ones: here a selection of 22 posters – divided into five thematic sections – is published, from the 43rd International Conference of EABCT hold in Marrakech in September 2013.

However, this is a very special occasion. In fact, we celebrate in 2013 our 40th anniversary of the first assembly which established SITC in Rome, the Italian Society of Behaviour Therapy (which in 1982 became SITCC, the other C being "cognitive"). In 1973 we were just a small group of young clinicians, many still in their training years, but possessing a strong sense of exploring and pioneering a wholly new pathway in psychotherapy, completely opposed to the psychoanalytic movement dominating psychiatry of that period. The members of that first Directing Committee of SITC were to become outstanding clinicians or researchers who contributed a lot to the dissemination in Italy and abroad of the concepts and methods of "behavioural psychotherapy", as it was named before, and of "cognitive therapy", as the new approach was labelled later: Vittorio Guidano (first president, unfortunately deceased), Giovanni Liotti and the writing authors.

Formally founded in December 1972, SITC already in April 1973 participated to a memorable Conference hold in Amsterdam, one of the earliest Conferences of the newly established European group, the EABT, which later became EABCT. This 1973 Conference was the occasion for a few National groups in Europe to join, discuss and acknowledge their common scientific involvement – at clinical and research level – in the practice and theory of behaviour therapy. Such groups were mainly the British one, the Dutch and the German ones. Leading names at that time were those of Hans J. Eysenck, Johannes C. Brengelmann, Ron Ramsay, Isaac Marks, Victor Meyer, John Wolpe, Michael G. Gelder, Stanley Rachmann. We still remember the atmosphere of that Conference, as if each of us was involved in a revolutionary movement.

As it happened in Italy, new National Associations were also born in those years in other Countries: BABP was also established in 1972, chaired by H Gwynne Jones, with Isaac Marks as vice. This was seminal for the foundation of SITC: we had already had met Marks the year before (1971) at the Maudsley Hospital, where he was working at that time. He was the one who advised us to visit Victor Meyer at the Middlesex Hospital in London, who run one of the first units implementing behaviour therapy. The encounter with him was very friendly, and it was the beginning of a very important relationship, which was continued in the following years.

The year later Meyer was in Rome, attending the International Congress on "*Recent Developments in Psychology of Learning*", organised by Ettore Caracciolo at the European Centre of Education of Villa Falconieri in Frascati, near Rome, together with the most qualified National and International experts such as M. Cesa-Bianchi and H. J. Eysenck. In that occasion, Meyer gave a seminal lecture at the outpatient Unit of the Institute of Psychiatry of the University of Rome "La Sapienza": his infectious enthusiasm gave us the thrust for beginning the new enterprise and reinforced the belief that time was ripe to establish an Italian Association for Behaviour Therapy, which, as mentioned before, was soon after founded. In 1973 a first Assembly gathered a score of Colleagues interested in the new approach and since then for a few years the Institute of Psychiatry became the theatre of lively and passionate discussions, which strengthened the group identity; in a context of a psychiatric culture still heavily conditioned by psychoanalysis.

While the Italian presence in the Amsterdam Conference was very scanty, almost limited to the Directing Committee members, the year later, in the London EABT Conference, it was much higher. In 1974 we could also attend clinical seminars in London, run by Vic Meyer, who became a reference figure, and whose heritage can be traced up-to now in our clinical work, in particular as regards the "clinical case formulation"[1] and the use of learning principles. In fact, he was later, in 1976, invited by us in Rome at the Clinic for Nervous and Mental Diseases of "La Sapienza" University

[1]Borgo S. (2010) *Supervisione clinica* [Clinical supervision]. Roma: Alpes Italia Ed.

for a three-days workshop, which prompted the first Italian volume on behaviour therapy[2]. In 1977 a second Italian association for behaviour analysis and modification (AIAMC) was established.

Meanwhile, we regularly met Isaac Marks at the EAB(C)T Conferences, who also became its president in 1979-80. However, it was only in the year 2000 – during the International Conference of the International Association for Cognitive Psychotherapy organised in Catania in June 2000 by our colleague T. Scrimali – that we were surprised to discover that we were shared a common scientific interest with Marks, present since those early days: the challenge to establish a common language in psychotherapy which could foster the study of active components of procedures and their classification.

As it is shown in the historical paper by Marks published in 1973 (reproduced in the current issue), at that time he was interested in the search of common mechanisms of action of psychotherapy procedures, a goal which required their operational definitions. On the other side, we had published in the same year an experimental paper[3] on conceptual models used by psychiatrists, showing how diagnostic labels and therapeutic interventions needed unequivocal definitions. Eventually, in 1991, we had already edited for the Italian National Research Council a *Thesaurus[4] of behavioural psychotherapy*, and, in the year 2000, we were sending to print a Dictionary of CBT in Italian[5].

Isaac Marks proposed to set up an EABCT Task Force to work towards a common language for psychotherapy (CLP) procedures. This CLP project, with the help of a website[6] and the support of many other National and International Scientific Associations, has produced so far about 100 operational definitions of procedures (each with a clinical case illustration) from any psychotherapy orientation. A volume has been published (2010), both in paper format[7] and in electronic downloadable version[8]. The CLP project, together with the volume, was presented by Marks during the EABCT 40th Conference in Milan in 2010. An update of the project was given at the Marrakech Conference in a Panel on "*Clp: Classifying psychotherapy procedures"* reported in this issue.

We met scores of other Colleagues, presented papers and posters, organised Symposia, difficult to mention in a short space such as this one; but we hope that this short historical sketch – based on our personal experience – may give a sense of the continuity of the "flight" of (C)BT from its beginnings up to now, and how the personal life courses of the people involved has been entangled with the life of associations and the pathways of scientific development in the field.

Stefania Borgo and Lucio Sibilia

Roma, December 2013

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2 Borgo S., Sibilia L. (1978). *Analisi e Modificazione del Comportamento* [Behavior Analysis and Modification]. Roma: Bulzoni Editore.

3 Borgo S., Liotti G. & Sibilia L. (1973). Modelli concettuali in psichiatria [Conceptual models in psychiatry]. *Riv. di Psichiatria*, 8, (3-15).

4 Borgo S., Sibilia L., a cura di (1991). *Thesaurus di Psicoterapia Comportamentale. Interfaccia Medicina-Psicologia*. *Studi e Ricerche*. Roma: CNR - S.T.I.B.No.T.

5 Borgo S., Della Giusta G., Sibilia L., a cura di (2001) *Dizionario di Psicoterapia Cognitivo-Comportamentale* [Dictionary of Cognitive-behaviour psychotherapy]. Milano: Mc-Graw-Hill Italia.

6 http://www.commonlanguagepsychotherapy.org/

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

8 https://www.researchgate.net/publication/235345467_COMMON_LANGUAGE_FOR_PSYCHOTHERAPY_PROCEDURES._THE_FIRST_80

From Amsterdam to Marrakech: an EABCT Journey

The annual congress must be the most important event in the calendar of EABCT and one that had now been successfully run continuously since the founding of EABCT in July 1971. While we may have changed our name from EABT to EABCT and grown from a handful of European associations to the largest umbrella association of CBT in the world with 52 individual associations from 38 different countries, our annual congress has been a consistent event each year.

Each EABCT association is committed to the empirically based principles and practice of behavioral and cognitive therapy approaches in health, social, education and related fields and we all share a common goal of developing the highest standard of clinical practice. We do this through the development of training, continuing professional development and evidence based practice and it is at the EABCT annual congress that we have the opportunity to make this a reality, to welcome new associations and learn from each other how to improve and develop our science and practice.

We have been everywhere – from Amsterdam in 1973 to Marrakech in 2013. We have met in every corner of Europe and beyond and there are only a few countries that have yet to host our annual congress. We have been to Milan, Rome and Venice. We have been to Munich and to Dresden, and to the capital cities of Paris (three times), London (twice), Vienna (twice) and Brussels. We have bathed in the sunshine of Spetsae. Corfu, Thessaloniki and Athens in Greece, Mallorca in Spain, Coimbra in Portugal and Dubrovnik in Croatia. We have seen the magic of the Nordic cities of Reykjavik, Helsinki, Oslo, Uppsala and Trondheim. We have been to the lakes of Lausanne and Geneva, the tranquility of Wexford and Cork in Ireland, the unique cities of Granada, Istanbul, Budapest and Prague and we have even been to Maastricht and Manchester!

We have turned our EABCT congress into global events by hosting world congresses in Jerusalem (1980), Edinburgh (1988), Copenhagen (1995) and Barcelona (2007).

Wherever we have gone EABCT's commitment to developing cognitive and behavioral therapies through clinical practice, research and a shared understanding has been our goal but as a bonus our congresses have also led to collaboration, joint working and friendship across the member associations of EABCT. EABCT congresses are know not just for their scientific programme but also for the social programme and fun that are an integral part of EABCT.

Most congresses are organized by the EABCT association in the country where the congress is being held and the organizing committee and scientific committees work for years to ensure that every year the congress grows and develops. Where there are two or more associations in the host country we now find that they join together as they did with such success in Helsinki in again in Geneva. More recently EABCT itself has used its own organizational skills to run the congress on behalf of all member associations as we did for the World Congress in Barcelona and the 2013 congress in Marrakech.

Our journey is not finished and we will continue our travels long after "Amsterdam to Marrakech" and welcome more associations into the EABCT family. Plans are already completed for a return to the Netherlands for the next congress in Den Haag in 2014. Plans are also well advanced for Jerusalem in 2015 and we then have more examples of collaboration when the two Swedish associations and the two Turkish associations host the congress in Stockholm and Istanbul in 2016 and 2017 respectively. And then there is another big one. The World Congress in Berlin to be once again hosted and run by EABCT.

I have been fortunate to have attended 32 EABCT congresses since London in 1974 and to have been involved in the organsiation of 6 of them including the last world congress in Barcelona and the 2013 congress in Marrakech. Through this personal experience of both participating in and organizing EABCT congresses. I have come to appreciate the success of EABCT and the dedication of the congress organizers working in the interest of EABCT. Our thanks go to all of them over the years. It must also go to all the people who have actively participated in the congresses as workshop leaders, keynote speakers, symposium convenors, clinical and research speakers and as poster presentations and finally none these congresses would be a success without the delegates who have supported the congresses and EABCT in our journey from Amsterdam to Marrakech.

Rod Holland
President EABCT

EABCT Congress 2013 in Morocco.
A challenge won

When the EABCT Board suggested to organize the 43rd Annual Congress of our association in Morocco, the feedback was not very positive as there were many concerns and challenges ahead.

The following questions were raised: Why should we have a European Congress in Morocco? What kind of advantages will we have? What kind of participation can we expect in a non European country?

These kinds of doubts were certainly valid given the fact that for the first time in the history of EABCT we were challenged with new experience.

Our goal was to organize the European Congress looking at the Europe from the other side of the Mediterranean in order to disseminate CBT even in such areas of the world where this psychotherapeutic methodology is still not well known.

Prior to organizing the Congress in Morocco, the EABCT was planning to create a task force for Africa with the aim to improve scientific contact with that part of the world, giving clinicians, academics and researchers interested in CBT in Africa the possibility to work together.

In fact, we realized that we had a very limited knowledge about CBT in African countries and that there was no umbrella association like EABCT and, as a result, the idea of creating a kind of Pan African CBT Network was born. We realized that our Congress could be a great opportunity to achieve such goals.

The results of the Congress were very rewarding to the organizers who had this intuition, given the fact that not only many African students and colleagues attended this Congress, but also many European and non European colleagues participated in it, exceeding organizers' own expectations.

The scientific program was based on multiple themes that were internationally relevant and covered both the theory and practice of contemporary CBT. We had invited internationally recognized experts in CBT, as our speakers, and had a wide range of parallel sessions, including symposiums, panel debates, roundtables and a program of half day in-congress workshops, open papers and poster sessions, Special Interest Groups (SIGs) professional and scientific sessions, exhibitions and displays. We also focused several symposiums and panel discussions on culturally sensitive aspects relevant for CBT population in Africa and organized some of these sessions in French language in order to accommodate the wider audience.

Moreover, for the first time within an EABCT Congress, Specialized Interest Groups was given a special attention as it gave an opportunity for people from many countries to work together on a more specific area within CBT. More specifically, the following SIGs were created at this Congress: Bipolar Depression, Depression, Low Intensity CBT, Psychosis, Trauma, OCD, Personality Disorders, Sex and Couple Therapy, Worrying and Rumination, Training Standard.

With respect to other scientific programs, the Congress incorporated many of the most important scientific topics such as Trauma and War, Cognitive Process of Psychological Disorders, Early Intervention in different Pathologies, The integration of CBT with The "Third Generation Therapies", Anxiety and Mood Disorders, OCD, Schizophrenia and many others, which stimulated discussions and debates.

Finally, the warm atmosphere of the hosting country, the magnificent landscapes of the desert and the unique flavors of the culture contributed to the success of the Congress and to building the bridge between two parts of the world where we found more similarities than differences and enriched our personal experiences giving us the possibility to create new projects and reinforcing our initial commitment to continue working together.

Antonio Pinto
EABCT Scientific Coordinator

REDUCTION OF FEAR: TOWARDS A UNIFYING THEORY*

ISAAC M. MARKS, M.D.[1]

In recent years many new psychological methods for the treatment of phobic disorders have been introduced. Among these are desensitization, flooding (implosion), prolonged exposure, aversion relief, paradoxical intention, modelling, cognitive rehearsal and sedative drugs (10). When many methods appear to have a similar effect it is natural to search for a common mechanism of action, and it seems that one important mechanism shared by all these techniques is exposure of the phobic patient to the phobic situation until he gets used to it — this process is sometimes called 'extinction'. Exposure to the phobic situation can be to internal stimuli (for example, phantasies) or to overt frightening situations.

The original explanation for the action of systematic desensitization was that it acts by reciprocal inhibition (22). According to this theory the active ingredient of treatment was the neutralization of anxiety (usually the imagining of phobic scenes) by an antagonistic response such as muscular relaxation or assertive responses. Although the evidence about this hypothesis is somewhat conflicting, a surge of articles in the last few years has indicated that reciprocal inhibition occurs only exceptionally, and that the action of desensitization is not generally impaired when muscular relaxation is omitted from the procedure (3). When relaxation is omitted from desensitization what is left is repeated imagining of phobic scenes, starting with items which are only slightly anxiety-provoking and working up eventually to the most terrifying ones. Likewise there is now evidence that this gradation is also not essential for improvement and that improvement occurs at a similar rate whether going up, down or randomly across the hierarchy (21). Several studies have shown that during the presentation of phobic imagery physiological arousal occurs to a similar degree whether or not relaxation is present (13).

In the procedure known as 'flooding' the patient is literally thrown into the deep end, in contact with the phobic situation either in phantasy or in real life. In this procedure no emphasis is laid on processes such as relaxation, and the element of exposure to the phobic object is obvious; what is not obvious is the *optimum* pace at which exposure should proceed and what part subjective anxiety plays in improvement. In the course of a series of flooding trials which demonstrated the efficacy of flooding procedures in phobic patients, an efficacy which was greater than that of desensitization (9, 19, 20), it appeared that anxiety provocation itself might not be the crucial element for the reduction of avoidance behaviour, and that contact with the phobic situation seemed more important. It also appeared that contact with the real life situation was much more effective than contact with imaginary scenes only. This point is similar to observations that desensitiza-

*Presented at the Joint Meeting of the Canadian Psychiatric Association, the Royal College of Psychiatrists, and the Quebec Psychiatric Association, Montreal, June, 1972.

[1]Institute of Psychiatry, The Maudsley Hospital, London, England.

Canad. Psychiat. Ass. J. Vol. 18 (1973)

tion *in vivo* is more rapid than desensitization in phantasy.

The efficacy of operant conditioning procedures in the reduction of phobic behaviour poses no problems for the exposure hypothesis (2, 11). The essential aspect of the operant treatment of phobias is systematic reward of the patient for steady approach towards the phobic situation; it is quite obvious that during operant treatment the therapist never shapes behaviour away from the phobic situation. An integral part of the procedure thus consists of graduated exposure.

The same applies to treatment by modelling. Studies such as those of Bandura *et al.* (1) and Ritter (17) have shown that when the subject watches a model coping with the phobic situation he becomes more able to do so himself. As with operant shaping the modelling procedure inevitably has a crucial element of exposure in it. The patient is asked to watch the model on films, or in real life (which is more effective). In the experiment by Bandura *et al.* the live model slowly approached a snake while being observed by a patient with snake phobia who was then encouraged and cajoled into executing the same task. The procedure was thus essentially one of exposure *in vivo* after a model.

Procedures such as cognitive rehearsal also reduce phobic anxiety (6). Simply preparing a tape recording to instruct the patient how to overcome his fears can have therapeutic value. It is clear that in this process the patient rehearses imagery concerning phobias.

The procedure known as 'paradoxical intention' (4) is similar in many ways to exposure *in vivo*. In one example described by Frankl an obsessive-compulsive patient with fears of contamination by dirt was asked to watch Frankl dirtying his hands on the floor and then touching his face, and the patient was then asked to do the same. This was called 'paradoxical intention' — a procedure identical with that called 'exposure *in vivo*' (16).

In the use of sedative drugs, either intravenously with methohexitone (5, 14) or orally with diazepam (12), the drug is used to facilitate the contact of the phobic patient with the phobic situation. There are many problems here about the best route by which to administer the drug, what class of drug to use and how to time the exposure with reference to drug administration; nevertheless, most drug effects incorporate the element of exposure. Tricyclic drugs such as imipramine (7, 8) for agoraphobia and school phobia have also been combined with firm insistence on the patient contacting the phobic situation, and Klein suggested that there might be a synergistic action in which the antidepressants relieve the affective component of the disorder and thus facilitate exposure to the phobic situation.

Although many of the newer methods of treatment can thus be seen as acting through a common mechanism, it is still by no means clear how best to apply this mechanism of exposure. We know that prolonged exposure *in vivo* for several hours at a time is a highly effective method of reducing phobias and has a long-lasting effect. It is not known whether this effect would be even greater were anxiety to be deliberately evoked during exposure instead of simply allowing it to emerge as an inevitable and unfortunate by-product of contact; nor is it known whether, if anxiety is beneficial, it should be relevant or irrelevant to the phobia. Watson and Marks (19) have shown that both relevant and irrelevant fear cues significantly reduce phobias but that they seem to act through different mechanisms. The experiments by Meichenbaum (15) with volunteers suggest that subjects might be immunized to stress, including phobias, by deliberately subjecting them to stresses which are not connected with their particular phobias. If this is substantiated in patients then the most beneficial results in the long run might be through exposure, not simply to the phobic object alone but also to other stresses, in a manner which teaches a general set of coping with unpleasant experiences.

Phobias are complicated sets of responses — avoidance, physiological arousal in

several dimensions and also subjective anxiety — each of which varies according to the precise stimulating properties of the phobic situation at a given time. Furthermore these various responses might each be extinguishable independently, with only partial generalization from one to the other. It follows that the most wide-ranging improvement might be obtained, not simply by confronting the phobic patient with his phobic situation (without allowing avoidance so that avoidance is extinguished) but also by adding deliberate anxiety concerning the phobic object, in order to extinguish the subjective discomfort as well as the avoidance, and in addition by inducing irrelevant anxiety and other unpleasant emotions in order to teach the patient how to cope with other disagreeable effects. Meichenbaum showed that phobic volunteers overcame their fear even better when desensitization was combined with deliberate attempts by the subject to manage the discomfort induced by electric shocks (15).

Perhaps the message is that the more discomfort the patient is exposed to, the more he learns to tolerate. Obviously there must be limits to this idea, and the conditions under which it applies would require much work to delineate. Theoretically, under certain conditions the patient might be sensitized instead of habituated.

Why should exposure to noxious stimuli lead to phobias under certain circumstances and to elimination of those phobias under others? One important variable is duration. Prolonged exposure for two hours to the phobic stimulation *in vivo* leads to more effective reduction of phobias than four half-hour periods over the same day (18). Long exposure is more therapeutic than short exposure and very brief exposure, with avoidance allowed, may actually be sensitizing.

Patients commonly say that they have had experiences during which they were exposed to the phobic situation for an hour or more before they came to treatment, and yet were more anxious after that experience. Close enquiry often reveals that during such exposure they were rehearsing internal avoidance responses throughout the exposure and saying to themselves 'I want to get out, I want it to end, help'. During treatment patients are taught the opposite 'I must stay here until I am used to it'. Of course these are variables such as 'set' which are difficult to investigate, but they may be vital experiments and must be done.

The exposure hypothesis does not explain one important set of phenomena — the relief of fears and other problems after abreaction, not only of fear but also of anger, guilt and other affects. Unfortunately evidence in this area is nearly all anecdotal, and experimental data are badly needed. Clearly, relief of phobias after abreaction of anger does not fit neatly into the exposure hypothesis. Although the analytic concept of defence against aggression might spring to mind here, this does not explain all the facts available. Perhaps it will eventually be found that exposure to noxious stimuli can lead to improvement under many conditions but that other mechanisms which are so far unknown can also be therapeutic — science has its growing points where hypotheses do not quite fit all the facts.

Summary

In recent years many new methods which alleviate phobic disorders have been introduced. These include desensitization, operant shaping, flooding (implosion), prolonged exposure, paradoxical intention, modelling, cognitive rehearsal and intravenous short-acting sedatives. Different theories have been invoked to explain the action of these procedures, and these are often contradictory. Current evidence suggests that the same therapeutic principle is responsible for the efficacy of most of these methods, this being the continued exposure to the phobic situation until anxiety and avoidance responses are extinguished. This exposure is greatly facilitated when carried out in real life rather than in phantasy. The conditions for successful exposure are explored and other possible therapeutic elements are discussed.

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Résumé

De nombreuses méthodes pour atténuer les troubles phobiques ont été introduites au cours des dernières années. Parmi ces méthodes, il faut citer la désensibilisation, façonnement opérante (shaping), l'implosion (flooding), exposition prolongé, intention paradoxal, le modelage, répétitions de pensées, et l'injection en intraveineuse de sédatifs à action *rapide*. On a fait appel à differentes théories pour essayer d'expliquer l'action de ces méthodes et elles sont souvent contradictoires. Il semble actuellement que ce sont au même principe thérapeutique qu'est due l'efficacité de ces méthodes: l'exposition constante à la situation phobique jusqu'à ce que l'anxiété et les réactions d'évitement disparaissent. Cette exposition et grandement facilitée lorsqu'elle est effectuée dans la vie réelle plutôt qu'en imagination. Les conditions requises pour que la méthode d'exposition réussisse sont actuellement à l'étude et on envisage les autres éléments thérapeutiques possibles.

EABCT Congress 2013 - Panel Discussion

Title: ***Clp: Classifying psychotherapy procedures.***

Convenor: Mehmet Sungur, *Dept. of Psychiatry Medical School of Marmara University, Istanbul, Turkey*

Chair: Stefania Borgo, *Centre for Research in Psychotherapy, Roma, Italy*, stefania.borgo@uniroma1.it

Speakers:
1) Mehmet Sungur, *Dept. of Psychiatry Medical School of Marmara University, Istanbul, Turkey*.
2) Lucio Sibilia, *Dept. of Psychology and Developmental Processes, Sapienza University, Roma, Italy*.

Stream: Therapeutic and applied issues.

Abstract:
One of the main requirements for the evolution of psychotherapy from art into a science is to establish a common psychotherapy language. At present, similar procedures are given different names by different schools or the same label (name) may denote different procedures in different hands. The EABCT and AABT have recognized the need to reduce this confusion by appointing a joint task force to work on a project towards a common psychotherapy language. Panel members will outline the project. It aims to evolve a dictionary of psychotherapy procedures of therapists from different schools, with the hope of encouraging shared use of the same terms for given procedures. A common language might reduce confusion and facilitate scientific advance in the field. The project will use plain language. It will not lead to an encyclopaedia or textbook or theoretical exposition of psychotherapies. The dictionary will concisely describe terms for a comprehensive set of psychotherapy procedures in simple language as free from theoretical assumptions as possible, each with a brief case example (up to 450 words), note of its first known use, and 1-2 references. The terms will try to describe what therapists do, not why they do it (the latter too is important and could be the subject of a separate project). Regular updates of the Dictionary will be aimed at via the CLP website that should operate shortly. Submissions will be invited of 1st-draft entries of terms to the clip task force. The Panel will describe the project's significance and hoped-for outcome, give examples of completed entries and their authors, and how to make 1st-draft submissions and the iterative process toward their completion. Most of the Panel's 1.5 hours is expected to be taken up by audience feedback to help shape the project even further.

Potential implications for the everyday clinical practice of CBT:
Using a plain common language to describe unambiguously each psychotherapy procedure will not only foster scientific research, but also facilitate communication among clinicians and with patients.

THE POSTERS

Assessment instruments

ANXIETY DISORDERS INTERVIEW SCHEDULE FOR DSM-IV: CHILD VERSION (ADIS-C) APPLIED TO AN ADOLESCENT POPULATION:

CONCURRENT VALIDITY, INTER-RATER AGREEMENT AND ACCEPTABILITY OF THE CLININAL INTERVIEW

Research Unit of the Cognitive-Behavioral Center for Research and Intervention
Psychology Faculty, University of Coimbra

Catia Cassiano Martins & Maria do Céu Salvador | 2013
catia.cassiano@gmail.com | ceusalvador@gmail.com

ABSTRACT

An extensive evaluation of psychopathology is critical in the psychotherapeutic and research processes. Usually, researchers and clinicians are dependent on the accuracy of tools used to determine diagnosis, and this process can affect both assessment reliability and treatment efficacy. As such, it is essential to use validated tools concerning reliability, sensitivity and specificity.

The Anxiety Disorders Interview Schedule for Children (ADIS-C; Silverman & Albano, 1996) has shown its efficacy and reliability in several international investigations. In Portugal its psychometric properties have not yet been studied thus being the aim of our study.

The final sample consisted of 240 adolescents (172 in the clinical group and 68 in the non-clinical group, all assessed by the ADIS-C) aged between 14 and 18 years old. ADIS-C and several Self Report, Parent and Teacher Report Questionnaires were used.

Concurrent validity, inter-rater agreement and acceptability of the interview obtained good results. Thus, ADIS-C proved to generate valid and reliable diagnosis.

The use of this instrument may confer advantages to clinical practice and research, particularly in the reduction of variability in the assessment process, providing accuracy in the diagnosis of comorbidities (Ulloa et al, 2006) and delimitating symptoms and clinical populations through a clear and objective evaluation.

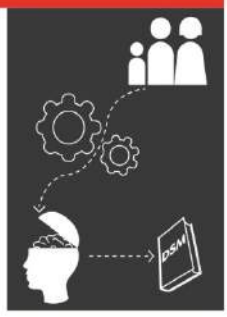
Key Words: ADIS-C, psychometric properties, validity, reliability, adolescents.

INTRODUCTION

Adolescence is a marked period of physical, cognitive and emotional changes. This process is complex and, in many cases, may involve high levels of anxiety, making this period the most propitious for the development of psychological disorders, particularly, Anxiety Disorders, the most prevalent disorders in children and adolescents (Alyahri & Goodman, 2008; Cartwright-Hatton, McNicol & Doubleday, 2006). In addition to Anxiety Disorders, adolescents are highly vulnerable to other psychiatric disorders, including Major Depressive Disorder (Lewinsohn, Zinbarg & Seeley, 1997) and Attention deficit hyperactivity disorder (ADHD) (Kendall, Brady & Verduin, 2001).

Given the high prevalence, the serious consequences and the high social spending, it is crucial to develop and invest in reliable assessment methods to define reliable diagnosis for research, prevention and objective and structured treatment (Breinholsta, Esbjørna, Reinholdt-Dunnea & Stallard, 2012).

The Anxiety Disorders Interview Schedule for Children (ADIS-C; Silverman & Albano, 1996) has shown its efficacy and reliability in several international investigations. This is the first Portuguese study of the ADIS-C psychometric properties, namely, concurrent validity, inter-rater agreement and the acceptability assessed by adolescents.



METHOD

PARTICIPANTS

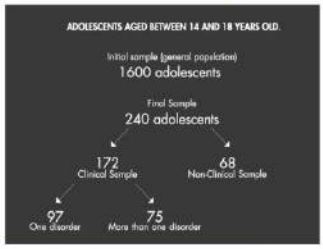


Table 1. Distribution of diagnosis by gender.

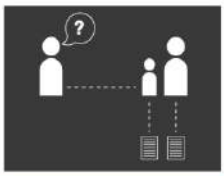
Diagnosis	Gender		Total
	Male n (%)	Female n (%)	n
Non-clinical population	42 (61.76)	26 (38.24)	68
Anxiety Disorders	55 (32.35)	115 (67.65)	170
Generalized Social Phobia	30 (32.61)	62 (67.39)	92
Specific Social Phobia (Test Anxiety)	9 (27.27)	24 (72.73)	33
Mood Disorders	2 (11.11)	16 (88.89)	18
ADHD	2 (22.22)	7 (77.78)	9

MEASURES

Diagnostic Interview: Anxiety Disorders Interview Schedule for DSM-IV: Child Version - ADIS-C; Silverman & Albano, 1996).

Self Report Questionnaires: Social Anxiety and Avoidance Scale for Adolescents (SAAS-A; Cunha, Pinto Gouveia, Salvador, & Alegre, 2004); Reaction to Test (RT; Saranson, 1984); Multidimensional Anxiety Scale for Children (MASC; March, Parker, Sullivan, Stallings, & Conners, 1997); Children's Depression Inventory (CDI; Kovacs, 1985); Youth Self-Report (YSR; Achenbach, 1991c); Acceptability of the clinical interview (Sørensen, Thomsen & Bilenberg, 2007).

Parent and Teacher Report Questionnaires: Child Behavior Checklist (CBCL; Achenbach, 1991a); Teacher Report Form (TRF; Achenbach, 1991b).



RESULTS

CONVERGENT VALIDITY

GENERALIZED SOCIAL PHOBIA AND SPECIFIC SOCIAL PHOBIA (TEST ANXIETY)

Table 2. Correlations between the diagnosis of Generalized Social Phobia, Specific Social Phobia (Test Anxiety) and the scores obtained in Self Report and Parent and Teacher Report Questionnaires.

	Generalized Social Phobia
SAAS-A	.526*
CBCL	
Social Problems	.042
Isolation	.042
TRF	
Social Isolation	.094
Social Problems / Unpopular	-.102
	Specific Social Phobia (Test Anxiety)
RT_total	.197**

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

ANXIETY DISORDERS, MOOD DISORDERS AND ATTENTION DEFICIT HYPERACTIVITY DISORDER

Table 3. Correlations between the diagnosis of Anxiety Disorders, Mood Disorders, Attention deficit hyperactivity disorder and the scores obtained in Self Report and Parent and Teacher Report Questionnaires.

	Anxiety Disorders
MASC	.393*
CBCL	
Anxiety	.099
TRF	
Anxiety	.082
	Mood Disorders
CDI	.235*
CBCL	
Depression	.350**
	ADHD
YSR_Attention Problems / Hyperactivity	.271**
CBCL	
Hyperactivity/Attention Problems	.169

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

DIVERGENT VALIDITY

ANXIETY AND SOCIAL AVOIDANCE, SOCIAL DIFFICULTIES AND GENERAL ANXIETY

Table 4. Correlations between the diagnosis of Mood Disorders and ADHD and the scores obtained in Self Report and Parent and Teacher Report Questionnaires of anxiety and social avoidance, anxiety testing, general anxiety, social difficulties and isolation.

Diagnosis	MASC	SAAS-A	RT	CBCL_ Anxiety	CBCL_Social Problems	CBCL_ Isolation	TRF_ Anxiety	TRF_Social Problems	TRF_ Isolation
Mood Disorders	.073	.035	.026	.262**	.260**	.071	.312**	.340*	.149
ADHD	-.030	-.054	.106	.107	.075	-.085	.056	.143	-.151

*p<.01; **p<.05

DEPRESSIVE SYMPTOMATOLOGY

Table 5. Correlations between the diagnosis of Generalized Social Phobia, Specific Social Phobia, Anxiety Disorders and ADHD and the scores obtained in Self Report and Parent Report Questionnaires in measures of depressive symptomatology.

Diagnosis	CDI	CBCL_Depression
Generalized Social Phobia	.421*	.067
Specific Social Phobia	-.005	-.067
Anxiety Disorders	.325*	-.015
ADHD	.182**	.141

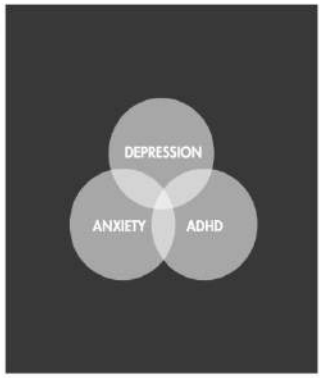
*p<.001; **p<.01

ATTENTION PROBLEMS AND HYPERACTIVITY

Table 6. Correlations between the diagnosis of Generalized Social Phobia, Specific Social Phobia, Anxiety Disorders and Mood Disorders and the scores obtained in Self Report and Parent Report Questionnaires in measures of Attention Problems / Hyperactivity.

Diagnosis	YSR_ Attention Problems / Hyperactivity	CBCL_ Hyperactivity/Attention Problems
Generalized Social Phobia	-.026	-.177
Specific Social Phobia	.033	.033
Anxiety Disorders	.091	-.182
Mood Disorders	-.009	.244*

*p<.05

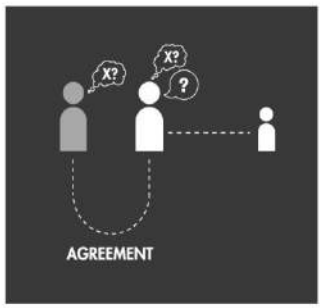


INTER-RATER AGREEMENT

Table 7. Kappa Coefficient of the interrater agreement.

Diagnosis	n Principal Interviewer	n Observer	K
Without Diagnosis	58	57	.901*
Anxiety Disorders	58	56	.935*
Generalized Social Phobia	22	20	.891*
Specific Phobia	24	24	.819*
Specific Social Phobia (Test Anxiety)	16	15	.879*
Generalized Anxiety Disorder	5	5	.786*
ADHD	5	5	1.000*
Separation Anxiety Disorder	4	3	.851*
Mood Disorders	5	5	1.000*

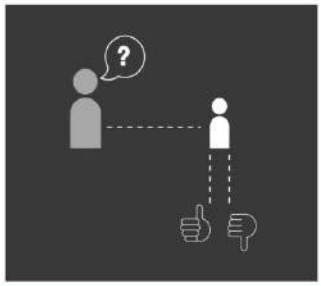
*p<.001



ACCEPTABILITY OF THE CLINICAL INTERVIEW ADIS-C, BY ADOLESCENTS

Table 8. Adolescents' evaluation of the interview.

Acceptability of the interview (n=122)	n (%)
Tiredness	
Very tired	0 (0)
A little tired	19 (14.4)
Not tired	112 (85.6)
Annoyance	
Very boring	0 (0)
A little boring	12 (9.8)
Not boring	110 (90.2)
Way to talk about himself	
A very good way	80 (60.6)
A fairly good way	49 (31.1)
Not a good way	3 (2.3)
Feelings after the interview	
Worse than before	0 (0)
As before	91 (68.9)
Better than before	41 (31.1)



CONCLUSION

ADIS-C in adolescents showed good concurrent validity, inter-rater agreement and acceptability. These results seem to indicate accuracy generate valid, reliable and trustworthy diagnoses, contributing to both research and clinical practice.

This study also reveals other important results:

- Both Parents and Teachers failed to recognized anxiety problems and behavior problems not yet diagnosed. Since adolescents depend on caregivers to be clinically referred, this may hinder their possibility of getting professional help.
- Parents seem to misperceive mood disorders as hyperactivity and attention deficit problems, which is in line the expressivity of mood disorders in children and adolescents.

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Development of the Exposure to Combat Severity Scale of the Combat Experiences Questionnaire (QEC)

Teresa Carvalho [1,2], **Marina Cunha** [1,2], & **José Pinto-Gouveia** [1]

(teresacarvalho.psi@gmail.com) (marina_cunha@ismt.pt) (jpgouveia@fpce.uc)

1- CINEICC, Faculty of Psychology and Educational Sciences of the University of Coimbra, Portugal

2- Higher Institute Miguel Torga, Coimbra, Portugal

I) INTRODUCTION

Several empirical studies show that combat exposure has a positive association with Post-traumatic Stress Disorder (PTSD) in war veterans populations (King, King, Vogt, Knight, & Samper 2006; Koenen, Stellman, Stellman, & Sommer, 2003), being an important risk factor for this disorder (Schnurr, Lunney, e Sengupt, 2004). Longitudinal studies confirm the long-term impact of those experiences in the military physical and mental health as well as in their longevity (Elder, Shanahan, & Clipp; 1997; Lee, Vaillant, Torrey, & Elder, 1995).

This study aimed to develop the first section (QEC A) of a new self-report measure, the Combat Experiences Questionnaire (QEQ), and investigate its psychometric properties on Portuguese Colonial War veterans. This independent scale assesses the severity of exposure to objective and typical combat situations.

II) METHOD

2.1. Participants

The structure and divergent validity of QEC A was explored in a group of 708 males from the general population of Portuguese Colonial War veterans initially recruited through personal contacts (convenient sampling). The subsequent contacts were obtained through snowball sampling. Test-retest reliability was assessed in a subset of 112 participants. In order to assess discriminant validity, a clinical group of war veterans with PTSD (N = 40) and a non-clinical group without PTSD from the general population of Portuguese Colonial War veterans (N = 47) were established based on a structured diagnostic interview, the Clinician Administered PTSD Scale (CAPS; Blake, et al., 1995). The latter two samples do not significantly differ concerning age, $t_{(85)}$ = .69; p = .492, and missions time, $t_{(85)}$ = -.43; p = .672. Significant difference were found in years of education, $t_{(85)}$ = 2.39; p = .019, with the clinical group with PTSD being less educated (M = 5.62) than the non-clinical group without PTSD (M = 7.45).

Sample characteristics are presented in Table 1.

Table 1. *Sample characteristics*

	Group From the General Population of Veterans (N = 708)				Clinical Group With PTSD (N = 40)				Non-Clinical Group Without PTSD (N = 47)			
	M	*DP*	Min	Max	*M*	*DP*	Min	Max	*M*	*DP*	Min	Max
Age	63.38	5.00	50	83	64.03	4.02	58	77	64.68	4.74	57	74
Years of education	7.81	4.28	2	22	5.62	3.04	4	16	7.45	3.92	4	17
Missions time (months)	20.36	18.66	1	172	26.14	10.64	11	85	21.30	11.33	4	72

Note. Min = Minimum; Max = Maximum.

2.2. Items development

The 23 items of the QEC A were developed in collaboration with two army officers who had completed several missions in operations theaters of Portuguese Colonial War (Angola, Mozambique, Guinea and India). This task was also based on the literature review, international questionnaires with similar purposes and clinical experience. Response categories were generated from a continuous scale converted into quantitative intervals sequentially ordered and scored in a 6-point response scale (ranging from 0 to 5 points). Quantitative intervals vary over the items according to the frequency of occurrence of situations. However, the response scale is constant over the items, namely: zero corresponds to *not have been exposed* and 5 degrees of intensity are available to be reported by subjects who were exposed. The scale was subsequently administered to 30 war veterans to assess items adequacy and comprehensibility.

2.3. Instruments

PTSD Checklist-Military Version (PCL-M; Weathers, Litz, Huska, & Keane, 1994; Portuguese version by Carvalho Cunha, Pinto-Gouveia, & Duarte, 2013): 17-items self-report questionnaire that measures, in a 5-point scale, the severity of PTSD symptoms according with *DSM-IV*:*DSM-IV-TR* (APA, 1994, 2000). In our samples the PCL-M showed adequate internal consistency for the group from the general population of war veterans (α = .96), clinical group with PTSD (α = .88) and non-clinical group without PTSD (α = .94).

Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Portuguese version by Vaz Serra & Abreu, 1973): 21-items self-report instrument that assesses depressive symptoms. In this study we obtained an internal consistency of α = .94, α = .89 and α = .93 for the group from the general population of war veterans, clinical group with PTSD and non-clinical group without PTSD, respectively.

Anxiety and Stress Scales of DASS-21 (Lovibond & Lovibond, 1995; Portuguese version by Pais-Ribeiro, Honrado, & Leal, 2004): the DASS is a 21-items self-report measure designed to assess three dimensions of psychopathological symptoms: depression, anxiety and stress. In the present study we used the anxiety and stress subscales that showed adequate internal consistency for the group from the general population of war veterans (α =.88 for the anxiety subscale; α =.93 for the stress subscale), clinical group with PTSD (α =.89 for the anxiety subscale; α =.83 for the stress subscale) and non-clinical group without PTSD (α =.86 for the anxiety subscale; α =.91 for the stress subscale)

Clinician–Administered PTSD Scale (CAPS; Blake et al., 1995; Portuguese version by Pinho & Coimbra, 2003): is a structured clinical interview designed to diagnose current (and lifetime) PTSD. In this study, a current PTSD symptom is considered present if the item has a frequency of at least 1 (*once or twice*) and an intensity of 2 (*moderate*) or more. This scoring rule works better for differential diagnosis since it minimizes overall numbers of diagnostic errors by giving equal weight to false positives and false negatives (Weathers, Ruscio, & Keane, 1999).

2.4. Procedures

All the participants received the self-report protocol, a description of the study aims and an informed consent form in person or by mail (including stationary envelopes). From the 2.522 questionnaire packs delivered, 28.07% (708) were successfully completed and returned. To assess test-retest of the PCL–M, a sub–group of participants filled out the questionnaire a second time, 21 to 35 days after the first administration. Participation was voluntary and research ethical principles were attained.

III) RESULTS

3.1. Structure Analysis Using Rasch Model

Rasch Model (RM) was used to assess the uni-dimentional structure of QEC A because response categories (intervals of exposure frequency) vary over the items. For this reason the usual Classical Test Theory (CTT) did not apply. The RM provides standard fit statistics including item and person (Infit and Outfit MNSQ) to examine the model-data fit. The Outfit statistic is the average of the squared standard deviations between observed and expected performance and is sensitive to outliers. Items with high Outfit statistics have more noise than signal. Infit is an information-weighted fit statistic that is sensitive to overall item performance. Items with high Infit statistics are overly predictable from the other items in the measure. According to Linacre (2006), fit statistics > 2.0 degrade the measurement; from 1.5 to 2.0 are unproductive for measurement construction; from 0.5 to 1.5 are productive for measurement; and < 0.5 are less productive for measurement, but not degrading.

QEC A: MODEL 1

The first model of QEC A (Model 1) tested involved all subjects and the 23 original items of the scale.

Global fit statistic (Model 1)

For this model we started by analyzing the global fit statistic for subjects and items. Regarding the adjustment for subjects, we obtained appropriate average values for Infit (M = 1.02, SD = 0.51) and Outfit (M = 0.98, SD = 0.86).The maximum values of Infit and Outfi inform about the existence of subjects whose results do not fit the model. This was only observed in 0.95% of the sample. The amplitude of combat exposure (measure) ranged from -3.64 to 0.84 logits.

With respect to items, the average values of Infit (M = 1.14, SD = 0.52) and Outfit(M = 1.32, SD = 1.04) are also adequate. The items have a maximum Infit of 2.80, indicating the existence of at least one item with poor fit. The logits rage from -1.29 to 3.20. The model error is low, ranging from .03 to .27. To sum, items have conditions to produce an appropriate measurement, with good psychometric properties.

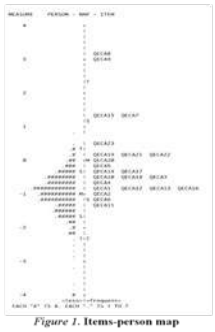

Figure 1. **Items-person map**

Items-person map (Model 1)

Items-person map provides a comprehensive and integrated understanding of the test, ranking subjects and items along a continuum measurement interval. Figure 1 allows to visualize the distribution of subjects and items for the measure (θ) – combat exposure. The subjects, represented by #, are displaced downward from the midpoint of the measurement (zero logits) while the mean of the subjects was -0.99 logits (positive asymmetrical distribution). Thus, the items have the capacity to represent a higher exposure intensity than the one reported by the subjects of the sample. Consequently, new items could have been developed to represent lower intensity of combat exposure. However, the 23 items include all combat situations theoretically and clinically relevant. The items 8 (related to being a prisoner of the enemy) and 9 (related to being a victim of mistreatment and cruelty) correspond to higher degrees of exposure. The distance between these items and the following ones (7 and 15) indicates that if they were removed, the intensity of exposure would be estimated with greater error. Some items are laterally positioned measuring the same intensity of combat exposure. Some of these items could be excluded. However at this stage, no items were excluded because each one had a specific theoretical meaning and a unique place in the construct mapping.

Items Fit Statistic (Model 1)

Twenty-one items present Infit values below 2.0 (ranging from 0.73 to 1.59) and Outfit values ranging between 0.73 and 1.54. For items 8 and 9 Infit values are 2.80 and 2.56 and Outfit values are 4.46 and 4.48, respectively. This situation can result from the fact that these two items report rarer situations with low representation in the sample. Given its importance in the construct mapping and its theoretical and clinical relevance we decided to examine an alternative solution which includes its maintenance on the scale (Model 2 presented below). However, data globally support the conclusion from global fit statistic: taken as a whole the scale presents good psychometric properties.

Response categories Fit Statistic (Model 1)

Fifteen of the 23 items showed adequate response options performance (items 1, 3, 4, 6, 7, 10, 11, 12, 13, 15, 16, 17, 18, 19 and 21). Each of these items showed: a) a monotonic growth measure (θ) - combat exposure - over the 6-points scale (ranging from 0 to 5) reaching the lowest value in the response option "0" and the higher one in the option "5", (b) an Infit value less than 2; (c) a correlation (r) between the measure and the 6-points scores starting with high or moderate negative correlation in the lowest option (0) and ending with high or moderate positive correlation in the highest option (5). In the remaining 6 items (2, 5, 14, 20, 22 and 23) ordination of θ is not monotonic. Categories with approximate values of θ were aggregated. Thus, a good performance was found for all categories.

QEC A: Model 2

In Model 1 the items 8 and 9 were the ones with Infit values greater than 2. Given its described relevance, in this model (Model 2) the information of these two items was aggregated (item 8 ∪ item 9). Response categories formerly aggregated were maintained (Model 1). The scores of new item 8∪9, correspond to the highest score observed in the 2 items. We had previously identified 0.95% subjects with Outfit scores greater than 2 (outliers), who were excluded from the analysis. The exclusion of these subjects can improve the fit model (Linacre, 2006).

Global fit statistic (Model 2)

In Model 2, the global fit statistic preserved an adequate mean and standard deviation of Infit. For items, the maximum Infit value was 2.03, very close to the critical value of 2 proposed by Linacre (2006). So, this model suggests a better global fit of the QEC A. The global fit measures are presented in Table 2.

Table 2. *Global fit statistic (Model 2)*

		Measure	Model Error	Infit	Outfit
Subjects fit	*M*	-0.89	.21	1.02	1.01
	DP	0.66	.07	0.48	0.77
	Maximum	0.99	.88	3.28	9.90
	Minimum	-3.58	.18	0.25	0.23
Items fit	*M*	0.00	.05	1.04	1.22
	DP	0.99	.04	0.32	0.58
	Maximum	3.19	.24	2.03	3.58
	Minimum	-1.19	.03	0.74	0.76

Items and response categories fit statistic (Model 2)

The item 8∪9 showed an acceptable Infit value of 2.03. The other items showed adequate fit values (ranging from 0.74 to 1.65). Response options also presented satisfactory results, with all items meeting the listed requirements.

3.2. Test–retest Reliability

Test-retest reliability was studied in a sub-group of 112 veterans who completed the QEC A in a 21 to 35 days interval after the first administration (M = 24.26 days). Pearson product–moment correlation coefficient between test and retest was .94, which indicates high temporal stability.

3.3. Convergent Validity

Regarding convergent validity, the QEC A was, as hypothesized, positively and significantly correlated with PTSD symptoms (PCL-M), depression (BDI), anxiety (DASS-anxiety subscale) and stress (DASS-stress subscale). As expected, a higher association was obtained with PTSD symptoms (Table 3).

Table 3. *Pearson correlations between the QEC A and symptoms measures*

	Symptoms Measures			
	PCL-M PTSD Symptoms	BDI Depression Symptoms	DASS21 Anxiety Symptoms	DASS21 Stress Symptoms
QEC A	.44**	.26**	.25**	.26**

Note. ** p <.001.

3.4. Discriminant Validity

To study the QEC A ability to discriminate patients with a diagnosis of war-related PTSD disorder, we compared the clinical group of Portuguese Colonial War veterans with this disorder (N = 40) and the non-clinical group without PTSD from the general population of Portuguese Colonial War veterans (N = 44). Both groups were clinically assessed by a trained therapist using the CAPS, a structured interview for PTSD diagnosis. The patients' QEC A scores mean was 45.34 (SD = 16.95), whilst the non-clinical group' mean was 34.77 (SD = 14.77). T-tests showed significant differences between the groups, $t_{(85)}$ = -3.11, p = .003, with PTSD patients reporting a higher severity of combat exposure than the veterans without PTSD.

IV) DISCUSSION

The structure of QEC A presents an adequate fit to the data, after aggregation of certain response categories and the information from two items. The QEC A reveals excellent test-retest reliability and significant correlations with PTSD, depression, anxiety and stress symptoms. It shows a good capacity to discriminate between veterans with and without war-related PTSD symptoms. To sum up, this scale was found to be a valid and reliable measure to assess the severity of exposure to objective and typical combat situations. Future studies should confirm these results.

Future clinical application of this self-report measure to veterans populations, particularly to the Portuguese Colonial War veterans, will enable a more complete clinical assessment and a consequent maximization of therapeutic gains.

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The Self and Other Scale: a second step toward its French validation in patients with depression

Adriano Zanello, Sandra Huri and Jean-Pierre Bacchetta

University Hospitals of Geneva, Department of Psychiatry and Mental Health
and University of Geneva, Faculty of Medicine, Academic Psychiatric Department, Geneva, Switzerland

BACKGROUND

- The construction of the schema of the *Self* emerges from repeated self-other social interactions (Beck et al 1979). The fear of exclusion, indifference and rejection or intrusion and control by significant others threaten to achieve an optimal *Self*, leading respectively to the *Insecure Self* and to the *Engulfed Self* construction (Trower and Chadwick, 1995).

- To assess *Insecure and Engulfed Self* dimensions, Dagnan et al 2002 have developed a short self-administered instrument: the Self and Other Scale (SOS). There are two versions of the SOS (frequency, endorsement). The French endorsement version of the SOS has good psychometric properties (Zanello et al 2012). However, little is known on the relation between the SOS and other instruments.

- In the present study we examined the association of the SOS with others measures of symptoms, of clinical outcome, of attachment style and personality.

RESULTS

As shown in Table 1:

- Higher Insecure Self scores are positively related to psychiatric symptoms of depression (MADRS, p<.001), of phobic anxiety-BSI (p<.001) and of psychoticism-BSI (p=.017) as well as negatively associated with the openness dimension of BFI (p=.027)

- Higher Engulfment Self Scores are related to the Obsessive-Compulsive (p=.03) and Paranoid Ideation (p=.03) dimensions.

- No other correlation reached statistical significance.

	SOS	
	Insecure Self	Engulfed Self
Measures		
Psychiatric Symptoms		
MADRS	.56***	.17
HAMA	.24	.23
BSI		
Obsessive-Compulsive	.04	.36*
Interpersonal Sensitivity	.18	.21
Depression	.31	-.05
Anxiety	.04	.30
Hostility	.14	.20
Anxiety	.58***	.14
Paranoid Ideation	.16	.36*
Psychoticism	.42*	.29
Somatization	.17	.31
Clinical Outcome		
HONOS	.14	.26
GAF	-.18	-.17
CGI	.34	-.03
Attachment Style (AAS)		
Close	.16	.16
Dependent	.28	.19
Anxiety	.07	-.34
Personality (BFI)		
Extraversion	-.06	-.31
Agreeableness	-.27	-.18
Conscientiousness	-.14	-.30
Neuroticism	.15	.30
Openness	-.40*	-.12

METHOD

Patients

Thirty-two outpatients (21 women) with mood disorders according to ICD-10 (mean age=38.22, SD=11.73 years) were administered the SOS as well the Montgomery-Åsberg Depression Rating Scale (MADRS), the Hamilton Anxiety Scale (HAMA), the Brief Symptom Inventory (BSI), the Health of the Nation Outcome Scales (HONOS), the Global Assessment of Functioning (GAF), Clinical Global Impression (CGI), the Adult Attachment Scale (AAS) and the Big Five Inventory (BFI). The assessments were completed at intake in a centre specialized in crisis treatment.

Analyses

The relationship between the SOS and the other measures were analysed with the Spearman's rho coefficient.

Discussion

In patients with mood disorders, Insecure Self and Engulfed Self dimensions :
- are differentially related to psychiatric symptoms.
- are not associated to close theoretical constructs, such attachment and personality dimensions
- seem to be unrelated to the current global social and clinical functioning.

Limitations

There are some limitations preventing the generalization of the findings:

- the sample size
- the lack of non-clinical and clinical control groups
- the lack of measures related to Self (e.g. Self-Esteem)
- the lack of interpersonal measures

Clinical Implications

The SOS may be helpful to identify self construction treats and to recognize them when they emerge in the therapeutic alliance in order to tailor the interventions accordingly.

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e.mail adress: adriano.zanello@hotmail.ch

Cognitive-behavioural dysfunctions

Unwanted intrusive thoughts in OCD and ED patients: which variables predict the experienced *disruption*?

[1] Gemma García-Soriano; [1] Amparo Belloch; [1] María Roncero; [1,2] Conxa Perpiña
[1] Universitat de València (Spain); [2] CIBER Fisiopatología de la obesidad y Nutrición (CIBEROBN).
Contact e-mail: gemma.garcia@uv.es

INTRODUCTION

Unwanted clinically relevant intrusive thoughts (or images or impulses) are described as unwanted, unintended, recurrent, disrupting the ongoing activity, and difficult to control (Clark, 2005). Those intrusions are present in different mental disorders, Obsessive-Compulsive (OCD) and Eating (ED) Disorders among others. Intrusions present in OCD are related with aggressive, sexual/ immoral, doubt about mistakes, order, or contamination concerns; whereas ED intrusions are related with body and food. Little effort has been devoted to analyze differences and similarities between both kinds of intrusions.

AIM

To analyze which variables predict the disruption caused by the most disturbing intrusion in two clinical samples: OCD and ED patients. Specifically addressing the following questions:

- Do intrusions misinterpretation and control strategies predict the disruption associated with OCD and ED intrusions?
- Are there differences in the variables that predict disruption in OCD and ED patients?

METHOD

79 OCD patients (mean age = 34.75 (*SD* = 11.99) years old)

Completed the INPIOS (Obsessional Intrusive Thoughts Inventory)

Participants indicate the **FREQUENCY** with which 48 **unwanted OBSESSIVE intrusive thoughts**, images and impulses were experienced during the past *3 months* related to aggressive; sexual/religious/immoral; contamination; doubts/mistakes, symmetry/order; superstition OITs.
From 0 ("*I have never had this intrusion*") to 6 ("*I have this intrusion frequently during the day*")

177 ED patients (mean age = 26.67 (*SD* = 9.34) years old)

Completed the INPIAS (Eating Intrusive Thoughts Inventory)

Participants indicate the **FREQUENCY** with which 50 **unwanted EATING Disorder-related intrusive thoughts**, images and impulses were experienced during the past *3 months* related to dieting, body appearance and the need to do exercise.
From 0 ("*I have never had this intrusion*") to 6 ("*I have this intrusion frequently during the day*")

➢ Participants select from the previous list the single **MOST UPSETTING INTRUSION** they had experienced during the last 3 months.

➢ Participants evaluate the **intrusion** across several **DIMENSIONS** from 0 (*not at all*) to 4 (*extreme*):
- emotional reactions
- interference
- dysfunctional appraisals *(i.e., importance of the thought, thought-action fusion (TAF)-moral, personal significance, TAF-likelihood, responsibility, importance of control, over-estimation of threat, and intolerance to uncertainty).*

➢ Participants record how often (0 "*never*" to 4 "*always*") they used a list of **CONTROL STRATEGIES** to get rid of the intrusion:
- general strategies to control anxiety
- covert thought control strategies
- distraction
- overt compulsions
- do nothing

➢ In order to compare the disturbance of the most upsetting intrusion both using INPIOS and INPIAS a new variable was generated

DISRUPTION score:
the mean of : "*how unpleasant was the intrusion*" and at "*what extent interrupted concentration*".
It indicates the degree in which the intrusion is unpleasant and interrupts or interferes in their thought and/ or task performance.

RESULTS

A series of separate hierarchical multiple regression analyses were conducted for each sample.

OCD sample
DV: disruption of their most disturbing obsessional intrusion
IV:
Step 1: Appraisals
Step 2: Emotional Reactions
Step 3: Control strategies
→ 39.3 % disruption variance

ED sample
DV: disruption of their most disturbing eating disorder-related intrusion
IV:
Step 1: Appraisals
Step 2: Emotional Reactions
Step 3: Control strategies
→ 47.2 % disruption variance

With the following variables entering as significant individual predictors in the last model:

- difficulty controlling the thought
- control importance
- intolerance to uncertainty

- difficulty controlling the thought
- importance of the thought
- negative emotional reaction

Table 1. Summary statistics for the final step of the regression equations predicting the disruption caused by the main obsession in the OCD and ED groups.

	β	t	p
Predicting OIT disruption in OCD sample			
Control difficulty	.332	3.476	.001
Control importance	.301	3.197	.002
Intolerance to uncertainty	.283	3.047	.003
Predicting EDIT disruption in ED sample			
Control difficulty	.324	5.216	<.001
Importance of the thought	.287	4.353	<.001
Intolerance to uncertainty	.091	1.569	.119
Negative emotional reaction	.254	4.164	<.001
Compulsions	.129	2.315	.022

DISCUSION

A similar percentage of the variance of the obsessional and eating disorder-related intrusions' disruption was predicted in both samples.

•**Importance of controlling the thought** explained both samples variance.

•**Control importance** and **intolerance to uncertainty** emerged as relevant in predicting obsessional intrusive thoughts' disruption in OCD patients.

•**Importance of the thought** and **negative emotional reactions** predicted eating disorder-related intrusive thoughts' disruption in ED patients.

The role of intrusions as a transdiagnostic variable requires further investigation.

Knowing the variables that predict the disruption caused by unwanted intrusive thoughts will help clinicians to have a better **psychopathological definition of OCD and ED patients**.

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The Predictive Value of War/Combat Exposure-Related Experiences for Post-Traumatic Stress Disorder (PTSD) Symptoms: A Study with Portuguese Colonial War Veterans

Teresa Carvalho [1,2], **Marina Cunha** [1,2], & **José Pinto-Gouveia** [1]

(teresacarvalho.psi@gmail.com) (marina_cunha@ismt.pt) (jpgouveia@fpce.uc)

1- CINEICC, Faculty of Psychology and Educational Sciences of the University of Coimbra, Coimbra, Portugal

2- Higher Institute Miguel Torga, Coimbra, Portugal.

INTRODUCTION

The association between related to war/combat exposure experiences, particularly war-zone stressors, and the development of Post-traumatic Stress Disorder (PTSD) symptoms is largely mentioned in literature. Examples of these stressors are the severity of the traumatic event (Brewin, Andrews, & Valentine., 2000), situations involving subjective distress (King, King, Gudanowski, & Vreve, 1995), personal threats, discomfort regularly or daily felt in face of adverse events or circumstances (King, King, Foy, Keane, & Fairbank, 1999; King, King, Gudanowski, & Vreven, 1995), dissociation (Ozer, Best, Lipzey & Weiss, 2003) and duration of war exposure (McTeague, McNally, & Litz., 2004). In the cited studies these variables have often been studied in war veterans populations as predictors or risk factors for PTSD. On the contrary, the unit cohesion/social support has a protective role in the veterans' health and well-being (McTeague et al., 2004).

Little is known about the relationship between such variables and current PTSD symptoms in Portuguese colonial war veterans. Thus, this study aims to analyze in a sample of this population of veterans a predictive model composed by the following variables: missions time, missions number, severity of exposure to stereotyped situations of Portuguese Colonial War and consequent emotional distress, exposure to repeated stressors resulting from the war-zone environment, perceived threat, peritraumatic dissociation and deployment social support.

METHOD

Participants

A sample of 650 males from the general population of Portuguese Colonial War veterans was collected. Participants were initially recruited as a convenient sample, through personal contacts. The subsequent contacts were obtained by snowball sampling. In order to test in this sample the validity of the methodology used to assess war-related PTSD (by self-report instruments according to *DSM-IV/DSM-IV-TR* diagnostic criteria) and to select the variables to be included in the predictive model, sub-groups without and with PTSD were identified (n = 532; n = 118, respectively). For the first purpose (validation of PTSD diagnostic methodology), a clinical sample of 40 war veterans with war-related PTSD from several outpatient psychiatric services was also recruited. These patients were clinically assessed through a structured diagnostic interview, the Clinician Administered PTSD Scale (CAPS), and compared with the sub-group with PTSD from the general population of veterans.

No significant differences between sub-groups without and with PTSD were found for age, $t_{(648)} = 1.89$, $p = .059$, missions time (months), $U = 29199.00$, $z = -1.19$, $p = .233$, and missions number, $U = 30797.50$, $z = -0.67$, $p = .504$. These sub-samples showed statistically significant differences in years od education, $t_{(196.38)} = 5.33$, $p = < .001$.

The PTSD sub-group and the clinical sample with PTSD did not significantly differ regarding age, $t_{(150)} = -1.87$, $p = .063$, years of education, $t_{(156)} = 0.51$, $p = .614$, months of exposure to combat zone, $U = 2235.00$, $z = -0.50$, $p = .614$, and missions number, $U = 2317.00$, $z = -0.41$, $p = .684$.

Sample characteristics are presented in Table 1.

Table 1. *Sample characteristics*

	General Population of Veterans (N = 650)				Sub-group without PTSD (n = 532)				Sub-group with PTSD (n = 118)				Clinical Sample with PTSD (N = 40)			
	M	*SD*	Min	Max	*M*	*SD*	Min	Max	*M*	*SD*	Min	Max	*M*	*SD*	Min	Max
Age	63.31	4.99	53	83	63.48	5.07	53	83	62.53	4.56	55	74	64.05	4.11	58	77
Years of education	7.92	4.31	2	20	8.30	4.35	2	20	6.23	3.69	2	16	5.90	3.14	4	16
Missions time (months)	28.81	18.86	2	172	29.12	19.43	2	172	27.44	16.08	4	117	26.91	10.57	11	85
Missions number	1.19	0.69	1	5	1.19	0.71	1	5	1.15	0.62	1	5	1.10	0.30	1	4

Note. Min = Minimum; Max = Maximum.

Instruments

Social and Clinical Characterization Questionnaire of Portuguese Colonial War veterans (Carvalho, Cunha, & Pinto–Gouveia, 2010): self–report instrument designed to collect personal, military and clinical information regarding the current period, the period before the first military mission and the period in accomplished military missions. In this study personal and military information was used as well as clinical data regarding to the presence of the *DSM-IV/DSM-IV-TR* Criterion A2 (APA, 1994, 2000).

PTSD Checklist-Military Version (PCL-M; Weathers, Litz, Huska., & Keane, 1994; Portuguese version by Carvalho et al., 213a, 213b): this is a 17-items questionnaire that refers to the 17 PTSD symptoms outlined in *DSM–IV/DSM-IV-TR* (APA, 1994, 2000). It can be used as a continuous measure to assess symptoms' intensity and as a dichotomous measure to assess actual PTSD diagnosis (in last month). The combination of these procedures is required to obtain a PTSD diagnosis. In order to achieve a positive PTSD diagnosis (at least 1 Re-experiencing item, 3 Avoidance items, and at least 2 Hyper arousal items), the authors of Portuguese version suggest an optimal cutoff point of 49 for the PCL–M total score and cutoff points for each of its 17 items are also recommended.

Questions assessing the presence of de DSM-IV/DSM-IV-TR Criterion F (APA, 1994, 2000): significant distress/functional impairment related to PTSD symptoms was evaluated by three self-report questions developed for this purpose. The questions assess, in a 5-point scale (0 – *do not upset me*; 5 – *extremely upset me*), the family, social and employment/occupational living areas. We considered that the distress or functional impairment is significant when respondents endorsed at least one living area with a 4-point response (*upset me quite a bit*) or more.

Combat Experiences Questionnaire (QEC; Carvalho et al., 2013d; 2013e): this is a self-report measure comprising two independent sections (QEC A and B) formed by the same 23 items designed to assess the severity of exposure to objective and typical combat situations of Portuguese Colonial war (QEC A) and consequent emotional distress that occurred during wartime (QEC B). In the current study, the QEC showed good internal consistency for the general population of war veterans and clinical group (QEC A: α = .88 and α = .87, respectively ; QEC B: α = .91 and α = 81, respectively).

Difficult Living and Working Environment Scale-Modified Version (DLWES-M; King, King, & Vogt, 2003; King, King, Vogt, Knight, & Samper, 2006; modified version by Carvalho et al., 2011a): this is a 20-items self-report scale of the Deployment Risk and Resilience Inventory (DRRI). It assesses the exposure to events or circumstances representing repeated or day-to-day annoyances and pressures related to life in war zone (especially in combat zone at the stage of forces employment). Internal consistency in this study was α = .88 and α = .70 respectively for general population of veterans and clinical group.

Perceived Threat Scale-Modified Version (PTS-M; King et al., 2003, 2006; modified version by Carvalho et al., 2011b; 2013c): 15-items self-report questionnaire of DRRI that assesses the perceived threat to security and personal well-being in a theatre of military operations, reflecting emotional or cognitive appraisals of situations that may or may not accurately represent objective or factual reality. The Portuguese modified version adapted to Portuguese Colonial War is comprised of two dimensions: the Combat Threats assesses the perception of threats arising from the potential exposure to situations resulting directly from combat (employment of forces in combat zone) and the Non-Combat Threats measures the fear in face of potential exposure to circumstances perceived by war veterans as non-combat operations but that may occur in the stages of preparation, deployment and employment of force (e. g.: ingestion of improper for consumption water, accidents). In this study adequate Cronbach's alphas were found (general population of veterans: the Threats Combat subscale shows a α = .80 and the Non-Combat Threats subscale a α = .71; clinical sample: α = .82 for the Threats Combat subscale and α = .73 for the Non-Combat Threats subscale).

Deployment Social Support Scale (DSSS; King et al., 2003, 2006; Portuguese version by Carvalho et al., 2012): this is a 12-items self-report scale of DRRI that measures the amount of assistance and encouragement in the war zone from the military in general, unit leaders, and other unit members. DSSS showed a Chronbach α = .91 in the veterans general population and an α = .90 in the clinical group.

Peritraumatic Dissociative Experiences Questionnaire (PDEQ, Brooks, Bryant, Silove, Creamer, O'Donnell, McFarlane, & Marmar, 2009; Portuguese version by Carvalho et al., 2013): this self-report measure assesses the dissociation at the time of a traumatic event or immediately after. PDEQ includes two latent factors: Altered Awareness and Depersonalization/Derealization. We obtained for general populations of veterans sample and the clinical group an internal consistency of, respectively, α = .89 and α = .84 for factor Altered Awareness and α = .80 and α = .76 for Depersonalization/Derealization dimension.

Clinician–Administered PTSD Scale (CAPS; Blake et al., 1995; Portuguese version by Pinho & Coimbra, 2003): is a structured clinical interview designed to diagnose PTSD. In this study, a current PTSD symptom is considered present if the item has a frequency of at least 1 (*once or twice*) and an intensity of 2 (*moderate*) or more. This scoring rule works better for differential diagnosis since it minimizes overall numbers of diagnostic errors by giving equal weight to false positives and false negatives (Weathers, Ruscio, & Keane, 1999).

Procedures

All participants received the self-report protocol, a description of the study aims and an informed consent form in person or by mail (including stationary envelopes). From the 2 830 questionnaire packs delivered, 22.97% (650) were successfully completed and returned. Participation was voluntary and research ethical principles were attained.

Analysis procedures will be described together with the results.

RESULTS

Validation of PTSD Diagnostic Methodology

In order to select the variables to be included in the predictive model participants with and without PTSD (n = 118 and n = 532, respectively) from the general population of war veterans (N = 650) were initially identified . As the diagnose of war-related PTSD was assessed in this sample by a self-report instruments that follows all *DSM-IV/DSM-IV-TR* diagnostic criteria (meaning not by a structured diagnostic interview) we analyzed also the validity of this assessment methodology. For this purpose we compared the sub-group with PTSD (n = 118) with the clinical sample with PTSD (N = 40), assessed by CAPS, regarding the PCL-M total, distress or functional impairment (family, social and employment/occupational) and potential predictors under study. The non-parametric alternative to the t-test for independent samples, the Mann-Whitney test, was used when Skewness (SK) and Kurtosis (Ku) values presented a serious bias to normal distribution (SK > |3| and Ku > |10|; Kline, 2005). The t-test with Welch correction is used when t-test normality assumption occurs but homoscedasticity assumption is not verified (Howell, 2007). Results showed no statistically significant differences between the two groups (p-values ranged from .062 to .953). These data confirmed the validity of the methodology used.

Predictive Model

The predictive model was analyzed in the sample of general populations of war veterans (N = 650). To select the variables to include in predictive model we analyzed whether the sub-groups with and without PTSD (n = 118 and n = 532, respectively) presented statistically significant differences regarding PTSD symptoms severity (PCL-M total) and potential predictors under study. The Wilcoxon–Mann–Whitney test (U) was used as non-parametric alternative to the t-Student test (t) when the variables presented SK > |3| and Ku > |10| (Kline, 2005). The t-Student test with Welch correction was used when was used when normality assumption occurs but not homoscedasticity assumption (Howell, 2007). As shown in Table 2, most variables under study showed significant differences between the sub-groups, namely, exposure to war/combat situations (QEC A), consequent emotional distress (QEC B), exposure to stressors in war-zone environment (DLWES), combat threats (PTS), non-combat threats (PTS), altered awareness (PDEQ) and depersonalization/derealization (PDEQ), with PTSD veterans reporting higher mean or median scores.

Table 2. *Means (M), Standard Deviations (SD) and Medians (Md) for sub-groups with and without PTSD and comparison regarding potential predictive variables of PTSD symptoms severity (PCL-M total)*

Variables	Sub-group without PTSD (n = 532)			Sub-group with PTSD (n = 118)			*t/U*	*df/z*	*p*
	M	*SD*	*Md*	*M*	*SD*	*Md*			
QEC A	30.45	15.47	30.00	40.59	16.75	41.00	-6.34	648	.000
QEC B	28.59	15.75	27.00	48.79	17.80	48.00	-12.30	648	.000
DLWES	58.23	14.52	59.00	73.65	12.02	75.00	-12.12	200.40	.000
PTS - Combat Threats	28.49	7.18	30.00	35.58	4.34	37.00	-14.00	279.44	.000
PTS - Non-Combat Treats	19.71	6.70	19.00	25.41	6.15	27.00	-8.84	684	.000
PDEQ - Altered Awareness	6.91	3.60	5.00	12.64	4.60	12.50	-12.69	150.33	.000
PDEQ – Dopersonalization/Dereallization	6.65	3.57	5.00	11.42	4.54	11.00	11799.00	-10.90	.000
DSSS	51.83	8.94	53.00	49.09	10.21	52.00	1. 28	648	.220
Mission Time (months)	29.12	19.43	26.00	24.44	16.08	25.00	29199.00	-1.19	.233
Mission Number	1.19	0.71	1.00	1.23	0.62	1.00	30797.50	-0.67	.504

Previous data concerning potential predictors was confirmed particularly for PTSD symptoms severity (PCL-M total) in the total sample (N = 650). Results of Pearson correlations showed a significant association between PCL-M total and QEC A, QEC B, DLWES, PTS-Combat Threats, PTS-Non-combat Threats, PDEQ-Altered Awareness and PDEQ-Depersonalization/Derealization. Non-significant correlations were found between PCL-M and DSSS, missions time and missions number (Table 3).

Table 3. *Pearson correlations between PCL-M and potential predictors measures in the general population of war veterans sample (N = 650)*

	QEC A	QEC B	DLWES	PTS Combat Threats	PTS Non-Combat Threats	PDEQ Altered Awareness	PDEQ Deper./Derea.	DSSS	Missions Time	Missions Number
PCL-M	.33**	.56**	.56**	.50**	.46**	.67**	.56**	-.05	.05	.06

Note. Deper. = Depersonalization, Derea. = Derealization; **p < .001.

To maximize the model predictive power only the variables/measures that showed significant differences between sub-groups with and without PTSD diagnosis and significantly correlated with PTSD symptoms severity (the same variables) were included into multiple regression analysis (using enter method). Multicollinearity was validated by the Variance Inflation Factor (VIF) values. VIF < 5 indicated the absence of β estimation problems. No evidence of multicollinearity among the variables was found (VIF values ranged from 1.56 to 3.24). Results in Table 4 show that the independent variables related to war-zone stressors produced together a significant model accounting for 58% of the variance in PTSD symptoms severity (dependent variable measured by PCL-M total). In addition, the standardized regression coefficient (or beta weight) revealed the significant independent contribution of each variable to the prediction of the outcome variable when all the other variables in the equation were held constant.

Table 4. *Model summary and standardized coefficient values for multiple linear regressions (enter method) for PTSD symptoms severity assessed by PCL-M total*

	R	R^2	Adjusted R^2	*F*	*P*	Change Statistic			Coefficients		
						R^2 change	*F*	*P*	*β*	*t*	*p*
Model	.76	.58	.58	128.87	.000	.58	128.87	.000			
Constant									-	-1.58	.114
QEC A									-.18	-4.34	.000
QEC B									.37	8.16	.000
DLWES									.17	4.74	.000
PTS - Combat Threats									.07	2.16	.031
PTS - Non-Combat Treats									.09	2.96	.003
PDEQ - Altered Awareness									.32	7.90	.000
PDEQ - Depersonalization/Derealization									.09	2.48	.013

DISCUSSION

This study, pioneer in Portugal, examined the contribution of the predictive value of a set of experiences related to war/Combat exposure for PTSD symptoms severity in a large sample of general population of Portuguese Colonial war veterans. Severity of exposure to war/combat situations, consequent emotional distress, exposure to stressors in war-zone environment, combat and non-combat threats, altered awareness and depersonalization/derealization (variables used in the predictive model) showed an association with PTSD diagnosis and particularly with symptoms severity of this disorder. All together these variables produced a significant model accounting for 58% of the variance in current PTSD symptoms severity. Furthermore, each variable showed a significant independent contribution in the prediction of war/combat-related symptomatology. Overall, these data are consistent with those described in the literature about predictors and risk factors for PTSD in war veterans populations (King et al, 1995, 1999, McTeague et al., 2004; Ozer et al., 2003). Future studies may confirm our results and explore whether the variables involved may be considered as a risk factor for the development and/or maintenance of war-related PTSD symptomatology.

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BURNOUT AND AGGRESSION

A study in residential aged care facilities.

Dadà P.(1), Filipponi L.(2), Pizzo S.(1), Galeazzi A.(1)
(1) Miller Institute, Genoa; (2) Department of Psychology - Univerisity of Padua
paola.dada@alice.it

BACKGROUND

The burnout syndrome expresses a deterioration that affects the values, dignity, spirit and will of the people and expresses that a corrosion of mind (Maslach and Leiter, 1997). This condition causes the person lives within the working environment, a situation of imbalance between what the job requires and what the person can give. The employee feels increasingly inefficient at work and tends to work in a more cynical and detached. The burnout syndrome is very common in relations professionals to help, especially in areas such as health and social care. According to the current terminology these professions are high-touch (continuous contact), they imply, that is, numerous direct contacts with people in difficulty (Maslach and Leiter, 1997). Referring to a research carried out in the Czech Republic (Bužgova & Ivanová, 2011) on the violation of ethical principles in nursing homes for the elderly, it appears that their dissatisfaction with the work environment and the presence of burnout syndrome can lead to the manifestation of aggressive behavior towards the elderly present in the structure.

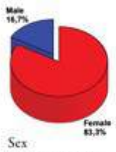
AIM

The overall objective of this research is to analyze the variables that can increase the risk of burnout and study the causes and the type of aggression that can come from it among the professionals who work within residential facilities for the elderly.
We also valuated the internal consistency of the questionnaire specially constructed for the detection of aggressive behaviors of care workers.
Specifically, this research aims to analyze the aggressive behavior (physical and / or psychological) put in place by the professionals (personal OSA / OSS) towards colleagues and towards older users present in the structure.

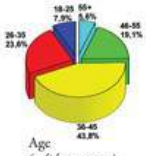
METHOD

PARTICIPANTS

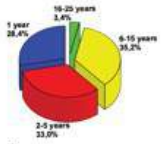
The sample consists of 93 care workers who work in six residential care for elderly users in Northern Italy (Liguria, Tuscany, Emilia Romagna, Lombardia).



Sex
(valid percentage)



Age
(valid percentage)



Seniority
(valid percentage)

PROCEDURES AND MEASUREMENTS

The data are collected through the administration of the following questionnaires:

- data sheet (anonymous) for this purpose, consisting of 6 items;
- ELOT scale for evaluating the size of optimism, consisting of 20 items;
- Maslach Burnout Inventory (MBI), for the evaluation of the level of burnout, consisting of 22 items;
- Internal-External Locus of Control Scale to assess locus of control, consisting of 29 items;
- Inventory of provocations Novaco, to assess the predisposition to feel anger, consisting of 80 items;
- A questionnaire specially built to investigate the difficult period of integration ("novice"), consisting of 23 items;
- A questionnaire specially built to investigate aggressive behavior towards older users present in the structure, consisting of 96 items (48 items described in the first person, as witnesses item 48).
- A questionnaire specially built to investigate aggressive behavior towards colleagues consists of 52 items (26 items described in the first person, the 26 items as witnesses).

RESULTS

Below are the most significant findings emerged from the data.
As shown in Table 1, the newly hired care workers say they have difficulties in finding work group (73.7% of subjects), since the beginning, colleagues hired more time impose a "novice" in which all must undergo (44% claimed they had experienced the novitiate).
The type of aggression that is acted is psychological and manifests towards colleagues mainly in the following ways:

- Spend the turn without turning the word to a colleague (Figure 1);
- Talking with colleagues in turn a mistake of a colleague not present (Figure 2);
- Tell a colleague "you're slow" (Figure 3);

There has been inappropriate behavior towards users elders present in the structure, which manifest themselves:

- Use methods of restraint agitated with users even if they have a doctor's prescription (Figure 4);
- Use methods of restraint with peaceful users (Figure 5);
- Use methods of restraint "alternative" (Figure 6);
- To comply with the rhythms of the work plan, do not give the whole meal to an elderly eating slowly (Figure 7).
- Fooling around with immobile elderly and / or end stage (in a state of unconsciousness) (Figure 8).

Analysis of data on the internal consistency of the questionnaire specially constructed:

	Novitiate	Aggression vs. colleagues (witness)	Aggression vs. colleagues (protagonist)	Aggression vs. users (witness)	Aggression vs users (protagonist)
Cronbach's α	.756	.873	.824	.802	.829

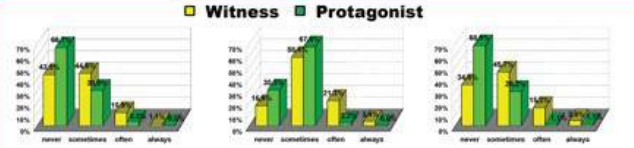


Figure 1
"Spend the turn without speaking to a colleague"

Figure 2
"Talking with colleagues on call about a mistake of a colleague not presena"

Figure 3
Telling to a colleague "You're slow"

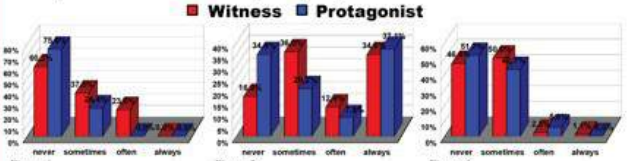


Figure 4
Use in particular moments, methods of restraint (petorine, bed rails ... etc) with elderly very agitated and difficult to handle them, even if they do not have prescription

Figure 5
Use methods of restraint (bibs, bed rails ... etc) with seniors who have a prescription, even if in that moment are quiet

Figure 6
Use methods of restraint "alternative" to calm the agitated elderly (ex. put the old man with a chair under a table near a wall)

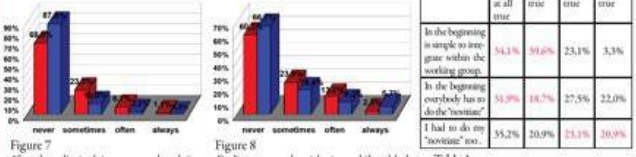


Figure 7
If you have limited time on your hands (to hold by the work plan) and the elderly eat slowly, happens to not give the entire meal

Figure 8
Fooling around with immobile elderly and/or end stage (in a state of unconsciousness)

	Not at all true	Little true	Quite true	Very true
In the beginning is simple to integrate within the working group	34,1%	39,6%	23,1%	3,3%
In the beginning everybody has to do the "novitiate"	51,9%	18,7%	27,5%	22,0%
I had to do my "novitiate" too.	35,2%	20,9%	23,1%	20,9%

Table 1
Difficulty of integration in the working group ("novitiate")

CONCLUSION

Analysis of the data shows that the work within residential facilities for elderly users are at a high risk of burnout. High levels of stress at work are reflected in the interpersonal dynamics (both in relationships with colleagues both in respect of users residing in the structure).
Specifically, as regards the relationship between colleagues is detected:

1. Difficulty of insertion of the working group (novitiate);
2. Operators with more seniority assume roles that do not belong to (control function);
3. The working group is cohesive to the outside but at the same time shows a high conflict inside (lack of direct communication).

In addition to high levels of burnout correspond inappropriate behavior towards older users present in the structure, in particular it includes:

1. Overuse and inappropriate methods of restraint;
2. Selective attention to the work plan (timetable raised, meals, tasks ...) even in cases where they are not respected the time and needs of the user elder.

Even if the sample used is very narrow to draw a conclusion, at the moment all the 96 items of the questionnaires have a good internal consistency. We are planning to increase it in the future.

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IS BODY IMAGE RELATED TO THE EGOSYNTONICITY OF SYMPTOMS IN PATIENTS WITH EATING DISORDERS?

Conxa Perpiña[1,2]; María Roncero[1]; Amparo Belloch[1];
1.-Universitat de València (Spain). 2.-CIBER Fisiopatología de la obesidad y Nutrición (CIBEROBN).
e-mail: perpinya@uv.es

INTRODUCTION

The overvaluation of weight and body shape on self-evaluation has been identified as the essential feature in Eating Disorders (ED). The "*relentless pursuit of thinness*" is self-imposed by the patients with determination. Although it is assumed that ED symptoms are ego-syntonic, patients with ED also report recurrent and Unwanted Intrusive Thoughts, images, and/or impulses, with contents related to their eating, dieting concerns, body shape and weight (UIT-EDs), which are appraised as disturbing and ego-dystonic to the patient in some extent.

AIM

To analyze to what extent Body Image (BI) dimensions predict the ego-syntonicity/dystonicity of UIT-EDs in ED patients.

METHOD

98 Eating disordered women patients
- mean age =7.19 years (SD=9.59)
- mean BMI=18.72 (SD=2.87)

(Anorexia Nervosa=36; Bulimia Nervosa=16;EDNOS =46)

Egosyntonicity and Egodystonicity of UIT-ED (EDQ-R &ESQ-R) (Belloch et al., 2012))

Ego-Dystonicity Questionnaire-Reduced (EDQ-R)
- Undesirability of thought
- Irrationality
- Inmorality.

Ego-Syntonicity Questionnaire (ESQ)
- Desirability of thought
- Rationality
- Morality

Multidimensional Body-Self Relations Questionnaire (MBSRQ; Cash, 2004).

- Appearance Evaluation,
- Appearance Orientation,
- Overweight Preoccupation,
- Self-Classified Weight,
- BASS (Body Areas Satisfaction)

RESULTS

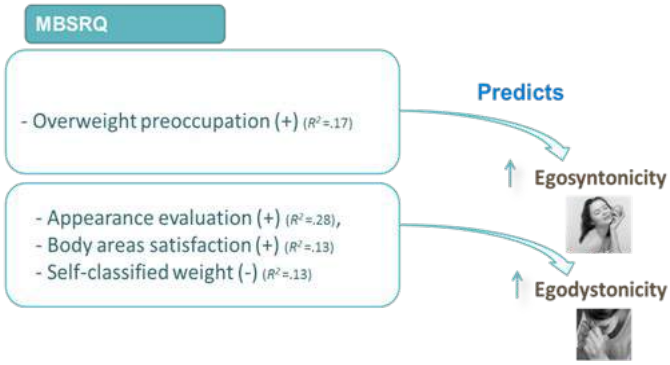
- Significant relationships between Ego-syntonicity-rationality of UIT-ED and MBSRQ-Overweight Preoccupation were found, while Ego-dystonicity-irrationality of UIT-ED was associated with MBSRQ-Appearance Evaluation (p<.001). See Table 1
- MBSRQ-Overweight Preoccupation predicted the Ego-syntonicity-rationality of UIT-ED (*R2 = .17; B = .39; t= 2.48; p<.02*). See Figure1
- MBSRQ-Appearance Evaluation and Body-Satisfaction predicted the *Ego-dystonicity- irrationality* of UIT-ED (*R2 = .28; B=.53; t= 3.70; p<.001*). (Figure 1)
- MBSRQ-Self-classified weight (in negative) predicted the *Ego-dystonicity- irrationality* of UIT-ED (*R2 = .13; B=.-.36; t= -2.32; p<.03*). (Figure 1).

Table 1. Bivariate correlations between ego/syn-dys/tonicity (EDQ-ESQ) and BI (MBSRQ).

	App. evaluation	App. Orient.	Body a. sat.	Overw. preocc.	Self-class. weight
Desirable	0.32	0.00	-0.03	0.22	0.21
Rational. Coherent	-0.32	-0.08	-0.20	0.39**	0.22
Moral	-0.05	-0.03	-0.10	0.27	0.30
Egosyntonicity.Total	-0.06	-0.06	-0.16	0.42**	0.33*
Undesirable	-0.13	0.14	-0.02	-0.12	-0.36*
Irrational/Incoherent	0.53***	0.07	0.50***	-0.33*	-0.01
Immoral	0.30	0.09	0.28	-0.18	-0.11
Egodystonicity.Total	0.33*	0.14	0.36*	-0.30	-0.23

** p<0.05; ** p<0.01; *** p<0.001*

Figure 1. Regression analysis. Predictor variables: BI variables (MBSRQ).



DISCUSION & CONCLUSSIONS

- Both Ego-syntonicity/distonicity correlated with MBSRQ scales.
- The preoccupation of ED patient with being fat predicted the *Rationality and coherence* of the UIT-ED with the self, while Body satisfaction predicted the *Irrationality and Egodystonicity* of the intrusion.
- These results suggest that the fear of being overweight and the excessive concern with weight/dieting are more relevant as regards to the ego-syntonicity of an UIT-ED, than the body dissatisfaction itself.
- A greater *body satisfaction* will make the person rate an UIT-ED as *irrational and incoherent* with what the person thinks about him/herself.
- ✓ Conflicting beliefs about food and body produced ambivalent attitudes in ED patients. The kowledge the ambivalent meaning of the ED symptoms is central in order to approach the treatment of these disorders.

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Do Paranoid delusions function as experiential avoidance of current shame feelings?

Rodrigues, M. & Castilho, P.

Faculty of Psychology and Educational Sciences - University of Coimbra

cineicc
Centro de Investigação do Núcleo de Estudos e Intervenção Cognitivo-Comportamental

Introduction

Paranoid Delusions are present in many mental disorders and are a frequently observed clinical phenomenon. Paranoid Delusions constitute a key clinical manifestation of psychosis, having a particular significance for the diagnosis of Paranoid Schizophrenia. The vulnerability to experience Paranoid beliefs has been associated with high levels of shame (Gilbert et al., 2005), where an individual's self-perception of being inferior (in a low rank position), subordinate, unattractive and unvalued may then give rise to shame feelings and to the subsequent activation of submissive defenses, in order to minimize harm from others, avoid conflict and appease others (Pinto-Gouveia et al., 2012). Hence, a permanent sense of threat to the self, who is left to feel vulnerable, inferior or undesired, and a view of others as dominant, hostile and threatening, who may harm, reject, exclude or persecute the self could compromise the access to feelings of safeness and security, elevating the vulnerability to experience Paranoid symptoms (Matos et al., 2013). Paranoid symptoms might be undermined if patients use avoidance as a method of regulating experiential content (Bach & Hayes, 2002). So, A process of Experiential Avoidance (EA) of current shame feelings might operate as a form of protecting the self from damages against one's self-image, possible criticism and attacks from others.

Aims :This study sets out to explore the nature of Paranoid Delusions as a process of Experiential Avoidance of external shame.
We are interested in investigating if the effect of shame on Paranoid Delusions is generated by Experiential Avoidance. So, in other words, we hypothesized that individuals with Paranoid Schizophrenia who believed they are fully depreciated and devalued by others and also have higher levels of Experiential Avoidance will present more frequent, convincing and distressful Paranoid Delusions.

Method

Participants and Procedures

Participants in this study were 30 patients with Paranoid Schizophrenia (25 men and 5 women) recruited from the Psychiatric Services of the "Centro Hospitalar e Universitário de Coimbra". The diagnoses of all the participants were given by experienced psychiatrists who worked in those services and followed the case. Participants' mean age was 38 (SD =10.10), ranging from 18 to 58. The majority of the participants were single (70%, n = 21) and lived with their parents (63.3%, n = 19). In terms of academic education, participants tended to range between intermediate school (7 years of study) and university degrees (more than 12 years of study), and were mostly employed (56.7%, n = 17). All of the participants were taking anti-psychotic medication. No gender differences were verified concerning these socio-demographic variables.

Measures

Other As Shamer (OAS; Allan, Gilbert, & Goss, 1994; Goss, Gilbert, & Allan, 1994; Portuguese version by Matos, Pinto-Gouveia & Duarte, 2012).The scale consists of 18 items measuring external shame (global judgements of how people think others view them). In the present study we obtained a Cronbach α of .91.

Acceptance and Action Questionnaire (AAQ-II; Bond, Hayes, Baer, Carpenter, Guenole, Orcutt, Waltz, & Zettle, 2011; Portuguese version by Pinto-Gouveia, Gregório, Dinis & Xavier, 2012). The scale consists of 7-items that reflects the single domain of psychological inflexibility with higher scores indicating greater psychological inflexibility, or experiential avoidance. In our study we obtained a Cronbach α of .87.

Shame Avoidance Questionnaire in Paranoia (SAQP; Castilho, Rodrigues and Pinto-Gouveia, 2013, manuscript in preparation). The SAQP was developed to measure the shame avoidance in Paranoia. This scale is composed by 11 items that assesses the level of shame avoidance in Paranoia. Participants indicate the frequency on a 7-point Likert scale to items such as, "If I feel more different, inadequate and full of doubts about myself, I will have more Paranoid thoughts and feelings" and "My Paranoid thoughts and feelings prevent me from feeling that there is something wrong with me and that I have defects as a person". In our study we obtained a Cronbach α of .88. This measure is in a conclusive phase whereas its psychometric properties are being analyzed.

Paranoia Checklist (PC; Freeman, Garety, Bebbington, Smith, Rollinson, Fowler, Kuipers, Ray & Dunn, 2005), Portuguese version by Lopes & Pinto Gouveia (2005). This scale was developed to explore Paranoid thoughts of a more clinical population in order to allow a multidimensional evaluation of Paranoid ideation. Items are rated in five-point Likert scale (1-5) with regard to frequency, conviction and distress of Paranoid thoughts. In our study we obtained a .89 Cronbach's α of .90 for frequency; .83 for conviction; and .95 for distress.

Results

Descriptives

An independent-samples t-test was conducted to compare the gender differences between the variables in study. The results show that no gender differences were obtained.

Correlation analysis

All of the analyzed variables showed a positive relation between them. Table 1 illustrates the correlations between external shame (OAS), experiential avoidance (AAQ_II), shame avoidance in Paranoia (SAQP) and Paranoid thoughts, specifically their frequency (PC_Frequency), the conviction in Paranoid thoughts (PC_Conviction) and the distress associated (PC_Distress).

Table 2. *Cronbach's alphas, Means (M), Standard Deviations (SD), and Intercorrelation scores on self-report measures (N = 30)*

Measures	*α*	*M*	*SD*	*1*	*2*	*3*	*4*	*5*	*6*
1.AAQ_II	.87	27.20	9.19	1					
2.OAS	.91	31.63	12.26	.62**	1				
3.PC_Frequency	.90	43.83	14.85	.66**	.65**	1			
4.PC_Conviction	.83	47.23	11.10	.54**	.50**	.59**	1		
5.PC_Distress	.95	34.73	18.56	.43*	.54**	.67**	.54**	1	
6.SAQP	.88	38.83	12.70	.72**	.53**	.53**	.32**	.62**	1

*Note: AAQ_II = Acceptance and Action Questionnaire_II; OAS = Other as Shamer Scale; PC_Frequency = Paranoia Checklist (Frequency); PC_Conviction = Paranoia Checklist (Conviction); PC_Distress = Paranoia Checklist (Distress); SAQP = Shame Avoidance Questionnaire in Paranoia). *p <.050. **p <.01*

Mediation analysis

We hypothesize that experiential avoidance (psychological inflexibility) and shame avoidance in Paranoia may function as mediators in the relationship between external shame and Paranoid thoughts. According to Baron and Kenny (1986), we performed multiple regression analysis to explore the effect of experiential avoidance and shame avoidance in Paranoia in the relationship between external shame and the dependent variable.

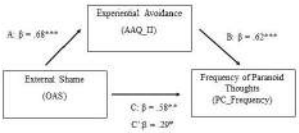

Figure 1. The relationship between Social External Shame (OAS) and the Frequency of Paranoid Thoughts (PC_Frequency) mediated by Experiential Avoidance (AAQ_II). A = relation between the independent variable and mediator, B = the relation between mediator and dependent variable, C = the direct effect of the independent variable on the dependent variable, C' = the indirect effect of the independent variable on the dependent variable controlling for the mediator; *p<0.05, **p<.01, ***p<.001, ^p=.152

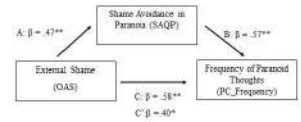

Figure 2. The relationship between Social External Shame (OAS) and the Frequency of Paranoid Thoughts (PC_Frequency) mediated by Shame Avoidance in Paranoia (SAQP). A = relation between the independent variable and mediator, B = the relation between mediator and dependent variable, C = the direct effect of the independent variable on the dependent variable, C' = the indirect effect of the independent variable on the dependent variable controlling for the mediator; *p<0.05, **p<.01, ***p<.001.

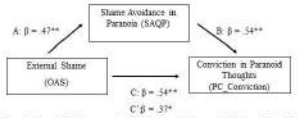

Figure 3. The relationship between Social External Shame (OAS) and the Distress caused by Paranoid Thoughts (PC_Conviction) mediated by Shame Avoidance in Paranoia (SAQP). A = relation between the independent variable and mediator, B = the relation between mediator and dependent variable, C = the direct effect of the independent variable on the dependent variable, C' = the indirect effect of the independent variable on the dependent variable controlling for the mediator; *p<0.05, **p<.01, ***p<.001.

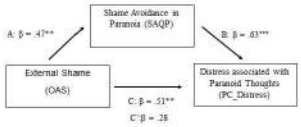

Figure 4. The relationship between Social External Shame (OAS) and the Distress caused by Paranoid Thoughts (PC_Distress) mediated by Shame Avoidance in Paranoia (SAQP). A = relation between the independent variable and mediator, B = the relation between mediator and dependent variable, C = the direct effect of the independent variable on the dependent variable, C' = the indirect effect of the independent variable on the dependent variable controlling for the mediator; *p<0.05, **p<.01, ***p<.001, p=.092^

Discussion

Despiste the transversal and exploratory nature of our study, our findings support the hypothesis and provide evidence for the theoretical suggestion that Paranoia functions as a process of experiential avoidance of shame feelings. After realize that our analyzed variables were significantly correlated, we tested the mediation effect of experiential avoidance (AAQ_II) and shame avoidance questionnaire (SAQP) in the relationship between external shame (OAS) and Paranoid thoughts (frequency, conviction and distress). Results suggest that experiential avoidance work as a mediator in the relationship between external shame and the frequency of paranoid thoughts whereas shame avoidance in Paranoia seems to work as a mediator in the relationship between external shame and distress of Paranoid thoughts. A partial mediation of shame avoidance in paranoia was also found between external shame and the frequency and conviction of paranoid thoughts. Thus, our data indicates that the degree in which external shame affects the frequency, conviction and distress of Paranoid delusions is dependent on how one is trying to avoid his personal shame feelings. Individuals with Paranoid schizophrenia who feel diminished and devalued in the eyes of others and sought to avoid those feelings and cognitions related to shame will experience more frequent, convincing and distressful Paranoid delusions.

Conclusions and Limitations

Our study adds to previous knowledge concerning the relation between shame and Paranoid symptoms in Paranoid Schizophrenia, by suggesting that experiential avoidance and particularly shame avoidance have a significant mediator effect on the relationship between shame and Paranoid symptoms. These are interesting findings, as they highlight the important role of experiential avoidance of shame and offer new insights on how external shame operates in Paranoid delusions. Our results seem to offer significant and novel data for future research and for clinical work, supporting the application of psychotherapies that seek to reduce EA of shame in the treatment of Paranoid delusions. ACT seeks to promote psychological flexibility by directing clients towards acceptance of unpleasant thoughts and emotions (e.g., Shame) and a commitment towards the achievement of valued life directions. Thus, it might be useful the use of a psychological treatment as ACT focused specifically on reducing EA and encouraging psychological flexibility, as an adjunctive psychotherapeutic treatment for psychosis.

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Children and adolescents

The impact of Traumatic Shame Experiences in Social Anxiety – the moderator role of Emotional Intelligence

Maria da Luz Antunes & Maria do Céu Salvador & Alexandra Alves | 2013
mluzantunes@hotmail.com
ceusalvador@gmail.com

Research Unit of the Cognitive-Behavioral Center for Research and Intervention
Psychology Faculty, University of Coimbra, Portugal

ABSTRACT

Adolescents whose traumatic shame experiences (TSE) reveal traumatic characteristics tend to develop a sense of self as shameful. Social anxiety (SA) can be influenced by current and pervasive feelings of shame and since emotional intelligence (EI) may enhance the ability to effectively cope with traumatic experiences, it may perform an important role in the association between the impact of TSE and SA. This study explored the associations between the impact of TSE, SA and EI, in 1018 adolescents. Although the association between the impact of TSE and SA was weak, the impact of TSE had a significant predictive effect on SA. The relationship between the impact of TSE and EI was also statistically significant. Furthermore, EI had a moderator role in the predictive effect of the impact of TSE on SA.

Key-Words: Social anxiety, impact of traumatic shame experiences , emotional intelligence.

INTRODUCTION

The Centrality of Event Theory (Berntsen & Rubin, 2006; 2007) postulates that trauma memories or emotional negative events become central in the individual's life history and identity, and create internal stable global attributions associated with post-traumatic stress reactions, depression and anxiety. Adolescents whose TSE reveal traumatic characteristics and regard shame events as key to identity and as turning points in their life story, tend to develop a sense of self as existing negatively in the eyes of others and in their own eyes, and the impact of shame memories operates through their influence on fostering shame feelings (Cunha et al., 2012). Nevertheless, adolescents with high EI report fewer psychological symptoms resulting from traumatic experiences (Tolegenova et al., 2012). Furthermore, socially anxious individuals are particularly prone to interpret a variety of experiences as distressing or traumatic (Carleton et al., 2011) and demonstrate re-experiencing, avoidance and hyperarousal at intensities that interfere with their processing (Erwin et al., 2006).
Will EI moderate the association between the impact of TSE and SA?

METHOD

PARTICIPANTS

Adolescents from the general population, aged between 14 and 18.

TABLE 1. Sample's distribution by gender

Boys	Girls	Total
436	582	1018

INSTRUMENTS

SELF RESPONSE QUESTIONNAIRES:

Social Anxiety Scale for Adolescents (SAS-A; La Greca & Lopez, 1998); The Impact of Event Scale-Revised (IES-R; Weiss, & Marmar, 1997); Trait Meta-Mood Scale (TMMS; Salovey et al., 1995); Children's Depression Inventory (CDI; Kovacs, 1985).

RESULTS

CORRELATIONS and REGRESSION

Partial *Pearson* correlations were computed between all variables (Table 2), controlling for gender. A hierarchical regression analysis was performed to test the impact of TSE on SA. Gender and depressive symptoms were controlled (Table 3).

TABLE 2. Partial Pearson correlations of SA, the Impact of TSE and EI.

	TSE (IES-R)	EI (TMMS)
	r	r
SA (SAS-A)	.36***	-.29***
FNE (SAS-A)	.35***	-.20***
SADN (SAS-A)	.25***	-.24***
SADG (SAS-A)	.32***	-.34***
TSE (IES-R)		-.29***

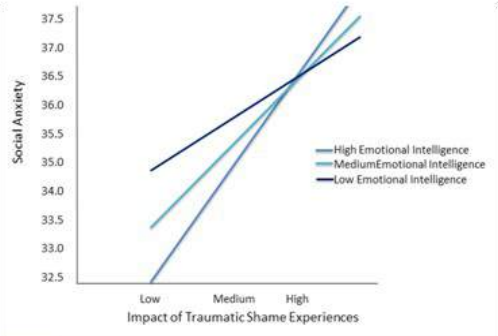
TABLE 3. Independent effects of Gender, Depression and the impact of TSE on SA, in the last model.

	R^2	ΔR^2	β	F
Model 3	.329	**.016**		165,492***
Gender			.040***	
CDI			.477***	
IES-R			.145***	

***$p<.001$

MODERATION ANALYSIS

The association between the impact of TSE and SA was moderated by EI.



DISCUSSION

Studies concerning the impact of TSE on SA and the role of EI in adolescents are indeed scarce. This study highlights: (1) the weak association between the Impact of TSE, SA and EI; (2) the weak predictive effect of the Impact of TSE on SA; (3) and the moderator role of EI in the association between the impact of TSE and SA. Below possible explanations for these findings are presented.

Why is there a weak association and predictive effect of the Impact of TSE on SA?

- Variability in the interpretation of what constitutes a traumatic experience
- Social deseriability
- Avoidance of schema activation to avoid intense emotionality
- IES-R may not capture the essence of the impact of TSE associated with SA.

Future research

Structured interviews with emotional activation may allow a more insightful, accurate, enhanced and comprehensive exploration of the impact of TSE and the traumatic characteristics of shame events in SA.

Why adolescents with high EI present a higher impact of TSE on SA, compared with adolescents with medium and low levels of EI?

Adolescents with high EI, experiencing the same high level of the impact of TSE as adolescents with low or moderate EI, may be more attentive to their own emotions and may be more capable of identifying and clarifying their emotions (e.g. anxiety in social situations), therefore, experiencing and reporting higher levels of SA

Adolescents with high EI may be more conscious of the importance of not avoiding social situations, therefore continuing to confront social situations with high SA in spite of their high EI

Both results may also be due to the fact that our sample was not a clinical sample of adolescents with Social Anxiety Disorder. In such a sample, results may be more expressive.

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Specific and generalized social phobia: differences and similarities in shame, selfcriticism and impact

Cátia Garcia & Maria do Céu Salvador | 2013
catia.d.garcia@gmail.com & ceusalvador@gmail.com

ABSTRACT
In the DSM-5 the subtype specific was included to designate restricted situations of performance anxiety. Although some authors already previously pointed in this direction, studies in this clinical population are rather scarce. In the present study, using an adolescent sample, we aimed to compare generalized social phobia (GSP) and specific social phobia (test anxiety) (SSP), in internal shame, external shame, self-criticism and impact (interference, comorbidity and quality of life). Results showed that the GSP and SSP groups did not significantly differ in terms of internal shame, external shame and self-criticism. Nevertheless, significant correlations between the previous variables were found in the GSP group while this did not happen in the SSP group. GSP presented higher levels of depressive symptomatology; however, the groups only differed regarding quality of life in the *Social Support* dimension. Internal shame, and external shame factors *Inferiority* and *Reaction of others to my mistakes* showed to be predictors of generalized social anxiety. Only external shame (inferiority) showed to be a significant predictor of test anxiety.
Key-words:**Social Anxiety, Specific Social Anxiety, Internal Shame, External Shame, Self -criticism, Quality of Life**

INTRODUCTION

Turner, Beidel and Townsley (1992) defend the inclusion of individuals with high anxiety in social interaction situations in the generalized subtype, and the inclusion of people with only fear of performance situations in the specific subtype. McNeil (2001) considers that generalized social phobia and specific social phobia are two different disorders, despite having phenotypical similarities.

Individuals with generalized social phobia diagnosis present more precocious sympomatology , higher levels of introversion, more severe symptoms and higher rates of associated psychopathology (Turner et al, 1992). In the specific subtype, studies are scarce, namely in children and adolescents.

The current study aimed to explore possible differences between generalized social phobia and specific social phobia (test anxiety), with a group with other anxiety disorders (OAD) and a non-clinical group (N) as control groups. All the groups were compared in terms of impact (interference, comorbidity and quality of life), and in the GSP group the relationship between social anxiety, shame and self-criticism were explored.

METHOD

PARTICIPANTS

Adolescents aged between 14 and 18.

Generalized social phobia (GSP)	N=85	**N= 231**
Specific social phobia (SSP)	N=34	
Other anxiety disorder (OAD)	N=44	
Adolescents without psychopathology (N)	N=68	

INSTRUMENTS

Social Anxiety and Avoidance Scale for Adolescents: **SAASA (**Cunha, Pinto-Gouveia, Salvador & Alegre, 2004); Reaction to Tests: **RT (**Sarason, 1984); Other As Shamer Scale: **OAS** (Goss, Gilbert, & Allan, 1994); Internalized Shame Scale: **ISS (**Cook, 1996); *Forms of Self-Criticizing and Reassuring Scale:* **FSCRS (**Gilbert et al., 2004); *Children's Depression Inventory:* ***CDI*** *(*Kovacs, 1985); **Kidscreen-27-** Quality of Life Measure for Children and Adolescents: **(**Matos, Gaspar Calmeiro & KIDSCREEN-27 Group Europe, 2005; Ravens-Sieberer & European KIDSCREEN-27 Group, 2005); ***Anxiety Disorders Interview Schedule for DSM-IV: Child Version*** (Silverman & Albano, 1996).

RESULTS

INTER-GROUP STUDY

TABLE 1. Comparisons between groups in CDI, Kidscreen-27, ISS, OAS and FSCRS

Measures of depression, quality of life, shame and self-criticism	Differences	Efect size (ηp^2)
CDI	GSP>SSP	0.55
	GSP>OAD	0.79
	GSP>N	1.18
	SSP>N	0.69
Kiscreen-27 Physical well-being	GSP<N	0.99
	SSP<N	0,71
	OAD<N	0,70
Kiscreen-27 Peers & Social Support	GSP<SSP	0,57
	GSP<N	0.62
Kiscreen-27 School Environment	GSP<N	0.66
	OAD<N	0.68
ISS- Internal Shame	GSP > OAD	0.79
	GSP > N	1.13
	SSP > N	0.81
OAS- External Shame	GSP > OAD	1,28
	GSP > N	0.86
	SSP > N	0.70
FSCRS – Self-Criticism	GSP>OAD	0.55
	GSP>N	1.08

Only statistically significant differences are presented.

INTRA-GROUP STUDY: CORRELATIONS AND REGRESSIONS

In order to better understand the role of shame and self-criticism in the GSP and SSP groups, correlational and regression analyses were realized.

TABLE 2. Correlations in GSP and SSP groups

		ISS	OAS	FSCRS Self-Criticism	FSCRS **Self**-Reassurance
GSP	**SAASA** Discomfort	.41**	.42**	.31**	-.09
	SAASA Avoidance	.43**	.39**	.31**	.01
	RT	.39**	.28**	.24**	.13
SSP	**RT**	.25	.30	-.04	.12

**p<.01 (2-tailed).

But

		OAS Inferiority
SSP	**RT**	.38**

TABLE 3. Significant predictors in the last model

GSP		SSP
	Predictors → Dependent Variable	Predictors → Dependent Variable
Shame	CDI+ISS → SAASA (D)	CDI+ OAS Inferiority → RT
	CDI+ OAS → SAASA (D)	
Self-critiscim	CDI+ FSCRS → SAASA (D)	----------

Predictors	R^2	ΔR^2	ΔF	β
Model 2	.209	.085	8.378**	
CDI				
OAS Inf.				.370**

Predictors	R^2	ΔR^2	ΔF	β
Model 2	.203	.079	7.746**	
CDI				
OAS Oth.				.343**

Predictors	R^2	ΔR^2	ΔF	β
Model 2	.185	.060	5.651*	
CDI				
ISS				.338*

External and internal shame predicted SA

*p<.05 (2-tailed).
**p<.01 (2-tailed).

Predictors	R^2	ΔR^2	ΔF	β
Model 2	.145	.141	4.449*	
CDI				
OAS Inf.				.386*

Only external shame predicted test anxiety

*p<.05 (2-tailed).
**p<.01 (2-tailed).

CONCLUSIONS

Results point to the inexistence of significant differences between generalized social phobia and specific social phobia (test anxiety) in terms of internal shame, external shame and self-criticism. Despite that, differences were found in depressive symptomatology and also in the perception of social support.

Significant correlations between the previous variables were found in the GSP group while this did not happen in the SSP group.

In the regression analysis, while social anxiety was explained by external (inferiority and others reactions to my mistakes) and internal shame, anxiety in test situations seems to be predicted only by external shame (inferiority).

Once DSM-5 (APA, 2013) has now introduced the possibility to specify social anxiety disorder as "specific", it seems the best moment to develop research to explore differences and similarities between this specific subtype and the generalized social anxiety disorder.

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Adolescents' susceptibility to peer pressure: Teach them to say no is not enough

MARTINA LOTAR RIHTARIĆ
University of Zagreb, Croatia

INTRODUCTION

A conceptual model of peer influence process (Brown et al., 2008) proposes the existence of different individual and contextual factors that may affect adolescent behavior in a situation of peer pressure. Adolescents respond to the peer pressure by accepting it and conforming to their peer's norms, expectations or demands or ignoring it, or by confronting it with a counter influence. When this basic sequence is activated, there are numerous factors that determine an adolescent's reaction to peer pressure. Research results suggest that susceptibility to peer pressure will be greater among boys (e.g. Brown, Clasen & Eicher, 1986; Lotar, 2011; Pardini, Loeber & Stouthamer-Loeber, 2005), adolescents about 15 years of age (e.g. Brown, Clasen & Eicher, 1986; Steinberg & Monahan, 2007), adolescents with higher anxiety and/or avoidance in relations with friends (Allen et al., 2007; Lotar & Kamenov, 2013).
There are different approaches to measure the susceptibility to peer pressure so this study will compare results from correlational and experimental approach.

AIM

The first aim of this study was to compare adolescents' susceptibility to peer pressure measured by self-report and their susceptibility in experimental situation. Second aim was to determine predictors of self-reported susceptibility to peer pressure for misconduct and predictors of adolescents' behaviour in situation of peer pressure.

METHOD

Self-reported Susceptibility to peer Pressure (first part of the study)

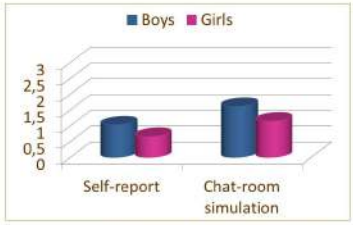
- **Participants:** 477 second grade high school students participated (41% boys and 59% girls) with average age M=16,02 (SD=0,33)
- **Instruments:**
  - Susceptibility to Peer Pressure was measured as self-report with ***Susceptibility to Peer Pressure Questionnaire*** *(SPPQ; Lotar, 2012)*
    - descriptions of seven hypothetical situations concerning peer pressure to misconduct (smoking, alcohol consummation, smoking marihuana, stealing, cutting classes, breaking parents' rules, imprudent sexual behaviour)
    - participants needed to imagine themselves in each situation and choose one of the four answers that would describe their reaction in given situation
  - Attachment to friends (Anxiety and Avoidance) - ***Modified Experiences in Close Relationships Inventory*** *(Kamenov & Jelić, 2003)*
  - Actual-ought self-discrepancy and Actual-ideal self-discrepancy - ***Self Concept Questionnaire*** (Conventional Construct Version, SCQ-CC; Watson, 2001, 2004)
  - Cooperation - ***International Personality Item Pool (IPIP)***
  - Desirability of risk behaviours from hypothetical situations – ***Desirability of Risk Behaviours Scale*** *(Lotar, 2012)*

Susceptibility to Peer pressure in chat-room simulation (second part of the study)

One month later, 80 boys and 80 girls were randomly chosen from the pool of participants and in **second part of the study**, they completed the same parallel form of SPPQ in a chat-room *simulation*. Participants were convinced that they can see answers of other students in chat-room and that their own answers could be seen by other three students from the same school.

RESULTS

The results of ANOVA have shown that boys are more prone to conform to peers' behaviour than girls. Also, the adolescents are more susceptible when they were exposed to real peer pressure in experimental situation then they report in pen and paper questionnaire.
Interaction between gender and methodological approach to measurement of susceptibility to peer pressure was not significant.



$F_{method.\ approach}(1,156)=133,74$; **p<,01**; **$\eta^2$=,46**
$F_{gender}(1,156)=22,82$; **p<,01**; **η^2=,13**
$F_{int.}(1,156)=1,05$; ***ns***

Hierarchical regression analysis were conducted with susceptibility to peer pressure as criterion. In first hierarchical regression analysis criterion was susceptibility to peer pressure measured as self-report and in second criterion was susceptibility to peer pressure demonstrated in experimental situation.

Gender (β=-,19) Actual-ought self discrepancy Actual-ideal self discrepancy	**Cooperation (β=-,12)**	*Attachment to friends:* **Anxiety (β=,08)** Avoidance	**Desirability of risk behaviours (β=,47)**	**Self-reported Susceptibility to Peer Pressure**
R^2=0,077	ΔR^2=0,072	ΔR^2=0,024	ΔR^2=0,186	R^2=0,350

Gender (β=-,23) Actual-ought self discrepancy Actual-ideal self discrepancy	**Cooperation (β=-,18)**	*Attachment to friends:* Anxiety Avoidance	**Desirability of risk behaviours (β=,28)**	**Susceptibility to Peer Pressure in chat-room simulation**
R^2=0,125	ΔR^2=0,064	ΔR^2=0,026	ΔR^2=0,056	R^2=0,236

Results of hierarchical regression analysis have shown that higher percentage of variance is explained by included predictors when susceptibility to peer pressure was operationalized as self-report (35% vs. 24%). It seems that adolescents' behaviour in the situation of pressure is more determined by different situational than individual factors.

Self-reported susceptibility to peer pressure is higher among boys, adolescents with lower cooperation, higher anxiety in relation with friends and higher desirability of risk behaviours. Susceptibility to peer pressure in experimental situation is predicted by gender, cooperation and desirability of risk behaviours, while attachment to friends is not a significant predictor. Desirability of risk behaviours proved to be the best predictor of susceptibility to peer pressure. It explains 19% of self-reported susceptibility and only 6% of susceptibility to peer pressure in experimental situation.

DISCUSSION AND CONCLUSION

Adolescents report about their intention to behave in pen and paper questionnaire. However, in situation of peer pressure, they are more prone to meet their friends expectations. It can be concluded that in real life situation adolescents' reaction to peer pressure is determined by other factors that were not included in this research. Results indicate that in real situation adolescents do not think much about how they want to behave and what behaviours are acceptable to them, so it is not enough to teach them '*just say no*' to socially undesirable behaviours. It is important to examine motivation for conformation to peers' behaviour and to teach adolescents how to resist peer pressure in different situations but in, for adolescent, acceptable way.

43rd Annual Congress, European Association for Behavioural and Cognitive Therapies, Marrakech 2013
e-mail: martinal@erf.hr

Self-perception and anxiety as predictors of depression symptoms among Croatian adolescents

Marija Lebedina Manzoni, Martina Lotar Rihtarić & Marina Taslak
University of Zagreb, Croatia

Introduction

Research results suggest that negative self-perception is related to negative emotional experiences, especially to depression symptoms (Burwell & Shirk, 2009). Furthermore, there is high co-occurrence of depression and anxiety symptoms, especially social anxiety (Epkins & Heckler, 2011) and it has been proven that anxiety mostly precedes depression (Huppert, 2008).

Aim

The aim of this study was to determine how well general self-worth, different aspects of self-perception, social anxiety and worry explain adolescents' depression symptoms at nonclinical level.

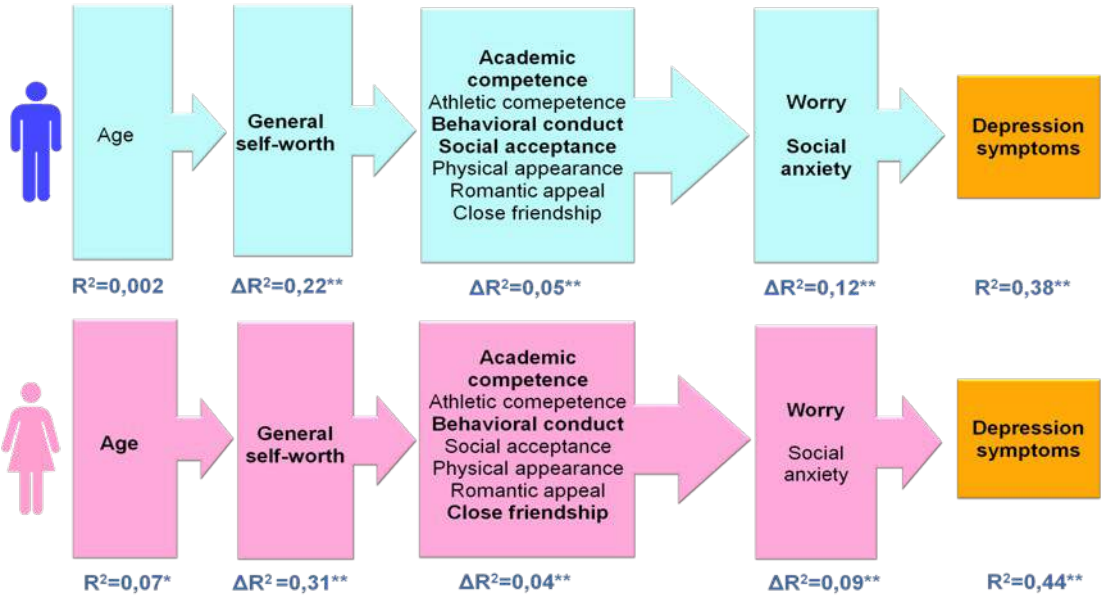
Method

A total of 938 elementary and high school students aged from 12 to 18 (M_{age}=14.82; SD_{age}=1.476) participated in the study (55% girls and 45% boys). The following instruments were applied:

- **Depression Scale** for Children and Adolescents (Vulic-Prtoric, 2003),
- **Worry** and **Social anxiety** subscales from *Fear and anxiety scale for children and adolescents* (Vulic-Prtoric, 2004),
- The **Self-Perception Profile** for Adolescents (Harter, 1985), which measures *general self-worth* and following *self-perception domains*:
  - *academic-scholastic competence, athletic competence, physical appearance, social acceptance, romantic appeal, behavioral conduct and close friendship (job competence was excluded from data analysis because content of this domain is not suitable for adolescents in Croatia)*

Results

Separate hierarchical regression analysis were conducted for boys and girls with **depression symptoms as criterion**, and *age, general self-worth, self-perception domains, worry and social anxiety as **predictors***.



** p< .01; * p< .05

Results have shown that **general self-worth** and **worry** were **significant predictors** of depression symptoms **for both genders**.

Among self-perception domains, **academic competence and behavioral conduct** were significant predictors **regardless of gender.**

Additional to those common predictors, ***boys***' only depression symptoms were also explained by **social acceptance** and **social anxiety,** while only in ***girls***' subsample **close friendship** turned out to be a significant predictor of depression symptoms. ***Girls'*** **age** alone already explains significant portion of depression symptoms variance.

Discussion and conclusion

It is evident that used set of predictors explains very significant part of variance in depression symptoms' among Croatian adolescents. Regardless of their' gender and in line with expectations and available research data, worry and general self-worth seem to be important in explaining the level of their depression symptoms – a finding which stands for adults alike. Our findings show the same gender difference in Croatian adolescent sample as is found elsewhere in western civilization societies: only girls' age explains significantly their depression symptoms level (increase following puberal age). Results once again indicate importance of peers in adolescents' self-perception, showing that being accepted member of a (larger) peer group for boys as well as having a close friendship for girls can make a significant difference in their lives.

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e-mail: marija@erf.hr

SOCIAL ANXIETY IN ADOLESCENCE : THE ROLE OF SHAME

Eva Soraia Teixeira Rodrigues & Maria do Céu Salvador | 2013
eva_s1013@hotmail.com I ceusalvador@gmail.com

Research Unit of the Cognitive-Behavioral Center for Research and Intervention
Psychology Faculty, University of Coimbra, Portugal

ABSTRACT : Symptoms associated with social anxiety disorder and shame arise mainly during early adolescence. All changes associated with adolescence call attention to the self and its exposure and shame experiences recruit anxiety and are typically associated with the perception that the individual is being submitted to the scrutiny of others. The Experience of Shame Scale (ESS) that assesses three types of shame (Characterological, Behavioral and Bodily shame) was used to explore the relationship between social anxiety and shame among adolescents with social anxiety disorder (N=45). Two groups were used as control groups (Others Anxiety Disorders and Non-Clinical group). There were significant differences between groups in Characterological and Behavioral Shame. Shame was positive and significantly correlated with social anxiety among adolescents with Social Anxiety Disorder. Only Characterological Shame was a significant predictor of social anxiety.
Key-Words: Experience of Shame Scale (ESS), Social Anxiety Disorder (SAD), Shame and Adolescence

INTRODUCTION

Adolescence seems to be an important period to the development of both shame and social anxiety. It is a period in which we assist to a rapid magnification of shame, in the way that great changes take place such as the pubertal process, identity formation and emerging sexuality (Reimer, 1996). All these changes call attention to the Self and to its exposure, as well as to all the inherent social comparison processes (Kaufman, 1996).

When experiencing shame, young people tend to focus attention on prosocial behavior, in order to increase the acceptance by others, which contributes to further increase fear of negative evaluation and anxiety in social situations. Thus, over time, shame can contribute to the increase of social anxiety (Mills, 2005).

We sought to explore the relationship between social anxiety (SA) and shame, in a sample of adolescents with Social Anxiety Disorder (SAD).

METHOD

PARTICIPANTS

Adolescents from the general population, aged between 14 and 18.

Adolescents with Social Anxiety Disorder (SAD)	N=45
Adolescents with Other Anxiety Disorder (OAD)	N=24
Adolescents with No Psychopathology – Non Clinical Group (NCG)	N=33
Total Sample	N=102

INSTRUMENTS

DIAGNOSTIC INTERVIEW: ***Anxiety Disorders Interview Schedule for DSM-IV, Child Version*** (ADIS-C; Silverman & Albano, 1996; Cunha & Salvador, 2003)

SELF-REPORT QUESTIONNAIRES: ***Experience of Shame Scale*** (ESS; Andrews, Qian & Valentine, 2002; Rodrigues & Salvador, 2013); ***Social Anxiety Scale for Adolescent*** (SAS-A; La Greca & Lopez, 1998; Cunha, Pinto Gouveia, Alegre & Salvador, 2004).

RESULTS

INTER GROUP STUDY
Mean differences - ANOVA'S and Post-Hoc Tukey Test

Table 1. Significant differences between groups

Measures	F	Post-Hoc
ESS_TOTAL	8,899*	SAD> OAD, NCG
ESS_CHARACTEROLOGICAL SHAME	9.181*	SAD> OAD, NCG
ESS_BEHAVIORAL SHAME	8.355*	SAD>OAD SAD,NCG OAD,NCG
ESS_BODILY SHAME	3.359	SAD,OAD,NCG

*p <.05

SHAME AND SAD: AN INTRA GROUP STUDY
Preliminary Analysis: Gender differences for Social Anxiety and Shame

The only significant difference found between genders was in Factor 3 of the ESS (t (43) = -2.182, p = .035), where girls scored higher than boys. Therefore, gender was not controlled for in any of the following analysis.

CORRELATIONS

Table 2. Correlations between Shame and Social Anxiety

	Group SAD (N=45)	SAS-A FNE	SAD-N	SAD-G	Total
ESS	Total	.61**	.30**	.47**	.56**
	Characterological Shame	.58**	.38**	.54**	.60**
	Behavioral Shame	.58**	.36**	.42**	.55**
	Bodily Shame	.39**	-.13	.17	.18

FNE=Fear of Negative Evaluation; SAD-N=Social Avoidance and Distress Specific to New Situations; SAD-G=Generalized Social Avoidance and Distress; SAS-A Total= Social Anxiety Scale for Adolescents: ESS=Experience of Shame Scale
**p<.01

REGRESSIONS

To test for the role of shame on social anxiety, a hierarchical regression analysis was performed.

Table 3. Hierarchical Regression analysis on Social Anxiety: independent effects of Characterological Shame and Behavioural Shame

	Predictors	R	R^2	B	β	F	t
ESS	Model 1	.608	.369			12.304***	
	Characterological Shame			.665	.474		2.096*
	Behavioral Shame			.293	.152		.671

*p<.05; ***p<.001

DISCUSSION

Shame seems to be a construct more associated with social anxiety disorder than to other anxiety disorders. In fact, social anxiety disorder is characterized by negative thoughts and beliefs about how the self is inferior, inadequate, unattractive, defective and fear to get known because he/she will be rejected for being who they are.

Shame was more highly associated with fear of negative evaluation than with other social anxiety factor, which comes back to the assumption, and our hypothesis, that shame and social anxiety disorder are closely related, since fear of negative evaluation is social anxiety's nuclear fear.

Characterological Shame was a significant predictor of social anxiety. However, Behavioral and Bodily Shame did not emerge as significant predictors of social anxiety. These result seem to be indicate that the core fear of SAD is to be negatively evaluated by others regarding their personal characteristics, i.e., the person they are.

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Behavioural medicine

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Klinische Psychologie und Psychotherapie

Preventing side effects of adjuvant endocrine treatment in breast cancer?

Design and first results of a randomized controlled trial.

Shedden Mora, M.C.[1], von Blanckenburg, P.[2], Schuricht, F.[2], Heisig, S.[1], Albert, U.S.[3], Nestoriuc, Y.[1]

[1] Department of Clinical Psychology and Psychotherapy, University of Hamburg, Germany
[2] Department of Clinical Psychology and Psychotherapy, Philipps University Marburg, Germany
[3] Clinic for Gynaecology, Gynaecological Endocrinology and Oncology, Philipps University Marburg, Germany

Background

Adjuvant endocrine therapy (AET) considerably improves disease free survival and time to recurrence in women with **breast cancer**. However, AET is associated with considerable **side effects** that reduce patients' quality of life and might result in non-adherence (ATAC-Trialists'Group, 2008).
The majority of side effects is considered unspecific (**nocebo effects**), thus their development depends more on the treatment context and individual **expectations** rather than on the pharmacological action of the drug (Garg, 2011). Psychological interventions might be promising to prevent side effect burden and treatment discontinuation.

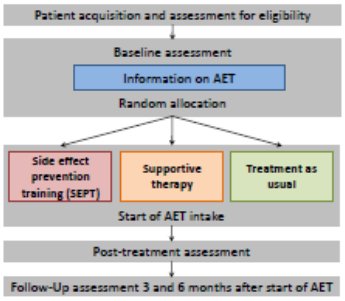
Aim of Study

To evaluate a cognitive behavioral **Side Effect Prevention Training** (SEPT) in a randomized controlled trial that

⇨ **optimizes** patients' response **expectations** before starting endocrine therapy and

⇨ **prevents nocebo side effects** during longer term drug intake.

Design



Sample: 160 women with estrogene receptor positive breast cancer, recommendation for adjuvant endocrine therapy (AET)

Intervention

Side Effect Prevention Training

1. Session:
Psychoeducation ⇨ reduce concerns about side effects and strengthen necessity beliefs
Guided imagery ⇨ integrate positive aspects of medication into daily life and decrease treatment distress.

2. Session: **Side effect management training** ⇨ enhance self-efficacy expectations about coping with possible side effects

3. Session: Activation of personal ressources

3 Booster calls ⇨ strengthen coping strategies

Outcomes:

- Side effects (GASE)
- Coping with side effects (GASE-Cope)
- Quality of life (EORTC QLQ C-30/BR-23)
- Adherence (MARS-D)

Results

Sample: Pilot data of n = 75 patients:

Table 1. *Demographic and medical characteristics*

Variable	ATEM	Supportive Therapy	TAU
N	26	25	24
Mean age (SD, range)	54.7 (8.5, 40-71)	55.5 (7.0, 40-72)	55.6 (8.8, 41-68)
Type of surgery			
Breast conserving	88.5%	92.0%	87.5%
Mastectomy	11.5%	8.0%	12.5%
Type of AET			
Aromatase Inhibitor	24.6%	40%	42.1%
Tamoxifen	76,4%	60%	57.9%
Staging			
Stages 0 or I	61.5%	56%	66.7%
Stage II	26.9%	36%	20.9%
Stages III and IV	7.6%	4%	8.3%

Patients' needs

84.2% of the patients expressed their need to talk about their **expectations.**
67.2% expressed their need to talk about their **emotions.**

Evaluation of interventions

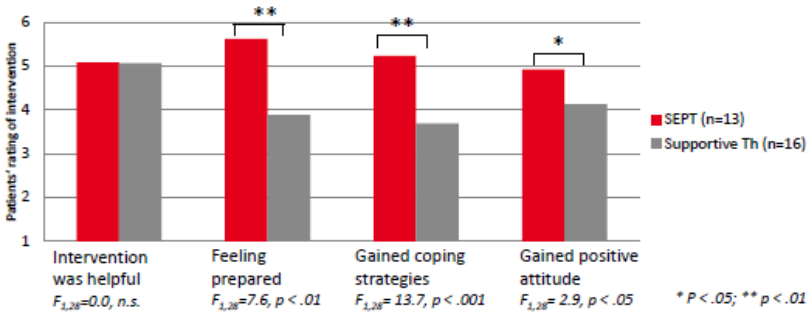


Figure 5. *Evaluation of interventions (scale range from 1 ‚not at all' to 6 ‚very much')*

Conclusion

In this pilot analysis, patients expressed high needs to address their treatment expectations concerning AET. The Side Effect Prevention Training was evaluated very positively, and patients reported to feel better prepared, to have gained better coping strategies and a more positive attitude compared to Supportive Therapy.
Psychological prevention programs for side effects might be potential pathways in health care to improve patients´ quality of life during medication intake.

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Contact: meike.shedden.mora@uni-hamburg.de

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Klinische Psychologie und Psychotherapie

„Is medical information processed differently if it is perceived as self-relevant and threatening? A case-control study in patients with breast cancer. “

Heisig, S.[1], Shedden Mora[1], von Blanckenburg, P.[2], Schuricht, F.[2], M., Rief, W.[2], Albert, U.-S.[3], & Nestoriuc, Y.[1]
[1]Department of Clinical Psychology and Psychotherapy, University Hamburg, Germany; [2]Department of Clinical Psychology and Psychotherapy, Philipps-University, Marburg, Germany;
[3]Department of Gynecology, Gynecological Endocrinology and Oncology, Philipps-University, Marburg, Germany

Theoretical Background

In medical settings patients need to be informed about their disease and treatment to be enabled to participate in treatment decisions. Information that is perceived as threatening and self-relevant is encoded differently from neutral information (Croyle et al., 2006; Kessels, 2010; Rogers, Kuiper, & Kirker, 1977). The aim of this study is to demonstrate that the relevance of medical information to a patient has to be pointed out in patient education to ensure successful processing of the information.

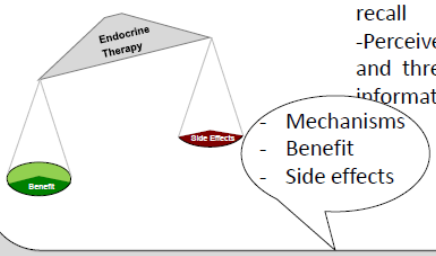
Hypothesis

Side effect information on endocrine therapy is processed worse in terms of comprehension and recall in breast cancer patients than in healthy controls, especially when patients do not evaluate the information as self-relevant and threatening.

Methods

Patient education → **Measures**

-Comprehension and recall
-Perceived relevance and threat of information



Sample

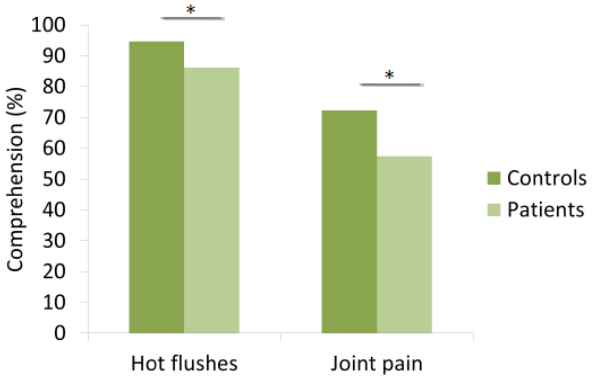
N=95 postoperative patients with breast cancer

N=95 matched healthy controls

Age in both groups:
M=56.44 (SD=10.82)

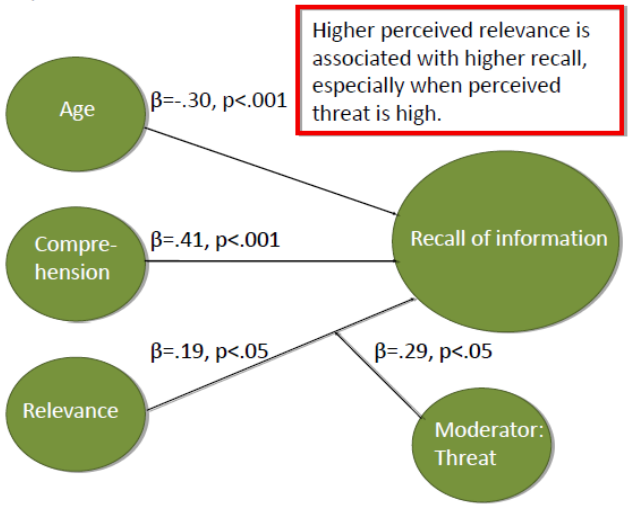
Results: Group differences

- Comprehension was high, recall medium to high.
- Patients showed lower comprehension of specific side effect information than healthy women (χ^2 (1) = 4.02 to 4.12, p<.05)



Results: Patients

Predictors and moderators of recall:
R^2=.46, F(5,88=)15.17, p<.001



Conclusion and clinical implication

This study demonstrates that patients process side effect information differently than healthy women. Perceived relevance and threat of medical information influence how medical information is processed. **In medical settings patients' perceived relevance and threat of treatment information should be taken into account. The relevance of treatment information should be emphasized.**

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Contact:
Dipl.-Psych. Sarah Heisig, Department of Clinical Psychology and Psychotherapy, University Hamburg, Germany, von-Melle-Park 5, 20146 Hamburg
Email: sarah.heisig@uni-hamburg.de

Outcome and process research

A CBT PROGRAM TO MANAGE CLINICAL PERFECTIONISM ON A UNIVERSITY SAMPLE: PILOT STUDY RESULTS

Arana Fernán, Lago Adriana, Galarregui Marina, Partarrieu Andrés, Miracco Mariana & Eduardo Keegan

Instituto de Investigaciones, Facultad de Psicología, Universidad de Buenos Aires
Consejo Nacional de Investigaciones Científicas y Técnicas

INTRODUCTION

Perfectionism is characterized by the pursuit of excellence and an inclination to set high standards of performance, accompanied by a self-evaluative hypercritical tendency and worry about making mistakes. Local studies have shown an incidence of perfectionism in Psychology students of more than half of respondents (56% of 761 evaluated subjects). Perfectionism has been considered a factor of causality and maintenance of various mental disorders such as depression, social phobia, generalized anxiety disorder, obsessive-compulsive disorder, and anorexia nervosa. Hence, the need to develop preventive transdiagnostic treatments, as well as psychoeducational interventions aimed at reducing the impact of dysfunctional aspect associated with this trait has been raised in the fields of clinical and preventive psychology. To this end, our research team has designed a psychoeducational intervention (PI) on perfectionism oriented to Argentine college students.

OBJECTIVE

- To evaluate the impact of a psychoeducational intervention on clinical perfectionism
- To present preliminary results in a group setting (Psychoeducational Intervention)

METHODOLOGY

The study design is quasi-experimental, longitudinal two repeated measures (pre-and post-intervention). Two measurements were taken tracking (3 months and 6 months) that remain in the process of data analysis. It was hypothesized that the intervention would lead to a significant reduction of perfectionism dysfunctional. A t test for realted samples was used for data analysis.

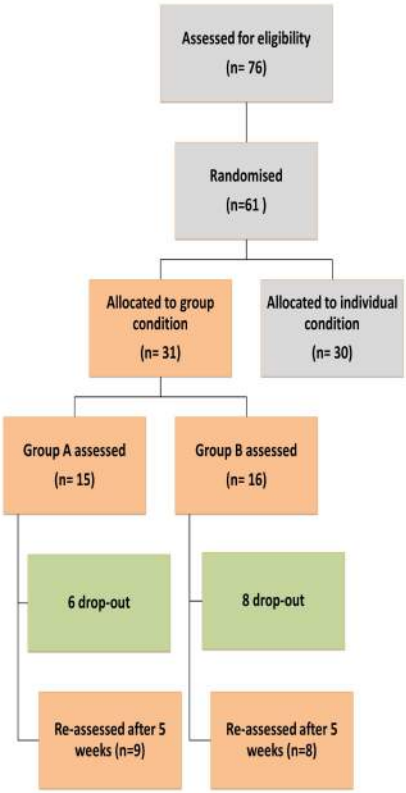
MATERIALS

- Demographic Questionnaire.
- Perfectionism, APS-R. Almost Perfect Scale-Revised (Slaney et al., 2001; Arana et al., 2009).
- Depression, BDI-II. Beck Depression Inventory (Beck, AT, Steer, RA, & Brown, GK 2006).
- Anxiety, STAI. State-Trait Anxiety Inventory. Y-I forms (Spielberger et. Al., 1983).
- Psychoeducational guide on perfectionism for Argentine university students.

PROCEDURE

PI involved five weekly group sessions. Measures of perfectionism (discrepancy) and psychological distress (anxiety and depression symptoms) were taken at the initial week, fifth week, and three months after PI was completed. We expect an improvement on those variables at the end of the program. Data from follow-up are not ready yet so analyzes yield only two-points.

CONSORT diagram showing the flow of participants through each stage of the study



PARTICIPANTS

From a total of 31 subjects who began the workshop, only 14 completed it, with a dropout rate of 45% (14 subjects). Given this last ratio, we proceeded to assess whether differences existed prior to baseline measures that might indicate reasons for dropouts. No statistically significant differences between groups were found, but in descriptive terms we could see that the dropout group scored slightly lower on measures of clinical distress and discrepancy.

Variable	PI completer Group (n=17)		Dropout Group (n=14)		*t (df)*	*d*
	M	*(SD)*	M	*(SD)*		
Discrepancy	58,14	*18,9*	51,12	*17,19*	-1,08 (29)	0,41
Depression	18,14	*9,28*	16,18	*10,35*	-0,55 (29)	0,19
Anxiety-S	46,79	*13,05*	43	*11,17*	-0,87 (29)	0,34
Anxiety-T	54,5	*13,48*	51,06	*14,18*	-0,36 (29)	0,24

Note: Discrepancy = subscale APS-R, Depression = BDI-II, Anxiety-S = STAI State, Anxiety- T= STAI Trait

RESULTS

Significative differencies were found at pre-post PI for both perfectionism and clinical measures [Discrepancy = t (13) = 5.15, p <.0001; Depression = t (13) = 5.56, p <.0001, State-anxiety = t (13) = 4.10, p <.001; Trait-anxiety = t (11) = 3.21, p <.01]. Effect sizes (d) were large for all variables (from 0.88 to 2.99.) Data at follow up could confirm this trend, encouraging us to design a new controlled intervention.

Variable	Pre Intervention		Post Intervention		*t (df)*	*d*
	M	*(SD)*	M	*(SD)*		
Discrepancy	58,14	*18,9*	41,79	*13,23*	5,15 (13)***	1,24
Depression	18,14	*9,28*	5,86	*4,11*	5,56 (13)***	2,99
Anxiety-S	46,79	*13,05*	32,64	*6,44*	4,10 (13)**	2,2
Anxiety-T	54,5	*13,48*	44,3	*11,63*	3,21 (11)*	0,88

Note: Discrepancy = subscale APS-R, Depression = BDI-II, Anxiety-S = STAI State, Anxiety- T= STAI Trait
*** = p < .0001
** = p < .001
* = p < .01

DISCUSSION

The results obtained so far are favorable in terms of the effectiveness of the intervention, although maintenance of gains in future monitoring remains to be assessed. All variables associated with psychological distress decreased significantly after the intervention. On the other hand, the high dropout rate affected the intervention in terms of feasibility. One possible strategy for dealing with this difficulty is to adjust our inclusion criteria in future interventions.

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COGNITIVE BEHAVIOURAL GROUP TREATMENT FOR INTERPERSONAL EFFECTIVENSS: A STUDY OF WOMEN IN A MEDIUM SECURE PSYCHIATRIC HOSPITAL

Clive Long, Barbara Fulton and Olga Dolley
St Andrew's Northampton

St Andrew's Academic Centre

Institute of Psychiatry at The Maudsley | King's College London, University of London | St Andrew's

INTRODUCTION

Failure to interact with others in a competent and successful way is of particular significance for women with a diagnosis of personality disorder or schizophrenia and may have far reaching consequences. Interpersonal effectiveness is an expression of emotional intelligence and represents essential skills for the effective transition from hospital to community life. However, interpersonal effectiveness treatment for women with a dual diagnosis in secure settings has not been well researched.

This study reports the results of a manualized group cognitive behavioural treatment for interpersonal effectiveness developed to meet the needs of women admitted to medium secure psychiatric services.

GROUP TREATMENT

The interpersonal effectiveness group uses closed group format. It is preceded by an individual orientation session and followed by a post-group individual session to capture learning and behavioural changes that have occurred through treatment.

The three parts of the group programme focus on:

- understanding relationships (sessions 1-4)
- understanding the principles of self management in relationships (sessions 5-8)
- skills for self management in relationships (sessions 9-12).

Table 1 gives details of sessions and pre-post evaluation measures of interpersonal problems, self efficacy, company, relationships and risk behaviours.

Table 1. Individual sessions in the group programme

Group Sessions	Pre-post assessment measures
Understanding relationships • introducing the programme • the functions and benefits of relationships • exploring rewarding and unrewarding relationships • what stops us enjoying relationships and how we can increase our enjoyment. **Principles of self management in relationships** • understanding and recognizing your needs in relationships • understanding expectations in different types of relationships • understanding responsibilities in relationships • understanding boundaries. **Skills for self management in relationships** • expressing needs in relationships positively • saying 'no' • skills for improving relationships • how to effectively give and receive support • review of the group.	1. Inventory of Interpersonal Problems 32 2. Generalised self-efficacy scale 3. Camberwell assessment of need forensic version item 14: company 4. Health of the Nation Outcome Scale-Secure Item 9 Problem with Relationships 5. Risk Behaviours

RESULTS

Participants: Thirty four women with a primary diagnosis of either personality disorder (emotionally unstable or with mixed features) or schizophrenia participated.

Completers v Non Completers: Patients were divided into treatment completers (n=22; 65%) and non completers (n=12;35%). Completers were younger and more likely to have experienced psychotherapy in the past. Pre-group psychometric measures showed no differences between the completers and non completers.

Risk Behaviours: Treatment completers showed a significant reduction in aggression to self and others following treatment.

Pre-Post Change on Psychometric Measures: Completers showed significant changes on all measures, in contrast to non completers.

DISCUSSION

Improvements evident post-groups provide confirmatory evidence for the value of social skills and communication skills training for individuals with a primary diagnosis of personality disorder and schizophrenia.

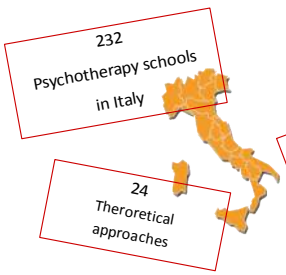
The group focusses on the social skills and social performance aspects of social competence in emphasizing that 'effectiveness' means obtaining desired social changes and keeping both the relationship and one's self respect. In this regard, changes in the 'non assertive', 'socially inhibited', 'vindictive/ self centered' and 'domineering/ controlling' subscales of the Inventory of Interpersonal Problems 32 are encouraging.

That one third of patients did not complete treatment raises questions about timing, applicability and readiness for treatment. Further work to develop and evaluate the intervention is needed.

Young psychotherapists today:

the impact of a four years training in an Italian CBT school.

Colombo P., Di Berardino A., Bizzozero A., Paganuzzi P., Raffognato C. e Meneghelli, A. (***ASISPE, ITA***)



40
Cognitive—Behavioural schools

AIAMC
Italian Association for Behaviour Analysis, Modification and Behavioural and Cognitive Therapy
(13 centres, 7 schools)

SITCC
Italian Society of Behavioural and Cognitive Therapy
(28 schools)

ASISPE
Milano, since 1994
more than 500 psychoterapists formed

OBJECTIVE

The study aims to investigate the impact on trainee psychotherapists of four years postgraduate specialist training in a Cognitive-Behavioral school.

Althought the Cognitive Behavioural approach has a strong evidence-based orientation, we have very few, almost zero, datas about the effects that the training received by future psychotherapists has on on the psychotherapists themselves.

We should to ask not just:

✓ *Does he/she knows all the things a therapist should know?*

But also

✓ *Has he/she developed the personal characteristics that he/she promotes?"*

This work goes in the direction of being the first step in answering those two questions, starting from

A **demographic snapshot**

Subjects are described according to socio-demographic variables such as age, sex, place of origin, employment status, etc

A **survey of variables such as self-esteem, assertiveness, explanatory style and quality of life**

dimensions investigated by standardized self-report questionnaires

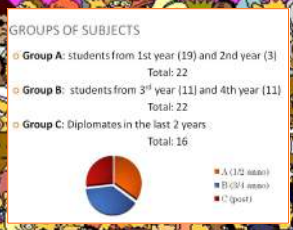
SUBJECTS

All participants belongs to the quadrennial post-graduate School in Cognitive and Behavioral Psychotherapy of Milano: **ASISPE**. Member of the AIAMC (Italian Association of Behavior Analysis and Modification) and, as such, affiliate EABCT.

The sample consist of No. 84 subjects, distributed into three groups: 28 subjects attending the first two years in training, 28 subjects attending the last two years in training and 28 subjects in the first and second year post training.

Questionnaires delivered by e-mail to more than 160 Asipse's students and ex-students. Returned forms: 84. Valid forms: 60.

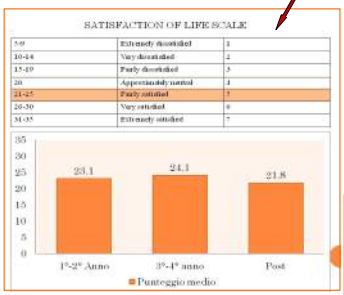
The average age at the time of Graduation is **26,5 years**
(the youngest at 24 years old, the oldest 37)
The average age of entry at **Asipse** is **30 years**
(from 25 to 60 years old)
The time between graduation from university and the entry at Asipse varies from 1 year to 23 years.



Distance home - ASISPE

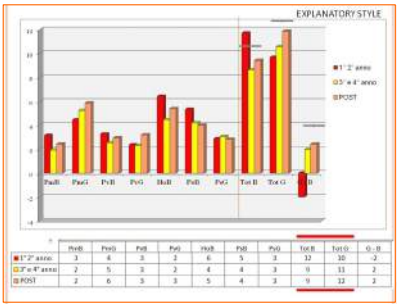
1-50 KM	26
51-100 KM	21
100-150 KM	10
> 150KM	3

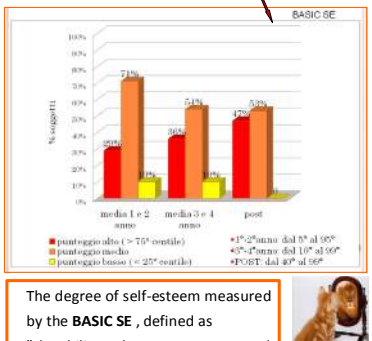
SATISFACTION WITH LIFE SCALE - ATTRIBUTIONAL STYLE Q. - BASIC SE (Self-esteem Scale) - SIB (Scale for Interpersonal Behavior)



The **SWLS** scores ranging between 21 and 24 indicate a total sample
" fairly satisfied "

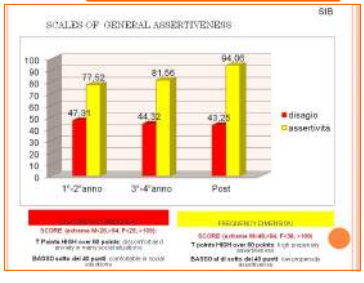
In the **explanatory style**, especially in group A (1 and 2 year), there's marked pessimism - the tendency to see negative events as permanent , which effects are perceived as pervasive and , together with an internal style of personalization, leads to lower self-esteem.





The degree of self-esteem measured by the **BASIC SE** , defined as "the ability to have open , warm and rewarding relationships with others, the freedom to feel and express emotions with a sense of security, integrity and assertiveness ," is instead not compromised.

In the **SIB** a self-assessment is required about both the level of discomfort experienced in implementing a behavior , and, regardless of the discomfort , the frequency of the same behavior ;
results show that , if the size of the discomfort does not undergo big changes , remaining at an average level , the propensity assertive grows considerably (note that in the course of training, there's an assertiveness training)



CONCLUSIONS

It was expected that the changes should go in the direction of a general increase of the dimensions investigated (such as, for example, self-esteem and assertiveness) and that the training in a cognitive-behavioral school of psychotherapy, would proves to be not just a path of acquisition of technical knowledge , but also a useful support in the self development. Data shows a general framework moderately positive, considering the unfavorable historical period for the new generation, psychotherapists of tomorrow, today, seem to have a not so high satisfaction, a high degree of pessimism , but self-esteem is strengthened at the end of the training , as well as assertive skills are increasing.

for communications: petra.colombo@gmail.com

Results From A Pilot Trial Using Compassion and Loving Kindness Practices in a Group Setting with Patients suffering from Chronic Depression

Johannes Graser, Volkmar Höfling, Charlotte Weßlau & Ulrich Stangier

Goethe University Frankfurt – Psychology Department – Clinical Psychology and Psychotherapy Unit

THEORETICAL BACKGROUND

Established mindfulness interventions such as MBSR and MBCT have proven successful in reducing symptoms in acute (Hofmann, Sawyer, Witt & Oh, 2010) and chronic depression (Barnhofer, Crane, Hargus, Amarasinghe, Winder & Williams, 2009). Little research has been conducted on further meditation and mindfulness practices such as Loving Kindness Meditation and Compassion practices. As depression is associated with self-criticism (Murphy, Nierenberg, Monson, Laird, Sobol & Leighton, 2002) Loving Kindness Meditation and Compassion practices could be a useful tool for reducing depressive symptoms as these techniques foster a more benevolent and therefore adaptive way to relate to oneself (e.g. Frederickson, Cohn, Coffey, Pek & Finkel, 2008; Gilbert & Procter, 2006; Neff & Germer, 2013). In an outpatient clinic a 9 week pilot trial using these techniques on patients suffering from chronic depression was conducted.

METHOD

Sample

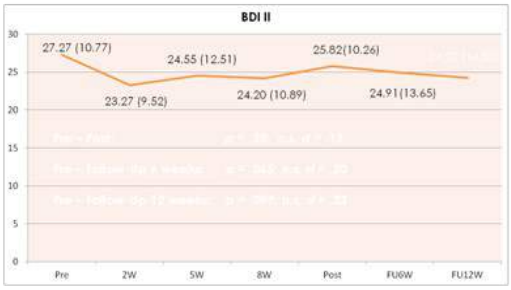
- *N* = 11 Patients suffering from chronic depression (Dysthymia; recurrent depressive disorder without sufficient remission for at least 2 years or double depression; Diagnosed with SKID I; SKID II; Psychiatric Status Rating (*PSR*: Instrument for assessment of chronic depression)
- 7 female patients, 4 male patients
- Medium age 37.55 years (*SD* = 11.84; Range 24-55)
- Average duration of chronic depression 6.32 years (*SD* = 5.10; Range 2-17)
- Mostly no meditation experience
- Patients with acute addictions, manic or psychotic symptoms, PTSD or odd/dramatic personality disorders were not included
- Included patients were allowed medication but no current psychotherapy

Program structure

- 9 weekly group sessions (8 x 100 minutes, 1 x 200 minutes = Retreat)
- 1 main meditation exercise every week:
  - 3 Mindfulness exercises: Mindfulness of a stone / breath / feelings
  - 2 Self-Compassion exercises: Self-Compassion Break (2 weeks), Self-Compassion for my feelings
  - Loving Kindness Meditation (3 weeks)
- The sessions started off with the practice of last weeks homework exercise, afterwards group discussion: „How was that exercise for you and how did the practice go at home?"
- Theoretical input on Mindfulness / Self-Compassion / Loving Kindness
- Introduction of a new exercise and group discussion
- Sometimes informal practices
- Discussion of homework (30 minutes of daily practice with provided taped exercises was recommended)

RESULTS

Depression



Self-reported changes

(Pre - Post / Pre - Follow-Up 6 weeks / Pre - Follow-Up 12 weeks)

	Much worse	Worse	Slightly worse	No changes	Slightly better	Better	Much better
Mood	0/0/0	1/0/0	2/1/0	4/4/4	3/4/5	1/2/2	0/0/0
Being able to perceive feelings	0/0/0	0/0/0	0/0/0	6/5/3	4/4/6	1/1/1	0/1/1
Dealing with feelings	0/0/0	0/0/0	0/0/0	5/3/4	4/6/5	2/2/2	0/0/0
Drive	0/0/0	0/1/0	1/1/0	6/5/8	3/4/3	1/0/0	0/0/0
Self-Esteem	0/0/0	0/0/0	0/3/0	7/6/7	4/1/3	0/1/1	0/0/0
Rumination	0/0/0	1/1/0	1/0/0	6/5/8	2/4/3	1/1/0	0/0/0

	Much less	Less	Slightly less	No changes	Slightly more	More	Much more
Self-care	0/0/0	0/0/0	1/1/0	1/3/3	6/5/5	3/2/3	0/0/0
Self-Compassion	0/0/0	0/0/0	1/0/0	2/4/4	7/7/5	1/0/2	0/0/0
Loving Kindness towards self	0/0/0	0/0/0	0/0/0	2/5/4	8/5/5	1/1/2	0/0/0
Loving Kindness towards others	0/0/0	0/1/0	0/0/0	7/7/5	4/3/4	0/0/2	0/0/0
Positive affect	0/0/0	0/0/0	2/0/0	5/7/5	4/4/4	0/0/0	0/0/0
Negative affect	0/0/0	0/0/1	2/2/2	8/9/8	1/0/0	0/0/0	0/0/0

(Post / 12 Week Follow-UP)	Not helpful at all	Not helpful	Rather not helpful	No effect	Rather helpful	Helpful	Very helpful
Overall evaluation of therapy	0/0	0/0	2/0	2/1	6/7	0/2	1/1

Correlations: Practice time – Difference depressive symptoms

	Difference BDI II Pre - Post	Difference BDI II Pre – 6 week Follow-Up	Difference BDI II Pre – 12 week Follow-Up
Practice time during 9 week program: *M* = 745.5 minutes (*SD* = 434.9; Range 100-1455)	**.55* (*p* = .040)**	.38 (*p* = .13; n. s.)	.43 (*p* = .094; n. s.)

Other Scales

Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965; German version: von Collani & Herzberg, 2003)

Pre	Post	*p*	*d*	12 week Follow-Up	*p*	*d*
2.40 (.57)	2.53 (.67)	.21 (n. s.)	0.21	**2.64 (.56)**	**.009***	**.43**

*: $p < .05$

Self-Compassion Scale (SCS; Neff, 2003; German version: Hupfeld & Ruffieux, 2011)

Scale	Pre	Post	*p*	*d*	12 week Follow-Up	*p*	*d*
Overall Scale	2.43 (.67)	2.56 (.66)	.074 (n. s.)	.21	2.59 (.69)	.062 (n. s.)	.24
Self-Kindness	**2.18 (.77)**	**2.62 (.81)**	**.022***	**.56**	**2.62 (.81)**	**.022***	**.56**
Self-Judgment	3.72 (.71)	3.54 (.87)	.14 (n. s.)	.24	3.64 (1.00)	.24 (n. s.)	.31
Common Humanity	2.50 (.85)	2.48 (.87)	.44 (n. s.)	-.02	2.48 (.87)	.44 (n. s.)	.06
Isolation	3.48 (.96)	3.38 (.94)	.16 (n. s.)	.11	3.47 (1.00)	.15 (n. s.)	.01
Mindfulness	**2.60 (.57)**	2.68 (.50)	.31 (n. s.)	.16	**2.86 (.52)**	**.017***	**.48**
Over-Identification	3.53 (.77)	3.53 (.71)	(n. s.)	.00	3.32 (.71)	.084 (n. s.)	.28

DISCUSSION

The main outcome *depression*, measured with the *BDI II*, did not reach a significant decrease, a trend was reached though at the time of the 6-and 12-week follow-up measures. Participants who practiced more, experienced a stronger decrease in depression. *Self-Esteem* was increased significantly with a medium sized effect at 12-week follow-up. The *overall Self-Compassion Scale* did not increase significantly, the subscales *Self-Kindness* (post and follow-up) and *Mindfulness* (follow-up) showed medium sized increases. Further post and follow-up self reports comparing the patients current state with the state before therapy showed mostly slight improvements in the inquired areas. The majority of the patients evaluated the program as (rather) helpful, though the results on depression are not satisfactory yet. In a second trial we will reduce the size of the exercises to allow more practice for each exercise. We also decided to prolong the treatment from 9 to 12 weeks. In addition we want to address issues with the exercises that caused problems for some patients such as „fear of compassion" (Gilbert, 2011) and other problems we came across with these exercises (e.g. "I don`t deserve / feel compassion").

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Dialectic Behavioural Therapy –based skills training in group for adults with ADHD

T. Hirvikoski, E. Morgensterns, J. Alfredsson, & B. Bihlar

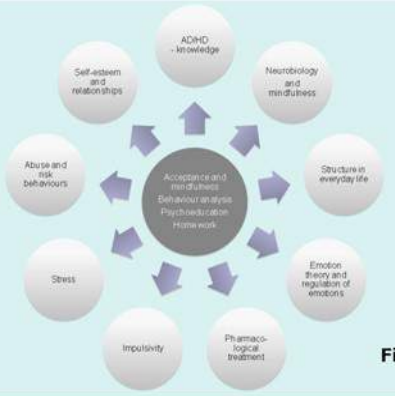

Fig1. Treatment components (in the middle) are applied on different ADHD-related themes.

Conclusions

- Approximately 80 % of participants completed the program in oupatient psychiatric care and 60% in compulsory care context
- Participants satifaction in both context was good
- The skills training was associated with a significant reduction in ADHD symptoms
- DBT-based skills training in group is a promising treatment for adults with ADHD in different clinical contexts

STUDY 1: RCT effectiveness study

In a Swedish outpatient psychiatric context we evaluated effectiveness (feasibility and efficacy) of Dialectical Behavioural Therapy (DBT) -based skills training groups for adults with ADHD (Hesslinger, Philipsen & Richter, 2004; Philipsen et al, 2007).

Methods

The participants were recruited at an outpatient psychiatric clinic and randomized to skills training (n=26) or discussion group/control group (n=25). The assessments were performed pre- and post-treatment.

Results

- DBT-based skills training was judged as suitable treatment option for 75% of adults diagnosed with ADHD.
- Approximately 80% of the participants completed the group (in both gorups).
- DBT skills training was perceived more ″logical″ and ″helpfull″ as compared to discussion/control group.
- ADHD-symptoms were reduced in the skills training group, but not in the control group.


Behaviour Research and Therapy

Reduced ADHD symptoms in adults with ADHD after structured skills training group: Results from a randomized controlled trial

Fig2. The RCT study was published 2011.

STUDY 2: Predictors of treatment effects and drop-out

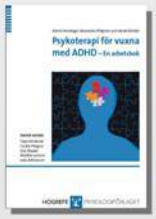

Fig3. Study 2 was performed according to the Swedish version of the treatment manual, published 2010.

Aims

In a Swedish outpatient psychiatric context we study which background variables moderate the treatment effects and/or drop-out.

Methods

We have enrolled 102 adults with ADHD at five sites in this open multicenter effectiveness study. The assessments are performed pre- and post-treatment, as well as three months after finished treatment.

Preliminary results

Preliminary results show positive treatment effects on ADHD-symptoms, perceived disability in everyday life, co-existing psychiatric symptoms, quolity of life as well as ability to accept emotions and to be mindful in the present moment.

STUDY 3: Feasiblity for males with ADHD and severe SUD in compulsory care

Aims

In an open effectiveness study we are evaluating feasibility and efficacy of DBT-based skills training in group for adult men with ADHD and severe SUD.

Fig 4. The treatment is performed as a voluntary intervention in a compulsory care context at SiS-Institution Hornö.

Methods

So far, we have included 25 men with ADHD and SUD. The assessments are performed pre- and post-treatment, as well as six months after discharge from compulsory care.

Preliminary results

Approximately 60% of participants have completed the treatment; an acceptable feasibility in the compulsory care context.

We are currently also evaluating cognitive behaviour therapy –based psychoeducational groups for adults with ADHD and their significant others.

Principal investigator/corresponding author
Tatja Hirvikoski, PhD/neuropsychologist
KIND Karolinska Institutet Center of Neurodevelopmental disorders
E-mail: tatja.hirvikoski@.ki.se
Tel: + 46 (0) 708 327 637

Changes in Thought-Action Fusion and Inferential Confusion Scores with Cognitive-Behavioral Group Therapy for Obsessive-Compulsive Disorder

Yasir Safak[1], Kadir Özdel[1], Emrah Karadere[2], Turkan Dogan[3], M. Hakan Turkcapar[4], S. Olga Guriz[1]
[1]Ankara DYB Research and Training Hospital Psychiatry Clinic
[2]Hitit University Research and Training Hospital Psychiatry Clinic
[3]Aksaray State Hospital Psychiatry Clinic
[4]Hasan Kalyoncu University Department of Psychology
E-mail: *dr.yasirsafak@yahoo.com*

Key Words: Obsessive-compulsive disorder; Thought-action fusion; Inferential confusion; Treatment efficacy

OBJECTIVES:

Thought–action fusion (TAF) have been claimed to contribute to the development of obsession and obsession-like intrusions[1,2]. Inferential confusion (IC) is proposed to be a meta-cognitive confusion particularly relevant to obsessive compulsive disorder (OCD) [3]. Inference-based model where the reasoning process is put in the center is proposed to be more relevant than appraisal-based models of OCD where the focus is on beliefs guiding the appraisal of intrusive cognitions in the development and maintenance of OCD[5]. There are many studies devoted to examine the significance of TAF and IC. Results indicate that TAF and inferential confusion are correlated with severity of psychopathology[4,5,6,7]. As well, mean scores on the TAF and IC measures decreased significantly from pre- to post-treatment, indicating that TAF and IC are susceptible to change during psychotherapy[8]. In this study, we aimed to assess these two related cognitive features (e.g., thought–action fusion, inferential confusion) in the same sample of OCD patients that were treated with cognitive behavioral group therapy.

METHODS:

Thirty-seven patients with OCD, according to DSM-IV criteria entered to study. Organic brain disease, bipolar, psychotic and severe personality disorders, substance-use disorders were excluded. All subjects provided written informed consent that was approved by the institutional review board.
Groups were conducted as four different outpatient groups lasting 14 sessions which included 8-10 patients. Patients were randomly distributed into groups regardless of their obsession types. Patients were attended 14 sessions of group CBT by 4 different therapists who were trained for Cognitive-behavioral therapy. Treatment sessions were also supervised by a senior cognitive behavior therapist (5th author). Sessions were performed once a week, 90-120 minutes long.
Efficacy of treatment was rated according to the reduction in scores on the Yale-Brown Obsessive Compulsive Scale (YBOCS), Beck-Anxiety Inventory (BAI), Beck-Depression Inventory (BDI). Thought-Action Fusion Scale (TAFS) and Inferential Confusion Questionnaire (ICQ) were used for the measurement of the cognitive features. YBOCS, BAI, BDI, TAFS and ICQ scales were administered pre- and post treatment. Mean scores were compared with dependent sample t-tests.

RESULTS:

Socio-demographic variables and disorder duration were shown in the table-1.

TABLE 1- Socio-Demographic Features of the Patients Who Involved to Group Therapy

Sociodemographic Features	Number	Percentage
Gender		
Men	9	% 24,3
Women	28	% 75,7
Age		
16-24	8	%21,6
25-40	24	%64,9
41-65	5	%13,5
Mean	32,13 ± 9,85	
Education as years		
8 years≤	12	%32,5
9-11 years	14	%37,8
12 years≥	11	%29,7
Mean	10,59±3,58	
Age at Onset		
Mean	23,24 ± 5,89	
Disorder Duration (years)		
Mean	8,89±9,09	

Alterations in YBOCS, BAI, BDI, TAFS and ICQ were shown in the table 2. We found CBGT is effective. Hence, statistically significant difference between the initial and final scores (YBOCS, BDI, BAI) of the patients was detected. Also, alterations in TAFS and ICQ are both statistically significant at the level of p<0,001.

Table -2 Difference of initial and final BDE, BAE, YBOCS, TAF and ICQ scores of the groups

Average Difference	Average	Std. D	p
Initial YBOCS – Final YBOCS	15,72	6,04	,001
Initial BAE – Final BAE	8,65	9,98	,001
Initial BDE – Final BDE	7,37	6,37	,001
Initial TAF-Final TAF	16,13	15,55	,001
İnitial ICQ-Final ICQ	9,72	13,82	,001

CONCLUSION:

Inference-based model where the reasoning process is put in the center is proposed to be more relevant than appraisal-based models of OCD where the focus is on beliefs guiding the appraisal of intrusive cognitions in the development and maintenance of OCD. As the previous studies conducted in different samples in our study mean scores on the TAF and IC measures decreased significantly from pre- to post-treatment, indicating that TAF and IC are susceptible to change during CBGT.

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An experimental study of "written emotional expression": mechanisms and effectiveness

Lucio Sibilia, MD Dept. of Psychology and Developmental Processes - Faculty of Medicine and Psychology, Sapienza University of Roma, Italy
Anna Rita Colasanti, Faculty of Educational Sciences, Università Pontificia Salesiana, Roma
Margherita Cirillo, Center for Research in Psychotherapy (CRP) Rome, Italy

Background.
The Expressive Writing Therapy (EWT) proposed by J. Pennebaker - a form of written emotional expression - has been shown in several studies to produce noticeable improvements in well-being and health-related outcomes in normal and clinical populations.
However, its therapeutic mechanisms are still debated; in the theoretical underpinnings of the proponent and other authors, the key factor is the expression of emotions. The present study aimed at testing this hypothesis.

Hypotheses
1. If the writing experience would work through stimulating or allowing the expression of emotions, independently from their sign (- or +), then:
•EWT technique and King's technique would have the same benefits
•the number of emotional words would be positively correlated with the emotional outcomes.
2. If the expression of negative emotions would be the therapeutic mechanism, then we should find a correlation between the number of negative emotional words and the emotional outcomes of the writing experiences.

Method
120 undergraduate students were enrolled and randomly divided into 3 groups of 40 SS each. The first underwent three EWT sessions about their own traumas, the second underwent three sessions of a mood enhancing writing technique (according to the method of Laura King), and the third was invited to write about neutral experiences.
Both at baseline and 40 days after the end of the experimental period, the scores of Well-Being were gathered with the Ryff Scale (RS) and of Depression with the Beck Depression Inventory (BDI).
All the written reports about the traumatic experiences were gathered, and were assessed for the frequency of emotional words (positive, negative) as a measure of emotional expression, and total word count as a measure of descriptive detail.

Assessment procedure

Instruments used:
- *Well-being*: **Ryff Scales of Psychological Well-Being** by Carol Ryff (Ryff)
- *Depression*: **Modified Beck Depression Inventory** (Mod. BDI)
- *Emotional expression*: **Linguistic Inquiry and Word Count** (LIWC)

Variables assessed:
- Well-being scores (PWB)
- Depression scores (Mod. BDI)
- Positive emotions (LIWC - PE)
- Negative emotions (LIWC - NE)
- Cognitive words (LIWC - CW)
- Word count (LIWC - WC)

Phases of study:
I. Baseline assessment - All groups - Variables: PWB, Mod. BDI
II. Treatment phase - Group 1 (EWT), Group 2 (King T.), Group 3 (Control)
III. End of treatment assessment, Group 1 and Group 2 - Variables: all
End of treatment assessment, Group 3 - Variables: PWB and Mod. BDI

Results
Only SS in the first group (EWT) exhibited both a significant reduction in BDI scores (depression level) and an improvement in PWB scores (well-being), as compared either to the second group (L. King's technique) and to the control one. The SS in the second group did not show any significant improvement in the two outcome measures.
In the written reports, the number of positive emotions was not significantly correlated with the outcome in neither technique, and the number of negative words was significantly correlated with the outcome in EWT, but inversely as expected, whereas it was rather the total number of words to be associated with increases of well-being in EWT.

Tab. 1 Composition of sample

Gender	N.	%
Males	24	20
Females	96	80
Age (yrs.)		
19- 21	27	22,5
22-27	70	58, 3
28-33	12	10
> 33	11	9,2
Nationality		
Italian	106	88, 3
Not Italian	14	11,7

The technique of Emotional Writing Therapy (EWT)
Subjects are required to produce in about 15'-20' in a single occasion a written description of a specific emotional episode they have experienced, which can be labeled as a very unpleasant or a traumatic experience, including inner emotions and thoughts.
One or more days after this first description, the same or other episodes can be described, of the same kind.
While writing, similar emotional states are aroused in the subject, albeit in a lesser degree, evoking some emotional distress, which, however, are usually estinguished shortly after.

The technique of Laura King
Requires SS to produce a description of own inner desires, by imagining future goals and achievements as attained, and the emotions attached to them.

Tab. 2 Effectiveness of EWT as compared with King's technique (delta = base - final scores)

	Average	S.D.	Student t	p(t)
Group 1 (EWT)				
Ryff (delta)	**-2,95**	**3,86**	**-4,84**	**<0,00001**
Mod. BDI (delta)	**9,78**	**25,49**	**2,43**	**0,02**
Group 2 (King)				
Ryff (delta)	-0,78	6,62	-0,74	n.s.
Mod. BDI (delta)	3,97	24,69	1,02	n.s.
Group 3 (Control)				
Ryff (delta)	1,30	20,57	0,3997	n.s.
Mod. BDI (delta)	-0,03	4,73	-0,0335	n.s.

Tab. 3 - Pearson's r of correlations between LIWC parameters and well-being and depression delta scores (delta = base - final scores)

Group 1 (EWT)	**Ryff (delta)**	**Mod. BDI (delta)**
Positive emotions	-0,0610	-0,1480
Negative emotions	**0,3223(a)**	-0,1314
Cognitive words	0,0017	-0,1323
Word count	**-0,5662**(b)	0,2241
Group 2 (King)		
Positive emotions	-0,0425	0,1717
Negative emotions	-0,1970	0,0769
Cognitive words	-0,0661	0,1731
Word count	0,1618	0,0050
(a): p<0,05; (b): p< 0,001		

Tab. 4 Possible theoretical levels of change other than "emotional expression" allowed by the Emotional Writing Therapy.

LEVEL OF CHANGE:	***From***	***To***
Cognitive content	private	public/shared
Representation	iconic	propositional
Time range	present	past
Emotional attitude	avoidance	acceptance
Resilience awareness	low	high
Memory of the experience	episodic	autobiographic

Conclusions
None of the hypotheses was confirmed, apart from the ability of J. Pennebaker's technique of written emotional expression to produce positive effects both in terms of improvement in well-being and of reduction of depressive mood in normal subjects, effects which persist after 40 days after the writing experience. Describing positive experiences (as in L. King's technique) does not show similar mood-enhancing effects, as these effects (if any) are not maintained at final assessment. Therefore, the expression of both negative and positive emotions is unlikely to account for the therapeutic effect of the written emotional expression; rather, in contrast with the alleged mechanism, the expression of negative emotions (as measured by the number of negative words) results detrimental to well-being. Only the amount of details of subjects' descriptions of own traumatic experiences seems to be associated to the observed improvements. Thus, changes at different levels should be advocated as therapeutic mechanisms than the expression of emotions, such as changes at cognitive, representational, or memory levels, which are here proposed.

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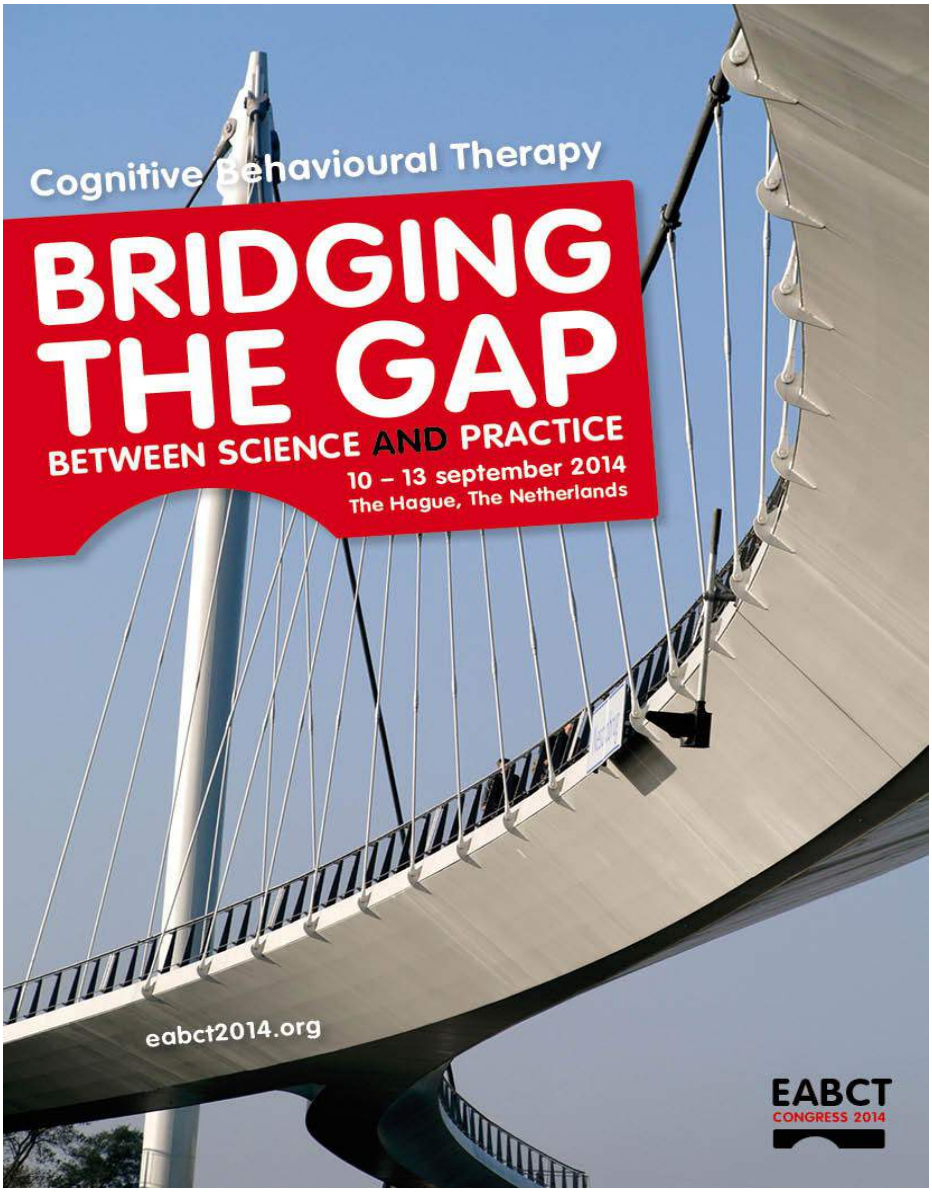

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