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Editorial

Dear readers,

as you may remember, six years ago, in december 2008, *Psychomed* started to publish some posters of the 6th Conference of the International Association of Cognitive Psychotherapy (IACP). Since then, other posters were published from subsequent International conferences in the field of CBT, Behavioural Medicine, Health Psychology and Psycho-social Intervention. And so it did in 2009, 2010, 2011 and 2013. The organising Associations were the IACP, the EABCT, the ISBM. This year, once again, we are offering you a special issue containing a sample of the posters presented at the 44th Annual Congress of the European Association for Behavioural and Cognitive Therapies (EABCT).

The Congress was held in Hague (The Netherlands) the last September and aimed at "*Bridging the gap between science and practice*". Bridging gaps has also been a key part of our editorial policy since the beginnings of *Psychomed*: for example, bridging the gaps between young and seasoned researchers, but also between researchers and clinicians. The poster format, when used to communicate scientific work, is another way to bridge a gap: the one between an abstract and a paper. This was the initial idea of members of the editorial committee of *Psychomed*, when we developed our publishing policy: since we started in 2006, we encouraged authors to submit short papers, in particular by young authors, as an easy tool to update readers with current literature. However, it became soon evident that posters exhibited in Conferences were already implementing that idea, albeit they remained unpublished on scientific journals, for obvious reasons, the main one being that they were too large to be compressed in a journal page. But this is not a limitation for an online journal: its pages can be enlarged on computer screens at will, and small writing can become well readable with no loss of information. So, the proposal was put forward and it was successful. *Psychomed* since then could publish posters by young authors, whose work is sometimes unjustly appraised as "second rate", but which has very often the same scientific quality of paper presentations.

Through the years, and particularly in the last four years, this opportunity has became even more evident also to the Organizing Committees of the Congresses: now they collaborate much more closely with the Editorial Board of *Psychomed*, and inform in advance poster presenters about this opportunity, by sending the announcement of it to their mailing list. It also happened that Presidents of the hosting Associations or the Chair of the Scientific Committees have started working together with the Ediotrial Board, either to select the posters, to co-write editorials or the introduction to the special issues. As a result, our initiative has now become much more welcomed by poster presenters themselves, who have started looking forward to publish their work on *Psychomed.*

In the current special issue, the 36 resulting posters accepted for this publication come

from 18 different countries (new entry: Cyprus), grouped according to their large thematic areas. Among them, you will find one of the nominates for the poster prize: *A brief cognitive-behavioral therapy for the breast reconstruction decision-making. Psychological effects of the breast reconstruction*, by Mª José Gallego (Spain).

Finally, posters have received a minimal editing. Sometimes, we had to contact the Authors for improvements or clarifications. Whenever minor errors in English were found, they were left untouched, provided they did not hamper the understanding.

Again, we leave the final word to you,

Dimitra Kakaraki

Lucio Sibilia

Rome, December 2014

The Posters

Adolescents

Why are students absent?

The predictive role of risk-health behaviors and symptoms of psychopathology for boys and girls

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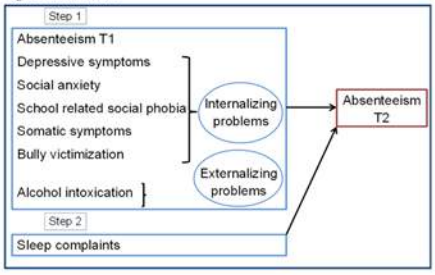
BACKGROUND

- Background
  - Adolescents skipping school are at risk for present and future problems
  - Prevalence is the same for boys and girls
  - Students skip school because...
    - ✓ they are anxious and depressed
    - ✓ they fear evaluation by teachers and peers
    - ✓ they engage in delinquency outside school
    - ✓ they do not sleep well
- Problems
  - Few studies have looked at all of these issues together, but they should
    - ✓ Depressed and anxious students may feel uncomfortable at school, but they do not all skip school (Ingul et al., 2012)
    - ✓ Poor sleep may play a role in maintaining other problems
  - Because boys and girls are absent at the same rate (Kearney, 2008a), it is assumed that the reasons are the same, BUT...
    - ✓ Different patterns of absenteeism
    - ✓ Different coping strategies that may lead to avoiding school
  - The majority of studies are cross-sectional
- Questions
  - Does a combination of these reasons predict absenteeism?
  - Do sleep complaints predict absenteeism over and above internalizing problems?
  - Does this model work for both boys and girls?

Figure 1. The Model



METHOD

- Longitudinal study
- Participants
  - 406 (46.3% girls)
  - Age range 16-20
  - Wave 1 (grade 10-11) → Wave 2 (grade 11-12)
- Measures

Construct	Measurement	α	M(SD)/% boys	M(SD)/% girls
Absenteeism T2 (1)	"Have you been away a whole day from school in the last three months?" 1 (no, I haven´t) to 5 (more than 10 times)	-	12%	17%
Depressive symptoms (6)	CES-DC: Olsson & Von Knorring, 1997 (short) 1 (rarely/never) to 4 (most or all of the time)	.86	8.49(2.96)	12.33(4.38)
Social anxiety (8)	SPSQ-C: Gren-Landell et al., 2009 (modified) 1 (no fear) to 3 (marked fear)	.75	11.06(2.58)	12.36(2.84)
School social phobia (1)	SPSQ-C, "does this happen in school?" (yes/no)	-	5%	14%
Alcohol intoxication frequency (1)	"How often have you been drinking to the point of feeling drunk in the last 3 months?" 1 (no, I haven´t) to 5 (more than 10 times)	-	8%	11%
Bully victimization (1)	"Have you been the victim of bullying in the last three months?" (yes/no)	-	7%	10%
Somatic symptoms (3) (stomach, head, back)	Modified Somatic Perception Questionnaire: Main, 1983 1 (not at all) to 4 (a lot of pain)	.79	1.37(.61) 1.78(.83) 1.66(.85)	1.97(.91) 2.20(.93) 1.92(.96)
Sleep complaints (4)	BNSQ: Partinen & Gislason, 1995 and Uppsala Sleep Inventory: Liljenberg et al., 1988	-	6%	14%

- Analyses
  - Logistic regression, block entry method with Sleep complaints added in Step 2 (see fig. 1)
  - Tested separately for boys and girls

RESULTS

Table 1. Binomial logistic regression - girls.

	Step 2				
Variable	B (SE)	Wald	*p*	Exp(B)	95% C.I. for Exp(B)
Absenteeism T1	1.32 (0.56)	5.44	.020	3.73	1.23-11.27
Alcohol intoxication	0.84 (0.51)	2.75	.097	2.31	0.86-6.22
Bully Victimization	-0.25 (0.62)	0.16	.689	0.78	0.23-2.62
Social Phobia	1.51 (0.52)	8.62	.003	4.54	1.65-12.47
Depressive symptoms	0.00 (0.06)	0.00	.971	1.00	0.89-1.12
Social Anxiety	-0.12 (0.08)	2.16	.142	0.89	0.76-1.04
Somatic (stomach)	-0.10 (0.25)	0.17	.683	0.91	0.56-1.46
Somatic (head)	0.13 (0.25)	0.25	.615	1.14	0.69-1.85
Somatic (back)	0.20 (0.24)	0.71	.398	1.23	0.76-1.97
Sleep complaints (L)	-0.52 (0.63)	0.69	.407	0.59	0.17-2.04
Sleep complaints (H)	1.46 (0.53)	7.57	.006	4.32	1.52-12.25

Note. Step 2 model fit: R^2 = .169 (Cox & Snell), .266 (Nagelkerke), Model χ^2 (11) = 34.81, p < .001.

Table 2. Binomial logistic regression - boys.

	Step 2				
Variable	B (SE)	Wald	*p*	Exp(B)	95% C.I. for Exp(B)
Absenteeism T1	0.08 (0.80)	0.01	.919	1.08	0.24-4.85
Alcohol intoxication	1.10 (0.54)	4.13	.042	3.01	1.04-8.72
Bully Victimization	0.38 (0.66)	0.33	.563	1.47	0.40-5.34
Social Phobia	-0.51 (0.89)	0.33	.565	0.60	0.10-3.44
Depressive symptoms	0.12 (0.09)	1.97	.161	1.13	0.95-1.33
Social Anxiety	-0.05 (0.12)	0.16	.694	0.96	0.77-1.20
Somatic (stomach)	-0.67 (0.61)	1.20	.274	0.51	0.16-1.69
Somatic (head)	-0.51 (0.33)	2.38	.123	0.60	0.31-1.15
Somatic (back)	-0.37 (0.32)	1.34	.246	0.69	0.37-1.29
Sleep complaints (L)	0.68 (0.60)	1.27	.259	1.97	0.61-6.40
Sleep complaints (H)	0.09 (1.23)	0.01	.944	1.09	0.10-12.25

Note. Step 2 model fit: R^2 = .094 (Cox & Snell), .165 (Nagelkerke), Model χ^2 (11) = 16.44, p = .125.

CONCLUSIONS

- Sleep complaints is an important issue independently of sex
  - By targeting sleep hygiene and schedules, one would not only improve school attendance directly but also through an improvement in overall psychological health
- Girls with social phobia had more problems attending school as compared to boys with the same fears
- By testing the model separately for boys and girls, different reasons for school absenteeism emerged
  - These differences are important when planning a preventive intervention

Explicit memory bias and eating disorders : evaluation among young French women with high body dissatisfaction or suffering of eating disorders.

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CONTEXT

Eating disorders cognitive model proposed that women suffering from eating disorder develop a ***self-schema*** about weight and shape that is considered as the core of eating disorder pathology (Vitousek & Hollon, 1990). This self-schema result in cognitive biases for congruent information and many studies highlighted these biases in clinical sample.

Cognitive bias for congruent information was implied in development and maintain of eating disorders (Williamson, Muller, Reas & Thaw, 1999). However, results are inconsistent in women suffering from subclinical disorders or with high body dissatisfaction.

The aim of this study was to investigate whether **non-clinical women** with eating disorder or high body dissatisfaction demonstrate a **memory bias congruent with their concerns** about weight and shape.

METHOD

Participants :

42 young women, college students

mean age : 20.98 ± 2,09 (min = 18 ; max = 25).

mean BMI : 21.8 ± 4,16 (min = 17 ; max = 39).

Questionnaires :

Body Shape Questionnaire (BSQ) (Cooper et al., 1987) :

self-report measure of body dissatisfaction

Eating Attitudes Test (EAT-26) Garneret al. 1982) :

self-report measure of symptoms and concerns characteristic of eating disorders

Questionnaire for Eating Disorder Diagnosis (QEDD) (Mintz et al., 1997) :

questionnaire assessing the diagnostic criteria for AN, BN, BED, EDNOS and subclinical disorders

Procedure :

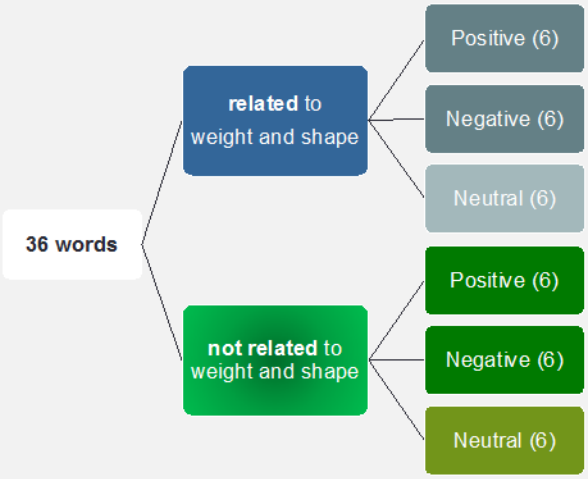
Women watched target and control words.

They performed a self-referent encoding task (imagination task) during the exposition on a computer to experimental material.

Then,memory recall of words was subsequently assessed.

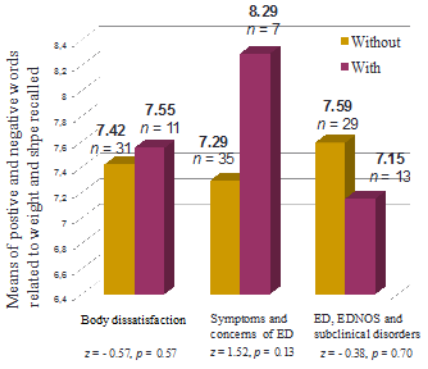
Finaly, self-report measures were taken.

Experimental material :

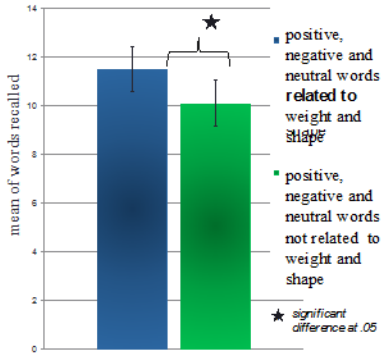


RESULTS

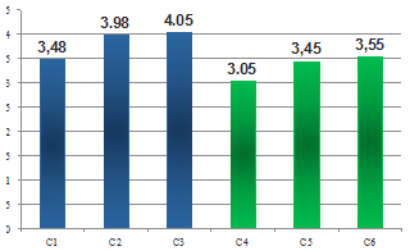
Means of positive and negative words related to weight and shape recalled by all women



Average number of words recalled according to the type of words for all 42 participants



Average number of words recalled according to word category for all 42 participants



C1, C2 & C3 : positive , negative and neutral words related to weight and shape

C4, C5 & C6 : positive , negative and neutral words not related to weight and shape

Only differences between C2 and C4 and between C3 and C4 are significant at adjusted level < 0,002

DISCUSSION

- Our results are in contradiction with hypothesis based on cognitive model. Indeed, all women demonstrated a memory bias for information related to the self-schema about weight and shape, suggesting that this specific self-schema was activated for all women.
- Moreover, women did not recall selectively information congruent with this specific self-schema.
- **These results could have implications for therapeutic interventions: it could be relevant to target the development and valorisation of other self-schemas and also the drive for thinness as a maintain factor.**
- **Therefor, information related to weight and shape that women "desire" achieve (and not only the "fear to be or become fat") could also be a target in therapeutic intervention focused on cognitive bias modification.**

Vitousek, K. B., & Hollon, S. D. (1990). The investigation of schematic content and processing in eating disorders. *Cognitive Therapy and Research, 14*, 191–214
Williamson, D.A., Muller, S. L., Reas, D. L., & Thaw, J. M. (1999). Cognitive bias in eating disorders: Implications for theory and treatment. *Behavior Modification, 23*, 556–577

EABCT CONGRESS 2014

THE ROLE OF PARENTAL BEHAVIOR IN EXPLAINING ADOLESCENTS' DEPRESSION AND ANXIETY

Introduction

Family is the first and the most important environment for child development, and is often viewed as a major socialization agent by a number of different theoretical approaches (e.g. ecological system theory, social learning theory, attachment theory). Parental behavior and child-rearing practices affect the entire socio-emotional development of children. Soenens, Vansteenkiste & Luyten (2010), Lebedina Manzoni, Ricijaš (2013) show that parents behavior may render adolescents vulnerable to internalizing problems (anxiety and separation problems) and to depressive symptoms in particular.

Aim

The aim of study was to examine relation between parental behaviour and depression and social anxiety symptoms in urban adolescents in Croatia as well as to test for gender differences.

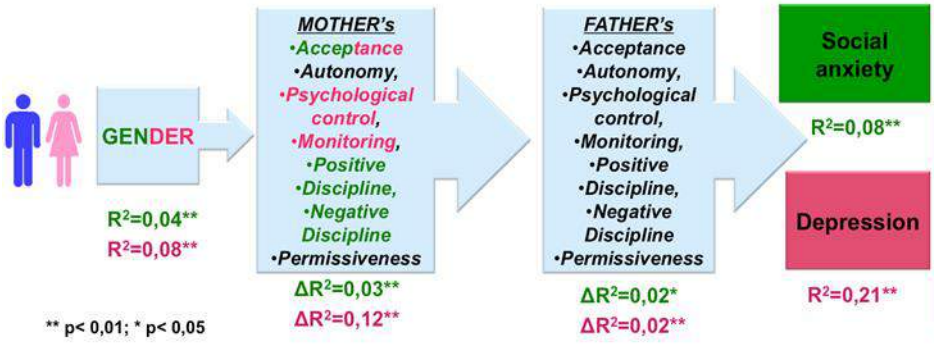
Method

A total of 940 elementary and high school students aged from 12 to 18 (M_{age}=14.82; SD_{age}=1.476) participated in the study (55% girls and 45% boys). The following instruments were applied:

- **Fear and anxiety scale for children and adolescents** (Vulić-Prtorić, 2004) (subscales: *Worry and Social anxiety),*
- **The Depression Scale for Children and Adolescents** (Vulić-Prtorić, 2003),
- **The Parental Behavior Questionnaire (PBQ-29)** (Keresteš, Kuterovac-Jagodić & Brković, 2009) (subscales: *Acceptance, Autonomy, Psychological control, Monitoring, Positive Discipline, Negative Discipline and Permissiveness)* - each participant separately assessing mother and father on a four level scale.

Results

Separate hierarchical regression analyses were conducted for boys and girls with **social anxiety** and **depression symptoms as criteria**, and **parental behavior variables** (perception of *mother's and father's behavior separately)* as ***predictors***. First, results on the whole sample will be shown, to represent the manner analyses per gender were later on conducted.



Results have shown that *parental behavior variables* serve **better in predicting depression** (21% of criterion variance) then social anxiety symptoms. When boys' and girls' results are analysed together, **father's behavior** don't seem to add to the explanation of social anxiety and depression syptoms.

In following tables, **significant predictors and percentage of explained criteria variance** are presented for **boys and girls:**

***Significant predictor variables* in final step of the RA, for both criteria**

	CRITERION VARIABLE	
	SOCIAL ANXIETY	DEPRESSION
boys	• autonomy (from the mother) • mother's monitoring • father's negative discipline	•mother's acceptance
girls	• mother's acceptance	• mother's psychological control • mother's positive discipline

Percieved parents' behavior seems to play different roles in explaining anxiety and depression across gender, with **social anxiety being better explained by these variables in boys**' then in girls' sample, and **depression being explained by parental variables in a larger amount in girls**' then in boys' subsample.

***Percentage of explained variance* per criterion, for boys and girls:**

	CRITERION VARIABLE	
	SOCIAL ANXIETY	DEPRESSION
boys	9,2 %	13,6 %
girls	4,8 %	17,0 %

Both mother's and father's variables (as risk/protective factors) play a significant predictive role (level of autority and monitoring from mother, as well as percieved father's negative discipline) for the social anxiety level in our adolescent boys. Percieved mother's acceptance seems to be predictive for girls' anxiety, whilst for boys it acts as depression predictor. Girls depression is best explained by two different mothers' behavior varables - percieved level of psychological control and positive discipline.

Conclusion Percieved parental behavior plays a significant role in explaining anxiety & depression symptoms in our adolescents, with important differences evident in gender comparisons. Along with information on personal and peers variables' effects, accounted for in our previous research, these may have additional implications for both prevention and treatment.

44th Annual EABCT Congress, The Hague

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Psychometric Proprieties of the Portuguese Version of the Post-Event Processing Questionnaire (PEPQ) in Adolescents and Adults

2014
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Abstract

Although social anxiety may not be disabling of social functioning *per se*, in an excessive level, it may be uncomfortable, emotionally exhausting and highly disabling, from which point it is designated social anxiety disorder (SAD). Concerning information processing of SAD patients, post-event processing (PEP) is pointed out as a crucial maintenance factor of the disorder (Clark & Wells, 1995). Thus, research on this subject is imperative to better understand and assess SAD and improve clinical practice. One of the widely used questionnaires to assess post-event processing is the Post-Event Processing Questionnaire (PEPQ; Fehm et al., 2008). Since in Portugal, there was no measure to assess this construct, the aim of this study was to validate the PEPQ both in adolescents and adults. The psychometric properties of both versions were good. The factor structure of the Portuguese version, regardless of the sample, revealed a 3-factor structure (unlike the 4-factor original version): *Persistent Rumination*, *Specific Rumination* and *Control Attempts*. The PEPQ has demonstrated good internal consistency and reasonable validity, thus becoming a valuable asset in clinical evaluation and research of SAD in general, and of PEP, in particular.

Keywords: **SAD; Post-Event Processing; PEPQ; Assessment; Validation; Psychometric characteristics.**

Background

CBT models for Social Anxiety Disorder (SAD) are based on the premise that socially anxious individuals engage in biased cognitive processing (Gaydukevych & Kocovsky, 2012). According to Clark and Wells (1995), Post-Event Processing (PEP) is one of the important cognitive factors in the maintenance of SAD. PEP refers to a *post-mortem* rumination where the subject reviews critically and with detail what went wrong in the social situation. The most used measure of PEP is the Post-Event Processing Questionnaire (PEPQ; Fehm et al., 2008), that includes 17 items divided by 4 factors: *Cognitive Impairment, Negative Self, Past and Future* and *Avoidance*. The aim of this research was to study the psychometric properties of the PEPQ, consisting in the first Portuguese study of an instrument to measure PEP both in adolescents and adults.

Method

Participants & Measures

295 Adolescents	292 Adults
♂ 46.80% ♀ 53.20%	♂ 52.10% ♀ 47.90%
PEPQ: Post-Event Processing Questionnaire (Fehm et al, 20008)	**PEPQ**: Post-Event Processing Questionnaire (Fehm et al, 20008)
SAS-A: Social Anxiety Scale for Adolescents (La Greca & Lopez, 1998)	**SIPAAS**: Social Interaction and Performance Anxiety and Avoidance Scale (Pinto-Gouveia et al., 2003)
FAQ: Focus of Attention Questionnaire (Woody et al., 1997).	**FAQ**: Focus of Attention Questionnaire (Woody et al., 1997)
MASC: Multidimensional anxiety Scale for Children (March et al., 1997)	**DASS-21**: Depression, Anxiety and Stress Scale Scale 21-Item Version (Lovibond & Lovibond, 1995).

Results

Factor Structure

F1: Persistent Rumination	M(DP)[1]	M(DP)[2]
1 Frequent thoughts about the event	4.8(3.1)	38.1(29.9)
2 Undesirable and recurrent thoughts	4.2(3.2)	32.3(29.4)
3 Impairment in concentration	3.5(3.0)	27.8(27.2)
4 Difficulty to stop thinking about event	4.2(3.3)	32.3(31.0)
5 Conscious effort to avoid the thought	3.9(3.3)	27.1(28.3)
6 Aggravation of event-related feelings	3.1(2.8)	22.3(26.5)
15 Thinking about the event more than wanted	4.0(3.2)	33.1(31.3)
F2: Specific Rumination		
11 Memory evokes shame	3.7(3.0)	30.2(29.9)
12 Thoughts about anxiety	4.0(3.0)	37.6(31.1)
13 Remembering past failures	3.6(2.9)	33.0(28.8)
14 Self-criticism	4.0(3.1)	33.6(30.8)
16 Thoughts about bodily sensations	3.9(3.2)	32.5(29.9)
17 Positive/negative self-evaluation	4.5(2.6)	41.7(26.6)
F3: Control Attempts		
7 Thoughts about prevention	4.8(3.1)	37.6(30.5)
8 Wish to "turn back to clock"	5.7(3.5)	42.1(34.3)
9 Avoidance of similar events	4.6(3.2)	40.4(33.6)
10 Aggravation of existing avoidance	4.4(3.2)	39.1(33.5)

[1] Adolescents (0-10 scale); [2] Adults (0-100 scale)

Reliability, Validity & Sensibility

	Adolescents	Adults
Reliability	**Internal consistency & Test-retest**	**Internal consistency & Test-retest**
	Total Scale: α= .96 r= .78**	Total Scale: α= .96 r= .80**
	F1: α= .94 r= .79**	F1: α= .94 r= .77**
	F2: α= .91 r= .72**	F2: α= .91 r= .81**
	F3: α= .88 r= .64**	F3: α= .89 r= .39**
Validity	**Convergent validity**	**Convergent validity**
	SAS-A (total) r= .51**	SIPAAS (total) r= .39**
	FAQ (F1) r= .51**	FAQ (F1) r= .42**
	FAQ (F2) r= .41**	FAQ (F2) r= .32**
	Discriminant validity	**Discriminant validity**
	MASC-A (F1) r= .29**	DASS (anxiety) r= .29**
	MASC-A (F2) r= .20**	DASS (depression) r= .38**
Sensibility	**Differences SAD vs general pop.**	**Differences SAD vs general pop.**
	F1: $t_{(66)} = 3.05$, $p = .003$	F1: $t_{(62)} = -4.4$, $p < .001$
	F2: $t_{(66)} = 3.79$, $p < .001$	F2: $t_{(62)} = -4.6$, $p < .001$
	F3: $t_{(66)} = 3.37$, $p < .001$	F3: $t_{(62)} = -2.8$, $p = .007$
	Total: $t_{(66)} = 3.68$, $p < .001$	Total: $t_{(62)} = -4.5$, $p < .001$

Conclusion

In both samples, PEPQ revealed a quite distinct factorial structure from the original version.
PEPQ showed a good reliability, validity and sensibility, indicating an accurate and trustworthy measure, contributing for both research and clinical practice.

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GOETHE UNIVERSITÄT FRANKFURT AM MAIN

EABCT CONGRESS 2014

Regulation of Shame and Pride in Adolescents with Collectivistic Migration Background

Iryna Struina, Annabelle Starck, Ulrich Stangier

Introduction

According to Matsumoto, Yoo & Le Roux (2004) the capacity to regulate emotions effectively is crucial for successful intercultural adjustment. Particularly self-conscious emotions pride and shame play an important role in the acculturation process of immigrants and development of their children (experiences of discrimination, conflicts between the culture of origin and receiving culture etc.). They also contribute significantly to the development of mental disorders such as depression or social phobia (Hofmann, Anu Asnaani & Hinton, 2010). Cultural comparative studies could show that social-engaged emotions like shame are experienced more often and shown more overtly in cultures with more collectivistic background as compared to those with a stronger individualistic orientation. Whereas social disengaged emotions such as pride are experienced and shown less in collectivistic cultures (Tracy & Matsumoto, 2008). At the same time studies conducted on emotion regulation in general and on other emotions (e.g. anger) have shown that participants with collectivistic orientation tended to suppress their emotions more than those with individualistic orientation (Matsumoto, Yoo & Nakagawa, 2008; Novin, Banerjee & Rieffe, 2012).
The objective of the present study is the investigation of the experience and regulation of experimentally-induced shame and pride in adolescents considering the cultural orientation.

Hypotheses

1. Migration background (MB) and emotion intensity:

1.1 Pride: Adolescents with MB report less intensity of pride than adolescents without MB.

1.2 Shame: Adolescents with MB report more intensity of shame than adolescents without MB.

2. Migration background and emotion regulation:

2.1 Pride: Adolescents with MB suppress pride more & accept less than those without MB.

2.2 Shame: Adolescents with MB suppress shame less & accept more than those without MB.

Method

Sample

- Based on Hofstede's (2001) cross-cultural research adolescents with Turkish, Russian (countries of the former Soviet Union) and Arabic migration background were regarded as a sample for collectivistic orientation while German adolescents without migration background were referred to as an individualistic oriented sample.
- Age: 13-18 years
- Migration background (MB): At least one parent was born in Turkey/ former Soviet Union country/Arab country and both parents regard the respective language (Turkish, Russian, Arabic) as their mother tongue.

	without MB	with MB	Turkish MB	Russian MB	Arabic MB	p
N	37	79	30	25	24	
Age M (SD)	15.62 (1.48)	16.24 (1.40)	16.83 (1.05)	15.72 (1,54)	16.04 (1,40)	.003**
Gender (% female)	64.86%	49.37%	50.00%	56.00%	41.67%	.326
COS-Score	4.07 (0.46)	4.44 (0.52)	4.41 (0.52)	4.48 (0.49)	4.45 (0.56)	.004**

Assessment

- Interview on socio-demographic data
- SDQ - Strengths and Difficulties Questionnaire (Goodman, 1997)
- Habitual affective style:
  - ASQ-KiJu - Affective Style Questionnaire for children and adolescents (Bohn, unpublished; Hofmann & Kashdan, 2010)
  - FEEL-KJ: Questionnaire for Assessment of Emotion Regulation in Adolescents (Grob & Smolenski, 2005)
- FRAKK 11-18-R: Frankfurt Acculturation Scale for Adolescents (Frankenberg, Kupper, & Bongard, 2013)
- COS: Cultural Orientation Scale (Bierbrauer, Meyer, & Wolfradt, 1994)
- Intensity of shame and pride:
  - SSGS: State Shame and Guilt Scale (Marschall, Sanftner, & Tangney, 1994)
  - PANAS: Positive and Negative Affect Schedule (Watson & Clark, 1988)
- Emotion regulation strategy being used: ASQ-KiJu-State (6 Items from ASQ-KiJu, 2 for each scale)
  - Suppression, Reappraisal, Acceptance
- Physiological assessment: EDA, ECG

Procedure
(in balanced order)

T0: Assessment of control variables → Baseline PANAS and SSGS

T1: Written report of pride-eliciting autobiographical event → PANAS, SSGS, ASQ-KiJu-State

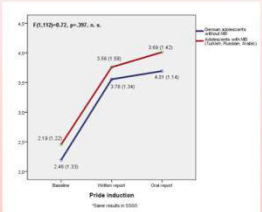
T2: Oral report of pride-eliciting autobiographical event → PANAS, SSGS, ASQ-KiJu-State

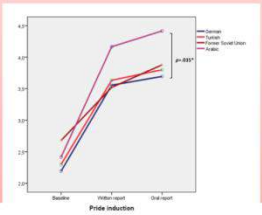
T3: Written report of shame-eliciting autobiographical event → PANAS, SSGS, ASQ-KiJu-State

T4: Oral report of shame-eliciting autobiographical event → PANAS, SSGS, ASQ-KiJu-State

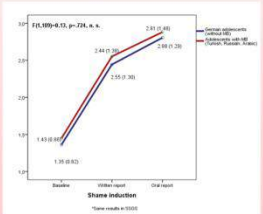
Results

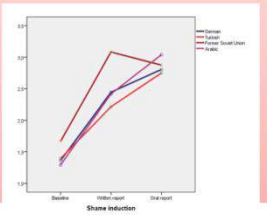
Differences in intensity of pride (PANAS)



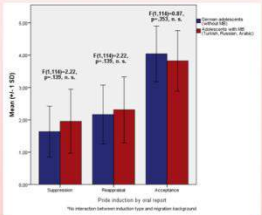


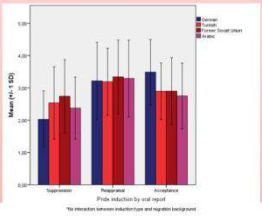
Differences in intensity of shame (PANAS)



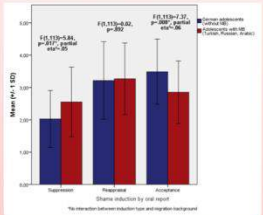


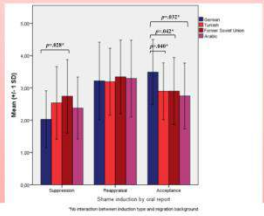
Differences in ER after pride induction





Differences in ER after shame induction





Discussion

Although pride and shame were induced in all groups, no differences occurred between adolescents with and without migration background in the reported intensity of pride and shame as well as in the regulation of pride. When regarding the groups separately contrary differences between the German and the Arabic groups occurred in the intensity of pride. The pattern of significant differences in the regulation of shame also contradicts our hypothesis. Higher suppression and less acceptance could account for lack of differences in the intensity of shame. These findings could support previous research indicating more suppression in collectivists in general as well as point out other relevant factors besides cultural orientation e.g. minority status, acculturation style.

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Anxienty and Trauma

Adult Attachment, Attention, and Social Anxiety: The Influence of Adult Attachment Style and Attention on Treatment Outcome for Those with Social Anxiety Disorder

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Introduction

•Attention is implicated in the major theoretical models of social anxiety disorder (SAD).

- Clark & Wells (1995): individuals with SAD avoid focusing attention on threat signals.
- Rapee & Heimberg (1997): SAD individuals are initially vigilant to threat cues. Once threat is detected these individuals have difficulty disengaging from threat.

•Previous research suggests that those with SAD often experience difficulties forming close interpersonal relationships.

- Adult attachment style is measured on two dimensions, attachment anxiety and attachment avoidance.
- Attachment Theory predicts that those with:
  - High attachment anxiety = vigilant to threat.
  - High attachment avoidance = avoidance of threat.

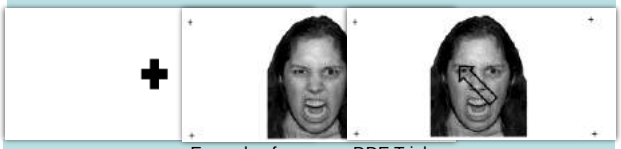
Research Questions:
• Does difficulty disengaging from threat predict treatment outcome for those with social anxiety disorder?
• Does adult attachment style (attachment anxiety and attachment avoidance) moderate this relationship?

Method

•Thirty three clinical participants with a primary diagnosis of SAD (DSM-IV).
•Eye tracking task (difficulty to disengage (DDE)) at pre-treatment, measures of social anxiety (SIAS), adult attachment (ECR-R) & depression (DASS) completed at pre and post treatment.
Statistical Analysis: A hierarchical linear regression was conducted with social anxiety severity scores measured at post treatment as the dependent variable. Independent variables (attachment anxiety, attachment avoidance, angry DDE Scores, neutral DDE Scores, happy DDE Scores).

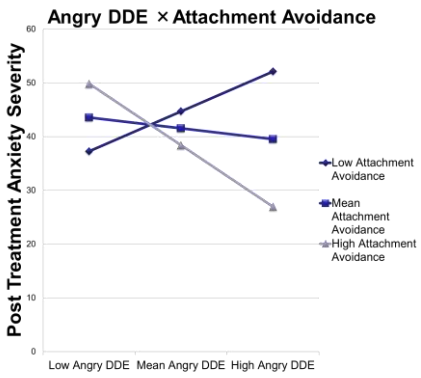
Controlled for pre-treatment social anxiety severity and depression.

Calculating DDE Scores:
The amount of time taken to disengage attention from the stimulus/the number of trials with valid eye movements.
Low DDE Scores = quick to disengage
High DDE Scores = slow to disengage.

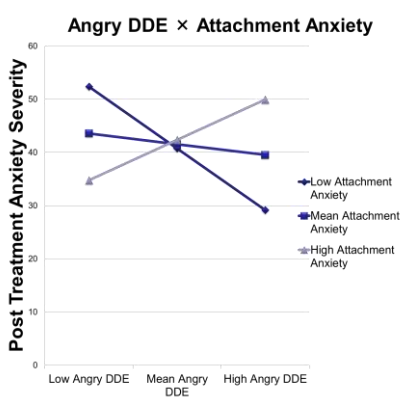


Example of an angry DDE Trial

Results



Model	R Square Change	Sig. F Change
Depression Pre-treatment Social Anxiety	.44	>.001
Attachment Avoidance Attachment Anxiety Happy DDE Neutral DDE Angry DDE	.15	.142
Att Avoidance × Angry DDE Att Avoidance × Neutral DDE Att Avoidance × Happy DDE Att Anxiety× Angry DDE Att Anxiety× Neutral DDE Att Anxiety× Happy DDE	.29	.001



Summary & Conclusions

Attachment moderates the relationship between attention and treatment outcome.

- Those who are *high on attachment anxiety* and were *quicker to disengage* from the angry face at pre-treatment had lower SAD severity at post-treatment.
- Those who are *high on attachment avoidance* and were *slower to disengage* from the angry face at pre-treatment had lower SAD severity at post-treatment.

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ADULT ANXIETIES eCentreClinic AGEING WISELY COOL KIDS

A sequential analysis of parent-child interactions: Differences between anxious and non-anxious children

INTRODUCTION

Anxiety disorders are among the most prevalent problems during childhood. In many cases, they have huge impact on children and family lives and are associated with important health and social costs (Bodden, Dirksen, & Bögels, 2007). Theoretical models and research have highlighted the role of certain parental factors in children's anxiety (e.g. Barlow, 2002) and have undermined the bidirectional influence of parents and child's behaviors in the development of childhood anxiety problems (e.g. Rapee, 2001).

Few studies were capable to identify and measuring these reciprocal and interactional processes. Furthermore, the differences between fathers and mothers behaviors in interactions with anxious children remain unclear. The present study pursued those purposes, using time-window sequential analysis in order to explore parents-child interactions during moderate anxiety induced situations.

OBJECTIVES

The study examined the role of children's anxiety and parental behaviors during parent child interactions and intented to:

1. Compare parenting behaviors of parents from anxious and non-anxious children;
2. Analyze the co-ocurrence of negative parental practices, such as overinvolvement and rejection, and children anxiety manifestations;
3. Compare mother's and father's behaviors towards the children.

METHOD

Participants: Thirty-three children (ages 9-12 years; M = 9,90, DP = 1,02; 57,1% girls) and their fathers and mothers. The anxiety disordered group (n=20)included children with a primary diagnosis of anxiety disorder (Generalized anxiety: 17.1%, social phobia: 17.1%, specifiic phobia: 14.3%, separation anxiety: 8.6%). The control group (n=13) included non-disordered children. Children were recruited in Portuguese public schools through a multi-level screening method.

Measures: Chidren's anxiety was evaluated by *Screen for Childs Anxiety Related Emotional Disorders-Revised* (SCARED-R; Muris, Merckelbach, Schmidt e Mayer, 1999; Children's version) and by *Anxiety Disorder Interview Schedule - Parents and Child adapted version* (ADIS-P&C; Albano e Silverman, 1996)

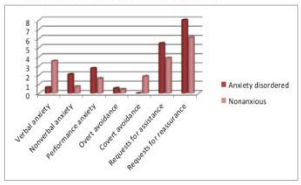
Interaction tasks:

1. "Make a speech": Children prepared and presented a speech about a theme suggested by the researcher with their prents help;
2. "Exploring blackboxes": Children put their hand inside six blackboxes and tried to discover what was in there with the orientation of the parents.

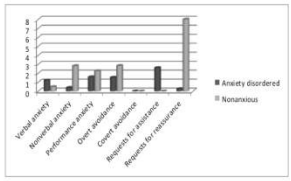
Procedure: Design 2 Task (speech/blackboxes) x 2 Dyad (father-child/mother-child) was used. Each task had 3 minutes long.

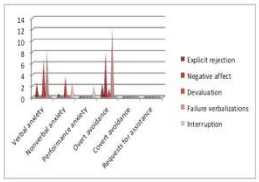
Data Analysis: Sequential analysis was used to code observations according to discrete event-units and to precise time-units. Using individual content codes, superordinate categories were created based on theorectical definitions, namely overinvolvement (McLeod, Wood & Weisz, 2007).

Graphic1. Mother's overinvolvement according to child's anxiety manifestations in anxious and nonanxious children[1]



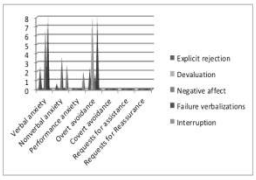
Graphic 2. Father's overinvolvement according to child's anxiety manifestations in anxious and nonanxious children



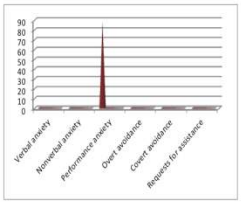


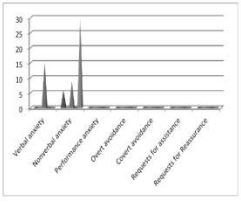
Graphic 3. Mother's rejection behaviors according to child's anxiety manifestations in anxious children

Graphic 5. Father's rejection behaviors according to child's anxiety manifestations in anxious children



Graphic 4. Mother's rejection behaviors according to child's anxiety manifestations in nonanxious children





Grafic 6. Father's rejection behaviors according to child's anxiety manifestations in nonanxious children

[1] Graphics include Odds ratio values between variables. Associations were considered statistical significant if odds ratio > 1.25, if adjusted residuals (z) > 1.96 (p< .05) and if Yules Q > .11. Only those significant results are mentioned in Discussion.

RESULTS

Mothers from anxious children are probable to be overinvolved confronted to diverse child'sanxiety symptoms (e.g. nonverbal anxiety, performance anxiety, request for assistance and for reassurance). Mothers from nonanxious children are overinvolved only when children verbalize their anxiety feelings. **Fathers** from anxious children only are overinvolved when children request their assistance, showing lesser overinvolvement than fathers from control group.

Mothers and **fathers** from anxious children are probable to act in rejecting ways (e.g. explicit rejection, devaluate child's feelings, negative affect) when children manifest diverse anxiety symptoms (e.g. verbal and nonverbal anxiety), whereas parents from control group express rejection in fewer situations.

DISCUSSION

As expected, parents from anxious children are more rejecting compared to non-anxious. Also, mothers from anxious children were more overinvolved, however their fathers were surprisingly less involved, showing that parenting behaviors may vary according to parent's gender. Furthermore, specific children's anxiety symptoms mayelicit and be a consequence of overinvolved and rejection parental behaviors.

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Are Police applicants particularly resilient to trauma ?

Background

Police service is widely acknowledged as one of the most stressful occupations. Police officers are routinely exposed to numerous traumatic situations that could contribute to the onset of emotional disorders (Marmar et al., 2006). Despite this recurrent trauma exposure, only a minority of Police officers suffer from chronic post-traumatic stress disorder (PTSD) and/or noteworthy affective illnesses (Ghazimour et al., 2010). Thus, Police officers seem to be particularly resilient. However, they are widely reported to have difficulties in recognizing negative emotions and to implement emotion regulation strategies highly associated with a repressive coping style (Berking et al., 2010). The first aim of the current cross-sectional study is to describe in Police applicants (before professional trauma exposure) specific personality traits leading to a general positive response bias in self-presentation. The second aim, is to explore the associations between this over-positive disposition and the risk of aggressive attitudes.

Methods

Population

Table 1 : Police applicants and control individuals characteristics

	Police applicants (*N*=106)		Control individuals (*N*=110)		Tests
	M	***SD***	***M***	***SD***	***t***
Age	*23.283*	*3.149*	*24.054*	*3.211*	*-1.782 n.s.*
Siblings	*1.410*	*0.874*	*1.651*	*1.022*	*-1.858 n.s.*
	***N* women**	***N* men**	***N* women**	***N* men**	χ^2
Sexe	21	85	25	85	0.274 *n.s.*
Education	15	67	24	76	13.926 *n.s.*
Prof. training	8	43	16	34	
Prof. High school	3	10	2	27	
High school	4	14	6	15	

Note: n.s. = non-significant

Assessment

Emotions

Anxiety: STAI (Spielberg,et al., 1993)
Happiness: SDHS (Joseph et al., 2004)
Aggression: Buss-Perry Aggression Questionnaire (Bryant & Smith, 2001)

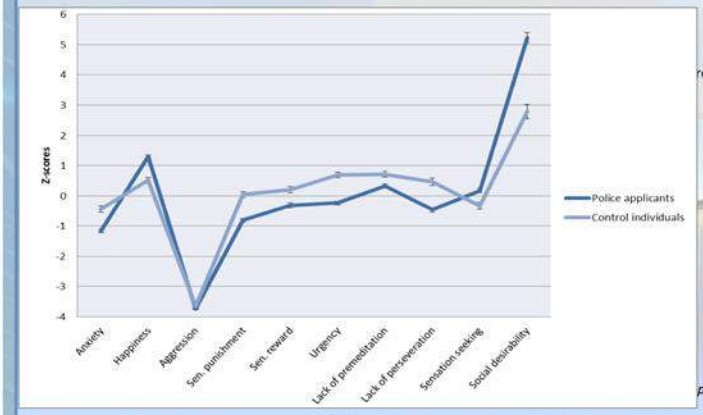
Personality

Sensitivity to punishment and *sensitivity to reward*: SPSQ (Lardi et al., 2008)
Impulsivity (*urgency, lack of premeditation, lack of perseveration* and *sensation seeking*): UPPS-Impulsive Behaviour Scale (Billieux et al., 2006)

Coping style

Social desirability: Marlowe Crowne SDS (Crowne & Marlowe, 1960)

Results



ression analyses predicting aggression (z-scores)

Aggression	Predictors	*Beta*	*t*	Sig.	R^2	R^2 Change
Step 1	Happiness	-.335	-4.041	.000	.308***	
	Anxiety	.262	3.159	.002		
Step 2	Happiness	-.228	-2.948	.004	.428***	.120***
	Anxiety	.201	2.632	.009		
	Social desirability	-.381	-6.601	.000		
Step 3	Happiness	-.243	-3.344	.001	.517***	.089***
	Anxiety	.216	2.988	.003		
	Social desirability	-.271	-4.640	.000		
	Sen. punishment	-.110	-1.846	.066		
	Sen. reward	.326	6.013	.000		

p<.001. *N*=216

Figure 1: Emotion, personality and coping style profile for police applicants and control individuals: Mean and standard error.

Aggression is significantly predicted by social desirability, even after having accounted for happiness/depression and anxiety (Step 2; ΔR^2=.120; $F(1,207)$=43.578; p=.000). Regression in Step 3 indicates that sensitivity to punishment and sensitivity to reward make an additional contribution to predict aggression attitude (ΔR^2=.089; $F(2,205)$=18.926; p=.000). Individuals more sensitive to reward tend to be more aggressive (β=.326; t=6.013; p=.000) independently of their social desirability, happiness/depression and anxiety levels. Same findings have also been described within the Police applicants subsample.

Conclusion

In agreement with previous research, the current cross-sectional study confirms that Police applicants compared to community individuals matched for age, gender and education report a specific emotion and personality profile biased by a social desirable self-presentation style. Plausibly, this strong social desirable disposition impacts the cognitive evaluation of any event, including the adverse ones and the stimuli that trigger aggressive attitudes. Thus, independently of emotional state and social desirability, Police applicants' aggressive attitude is accounted for by sensitivity to reward. This reward-drive disposition is compatible with Gray & McNaughton (2000) "Behavior Activation System". Even if a longitudinal design is needed to draw cutting edge causal conclusions, our findings point toward the importance of considering sensitivity to reward as a predictor of aggressive attitudes in at-risk population.

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ALCOHOL USE AS AN EXPERIENTIAL AVOIDANCE STRATEGY IN SOCIAL ANXIETY

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ABSTRACT

According to Acceptance and Commitment Therapy, underlying any anxiety disorder is the unwillingness to experience internal events (Hayes et al., 1999). In line with this assumption, Herbert & Cardaciotto's model (2005) for Social Anxiety Disorder (SAD) postulates that a context of low acceptance will contribute to the use of a wide variety of strategies to control internal experiences. Social anxiety has been widely associated with alcohol consumption, used as self-medication to reduce unpleasant symptoms of anxiety, thus encouraging an increase of the frequency of the consumption (Kushner et al., 2000). The present research aimed to study the psychometric characteristics of an acceptance scale in social anxiety (SA-AAQ; McKenzie & Kocovski, 2000) (Study 1), to clarify the relation between Social Anxiety, Alcohol Consumption and Acceptance (Study 2), using two different samples – one sample of individuals with SAD and one sample of individuals with alcohol use disorders (AUD).In Study 1, SA-AAQ revealed good psychometric properties and a two-factor structure - acceptance and action - unlike the original unidimensional scale. Regarding Study 2, the findings were different in each sample. In the sample of individuals with SAD, the absence of associations between the variables did not allow the mediation analysis. On the other hand, results in the AUD confirmed our hypothesis. Acceptance was revealed as a total mediator of the relationship between social anxiety and expectations about alcohol effects.

INTRODUCTION

Herbert & Cardaciotto's model (2010) for Social Anxiety Disorder (SAD), in line with the Acceptance and Action Therapy (Hayes et al., 1999), postulates that reduced acceptance promotes the use of experiential avoidance strategies that will paradoxically lead to an increase of the symptoms and to a disruption of behavior. Alcohol consumption is widely associated to SAD (Carrigan & Randall, 2003), while, on the other hand, individuals with alcohol abuse frequently exhibit social anxiety (Lepine & Pélissolo, 1998). Given alcohol's pharmacological effects reducing aversive anxiety symptoms and other negative emotions, alcohol consumption could then be considered an experiential avoidance strategy. However, the literature linking SAD, alcohol and acceptance is scarce.

PARTICIPANTS

Individuals aged between 18 and 65 years old

Table1. Participants by gender

		GENDER		
	DIAGNOSIS	Male – n (%)	Female – n (%)	Total
Study 1	GENERAL POP.	143 (47.4%)	159 (52.6%)	302
Study 2	SAD	7 (21.9%)	25 (78.1%)	32
	AUD	26 (74.3%)	9 (25.7%)	35

MEASURES

ADIS-IV (Anxiety Disorders Interview Schedule-IV; Di Nardo et al.,1994); **SIAS** (Social Interaction Anxiety Scale; Mattick & Clark, 1998); **SIPAAS** (Social Interaction and Performance Anxiety and Avoidance Scale; Pinto-Gouveia et al., 2003); **SA-AAQ** (Social Anxiety-Acceptance and Action Questionnaire; MacKenzie & Kocovski, 2010); **IPBEA** (Inventory of personal beliefs and expectations about alcohol; Pinto-Gouveia et al., 1993); **DASS-21** (Depression, Anxiety, and Stress Scale 21-Items Version; Lovibond & Lovibond, 1995).

RESULTS

STUDY 1

The Exploratory Factor Analysis performed to explore the SA-AAQ dimensionality revealed a bifactorial structure - acceptance and action - explaining 58.75% of the variance. The SA-AAQ showed good internal consistency, reasonable to very good temporal reliability in a 4-6 interval, acceptable convergent and discriminant validity, and sensitivity to differentiate subjects with SAD.

STUDY 2

Table 2. *Pearson* correlations between all variables

	GROUP SAD (N=32)	IPBEA-4	IPBEA-6	SIAS
SA-AAQ	TOTAL	-.26	-.22	-.47
	ACCEPTANCE	-.27	-.32	-.46
	ACTION	-.01	.00	-.47**
SIAS		-.16	-.15	-
	GROUP AUD (N=35)	IPBEA-4	IPBEA-6	SIAS
SA-AAQ	TOTAL	-.49**	-.52**	-.34*
	ACCEPTANCE	-.54**	-.58**	-.30
	ACTION	-.12	-.09	-.25
SIAS		-.38*	-.42*	-

Mediation

Multiple regression analysis were computed to explore the mediation role of acceptance in the relationship between SA and expectations about alcohol (escape the negative emotional states and decrease negative feelings of self and anxiety evaluative) (Figure 1 and 2).

Fig. 1: Regression for the relationship between SIAS and IPBEA-4 mediate by acceptance

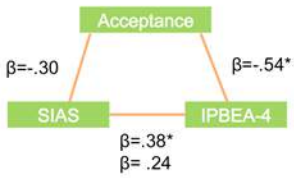
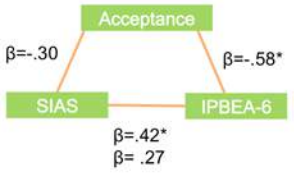


Fig. 2: Regression for the relationship between SIAS and IPBEA-6 mediate by acceptance



Note: IPBEA-4 = Escape from Negative Emotional States. IPBEA-6 = Decrease in Negative Feelings of self and Evaluation Anxiety

DISCUSSION & CONCLUSION

- The SA-AAQ proved to be a valid and reliable measure of acceptance in social situations
- In the sample PAS, contrary to expectations, there were no significant associations between variables of social anxiety (SIAS) and expectations regarding the effects of alcohol (IPBEA), thus hindering mediation analysis.
- In the AUD sample, acceptance completely mediated the relationship between social anxiety and expectations regarding alcohol effects.

Acceptance, thus revealed to be a fundamental process in the relationship between social anxiety and expectations about alcohol use, which will then lead to alcohol consumption, in a sample of individuals with alcohol use disorders. ACT may be a valid option to work with such a condition.
Further research is needed to investigate this relationship in individuals with SAD.

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Factors associated with clinical levels of somatization and hypochondriasis: The role of anxiety and panic symptoms

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Introduction

- Clinical levels of somatization and hypocondriasis (or severe health anxiety) influence the individuals' functioning in the psychological, social, professional and other domains, mostly due to avoidance of daily activities in order to prevent worsening of symptoms, frequent health care visits and high comorbidity with other psychological disorders (e.g. Terluin, van Rhenen, Anema, & Taris, 2011; Woolfolk &Allen, 2010).
- Prevalence in general population reported in DSM-5 (APA, 2013):
  6-7% for somatic symptom disorder (somatization)
  1.3-10% for illness anxiety disorder (hypochondriasis)
- Previous studies reported associations of somatization and hypochondriasis with demographic characteristics, such as gender and age, personality traits, such as anxiety sensitivity and experiential avoidance, social support and coping strategies (e.g Leibbrand et al, 2000; Macatee & Cougle, 2013; Zvolensky & Forsythe, 2002).
- High comorbidity is especially presented between somatization and hypochondriasis with anxiety disorders such as generalized anxiety disorder and panic disorder (e.g. Barsky, 2001; Weck et al, 2012; Deacon & Abramowitz, 2008).
- Further examination of the links of the two somatoform disorders with the factors mentioned above and the comorbid conditions might better explain the onset and maintenance mechanisms of the disorders, and provide guidance on the improvement of the prevention and therapeutic interventions.

Aim: To identify possible predictors of somatization and hypochondriasis and factors that characterize clinical levels of symptomatology

Methods

Participants

- 295 Greek-Cypriot community volunteers (182 females; M_{age} = 44.84, SD = 1.17) recruited for the purposes of a larger epidemiological study on anxiety disorders

Procedure

- Stratified random sampling through the telephone catalogues
- Printed questionnaires sent to the participants with a return envelope

Measures

- Psychiatric Diagnostic Screening Questionnaire (PDSQ; Forehand & Long, 2010)
- Anxiety Sensitivity Index (ASI; Reisss, Peterson, Gursky, & McNally, 1986)
- Acceptance and Action Questionnaire (AAQ-II; Bond et al., 2011)
- Perceived Stress Scale (PSS-10; Cohen, Kamarck, & Mermelstein, 1983)
- Brief COPE (Carver, 1997)
- World Health Organisation's Quality of Life Instrument, Short Form (WHOQOL-BREF; Harper, Power, & Group, 1998)
- Social Support Questionnaire (SSQ-44; Sarason, Levine, Basham, & Sarason, 1983)
- Questions about demographics and the health status

Results

Predictors of somatization

	ΔR^2	*B*	*SE*	β	95% CI
Step 1	.251***				
Severity of health condition		.143	.015	.501***	.114, .173
Step 2	.076***				
Severity of health condition		.132	.014	.462***	.104, .160
Experiential avoidance		.035	.006	.278***	.022, .047
Step 3	.026**				
Severity of health condition		.125	.014	.436***	.097, .153
Experiential avoidance		.026	.007	.211***	.013, .039
Anxiety sensitivity		.019	.006	.179**	.008, .031
Step 4	.149***				
Severity of health condition		.118	.013	.411***	.093, .142
Experiential avoidance		.001	.007	.005	-.013, .012
Anxiety sensitivity		.009	.005	.087	-.001, .020
Panic symptoms		.095	.038	.134*	.019, .170
Anxiety symptoms		.149	.022	.384***	.106, .191
Total R^2	.502				
F	55.06***				

Note. Excluded variables: Support seeking (β=.021), Avoidance (β=.005), Negative affect (β=-.020), Social support total (β=-.082); *p<.05,**p<.01, ***p<.001

Predictors of hypochondriasis

	ΔR^2	*B*	*SE*	β	95% CI
Step 1	.074***				
Severity of health condition		.081	.017	.271***	.047, .115
Step 2	.036**				
Severity of health condition		.070	.017	.233***	.036, .104
Anxiety Sensitivity		.022	.007	.193**	.009, .035
Step 3	.013*				
Severity of health condition		.067	.017	.225***	.033, .101
Anxiety sensitivity		.016	.007	.146**	.003, .030
Experiential avoidance		.016	.008	.125*	.000, .032
Step 4	.099***				
Severity of health condition		.067	.016	.225***	.035, .099
Anxiety sensitivity		.005	.007	.146	-.008, .019
Experiential avoidance		.000	.009	.007	-.016, .018
Panic symptoms		.273	.050	.371***	.175, .372
Anxiety symptoms		-.005	.028	-.012	-.060, .051
Total R^2	.222				
F	15.58***				

Note. Excluded variables: Avoidance (β=.046), Social support total (β=-.034); *p<.05,**p<.01, ***p<.001

Comparisons between clinical and typical groups

	Somatization (*n*=9)	Hypochondriasis (*n*=18)	Both Diagnoses (*n*=12)	Typical (*n*=88)			
	Adjusted *M (SD)*	Adjusted *M (SD)*	Adjusted *M (SD)*	Adjusted *M (SD)*	*F*	*p*	η^2
Perceived Stress	17.67 (1.81)[a]	15.72 (1.21)[a]	19.40 (1.68)[a]	11.13 (0.58)[a]	9.27	.000	.186
Physical QoL	59.47 (4.57)[ab]	73.89 (3.05)[ab]	69.55 (4.25)[a]	84.21 (1.47)[a]	10.02	.000	.198
Psychological QoL	57.77 (5.33)[a]	65.54 (3.56)[a]	54.08 (4.95)[a]	76.96 (1.71)[a]	8.00	.000	.164
Social QoL	63.97 (6.75)	67.33 (4.50)	69.12 (6.27)	78.22 (2.16)	2.33	.078	.054
Environmental QoL	57.63 (4.51)[a]	62.60 (3.01)[a]	59.77 (4.19)[a]	74.41 (1.45)[a]	7.38	.000	.154

Note. [ab] PostHoc univariate analyses between the four groups based on a sub-sample of participants.

Comorbidity with anxiety and panic symptoms

	Panic Symptoms χ^2 (3)=62.01, *p*=.000		Anxiety symptoms χ^2 (3)=86.47, *p*=.000	
	Typical	Clinical	Typical	Clinical
Typical	151	0	151	0
Somatization	22	10	24	8
Hypochondriasis	12	6	9	9
Somatization & Hypochondriasis	10	8	7	11

Discussion

- Controlling for the severity of medical conditions, the clinical groups indicated significantly higher levels of perceived stress and lower physical, psychological and environmental quality of life, compared to the typical group.
- Panic and anxiety symptoms presented comorbidity with symptoms of somatization and hypochondriasis based on PDSQ criteria.
- Experiential avoidance and anxiety sensitivity were the only significant predictors of both somatization and hypochondriasis after controlling for the severity of medical conditions. However, when generalized anxiety and panic symptoms were added in the models the predictive value of the two personality traits disappeared.
- **Concluding, this study indicates that the links between the two somatoform disorders and the personality traits of experiential avoidance and anxiety sensitivity are better explained by the presence of anxiety and panic symptoms among somatizers and health anxious individuals .**
- These results provide preliminary evidence that psychological interventions directed to somatizers and health anxious individuals might be effectively enhanced by components that target anxiety and panic symptomatology.

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SOCIAL ANXIETY AND VIOLENCE AMONG PEERS: THE ROLE OF ATTACHMENT

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ABSTRACT

Literature suggests that lower attachment quality is significantly related with the beginning and/or maintenance of anxiety disorders, including Social Anxiety Disorder (SAD). In this study, we analysed the relationship between attachment (attachment to parents and to peers) and peer relationships in a sample of adolescents with SAD. We hypothesised that peers attachment would represent a protective factor of being victimized by peers. The final sample consisted of 65 adolescents (34 in the clinical group and 31 in the non-clinical group, all assessed by the ADIS-C and several self-report questionnaires) aged between 14 and 18 years old. Intergroup analyses indicated that adolescents with SAD reported significantly lower levels of attachment and a significantly higher levels of tendency to be victimized compared to adolescents without psychopathology. There were no significantly differences in the tendency to be a bully and in the prosocial tendency. Analyses in adolescents with SAD exhibited that only peer attachment showed a predictive role of the tendency to be victimized by group. Results suggest that prevention and intervention in SAD, specifically in adolescents, should target the quality of peer's attachment.

Key Words: Social Anxiety Disorder, Violence among Peers, Attachment, Peers Attachment

INTRODUCTION

For some adolescents, the transition from family support to peers support can be problematic due the important role that these last ones play in the emotional development of the adolescent (La Greca & Harrison, 2005). Due to the psychological, interpersonal and social modifications that are characteristic of this stage, the influence of parents in the adolescent's daily life tend to decrease and peer relationships become progressively a more important source of support and values (Batgos & Leadbeater, 2004).

Few studies approach the relation between attachment and violence among peers in adolescence. Associations have been found between insecure attachment and a higher risk of being victimized by peers (Finnegan et al., 1998). Anxious adolescents show submissive behaviours compared to other adolescents, show less group acceptance and higher levels of peer's rejection (Spence et al., 1999). Recently, Kokkinos (2013) concluded that pre-adolescents that report an insecure attachment (to parents) revealed a greater tendency to be victims of peer violence.

METHOD

PARTICIPANTS

Adolescents aged between 14 and 18 years old.

Table 1. Distribution of the samples by gender.

	Gender		
Sample	Male	Female	Total
	n (%)	n (%)	n
SAD	7 (20.6)	27 (79.4)	34
Non-clinical population	14 (45.2)	17 (54.8)	31

MEASURES

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

Self Report Questionnaires: Social Anxiety Scale for Adolescents (SAS-A; La Greca & Lopez, 1998); Children's Depression Inventory (CDI; Kovacs, 1985); Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987b); Peers Relations Questionnaire (PRQ; Rigby & Slee, 1993).

RESULTS

INTERGROUP ANALYSES

Table 2. Means (M) and standard deviations (SD) of the variables under study for both groups. T test to analyse differences between groups.

	SAD		Non-clinical		
	M	SD	M	SD	*t*
SAS-A	79.00	10.52	76.88	10.59	10.41**
CDI	16.65	5.75	7.84	5.45	6.32**
IPPA Mother	69.79	9.67	76.88	10.59	-2.81**
IPPA Father	60.72	8.08	65.81	9.48	-2.30**
IPPA Peers	65.74	14.15	79.42	8.58	-4.66**
PRQ Bully	5.94	1.21	5.97	1.71	-.29
PRQ Victim	6.82	1.75	5.77	1.65	2.48*
PRQ Prosocial	13.18	2.11	13.83	3.04	-1.01

*p < 0.050 ; ** p < 0.010

INTRAGROUP ANALYSES

Social Anxiety Disorder Group

Table 3. Correlations between attachment and interpersonal relationship in SAD

Measures	1	2	3	4	5	6
1. IPPA Mother	-					
2. IPPA Father	.69**	-				
3. IPPA Peers	.56**	.57*	-			
4. PRQ Bully	-.35*	-.21	-.04	-		
5. PRQ Victim	-.43*	-.51**	-.65**	.27	-	
6. PRQ Prosocial	.25	.49**	.46**	.22	-.10	-

*p < .050 ; ** p < .010

Table 4. Hierarchical multiple regression for attachment to mother and attachment to peers predicting the tendency to be victim of violence among peers in SAD.

	R	R^2	B	β	F	*t*
Model 1	.43	.185			7.05	5.92**
IPPA Mother			-.08	-.43		-2.66**
Model 2	.68	.461			12.84	-3.85**
IPPA Mother			-.01	-.08		-.47
IPPA Peers			-.08	-.63		-3.92**

*p < .050 ; **p < .010

Table 5. Hierarchical multiple regression for attachment to father and attachment to peers predicting the tendency to be victim of violence among peers in SAD.

	R	R^2	B	β	F	*t*
Model 1	.51	.257			10.54	6.47**
IPPA Father			-.11	-.51		-3.12**
Model 2	.70	.487			13.77	7.73**
IPPA Father			-.04	-.18		-1.10
IPPA Peers			-.07	-.58		-3.61**

*p<.050 ; **p<.010

CONCLUSION

Adolescents with SAD revealed lower levels of attachment and higher levels of tendency to be victimized compared to non-clinical adolescents.

Attachment to parents was a predictor of the tendency to be victim in the absence of peers attachment. However, when attachment to peers was introduced this was the only variable behaving as a predictor of the tendency to be victimized by peers, in adolescents with SAD (total mediation). These data suggest that the presence of secure relationships to peers may attenuate the tendency to be victim that characterizes SAD.

BRIDGING THE GAP BETWEEN INFORMATION PROCESSING AND EVOLUTIONARY VARIABLES IN SOCIAL ANXIETY DISORDER

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ABSTRACT

Social Anxiety Disorder (SAD) is the most common anxiety disorder and the third most prevalent mental disorder (Clark & Beck, 2010). According to Clark and Wells' (1995) cognitive model for SAD, two of the maintenance factors of this disorder are Self-Focused Attention (SFA) and Post-Event Processing (PEP). The focus on one's thoughts, feelings and behaviour during the situation (SFA) and the detailed revision of the negative aspects of the individual's performance during the situation (PEP) could explain the feeling of shame that persists long after the situation has subsided. In fact, shame and self-criticism (SC) are two other constructs that have been associated to SAD (Cox et al., 2004; Xavier & Salvador, 2014). Trying to bridge the cognitive model of SAD with these evolutionary constructs, this study aimed to analyse the relationship between social anxiety (SA), SFA, PEP, SC and shame (both internal and external). Using a clinical sample of 32 adults with SAD, it was hypothesized that SFA and PEP would be strongly associated to SC and shame in patients with SAD, and that SC and shame would mediate the relationship between SA and these two types of information processing (SFA and PEP). Positive and significant associations between SFA, PEP, SC and shame were found. Results also revealed that only internal shame had a mediator role in both the relationship between SA and SFA, and in the relationship between SA and PEP, even when controlling for depression.

Keywords: Social Anxiety Disorder; Self Focused Attention; Post Event Processing; Self Criticism; Shame; Mediation

BACKGROUND

Social Anxiety Disorder (SAD) is characterized by a marked fear or anxiety in situations where the individual might be exposed to the possible scrutiny by others (APA, 2013). Two typical information processing strategies implicated in the maintenance of SAD (Clark & Wells, 1995) are Self-Focused Attention (SFA) and Post-Event Processing (PEP). SFA is an attentional bias for the subject's own thoughts, emotions and bodily sensations (Carver & Scheier, 1981). These information will used in *post-mortem* rumination (PEP) where the subject reviews critically and with detail what went wrong in the social event. Self-Criticism (SC) is a pernicious form of self-evaluation involving feelings of inadequacy and guilt (Blatt, 1974). Internal Shame (IS) is related to negative self-perception and External Shame (ES) is related to the way people think they exist in the other's mind (Gilbert, 1998).

To our knowledge, there is no study bridging the gap between these cognitive variables (SFA and PEP) and evolutionary variables (SC and Shame). However, the clinical practice shows that SFA promotes SC with the detection of failures and can result in shame. Regarding PEP, the content of this rumination has, apparently, a more critical and violent character and is also accompanied by shame feelings.

RESEARCH QUESTION:

Will Self-Criticism and Shame mediate the relationship between Social Anxiety and Self-Focused Attention/Post-Event Processing?

METHOD

Participants

32 Portuguese subjects with SAD (♀ 78,10%; ♂ 21,90%)

Measures

ADIS-IV (Anxiety Disorders Interview Schedule-IV; Di Nardo et al.,1994)
SIAS (Social Interaction Anxiety Scale; Mattick & Clark, 1998)
SFA (Self-Focused Attention Scale; Bögels et al., 1996)
PEPQ (Post-Event Processing Questionnaire; Fehm et al., 2008)
FSCRS (Forms of Self-Criticism/Attacking & Self-Reassuring Scale; Gilbert et al., 2004)
ISS (Internalized Shame Scale; Cook, 1994, 2001)
OAS (Other As Shamer Scale; Goss et al., 1994)
DASS-21 (Depression, Anxiety, and Stress Scale 21-Items Version; Lovibond & Lovibond, 1995)

RESULTS

Correlations

Pearson correlations were computed between all variables (Table 1)

Table 1
Correlations between all the variables

	1	2	3	4	5	6	7	8	9	10	11	12
1. SIAS	1											
2. SFA (total)	.51**	1										
3. SFA (behaviour)	.42**	.78**	1									
4. SFA (activation)	.44**	.90**	.43**	1								
5. PEPQ (total)	.37**	.60**	.54**	.49**	1							
6. PEPQ (F1)	.38**	.58**	.56**	.45**	.94**	1						
7. PEPQ (F2)	.44**	.66**	.60**	.54**	.95**	.88**	1					
8. PEPQ (F3)	.16	.37*	.27	.34	.83**	.64**	.70**	1				
9. FSCRS (SC)	.54**	.43**	.42**	.33	.37*	.44*	.43*	.07	1			
10. ISS	.70**	.63**	.64**	.47**	.56**	.58**	.59**	.32	.74**	1		
11. OAS	.54**	.39**	.52**	.20	.40*	.44*	.39*	.22	.36*	.67**	1	
12. DASS (dep.)	.32	.52**	.41**	.49**	.33	.24	.37*	.29	.29	.54**	.56**	1

* p < .05, ** p < .001

Mediation

Multiple regression analysis were computed to explore the mediation role of SC, IS an ES in the relationship between SA and SFA/PEP, controlling for depression. IS was the only significant mediator in both relationship (Fig.1 and 2).

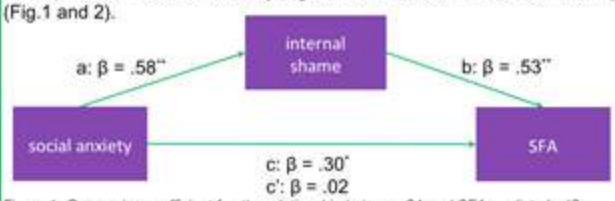

Figure 1: *Regression coefficient for the relationship between SA and SFA mediate by IS.*

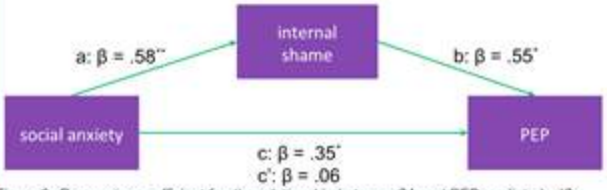

Figure 2: *Regression coefficient for the relationship between SA and PEP mediate by IS.*

DISCUSSION

Conclusion: Results suggest that SFA and PEP does not directly depend on social anxiety levels but on internal shame levels. In other words, IS is the mechanism through which social anxiety impacts on SFA and PEP processes. This result seems to indicate that both SFA and PEP are dominated by inferiority issues related to the self and that it is this characteristic of SAD that is responsible for these processes.

Clinical implications: Once these two SAD's maintenance processes are mainly related to internal shame, intervention should be mainly focused in this variable. Compassion focused therapy could be a valid approach to develop tolerance, understanding and warmth.

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CBT Interventions

CBT of hearing voices; a case study of IDD client

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Aim: To diminish auditory hallucinations.

Method: Cognitive behavioural psychotherapy once a month, eight times.

Subject: 25 year old young woman with CP lives in a group home. Ten years´ history of hearing voices, situation was getting worse before the therapy. Challenges: Shouting loudly (10 min – 1,5 h) daily, maximum volume of stereos, throwing things, threatening to kill herself, refusal of daily living activities (cleaning etc.).

Approach: To make voices more concrete: Is it a man´s/woman´s voice?, What does it say? Can you make a difference of your own thoughts and the voices, is it a friendly or angry voice? etc.
What do you think and feel, when you hear the voice? -> Teaching to dispute the voices, giving a different meaning.
The assessment was made by the client, group home personnel and the therapist.

Results

First session intervention: Behavioural analysis of the situation. Intervention: the shouting angry man must fear for you, if he doesn´t dare to speak to you properly. -> Big relief and long lasting laugh. The situation was much better in group home.

2nd session: Making things more concrete. What other things the angry man´s voice say: "You are no good, you are retarded" (repeatedly). Talking about disability, at what things you are good.

3-5th sessions: She hears voices, but they are not so frightening any more.
Co-operation with personnel and relatives is much better: no more shouting and crying. Rocking behavior when sitting is not so intense. Appears that it is also a means to cope with voices.
Roleplay about being, feeling disabled.
Walking is much better, motivation improves.

6th session: Changes in physical health shadows also psychological aspects. Anxious, fear of death grows, less hallucinations.

7-8th sessions: Fears diminish. Disability issues discussed. Less shouting.

Conclusion

CBT even once a month basis can diminish hearing voices to "acceptable level".
Secondary problems diminished considerably.

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A brief cognitive-behavioral therapy for breast reconstruction decision-making. Psychological effects of the breast reconstruction.

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INTRODUCTION

Psychosocial factors associated with decision regret in the context of breast reconstruction are low satisfaction with preparatory information, depression, anxiety and stress (Sheehan *et al.*, 2007). Patients that underwent breast reconstruction found the information given by surgeon, contact with other patients, written information and the internet helpful (Wolf, 2004). Regarding the depression and anxiety, brief cognitive-behavioral interventions have been shown to be effective in the reduction of these disorders (van Beek *et al.*, 2013). As far as we know there are not studies of psychological support in breast reconstruction decision-making.

The aim of the present study is to assess the effectiveness of a brief cognitive-behavioral group therapy for the breast reconstruction decision-making in mastectomy-treated breast cancer

METHOD

PARTICIPANTS

Forty eight oncologic patients that were waiting for breast reconstruction after mastectomy participated in the study. The mean age was 50.69 (*SD*=7.83), the range was from 35 to 69 years old.

Graph 1: Level of education

INSTRUMENTS

1. The Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983
2. Body Image Scale (Hopwood, 1993)
3. Rosenberg Self-Esteem Scale (Rosenberg, 1965)
4. Perceived Social Support Scale (Zimet, Dahelm, Zimet & Farley, 1988)
5. Questionnaire of Couple Relationship and Sexuality (Peris & Gallego, 2013)
6. Aesthetic satisfaction with breast reconstruction (Alderman, McMahon & Wilkins, 2003)
7. Motivation/ Satisfaction with the psychological treatment (Nau & Borkovec, 1972)

TREATMENT

The brief cognitive-behavioral group therapy for breast reconstruction decision-making (CBTBR) was conducted by two clinical psychologists and the length was 3 sessions of 90 minutes. The treatment components were: techniques to improve the self-esteem and body image, sexuality, problems solving, information about breast reconstruction, psychological aspects of the surgery and cognitive-behavioral techniques for depression and anxiety. The plastic surgeon who was to perform the reconstruction also collaborated in the treatment answering questions. Two women who had already undergone breast reconstruction talked about their experiences.

PROCEDURE

Participants were randomized to:

1. A brief cognitive-behavioral therapy for breast reconstruction decision-making (N=25)
2. A waiting list control condition (N=23)

Assessments:

Pre-test → Post-test → At 6-months after the breast reconstruction

RESULTS

There were not significant differences between both experimental groups in the pre-test.

In order to analyze the changes from pre-test to post-test repeated measures analysis of variance (ANOVAs) were applied. Repeated ANOVAs between both experimental conditions were also carried out from pre- to 6 months after reconstruction.

Table 1. Means and standard deviations (between brackets) of relevant measures related to breast reconstruction

	Pre-treatment		Post-treatment		6 months after reconstruction	
Measure	CBTBR	WL	CBTBR	WL	CBTBR	WL
Anxiety	11.77 (2.00)	11.50 (2.76)	12.45 (1.53)	10.50 (2.37)	12.65 (1.72)	11.47 (2.55)
Depression	3.36 (2.52)	3.81 (3.10)	2.59 (2.86)	3.90 (3.48)	2.05 (1.92)	3.41 (3.43)
Body Image	30.41 (5.74)	28.85 (7.44)	29.84 (7.18)	29.81 (7.84)	20.22 (5.54)	24.06 (8.70)
Self-esteem	18.82 (3.59)	16.95 (6.37)	17.32 (4.28)	18.18 (6.05)	16.89 (4.24)	16.82 (4.91)
Social support	73.95 (17.45)	76.67 (9.97)	76.32 (10.02)	73.38 (10.96)	75.73 (10.17)	73.00 (13.74)
Sexuality	5.57 (3.82)	4.37 (3.02)	6.71 (2.98)	4.00 (3.21)	7.33 (2.21)	6.00 (2.94)
Aesthetic satisfaction	9.81 (4.21)	10.43 (5.23)			23.25 (4.43)	19.93 (7.19)

Repeated ANOVAs between both experimental conditions in self-esteem from pre- to post-test showed a significant interaction effect ($F(1, 42)=7.38$, $p<0.05$), there was a slight improvement in self-esteem in the treatment group and a little worsening of self-esteem in the waiting list group. Repeated ANOVAs for anxiety, depression, body image, social support and sexuality did not show any significant effect.

Table 2. Repeated ANOVAs from pre-test to 6 months after reconstruction in relevant measures related to breast reconstruction

	Time effect		Group effect		Interaction effect	
Variables	*F*	*p*	*F*	*p*	*F*	*p*
Anxiety	3.60	.066	.54	.468	3.60	.066
Depression	1.65	.209	1.02	.320	1.34	.255
Body Image	48.24	.000**	.34	.563	4.05	.054
Self-esteem	5.01	.032*	.52	.476	1.59	.216
Social support	.29	.593	.15	.699	.65	.427
Sexuality	11.02	.003**	.34	.565	1.55	.225
Aesthetic satisfaction	108.97	.000**	.70	.408	3.21	.084

Table 3. Means and standard deviations of the acceptability variables

	M	*SD*
Motivation	8.96	1.57
Logic	9.47	.81
Satisfaction	9.57	.81
Confidence	8.79	1.59
Recommendation to others	9.71	.64
Aversiveness	.43	1.75
Utility	9.71	.46

Three participants in the treatment group decided not to undergo reconstruction and two participants in the control group.

CONCLUSIONS

A brief cognitive-behavioral therapy for the breast reconstruction decision-making was shown to be effective to enhance self-esteem, although it did not help to reduce anxiety and depression. We have to take into account that participants were not anxious or depressed at pre-test.

The participants were satisfied with the group treatment and they considered it very useful.

The psychological effects of breast reconstruction were an enhancement of self-esteem and aesthetic satisfaction, moreover there was an improvement in sexual relationships and body image.

Regarding future studies it would be interesting to apply this treatment to patients with high scores on anxiety or depression.

The present work is the first randomized controlled study in breast cancer patients that uses a cognitive-behavioral therapy to support breast reconstruction decision-making.

An Internet-based treatment to quit smoking vs. a smoking cessation group therapy: A controlled Trial

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Smoking has a huge impact on human health, diseases like chronic obstructive disease (COPD), cardiovascular disease, stroke and lung cancer have a strong relationship with cigarette use. In Spain 108.539 people died in 2009 from smoking-related diseases (Regidor & Gutiérrez-Fisac, 2012). The best way to prevent these diseases is smoking cessation, but it is extremely difficult for many individuals and relapse is common, in fact the *Treating Tobacco Use and Dependence Clinical Practice Guideline* (Fiore, Bailey & Cohen, 2000) describes nicotine dependence as a chronic disease. However, there is a wide spectrum of effective smoking cessation treatments available for smokers who want to quit (Stead & Lancaster, 2012). The treatment of choice for giving up smoking is the combination of cognitive-behavioral therapy with pharmacological treatment (Wise y Correia, 2008). In a recent review Civljak et al. (2013) affirm that Internet-based interventions can assist smoking cessation at six months or longer, particularly those which are interactive and tailored to individuals.

The aim of the present study is to compare the efficacy of an Internet-based cognitive-behavioral treatment to quit smoking (Lenert *et al.*, 2003) with a smoking cessation group therapy both combined with pharmacological treatment as usual.

Method

Participants N= 70

Gender	28 men 42 women	**Level of education**	Primary school 27.5% High school 29% University 43.5%
Age	Range 24-61 Mean 42.87 (9.44)	**Number of cigarettes /day**	Mean 27.18 (9.86)
Attempts to give up smoking	Mean 2.73 (4.83)	**Carbon monoxide test (ppm)**	Mean 17.41 (8.11)
Stages of change	Preparation 38.3% Contemplation 61.7%	**Fagerström**	Mean 4.69 (2.15)

Measures

Carbon monoxide test (Jarvis & Russell, 1980)

Questions related to smoking (Becoña & Vázquez, 1998)

The Fagerström test for nicotine dependence (Heatherton, Kozlwski, Frecker & Fagerström, 1991)

Trait anxiety inventory (STAI-R; Spielberger, Gorsuch & Lushene, 1983)

Beck depression inventory (BDI-13; Beck, Rial & Rickels, 1974)

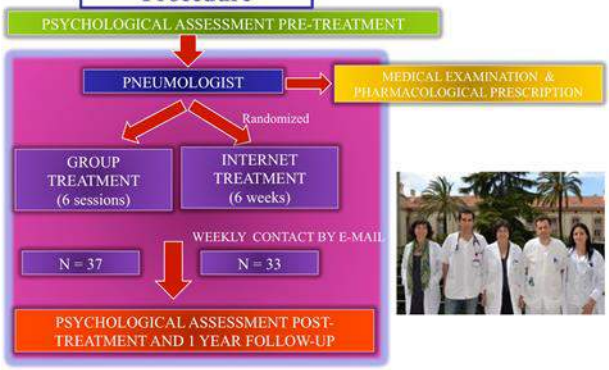
Treatment satisfaction (Borkovec & Nau, 1972)

Treatment

Internet: This is an Internet-based cognitive-behavioral treatment to giving up smoking created by Lenert et al. (2003). It is composed of 8-week web-based course, online tools for self-monitoring of behaviors, computer-tailored e-mail messages and a virtual support group. The web-based course included the following topics: influence of emotions on smoking, mood management, social support to stop smoking, relaxation techniques and learning to live without smoking.

Group therapy (Moreno & Herrero, 2004): This is a cognitive-behavioral treatment to stop smoking with similar contents to the Internet one. It is composed of 6 sessions of 90 minutes each one.

Procedure



Results

There were no significant differences between both experimental groups at pre-test in relevant variables like carbon monoxide test, number of cigarettes, Fagerstöm Test, STAI-R and BDI.

Table 1. ANOVAs pre-post. Means and standard deviations

	Internet treatment				Group treatment					
	Pre-test		Post-test		Pre-test		Post-test			
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	Time effect	Interaction effect
CO test	16.13	7.51	3.44	4.16	16.14	5.71	4.14	7.43	$F(1, 28) = 63.92, p < .001$	$F(1, 28) = .05, p = .83$
Number cigarettes	20.96	11.93	1.96	4.53	20.65	10.18	3.23	10.16	$F(1, 39) = 90.17, p < .001$	$F(1, 39) = .17, p = .68$

Table 2. Abstinence rate at post-treatment and at one- year follow-up

Post-treatment		One year follow-up	
Internet	Group	Internet	Group
%	%	%	%
81.3	83.3	50%	34.5%

Table 2. Participants that start treatment and drop-outs

	Internet		Group	
	N	%	N	%
Start treatment	16	48.5	29	78.4
Do not start treatment	17	51.5	8	21.6
Drop-outs	1	3	13	35.1

Table 2. Pharmacological treatment

	Internet		Group	
	N	%	N	%
No medicines	17	51.5	25	67.6
Nicotine replacement	3	9.1	0	0
Varenicline	13	39.4	12	32.4

Table 3. Means and standard deviations of the acceptability variables

	Internet		Group		
	M	*SD*	*M*	*SD*	
Motivation	9.23	1.25	9.40	1.00	$F(1, 58) = .32, p = .57$
Logic	8.06	1.69	8.21	1.37	$F(1, 28) = .07, p = .79$
Satisfaction	8.50	1.75	8.79	1.31	$F(1, 28) = .25, p = .62$
Confidence	8.38	1.86	8.36	1.28	$F(1, 28) = .00, p = .98$
Recommendation to others	9.06	1.61	9.07	1.07	$F(1, 28) = .00, p = .99$
Aversiveness	.13	.35	.07	.27	$F(1, 28) = .28, p = .60$
Utility	8.13	2.03	8.50	1.79	$F(1, 28) = .27, p = .61$

Conclusions

The present controlled study shows that an Internet-based cognitive-behavioral treatment to quit smoking is as effective as a group cognitive-behavioral therapy at one year follow-up, both used under health professional guidance and combined with pharmacological treatment as usual.

Participants were motivated to start both psychological treatments to giving up smoking, moreover at post-test they were satisfied and they trusted the treatment, they thought that it was logic, useful and they would recommend it to a friend.

Future studies are needed to find methods to increase the number of participants that start the Internet treatment. Besides it is essential to implement works that use medicines as a stable variable.

The Use of Cognitive Behavioral Therapy in the Recovery of Patient After Undergone Encephatlitis - Case Study

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Encephalitis is an acute inflammation of the brain parenchyma, usually caused by a viral infection. Symptoms include headache, fever, confusion, focal neurological signs, disorientation and memory problems. Advanced symptoms include tremors or paralysis, hallucinations, inability to talk coherently, lack of muscle coordination and coma. The indcidence of acute encephalitis in Western countries is 7.4 cases per 100,000 population per year. In tropical countries, the incidence is 6.34 per 100,000 per year.

In this paper I would like to present case study of a patient, aged 30, who underwent Encephatlitis. The patient reported problems with a long-term and short-term memory and lack of concentration and also difficulties with recogniton of family members, important facts of her life and her job duties, what deepened her anxiety and depressive mood. Initially, the psychological intervention focused on the cognitive functions monitoring and then on cognitive rehabilitation. Once the symptoms became milder, cognitive behavioral therapy (CBT) could be applied.

According to the patient´s family and subconsequently her own informations, patient has never experienced any psychological problems before, now she reported sadness, hoplessness, anxiety, worry and crying. Major stressor was the experience of undergone ilness. Those symptoms indicated Adjustment disorder (AD). There were 13 sessions, concentrated on authomatic toughts and beliefs about patient´s ability to rehabilitation, supported with psychoeducation, relaxation, mindfulness techniques. Therapy was modified by adding and cognitive rehabilitation monitoring as well. Patient´s mood was controlled with a Beck Depression Inventory and Mood Questionnaire. After 13th session cognitive tests results indicated reduction of memory problems, depressive moods decreased.

Presented case study confirmed CBT efficacy and proved that this psychotherapeutic approach can be applied in a wider range of the problems - it is beneficial tool for patients with psychological or psychosomatic background, but it is also useful tool for somatopsychic area.

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5. Steady Project Intervention Manual, Clarke i in., 2002

Cognitive Behavioral Therapy for Depression among Adult HIV-Infected Patients - Case Series

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Human Immunodeficiency Virus (HIV) is a retrovirus responsibile for suppresion of CD4 lymphocytes resulting in immunological deficiency linked with multiple opportunistic infections and non-infectious comorbidites such as HIV-associated neurocognitive disorders (HAND) or depression. The prevalence of major depression in HIV-infected populations is reported to be up to 20-40% versus 7% in general population.
Specific stressors may include: stigmatization, disruption in relationships with a partner and family, life-style disruptions, sexual dysfunction and decreased self-esteem.

In this paper we would like to present case series of six adult HIV-infected patients, aged 30-57, both heterosexual and MSM (*men who have sex with men)*, suffering from depression, who have been applied cognitive behavioral therapy (CBT). Their psychotherapy took place between 2011-2014. They differ with number of sessions, time of infection, viral load and clinical status. Psychotherapy was run according to the cognitive-behavioral approach, by R. L. Leahy and S. J. Holland depression treatment plan, modified by adding HIV/Aids education elements and crisis intervention, if necessary.
Patients´ mood was monitored with a Beck Depression Inventory and Mood Questionnaire.

CBT applied in all observed cases showed satisfying efficacy. The beneficial effect of CBT was not only immediate but also sustained at post-treatment evaluation, what is crucial not only for the patients´ psychological quality of life, but also for their somatic condition. Based on cases reported in this paper, we have noticed better response for CBT for depression in the group of MSM. These are preliminary observations from our clinical experience, which need to be confirmed and developed in further studies.

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6. *Steady Project Intervention Manual, Clarke i in., 2002*

Positive Psychology vs. CBT for clinical depression: Results from a 6-month follow-up study

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Introduction

Despite a variety of empirically supported treatments for depression, fewer than half of patients who receive psychotherapy will completely recover from depression (Casacalenda, Perry & Looper, 2002). Therefore, it is important to increase the range of therapeutic techniques offered to depressed patients.

Over the past decade, research in the field of positive psychology has supported the efficacy of happiness-promoting exercises in clinical problems like depression (Sin & Lyubomirsky, 2009; Bolier, et al., 2013). Positive psychotherapy delivered to depressed individuals significantly boosts well-being, decreases depression and it can be especially effective for treating residual symptoms and preventing future relapse (Seligman et al., 2006).

However, the efficacy of these interventions has not been systematically compared to available empirically-based treatment for depression, such as cognitive behavior therapy (CBT).

Objective

The aim of this study is to compare the efficacy of a positive psychology program with a CBT for depression at the end of the treatment and 6 months afterwards (follow-up).

Methods

Participants: Adult women (N=73) with a DSM-IV-TR diagnosis of major depression or dysthymia recruited from a Women's Community Centre in Madrid (Mean age 50.6 years). At follow-up, 34 women have been assessed so far.

Treatments: Participants were assigned to one of two manualized protocols; (1) a PPI program, including well-validated hedonic and eudaimonic interventions, or (2) a standard CBT program (Muñoz et al., 1995). Both treatments had a 10-session group format.

Measures:

- *Structured Clinical Interview for the DSM-IV Axis I Disorders* (First, Spitzer, Gibbon, y Williams, 1996).
- *Beck Depression Inventory-II* (BDI-II; Beck, Steer, & Brown, 1996): 21 items measuring severity of depression.
- *Pemberton Happiness Index* (PHI; Hervas & Vazquez, 2013): An 11-item index combining hedonic, eudaimonic, and social well-being.

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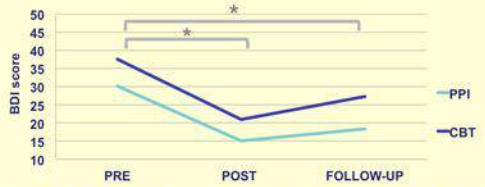
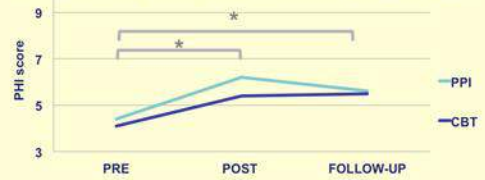
Results

PPI is as effective as CBT

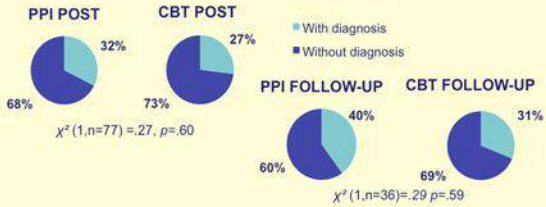


Time: F (2,31) = 37.62 p <.001, partial η^2 =.71, Time x Group: F (2,31) = .26 p= .77



Time: F (2,31) = 16.26 p <.001, partial η^2 =.51, Time x Group: F (2,31) = .60 p = .55

Improvements are clinically significant

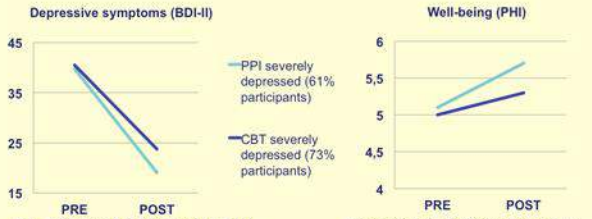


χ^2 (1,n=77) =.27, p=.60

χ^2 (1,n=36)=.29 p=.59

Percentage of participants with clinical SCID-I-based diagnosis of depression or dysthymia at the end of the treatment and at 6 month follow-up

PPI is also effective for severe depression



Time x Severity F (1,69) = 14.47 p <.001, partial η^2 =.17,Time x Severity x Group F (1,69)= 1.24, p= .27

Time x Severity F (1,67) = 7.44 p <.001, partial η^2 =.10, Time x Severity x Group F (1,67) =.14, p=.71

Conclusions

Improvements in both groups were comparable, lasting their effects for at least 6 months. PPI was as effective as an established CBT for people with severe depression. PPI can be a promising therapeutic option for the treatment of clinical depression. These findings contribute to increase the range of therapeutic techniques offered to patients. Future research should delineate how to combine the most effective components of both treatments.

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Maastricht University G G Z W N B

Treatment outcome of an anger management group therapy for spousal assaulters

C.M.B. Serie[a], C.A. van Tilburg[a,b], A. van Dam[b,c] and C. de Ruiter[a]

Introduction

At a regional institution for mental health care in The Netherlands (GGZ WNB), a 12-week IPV and anger management group treatment was developed ("Not loosing it anymore"; Van Dam, Van Tilburg, Steenkist, & Buisman, 2009). The treatment program can be defined as cognitive-behavioural. Perpetrators are confronted with the consequences of their aggression, and are taught alternative coping, responses and behaviours. Components such as (social) skills training and anger management are combined. The combination of these components is found to be effective in the treatment for generally violent men (De Ruiter & Veen, 2006; Warnaar & Wegelin, 2003).

This study examined the effectiveness of the above-mentioned anger management group therapy for spousal assaulters in the Netherlands. A decrease in self-reported aggression and hostility was expected. Furthermore, since emotional dysregulation and dysfunctional coping has proven to be a strong predictor of IPV (Tull, Jakupcak, Paulson, & Gratz, 2007) and greater use of active coping and less use of passive coping are related to lower levels of experience and expression of anger (Mao, Bardwell, Major, & Dimsdale, 2003), we expected a decrease in passive coping styles and an increase in active coping styles. Consequently, a decrease in overall psychopathology was expected.

Method

The sample consisted of 62 men with anger-control problems referred to GGZ WNB in The Netherlands, who completed at least one treatment round, which consisted of at least nine sessions. Before and after a treatment round patients were asked to fill out several self-report measures:

- The **Symptom Checklist 90** (SCL-90; Arrindell & Ettema, 2005), a multidimensional screening checklist for psychological and physical symptoms.
- The Dutch version of the **Buss-Durkee Hostility Inventory** (BDHI-D; Lange et al., 1995), self-report measure for direct and indirect aggression.
- The **Utrechtse Coping lijst** (UCL; Schreurs, van de Willige, Brosschot, Tellegen, & Graus, 1993), a Dutch self-report questionnaire that measures different coping styles.

Pre- and postmeasures were compared using GLM repeated measures ANOVA's in SPSS

Results

	Pre Treatment Score Mean (*SD*)	Post Treatment Score Mean (*SD*)	*F*	*p*
Psychopathology	204.91 (57.62)	192.96 (64.25)	2.98	0.09
Aggression				
Hostility	*16.26 (5.72)*	*13.41 (4.71)*	*16.26*	*<.001*
Direct Aggression	13.12 (2.07)	12.69 (2.15)	1.93	0.17
Indirect Aggression	12.62 (4.24)	11.62 (4.98)	3.69	0.06
Coping styles				
Active	16.20 (4.28)	16.73 (3.82)	1.27	0.28
Social support	11.18 (3.22)	11.42 (3.55)	0.40	0.53
Expression of emotions	*8.24 (2.05)*	*7.78 (1.67)*	*4.10*	*0.05*
Passive	16.59 (4.46)	15.72 (4.26)	2.86	0.10
Palliative	17.61 (4.05)	18.11 (3.98)	1.37	0.25
Avoidant	16.93 (3.57)	16.7 (3.63)	0.26	0.60

Discussion

A trend that indicates a decrease in overall psychopathology, decreased hostility, a clinically relevant decrease in indirect aggression, and a trend in which the use of a passive coping style decreased suggests a positive effect of the anger management treatment.

Furthermore, expression of emotions decreased significantly, but still remained high when compared to the general population. These results are in line with literature that suggests effective emotion regulation requires emotional experiences to be accepted and actively and adequately processed (Roberton, Daffern, & Bucks, 2012). Consequently, an active coping strategy is able to reduce angry emotions and cognitions and may help to prevent anger being expressed as aggressive behaviour (Mao et al., 2003).

Nevertheless, these results should be interpreted with caution since drop out rate was high (59.7%), data were collected from a small (*N*=63) sample without a control group, and only self-report questionnaires were used. Future research including a larger sample, more objective outcome measures and a control group is recommended.

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Under Construction

A CBT Protocol for the Treatment of Anxious Depression

A Case Report

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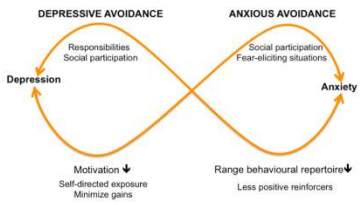
INTRODUCTION

- **MORE THAN HALF** OF THE DEPRESSED PATIENTS SUFFER FROM CONCURRENT ANXIETY (DISORDER) AND VICE VERSA[1]
- ANXIETY IN DEPRESSION IS CHALLENGING AS IT RESULTS IN **HIGHER SEVERITY**, POORER RESPONSE TO TREATMENT, MORE RESIDUAL SYMPTOM AND MORE SUICIDALITY.[2-4]
- **GUIDELINES** OFFER LITTLE TO NO INFORMATION ON TREATMENT
- FROM A CBT PERSPECTIVE INTERACTION OF DEPRESSIVE AND ANXIETY SYMPTOMS CAN BE SEEN AS **'GORDIAN KNOT'** WHERE:
- **DEPRESSIVE AVOIDANCE BEHAVIOUR** DEPRIVES THE PATIENT OF POSITIVE REINFORCERS, LOWERS MOTIVATION FOR SELF-DIRECTED EXPOSURE AND WHERE **ANXIOUS AVOIDANCE BEHAVIOUR** LEAVES INCORRECT ASSUMPTIONS INTACT AND NARROWS THE BEHAVIOURAL REPERTOIRE EVEN MORE.

Gordian Knot



CASE CONCEPTUALISATION

JANE IS AN INSECURE 35-YEAR OLD MOTHER, WHO AFTER DEVELOPING A POSTPARTUM DEPRESSION WAS SEVERELY HINDERED IN THE CARE OF HER NEWBORN AND LATER HER PROFESSIONAL CAREER BY BOTH ANXIOUS AS DEPRESSIVE AVOIDANCE BEHAVIOUR.

PRESENTING PROBLEMS: DEPRESSED MOOD, FEAR OF BEING ALONE OR UNDERTAKE ACTIVITIES WITH HER SON (5), PASSIVITY (AT HOME AND AFRAID TO RESTART WORK), SOCIAL ISOLATION, PARENTING PROBLEMS, FEAR OF HAVING A DISEASE.

PREDISPOSING FACTORS: MOTHER DIED OF BREAST CANCER WHEN SHE WAS 17 AND BEING THE ELDEST SHE TOOK OVER THE CARE FOR HER SIBLINGS BUT CONSTANTLY BEING CRITICIZED BY GRANDMOTHER. *'I'M A FAILURE'*

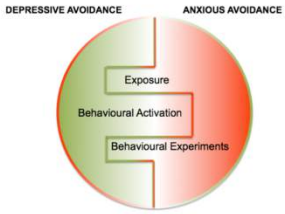
PRECIPITATING FACTORS: UNJUSTIFIED INVOLVEMENT OF CHILD CARE AND PROTECTION BOARD AFTER BIRTH OF HER SON. *'I'M A FAILURE AS A MOTHER'*

PERPETUATING FACTORS: AVOIDANCE AND SAFETY BEHAVIORS THAT GO WITH THE ANXIETY AND DEPRESSED MOOD (E.G. STAYING AT HOME, CONTINUOUSLY ARRANGING COMPANY); SLEEP DISTURBANCES; BAD HEALTH.

PROTECTIVE FACTORS: SUPPORTIVE PARTNER, FAMILY AND NEIGHBOR

TREATMENT PROTOCOL - 32 weekly sessions

- **CASE CONCEPTUALISATION:** MAIN TREATMENT TARGET: DEPRESSIVE AND ANXIOUS AVOIDANCE BEHAVIOUR
- **MOTIVATIONAL PHASE:** PSYCHOEDUCATION ON THE 'GORDIAN KNOT' AND *VALUING* (ACT) AS MOTIVATIONAL TECHNIQUE
- **TREATMENT PHASE:** BEHAVIOURAL ACTIVATION IN SERVICE OF EXPOSURE AND BEHAVIOURAL EXPERIMENTS: WEEKLY PREDEFINED VALUED GOALS.



OUTCOME

- **AVOIDANCE BEHAVIOUR:** MORE ACTIVE ENGAGEMENT WITH HER SON AND SOCIALLY, SHE RESTARTS WORK AND SPORTS.
- **SYMPTOMS:** DEPRESSIVE SYMTOMS:
  - IDS-SR: 38 (MODERATE) ➔ 15 (MILD)
  - SCL-90 DEP: 48 ➔ 32 (RCI: 4.77)

ANXIETY:

  - SCL-90 ANX: 36 ➔ 17 (RCI: 6.74)

DISCUSSION

- SHOULD THE DEPRESSION HAVE BEEN THE PRIMARY TARGET INSTEAD OF COMBINING?
- SHOULD THE TREATMENT OF COMORBID DEPRESSION AND ANXIETY ALWAYS BE A COMBINED TREATMENT: CBT AND MEDICATION?
- IS IT NECESSARY IN THIS TREATMENT PROGRAM TO DIFFERENTIATE BETWEEN ANXIETY DISORDERS, E.G. OCD, PTSD AND OTHER ANXIETY DISORDERS?

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The Effectiveness of Inquiry-based Stress Reduction (IBSR) on Irrationality, Dysfunctional Attitudes and Maladaptive Schemas

-The Work of Byron Katie in Learning Therapy-

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Introduction

In 1986 Ms. Byron Katie developed a technique 'The Work', a meditative process with self-inquiry on cognitions connected to stressful circumstances. As a tool in therapy it is called Inquiry-based Stress Reduction (IBSR). IBSR incorporates elements from CBT and Mindfulness approaches. The focus is not on changing the beliefs, but on becoming aware that they are incorrect and counteracting on emotions and behaviours. From this awareness the result can be a spontaneous letting go of the beliefs, resulting in a positive change in emotion and behaviour. In IBSR the inner wisdom 'Wise Mind' is addressed rather than the rationality and objectivity as in classical CBT.

1. Is it true?
2. Can you absolutely know that it is true?
3. How do you react and what happens when you believe that thought?
4. Who would you be without the thought?

Turn the thought around
Example of turnarounds for *(Name) doesn't appreciate me:*
- I don't appreciate me
- I don't appreciate (Name)
- (Name) does appreciate me

IBSR is deceptively simple: 4 questions and turnarounds.

Method

The purpose of this study was to examine the effectiveness of Inquiry-based Stress Reduction (IBSR) on irrationality, dysfunctional attitudes and maladaptive schema's in learning therapy. Measurements were taken immediately pre- and post intervention and from two subgroups also after one year.

Intervention

- between 2006 and 2008
- 50 sessions learning therapy according to a manual
- 8 groups with 8 participants each
- IBSR was used to identify and investigate stressful cognitions about personal and work-related matters

Participants (n=64)

- CBT trainees, who choose this method of learning therapy
- age range from 26 to 58, mean age 38.16 years (SD 8.57)
- 59 women (92.2%) and 5 men (7.8%)
- 50 living together (78.1%) and 14 single (21.9%)

Measurements

- Dysfunctional Attitude Scale form A (DAS-A; Douma 1991): a self-report scale to measure the presence and intensity of dysfunctional attitudes as defined by Beck's CBT;
- Belief Scale (BS; Boelen & Fornier, 2001): a 20-item self-report scale of irrationality, as conceptualized in rational-emotive behaviour therapy;
- Young Schema Questionnaire (YSV; Young & Pijnaker, 1999): a self-report scale to assess the amount and intensity of maladaptive schemas, as defined in Schema therapy.

Results

The mean scores for the DAS-A, BS and YSQ differed significantly between the pre- and post intervention measurements (see Figure 1). Effect sizes indicate ***medium to large effects*** (ranging from .80 to 1.78). This means that the intensity and amount of irrational beliefs, dysfunctional attitudes and maladaptive schema's largely decreased. Follow-up measurements among a subgroup indicated a lasting effect (Figure 2).

Figure 1 - Repeated measures DAS-A, BS and Npar test YSQ (n=64)

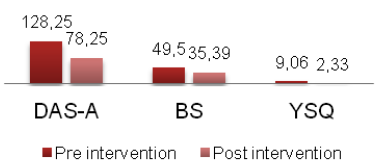
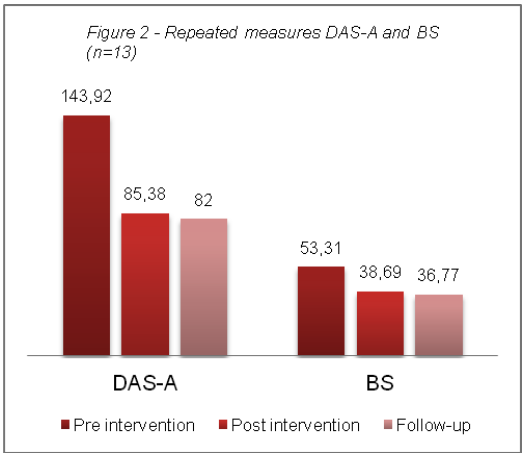


Figure 2 - Repeated measures DAS-A and BS (n=13)



Conclusion

Findings show that IBSR in learning therapy seems successful in reducing irrationality, dysfunctional attitudes and maladaptive schema's, even on the long term.

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Broadening our scope beyond the Individual: Training in Cognitive Behavioural Couples Therapy

Dr Michael Worrell, Prof. Sarah Corrie, Effie Molyva

Central & North West London Foundation NHS Trust
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BCT AND IAPT: BACKGROUND

BCT is an evidence-based psychological treatment that has acquired a significant amount of empirical support for the benefits it provides, both in terms of reducing couple distress *and* improving specific psychological disorders, such as depression. NICE guidelines for *The treatment and management of depression in adults*: An effective treatment for individuals suffering from depression, namely "*for people who have a regular partner and where the relationship may contribute to the development or maintenance of depression, or where involving the partner is considered to be of potential therapeutic benefit.*"

OVERVIEW OF THE TRAINING

A 5-day intensive post-qualification training in BCT for IAPT High Intensity Therapists, incorporating a model of sustained practice and on-going supervision for 12 months. The programme trained 3 selected cohorts of High Intensity Therapists. From each intake, 6 highly experienced therapists and supervisors enlisted to provide a monthly supervision group to the other trainees. These 6 experienced supervisors received monthly, online Skype supervision from Professor Baucom, in order to enhance their BCT therapeutic and supervisory skills, and hence cascade this knowledge to the remainder of the cohort. The 6 'Supervisors' also met monthly for small group Peer Support Supervision facilitated by Michael Worrell and Sarah Corrie. Currently our Supervision programme is on-going.

TRAINING METHODS

Didactic presentations with hand-outs
Videotapes of specific demonstrations of key BCT skills and interventions
Live role plays by the programme leaders of different therapeutic situations
Role play practice in small groups by the participants as therapists, with direct feedback from the programme team
Assigned readings

INITIAL POST-TRAINING EVALUATIONS

Multiple choice questionnaire – 12 items
Content of items related to: Therapist style; goals of therapy; timing of different interventions (and rationale for this); indicators for selecting different interventions and therapist understanding of core concepts relevant to BCT

Pass mark: 75%

All participants passed!

WHAT WAS COVERED?

Day 1:
Training overview
A model of couple functioning
Behavioural factors in couple distress and BCT

Day 2:
Intervening with emotion
'Sharing thoughts and feelings'
Strategies to regulate emotional experiencing and expression
Cognitive interventions: attributions

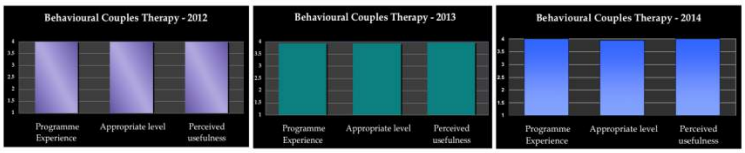
Day 3:
Cognitive interventions: relationship standards
Interventions for relationship standards
'The individual, the couple and the environment'
Individual factors
Couple interaction processes
Environmental factors

Assessment for BCT
Process and history
The use of individual sessions
Conceptualisation
Feedback sessions

Day 4:
Developing couple-based interventions
Research on couples and depression
Targets for intervention
Psychoeducation
Emotional expression training
Addressing negative cognitions
Suicidal ideation

Day 5:
Increasing positives and behavioural activation
Addressing the physical relationship
Social support
Focusing on the individual: partner assisted interventions
Bringing treatment to a close
Sequencing interventions

END OF TRAINING FEEDBACK



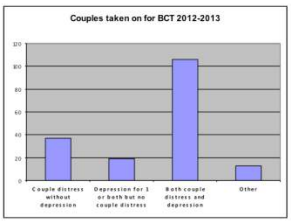
POST-TRAINING CLINICAL ACTIVITY

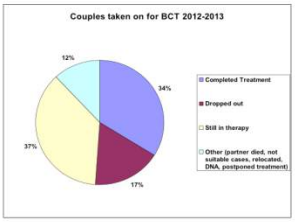
Supervision groups established and ran well
Post Training Audit - 12 months of BCT practice and experience in bringing the intervention into IAPT Context

All 52 trainees of the 2012 and 2013 cohorts were contacted and returns were received from 43 of these

Approximately half the participants (16) have up to a session per week (3-3.5 hours) for BCT with the remainder indicating providing 2 or more sessions, or was kept flexible according to need or simply not defined

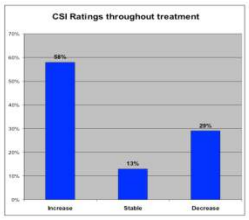
Couples seen for assessment = 215
Couples taken into treatment = 177
Total N of sessions offered = 1651
Average N of sessions = 9.54
N of completed Treatments = 60
Early Terminations = 29





TREATMENT OUTCOME DATA 2012-2013 INTAKES

Couple Satisfaction Index (CSI) administered at each session, as a standardized assessment of couple satisfaction. Significant increase in couples' CSI ratings upon completion of a course of BCT
(n=144, t=5.73, P<0.01, g=0.44)



THERAPISTS' EXPERIENCES TRANSITIONING FROM INDIVIDUAL TO COUPLE THERAPY

Further to the data collected through the training audits, 6 psychological therapists who received CBCT training and monthly Skype supervision were invited to participate in 2 focus groups aiming to provide a richer exploration of the rewarding as well as challenging aspects of incorporating CBCT in their practice. Thematic analysis was employed on the focus group transcripts and the key themes were identified.

FOCUS GROUP SUPERORDINATE THEMES

Theme no.1	The intensity of having two people in the room
Theme no.2	Managing multiple therapeutic relationships
Theme no.3	BCT Assessment is like 'putting a puzzle together'
Theme no.4	Moving from disorder-specific models toward a principle-based approach
Theme no.5	Therapy pacing differs across models and the lifespan
Theme no.6	Being more directive in couple therapy

Theme 1: The intensity of having two people in the room
'I wouldn't say it felt like a shock to me but I suppose it's a change..There's something about the intensity of having two people in the room… it's been a developmental learning curve… I don't think I've cracked it by any means but I'm more prepared to give it a go.'

Theme 2: Managing multiple therapeutic relationships
'I'm split in terms of who I empathise with, I mean you need to do both, but then I keep thinking what's been triggered, I mean what I'm aware of in the sessions is that I'm getting angry on behalf of one of the clients.'

Theme 3: BCT Assessment is like 'putting a puzzle together
'It does feel like putting a puzzle together and being able to listen to both perspectives of the situation and feels like a bit of a luxury to go into that detail.'

Theme 4: Moving from disorder-specific models toward a principle-based approach
'Because you have five patients in a day and not much time in-between, plus crises and on top of that you have to see couples as well..you have to change your mindset completely because its not the same protocolised structured approach as you have with the IAPT and I felt like I was starting from scratch again.'

Theme 5: Therapy Pacing differs across models and the lifespan
'I was struck by how dynamic and how constantly changing things are with the younger couples...although in terms of the pacing of therapy is slower what happens in the session feels like fast-forward'

Theme 6: Being more directive in therapy
'As time has gone on I have realised that I have just had to it's going to cause more distress for them. With the new couple I was intervening more quickly and assertively… that skill has developed in me is something that you would not do in one to one'

CONCLUSIONS

The high ratings of trainee satisfaction immediately at the end of training has been followed by very good ratings from trainees, 12 months post training, of how well prepared they feel they are to be offering BCT in their services.
Trainees frequently reported that services have experienced challenges in designing appropriate screening and referral strategies as well as how to accommodate BCT into the current IT systems. Services have been able to respond creatively to these challenges.
BCT is experienced by trainees as qualitatively different from individual CBT and involves the acquisition and development of a new set of clinical skills for working with couples.
From the results obtained it appears that trainees experience the training to have successfully equipped them with these skills.

Depression

Comparison of Personality Related Core Beliefs in Acute and Chronic Depression

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Objectives:

There may be differences in the personality related core beliefs of acutely and chronically depressed patients. This study was undertaken to find out any differences in personality related core beliefs between two groups of patients with different duration of depressive episodes.

Methods:

Patients diagnosed with MDD according to the DSM-IV-TR criteria who were either in an acute episode (n=150), or who were chronically depressed (n=125), and healthy controls (n=125) were recruited. Participants were administered the BDI and the PBQ. SPSS was used to perform the statistical analyses.

Results:

The chronically depressed patients scored the highest on the core beliefs of avoidant, dependent, passive-aggressive, obsessive-compulsive, antisocial, paranoid and borderline personality, and the healthy controls scored the lowest. The depressed groups did not differ in their scores related to the core beliefs of histrionic and schizoid personality, but they scored higher than the healthy controls. The chronically depressed patients scored the highest on the core beliefs of cluster B and C personality, and the healthy controls scored the lowest. The patients did not score differently on the core beliefs related to cluster A personality, but scored higher than the healthy controls. On the total score of core beliefs related to personality, chronically depressed patients scored the highest, and the lowest scores were obtained by the healthy controls.

Descriptive Statistics	ACUTE DEPRESSION (n=150)	CHRONIC DEPRESSION (n=125)	HEALTHY CONTROL (n=125)	p	Statistics	Post-hoc Analysis
Age (Mt±SD, years)	32.29±10.92	47.30±9.71	40.12±12.57	<0.001	F=62.498	C>H>A
Gender (F, %)	120 (%80)	83 (%66.4)	80 (%64)	0.006	X^2=10.097	A>C=H
Marital Status (Married, %)	82 (%54.6)	58 (%46.4)	79 (%63.2)	0.017	X^2=8.132	H>A>C
Level of Education (>8 years, %)	88 (%58.7)	34 (%27.2)	68 (%54.4)	<0.001	X^2=30.543	A=H>C
Occupation (Regular, %)	39 (%26)	12 (%9.6)	63 (%50.4)	<0.001	X^2=51.792	H>A>C

Clinical Data of the Depressed Groups	ACUTE DEPRESSION (n=150)	CHRONIC DEPRESSION (n=125)	p	Statistics
Duration of Illness (Mt±SD, wk/mo)	3.85±2.83	21.22±8.88	<0.001	t=-22.604
# of Episodes (Mt±SD)	1.60±0.81	2.43±1.20	<0.001	t=-6.824
# of Hospitalization (Ort±SS)	0.05±0.29	0.78±1.08	<0.001	t=-7.305
BDI (Mt±SD)	34.89±9.99	37.19±10.00	0.289	t=-0.137

Comparison of Groups According to Specific PD	ACUTE DEPRESSION (n=150)	CHRONIC DEPRESSION (n=125)	HEALTHY CONTROL (n=125)	p	Statistics	Post-hoc Analysis (Scheffe)
Schizoid PD	15.33±4.11	15.98±4.79	11.71±5.85	<0.001	F=27.775	C=A>H
Paranoid PD	14.16±5.57	15.90±5.40	8.03±5.41	<0.001	F=72.356	C>A>H
Antisocial PD	13.68±3.70	15.14±4.41	8.50±5.34	<0.001	F=76.442	C>A>H
Narcisistic PD	10.95±3.13	14.25±2.86	6.55±4.53	<0.001	F=147.783	C>A>H
Histrionic PD	9.49±4.48	10.82±3.82	5.46±5.20	<0.001	F=48.078	C=A>H
Borderline PD	13.55±5.13	15.42±4.87	6.47±4.77	<0.001	F=115.607	C>A>H
Avoidant PD	16.67±3.27	19.95±3.37	12.58±4.96	<0.001	F=111.823	C>A>H
Dependent PD	14.08±4.69	16.45±3.69	7.01±4.06	<0.001	F=172.129	C>A>H
Obsessive-Compulsive PD	14.63±4.81	18.69±3.25	11.62±5.25	<0.001	F=76.397	C>A>H
Passive-Aggressive PD	14.34±4.60	20.53±3.73	11.06±4.97	<0.001	F=145.138	C>A>H

Comparison of Groups According to Clusters	ACUTE DEPRESSION (n=150)	CHRONIC DEPRESSION (n=125)	HEALTHY CONTROL (n=125)	p	Statistics	Post-hoc Analysis (Scheffe)
Cluster A PD	29.49±8.43	31.89±8.29	19.74±9.67	<0.001	F=67.748	C=A>H
Cluster B PD	47.67±13.15	55.62±11.02	26.98±15.85	<0.001	F=151.885	C>A>H
Cluster C PD	59.72±14.18	55.62±11.02	26.98±15.85	<0.001	F=189.760	C>A>H
Any PD	123.33±28.30	147.71±21.78	82.52±35.05	<0.001	F=163.328	C>A>H

Conclusions:

These results suggest that for patients whose depressive symptoms turn out to become chronic, it is essential to deal with core beliefs related to personality. Specifically, it is demonstrated that core beliefs related to cluster B and C personality are important in the chronicity of depression. Therefore, for patients who are receiving cognitive behavioural psychotherapy, it may be more important to manage deeper personality related core beliefs rather than simply working on only the more superficial depressive cognitions.

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Reversal learning of negative self-thinking in depressive individuals

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[2]*KU Leuven, Center for the Psychology of Learning and Experimental Psychopathology, Belgium.*

[3]*The University of Tokyo, Graduate School of Arts and Sciences, Japan.*

Introduction

- Depressive individuals experience negative self-verification.
  - That is, they willingly gather information consistent with their negative self-concept (Giesler et al., 1996).
- Moreover, depressive individuals regard negative self-thinking as useful, and these positive beliefs about negative repetitive thoughts have been considered to promote ruminative thinking in such individuals (Papageorgiou et al., 2001).
- Thus, it is suggested that this preference for negative information is one of the fundamental issues underlying depressive symptoms.
  - Modifying these preferences could lead to symptom reduction.
- Against this background, we examined whether depressive individuals can break away from the positive beliefs associated with negative self-thinking and rewards, using a probabilistic reversal learning task.

  - If preference for positive topics is reinforced, negative self-thinking would be reduced relatively.

Probabilistic reversal learning task

① The association between "negative" topics and reward is learned.

  - This manipulation could experimentally simulate the preference for negative information.

② Conversely the association between "positive" topics and reward is learned.

  - The preference for positive information would be produced.
  - ✓ Can depressive individuals choose positive topics in reversal phase?
  - ✓ How long does the learning the association between positive topics and reward take for them?

Method

Participants

A total of 38 undergraduates (23 females; mean age: 19. 6 years; SD = 2.8; range: 18–36 years) agreed to participate in our experiment.

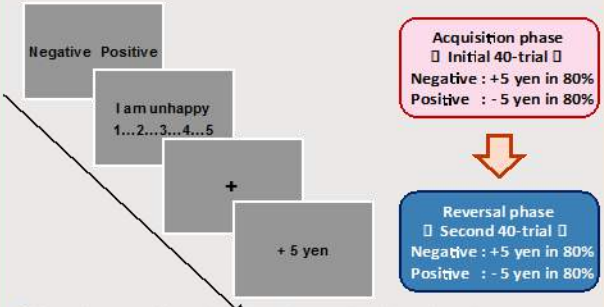
Measures

- *Center for Epidemiological Studies for Depression Scale (CES-D; Radloff, 1977).*

The CES-D is a 20-item inventory designed to assess depressive symptoms that occurred over the preceding week. Each item is rated on a 4-point frequency scale ranging from 0 (less than 1 day) to 3 (5–7 days).

Procedure

1. Participants were first required to choose one of two words: "Positive" or "Negative".
2. The affective phrase consistent with their choice was displayed, and they were required to rate these phrases on how much they resonated with themselves.
3. Reward (+ 5 yen or −5 yen) was displayed.



- Completion of learning was determined by choosing rewarded word for 5 consecutive trials.

Results and Discussion

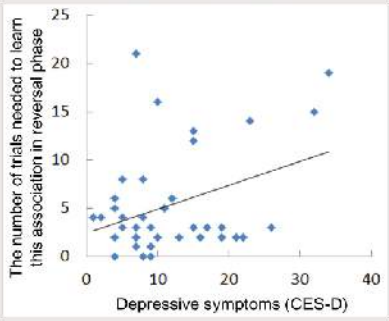


Figure. The association between the number of trials required for learning in reversal phase and depressive symptoms

- ✓ Even in individuals with a high level of depressive symptoms, the association between selecting "Positive" and reward was acquired within 25 trials in the reversal phase.
- ✓ However, there was a significant correlation between the number of trials needed to learn this association and depressive symptoms ($r = .36$, $p < .05$).
  - Thus, it is suggested that depressive individuals can break out of the preference for negative information, but this process takes longer for them than for non-depressive individuals.
- These resistance to updating the association between negative self-thinking and reward would affect the basis of depression.
  - Improving this resistance might be applicable to treatment for depression.

Baseline Severity: A Moderator of Antidepressant and Placebo Outcomes in Late-Life Depression. A Meta-Analysis.

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Introduction. Baseline severity is a crucial moderator of trial outcomes in adult depression. Mixed-age studies have showed that the mean differences between groups treated with antidepressant medication and placebo become larger as baseline severity increases. Kirsch et al. (2008) [1] argued that the increased benefit of drug treatment for severely depressed patients is related to a decrease in responsiveness to placebos. However, two meta-analyses have shown that initial severity predicted symptom improvement in adult patients who took antidepressant medication [2,3]. Yet, baseline severity has not been examined as a moderator of antidepressant and placebo outcomes in late-life depression.

Methods.
Outcome. Mean change in depressive symptoms (HDRS scores)

Inclusion. Peer-reviewed publications
- Randomized, double-blind, placebo-controlled design
- Mean or median age of 55 years or greater
- MDD, minor depressive disorder, dysthymia

Exclusion. Cerebrovascular disease, cognitive impairment, Parkinson's disease, cancer
- Case reports, comments, letters, and reviews

Data Analysis. Differences in means (Hedges's *g*), random-effects models
- Meta-regression

Results.
Overall Effect Size for Antidepressant and Placebo Treatment. 23 studies provided relevant data for the meta-analysis. **Patients in the treatment groups showed a significantly higher mean change in HDRS score than patients in the placebo groups** (Hedges's $g = 0.36$, 95%CI: 0.25 - 0.47, $p \leq .001$). **Studies exhibited moderate, yet significant between-studies heterogeneity** ($I^2 = 64.24$, $tau^2 = .03$, $p \leq .001$).

Baseline Severity and Mean Change in Depressive Symptoms. Significant increase in antidepressant trials ($Z = 2.67$, $p = .008$, $R^2 = .40$)
- Significant increase in placebo trials ($Z = 4.46$, $p \leq .000$, $R^2 = .50$)
- No significant severity x group interaction ($F(1, 27) = 0.02$, $p = .897$)

Discussion. With increasing baseline scores, change in depression symptoms increased in both interventions (see Figure 1). Our results indicate that placebo effects are important in the treatment of elderly people with different severity grades of depression.
Limitations. Limited to published data
- Only one study of severely depressed patients
- Possible regression to the mean effect
- Stable physical illness and comorbid disorders were common

Implications. We propose to combine a basic antidepressant therapy in clinical practice with a high level of psychosocial support and therapeutic contact in order to enhance placebo effects and keep adverse drug reactions at a minimal level.

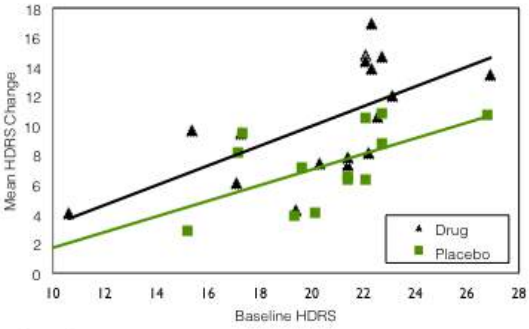

Figure 1. Relationship between baseline severity and mean change in HDRS score among the antidepressant and placebo groups.

References. [1]Kirsch et al., 2008. Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. *PLOS Medicine, 5*(2), e45. [2]Fournier et al., 2010. Antidepressant drug effects and depression severity: A patient-level meta-analysis. *JAMA, 303*(1), 47-53. [3]Khan et al., 2002. Severity of depression and response to antidepressants and placebo: An analysis of the Food and Drug Administration database. *Journal of Clinical Psychopharmacology, 22*(1), 40-45.

Relationships between rumination and actual vs. ideal implicit self-esteem discrepancy in dysphoria

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EABCT CONGRESS 2014

Introduction

- Rumination is a repetitive negative style of thinking about one's problems or negative experiences that is difficult to disengage from (Nolen-Hoeksema, 1991). Although past research has shown the consequences of acquiring a ruminative style (e.g. poor problem solving, maintenance of negative affect), there is less clarity on the mechanisms underlying rumination (Koster, et al. 2011).
- According with self-regulation theories of depression (e.g. Carver & Scheier, 1998) rumination is initiated by perceived discrepancies between one's current state and a desired state. Moreover, cognitive vulnerability models (e.g. Beevers, 2005) postulates that rumination would involve a maladaptive reflective processing triggered by negatively biased associative processing.
- In the present study we aimed to evaluate actual and ideal implicit self-esteem in dysphoric individuals, and to evaluate the associations between rumination and actual vs. ideal implicit self-esteem discrepancy.

Method

- **Participants:**

The sample was composed by 44 undergraduate students:

- Low BDI group (BDI ≤ 13) → n= 24 (54.2% female). Mean age: 20.08 (SD= 4.49).
- High BDI group (BDI ≥ 14) → n= 20 (80% female). Mean age: 18.85 (SD= 2.94).

- **Measures:**

- **Depressive symptoms.** Beck Depression Inventory-II (BDI-II; Beck, Steer, Ball, & Ranieri, 1996).

- **Ruminative style**. Ruminative Response Scale (RRS; Nolen-Hoeksema & Morrow, 1991).

- **Actual and ideal Implicit self-esteem.** We used two self-esteem variants of the Go/No-go Association Task (GNAT) (Nosek & Banaji, 2001) to evaluate automatic associations between actual and ideal self and positive and negative attributes: The actual self GNAT with the stimuli "I am", "I am not" (see table below) and the ideal self GNAT with the stimuli "I want to be", "I don't want to be".

	PRESS KEY		NOT PRESS KEY
Block 1. Positive-I am (20 practice trials) (40 critical trials)	I AM OR POSITIVE	SAMPLE ITEM	NEGATIVE
		Worthless	❍
	❍	I am	
	❍	intelligent	
Block 2. Negative-I am (20 practice trials) (40 critical trials)	I AM OR NEGATIVE	SAMPLE ITEM	POSITIVE
	❍	Stupid	
	❍	I am	
		Confident	❍
Block 3. Positive- I am not (20 practice trials) (40 critical trials)	I AM NOT OR POSITIVE	SAMPLE ITEM	NEGATIVE
		Inferior	❍
	❍	I am not	
	❍	nice	
Block 4. Negative- I am not (20 practice trials) (40 critical trials)	I AM NOT OR NEGATIVE	SAMPLE ITEM	POSITIVE
	❍	Useless	
	❍	I am not	
		successful	❍

Two indices were calculated for each actual and ideal self-esteem (SE) task:

- **Consistent actual SE**: Sum Reaction time (RT) "I am-Positive" block and RT "I am not-Negative" block divided by 2.
- **Inconsistent actual SE**: Sum RT "I am-Negative" block and RT "I am not-Positive" block divided by 2.
- **Consistent ideal SE**: Sum Reaction time (RT) "I want to be-Positive" block and RT "I don't want to be negative" block divided by 2.
- **Inconsistent ideal SE**: Sum RT "I want to be-Negative" block and RT "I don't want to be-Positive" block divided by 2.

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Results

Group differences in actual and ideal implicit self-esteem (SE).

A 2 (Group: high BDI group, low BDI group) x 2 (Task: actual, ideal) x 2 (Condition: consistent, inconsistent) mixed design ANOVA revealed a significant three way interaction, $F(1,42)= 4.10$, $p< .05$, $\eta^2 = .09$. Two separate 2 (Group) x 2 (Task) ANOVAs were conducted.

- For the consistent condition, analyses revealed a significant Group x Condition interaction, $F(1,42)= 4.30$, $p< .05$, $\eta^2 = .10$. Low BDI group did not differ in their reaction times for actual and ideal consistent SE. However, high BDI group showed longer reaction times associating ideal than actual consistent SE, $p< .01$, indicating a higher actual than ideal implicit SE.
- For the inconsistent condition, analyses revealed a non significant Group x Condition interaction, $F(1,42)= .11$, $p= .74$. (See table 1)

Table1. Mean and standard deviation in actual and ideal implicit SE for each group

	High BDI group (n = 20)		Low BDI group (n = 24)	
	M	*SD*	*M*	*SD*
Actual Consistent SE	499.88	53.46	487.26	54.02
Actual Inconsistent SE	513.24	63.91	497.50	52.44
Ideal Consistent SE	526.64	68.12	489.55	56.12
Ideal Inconsistent SE	532.32	68.15	512.22	62.48

Correlations

- Global rumination correlated significantly with ideal implicit SE and marginally with actual vs. ideal SE discrepancy.
- Brooding correlated marginally with ideal implicit SE and significantly with actual vs. ideal SE discrepancy. (See table 2)

Table2. Correlations between rumination and actual and ideal implicit self-esteem

	1	2	3	4	5	6
1.Rumination	---					
2. Reflection	.57**	---				
3.Brooding	.84**	.24	---			
4. Actual implicit SE	-.04	-.09	.18	---		
5. Ideal implicit SE	-.32*	-.07	-.26	.15	---	
6. Actual vs. Ideal implicit SE discrepancy	-.23	-.01	-.32*	-.60**	.79**	---

Note. * = $p < .05$; ** = $p < .001$

Conclusions

- Our findings showed that dysphoric individuals are characterized by an actual vs. ideal implicit self-esteem discrepancy, showing higher levels of actual than ideal self-esteem. Non-dysphoric individuals, however, did not show differences between their actual and ideal self-esteem.
- Our findings support the idea that rumination, and more specifically its maladaptive brooding component, is associated with discrepancies between the current self and the desired self (e.g. Carver & Scheier, 1998). And also support the idea that rumination could be generate by a negatively biased automatic processing (Beevers, 2005), as showed by this actual vs. ideal implicit self-esteem discrepancy.
- Our findings provide a better understanding about the possible mechanisms underlying rumination, and open an interesting line of research which may be important to develop new strategies of prevention and intervention of depressive rumination.

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The Co-occurring Patterns of Hoarding and Depression, and Disabilities: in a Sample of Japanese College Students

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Introduction

Major depression is the most common co-occurring condition in hoarding disorders (Frost, Steketee, & Tolin, 2011), and several studies have reported that the depression symptoms significantly correlated with hoarding severity (e.g. Abramowitz, Wheaton, & Storch, 2008). These studies suggest that the interaction between hoarding and depression can cause severe disabilities. Many studies, however, have recruited patients with Obsessive Compulsive Disorder (OCD). Although hoarding has been frequently associated with OCD, populations recruited from the community have tended to find less co-occurring OCD (e.g. Frost et al., 2011).

Purpose

- In the present study, therefore, we recruited college students, and addressed the co-occurring patterns of hoarding (HD) and depression (DEP).
- Also, we examined whether there are any related differences in the disabilities.

Methods

- Cluster analysis was performed to categorize Japanese college students (N = 365; 43% female; M age = 19.48) on the basis of hoarding (SI-R; Frost, Steketee, & Grisham, 2004), giving adequate consideration to depression (CES-D; Radloff, 1977).
- We studied the differences in disabilities measured by the Sheehan Disability Scale (SDS; Sheehan, 1983).

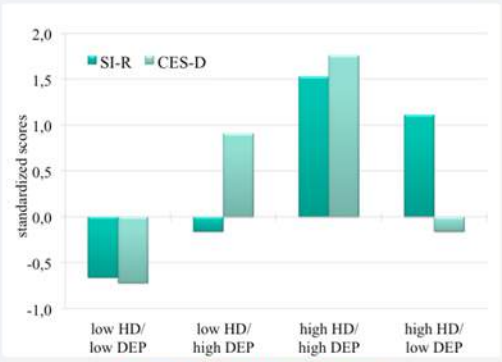

Figure1 Result of Cluster Analysis

Note. SI-R: Saving Inventory-Revised, CES-D: Center for Epidemiologic Studies Depression Scale, HD: Hoarding, DEP: Depression.

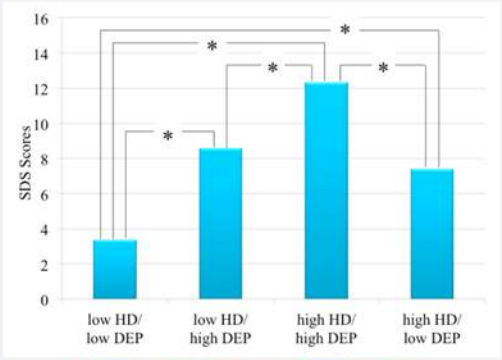

Figure2 Means of the Total Score on the SDS

(*p<.05)

Note. SDS: Sheehan Disability Scale, HD: Hoarding, DEP: Depression.

Results

- We identified four clusters characterized by "low HD/low DEP" (N = 171), "low HD/high DEP" (N = 90), "high HD/high DEP" (N = 30), and "high HD/ low DEP" (N = 74).
- We compared the outcomes of SDS scores across groups, finding highest outcomes among the "high HD/high DEP" group.
- Moreover, the "high HD/low DEP" group had moderately severe disabilities, which was almost as severe as the "low HD/high DEP" group.

Discussion

The result showed that the co-occurring of hoarding and depression in a Japanese college student sample was related to severe disabilities. High level of disabilities can lower treatment motivation. Also, Abramowitz & Foa (2000) found that a comorbid diagnosis of depression in an OCD sample predicted poorer symptoms reduction. Given that the co-occurring of hoarding and depression can cause severe disabilities, dealing with depression can be a primary target of the treatment strategy for hoarding.

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40 YEARS
Health Sciences University of Hokkaido

Psychological processes mediating the link between depression severity and the level of behavioural activation: Assessment of a conceptual model

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BACKGROUND

According to Kinderman (2013), *"biological factors, social factors and other environmental or life events lead to mental health problems through their conjoint effects on psychological processes, and these are the final common pathway to mental ill-health"*.

Our research focuses on **psychological processes** which characterize the **depression disorder**.

└ The influence of these processes on the level of **behavioural activation** is of interest because the inactivity (which is the behavioural avoidance) is one of the most important targets in depression treatments.

AIMS

To investigate the influence of the biased psychological processes on the behavioural avoidance.
To find the psychological processes which have a positive influence on the behavioural activation.
To present an integration of our results with Kinderman's psychological model of mental health (2013).

➢RELEVANCE

To provide a model which can help clinicians to find the impaired psychological processes involved in the weak mental health of the patients.

METHODS

SAMPLE
Table 1. Sociodemographic data.

Sample (N = 477)			
Sex (♀ /♂)	358/119	Age	34.25 (SD = 11.85)

MEASURES
Nine different kinds of psychological processes were assessed using several questionnaires (Factorial scores were computed for each psychological process)*.

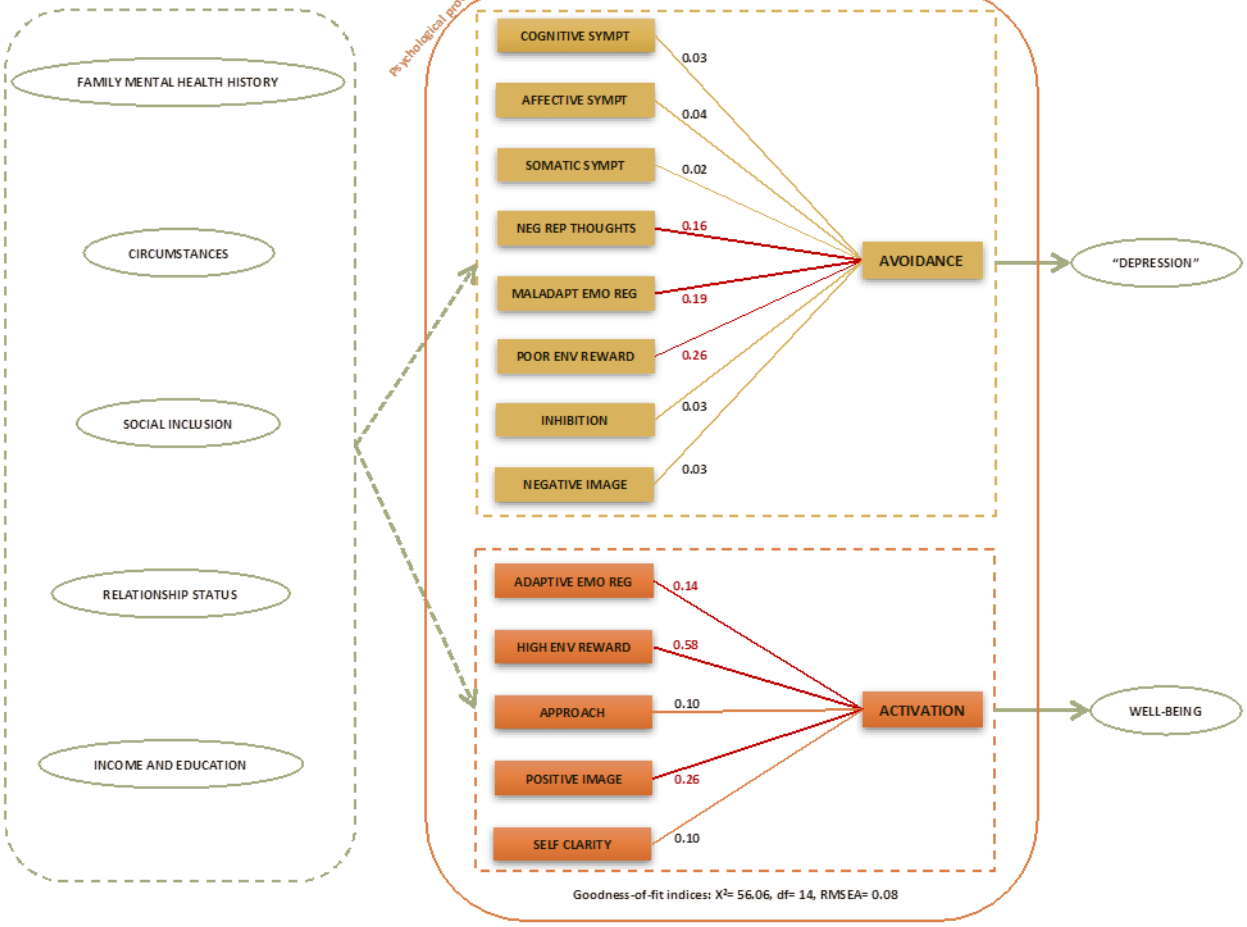
└ Cognitive symptoms, affective symptoms, somatic symptoms, negative repetitive thoughts, emotion regulation strategies, environmental reward, inhibition or approach, self-image, clarity of the self.

BDI-II, BADS-SF*, RSE, GSES, SCCS, RRS, BIS/BAS, GMS, EROS*, RPI*, CERQ, FFMQ, AAQ-2, DTS*

STATISTICAL ANALYSES.
Factorial scores were computed for each psychological process. Confirmatory factor analyses were conducted.

ACCORDING TO KINDERMAN

OUR RESULTS



DISCUSSION

The avoidance is highly influenced by
•Negative repetitive thoughts
•Poor environmental rewards
•Maladaptive emotion regulation strategies

The activation is highly influenced by
•High environmental rewards
•Positive self-image
•Adaptive emotion regulation strategies

According to their influence on both avoidance and activation, the environmental reward and the emotion regulation strategies appear to be important variables to work on during the treatment of depression.

Limitations: Women > > > Men

* These scales were validated by the authors and are available in French upon request by email.
This poster's bibliography is available on demand by email.

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Trans-diagnostic Dysfunctions

CHAMP
Center for Health And Medical Psychology

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School of Law, Psychology and Social Work

Stressing Emotions: Emotion Focused Transdiagnostic Treatment for Work Stress

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BACKGROUND

❖People with work stress often present with multiple problems within the realm of emotional disorders.

- Although stress and emotional problems are often comorbid, most evidence based CBT treatments are disorder specific.
- This presents a challenge for clinicians in assessment and in selecting treatment targets.
- There is a need for more parsimonious and flexible treatments to effectively address work stress.

❖ In clinical research there have been an increased focus on shared etiological and maintaining processes across disorders – *transdiagnostic processes.*

- Targeting these may treat several disorders with one protocol.

❖*Unified Protocol* for Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2011).

- Developed for treating anxiety *and* mood disorders.
- Addresses inflexible and maladaptive use of emotion regulation strategies.

Table 1. The eight modules in the Unified Protocol. Modules in italics are core modules.

	Unified Protocol Treatment Modules
1	Motivation Enhancement and Treatment Engagement
2	Psychoeducation and Tracking of Emotional Experiences
3	*Emotion Awareness Training*
4	*Cognitive Appraisal and Reappraisal*
5	*Emotion Avoidance and Emotion-Driven Behaviors (EDBs)*
6	*Awareness and Tolerance of Physical Sensations*
7	*Interoceptive and Situation-Based Emotion Exposures*
8	Relapse Prevention

❖*Should* be effective for other problems were emotions and emotion regulation are prominent.

- Work stress is one such condition.

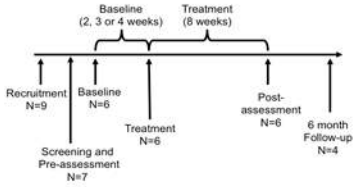
AIM

❖Test the feasibility of treating work stress with the Unified Protocol:

- Is a unified treatment approach for emotional problems perceived as acceptable by patients with work stress?
- Is it effective in decreasing levels of work stress?
- Is it effective in decreasing comorbid symptoms of anxiety and depression?

METHOD

❖ Single subject multiple baseline design:



❖ 6 individuals with work stress (LUCIE >0,385) + elevated levels of anxiety or depression (HADS ≥8 on 1 subscale).

❖ Recruited in an occupational health care facility.

❖ Treatment: Unified Protocol.

- Shortened to 8 sessions.
- All modules included.

Table 1. Measures

Construct (# items)	Time point	Measure	Example question & Scale	Cronbach's alpha
Work stress (28)	Pre-post	LUCIE: Karlsson & Österberg, 2010	"Trouble sleeping because of repeated thoughts about work" 1= Not at all; 4= Much	0.84 - 0.94
Perceived stress (14)	Weekly	PSS-14: Cohen et al., 1983	"How often have you felt nervous and "stressed""? 0= Never; 4= Very often	0.84 - 0.86
Anxiety & Depression (7*7)	Pre-post	HADS: Zigmond & Snaith, 1983	"I fell tense and wound up" 0=Never; 3=Most of the time	A: .68 - .93 D: .67 - .90
Anxiety (5)	Weekly	OASIS: Norman et al., 2006	"How often have you felt anxious?" 0=No anxiety; 4=Constant anxiety	0.89
Depression (5)	Weekly	ODSIS: Bentley et al., 2014	"How often have you felt depressed?" 0=Not at all; 4=Constantly	0.94

RESULTS

Figure 1. Weekly changes in perceived stress, depressive symptoms and anxiety for 2 participants

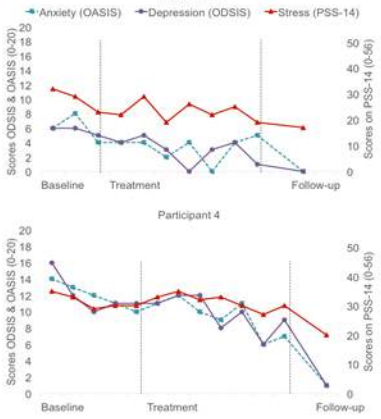


Figure 3. Pre- and post ratings of all participants

P	Work stress (LUCIE)			Anxiety (HADS)			Depression (HADS)		
	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change
1	.54	.06	-89 %	-*	-	-	12	4	-67 %
2	.39	.00	-100 %	-*	-	-	9	2	-78 %
3	.39	.33	-15 %	10	11	+ 10 %	-*	-	-
4	.64	.32	-50 %	18	12	-33 %	10	7	-30 %
5	.48	.66	+38 %	11	12	+9 %	16	16	+/-0 %
6	.63	.20	-68 %	15	11	-27 %	10	7	-30 %

* Not reaching cut-off at pre-treatment assessment

Figure 4. Evaluation of treatment

	Fully agree	Agree	Agree somewhat	Don't agree	Don't agree at all
Treatment foci addressed needs	2,3,4,6	1,5			
Treatment gave me tools	1,2,6	3,4	5		
	Yes	No			
Would recommend	1,2,3,4,5,6				

CONCLUSIONS AND FUTURE DIRECTIONS

❖Work stress patients found the treatment acceptable.

❖4 of 6 participant decreased in levels of stress.

❖4 of 6 participants decreased in levels of emotional symptoms.

❖Changes in stress and emotional symptoms were evident at about the same time (middle part of treatment).

❖Need RCT:s to confirm BUT…

❖Results indicate that it is feasible treating work stress and comorbid emotional symptoms with the Unified Protocol.

❖The possibility to treat work stress, anxiety and depression with ONE treatment is an important advancement in clinical practice.

❖Employing a unified CBT approach for stress would provide flexibility and parsimony for clinicians while retaining a strong theoretical framework and guiding principles.

The Role of Cognitive Behavioural Therapy Scales in Predicting Personality Disorder

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Objectives:

Although personality disorders are multifactorial, cognitions play an important role in the development of them. This study aims to investigate how some cognitive behavioural therapy scales may help predict the diagnosis of personality disorder.

Methods:

Participants with MDD and healthy controls were enrolled in this study, and they were asked to fill out the BDI, ATQ, DAS, LESS and PBQ. The PBQ scores were transformed into Z-scores, and participants with a Z-score of +1 or more were diagnosed with personality disorder, and the scores of the cognitive behavioural therapy scales were used to predict the personality disorder diagnosis by logistic regression analyses.

Results:

For the diagnosis of personality disorder according to the total score of core beliefs related to personality, the duration of illness, number of hospitalizations, frequency of automatic thoughts, dysfunctional attitudes related to need for approval, total score of dysfunctional attitudes, adaptive emotional schemas and rigid emotional schemas; for core beliefs related to cluster A personality disorders, the duration of ilness, being unemployed, the frequency of automatic thoughts, dysfunctional attitudes related to perfectionism, total score of dysfunctional attitudes, adaptive emotional schemas and rigid emotional schemas; for core beliefs related to cluster B personality disorders, the duration of illness, not being married, being unemployed, number of hospitalizations, the severity of depression, frequency of automatic thoughts, dysfunctional attitudes related to need for approval, total score of dysfunctional attitudes, adaptive emotional schemas and rigid emotional schemas and for core beliefs related to cluster C personality disorders, the duration of illness, frequency of automatic thoughts, dysfunctional attitudes related to perfectionism, total score of dysfunctional attitudes, adaptive emotional schemas and rigid emotional schemas were found to be statistically significant predictors.

Descriptives	Depressed (n=275)	Healthy (n=125)	p	Statistics
Age (years, M±SD)	39.12±12.79	40.12±12.57	0.601	t=-0.731
Gender (F, n, %)	203 (%73.8)	80 (%64)	0.045	X^2=4.003
Marital Status (Married, n, %)	148 (%53.8)	68 (%54.4)	0.914	X^2=0.012
Level of Education (≥ 8 years, n, %)	122 (%44.4)	68 (%54.4)	0.062	X^2=3.471
Occupation (Regular, n, %)	51 (%18.5)	63 (%50.4)	<0.001	X^2=42.793
Family History of Psychiatric Disorder (Y, n, %)	130 (%47.3)	46 (%36.8)	0.050	X^2=3.825
Traumatic Early Life Events (Y, n, %)	137 (%49.8)	27 (%21.6)	<0.001	X^2=28.288

Clinical Data	
Duration of Illness (mo, M±SD)	11.75±10.73
# of Episodes (M±SD)	1.98±1.09
# of Hospitalizations (M±SD)	0.38±0.84

Clinical Scale Scores	Depressed (n=275)	Healthy (n=125)	p	Statistics
BDI	35.94±10.04	5.41±3.07	<0.001	t=33.265
ATQ-Neg	88.61±23.06	48.37±19.84	<0.001	t=40.239
DAS-NFA	55.43±8.20	41.92±9.72	<0.001	t=13.509
DAS-P	82.54±20.39	45.04±17.88	<0.001	t=37.502
DAS-Total	179.90±19.27	138.08±23.26	<0.001	t=41.822
Adaptive ES	90.86±8.72	85.34±10.25	<0.001	t=5.526
Rigid ES	86.23±12.68	60.22±13.68	<0.001	t=26.001

Any PD	B	p	OR	95 % CI
Duration of Illness	0.129	0.012	1.138	1.029-1.259
# of Hospitalizations	-2.577	0.011	0.760	0.100-0.557
ATQ-Neg	-0.094	<0.001	0.911	0.869-0.955
DAS-NFA	-0.174	0.001	0.840	0.762-0.927
DAS-Total	0.231	0.001	1.259	1.095-1.449
Adaptive ES	0.732	<0.001	2.079	1.479-2.920
Rigid ES	0.126	0.003	1.134	1.045-1.231

Cluster A PD	B	p	OR	95 % CI
Duration of Illness	0.059	0.005	1.060	1.018-1.105
Occupation	1.410	0.009	4.097	1.422-11.801
ATQ-Neg	-0.024	0.007	0.976	0.959-0.993
DAS-P	-0.068	0.002	0.934	0.895-0.975
DAS-Total	0.085	<0.001	1.089	1.046-1.134
Adaptive ES	0.107	<0.001	1.113	1.061-1.166
Rigid ES	0.035	0.022	1.035	1.005-1.067

Cluster B PD	B	p	OR	95 % CI
Duration of Illness	0.146	<0.001	1.157	1.077-1.245
Marital Status	1.869	0.008	6.482	1.629-25.803
Occupation	2.600	0.029	13.457	1.298-139.474
# of Hopitalizations	-0.968	0.027	0.380	0.161-0.896
BDI	0.080	0.019	1.083	1.013-1.157
ATQ-Neg	-0.050	0.001	0.951	0.923-0.981
DAS-NFA	-0.130	0.003	0.878	0.806-0.957
DAS-Total	0.122	0.008	1.130	1.032-1.238
Adaptive ES	0.411	<0.001	1.508	1.310-1.736
Rigid ES	0.074	0.004	1.076	1.024-1.131

Cluster C PD	B	p	OR	95 % CI
Duration of Illness	0.077	<0.001	1.080	1.036-1.127
ATQ-Neg	-0.035	0.001	0.966	0.947-0.986
DAS-P	-0.087	0.002	0.917	0.867-0.969
DAS-Total	0.122	<0.001	1.130	1.066-1.198
Adaptive ES	0.120	<0.001	1.127	1.065-1.193
Rigid ES	0.035	0.042	1.035	1.001-1.070

Conclusions:

The frequency of automatic thoughts, dysfunctional attitudes and emotional schemas may be predictive of different clusters of personality disorders or a general personality disorder diagnosis.

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Choosing is losing: pain-avoidance versus valued non-pain goals

Nathalie Claes[a,b], Geert Crombez[b], Johan W.S.Vlaeyen[a,c,d]

Background

- Fear-Avoidance models propose that a catastrophic reappraisal of a painful experience may give rise to **pain-related fear** and consequent **avoidance behavior,** resulting in the development and maintenance of chronic pain problems [1,2]
- The experience of pain might install the salient **goal** to avoid pain, whilst other life goals might be simultaneously pursued [3;4]. Moreover, both type of goals might possibly **compete** with each other, often resulting in withdrawal from the non-pain goals [5]
- Little is known about the effects of goal competition on pain-related fear and associated avoidance behavior in clinical situations as well as in experimental situations [3]. Therefore, we conducted fundamental, experimental research in healthy volunteers

Aim 1: To investigate whether a competing goal (a **concurrent reward**) is capable of **diminishing** both pain-related fear and avoidance of a movement that predicts pain (CS+)

Aim 2: To investigate how **goal preference** impacts pain-related fear and avoidance behavior in a context of competing goals

Methods

Participants

- 65 healthy volunteers, after exclusion: 57
- 21 male; *Mean age*= 22.26 years (*SD* = 1.64)
- Categorized in **three groups**, based on preferred goal (self-report, a priori):
  - Pain-avoidance (n = 19)
  - Reward-seeking (n = 21)
  - Equally Important (n = 17)

Stimuli

Pain-US: painful electrocutaneous stimulation, individually determined at tolerance level

Reward-US: lottery tickets, representing a prize of participants' choice, worth approx. € 100

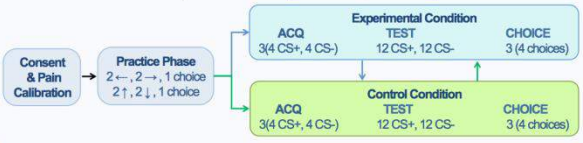
CS movements: performed with a joystick in the vertical (up/down) and horizontal (left/right) movement plane. Movements are either followed by one or both USs (CS+) or not (CS-)

Joystick movement paradigm

- 8000 ms intertrial interval
- Fixation cross indicates start of movement
- **Signaled trials**
  - The to-be-performed movement is signaled by a purple target (figure left)
- **Choice trials**
  - Participants can choose which movement to perform (figure right)
- Successful completion of a movement (yellow coloring target) is followed by administration of the pain-US alone (control) or with reward-US (experimental) for CS+ movements

Design

- Within-subjects crossover design
  - **Control** condition: CS+ accompanied by pain-US (↔ CS-: no US)
  - **Experimental** condition: CS+ accompanied by pain-US and reward-US (competition)
- Reinforcement rate in acquisition and test phase: 50%, in choice phase: 100%

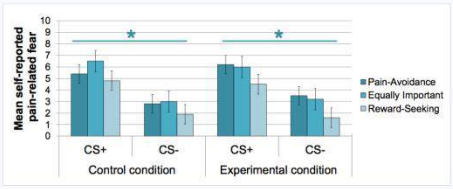


Results

- **Repeated Measures ANOVAs**
- **Successful acquisition** in both conditions and all groups:
  - **Expectancy of the pain-US** was higher for the CS+ than the CS- movement, $F(1,54)= 84.26$, $p< .001$, irrespective of condition and group, $F<1$.

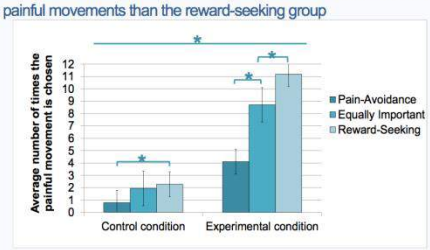
Pain-related fear

- Participants reported to be **more afraid of the painful movement** compared to the safe movement, $F(1,56) = 58.26$, $p < .001$. Adding the concurrent reward did not result in changes in pain-related fear. There were however small differences between groups in overall reported pain-related fear, $F(2,54) = 4.33$, $p = .018$.



Choice behavior

- Participants **chose to perform the painful movement more often** when a **concurrent reward** was presented compared to when it was absent, $F(1,54) = 166.03$, $p< .001$. This effect was influenced by **goal preference**, Group × Condition: $F(2,54)= 11.53$, $p< .001$
  - All groups show an increase in the number of painful movements performed
  - When a concurrent reward was presented, the pain-avoidance group performed less painful movements than the equally important group, which in turn performed less painful movements than the reward-seeking group



Conclusions

- Inclusion of a competing **non-pain goal** – a concurrent reward – did **not** result in changes in **pain-related fear**, but **did** result in **attenuation of avoidance** behavior (cf. Aim 1)
- **Goal preference** was associated with **differences** in overall level of **pain-related fear.** The impact of a concurrent reward on **avoidance behavior** is further explained by **goal preference** (cf. Aim 2)
- We found experimental **support** for the importance of **both** pain and non-pain **goals**, as well as **goal preference** in the attenuation of **avoidance behavior**.
- Cognitive-behavioral **interventions** that include both pain and other life goals in chronic pain management, rather than limiting focus to pain reduction only, might be warranted in order to encourage patients to resume life goals despite fear of pain.
- However, more research is needed to uncover the effects of non-pain goals and goal preference on pain avoidance

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KU LEUVEN

The Relationship Between Acceptance and Post-Event Processing

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ABSTRACT

If, in one hand, post-event processing (PEP), feeding on information from self-focused attention (SFA), has been highlighted as an important maintenance factor of social anxiety disorder (Clark & Wells, 1995). On the other hand, acceptance of social anxiety has been point as a protective factor for this disorder, once low levels of acceptance may lead to an increase of self-focused attention and greater experiential control (Herbert & Cardaciotto 2005). This study explored the mediating role of acceptance in the relationship between PEP and social anxiety/self-focused attention (SFA) in a sample of 65 adolescents (34 with Social Anxiety Disorder and 31 without any psychopathological condition).
Experiential acceptance fully mediated the relationship between social anxiety/SFA and PEP.

Keywords: SAD, Post-Event Processing; Acceptance; Self-Focused Attention; Acceptance and Commitment Therapy; Adolescence.

INTRODUCTION

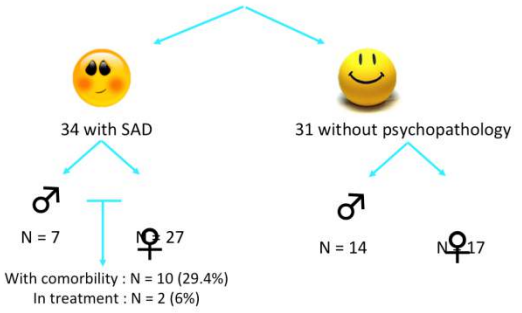
Unlike other phobic disorders, social anxiety in social anxiety disorder (SAD), does not decrease through exposure to the phobic stimulus in day to day life.
PEP, a process that feeds on information coming from self-focused attention, has been pointed out as one of the explanatory factors for this fact and, consequently, as an important factor for maintaining SAD (Clark & Wells, 1995).
On the other hand, Herbert and Cardaciotto (2005) postulated that lower levels of acceptance would increase levels of SFA and experiential control, and inevitably social anxiety.

According to this model, will acceptance have a mediating role in the relationship between social anxiety/SFA and PEP?

METHOD

PARTICIPANTS

65 adolescents aged between 14 to 18 years



MEASURES

Diagnostic Interview:

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

Self Report Questionnaires:

Social Anxiety Scale for Adolescents: SAS-A (La Greca & Lopez, 1998; Cunha et al., 2004)

Social Anxiety - Acceptance and Action Questionnaire: SA-AAQ (Mackenzie & Kocovski, 2010; Vieira et al., 2014)

Post-Event Processing Questionnaire for Adolescents: PEPQ-A (Fehm et al., 2008; Coelho & Salvador, 2014)

Focus of Attention Questionnaire: FAQ (Woody et al., 1997; Fontinho & Salvador, 2014)

Children's Depression Inventory: CDI (Kovacs, 1985; Marujo, 1994)

RESULTS

INTER GROUP ANALYSIS

Table 1. Significant differences between groups

Medidas	*F*	η^2
SAS-A	108.27***	.63
FAQ_{Self}	47.67***	.43
PEPQ-A Total	52.96***	.46
$SA\text{-}AAQ_{Acceptance}$	48.10***	.43

***p < .001

As expected, the groups differed in every variable. Adolescents with SAD obtained higher scores in all variables except in the acceptance variable where they obtained significantly lower values.

INTRA GROUP ANALYSIS

Correlations

Table 2. Correlations between PEP, SA, SFA, acceptance and depression, in a sample with SAD

	SAS-A	FAQ_{Self}	$SA\text{-}AAQ_{Acceptance}$	CDI
PEPQ-A	.42*	.57**	-.68**	.32

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

The positive correlations between social anxiety, SFA and PEP, as well as the negative correlation between acceptance and PEP are in line with expectations.
The fact that depression did not correlate significantly with PEP seems to meet the literature that sees PEP and depressive rumination as distinct constructs.

Mediations

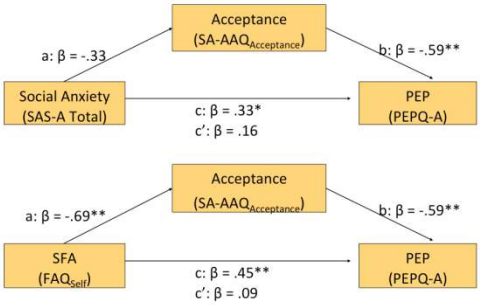


Figure 1: Regression coefficients for the relationship between Social Anxiety/SFA and PEP mediate by acceptance, controlling for gender, in a sample with SAD

In both analyzes Acceptance revealed itself as the only significant predictor, removing the significance of Social Anxiety, SFA and gender in predicting PEP.

CONCLUSION

The data seem to suggest that:

The problem is neither the levels of social anxiety experienced neither the level of SFA but the way the individual is available to accept these internal experiences.

Acceptance can be seen as a protective factor of PEP and consequently of PAS.

A therapeutic approach that focus on PEP, developing experiential acceptance seems promising.

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Self-Efficacy in People with Mild Dementia and their Carers

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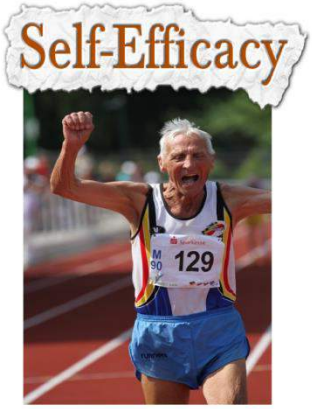

BACKGROUND

Self-efficacy is the belief in one's own ability to complete tasks and reach goals, and can influence how a person cope with a severe disease (1). New research demonstrates that self-efficacy is important for how a person with dementia cope with memory decline (2, 3).

However, few studies have examined the correlation between self-efficacy and other psychiatric symptoms of people with dementia and their carers.

METHOD AND MATERIAL

The study is based on the German Cordial-study (4), which is a manual based approach that consists of cognitive behavioural therapy . The aim is increase self-efficacy in persons with mild dementia (MMSE $\geq$ 20).

Sixty patients with dementia (52 % females , mean age (SD) 70.6 (8.0), mean MMSE (SD) 23.3 (3.0)), and their caregivers (62% females and 80 % spouses, mean age (SD) 67.0 (12.7), which are included in the study, completed standardized measures of self-efficacy (GSE) (5), depression and anxiety (HAD) (6) and quality of life (ADQOL) (7).

Thereafter, descriptive analysis, t-tests, correlation analyses and linear regression were completed in SPSS.

RESULTS

When controlling for age and gender, we found a negative significant correlation between patients' self efficacy and depression/anxiety (R^2 = 40 %) and between carers' self-efficacy and quality of life (R^2 = 25 %).

CONCLUSION

The aim of this study is to increase self-efficacy. We found:

- Low self-efficacy was associated with increased depression and anxiety in people with dementia
- Low self-efficacy resulted in low quality of life in carers.

As a consequence, it is important to target self-efficacy when conducting psychotherapy for people with dementia and their carers.

Cognitive behavioural therapy and cognitive rehabiliation for people with mild dementia (the Norwegian CORDIAL study)

- **WHAT?** A randomized, controlled trial which will include 200 people with dementia and their caregivers. The participants will be randomized into treatment as usual (n = 100) or a manual-based cognitive behavioural therapy and cognitive rehabilitation program.
- **WHY?** People with mild dementia are in need of psychotherapy to handle the diagnosis, to structure their daily life with memory aids and to increase pleasure events to decrease depressive symptoms.
- **WHO?** People with mild dementia (MMSE > 20) who are living at home and have regular contact with a family carer.
- **WHERE?** Patients that fulfil the inclusion criteria are recruited from outpatient clinics in Norway.

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Trans-national Comparisons

Resilience and Social Support as protective factors: Cross-Cultural compare of Germany, USA and Russia

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Introduction

- Chronical stress is a main cause of depression and anxiety [ref. 1, 2]
- Stress effects are moderated by individual resilience and social support [ref. 3, 4]
- But research is almost limited to western student samples

Research Question

Are resilience and social support protective factors against depression, anxiety, stress in representative population samples and different cultures?

Method

- Part of **"BOOM" ("Bochum Optimism and Mental Health Studies")**
- Representative population samples: Germany (*N* = 1894), USA (*N* = 2755), Russia (*N* = 2578)
- Materials [ref. 5-7]: Depression-Anxiety-Stress-Scale 21 (DASS-21), Resilience Scale (RS-11), Social Support Questionnaire (F-SozU K-14)

Results

Correlations

- Depression, anxiety and stress correlate significantly negatively with resilience and social support
- *Germany, USA*: correlations are equally strong
- *Russia*: correlations are markedly weaker

Table 1. Correlations of resilience, social support with depression, anxiety, stress

	Germany	USA	Russia
(1) res*depression	-.46**	-.40**	-.29**
(2) res*anxiety	-.36**	-.33**	-.20**
(3) res*stress	-.33**	-.33**	-.22**
(4) soc sup*depression	-.37**	-.37**	-.29**
(5) soc sup*anxiety	-.29**	-.28**	-.19**
(6) soc sup*stress	-.24**	-.28**	-.22**

Note. res = resilience, soc sup = social support; **$p \leq .001$

Social Support: high vs. low

- *Germany, USA*: negative correlations of resilience with depression, anxiety and stress are *stronger* when social support is *low*
- *Russia*: negative correlations of resilience are *stronger* when social support is *high*

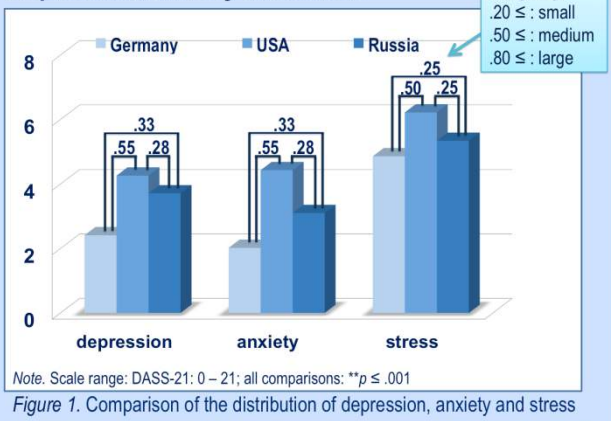
Table 2. Correlations of resilience with depression, anxiety, stress when social support is high or low

	Germany		USA		Russia	
	soc sup		soc sup		soc sup	
	high↑	↓low	high↑	↓low	high↑	↓low
(1) res*dep	-.32**	-.45**	-.25**	-.36**	-.24**	-.21**
(2) res*anxiety	-.21** <	-.38**	-.20** <	-.31**	-.18** >	-.13**
(3) res*stress	-.26**	-.32**	-.25**	-.28**	-.21**	-.14**

Note. res = resilience, soc sup = social support, dep = depression; **$p \leq .001$

Means

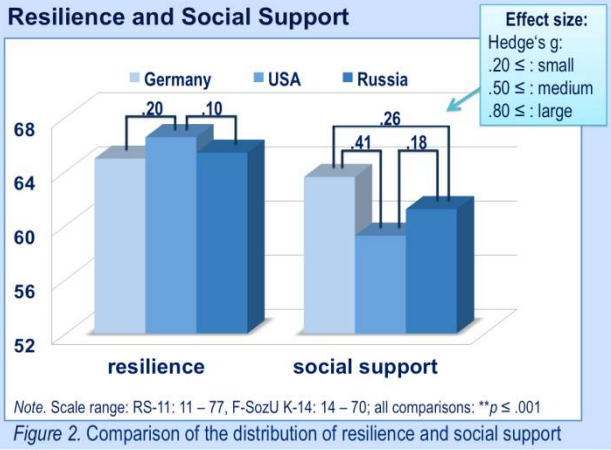
Depression, Anxiety and Stress



Note. Scale range: DASS-21: 0 – 21; all comparisons: **$p \leq .001$

Figure 1. Comparison of the distribution of depression, anxiety and stress

Resilience and Social Support



Note. Scale range: RS-11: 11 – 77, F-SozU K-14: 14 – 70; all comparisons: **$p \leq .001$

Figure 2. Comparison of the distribution of resilience and social support

Discussion

- In all three countries, resilience and social support protect against depression, anxiety and stress
- Resilience: highest in USA
- Social support: highest in Germany
- Depression, anxiety and stress: USA > Russia > Germany
- Partial compensatory relationship between resilience and social support in USA and Germany, but not in Russia: Reasons?

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The Disgust Scale - Revised (DS-R): Preliminary Reports of the Psychometric Properties in Greek Population

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Introduction

- Disgust is a core emotion that has been intensely investigated the last few years. Disgust is defined as the repulsive feeling caused by the prospect of eating a detestable object. From an evolutionary point of view disgust seems to act as the keeper of the mouth.
- Disgust is regarded as a multidimensional emotional state that comprises of three dimensions: core, animal reminder and psychological infection.
- Although pathological disgust is not included in DSM-V, there are studies that report a link between obsessive-compulsive disorder, specific phobia of little animals, blood/needle phobia and disgust.
- One of the scales that are used for the measurement of this emotional state is the Disgust Scale Revised (DS-R).

Aim Current Study

The aim of this study was to validate the psychometric properties of the Greek version of DS-R.

Method

Participants

The participants were 251 students (170 women, 81 men)

The age range was from 18 to 36.

Design

Each participant answered the DS-R and a Demographic Questionnaire.

Material

1. The DS-R consists of 27 items, each item is rated on a 5-point scale, ranging from 0 to 4.

15 of the items rate the agreement with the statements, on a 5 point scale:

0 = Strongly disagree (very untrue about me)
1 = Mildly disagree (somewhat untrue about me)
2 = Neither agree nor disagree
3 = Mildly agree (somewhat true about me)
4 = Strongly agree (very true about me)

Next 10 items rate the degree of disgust on a 5 point scale:

0 = Not disgusting at all
1 = Slightly disgusting
2 = Moderately disgusting
3 = Very disgusting
4 = Extremely disgusting

Moreover, the DS-R includes 2 "catch" questions (identification of people who are not paying attention or are not taking the task seriously).

2. Demographic data was collected for each participant (sex, age, education, work status, family income, religion, religiousness).

Results

1. Preliminary results showed that the Greek version of the DS-R possesses satisfactory psychometric properties (sensitivity and specificity) as compared with published results from other countries.

2. The three factors model that is proposed by the creators of DS-R (core disgust, reminder of animals and contamination disgust) has also been confirmed for the Greek version of DS-R as the results indicated that there was satisfactory reliability of the model, medium relation among the three factors and strong relation with the total scale.

	Core disgust		Animal Reminder		Contamination	
	Pearson r	p-value	Pearson r	p-value	Pearson r	p-value
Animal Reminder	0.5	<0.001				
Contamination	0.5	<0.001	0.4	<0.001		
Total	0.9	<0.001	0.8	<0.001	0.7	<0.001

3. Women had higher measurements of disgust than men.

DS-R	Men		Women		Independent samples t-test		
	Mean value	Standard deviation	Mean value	Standard deviation	t	df	p-value
Core Disgust	23.6	7.7	29.5	7.8	-5.69	249	<0.001
Animal Reminder	15.6	6.4	17.8	6.6	-2.57	249	0.011
Contamination	8.2	3.8	9.1	3.7	-1.85	249	0.065
Total	47.3	15.4	56.5	14.8	-4.53	249	<0.001

4. The level of religiousness correlated positively with the measurement of disgust while age presented a negative correlation with the contamination disgust.

	Age		Income		Religiousness	
	rho	p-value	rho	p-value	rho	p-value
Core Disgust	-0.012	0.853	-0.065	0.304	0.205	0.001
Animal Reminder	0.105	0.095	-0.057	0.370	0.230	<0.001
Contamination	-0.137	0.031	-0.074	0.240	0.295	<0.001
Total	0.001	0.985	-0.079	0.212	0.275	<0.001

Discussion

- It was the first attempt measuring the disgust sensitivity (DS-R) in Greece
- The results were satisfying (in accordance to previous research)
- The three factors model (core disgust, reminder of animals and contamination disgust) has been confirmed

Limitations of this study:

- The participants were students, thus we cannot generalize the findings in general population
- Not age-representative sample (mean age: 21.5)

Future research

- An assessment of test - retest reliability and a larger sample are needed

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Mental Health and Mental Illness Across the Lifespan

Transnational Comparison in Germany and Russia

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Introduction

Independent but correlated concepts of psychological symptoms and well-being (e.g., Keyes, 2007)

Inconsistent evidence for age differences in mental health and illness:

Increased mental health (Happel, 2011) ⇒ Australia
Unchainged mental health (Hanmer et al., 2006) ⇒ USA
Decreased mental illness (Westerhof & Keyes, 2009) ⇒ Netherlands

Issue: What are the differences of mental health and mental illness across the lifespan in a transnational comparison for Germany and Russia?

Methods

Two representative cross-sectional samples:
Germany (N=7583, Min_{age}=18, Max_{age}=99, M_{age}=47,64, 49.9% female)
Russia (N=2606, Min_{age}=18, Max_{age}=100, M_{age}=44.02, 54.5% female)
Self-report questionnaires:
Depression Anxiety Stress Scales (DASS-21)
Positive Mental Health Scale (P-Scale)
Marital Status
School education
Data collection:
Face-to-Face
Online
Offline Panel

Results

Overall differences:
Mental health is higher for Russians (M=20.90, SD=5.24) than for Germans (M=20.00, SD=5.18; p<.001)
Mental illness (including the subscales depression, anxiety and stress) is higher for Russians (M=11.18, SD=10.58) than for Germans (M=12.05, SD=11.11; p<.001)

Main finding:
Opposed directions of the relationships between age and mental health and mental illness in Germany and Russia

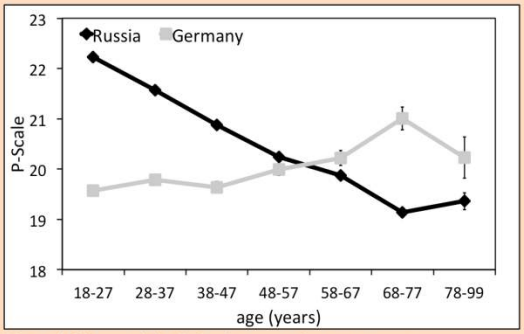

Figure 1: Means of the P-Scale across the age groups

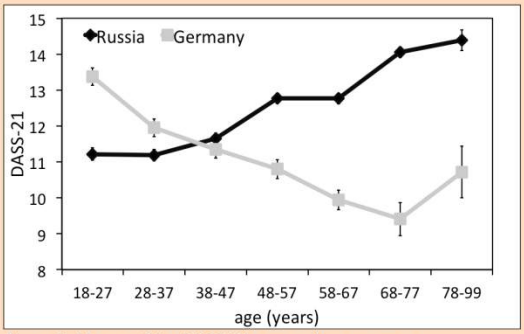

Figure 2: Means of the DASS-21 across the age groups

Age remains a significant positive predictor of mental health in Germany (β=.074, p≤.001) even after controlling for gender, school education and marital status; by contrast age is a negative predictor in Russia (β=-.167, p≤.001)
Both in Germany (β=.050, p≤.001) and Russia (β=.059, p≤.01) the relationship between age and mental health is curvilinear

Age has a negative effect on mental illness in Germany (β=-.132, p≤.001), even when sociodemographic variables are included in the model while it has a positive effect in Russia (β=.054, p≤.05)
The same results arise for depression (β=-.107, p≤.001), anxiety (β=-.062, p≤.001) and stress (β=-.170, p≤.05) in Germany and for anxiety (β=.103, p≤.001) in Russia

Conclusions

Substantial differences in the association between age and mental health and mental illness between the two cultures:
Today's older German people experience more mental health and less mental illness including depression, anxiety and stress
Conversely, older Russian people are less mentally healthy and report more psychological symptoms

In Germany, health increases with age. In Russia, however, mental health decreases and illness increases.

Findings from Russia differ from previous studies about mental state across the lifespan

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A cura di
Lucio Sibilia e Stefania Borgo

30 STORIE CLINICHE DI PSICOTERAPIA COGNITIVO-COMPORTAMENTALE

Presentazione di
Giorgio Rezzonico

La psicoterapia cognitivo-comportamentale ha una solida tradizione scientifica e la sua efficacia terapeutica, per la maggior parte dei disturbi psichici, è sostenuta da numerosissime ricerche sperimentali. Meno nota è l'attenzione data alla vicenda umana. Queste "storie cliniche", invece, comprendono non solo il resoconto tecnico delle terapie (il lavoro svolto nello studio del terapeuta), ma anche gli aspetti personali ed interattivi delle persone che ne fanno esperienza viva, nei due diversi ruoli: il libro evidenzia con linguaggio immediato come questa esperienza abbia inciso sulla storia di vita dei pazienti e, spesso, anche dei terapeuti.
I casi sono stati scelti tra quelli presentati dagli allievi per l'esame finale di diploma in psicoterapia. Il libro presenta quindi un interesse diretto per tutti i colleghi in formazione che stanno per prepararsi a questo importante passaggio.
La selezione dei casi, tuttavia, copre un'ampia gamma di disturbi e, pur con la vivacità della narrazione soggettiva, mantiene l'accuratezza del resoconto clinico. Per questo, anche lo psicoterapeuta esperto può trovare numerosi spunti di interesse in questo libro.
Infine il linguaggio scevro da tecnicismi rende la lettura agevole anche al profano che voglia soltanto curiosare o esplorare *dall'interno* la psicoterapia cognitivo-comportamentale.

Lucio Sibilia, professore a riposo della Sapienza, Università di Roma, dove ha insegnato psichiatria e psicologia clinica. Nelle sue ricerche, pubblicate anche su volumi e riviste internazionali, si è occupato dell'efficacia delle psicoterapie, dei metodi di gestione dello stress e dell'autocontrollo delle abitudini consumatorie, per il trattamento dell'obesità, del tabagismo e per la prevenzione dell'abuso alcolico.

Stefania Borgo, neurologo e psichiatra, didatta nelle due maggiori associazioni di psicoterapia cognitivo-comportamentale (SITCC e AIAMC), direttore del Centro per la Ricerca in Psicoterapia e della Scuola di specializzazione in psicoterapia cognitivo-comportamentale e intervento psicosociale. È autrice di numerose pubblicazioni nell'area della ricerca, in particolare sulle emozioni, e nell'area della formazione con due volumi sulla supervisione clinica e sull'analisi formativa.

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