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Contents

Editorial

This present new issue of *Psychomed* is devoted – in the same way as in a few of previous issues – to a noteworthy set of posters, presented in an International Conference. This time, the posters have been selected from those presented at the 12th International Conference of Behavioural Medicine, held in Budapest from Aug. 29 to Sept. 1, 2012, organised by the International Society of Behavioural Medicine (ISBM) and the Hans Selye Hungarian Society of Behavioral Sciences and Medicine.

The idea of publishing posters in a scientific journal may seem odd, but it is not new. Some time has already passed by since we started to publish posters on *Psychomed*, in the occasion of the 6th International Conference of Cognitive Psychotherapy (ICCP), hold in Rome in 2008. We received a favourable response. Several colleagues responded with enthusiasm and contributed with their posters. Then, the experience was repeated with selections of posters from other International Conferences: the EABCT Conference hold in Dubrovnik in 2009 and the EABCT Conference in Milan in 2010, and again from the 7th ICCP "Clinical Science" hold in Istanbul in June 2011.

The idea of publishing posters was not only welcomed but soon after it was followed by other Italian scientific journals as well. So, this publication is not any more unique in its kind. But it is certainly coherent with the editorial policy of our journal, which aims at providing an easy-to-use tool for scientific updating, a "workout tool" for colleagues engaged in the clinical work and experimental research in the area interfacing both medical and behavioural sciences.

The idea to publish their posters so far has been welcomed by the authors, as it does not require to write down an article, with all the attention to the "instructions to the authors", as the poster is ready to be displayed. Besides, due to the online nature of *Psychomed*, the journal is not limited in the quantity of material which can be published, unlike printed journals. Moreover, previous technical difficulties have been overcome: now we have succeeded in preserving on the journal the printing clarity of original posters, so that readers can enlarge at will the posters' images and texts comfortably on their computer screens and obtain the same view as when they approach in person the real paper poster at the Conference halls. Finally, it is to remind that there are also advantages for us as editors, as posters usually have been already undergone a process of selection by the Conference organisers, so that really very few have to be rejected or re-edited.

A large number of posters is usually displayed in International conferences, which have the same (or even higher) quality as the papers, albeit their authors, often young or non-English speaking, have not enough language skills to present them in symposia or in oral sessions. *Psychomed* allows to publish such scientific works. In addition, as regards the posters in this issue of *Psychomed*, they have also been screened by the ISBM Conference organisers and have been rated for their scientific quality, so that the selection presented here could exclude all posters with low ratings. For this, we would like to thank Dr. Frank Penedo, chairing the Scientific Program, and the Colleagues of the Scientific Committee

who assisted in the effort of collecting all the contributions.

The 28 posters have been gathered according their thematic content, spanning from aging to stress, from measurement problems and methods to gender related problems, from illness perception to quality of life. Finally, we are proud to be able to include contributions by Authors from many different countries, such as Bulgaria, Chile, Hungary, Indonesia, Lithuania, Mexico, Pakistan, Portugal, Russia, Spain, whom we thank for their interest in *Psychomed*.

A last but not least notation: the technology which allows us to read comfortably a poster on our computer as if we were in Conference venue should not let us forget that in a poster there is much more work than in a single journal page.

As usually, we leave the the last word to our readers.

Lucio Sibilia

Roma, May 2013

Studies on aging

The Impact of Person-Centered Therapy on Older Adults' Self-Esteem and Congruence

Sofia von Humboldt[a] & Isabel Leal[b]

[a,b] Research Unit in Psychology and Health, R&D, ISPA- Instituto Universitário

Objectives

1. To analyse the impact of person-centered therapy (PCT) on the degree of self-esteem (SE) and congruence of older adults and **2.** To evaluate the existence of a correlation between socio-demographic variables and the degree of SE.

Methods

Participants

The sample comprised 40 older adults aged 65 and over, from both genders, who completed eight sessions of PCT.

(M = 71.73, SD = 6.9).

(n = 40)

- 57,5% female;
- 37,5% married,
- 60% active.

Material

Socio-demographic Questionnaire

- Gender; Age; Marital Status; Professional Status; Nationality; Ethnicity; Medical Condition; Activity/Ocupation; Household.

Self-Esteem Scale (SES)[1,2]

- The evaluation of the gap between real self (RS) and ideal self (IS) constitutes the measure of the degree of SE, congruence and psychological adjustment.
- Comprised of 74 5-point self-reference semantic differential itens (Likert type), in which the individual classifies himself as he/she sees himself in reality (RS) and as he/she wishes to be (IS).

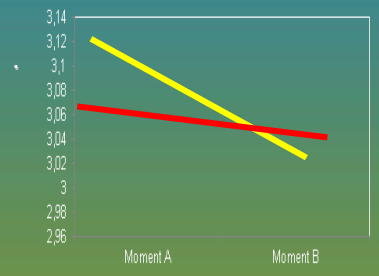
Procedure

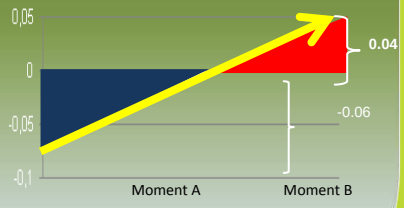
- Data was gathered in two moments of evaluation (A – before the beginning of therapy) and (B – after the end of therapy). All participants completed eight sessions of PCT.

Results

The degree of SE increased from -0.057 in moment A to 0.042, in moment B;

- After the therapeutic process, participants indicated an increase of the absolute value of SE (0.099);
- IS was higher than RS in moment B;
- Both components indicated a decrease of the absolute value: IS and RS, being the latter more accentuated than the first;
- The results also indicated no correlation between SE and the socio-demographic variables for a significance level (α = 0.05), in both moments.





Discussion and Conclusions

- Positive effect of PCT on older adults' SE, translated into a better adjustment of the RS and IS, and subsequently, an increase of their congruence level;
- The increase of the degree of SE was translated in a better correspondence between what older adults felt towards themselves in reality and what they wish for themselves in an ideal plan;
- Better association between self and experience and more trust in older adults' organismic experience;
- With the increase of congruence, older adults created conditions for a better future perspective, a belief in their self-fulfilment and project capacities, less defensiveness, less anxiety, more autonomy and flexibility and less solitude.

Acknowledgements:

This work was supported by the Portuguese Foundation for Science and Technology (FCT) [grant number SFRH/BD/44544/2008].

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Unidade de Investigação I&D Psicologia & Saúde

Approaching Older Adults' Sense of Coherence: The Effects of Religious Beliefs

Susana Santos, Sofia von Humboldt & Cláudia Carvalho

Introduction

The aging process implies adjustments both to the elderly's personal and social life, since this age group finds themselves significantly more vulnerable to disability, chronic illness, and / or other concomitant complications, which may limit their autonomy and reduce quality of life. The Sense of Coherence (SOC) can be defined as a general orientation to the world and/or for life, referring to a variety of stimuli, past and future, which express the extent to which the individual perceives life experiences, as dynamically comprehensible, manageable and with meaning, corresponding to all three dimensions of SOC: Comprehensibility; Manageability and Meaningfulness[1]. A high SOC allows the elderly to develop greater resilience to challenges and to better mobilizing the available resources and became more likely to lead healthy lifestyles, contributing to healthy aging . Religious beliefs have proven to of importance in helping the elderly patients, to endure invasive treatments or to accept psychological support, which indicates the desire to feel better and act accordingly to make it happen[2]. Religious beliefs play an already recognized role in health psychology being associated with better psychological health, physical health and better social support and well-being.

Aim

Explore the possible association between religious beliefs and older adults sense of coherence (SOC).

Methods

Participants

The research focused on a sample of 123 elderly aged above 74 years cognitively healthy (*M* = 82.4, *SD* = 5.6).

Instruments

- Sense of Coherence Scale (SOC) (Antonovsky, 1987; Port. Version, Nunes, 1999): Self assessment questionnaire with 29 Items. Each score presents a sentence to be rated in a scale from 1 (never happens) to 7 (always happens). Total SOC can vary from 29 to 203 points. A higher score corresponds to a higher SOC[1]. The Portuguese version presents high reliability (Cronbach's alpha of .83 to .90) and test-retest validity (r = .88)[3];
- Mini-Mental State Examination (MMSE)[4];
- Sociodemographic data were assessed, including the type of belief system or the absence of religious beliefs.

Procedure

Exploratory, descriptive and correlation study.
Convenience sampling.
Non institutionalized participants.
Confidentiality of data were assured, and after having been explained to each participant the objectives of the study, all participants provided their informed consent.
Questionnaires were hetero administered on face to face interview in the following order: MMSE; Sociodemographic questionnaire and the SoCS.
SPSS (Statistical Package for Social Sciences) (version 19.0, SPSS Inc., Chicago, IL) for the statistical treatment and analysis of results.

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Procedure

Exploratory, descriptive and correlation study.
Convenience sampling.
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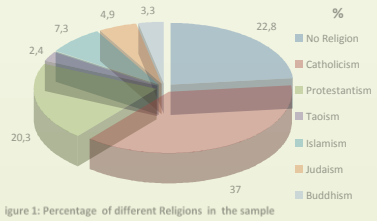
Confidentiality of data were assured, and after having been explained to each participant the objectives of the study, all participants provided their informed consent.
Questionnaires were hetero administered on face to face interview in the following order: MMSE; Sociodemographic questionnaire and the SoCS.
SPSS (Statistical Package for Social Sciences) (version 19.0, SPSS Inc., Chicago, IL) for the statistical treatment and analysis of results.

Results and Discussion

Distribution of the sample for the various religious beliefs is displayed on Figure 1



igure 1: Percentage of different Religions in the sample

Due to the small number of participants in several religious systems (e.g. Taoism, Islamism, Judaism and Buddhism) we performed the analysis considering 4 groups:
No Religion, Catholics, Protestants and Others.
The one way analysis of variance (ANOVA) performed did not revealed statistically significant differences between religious groups on the total SOC's scores (F (1, 122)=1.066; *p* = .366).

Table 2 : SOC´s total scores according to the Religious Group

Religion	M	SD
Non religious	132.93	4.64
Catholics	131.48	3.55
Protestants	134.16	4.91
Others	122.55	5.24

This exploratory research emphasizes the importance of SOC in the context of the elderly by enabling this population to give a meaning to their lives and to better face the challenges of late life. Further research with larger , representative and homogenous samples is warranted to further understand this topic of study.

Acknowledgements: This research was supported by the Portuguese Foundation for Science and Technology (FCT) [grant number SFRH/BD/44544/2008]

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PSYCHOSOCIAL ADAPTATION AND QUALITY OF LIFE OF PATIENTS WITH CRONIC CARDIOVASCULAR DISEASES

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The aim of the present review is an attempt to describe certain aspects of contemporary health psychology concepts and in specific searching the relationship between psychosomatic predisposition and possibilities to adapt (coping strategies) to life with chronic disease.

Considering this, the individual predisposition could be discussed, in the health-disease continuum, as a phenomena supporting the etiology on one hand and as a consequence of the disease, as a psychological resource of the personality to cope and adapt to life with chronic disease. Clarifying these correlations could have practical application for rationalizing some psychotherapeutic procedures.

Personality type D and depression – predictors for cardiovascular diseases

➲ In the last years as a result of the performed clinical trials, regarding coping styles in patients with ischemic heart disease, a new personalized psychological construct was determined, described by its author Johan Denollet as *a personality type D*. It presents with permanent character manifestations of negative affect and social isolation. These two dimensions are interpreted as predictors mainly of adaptational manifestations when coping with cardiovascular disease (7,8).

Negative affect represents a tendency to unite negative emotion, depressive manifestations, generalized anxiety, angriness and hostile attitude. *Social inhibition* manifests with typical avoidance of social contacts as a result of preliminary considering them dangerous, leading to negative consequences for personality and lack of satisfaction.

Research of D. Todorova-Papancheva and H. Silgidjan (2011) among patients with ischemic heart disease confirm the significance of the relationship between the specific correlates of cardiovascular diseases, such as adaptation inability and depressiveness, with the typical manifestations of personality type D functioning, which affect each other. These results correspond to recent international studies in this area. The characteristics of personality type D stand out distinctly in the examined patients in parallel with depressive symptoms (3).

Researchers from Tuborg University in The Nederland report three times increased risk in these persons of hypertonia, heart failure, unstable angina and myocardial infarction and follow interventions: angioplasty intervention and by-pass; transplantation. There is a tendency of increased anxiety, irritability, depressiveness and hiding these emotions from others as a result of fear of disapprovement. According to the authors personality type D and depression are marked manifestations of psychological distress with independent cardiovascular effects. Their research support the thesis for the simultaneous use of these markers for determining high-risk patients (7, 8).

Screening of patients with such predisposition gives opportunity for early intervention, psychological and behavioral consulting, aiming improvement of cardiovascular status.

➲ **Role of *depression and mood disorders* regarding cardiovascular diseases is perceived two-sidedly: *as a predictor and as a result*.**

Most studies concentrate on attempt to decipher the relationship between physiological and psychological symptoms and the factors, contributing to the development of depression in the presence of cardiovascular disease (CVD). Another part of the research aims to find correlation between predisposition to depression and the risk of cardiovascular diseases. In patients with cardiovascular disease and prominent depressive symptoms twofold increased risk is reported for consequent heart attacks and significant part of the tested patients are endangered to develop depression. According to Carney (2009) clinically significant depression not only could lead to loss of will to live, but could also represent important risk factor for cardiovascular disease (6).

Other authors report that some variables: decreased physical functioning, anxiety, social isolation and somatization are some evidence for possible causal relationship between already existing depression and potential possibility for developing cardiovascular disease (9, 10).

Coping strategies in patients with chronic cardiovascular diseases

➢ Patients with chronic disease use problem-focused as well as emotional-focused strategies and some orientated to overcoming problems of psychosocial adaptation of the person towards new health situation and others serve as mediators between social-demographic variables, personality qualities, environmental conditions and outcomes of psychosocial adaptation.

➢ Depending on the disease, social-demographic characteristics of patients combinations of emotional-focused and problem-focused strategies are observed with domination of some behavioral styles in certain stages of the disease: active processing and expressing experienced emotions, social support, information for the disease, positive attitude to life, self-confidence in strength and abilities, estimated as productive behavioral styles.

➢ Patients with internal control, whose main belief is that person could control disease development on their own, are defined as a model of positive strategy. On the contrary people with external control, finding others responsible for their condition (medical staff and others), exhibit behavior considered as nonproductive: diminished emotional control, lower self-esteem and inadequate adaptation to the disease (1,2).

Conclusions

Conclusions for the effect of adaptation strategies in patients with cardiovascular diseases.

. Individuals with internal control and optimistic attitude have better adaptation to the disease and exhibit lower level of emotional distress.

. Strategies, related to problem solving, positive reconsidering and seeking social support, result in better adaptation to the disease.

. Coping strategies like flight, lack of commitment, self-blaming and fatalism contribute to higher levels of emotional distress and low level of adaptation to the disease.

. Alteration of coping strategies during the course of the disease is also observed. In early stages after being diagnosed affective strategies dominate and after certain period redirecting to healthier and productive coping strategies is observed.

. Research of this area show that health programs conducted in the context of group mutual help and oriented to practical assignments encourage independence and personal responsibility, increase patient's self-care capacity and skills of fulfilled live with others.

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Adjustment to Aging and Subjective Age in Portugal and Romania: A Comparative Multiple Correspondence Analysis for Latent Constructs

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Aims

This research aims at:

Investigating latent constructs that can work as major determinants in adjustment to aging (AtA), and subjective age (SA)

Exploring relationships of these constructs in an older cross-cultural population.

Participants

64 eligible non-institutionalized participants were recruited from senior universities message boards, local and art community centres list-serves, in Lisbon , Bucharest and in the Algarve regions. The average age of the sample was 80.1 (*SD* = 5.48 range = 74-99).

Participants were culturally diverse, 65.6% female, 50.0% Portuguese, 57.8% married and 68.8% pensioners.

Material and Procedure

Semi-structured interviews based on an interview guide were conducted in the participants' own homes.

Each interview consisted of 2 open-ended questions: "How do you feel about your age?" and "I would like to understand what, in your point of view, contributes to your adjustment to aging in this phase of your life".

Data was analyzed, employing content analysis until the point of theoretical saturation was reached.[1]

Results and Discussion

Table 1. Three-dimensional representation for the overall model that joins the concepts of "adjustment" and "age" for Romanian older adults: factor loadings for each dimension, mean loadings and % inertia (variance) explained

	Dimensions			
Domains	Satisfied	Attentive	Concerne	Mean
With congruence	.063	.813	.003	.293
Without concern	.609	.107	.065	.260
With apprehension	.000	.017	.805	.274
Young-at-heart	.609	.107	.065	.260
Good enough	.001	.008	.785	.265
Family, Social and Interpersonal Attachment	.829	.005	.027	.287
Health status, Physical and Intellectual Functioning	.829	.005	.027	.287
Occupation, Profession, Autonomy and Leisure	.000	.197	.353	.183
Accomplishment, Personal Fulfilment, and Future Projects	.114	.024	.007	.049
Stability, Quality and Financial Situation	.536	.002	.057	.198
Valorization of Time and Age	.062	.822	.015	.300
Sense of Limit and Existential Issues	.054	.887	.007	.316
Eigenvalue	3.706	2.995	2.216	2.972
% of Variance	30.881	24.960	18.465	24.769

Table 2. Three-dimensional representation for the overall model that joins the concepts of "adjustment" and "age" for Portuguese older adults: factor loadings for each dimension, mean loadings and % inertia (variance) explained

	Dimensions			
Domains	Conciliated	Young-at-heart	Involved	Mean
With congruence	.783	.086	.009	.293
Without concern	.192	.614	.003	.270
With apprehension	.783	.086	.009	.293
Young-at-heart	.192	.623	.024	.280
Good enough	.813	.141	.002	.319
Family, Social and Interpersonal Attachment	.016	.004	.915	.312
Health status, Physical and Intellectual Functioning	.016	.004	.915	.312
Occupation, Profession, Autonomy and Leisure	.064	.052	.370	.162
Accomplishment, Personal Fulfilment, and Future Projects	.652	.062	.042	.252
Stability, Quality and Financial	.813	.141	.002	.319
Valorization of Time and Age	.119	.734	.000	.284
Sense of Limit and Existential Issues	.149	.766	.005	.307
Eigenvalue	4.592	3.313	2.297	3.401
% of Variance	38.269	27.609	19.144	28.341

Conclusions

The evidence on variety of aging well presented in this paper is an important contribution to the under-developed potential of the AtA concept in this population and its association with SA.

Growing evidence of gerontology and geriatrics is demonstrating that the potential of older people for aging well is relatively unexplored. This study's outcome can be useful in clinical practice, service planning and evaluation with older population.

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Acknowledgements: This research was supported by the Portuguese Foundation for Science and Technology (FCT) [grant number SFRH/BD/44544/2008

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Analysing Latent Constructs for Older Adults' Age Representation: The Importance of Time Perspective

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Aims

This research aims:

To investigate latent constructs that can act as major determinants in older adults' conceptualization of age representation (AR), in an older cross-national population.

To understand how these can yield a more distinguished approach on aging well and successful aging.

Participants

• The convenience sample comprised 231 eligible non-institutionalized and national-diverse individuals (*N* = 231; 74 - 102 years (*Mage* = 83.1; *SD* = 6.992). Subjects were recruited through senior universities message boards, local and art community centers list-serves, in Lisbon, Bucharest and in the Algarve regions. Participants were culturally diverse, 59.3% female; 62.8% married; 27.7% Romanian.

Material and Procedure

Semi-structured interviews based on an interview guide were conducted in the participants' own homes.

Each interview consisted of 1 open-ended question: "How do you represent your age at this moment?"

Data was analyzed, employing content analysis until the point of theoretical saturation was reached[1,2].

Results and Discussion

Categories	Dimensions			
	Future -oriented	Present-oriented	Past-oriented	Mean
Regret about the past	.065	.006	**.856**	.309
With dissatisfaction	.109	.027	**.791**	.309
As an opportunity	**.765**	.108	.047	.307
Future investment	**.792**	.133	.040	.321
Present challenge	**.751**	.147	.044	.314
Reconciliation with life	.027	**.543**	.004	.191
Dynamic life	.340	**.590**	.001	.310
With contentment	.340	**.590**	.001	.310
Eigenvalue	3.188	2.144	1.78	2.372
% of	39,85	26,803	22,2	29,647

As regards to AR, eight categories of answers emerged, namely, (a) 'regret about the past', (b) 'with dissatisfaction', (c) 'as an opportunity', (d) 'future investment', (e) 'present challenge', (f) 'reconciliation with life', (g) 'dynamic life' and (h) 'with contentment'.

'As an opportunity' was the most verbalized AR by the participants (20.5%). This was indicated by German (29.5%), Romanian (20.2%) and Brazilian (18.9%) participants.

"My age gives me the chance to be myself without any kind of masks." (Participant 67)

"Every day is a new day for me." (Participant 111).

Portuguese participants mostly verbalized 'dynamic life' and 'with contentment' (both 18.2%). These participants indicated an active life and enjoyment when representing their age.

"We are moving to a new house soon." (Participant 102).

"Age brought me the ability of laugh about me and be happy about my age." (Participant 113).

Finally, 'regret about the past' was the least mentioned AR for German (0.6%), Romanian (2.7%) and Brazilian (4.1%) participants whereas 'with dissatisfaction' was the least verbalized AR for Portuguese participants (3.4%).

"I do not want to look into the past. I did many wrong things and I regret them." (Participant 56).

A three-dimension model formed by 'past-oriented', 'present-oriented' and 'future-oriented' was indicated as a best-fit solution for AR (accounting for 89.0% of the total variance).

Conclusions

The evidence on variety of aging well , presented in this paper is an important contribution to the under-developed potential of the Ar concept in this population.

Enhancing AR might be an important target to improve older adults' interventions' outcomes and aging well.

Acknowledgements

This research was supported by the Portuguese Foundation for Science and Technology (FCT) [grant number SFRH/BD/44544/2008

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2.Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research, 5*, 147–149.

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Studies on illness and behaviours

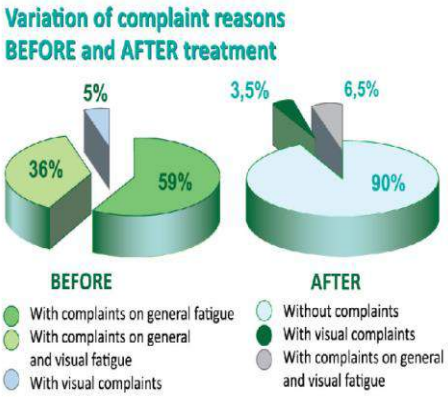
Health maintenance and development for persons under high cognitive load.

Costrikina I. Moscow City University of Psychology and Education, Research Department of social competence and intelligent, Moscow, Russia
Korzh T. Medical Department of fitness club «LO ´K O PARK», Moscow, Russia

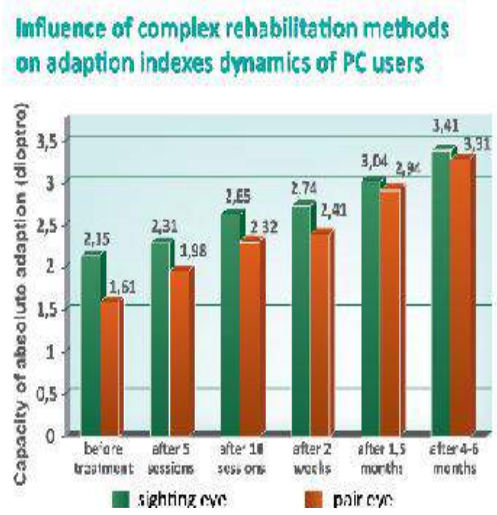
Goal of research – search of effective methods to maintain psychic and physical health of people whose professional activity is connected high cognitive load.

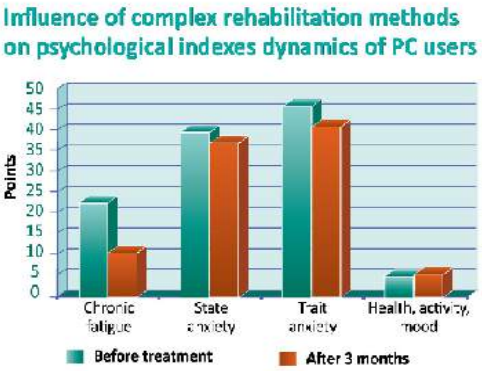
Data and research tools.

Participants: 300 people, whose professional activity is connected with high cognitive load : 164 operator microscopist and 136 PC users.



The study was supported by the Russian Foundation for the Humanities, project № 12-06-00279 «Cognitive predictors of performance highly skilled labor, economic behavior and socialization of young people."





Three types of rehabilitation were used:

1. sessions vibrating massage and gymnastics in general developmental exercises;
2. segmental and acupressure in combination with general developmental exercises;
3. sessions of the segmental and acupressure combined with corrective exercises. The result of treatment in 90% of asteno- physical complaints disappeared, the degree of chronic fatigue significantly decreased in 2.5. Accommodation volume rose by an average of 1.48 diopters.

Psychology & Health
Research Unit R&D

Diabetes and Hypertension: Assessing the Effects of Physical Illnesses on the Quality of Life of Elderly People

Dina Cardoso, Sofia von Humboldt, & Isabel Leal

1. Introduction

There is a set of organic transformations in the aging process that contribute to the appearance of diseases characteristic of this stage of life, such as hypertension and diabetes.[1] These diseases can lead to a decrease in QoL[2].

The adjustment to these pathologies can be facilitated, by understanding their effect on quality of life (QoL) of elderly people.

2. Research Aims

1To analyze significant differences in the dimensions of the QoL of the elderly with diabetes compared to elderly patients with other chronic diseases and elderly people without chronic diseases

2To analyze significant differences in the dimensions of the QoL of the elderly with hypertension compared to elderly patients with other chronic diseases and elderly people without chronic diseases

3. Method

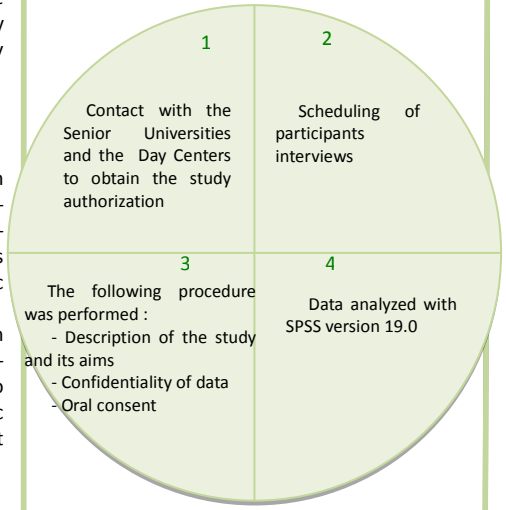
Sample: 120 participants, (mean age 80.18, *SD* = 5.26, (range 74-97).

		N	%	M	DP
Age		120		80,18	5,3
Gender	M	43	35,8%		
	F	77	64,2%		
hypertension		40	33,3		
Diabetes		40	33,3		
Group without hypertension /Group without diabetes		40	33,3		

Instruments:

- Assessment Questionnaire for Health Gains (SF-6D)[6].
- Demographics questionnaire
- Mini-Mental State Examination (MEEM) [7].

Procedure:



4. Results

- In some dimensions of QoL, there were significant differences in older adults with diabetes when compared with other groups.
- 'Mental health' was the only QoL dimension presenting significantly lower values in diabetes patients (*M*=2,85) when compared elderly with 'other diseases' (*M*=4,3)
- There were no significant differences in QoL dimensions of older adults with diabetes when compared with the 'no-disease' group.
- When compared with the 'no-disease' group, significantly lower values appear in elderly patients with hypertension in 'Physical Function' (*M*=4,20), 'Performance Limitation' (*M*=4,95), 'Physical Pain' (*M*=4,425) and 'Vitality' (*M*=4,74) dimensions.
- When compared with 'other diseases group' all dimensions have higher levels of QoL in people with hypertension except 'mental health' (*M*=3,60) which had significantly lower scores.

5. Discussion

✓ Stigma of diabetes, lack of support, lack of cure and treatment requirement may explain lower values of the 'mental health' dimension[4].

✓ The dimensions 'vitality' and 'physical function', in diabetes patients, have higher values than 'mental health', possibly due to adequate pharmacological treatment[5].

✓ In the dimension 'physical function', elderly people with hypertension have low scores, as already reported by other authors[1].

✓ The fact that there is not much emotional support for elderly patients with this disease in Portugal[5], the stigma of the disease, the changing of the elderly routine and the fact that it is an incurable disease may explain the low scores in the mental health dimension.

6. Conclusions

- ✓ This study indicates the impact of diabetes and hypertension in the dimensions of QoL of elderly Portuguese
- ✓ The impact of these diseases on the lives and routines of the elderly may compromise more than only their physical health. It is important to consider this statement in designing treatments which should cover physical, social and emotional / mental areas
- ✓ These results should be taken into account in clinical practice.

This research was supported by the Foundation for Science and Technology (FCT) [SFRH/BD/44544/2008].

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Ethical considerations in connection with cognitive therapies

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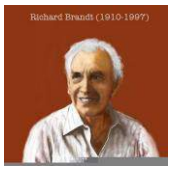
Cognitive therapy's ethical roots

- Ancient Greek philosophy: idea of connections among thoughts, emotions and behaviour (Socrates: „ignorance" and „passion", see Aristotle, Ethica Nicomachea 1145 b 23-32)
- Stoicism: emotions and common sense (Poseidonios), irrational decisions (Zeno of Citium), "Some things are in our control and others not. Things in our control are opinion, pursuit, desire, aversion, and, in a word, whatever are our own actions…The things in our control are by nature free, unrestrained, unhindered… Men are disturbed, not by things, but the principles and notions which they form concerning things."(Epictetus: The Enchiridion I, V)
- Stoic ethical implication: "Let us say what we feel, and feel what we say, let speech harmonize with life." (Seneca).
- Ethical basic principle: the pledge of the happiness is living in accordance with nature, including with our own human nature, too.




Aaron T. Beck's cognitive therapy

"…suggests that the individual's problems are derived largely from certain distortions of reality based on erroneous premises and assumptions. These incorrect conceptions originated in defective learning during the person's cognitive development… By pinpointing the fallacies in his thinking and correcting them, he can create a more self-fulfilling life for himself"

(A. T. Beck: Cognitive Therapy and the Emotional Disorders. London, 2006. p.3-4)

Note

"…a strong casecan be made that the thinking of relatively nonpsychopathological populations is dominated by the same type of schematic knowledge represen-tations and information-processing heuristics alleged by Beck to govern the thinking of depressives." (M.D.EVANS – S.D.HOLLON 1988)

Richard B. Brandt (1910-1997) moral philosopher, representative of the rule utilitarianism. In his "A Theory of the Good and the Right"(1979) he tries to answer the question: "what ought I, morally, to do?" He proposed a "reforming definition" of "morally right" and "rational person". Our action is rational in so far as it would "survive maximal criticism and correction by facts and logic." Can wants, beliefs, desires, aversions (attitudes) be corrected at all? Brandt calls cognitive psychotherapy the "process of confronting desires with relevant information by repeatedly representing it, in an ideally vivid way, and at an appropriate time." Typical mistakes: dependence on false beliefs, artificial desire-arousal in culture-transmission, generalization from untypical examples, exaggerated valences produced by early deprivation. "The process relies on… use of evaluative language, …use of artificially induced feeling-states like relaxation." (Quotation from Brandt, p. 113)

Summary

- People have a set of rules that form their intentions, behaviour and evaluation concerning what is morally Good or Wrong.
- According to Bernard Williams ethical investigations are very often founded on so-called poor concepts such as Good, Right, Wrong, Must. There are also rich concepts in particular in the usage of cognitive therapy (anxiety, sadness, transgression, self-criticism etc) We must make their meaning explicit.
- Brandt suggests the method of appeal to linguistic intuition and the method of reforming definitions. John Searle offers us the theory of speech acts.

State Anxiety in Surgical Patients

Madalena Cunha[1], Paula Lopes[2], Graça Aparício[1] & Carlos Albuquerque[1]

[1]*CI&DETS - Superior Health School - Polytechnic Institute of Viseu,* Portugal.

[2] CHTV

Introduction

The state anxiety is an emotion commonly experienced by surgical patients and documented in the literature as a determinant of their well-being, arrogating to preoperative visit as protector of its occurrence and an important indicator of patient satisfaction.

Methods, Participants and Material

The transversal observational study was conducted in a non-probabilistic sample of 180 pre-surgical patients (55.6% women and 44.4% men) with mean age of 57.25 years, using the Zung Anxiety Scale. (Ponciano, Vaz Serra, & Relvas,1982).

Objectives

Te studied the state anxiety in order to:

- Explain the influence of socio-demographic variables in state anxiety;

- To determine the influence of preoperative visit at the level of state anxiety.

Results

Anxiety

The level of anxiety is high in 51.7% patients (worse in women), mild in 39.4% and moderate in 8.9%. (table 1).

Table 1 – Ansiety Level and Sex

Sex / Ansiety	Men		Women		Total	
	n	%	n	%	n	%
Mild Ansiety	41	51,3	30	30,0	71	39,4
Moderate Ansiety	8	10,0	8	8,0	16	8,9
High Ansiety	31	38,7	62	62,0	93	51,7

Sex, School levels and Age vs Anxiety

The state anxiety is higher in women (M = 37.39) than men (M = 34.01) (U = 2852.5, p =. 001) (table 2), and also more severe in the less educated (H = 12,949, p =. 024) and older (r =. 233, p =. 002).

Age explains 5.4% of the variability in state anxiety.

Table 2 - Ansiety and Sex

	Min	Max	M	dp	Sk/erro	K/erro	CV (%)	U de Mann Whitney
Cognitive Ansiety								
Women	5	16	8,87	2,436	1,954	0,211	27,46	U=3001,0; Z=-2,906; p=0,004**
Men	5	15	7,90	1,946	4,033	4,255	24,63	
Total	5	16	8,44	2,277	4,088	1,742	26,98	
Vegetative Ansiety								
Women	10	27	16,47	3,454	1,195	-0,349	20,97	U=3544,0; Z=-1,319; p=0,187
Men	9	29	15,86	3,824	2,892	2,789	24,11	
Total	9	29	16,20	3,625	2,807	1,639	22,38	
Motor Ansiety								
Women	4	15	7,61	2,197	3,187	1,709	28,87	U=3051,5; Z=-2,763; p=0,006**
Men	4	12	6,79	2,054	3,230	0,430	30,25	
Total	4	15	7,24	2,168	4,392	1,517	29,94	
Ansiety of the Central System								
Women	2	8	4,44	1,452	1,008	-0,531	32,70	U=2390,5; Z=-4,772; p=0,000***
Men	2	5	3,46	0,913	-0,527	-1,498	26,38	
Total	2	8	4,01	1,331	2,961	0,736	33,19	
Global Ansiety								
Women	24	65	37,39	6,972	3,353	3,747	18,65	U=2852,5; Z=-3,308; p=0,001**
Men	20	58	34,01	6,946	2,609	2,954	20,42	
Total	20	65	35,89	7,142	3,828	4,139	19,90	

Nursing Preoperative visit vs. Anxiety

Patients who received preoperative visit were less anxious, but without statistical significance (X^2. =. 756, p =. 685). (table 3).

Table 3 – Nursing Pre-operative Visit

Sex	Female		Male		Total	
	n=100	100,0%	n=80	100,0%	n=180	100,0%
Previous surgical experience						
No	31	31,0	33	41,3	64	35,6
Yes	69	69,0	47	58,7	116	64,4
Nursing preoperatative visit						
No	43	43,0	30	37,5	73	40,6
Yes	57	57,0	50	62,5	107	59,4

Conclusions

It is inferred that sex, age and education influence the anxiety state, imposing consider them when planning a visit to the preoperative surgical patients.

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Acknowledgments: Portuguese Foundation for Science and Technology and Center for Studies in Education, Technologies and Health.

The Comparison of Functional Status Between Psychosis Patients Who Received Community Mental Health Services and Mental Hospital Patients.

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Background: Aceh Province is the first province in Indonesia that has been developing the community mental health program since 2007. The purpose of this study was to compare the functional status of psychosis patients who received community mental health program in primary health centers (PHC) and patients who was only treated to mental hospital (MH).

Methods: This study was conducted in 2011 in Aceh. The design of this study was cross sectional, subjects were psychosis patients; consisted of 139 from PHC and 160 from MH. The patients were 224 male and 75 women, the average duration of illness was 13, 6 years. Patients lives in Banda Aceh and partly in the district of Aceh Besar. The rater's were 11 mental health nurses who had trained for this study. The data was collected by visiting patient in their house. The functional status of patients was assessed by Health of Nations (HoNOS) Aceh version that have been tried in advance and had been assessed the agreement among nurses. The numerical data was assessed by two different test of the mean, while the categorical data was assessed by chi square.

Results: Table 1 describes background characteristics of subjects. The youngest subject was 15 years and the oldest was 68 years. Subjects who were from PHC older than mental hospital's (p=0.012). The shortest duration of illness was 1 year and the longest was 46 years. The majority of subjects were low education (no school, unfinished primary school, finished primary school to finished junior high school). In general subjects had no occupation (jobless). Eighty eight subjects had job including pension. The socioeconomic status was assessed by family expenditure. Quintile 1 was the poorest and quintile 5 was the richest. There were differences of gender (p=0.038) and marital status (p=0.001).

Table 2 informs the comparison between subjects. The mean of functional status of patients from primary health centre was 6.8 and 7.1 for mental hospital patients. (p = 0.782).

Table 1. Background characteristics of subjects

	Mental Hospital	PHC	p
1 Age	37.1*	40.6	0.012**
2 Duration of illness	13.2*	13.5	0.781**
3 Gender			
Male	127	97	0.038
Female	33	42	
4 Marrige status			
No married	119	80	0.001
Married	25	48	
Divorce	16	11	
5 Education status			
Low	92	84	0.876
Middle	63	51	
High	5	4	
6 Occupation			
No	118	91	0.153
Yes	41	47	
7 Expenditure			
Quintile 1-3	91	88	0.258
Quintile 4-5	69	51	

* mean ** t test

Table2. Functional status of subjects

	Mental Hospital	PHC	p
Functional status	7.4*	6.3*	0.782**

* mean ** t test

Conclusion: patients who received community mental health services had almost similar functional status than the patients who only sought treatment at a mental hospital. This study should be continued to assess cost of service both in community and mental hospital.

Key words: community mental health, Aceh, functional status, psychosis

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P96 LIFESTYLE DEFENSE MECHANISMS (RED/NH), SELF-EFFICACY (SE) MEASURES AND PHYSICAL SELF-CONCEPT OF THE TENNESSEE SELF-CONCEPT SCALE FOR EVENING COURSE STUDENTS AT THE SEMMELWEIS UNIVERSITY

Kornél Sipos, Zsuzsanna Györy-Gritz, László Tóth
Semmelweis University, Faculty of Physical Education and Sport Sciences, Budapest, Hungary

ABSTRACT

The aim of the study is the examination of the relationship of coping styles, self-efficacy and physical self-concept in connection with demographic characteristis (age, gender, marital status, number of dependent children, etc), physically active/inactive lifestyle, smoking habit, frequency of medicine use.

Sample (N=155) contains five groups: emergency medical technicians (n=19), medical nurses (n=55), optometrists (n=47), midwifes (n=13), physiotherapists (n=11), and students of recreation (n=10) of evening courses at the Semmelweis University.

Male/female ratio is 18,7% /81,3%; average age is 33,87 (SD=8,57). Physically active subjects (N=74); smokers: 31% of the sample. The sample is divided into subgroups according to demographic variables, smoker/no-smoker, and physically active/ sedentary lifestyle. Under 35 and above 35 years of age females' groups were compared, too.

Methods: Hungarian versions of the Lifestyle Defense Mechanisms Inventory's two subscales (R/ED & N/H), the Schwarzer et al (1993) "Generalized SE", "SE Towards Physical Exercise" and "SE Towards the Temptation to Smoke" scales; together with the Physical Self-Concept subscale of the Tennessee Self-Concept Scale are the psychometric variables.
Results: gender difference occurs in mean age (p <0,000) and number of dependent children (p <0,001). Females' age and number of children for them are higher. Smokers – non-smokers' comparison reveals higher self-efficacy towards the temptation to smoke (p <0,000), and self-efficacy towards physical exercise (p <0,014) for non-smokers.

Four factors are determined according to factor analysis. Factor 1 (self-efficacy towards the temptation to smoke: 0,868; cigarettes per day: -0,817), factor 2 (physical self-concept: 0,892; generalized self-efficacy: 0,764; and self-efficacy towards physical exercise: 0,486), factor 3 (number of dependent children: 0,897; calendar age: 0,848; factor 4 (need for harmony: 0,792; rational/emotional defensiveness: 0,775). The factor structure of variables for females, enriched with 2-2 subscales of R/ED & N/H LDM scales, showed different picture: Factor 1 ('Harmony centered coping', Factor 2 ('Mainly rational coping',Factor 3 (offspring number, age & smoking), Factor 4 (Wellbeing, healthy lifestyle).

In the Linear regression analysis model the generalized self-efficacy is the most frequent significant predictor of physical self-concept in different subgroups (see in the poster. The second significant predictor of physical self-concept is the self-efficacy towards physical exercise.

Keywords: physical self-concept, self-efficacy, lifestyle defense mechanisms

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AIM OF THE STUDY

The aim of the study is the examination of the relationship of coping styles, self-efficacy and physical self-concept in connection with demographic characteristics (age, gender, marital status, number of dependent children, etc), physically active/inactive lifestyle, smoking habit, frequency of medicine use.

METHODS

Hungarian versions of the
- 'Lifestyle Defense Mechanisms Inventory's two subscales' (R/ED & N/H), the
- 'Generalized SE',
- 'SE Towards Physical Exercise' and
- 'SE Towards the Temptation to Smoke' scales Schwarzer et al (1993);
- 'Physical Self-Concept' subscale of the 'Tennessee Self-Concept Scale'

are the psychometric variables.

SAMPLE

Sample (N=155) contains five evening course student groups: emergency medical technicians (n=19), medical nurses (n=55), optometrists (n=47), midwifes (n=13), physiotherapists (n=11), and students of recreation (n=10) at the Semmelweis University. Male/female ratio is 18,7% / 81,3%; average age is 33,87 (SD=8,57). Physically active subjects (N=74); smokers: 31% of the sample. The sample is divided into subgroups according to demographic variables, smoker/no-smoker, and physically active/ sedentary lifestyle, under 35 and above 35 years of age.

RESULTS

Table 1 - Descriptive Statistics: evening course student sample (N=155) at Semmelweis University (Budapest)

Variables	N	Minimum	Maximum	Mean	Std. Deviation	Cronbach -alpha
Calendar age	155	19,79	51,64	33,8777	8,1219	-
Physical Self-Concept	153	32,00	90,00	65,4837	12,0477	-
Generalized Self-Efficacy	155	18,00	56,00	31,3226	5,2767	0,87
Self-Efficacy towards the temptation to smoke	137	10,00	40,00	30,9781	8,8288	0,79
Self-Efficacy towards physical exercise	152	12,00	84,00	53,7368	15,8498	0,92
LDM: R/ED	155	17,00	78,00	35,1097	5,8616	0,59
LDM: N/H	155	16,00	63,00	40,8839	4,9359	0,79
Valid N (listwise)	134					

Table 2 - Factor Analysis: Selected Data of Evening Course Students at Semmelweis University (Budapest) – Total Sample (N=155). Rotated Component Matrix

Variables	Component			
	Smoking Habits	Self-Efficacy	Demographic data	Coping style
Self-efficacy towards temptation to smoke	,868			
Cigarettes per day	-,817			
Physical self-concept		,892		
Generalized self-efficacy		,764		
Self-efficacy towards physical exercise	,446	,484		
Offspring number			,897	
Calendar age			,848	
LDM: Need for Harmony				,792
LDM: Rational/Emotional defensiveness				,775

Extraction Method: Principal Component Analysis
Rotation Method: Varimax with Kaiser Normalization
A Rotation converged in 5 iterations
KMO=0,484; Cumulative%= 70,233

Table 3 - Factor Analysis: Selected Data of Evening Course Female Students (N=126) at The Semmelweis University (Budapest). Structure Matrix

	Component			
	Harmony Centered coping	Mainly Rational coping	Children, age & smoking	Well being, Healthy lifestyle
LDM N/H	,960			
LDM N/H: Self-Sacrifice	,874			
LDM N/H: Harmonious Relations	,824	,438		
LDM R/ED		,967		
LDM R/ED: Emotional defensiveness		,840		
LDM R/ED: Rationality		,745		
Offspring number			,830	
Calendar age			,803	
Self-efficacy towards the temptation to smoke			-,525	
Physical Self-Concept				,870
Generalized Self-efficacy				,750
Self-efficacy towards physical exercise	,416			,494

Extraction Method: Principal Component Analysis
Rotation Method: Promax with Kaiser Normalization
Cumulative%= 69,547

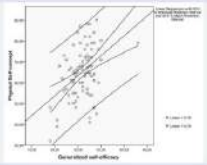

Figure 1 - Regression Analysis for female health science student group (N=126). Generalized self-efficacy predicts best the physical self-concept in the linear regression model.

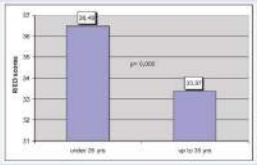

Figure 2 - Statistically significant difference is in the LDM 'Rational/Emotional Defensive' coping style for health science evening course female students' two age groups.

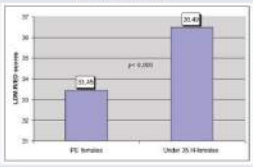

Figure 3 - Under 35 health science evening course, female students have significantly higher 'LDM 'Rational/Emotional Defensive' coping' mean than PE female students have.

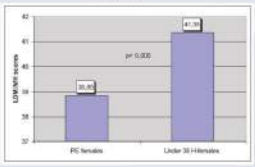

Figure 4 - Under 35 health science evening course, female students have significantly higher 'LDM 'Need for Harmony' coping' mean than female PE students have.

Reference information to LDM-H reliability and standards

Table 4 - Mean, SD and Cronbach alpha values of the Hungarian LDM scales & subscales for Physical Education university student sample (N=377)

Lifestyle Defense Mechanisms (LDM) Scales & subscales	N	Mean	SD	Cronbach alpha
Rational Emotional Defensiveness (R/ED) scale	377	32.46	4.396	.709
Rationality (RAT) subscale	377	14.66	4.41	.486
Emotional Defensiveness (EMD)subscale	377	12.51	2.63	.705
Need for Harmony (N/H) scale	373	39.67	45.11	.771
Harmonious Relations (HR) subscale	373	17.53	1.87	.62
Self-Sacrifice (SS) subscale	373	17.27	2.18	.647

CONCLUSIONS

- There was no gender difference in psychometric measures for the evening course student sample.
- In the Linear regression analysis model the generalized self-efficacy is the most frequent significant predictor of the physical self-concept. – Self-concept seems to be determined by self-efficacy.
- Evening course female students under 35 years of age have significantly higher R/ED mean than their colleagues up to 35. It may be a harmful prognostic signal for the younger health science female students' health behavior.
- Female PE students' R/ED & N/H score means are significantly lower than the same means of under-35 years of age female students of health science evening courses. It may be a favorable prognostic signal for the PE /Sport science female students' health behavior.

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THE RELATION BETWEEN AUTOBIOGRAPHICAL MEMORY, MALADAPTIVE SCHEMAS AND MAJOR DEPRESSION

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INTRODUCTION

Schemas have been considered by Beck, Rush, Shaw and Emery (1979), "Relatively stable cognitive patterns that form the basis for the regularity of interpretations of a particular set of situations" – (p.12).

Schemas would be intimately related to the processing of information and have a nuclear role in it. Their influence is present not only in the processing of information deriving from the outside world – by means of perception – but also in memory processes, from encoding to recall (Stopa & Waters, 2005).

We can therefore understand schemas as stable cognitive structures that, by functioning as an external experience's organizer, would be related with the subject's encoding, evaluation, interpretation and response processes in presence of an exterior event.

According to Beck's perspective (1967), we can consider schemas in depression to present the following characteristics:

They would be directed by the negative aspects of the *self* ; They would be idiosyncratic; They would integrate unattainable goals, dysfunctional attitudes and, by consequence, information processing biases; They would not be flexible; They would be accepted without questioning;

The contents of schemas in depression that are dysfunctional and negative, would be:

Negative representations of the self and the world; Specific beliefs about a negative and undervalued self; Dysfunctional Attitudes; Abstractions; Conditional hypothesis of negative valence regarding the self and the world.

There have been several works that have supplied experimental support to the dysfunctional contents of depressed subject's schemas (p.e. Williams (1984), Segal (1988), Segal & Vella, 1990, Cláudio, 2004, Calvete, Estevéz, Arroyabe & Ruiz, 2005, Oei & Baranoff, 2007).

In the different aspects of memory we can see the depression effects. In the autobiographical memories we can see several biases. A loss in depressed subject of the positive biases in the memories recalled.

In summary the depressed subject codify the specific events by the emotional aspects, which would obstruct the access to specific memories.

Is important noted the Mark, Williams and Dritschel (1992) definition of categorical and extended memories.

Categorical memories - would be a description of an intermediate level, involving a minor memory seeking and may be associate with a failure in the supervision attentional system.

Extend memories - They appear in the task of autobiographical memory when the subject prefers the originality than temporality. They would consist of the most individual aspects, would be older and appeared in response to emotional interpretation.

METHOD

Participants

42 subjects with a major depression diagnostic.
28 subjects with panic disorder diagnostic.
51 subjects without psychopathological disorder.

Instruments

Clinical Instruments

Portuguese Version of Schemas Questionnaire (J. Young & G. Brow (1989) revised in 1991), translate by Gouveia and Robalo (1994).

Portuguese Version of Hamilton's Depression Rating Scale, designed by Hamilton in 1957 and published, for the first time in 1960.

Portuguese Version of Beck's Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock and Erbaugh (1961).

Portuguese Version of Hamilton's Anxiety Rating Scale (1959), given by Luísa Figueira.

Portuguese Version of the State and Trait Anxiety Inventory (Y Form), Spielberger (1983), given by Américo Baptista.

Portuguese Version of the Adult's Sub-Verbal Test of the Wechsler Scale, given by Leandro de Almeida,

Experimental Instrument

Autobiographical Memory Task (Cláudio, 2004)

In this task we use:

10 Positive nouns - Friendship, Love...
10 Negative nouns- Disease, Loneliness…
10 Neutral nouns- Table, Pen…

The nouns were distributed on a false random form, since there arose more than two followed of the same valence.

HYPOTHESES

1º Hypothesis - The depressed participants recalled more autobiographical memories of negative content, than the other groups.

2º Hypothesis - The depressed participants exhibit a greater number of categorical memories than extended memories, compared with other groups.

3º Hypothesis - The depressed participants present a greater number of Early Maladaptive Schemas, compared with other groups.

	DEPRESSED n=42 A	SD	PANIC n=28 A	SD	W. PATHOLOGY n=51 A	SD	F
Total score S.Q.	324.0«♦	90.57	268.7 «●	64.57	214.9♦●	64.23	24.75*
Dependence	16.0♦	6.20	14.5 ●	4.83	11.2♦●	5.09	9.57*
Self-Sacrifice	42.1♦	14.03	36.5 ●	11.50	28.1♦●	9.35	16.92*
Vulnerability	31.9♦	12.22	30.3 «	8.25	22.6♦¢	8.84	11.28*
Afraid to loss control	25.1«♦	9.13	19.5«●	8.23	13.4♦●	6.41	25.71*
Emotional Deprivation	22.5♦	12.70	17.4	11.23	12.3♦	6.30	11.83*
Abandonment	18.8♦	7.18	17.2 ●	7.58	12.7♦●	5.76	10.17*
Mistrust	21.0♦	8.72	19.6 ●	6.71	15.0♦●	6.00	8.76*
Social Isolation	14.8«♦	6.99	10.0«●	4.58	6.9♦●	3.52	26.83*
Defectiveness	10.6«♦	6.06	6.8«	2.30	5.7♦	2.54	17.07*
Self- image	17.7«♦	10.28	13.2«	6.40	11.1♦	4.75	9.03*
Failure	20. 1«♦	10.13	13.2«	4.02	11.2♦	5.86	17.49*
Guilt	19.5«♦	16.68	13.0«	5.37	12.1♦	5.07	6.17*
Emotional Inhibition	12.6«♦	6.16	8.9«	3.63	7.4♦	3.67	14.64*
Unrelenting Standards	34.2♦	13.01	29.2	12.04	27.8♦	9.72	3.82*
Insufficient Self-Control	19.4	7.29	19.2	7.45	16.4	6.45	2.51

♦« ● - Significant difference (p< .05) in Tukey test between two groups in a factor
* -Significant difference (p< .05) in ANOVA test between the three groups

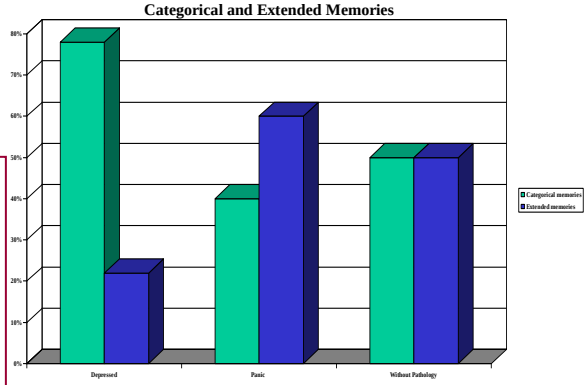
Recalled Events

	Depressed n= 42 X	SD	Panic n= 28 X	SD	Without Pathology n= 51 X	SD
Total recalled events	22.9	12.46	19.2	7.83	19.0	6.79
Total recalled of negative events	13.7 (1)	7.83	12.1 (2)	4.70	10.8 (3)	4,86
Total recalled of positive events	8.0 (1)	5.06	7.0 (2)	4.22	8.1 (3)	3.51

Relation between events recalled and the noun valence

	Depressed n= 42 X	SD	Panic n= 28 X	SD	Without Pathology n= 51 X	SD
Total recalled events with negative	9.1 (1)	6.89	7.4 (2)	2.92	6.9	2.85
Total recalled events with positive	7.1 (1)	4.57	6.4	3.37	6.0	3.17
Total recalled with neutral nouns	6.6 (1)	3.47	5.4 (2)	3.11	6.1	2.54

Categorical and Extended Memories



(p<.05) – Qui-square test between groups
(p<.05) – Q the Cochran in Depressed group

DISCUSSION

The results demonstrate the existence, in depressed participants, of a predominant processing, retention and recall of negative information. This implies, according to some theoretical models, a reinforcement of negative emotions. In depressed individuals, a preference for the recall of negative events allows for the maintenance and reinforcement of negative emotions like sadness, that are associated with a loss of valued objectives or with the impossibility to attain such valued goals.

Our results are also congruent with the relation between emotions and self-schema contents. Thus, in depressed individuals, a negative emotion ceases to be related exclusively to the triggering situation, and becomes more general, in a schema congruent way. The results illustrate this generalization of a preference for the processing and recall of negative information independent of the stimulus words presented, which demonstrates the existence, in depressed individuals, of a negative self-schema content. This schema would imply a privileged processing of negative valence information. We can consider these aspects as an explanation for the recall of negative events in words of different valences observed in depressed participants. These studies also reinforce what was stated by the ICS model (Interacting Cognitive Subsystems) (Teasdale & Barnard, 1993) concerning the activation of a previous existing schematic model that is triggered by the processing of information related to it.

The decrease in recall and processing of positive information, either due to less frequent remembering or to a cognitive slowing, allows for the maintenance of negative information and is consistent with the existence of negative self schemas that make the processing of incongruent emotional information more difficult. Because autobiographical memories are related to the self, this is a possible justification for depressed participant's recalling more events and for the predominance of negative events among those that are remembered.

Our results also showed that memory deficits in depression are complex, since there is a variability associated with the severity of depression. Hence, when depression was less severe, depressed participants wouldn't manifest memory deficits such as negative biases and a cognitive slowing. In these situations concerning information processing and recall, the results showed that depressed participants presented a profile similar to that of participants without psychological disorders.

We continue the study with the relation between attachment models, schemas and interpersonal relations in depression subjects.

Acute Stress Disorder Symptoms, Anxiety and Extent of Information among Patients Suffering from Dengue Fever

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ABSTRACT

This study examined acute stress disorder symptoms, level of anxiety and extent of information among patients suffering from Dengue fever. It was hypothesized that patients are likely to report acute stress disorder symptoms and would report anxiety. The sample consisted of 100 dengue fever patients and was recruited from one teaching hospital of Lahore and through snow ball sampling from common public. The patients ranged in ages between 18-60 years, with mean age of 32 (*SD* = 10.28). Acute Stress Disorder Scale and Beck Anxiety Inventory were used to assess acute stress disorder symptoms and level of anxiety in patients. A self constructed disease related questionnaire was used to assess patients' extent of information. The results indicated that a significant number of patients were experiencing acute stress symptoms and were experiencing anxiety. Moreover, the extent of information of the patients was very low. The findings highlight psychological implication of Dengue fever on patients and warrant the need for provision of psychological interventions for Dengue fever to enable them deal with their stress and apprehensions and also to need for provision of information related to Dengue fever.

Key words: dengue fever, acute stress disorder symptoms, anxiety, extent of information

INTRODUCTION

•Dengue viruses are transmitted to humans through the bites of infective female *Aedes* mosquitoes. It is mosquito borne illness. It starts after the mosquito bite (White, 2004).
•Dengue fever is flu like fever that effects badly, one may suffer from high fever, headache, pain behind the eyes, muscle and joint pains, and rash (White, 2004).
•Pant et al. (1973) described that the outcome of the dengue fever is devastating as it is responsible for many deaths across the world.
•The number of affected patients per year in South Asia is estimated as high as 50 million cases per year and it results around 24,000 deaths annually.
•The first epidemic outbreak was occurred in Karachi in November 2005. In 2010 there was again sudden raise in the number of cases suffering from dengue fever. During 2006 to October, 2011 the number of suspect cases was 480,054, number of confirmed cases was 21,590 and 316 deaths were reported (WHO, 2011).

•Patients suffering from epidemic diseases may show acute stress, depression, anxiety, agitation, anger and fear of some bad happening (Odets, 1995; Kapse, 2007).
•Majority of the patients suffering from dengue fever are reported to state that they are in a state of shock (Kapse, 2007; Jahan, 2011).
•Those who experience acute stress symptoms are more prone towards anxiety (Levin & Pick, 2010).
•Need for effective communication about the implications of the fever in Pakistan has been emphasized as people are unaware about symptoms, implications and precautions of the dengue fever (Jahan (2011; Tahir, Hafeez, &Chaudhry, 2010).

Objectives of the Study

The present study aimed to:
•Examine acute stress disorder symptoms in the Dengue patients.
•Assess anxiety level of the Dengue patients.
•Examine the extent of information in the Dengue patients.

HYPOTHESES

Acute stress disorder symptoms are likely to be higher in the patients suffering from Dengue fever.

•Anxiety is likely to be higher in the patients suffering from Dengue fever.

•The patients suffering from dengue fever are likely to have low level of information about symptoms, intervention and precautionary measures regarding Dengue fever.

METHOD

Sample

•The sample consisted of 100 Dengue fever patients with equal number of men and women and sample was recruited from one major teaching hospital in Lahore and from common public.
•The patients ranged in ages between 18 to 60 years with the mean age of 32 (SD =10.28) and majority of the patients were married (64%).
•Mean duration of disease was 13.37 days (SD =5.93) and mean duration of treatment was 8.09 months (SD = 4.00).

MEASURES

Disease Related Information Questionnaire (DRIQ)

A self-prepared questionnaire was used to gather information about the symptoms, causes, satisfaction with treatment, and satisfaction about steps taken by the Government to control dengue fever, facilities at the hospitals and suggestions to control dengue fever.

Acute Stress Disorder Scale (ASDS, Bryant, Moulds, & Guthrie, 2000).

The ASDS has 19 items with the 5 point-Likert scales ranging from not at all(1), mildly(2), medium(3),quite a bit(4) very much (5). The cut off score for Acute Stress Disorder Scale is 56. The scale was translated into Urdu after seeking permission from the author.

Beck Anxiety Inventory (BAI, Beck & Steer).

BAI is a self-report inventory of anxiety. It consists of 21 items. It is based on 4 point-Likert ranging from not at all (0), mildly (1), moderately (2) to severally (4). The clinical ranges for BAI are 0-7 minimum anxiety, 8-15 mild anxiety, 16-25 moderate anxiety and 26-63 severe anxiety.

Procedure

Approval sought by the Board of Studies, Department of Applied psychology, University of the Punjab, Lahore, Pakistan.

Permission from respective Medical Superintendent of the hospital was sought after sending him a letter explaining nature of the study and requesting cooperation for facilitation in data collection.

Informed consent was taken from patients meeting inclusion criteria and those willing to participate in the study.

Individual assessment was carried out at the premises of the hospital and researcher noted down patients' responses herself.

RESULTS

Data were analyzed using descriptive and inferential statistics.

Descriptive statistics was used to evaluate how many patients were stressed because of dengue fever.

Table 1

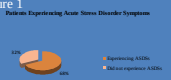
Patients Experiencing Acute Stress Disorder Symptoms (ASDSs)

Patients Experiencing Acute Stress Disorder Symptoms (ASDSs)

Variables	*F*	(%)	χ^2
Experiencing ASDSs	68	68%	0.78
Did not experience ASDSs	32	32%	

High numbers of patients were suffering from acute stress disorder symptoms.

Figure 1



Descriptive statistics was used to examine how many patients were anxious because of dengue fever.

Figure 2

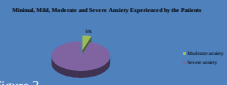
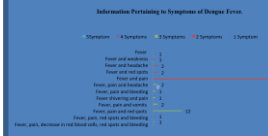


Figure 3



Majority of the patients showed low extent of information

Figure 4

Figure 5

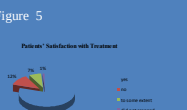


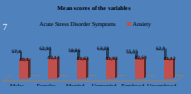
Figure 6

Correlational analysis was used to see relationship between education of the respondents and their level of acute stress disorder symptoms and anxiety Table 2*Relationship between education of the respondents and their level of acute stress disorder symptoms and anxiety*

Variable	Education of the respondents
Acute Stress Disorder Symptoms	-0.07
Anxiety	.07

p> 0.01 The results revealed that there was no relationship between the education level and level of acute stress disorder symptoms and anxiety of the respondents.

Figure 7



SUMMARY OF THE FINDINGS

•Majority of the patients were experiencing acute stress disorder symptoms and anxiety.

•Majority of the dengue patients had information about 1 or 2 symptoms.

•Most of the patients showed satisfaction with treatment and were satisfied with measures taken by the Government.

•The patients realized the need to expand facilities and number of care taking staff in the hospitals.

•There was no relationship between the education level and level of acute stress disorder symptoms and anxiety of the respondents.

•The findings on both scales using independent samples t-test were non-significant except there were significant gender differences on acute stress disorder.

CONCLUSION

It is concluded that the patients suffering from dengue fever experience stress and anxiety. The patients showed low level of information about causes and symptoms and causes of dengue fever. The patients also showed satisfaction with treatment but also emphasized the need for improvement. Findings highlight psychological impact of dengue fever and need for educating general masses about symptoms, causes and precautionary measures to be taken.

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Mental Health and Depression in Informal Caregiver's of Dependent People Post Stroke

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INTRODUCTION

The Stroke is a disease that threatens the quality of life in the elderly not only for its high incidence and mortality, but also by increased morbidity it causes, especially physical dependence and / or emotional changes.

And the care of dependent elderly at home by their relatives (caregiver's) requires the adoption of a widely varied range of strategies for him to "deal", noting that many empirical studies document the association of socio-demographic, clinical and with psychosocial quality of life and mental functioning of informal caregiver's.

In this context, the objective of the study is the mental health of informal caregiver's.

METHODS And OBJECTIVES

The research model adopted follows the model cross sectoral or cross, following a line of analysis explanation, with which it seeks to explore how personal and situational variables have an impact on mental functioning (mood and mental health), the caregiver informal.

PARTICIPANTS And MATHERIAL

A non-probability sample of convenience, was composed of 636 caregiver's (83.8% female and 16.2% male) aged M = 50.19 years.

Socio-demographic characterization of the Sample

The caregivers minimum age was 17 years old and the maximum 85, with the average of 50,19 years old. The most represented age group is from 35 to 55 years old.

The sample is not equilibrated according to gender, with 16,2% male and 83,8% female.

The married condition is predominant with 74,7 %.

Most of the individuals lives in rural areas (73,9%) and belongs to a middle class family and has a reasonable socioeconomic level (40,4%).

The protocol of data collection included:

. Inventory of Self-Concept (Vaz Serra, 1986)

. Scale of Social Aid (Matos & Ferreira, 2000)

. Eysenck Personality Inventory (Vaz Serra, Ponciano & Freitas, 1980)

. Inventory Beck Depression (Vaz Serra & Pio Abreu, 1973)

. Scale Screening for Mental Health (ER/80)

· Vulnerability to Stress Scale – 23 QVS (Vaz Serra, 2000)

· Questionário de Avaliação da Sobrecarga do Cuidador Informal (QASCI) (Martins *et al*, 2005)

RESULTS

The results showed that 62.8% of caregiver's did not have depression, and 16.1% have mild depression, moderate in 12.0% and only 9.1% had depression serious.

The score on the mental health, reflecting that 49.5% have good mental health, 37.1% have poor mental health and 13.4% is reasonable health.

Caregiver's with more positive mental functioning, scored with better self-concept, lowest overhead in size implications for personal life, satisfaction with the family role, needs and reactions to emotional overload, more social support, better functionality and family better socioeconomic level.

Caregiver's with poorer mental functioning, ie, poorer mental health, depressive symptoms had more severe and scored with a greater vulnerability to stress, a greater burden on the dimensions family support, financial burden, perception of efficacy and mechanisms of control and trait of neuroticism more sharp.

Table1 – Depression Level and Sex

Sex / Depression	Men n	Men %	Women n	Women %	Total n	Total %
Not Depression	78	75,7	322	60,4	400	62,8
Mild Depression	5	4,9	97	18,2	102	16,1
Moderate Depression	9	8,7	66	12,6	75	12,0
Serious Depression	11	10,7	48	8,9	59	9,1

CONCLUSIONS

The results support that the variables age, socioeconomic status, family function, overload, social support, self-concept, personality traits, vulnerability to stress, age of the dependent and the dependency ratio predict the mood of caregivers.

The variables age, socioeconomic status, family function, overload, social support, self-concept, personality traits, vulnerability to stress, age and the dependent elderly dependency ratio predict mental health of informal caregiver's, which suggests that health professionals should include in the planning of health actions that are addressed.

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Studies on stress in the clinical setting

Claustrophobia and adherence in Magnetic Resonance Imaging Procedure

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INTRODUTION

Claustrophobia, defined as the fear of being confined in small spaces[1], causes a huge distress to those who need Magnetic Resonance Imaging (MRI) because of the physical and functional characteristics of most of the equipment (see figures 1 and 2)[2].

According to Hollenhorst *et al* (2001), up to 37% of the patients can experience moderate to high anxiety levels. From that amount, 5 to 10% are not able to finish the full procedure due to claustrophobia. This contributes to the unsuccessful of the procedure and consequent failure of the diagnosis and/or clinical follow-up.[3]

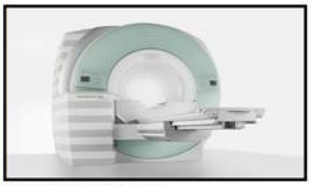


Figure 1: Closed MRI scanner.[4]

Figure 2: Open MRI scanner.[5]

Purpose

To contribute to maximize the success rate of MRI exams in claustrophobic patients.

METHODOS and DISCUTION

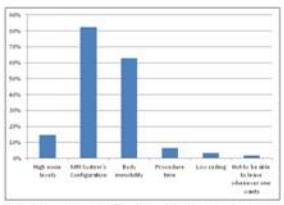
Were enquired 62 claustrophobic patients (see table 1). The patients were selected from the clinic database, which have completed at least one MRI in the institution's open system, without any other restrictions.

In a **first stage**, the patients were contacted either by phone or e-mail. They have authorized to take part in the study. In a **second stage**, the patients were called by phone and answered the survey. It was structured in three parts, the second part consisting of 16 items adapted from the paper *Claustrophobia Questionnaire* used for measuring levels of claustrophobia.[6]

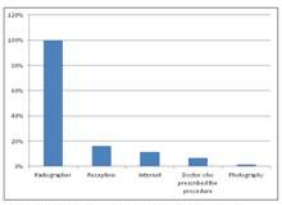
Sample
62 claustrophobic patients (46 are women and 16 men)
Sampling Type
Not Probabilistic, intentional for type or convenience
Validation of the Questionnaires
Face Validation (7 preliminary tests) and **Cronbach Validation Test of the Alpha Coefficient** (applied only in the 2nd part of the questionnaire, in which α=0,908).

Table 1: Characteristics of the investigation study's sample.

RESULTS



Graphic 1: Main difficulties felt during the MRI, as referred by the claustrophobic patients.



Graphic 2: Explanation of the MRI procedure.

Conditioning Factors	% Responses
MRI System's Configuration (open MRI system)	75,8 %
Presence of accompanying person in the procedure room	24,2 %
Attitude of the Radiographer	24,2 %
Persistence (self-control) to conclude the procedure	19,4 %
Closing the eyes during the procedure	6,5 %
Having had an anti-anxiety drug	4,8 %
Repositioning	4,8 %
Use of eye shades/blinders	4,8 %

Table 2: Factors the claustrophobic patients consider having contributed for the success of MRI procedure.

Other reported factors less referred were: alteration of the light intensity, ventilation, surrounding music, aromatherapy, decoration, and dimensions of the room, previous predisposition, and association of the closed space feeling to previous events.

Claustrophobia is quite a common symptom the patients who submit to MRI.[2,6] From those patients, 82.3% consider that the system's configuration is the main condition when carrying out such an examination, following body immobility (62.9%) and the level of noise (14.5%), which agrees with the study of Haddad et al (2005).[7]

Some of the patients inquired related that they do not remember to have felt any kind of claustrophobia symptoms before the MRI. In this sense, this procedure can be considered as an inductor of such a phobia, as previously related by McIsaac et al (1998).[8]

They also related that the radiographer explained them the procedure (100%), being such explanation recommended in the studies by some authors as Törnqvist et al (2006) and Escudero et al (2007).[9,10] It must be emphasized that 24.2% of those patients considered preponderant the paper of the radiographer in the success of the procedure, as related in the study carried out by Medina and Backes (2002), mentioned by Haddad et al (2005)[7].

CONCLUSIONS

This study gives good hints for the execution of an open MRI. Such a type of equipment revealed to be the crucial factor on reducing the anxiety in claustrophobic patients, thus assuring the success of the procedure. The radiographer was repeatedly reported by most of the patients as the main responsible for a broad understanding of the procedure, and thus for their relaxation and the good accomplishment of the examination.

In the table 3 is presented the easing strategies classified according the Technical, Technologic e Psychological dimensions.

Fields	Easing strategies
Technical	• Protocols with lesser procedure times; • Alternative positioning; • Sedation supported examination; • Use of anxiety drugs; • Change the light intensity.
Technological	• Procedure made with an open MRI system.
Psycológical	• Previous visit to the MRI room with brief; • Accompaniment allowance ; • Closed eyes/use of blinders; • Relaxation strategies; • Distraction strategies.

Table 3: Easing strategies for a MRI grouped according the Technical, Technologic e Psychological fields.

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PARENTS IN NUCLEAR MEDICINE DEPARTMENTS:
ISSUES SURROUNDING PREPARATION, INFORMATION AND HANDLING THE CHILD

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OBJECTIVE

Evaluate the perceptions of parents regarding pediatric kidney examinations in Nuclear Medicine (NM).

BACKGROUND

The Pediatric Nuclear Medicine is a subspecialty of Nuclear Medicine where the kidney examinations is the complementary diagnostic method most frequently performed[1]. These examinations have common characteristics, among which are: the administration of a radiopharmaceutical, the waiting time between administration of the radiopharmaceutical and image acquisition, and the need for restraint the child during image acquisition.

Successful completion of these examinations depends directly on the cooperation of the pediatric patient and his parents[2,3,4].

METHODOLOGY

Subjects

Convenience sample (n = 42) of parents of pediatric patients who underwent kidney examinations at NM departments of two private hospitals in the Lisbon area.

Parents were aged between 20 and 50 years old and 45.2% possessed the completed 12 years of high school.

Instruments

Two questionnaires were applied. The first questionnaire contained 16 close-response and 1 open-response questions. This questionnaire sought to characterize the sample and determine the level of information for parents and the feelings associated with the examination.

The second questionnaire consisted of 9 open-response questions. The indicators in assessment were the relevance of the information received and beliefs of the parents associated with suggestions for improving the customer service.

Procedure

The first questionnaire was collected before the examination, while the second was applied after the examination of the pediatric patient.

Concerning ethical procedures, the clinical directions of the MN departments allowed the application of the two questionnaires. All patients parents agreed to participate in the research study.

Data collection took place between April and June 2011.

RESULTS

First questionnaire

It was found that 92.9% of the sample received explanation of the procedures associated with the examination (*cf.* Table 1).

Table 1. Information provided before the examination.

Question Topics	N=42
Arrival time	37 (88.1%)
Total time	29 (69.0%)
Required preparation	29 (69.0%)
Procedure	29 (69.0%)
Instructions for parents	13 (31.0%)
Waiting time in examination	17 (40.0%)
Others	5 (11.9%)

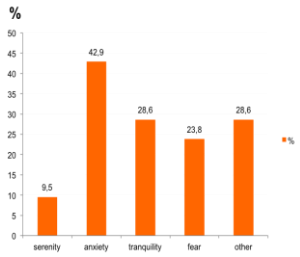

Figure 1. Feelings associated with the examination.

Regarding the feelings experienced by the parents before the examination (*cf.* Figure 1) the focus was on anxiety (42.9%).

Second questionnaire

Most parents (90.8%) indicated that the examination took place in an appropriate manner, and the whole sample considered useful the information received before the exam (*cf.* Figure 2). Nevertheless, 14.3% did not consider it complete and 28.6% received no instructions on how parents should conduct during the examination (*cf.* Figure 2).

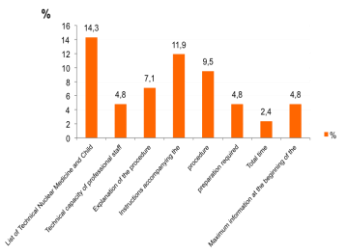

Figure 2. Information appreciated by the parents.

CONCLUSIONS

The results of this study indicate that the instructions given to parents of pediatric patients during the explanation of the procedures should have been taking more in consideration by the Nuclear Medicine Technologist.

It is understood that favor the relationship of Nuclear Medicine Technologist established with the child and parents/accompanying persons enables participants to become more informed and participants in the examination[5] Indeed, empathy and sensitivity of health professionals, allied to the way knowledge is transmitted, are aspects that will influence how the examination is perceived[6] by parents/accompanying persons.

Finally, it is suggested the development of a care program to the parents of pediatric patients performing NM kidney examinations, achieved by making a guideline, in order to promote better cooperation of them and consequently the adhesion and well being of children. This guideline focusing not only on information related to the procedures but also on psychosocial aspects of pediatric patients offer NM teams a agenda that could prove helpful in daily practice.

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THE EMOTIONAL IMPACT OF DIFFICULT CONVERSATIONS WITH PATIENTS: A STUDY WITH STUDENTS AND PHYSIOTHERAPISTS

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BACKGROUND

Helpful physiotherapists do not simply dispense services, but provide them in a manner that reflects patient's needs and understanding of his disease or disability[1]. In fact, communication with the patient should occupy a prominent place in the physiotherapists' work, but some results indicate that physiotherapists encounter many challenging conversations during their everyday work[2]. Yet, health schools curriculum offers few means to prepare them for difficult situations[3].

OBJECTIVE

The aim of this work is to identify students' and physiotherapists' anxiety levels in difficult communication situations.

METHODOLOGY

Subjects

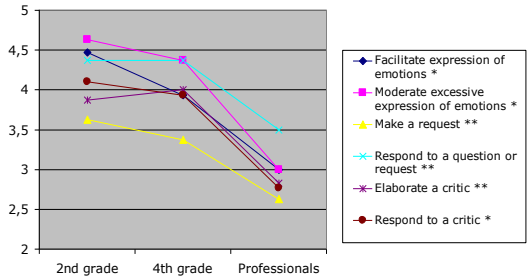
The study involved 60 2nd grade and 60 4th grade students of physiotherapy course from School of Health Technology in Portugal and 60 Portuguese physiotherapists.

Procedure

To evaluate the degree of anxiety experienced by subjects, were used videotaped scenarios, representing different problematic situations within the physiotherapist-patient interaction, related to specific assertive communication themes (e.g., *facilitate expression of emotions, moderate excessive expression of emotions, make a request, respond to a question/request, elaborate a critic and respond to a critic*). Subjects have to answer in direct speech to the simulated patient in the video, and then filled out a six-point Likert scale focused on their perception of anxiety in each interaction.

RESULTS

The groups differ significantly in their perception of anxiety, in each of the six assertive themes (Kruskal-Wallis for median comparison for independent samples).



Graphic 1: Median scores for perception of anxiety, by group and in each thematic (* p<0.001 , ** p<0.05)

Physiotherapists appears to experience less anxiety when facing different situations, comparing both groups of students. For all groups, the two themes related to emotionality (*facilitate expression of emotions, moderate excessive expression of emotions*) and the theme *respond to a question/request* seems to trigger higher levels of anxiety.

CONCLUSIONS

The results of this study reveals important differences between students and professionals, in the way subjects react to various communication scenarios. As mentioned by Yudkowsky, Downing and Ommert[4] the experience and clinical practice could attenuate the anxiety felt by physiotherapists, comparatively with other groups. The attendance in psychology and social sciences classes, with increased focus on patients' illness experiences and on communication skills, may also explained the better results in 4th grade students.

Some situations, like *respond to a question/request*, seems to trigger higher levels of anxiety in subjects. Acknowledge that are interactions with patients more exigent than others should be considered when training programs for communication skills are designed both in pre and post-graduate curricula in physiotherapy.

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Reaction to an Audiovisual Stressor and its Change Due to Relaxation Training in Individuals with Positive and Negative Affectivity

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I. Introduction

Probably it would be impossible to find a description of a disease, in which stress was not mentioned as one of etiological or progress stimulating factors. Stress does not necessarily cause diseases directly, but it had been proved to be a disease-enhancing factor. According to M. A. Santed (2003), people with negative affectivity are more responsive to stress, while positive emotions reduce the negative effects of stress on the body's physiological systems. Stress is a natural phenomenon and nobody can escape it, however, negative concequencies to health can be avoided or at least reduced by increasing peoples' resistance to stress and relaxation training. Yet, relaxations are not for everyone. There are not much studies analysing the relationships between stress and emotions when using objective reaction to stressor measurements and not scales measuring subjectively perceived stress. Psychologists are still struggling to understand the way mental states can impact on body functions and favor the development and progression of disease (Dantzer, 2001). So, the study aimed at assessing the reaction to an audiovisual stressor and it's change due to relaxation training in individuals with positive and negative affectivity.

II. Method

Subjects completed the Positive and Negative Affect Schedule (PANAS-X) created by D. Watson and L. A. Clark (1994) to measure their negative and positive affectivity.. Only Negative and Positive Affects scales were used in the analysis. The reliability of the scales was calculated by using Cronbach's alpha, which were 0,613 for Negative Affecta scale nd 0,781 for Positive Affect scale. The participants who scored above the mean in Negative Affect scale were assigned as subjects with high negative affectivity. All of the rest, who scored below or equal to the mean were assigned as subjects having low negative affectivity. Likewise, subjects who scored above the mean in Positive Affectivity scale were assigned as subjects with high positive affectivity. All of the rest, who scored below or equal to the mean were assigned as subjects having low positive affectivity.

Body temperature, skin electrical activity (skin conductance), heart rate and respiratory rate were recorded while measuring participants' reaction to the audiovisual stressor. Mind Media device NeXus 10 (serial number 0928050233, Holland) was used for the evaluation of participants' physical condition. The program of the audiovisual stressor was used as a stressor. NeXus 10 technology meets the European Community Council Directive 93/42/EEC for medical devices requirements (Mind Media BV. User manual for NeXus-10, 2004/2005).

Subjects: 90 people aged between 18-30 (mean age 21,9 ± 2,5) participated in this study. There were 19 men and 71 woman.

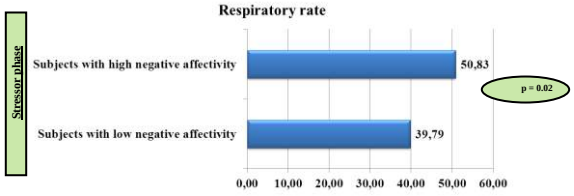
Procedure: The participants were randomly assigned to 3 different groups. Two groups received 4 relaxation training sessions (progressive muscle relaxation (30 (33,3 percent.)) or biofeedback relaxation (29 (32,2 percent.)) once a week, between two measurements of their reaction to the audiovisual stressor. The third group was a control group (31 (34,5 percent) which did not receive any relaxation trainings, but it had the same time intervals between the first and the second measurements of reaction to audiovisual stressors.

The measurement of psychophysiological reaction to the audiovisual stressor was performed twice: on the first visit and after the relaxation trainings (in 4 weeks approximately). The measurement of psychophysiological reaction to the audiovisual stressor for the control group subjects was also performed twice: the first time and after 4 weeks approximately without giving any relaxation trainings. Psychophysiological reaction to the audiovisual stressor was recorded in 4 phases: at rest, while waiting for the stressor, during the stressor phase and after the stressor while getting back to their usual state.

III. Results

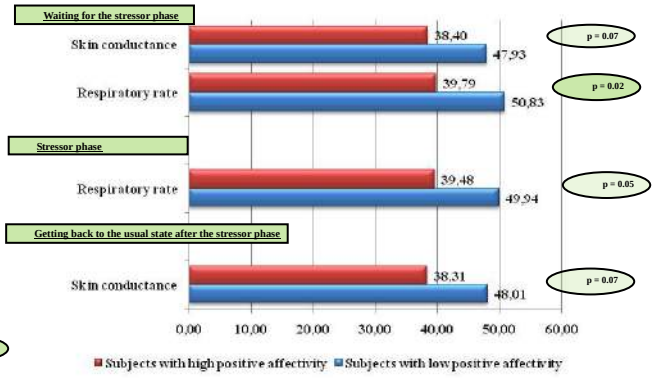
A comparison of psychophysiological response to an audiovisual stressor between subjects having high and low negative affectivity is presented in Figure 1. The results of the study showed, that subjects having high negative affectivity had higher respiratory rate at the stressor phase then subjects having low negative affectivity ($p<0.05$). It means that they were more tensed.

A comparison of psychophysiological response to an audiovisual stressor between individuals having high and low positive affectivity is presented in Figure 2. The results of the study showed that individuals with low positive affectivity were more tensed (had higher respiratory rate while waiting for the stressor ($p<0,05$) and at the stressor phase ($0,05<p<0,1$) and higher skin conductance while waiting for the stressor ($0,05<p<0,1$) and while getting back to their usual state after the stressor ($0,05<p<0,1$)). Thus, subjects having low positive affectivity reacted to an audiovisual stressor more then subjects with high positive affectivity.



** Lower respiratory rate mean rank shows less tension.*

Figure 1. Comparison of psychophysiological response to the audiovisual stressor between subjects having high and low negative affectivity



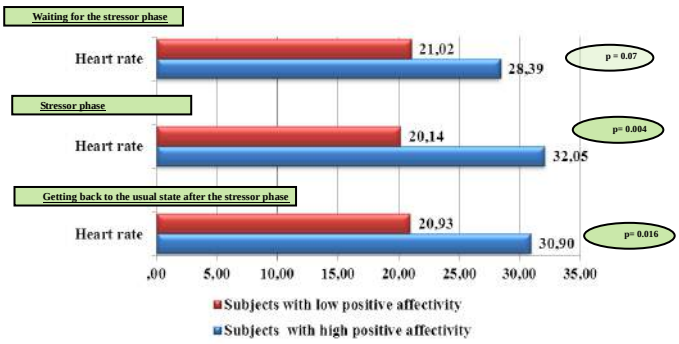
** Lower skin conductance mean rank shows less tension, * * Lower respiratory rate mean rank shows less tension*

Figure 2. Comparison of psychophysiological response to the audiovisual stressor between subjects having high and low positive affectivity

Students' having high negative and positive affectivity psychophysiological reaction between 1st and 2nd measurement to their reaction to an audiovisual stressor were analyzed. The results of the study showed that subjects having high negative reactivity reacted to an audiovisual stressor even more when measuring their reaction for the second time (respiratory rate at the stress phase and after the stress).However, subjects having high positive affectivity showed lower psychophysiological reaction after relaxation trainings while measuring their reaction to an audiovisual stressor for the second time (skin temperature and respiratory while waiting for the stressor, at the stressor phase and after the stressor and heart rate at the stressor phase). Subjects having high positive affectivity reacted to an audiovisual stressor less after biofeedback relaxation (heart rate) and skin temperature) and after progressive muscle relaxation (respiratory rate). There were no significant differences between the 1st and 2nd reaction to the audiovisual stressor measurements in subjects having high positive affectivity in the control group ($p>0.05$).

A comparison of psychophysiological response to the audiovisual stressor changes after relaxation trainings between subjects having high and low positive affectivity is presented in Figure 3. According to the survey after relaxation trainings, the subjects having high positive affectivity reduced their heart rate more while waiting for the stressor ($0,05<p<0.01$), during the stressor phase and after the stressor while getting back to their usual state than subjects having low positive affectivity. There were no statistically significant changes in psychophysiological response rates between subjects with high and low positive affectivity in the control group. ($p>0.05$). Statistical data analysis showed that subjects with high positive affectivity reduced their heart rate more after progressive muscle relaxation.

There were no significant differences between psychophysiological response to the audiovisual stressor after relaxation trainings between subjects having high and low negative affectivity ($p>0,05$).



** Higher heart rate change differences show that subjects were able to reduce their heart rate more ; lower heart rate change differences show that the subjects reduced their heart rate less*

Figure 3. Comparison of psychophysiological response to the audiovisual stressor changes after relaxation trainings between subjects having high and low positive affectivity

IV. Conclusions

Students with high negative affectivity had higher psychophysiological reaction to an audiovisual stressor while subjects with high positive affectivity reacted less. Subjects having high negative affectivity after attending relaxation trainings reacted to an audiovisual stressor even more while subjects having high positive affectivity were able to reduce their reaction to an audiovisual stressor while measuring it the second time after relaxation trainings.

Heart rate after relaxation trainings decreased more for subjects having positive affectivity in comparison to subjects having low positive affectivity.

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12th International Congress of Behavioral Medicine , Budapest, Hungary

Vulnerability to Stress in Patients in the Pre-surgery Phase

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Introduction

The patients vulnerability to stress in the pre-operative is assumed as determinants of well-being and pre-operative visit as an important protector of thenosological entity occurrence.

In this context, we studied the stress vulnerability in pre-surgery patients.

Fonte da foto: www.google.com

Objectives

- Explain the influence of socio-demographic variables in the patient stress;
- Infer the influence of pre-operative visit in the vulnerability of patients stress;

Methods, Participants and Material

The transversal observational study was conducted in a non-probabilistic sample of 180 pre-surgical patients (55.6% women and 44.4% men) with mean age of 57.25 years, using the Vulnerability to Stress Scale - 23 QVS (Vaz Serra, 2000).

Results

Vulnerability to stress

Patients Vulnerable to Stress - 55.6%

Patients not Vulnerable to Stress - 44.4%

Table 1 - Vulnerability to stress

Vulnerability to Stress	Men		Women		Total	
	n	%	n	%	n	%
Vulnerable to stress	46	57,5	54	54,0	100	55.6
Not vulnerable to stress	34	42,5	46	46,0	80	44,4

Vulnerability to Stress vs Sex, School levels and Age

Vulnerability to stress is higher in the:

- men (57.5%) than women (54%)
- individuals living alone (H = 16,349, p =. 000)
- less instructed (H = 18,023, p =. 003)
- those living in rural areas (U = 301.0, Z = -2,336, p =. 020)
- and older (r =. 287, p =. 000).

Age and Pre-operative Visit vs Vulnerability to Stress

Age explains 8.2% of the variability in vulnerability to stress and its also independent of the pre-operative visit, (U = 3452.0, p =. 186).

Table 2 - Pre-operative Visit

Sex	Female		Male		Total	
	n=100	100,0%	n=80	100,0%	n=180	100,0%
Previous surgical experience						
No	31	31,0	33	41,3	64	35,6
Yes	69	69,0	47	58,7	116	64,4
Nursing preoperatative visit						
No	43	43,0	30	37,5	73	40,6
Yes	57	57,0	50	62,5	107	59,4

Conclusions

It was found that age, education and cultural background, influence vulnerability to stress, being consider them when planning good practice in health care of pre-surgery patients.

Acknowledgments: Portuguese Foundation for Science and Technology and Center for Studies in Education, Technologies and Health.

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Studies on measurement and method

GHQ-12 in Romanian people: reliability, exploratory and confirmatory factor analysis

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Introduction

The General Health Questionnaire-12 (GHQ-12; Goldberg, 1972) is a self-administered screening measure for the detection of nonpsychotic problems in community and clinical settings. It also assess psychological well-being.

The first versions of the test, GHQ-60, GHQ-28 and GHQ-30 were designed as multi-dimensional measures. The GHQ-12 was originally developed as a unitary screening measure. However, several authors identified a multidimensional structure (Campbell, Walker & Farrell, 2003). For example, Politi et al. (1994) found two factors: general dysphoria and social dysfunction. Andrich & van Schoubroeck (1989) suggested that the positively worded items formed one factor and the negatively worded items formed another.

Graetz (1999), Martin (1999) and Worsely & Gribbin (1977) proposed three different 3-factor models.

Recently it has been suggested that the GHQ-12 should be used as a one-dimensional measurement (Hankins, 2008a, 2008b; Ye, 2009). These authors suggested that multifactorial structure is due to the fact that a mixture of positive and negative statements can produce an entirely artefactual division into factors, a psychometric phenomenon known as "method effect" (Hankins, 2008a).

In view of the previous results in different samples, we consider it relevant to confirm the validation of the scores of the questionnaire in Romanian population and to assess the dimensionality of the instrument by means of confirmatory factor analysis.

Objective

The purpose of this study is to analyze the internal consistency and the factor structure of the GHQ-12 in the Romanian general adult population, using a Likert-type scoring.

Method

Participants

→ Women N = 512	→ Men N = 293
→ Age range 16-71	→ Age range 17-78
→ Mean age= 29.53	→ Mean age = 28.40
→ S.D. = 10.63	→ S.D. = 11.77

Instruments

GHQ-12

The 12-Item General Health Questionnaire (GHQ-12) (Goldberg & Williams, 1988) consists of 12 items, each one assessing the severity of a mental problem over the past few weeks using a 4-point Likert-type scale (from 0 to 3). The score was used to generate a total score ranging from 0 to 36. The positive items were corrected from 0 (*always*) to 3 (*never*) and the negative ones from 3 (*always*) to 0 (*never*). High scores indicate worse health.

Procedure

The instruments have been translated from English to Romanian language following the recommendations of international regulations and national ones (ITC, 2011; Muñiz & Hambleton, 1996; van de Vijver & Poortinga, 1997).

It was used the "snowballing" method. In all cases the instruments were administered with a cover sheet indicating the instructions for filling-in. After having explained the purpose of the study, all the participants gave their informed consent on the participation. We also guaranteed the anonymity of their personal data.

Results

Reliability

To assess internal consistency, Cronbach's alpha coefficient was calculated. It was found a value of 0.70 for the entire sample.

Exploratory factor analysis

All factors have eigenvalues exceeding the unit, a criterion used to guide the number of significant factors. The first factor accounts for 34.94% while the three factors taken together account for 52.62 %of the variance in GHQ-12.

	Eigenvalue	Percentage of explained variance	Accumulated percentage	Correlation between factors		
				Factor 1	Factor 2	Factor 3
				1.00		
Factor 1	4.54	34.94	34.94			
Factor 2	1.24	9.56	44.50	.47	1.00	
Factor 3	1.05	8.12	52.62	-.19	-.52	1.00

Confirmatory factor analysis

Models	χ^2	GF	AGFI	NFI	CFI	RMSEA (90% CL)	ECVI [90% CL]
1. One-dimensional	522.94	.90	.86	.91	.92	.10 [.096, .11]	.71 [.62, .80]
2. One-dimensional with correlated errors	170.14	.97	.93	.97	.98	.065 [.055, .075]	.31 [.26, .36]
3. Three-dimensional (Graetz, 1991)	374.24	.93	.89	.94	.94	.089 [.080, .097]	.53 [.46, .61]

Conclusions

These results support the conclusion that the GHQ-12 is an effective measure for assessing the psychological well-being and detecting non-psychotic psychiatric problems in Romanian population.

The exploratory factor analysis showed that the GHQ-12 is a multidimendional measure. There were statistically significant correlations between all the items of the test and, when the confirmatory factor analysis was done, there were correlations between the factors. The study of French & Tait (2004) also showed strong correlation between the factors. This fact led the authors to recommend that it may be prudent to use the overall score rather than overinterpret the factors within the GHQ-12. As Hankins (2008a) proved the GHQ-12 fits better as a one-dimensional model with error correlations so the apparent two or three dimensional structure is artefactual. In the future, we propose to continue adapting the instrument and to apply it on the Romanian population living in Spain.

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LAW AND PSYCHOLOGY

DR. LÁSZLÓ KELEMEN

Two surveys were the basis of the monitoring of attitudes towards law and the operation of law and of comparing results.

The first, entitled **"What's Our Attitude Towards Law?"**, was organised in the spring of 2010.

The second was held in the spring of 2011 with the title **"Law and Society"**.

The 2010 study worked with a national representative sample of 1000 and - besides - a sample of 100 lawyers opening up an opportunity in the phase of analysing results to determine whether possible changes in comparison to the opinions measured in the previous year on the sample of lawyers come nearer or diverge. Changes between the two samples were mainly due to the changes in preferences regarding political parties. If the observed changes couldn't be attributed to answers regarding the changes observed in political party preferences, answers to this question were sought for among other socio-demographic attributes.

The interesting thing about the comparison is that Hungarian parliamentary elections were held between the two samplings. Comparison making between results of the two surveys followed a special method: Scales were made on statements of the 2010 study according to similar subject groups that allowed surveyors to determine, which was the scale where changes were detectable and what were the background variables that could explain the measured changes, with a special view on changes caused by political party preferences. Changes of the averages of scales - or uniformities, on the other hand - could identify modifications within each subject matter allowing the surveyors to draw conclusions. Through the examination of changes of all scales we were able to determine changes in the society reaching thereby, starting from a certain psychological viewpoint, a certain social viewpoint. Political party preferences reflected changes and uniformity at once. Comparing the results to each other it can be said that the ratio of supporters of FIDESZ, the party currently in power, has decreased seriously, while the ratio of the insecure electorate has increased highly. Meanwhile the ratio of opposition party supporters hasn't changed, whereby the correlation of forces has remained unchanged, and this influences considerably changes in attitudes, too. For if the opinion of voters of the governing party changes, that surely leads to significant changes in the society as a whole.

"Overall, in areas covered by the scales, the following changes in the society have come about in the last year:

In spite of changes in government, the critical attitude towards the political system has remained. Respondents are less and less able to believe in crime prevention strategies; and this is independent of all societal dimensions I have examined: it proves to be a phenomenon of the entire society. The Hungarian society is becoming more and more pessimistic about questions affecting the individual citizen. Respondents think that a strong State is still need. The belief in the administration of justice is somewhat stronger, but most voters still remain sceptical in this regard. Similarly to the previous year, the restoration of capital punishment was supported by the great majority. In opinion of the respondents, injustice and sin are parts of life therefore they are afraid of becoming victims of criminal acts. Unlike other groups of the society, voters of the governing party are more optimistic than the average regarding both dimensions of their beliefs in a righteous world; additionally they form the only group where it is perceptible that the last year has affected their attitudes positively."

EXTERNALIZING PERSONALITY AND EXECUTIVE COGNITIVE FUNCTION: A STUDY WITH A NON-CLINICAL SAMPLE

I. M. Santos[1,2], J. Costa[1], A. Pereira[1,2], P. Vagos[1], P. Rodrigues[3], A. Oliveira[1], N. DeFilippis[4] & C. Silva[1,2]
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Internalizing dimension:
Anxiety, depression and fobic disorders

Externalizing *spectrum* of personality and psychopathology [1,2,3]

Externalizing dimension:
Substance abuse and antisocial behavior/personality
Impulsivity and aggression
Poor behavioral control

A common behavioral pattern reflected in many manifestations of externalizing is an apparent failure to learn from experience, raising the possibility that externalizing may involve a deficit in executive cognitive function – a deficit in the ability to self-monitor ongoing behavior for errors[1,2,3].

The aim of this study is to examine the influence of externalizing on performance on the Halstead Category Test

METHOD:

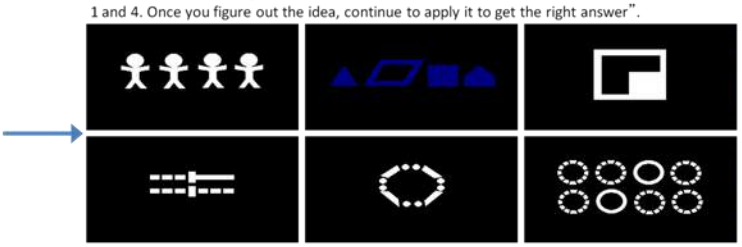
Participants: 37 university students (25 females and 12 males), between 18 and 46 years-old (M = 22.41), selected on the basis of their score on the Externalizing Spectrum Inventory (ESI)[4]: 12 with a high score, 14 with a medium score and 11 with a low score.

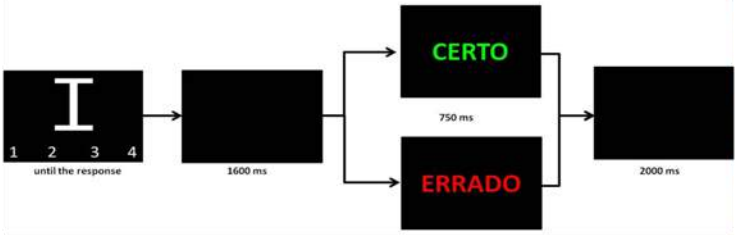
Materials: **Halstead Category Test (HCT)[5]**
– Provides a measure of executive function: assesses concept learning, flexibility of thinking, the ability to learn and apply new rules and monitor errors.
– Scales/variables: Number of errors (total); loss of set – attentional and conceptual; spatial positional reasoning; proportional reasoning , memory and perseveration.
– 208 stimuli divided into 7 sub-tests

Procedure: Participants completed the Portuguese reduced version of the ESI. Selected participants were posteriorly called to the lab, where they performed individually a computerized version of the the HCT.

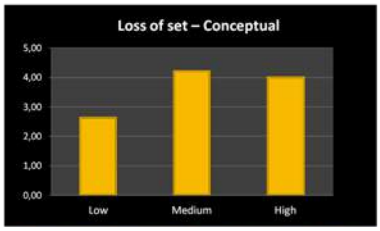
Data analysis: Kruskal-Wallis Tests were applied to analyse main effects of group for the total scores and the various sub-scales. Follow-up Mann-Whitney Tests were carried out whenever a main effect emerged in the previous analyses.

Instructions: "Something about the pattern on the screen will remind you of a number between 1 and 4. Once you figure out the idea, continue to apply it to get the right answer".





RESULTS:



- Significant differences emerged between high, low and medium externalizers in the scale Loss of set - Conceptual:

  $\chi^2(2)=6.35$, $p<.05$.

  - Medium (m=4.21, sd=1.67) and high (m=4.00, sd=2.37) externalizers had significantly more conceptual losses than low externalizers (m=2.64, sd=1.86).
    - Z=-2.27, p<.05 (medium vs low externalizers)
    - Z=-2.01, p<.05 (high vs low externalizers)

- No significant differences emerged for the total score of the Halstead Category Test or for any other sub-scale.

CONCLUSION:

Participants scoring high on the externalizing vulnerability performed significantly worse on the "Loss of Set – Conceptual" subscale than participants scoring low. The same pattern was observed in medium when compared to low externalizers.

The "Loss of Set – Conceptual" sub-scale assesses the ability to apply the same rule to slightly different patterns of figures. This suggests that a higher externalizing vulnerability is associated with an increased difficulty at the level of abstract concept formation and poor cognitive flexibility.

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Development and Validation of Working Women's Stressors Scale (WWSS)

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ABSTRACT

This research was carried out to identify the stressors in Pakistani professional women and to develop an indigenous tool to measure it. Both qualitative and quantitative research, in three phases, was carried out, on groups consisting of doctors, bankers, University professors, telecommunication officers, and pharmaceutical employees. In phase one, focus group discussions on stressors were carried out on three groups of professional women (N=18) of ages between 26 and 57, and the findings were used to develop the 60 items Working Women's Stressors Scale (WWSS), employing Likert scale (5-point). In phase two, pilot study, validation, and reliability testing were carried out. The pilot study conducted on working women (n=30) of ages between 23 and 52 revealed the high value reliability coefficient (α =.85). Option "any other" in the scale identified six more items for inclusion in WWSS scale, increasing the number of items to 66. In the third phase, factor analysis and assessment of construct validity was carried out for psychometric evaluation of WWSS, on working women (n=300) of ages between 21-59 years, with a mean of 31.37. It yielded alpha (α=.95). Six factors emerged from factor analysis i.e. family stressors (α =.97), daily hassles/personal stressors (α=.89), social stressors (α=.86), work stressors (α=.85), life events (α=.83), and catastrophic (α=.75).

INTRODUCTION

Role of women is changing due to their entry into the job market in the more traditional society like Pakistan. Their responsibilities then doubled and stresses are enhanced. While, the chances of experiencing irreconcilable expectations, besides/ or a lot of stress, depends upon the time limitations and strength available to an individual (Coser, 1974; Goode, 1960) In addition to occurrence of conflicting situations, a lot of stress, depends upon the time limitations and strength available to an individual (Kalyan, 2009). The increasing stress in Pakistani working women is alarming in a significant proportion. Stress in Pakistani working women is increasing in a significantly alarming proportion. Therefore, it is need of the hour to assess the stress of working women. To achieve the goal, In order to achieve the objectives, a scale with fundamental attributes (validity and reliability) was developed that guarantees dependable measurement of variables under exploration (Waltz, Strickland & Lenz, 2005).

METHODOLOGY

Phase 1: *Generation of items for the Questionnaire*

To generate items for an indigenous self report scale to measure the stressors of Pakistani working women.

To determine psychometric properties of the measure of stressors

Participants

Professional women (N=18) including six participants in each group, comprised of doctors, bankers, University professors, telecommunication officers, textile personal and pharmaceutical employees.

Procedure

Discussions on stressors were carried out on three groups of professional women. A list of statements was prepared, taking into account the description of stressors (causing stress in their lives), illustrated by the participants.

Results

During the focus group discussions, a total of 90 statements were recorded. Detailed notes were taken, summarized and variables were identified.

Generation of items for the Questionnaire

Considering the entire variable finalized during discussions, a 60 items Working Women's Stressors Scale (WWSS) was developed. Response options were given in the 5-point Likert rating scale format. An option of "any other" was also given to identify area, overlooked by the researcher or participants during discussions.

Phase 2: Pilot testing for the preliminary questionnaire

Participants

A purposive sample (N=30) of working women comprised of doctors, nurses, bankers, human resource officers, and some other organizations were selected for the pilot study.

Results of pilot study

Six items identified by the option "any other" in the questionnaire were also included in the final scale of WWSS increasing the total number of items to 66. Reliability analysis revealed significant correlation between the stressors with alpha (α=.85).

Phase 3: The Validation study

Method

Factor analysis was used to ensure and construct the validity of multidimensional scale WWSS (Gregory, 2006).

Participants

The participants of this study were (n=300), working women selected from banks, hospitals, Telecommunication, pharmaceutical manufacturing organizations, Universities and construction companies, within the age range of 21 to 59 years while the mean age was 33.80 year.

RESULTS

Table 1

Demographic Characteristics of Working Women (N=300)

Variable	Frequency	Valid%	Mean	SD
Age	----	----	33.80	10.27
Marital Status	----	----		
Unmarried	138	46	----	----
Married	125	41	----	----
Separated/ Divorced	25	8.4	----	----
Widows	12	4.0	----	----
Workplace				
Hospitals	70	23.30	----	----
Banks	49	16.30	----	----
Telecom	72	24.00	----	----
Universities	52	17.47	.....	.....
Pharmaceuticals	57	19.00	.....	.....

Factor analysis

The KMO coefficient was .89, and factor analysis progressed. Bartlett test of sphericity was significant (p<.001) indicating that data was distributed normally to allow an evaluation of the potential factor structure.

Table 2

KMO and Bartlett's Test

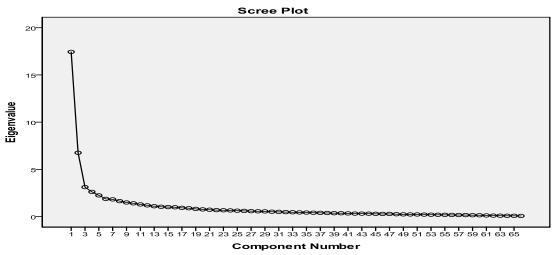
Kaiser-Meyer-Oklin Measure of Sampling Adequacy		.89
Bartlett's Test of Sphericity Appro.	Chi-square	13180.30

** (p<.001)

Scree Plot was consulted to decide the number of factors that should be extracted. A clear change in the plot can be noticed after factor six and nine.

Figure 1

Scree Plot Extractions of Factors & Eigen values for working women's Stressor Scale



Eigenvalue:

During successive trials, the six factors solution interpreted the most meaningful solution.

Table 3

Eigenvalues and Percentages of Variances of 66 Items (WWSS) Explained by Six Factors in the Factor Solution Obtained through Principle Component Analysis (N=300)

Factor	Eigenvalue	Items	Percentages of variances	Cumulative(%) percentage
1.Familystressors	17.44	19	26.42	26.42
2.Daily/ personal	6.76	18	10.23	36.37
3.Social stressors	3.12	8	4.72	41.39
4.Work stressors	2.61	10	3.96	45.35
5. Life events	2.24	6	3.40	48.50
6.Catastrophes	1.88	4	2.84	51.60

Table 4

Alpha Reliability of Working Women's Stressors Scale (WWSS) Subscales (N=300)

Item No	No of Items	ReliabilityCoefficient
Family stressors	19	.97***
Daily/personal stressors	18	.89***
Social stressors	8	.86***
Work stressors	10	.85***
Life events	6	.83***
Catastrophes	4	.75***

****p<.001,*

CONCLUSION

- WWSS has been validated to identify and measure the stressors of Pakistani working women.
- Significant correlation is found between items, indicating good support for validity of the scale, WWSS
- The six resulting factors of WWSS are found to be (i) family stressors, (ii) daily/personal stress-ors, (iii) social stressors, (iv) work stressors, (v) life events and (vi) catastrophes.

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Studies on gender related problems

THE IMPORTANCY OF BREAST CANCER ON ELDERLY WOMEN'S SENSE OF COHERENCE

Francis Carneiro, Sofia von Humboldt & Cláudia Carvalho

Introduction

The aging of the human organism is found to be associated with a continuous imbalance between gains and losses. This rhythm could be avoided, by implementing new strategies for a successful aging[1].

Breast cancer can influence different components of the female elderly life: like the psychological, the physical, the social and the existential dimentions[2 =>] Rather complex problems.

For some of the elderly patients the maximization of psychological and physical health levels and therefore maximizing the quality of life is the main goal in order to overcome the cancer treatment[3].

It becomes fundamental for health practitioners to (a) contextualize quality of life face to cancer situations related to the increasing of the prevalence of multiple bio-pshyco-socials symptoms that(b) increase the efficiency of the interventions such as on a physical level, such as a psychological level[4].

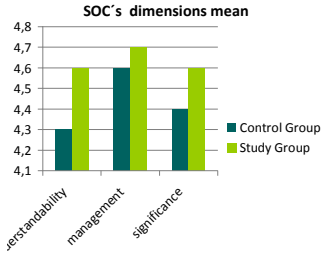
Overall Goal

- Analyze the effects of breast cancer in the SOC of the female elderly.

Specific Goals

- Analyze if there are any significant differences in the SOC of the female elderly in the presence of breast cancer.
- Avaluate if there are significant differencies in the female elderly with breast cancer.

Resultados



Method

Correlation Exploratory Study

Participants	*Inclusion Criteria*	Material	Procedure
• Sample: 124 female elderly with ages between 74 and 96 years old. • Control Group: 62 participants without breast cancer. • Study Group: 62 participants with breast cancer in remission.	• Female elderly with more than 74 years old. • Female elderly not diagnosed with mental disease. • Female elderly with intact cognitive capacities (MSME score= 30). • Not institutionalized elderly women.	• Mental State Mini-Exam (MSME)[5]. • Social-demographic characterization questionnaire. • Sense of Coherence Scale (SOC)[6]	• Volunteer and unpaid participation (informed written (and/or oral) consent). • Guaranty of confidentiality regarding personal data and anonymity. • Empirical data gathered during November and December 2011.

Social-Demographic data of participants

Variables	N	%
Household	124	100
0	10	8.1
1	27	21.8
2	72	58.1
3	11	8.9
4	4	3.2
Professional status	124	100
Retired	85	68.5
Professionally specialized	18	14.5
Non-specialized worker	6	4.8
Artist	15	12.1
Religion	124	100
Non-religious	4	3.2
Catholicism	112	90.3
Protestantism	4	3.2
Taoism	1	0.8
Other	3	2.4
Housing location	124	100
City	53	42.7
Town	13	10.5
Rural area	52	41.9
Village	6	4.8

Discussion

- Results reveal that female elderly with breast cancer in remission present superior scores in all SOC´s dimensions, when compared to the female elderly with no history of breast cancer.
- An elevated SOC can promote and protect the health of female elderly in stressful situations like the development of breast cancer[7].
- SOC can be considered as a likely protective factor against distress, which in its turn is responsible for the development of several psychological disturbances like depression and anxiety[7].
- Investigation for the link between SIC and oncologic patients distress is for the time being, insufficient[7].

Conclusion

Despite differential emotional experience of cancer diagnosis, it represents always a life threatening and a menace to the integrity of the individual that leads to a necessity for readapting the intrapsychic experiences[8,9]

Future investigation should (1) evaluate the distress scores related to physical and psychological symptoms related to cancer, in a way to help medical decisions to be formed in a more informed and adequate regarding each case, (2) identify the psychological related pre-treatment and treatment factors and (3) evaluate which the psychological consequences related to the treatment course and its impact in life quality, so that new efficient and adequate preventive strategies can be developed[3,10].

This investigation was supported by Fundação para a Ciência e Tecnologia (FCT) [bolsa com a referência SFRH/BD/44544/2008].

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Evaluation of the therapeutic process of women with couple's violence

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The purpose was to evaluate the process of psychological support therapy to women in violence situation given by a government institution.

The permanence of women in couple's violence can be explained by cultural factors that adjudicate women the responsibility for the wellbeing of the family members, fear associated with separation or the increase of violence, as well as psychological defenses such as negation or violence normalization.

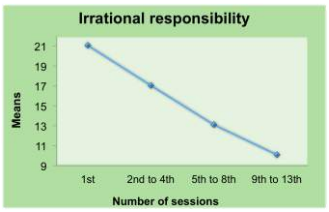
For a woman to be able to free herself from a couple's violence situation she should change believes, behaviors and emotions that kept her inside and did not allow her to leave couple's violence. This program is targeted to strengthen the women and help them to get free from a violent situation.
It is a structured therapeutic program, each session has it own objective

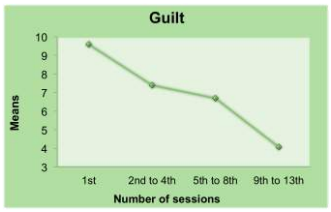
Method

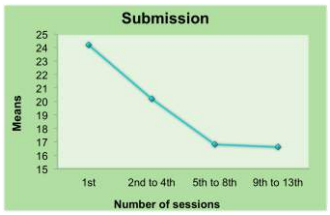
Three hundred and two women volunteer which attended to this psychological support program for couple's violence victims. For 56 it was the first time they had attended, 100 with 2 to 4 sessions, 80 with 5 to 8, and 66 with 9 to 13 sessions. The instrument "Feminine believes, behaviors and emotions towards couple's violence" (Mercado, 2012) that evaluates believes, behaviors and emotions that hold back women from getting out of a violence situation, as well as a factor of need of a better life was administered. It is a transversal design.

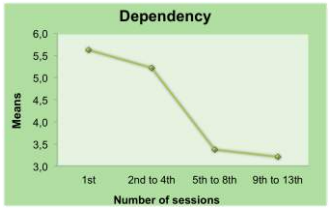
Results

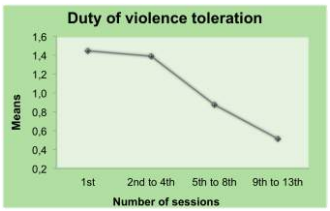
The results comparing the media between the groups with different number of sessions are being represented on the charts.

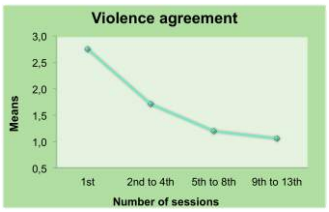












ANOVA produced, significant effects with a $p<0.05$ in the subscales of: Irrational Responsibility, Guilt, Submission, Dependency, Fear to Change, Violence Agreement, and Normalization. In every case the significance was because the measures decreased as the number of sessions increased. Which indicates the more therapeutic sessions, the more the women will change their believes, behaviors and emotions about the violence they live. It is suggested that when the women who looked up for psychological help, had already started the process to free themselves from violence. And the role that therapy plays is to give them tools and strength to feel secure of their own decisions, the ones they have taken and the ones they will take [decisions].

These results suggest that the therapeutic help produces several changes in cognitive, emocional and attitude variables that empower women in couple's violence situation.

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Contingent conditions to ending of couple's violence

Dolores Mercado Corona and Claudia Angélica Santos Loredo

National University of Mexico

The objective of this study was to describe some of the contingent conditions for either separation or permanency into the couple's violence.

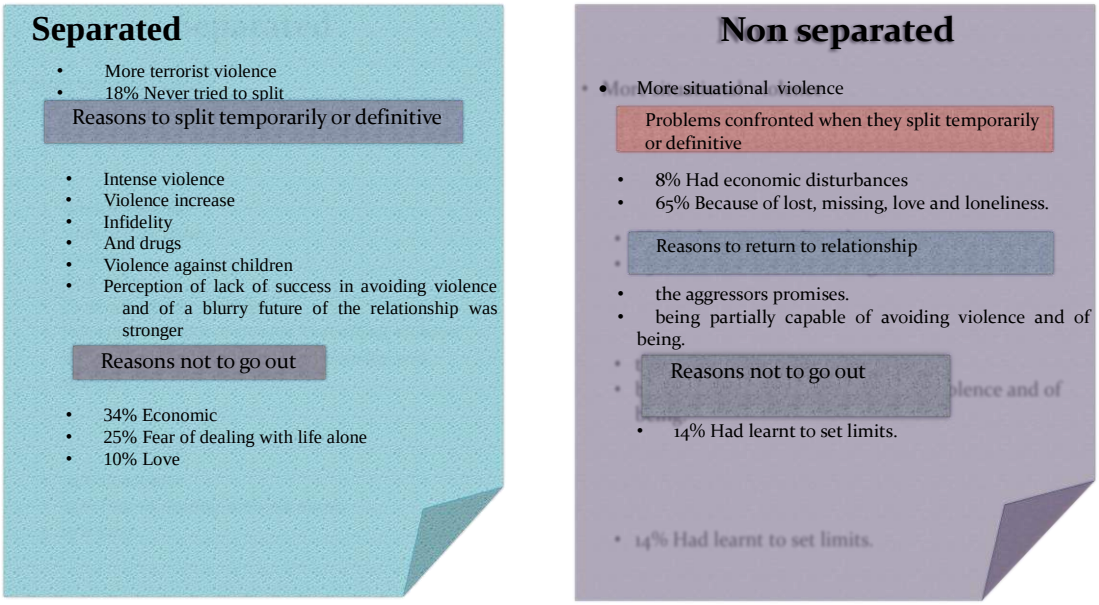
Method

27 women volunteered, all with couple's violence, they were already going to a support institution for domestic violence. Twenty of them were separated from the aggressor, 70% took themselves the decision and the remaining 30% was a decision of the couple, 7 were still into the relationship.
A semi-structured interview was applied about violence, its context and the women answer to violence.

Results

Results showed more terrorist violence in separated women and more situational violence in those that were not separated (Johnson, 2008).
When the violence started women did not reply violently, they tried to avoid it with several strategies:

1) They began to defend themselves violently (violent resistance),
2) Some did not defend themselves.



To get out from couple violence depends on a process: first women bear silently, with recurrence some present resistance, and finally violence intensification and lack of solution perspectives seem to be important for some women to take the decision of running out from couple's violence. When women decide to go out from a violent partner they need emotional and economic security. Family and social nets are natural support sources. Formal psychological and legal support enhances woman's empowerment to end with this public health problem.

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Gender Related Differences in Predicting Health Related Behaviour: Lithuanian Study

Gabija Jarašiūnaitė[1], Olga Riklikienė[2], Kęstutis Miškinis[3]

[1]Department of Theoretical Psychology, Vytautas Magnus University, Kaunas, Lithuania; [2] Lithuanian University of Health Sciences, Department of Nursing and Care, Kaunas, Lithuania; [3] National Health Insurance Fund under the MoH, Strategy Department, Vilnius, Lithuania

I. Introduction

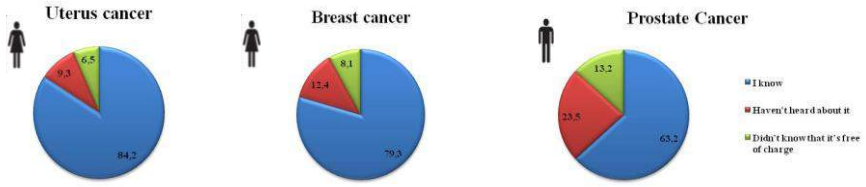
Research studies show the difference between gender and health related behaviour. It is said that man engage in more risky and health adverse behaviour, while woman engage in more preventive behaviour, as well as more treatment seeking and self-care for illness (8,10). Some of the findings support the gender role self-concept related with masculinity and weaker gender perceptions on health related behaviour (2,4,10). Other studies indicate factors related with health literacy. Men are less knowledgeable about health in general, specific diseases and their risk factors then woman (1); less able or likely to access, interpret and apply information to maintain and improve health (3) and exhibit low levels of health literacy even about male-specific health issues (5).

Lithuanian woman have higher lever of health literacy (9). According to Lithuanian health statistics on 2005, more women were vaccinated from influenza; blood pressure was also measured more often to women than men. After being diagnosed with higher blood pressure women (43.8 %) were more likely to change their lifestyle than men (30.9 %), equally more woman (88.7 %) than man (76.6%) used medications in case to lower their blood pressure (7). However, there are lack of studies analyzing gender related differences in predicting health related behavior in Lithuanian population.

II. Material and methods

1068 Lithuanian citizens (495 men and 573 women, aged 18 and above) representing the entire population of Lithuania completed the survey about health care system in Lithuania. The questionaire for research was created by Olga Riklikienė in 2009. The questionnaire consisted of 12 demografic and 47 thematical questions about Lithuanians' confidence in the national mandatory health insurance system, about users' satisfaction with health service and information demands. The reliability of the questionnaire was measured (Cronbach's alpha - 0,922). In this study the questions about respondents knowledge about 5 preventive programmes financed by national health mandatory insurance fund, evaluation of their responsibility about person's health, knowledge about generic and branded medicines are analyzed.

III. Results



According to National Health Insurance Fund under the Ministry of Health, 115345 females participated in uterus cancer preventive program in 2011. 76757 females participated in breast cancer preventive program and 112474 males were participated in prostate cancer preventive program for early detection of the disease. According to this, there were less males who participated in prostate cancer preventive program comparing to woman who participated in uterus or breast cancer preventive program in 2011.

The results revealed that women were well acknowledged about uterus cancer and breast cancer preventive programs (accordingly - 84,2 % and 79,3 %), while only 63,2 % men knew about existing preventive program for prostate cancer.

Figure 1. ***Respondents' knowledge about opportunity to participate in preventive programs financed by National mandatory health insurance fund***

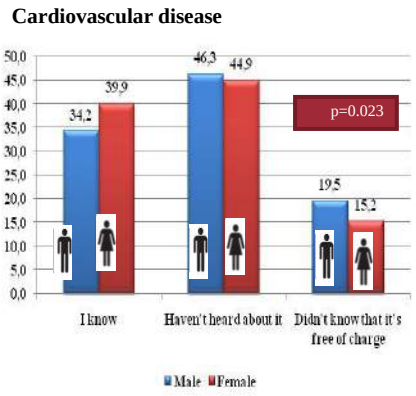


Figure 2. ***Respondents' knowledge about opportunity to participate in cardiovascular disease preventive program financed by National mandatory health insurance fund***

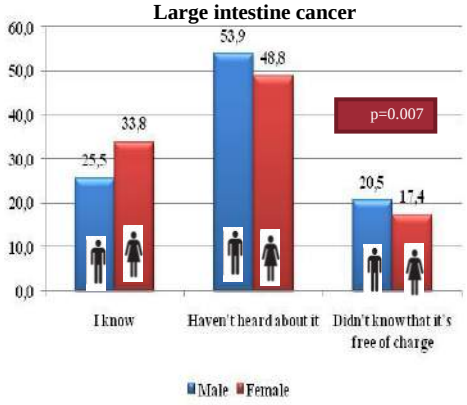


Figure 3. ***Respondents' knowledge about opportunity to participate in large intestine cancer preventive program financed by National mandatory health insurance fund***

Cardiovascular diseases are the most common cause of death in the Lithuanian population. In 2011, cardiovascular diseases accounted for more than 50 percent of the deaths (6). Thus, prevention of these diseases is very relevant.

By the data of National Health Insurance Fund, 171435 Lithuanian citizens participated in preventive program for cardiovascular diseases and 67641 - for large intestine cancer. The results confirmed that more females then males knew about possibility for free of charge cardiovascular disease preventive program ($p<0.05$). Also, more females then males know about large intestine cancer preventive program ($p<0.05$).

Respondents ranged some statements about health (Table 1.). The results showed that more females agreed on the statement that „Health is the biggest value" comparing to males ($p<0,05$). Contrarily, more men than women agreed on that „Preventive programs are simply vaste of time" ($p<0,05$). More females then males knew that drugs can be two types - original and generic ($p<0,05$). In addition, more females than males have had used some of the health care service in the last 12 months comparing to males ($p<0,001$) and more females, who didin't know about preventive programes or didin't know it is free of charge are planning to participate in it ($p<0,001$).

Table 1. ***A comparison of males and females agreements on statements about health importance and preventive programs***

Statements about health	Gender	Agree	Partly agree	Disagreep	
Health is the biggest value	Male	94.3	4.6	1.0	0.022
	Female	97.5	1.8	0.7	
Preventive programs are simply vaste of time	Male	19.3	25.3	55.4	0.039
	Female	14.7	24.7	60.6	

Table 2. ***A comparison of males and females knowledge about original and generic drugs, use of health care servises in the last 12 months and plans to participate in preventive programs***

	Gender	Yes	No	No opinion	P
Do you know that drugs can be original and generic?	Male	24.4	65.3	10.3	0.008
	Female	30.7	62.0	7.3	
Have you used any of health care servises in the last 12 months?	Male	67.7	32.3	-	0.001
	Female	76.8	23.2	-	
If you didn't know about preventive programmes or didin't know they are free of charge, now when you know about it, are you willing (planning) to participate?	Male	44.3	55.7	-	0.001
	Female	58.1	41.9	-	

IV. Conclusions

Lithuanian females are better acknowledged about National free of charge preventive programmes and more active in participating then majority of males threated preventive health activities as simply vaste of time. Lithuanian women in relation to men were also better informed about forms of drugs, more often use health care service. This study confirms existing health realted differences between Lithuanian women and men that predict some aspects of their health related behavior, especcially for health promotion.

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12th International Congress of Behavioral Medicine 29 August - 1 Septeber 2012, Budapest, Hungary

The Influence of Optimism and Coping Strategies in the Quality of Life of Women with Breast Cancer.

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INTRODUCTION

Breast cancer is a chronic disease and is the leading cause of cancer death among women worldwide (GLOBOCAN, 2001). Once knowing the diagnosis, some patients go through a grieving process due to the loss of health and/ or autonomy (Oblitas, 2004). The recommended treatments have a strong impact on the health of these women. The most common side effects of chemotherapy are alopecia, nausea, vomiting, anticipatory vomiting and weakening and isolation from their families and normal social activities (Gómez, 2005). Researchers have also described several emotional reactions associated with the diagnosis and its treatment, such as increased levels of anxiety, depression and fear (Ganz, Polinsky, Schag, & Heinrich, 1989). Therefore, cancer and its treatment have great effects in the quality of life (QOL) of these patients. There are a several psychological factors that have been associated with good QOL among patients with breast cancer, two of the most studied are optimism and coping .

BACKGROUND

Optimism and QOL:
A positive evaluation of the situation has been associated with positive mood and posttraumatic growth in women with breast cancer (Sears, Stanon, & Danoff-Burg, 2003). An optimistic explanatory framework , has been associated with an increased longevity in women who had breast cancer for a second time (Seligman, 1998).

Coping and QOL:
Passive coping has been associated with accelerated progress of the disease (Epping-Jordan, Compas, & Howell, 1994) and an increase in emotional distress (Manne, Classman, & DuHamel, 2000).

OBJETIVE

The aim of this study was to examine the relationship between optimism and coping strategies with quality of life in a sample of women with breast cancer.

METHODS

Participants: 25 women with breast cancer, between the ages of 29 and 67 (mean age 52.8, D.S.=10.1), who received support from an interdisciplinary team of health professionals, part of a nonprofit corporation called "Yo Mujer". All participants signed an consent form before being enrolled. The estimated statistical power was 0.87.

Data Collection and Measures: Participants completed a self-administered questionnaire that included: 1) WHOQOL-BRIEF developed by OMS to evaluate quality of life (World Health Organization, 1996); 2) the Spanish version of LOT-R to evaluate optimism (Otero, Luengo, Romero, Gómez-Fraguela, & Castro, 1998); 3) the Spanish version of CSI to evaluate coping strategies (Cano, Rodríguez & García, 2007) and 4) a questionnaire to collect sociodemographic and health data.

Analysis: We run descriptives, correlational and regression analyses. We report correlational and regression analyses.

RESULTS

Partial correlations: Controlling for: number of children, current treatments and mastectomy; QOL correlates positively with optimism and active coping, with both ratios of similar magnitude (see Table 1). And controlling for: number of children, mastectomy, education, occupation and current treatments; optimism variable correlates positively with seeking social support, and negatively with self-criticism (see Table 2).

Table 1. Partial correlation between QOL, Optimism and Coping

	Optimism	Active coping	Passive coping
QOL	**0.52***	**0.54***	**-0.42**

Nota: *p< 0,05; **p< 0,01.

Table 2. Partial correlaction between Optimism and Coping

	problem solving	emotional expression	social support	cognitive restructuring	social withdrawal	avoidance	wishful thinking	self criticism
Optimism	**0.33**	**0.27**	**0.44***	**0.30**	**-0.39**	**0.17**	**0.15**	**-0.47***

Nota: *p< 0,05; **p< 0,01.

Predictive model of QOL : The independent variables were entered using the method of successive steps. Only two variables were significant: social support (active coping) and self criticism (passive coping), which accounted for a 50.7% of the variance of QOL (see Table 3).

Table 3. Predictive model of QOL

	R^2	R^2 adj.	B	t	p
Social support	**0.396**	**0.370**	**0.552**	**3.772**	**0.001**
Self-criticism	**0.152**	**0.137**	**-0.397**	**-2.716**	**0.013**

DISCUSSION

Patients who use optimistic and active coping strategies have better QOL. The positive expectations are translated into efforts to actively address the situation (Ferrando, Chico & Tous, 2002), and active coping may help reduce psychological stress, as people perceive they control the disease and its treatment (Thompson et al., 1994). While coping is the strongest predictor of QOL, there is a significant association between optimism and other predictors (social support and self criticism), therefore, we can conclude that there is an indirect relationship between optimism and quality of life.

These findings also suggest that seeking social support promotes good QOL. Previous studies have shown that this variable was associated with longer survival in patients with metastatic (Spiegel et al., 1989).

Self-criticism impairs QOL. This coping strategy is a feature of pessimistic explanatory style (Peterson & Seligman, 1998) and may be detrimental for the QOL of these women.

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Submission closes	3rd March 2013
Submission closes for posters	21st April 2013
Notification of acceptance	Late April / May 2013

Programme

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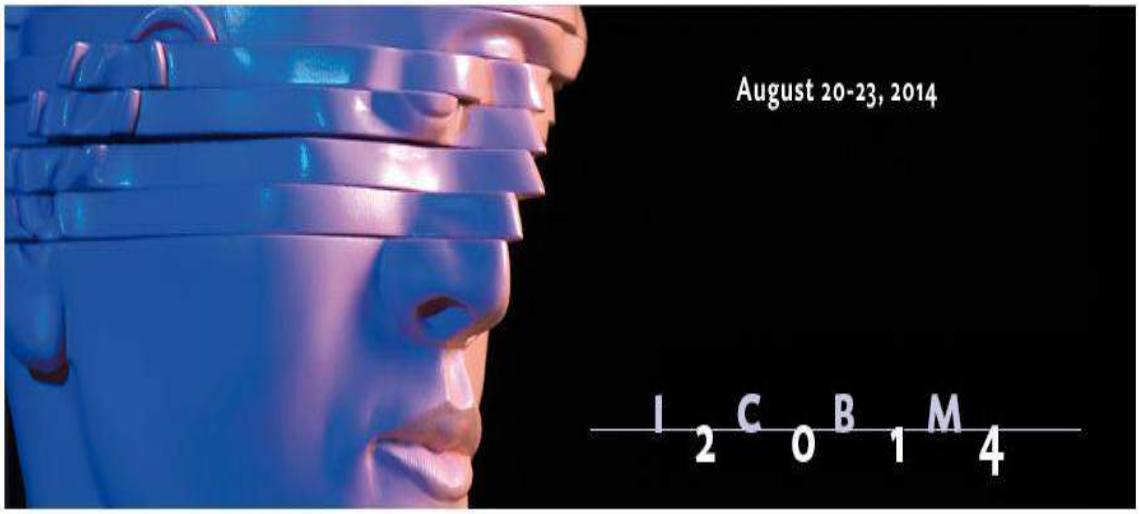

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Important dates

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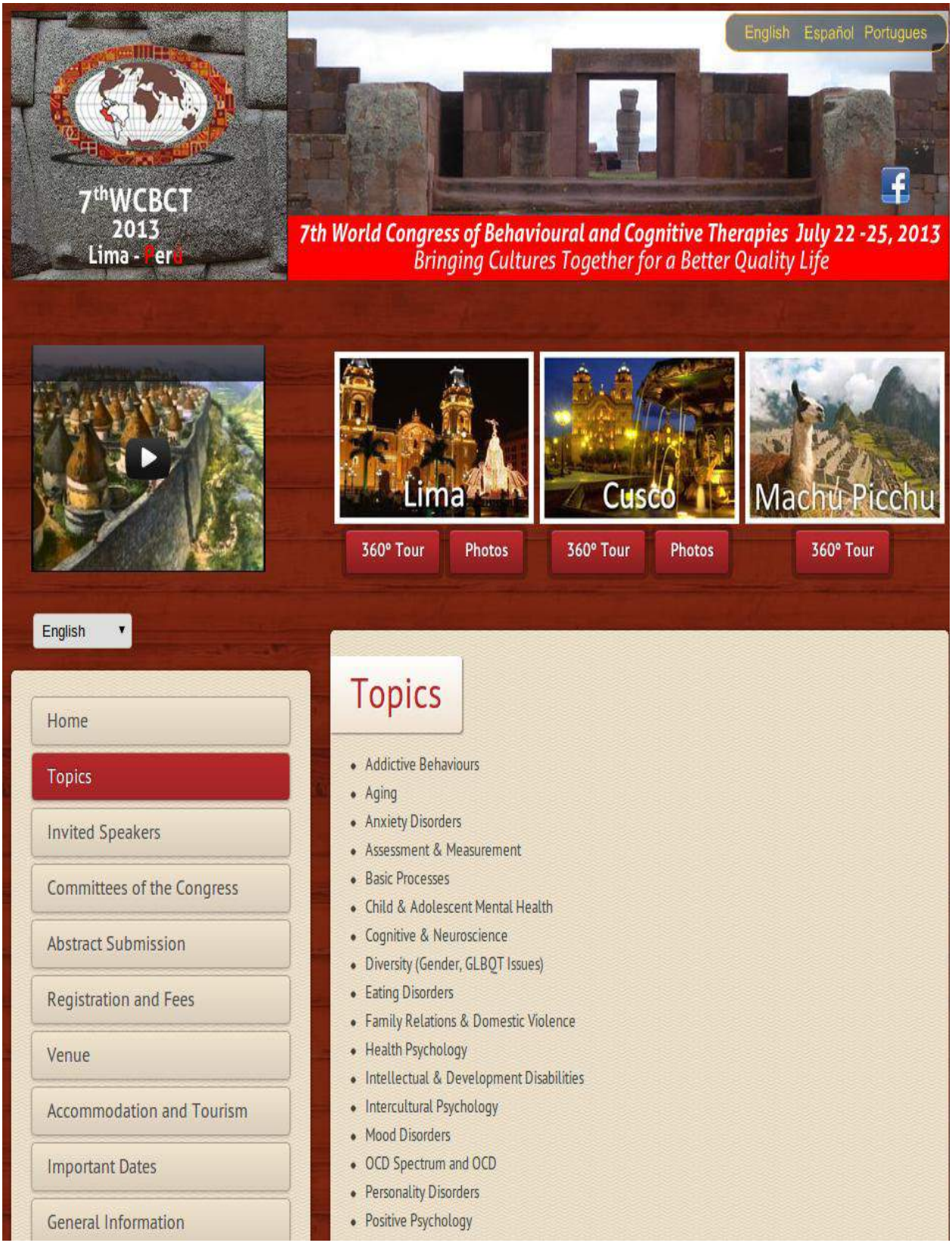
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