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EDITORIAL

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

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

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

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

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

The year later Meyer was in Rome, attending the International Congress on “Recent Developments in Psychology of Learning”, organised by Ettore Caracciolo at the European Centre of Education of Villa Falconieri in Frascati, near Rome, together with the most qualified National and International experts such as M. Cesa-Bianchi and H. J. Eysenck. In that occasion, Meyer gave a seminal lecture at the outpatient Unit of the Institute of Psychiatry of the University of Rome “La Sapienza”: his infectious enthusiasm gave us the thrust for beginning the new enterprise and reinforced the belief that time was ripe to establish an Italian Association for Behaviour Therapy, which, as mentioned before, was soon after founded. In 1973 a first Assembly gathered a score of Colleagues interested in the new approach, implementing behaviour therapy. The encounter with him was very friendly, and it was the beginning of a very important relationship, which was continued in the following years.

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

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

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

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

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

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

**Stefania Borgo and Lucio Sibilia**

*Roma, December 2013*


\(^6\) http://www.commonlanguagepsychotherapy.org/

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

\(^8\) https://www.researchgate.net/publication/235345467_COMMON_LANGUAGE_FOR_PSYCHOTHERAPY_PROCEDURES. THE_FIRST.80
From Amsterdam to Marrakech: an EABCT Journey

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

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

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


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

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

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

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

Rod Holland
President EABCT
EABCT Congress 2013 in Morocco.  
A challenge won

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

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

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

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

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

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

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

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

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

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

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

Antonio Pinto
EABCT Scientific Coordinator
Symposium — Behaviour Therapy

REDUCTION OF FEAR: TOWARDS A UNIFYING THEORY*

ISAAC M. MARKS, M.D.

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

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

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

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


tion in vivo is more rapid than desensitization in phantasy.

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

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

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

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

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

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

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

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

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

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

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

Summary

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


Résumé

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

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

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

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

Stream: Therapeutic and applied issues.

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

Potential implications for the everyday clinical practice of CBT:
Using a plain common language to describe unambiguously each psychotherapy procedure will not only foster scientific research, but also facilitate communication among clinicians and with patients.
Assessment instruments
ANXIETY DISORDERS INTERVIEW SCHEDULE FOR DSM-IV: CHILD VERSION (ADIS-C) APPLIED TO AN ADOLESCENT POPULATION: CONCURRENT VALIDITY, INTER-RATER AGREEMENT AND ACCEPTABILITY OF THE CLINICAL INTERVIEW

INTRODUCTION

Adolescence is a period of physical, cognitive, and emotional changes. This period is complex and in many ways, may involve high levels of stress, making this period the most propitious for the development of psychological disorders, particularly Anxiety Disorders, the most prevalent disorders in children and adolescents (Ayoub & Goodman, 2008; Carverchick, Mithen, & Bostock, 2004). In addition to Anxiety Disorders, adolescents are highly vulnerable to other psychiatric disorders, including major depressive disorder (Kovacs, Zbrozy & Szilagyi, 1997) and Attention deficit hyperactivity disorder (ADHD) (Kaur, 2012; Brat & Lichtenberg, 2007).

Given the high prevalence, the serious consequences and the high social spending, it is crucial to develop and invest in reliable assessment methods to achieve valid diagnostic for research, prevention, and objective and structured treatment (Garcia-Ayllon, Aguirre, Real, & Dones, 2012).

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

METHOD

PARTICIPANTS

Diagnoses for the interview: Anxiety Disorders Interview Schedule for DSM-IV: Child Version (Silverman, 1996)


RESULTS

CONVERGENT VALIDITY

Assignment: Social anxiety and Avoidance Scale for Adolescents (Oswald, 2004; Kohn, 2012; Silverman, Silverman, & Ruscio, 2002). Questionnaire for the interview: Anxiety Disorders Interview Schedule for Children (Silverman, 1996). The DSM-IV criteria for the diagnosis of all anxiety disorders are met by the clinical interview (Silverman, 2002).

ACCCEPTABILITY OF THE CLINICAL INTERVIEW ADIS-C, BY ADOLESCENTS

CONCLUSION

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

This paper also reviews the interaction with both parents and teachers to the recognition of anxiety and behavior problems also not yet diagnosed. Since adolescents depend on caregivers to be closely observed, this may hinder the possibility of getting problems help. Therefore, we suggest using the ADIS-C as a tool to identify anxiety and behavior problems, which is the most extensive in adolescents and children's development.

ABSTRACT

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

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

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

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

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

Key Words: ADIS-C, psychometric properties, validity, reliability, adolescents.
The structure and determinants of validity of QAC A: compared within the group of American subjects and between the groups. Figure 1 allows to visualize the distribution of subjects and items for the main test - combat exposure. The subjects, represented by circles, are classified according to their severity of combat exposure (QAC A). The different symbols (circles and triangles) represent different groups of subjects, with each group being defined by a different level of combat exposure. The figure clearly shows that the severity of combat exposure is positively correlated with the number of subjects in the group, indicating that the severity of combat exposure is a valid measure. The methodology for this study involves the analysis of the distribution of subjects and items for the main test - combat exposure. The subjects, represented by circles, are classified according to their severity of combat exposure (QAC A). The different symbols (circles and triangles) represent different groups of subjects, with each group being defined by a different level of combat exposure. The figure clearly shows that the severity of combat exposure is positively correlated with the number of subjects in the group, indicating that the severity of combat exposure is a valid measure. The methodology for this study involves the analysis of the distribution of subjects and items for the main test - combat exposure. The subjects, represented by circles, are classified according to their severity of combat exposure (QAC A). The different symbols (circles and triangles) represent different groups of subjects, with each group being defined by a different level of combat exposure. The figure clearly shows that the severity of combat exposure is positively correlated with the number of subjects in the group, indicating that the severity of combat exposure is a valid measure. The methodology for this study involves the analysis of the distribution of subjects and items for the main test - combat exposure. The subjects, represented by circles, are classified according to their severity of combat exposure (QAC A). The different symbols (circles and triangles) represent different groups of subjects, with each group being defined by a different level of combat exposure. The figure clearly shows that the severity of combat exposure is positively correlated with the number of subjects in the group, indicating that the severity of combat exposure is a valid measure. The methodology for this study involves the analysis of the distribution of subjects and items for the main test - combat exposure. The subjects, represented by circles, are classified according to their severity of combat exposure (QAC A). The different symbols (circles and triangles) represent different groups of subjects, with each group being defined by a different level of combat exposure. The figure clearly shows that the severity of combat exposure is positively correlated with the number of subjects in the group, indicating that the severity of combat exposure is a valid measure.
The Self and Other Scale: a second step toward its French validation in patients with depression

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BACKGROUND

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

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

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

RESULTS

As shown in Table 1:

- Higher Insecure Self scores are positively related to psychiatric symptoms of depression (MADRS, p < 0.01), of phobic anxiety (BSI p < 0.05) and of psychoticism (BSI p < 0.01) as well as negatively associated with the openness dimension of BFI (p = 0.027).

- Higher Engulfed Self Scores are related to the Obsessive-Compulsive (p < 0.03) and Paranoid Ideation (p < 0.03) dimensions.

- No other correlation reached statistical significance.

METHOD

Patients

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

Analyses

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

Discussion

In patients with mood disorders, Insecure Self and Engulfed Self dimensions:

- are differentially related to psychiatric symptoms,

- are not associated to close theoretical constructs, such as attachment and personality dimensions

- seem to be unrelated to the current global social and clinical functioning.

Limitations

There are some limitations preventing the generalization of the findings:

- the sample size

- the lack of non-clinical and clinical control groups

- the lack of measures related to Self (e.g. Self-Esteem)

- the lack of interpersonal measures

Clinical Implications

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

References

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Cognitive-behavioural dysfunctions
Unwanted intrusive thoughts in OCD and ED patients: which variables predict the experienced disruption?

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INTRODUCTION

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

AIM

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

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

METHOD

79 OCD patients (mean age = 34.75 (SD = 11.99) years old)
Complied the INPIOS (Obsessive Intrusive Thoughts Inventory)
Participants indicate the FREQUENCY with which 48 unwanted OBSESIVE intrusive thoughts, images and impulses were experienced during the past 3 months related to aggressive, sexual/religiosity/immoral, contamination, doubts/mistakes, symmetry/order, superstition OBE. From 0 (“I have never had this intrusion”) to 6 (“I have this intrusion practically every day”)

177 ED patients (mean age = 26.67 (SD = 9.54) years old)
Complied the INPIAS (Eating Intrusive Thoughts Inventory)
Participants indicate the FREQUENCY with which 48 unwanted EATING DISORDER-related intrusive thoughts, images and impulses were experienced during the past 3 months related to eating, body appearance and the need to do exercise. From 0 (“I have never had this intrusion”) to 6 (“I have this intrusion practically every day”)

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

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

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

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

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

RESULTS

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

**OCD sample**
- DV: disruption of the most disturbing obsessive intrusion
- IV: Step 1: Appraisals
  - Step 2: Emotional Reactions
  - Step 3: Control strategies

39.3% disruption variance

**ED sample**
- DV: disruption of the most disturbing eating disorder-related intrusion
- IV: Step 1: Appraisals
  - Step 2: Emotional Reactions
  - Step 3: Control strategies

47.2% disruption variance

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

- difficulty controlling the thought
- control importance
- intolerance to uncertainty
- difficulty controlling the thought
- importance of the thought
- negative emotional reaction

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

<table>
<thead>
<tr>
<th>Variable</th>
<th>OCD sample</th>
<th>ED sample</th>
</tr>
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<tbody>
<tr>
<td>Control difficulty</td>
<td>332</td>
<td>.347</td>
</tr>
<tr>
<td>Control importance</td>
<td>-281</td>
<td>.219</td>
</tr>
<tr>
<td>Intolerance to uncertainty</td>
<td>.283</td>
<td>.304</td>
</tr>
<tr>
<td>Control difficulty</td>
<td>324</td>
<td>.516</td>
</tr>
<tr>
<td>Importance of the thought</td>
<td>.287</td>
<td>.453</td>
</tr>
<tr>
<td>Intolerance to uncertainty</td>
<td>.911</td>
<td>.1569</td>
</tr>
<tr>
<td>Negative emotional reaction</td>
<td>.254</td>
<td>4.164</td>
</tr>
<tr>
<td>Compulsions</td>
<td>.129</td>
<td>2.315</td>
</tr>
</tbody>
</table>

DISCUSSION

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

- Importance of controlling the thought explained both samples variance.
- Control importance and intolerance to uncertainty emerged as relevant in predicting obsessive intrusive thoughts’ disruption in OCD patients.
- Importance of the thought and negative emotional reactions predicted eating disorder-related intrusive thoughts’ disruption in ED patients.

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

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

REFERENCES


Study supported by MICINN (PSI2010-18540 & PSI2009-10957) & PROMETEU/2013/066
The Predictive Value of War/Combat Exposure-Related Experiences for Post-Traumatic Stress Disorder (PTSD) Symptoms: A Study with Portuguese Colonial War Veterans

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INTRODUCTION

The link between trauma-related interpersonal rapports, post-traumatic stress symptoms, and development of post-traumatic stress disorder (PTSD) symptoms is extensively studied in the literature. Several studies have shown the relationship between interpersonal trauma and PTSD symptoms, particularly in war veterans (Gross, 2009). PTSD may result from exposure to traumatic events, such as combat-related experiences, which are common in war veterans (Breslau et al., 1991). PTSD symptoms can include a range of psychological and physical responses, such as intrusive thoughts, avoidance behaviors, and hyperarousal. These symptoms can have a significant impact on the quality of life for individuals who experience them.

METHOD

Participants

A sample of 325 veterans from the general population of Portuguese Colonial War veterans was included. Participants were jointly nominated as a control group, through personal releases. The veterans were obtained from various sources of the Portuguese Colonial War community. The study included participants from different age groups, and the sample had a mean age of 62.89 years (SD = 14.27) with a range of 30 to 89 years. The veterans were also categorized based on the number of combat experiences they had, with the categories being none, 1-5, 6-10, 11-15, and 16 or more. The veterans were also categorized based on their marital status, with the categories being married, single, divorced, and widowed. The veterans were also categorized based on their education level, with the categories being primary, secondary, and higher education.

RESULTS

The study found that the veterans who experienced more combat experiences had higher PTSD symptom scores. The veterans who experienced more combat experiences were also more likely to have PTSD symptoms than those who experienced fewer combat experiences.

DISCUSSION

The results of the study highlight the importance of understanding the role of combat experiences in the development of PTSD symptoms in war veterans. The findings suggest that education programs and support services should be developed to help war veterans cope with the psychological effects of combat experiences. The findings also suggest that researchers should continue to study the relationship between combat experiences and PTSD symptoms to better understand the factors that contribute to the development of PTSD.

REFERENCES


CONCLUSION

The findings of this study have important implications for understanding the role of combat experiences in the development of PTSD symptoms in war veterans. The findings suggest that education programs and support services should be developed to help war veterans cope with the psychological effects of combat experiences. The findings also suggest that researchers should continue to study the relationship between combat experiences and PTSD symptoms to better understand the factors that contribute to the development of PTSD.

The study was funded by the Portuguese Social Security Fund. The authors have no potential conflicts of interest to declare.

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BURNOUT AND AGGRESSION
A study in residential aged care facilities.
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BACKGROUND
The burnout syndrome expresses a deterioration that affects the values, dignity, spirit and will of the people and expresses that a combination of need (Maslach and Leiter, 1997). This condition causes the person less within the working environment, a situation of imbalance between goals and the person will be engaged. The employment feeling increasingly inefficient at work and tends to work in a more critical and detached. The burnout syndrome is very common in relation to professional to be especially in areas such as health and social work. According to the current sociological profession are high (number and sex), they imply that is, numerous direct contacts with possible to difficulty (Maslach and Leiter, 1997). Referring to a research carried out in the Czech Republic (Rovena & Jurcik, 2011) on the violation of ethical principles in nursing homes for the elderly, it appears that the dissatisfaction with the work environment and the presence of more overtime can lead to the manifestation of aggressive behavior towards the elderly present in the structure.

METHOD
Participants
The sample consists of 95 care workers who work in six residential care for elderly users in Northern Italy (Liguria, Tomaso, Emmice, Bergamo, Lombardy).

RESULTS
Below are the most significant findings emerged from the data.

CONCLUSION
An analysis of the data shows that the work within the residential facilities for elderly users is at a high risk of burnout. High levels of stress at work are reflected in the interpersonal dynamics (both in relationships with colleagues) and in the attitude of care (Treadwell & Leiter, 1997). Specifically, in regards to the relationship between aggression is increased:

- Use methods of routes with patients (Figure 4).
- Use methods of routes "alternative" (Figure 6).
- To comply with the rhythm of the work plan, do not give the whole area to elderly carers (Figure 7).
- To comply with the rhythm of the work plan, do not give the whole area to elderly carers (Figure 7).

An analysis of data on the internal consistency of the questionnaire specifically concerned:

- Use methods of routes with patients (Figure 4).
- Use methods of routes "alternative" (Figure 6).
- To comply with the rhythm of the work plan, do not give the whole area to elderly carers (Figure 7).
- To comply with the rhythm of the work plan, do not give the whole area to elderly carers (Figure 7).

BIBLIOGRAPHY


Witness

Protagonist

Witness

Protagonist

Witness

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

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INTRODUCTION

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

AIM

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

METHOD

98 Eating disordered women patients
- Mean age = 7.19 years (SD=9.59)
- Mean BMI=18.72 (SD=2.87)
(Anorexia Nervosa =36; Bulimia Nervosa =16; EDNOS = 46)

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

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<tr>
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<td>Desirable</td>
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<td>-0.20</td>
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<td>0.14</td>
<td>0.36*</td>
<td>-0.30</td>
<td>-0.23</td>
</tr>
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</table>

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

DISCUSSION & CONCLUSIONS

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

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**Do Paranoid delusions function as experiential or current shame feelings?**

Rodrigues, M. & Castilho, P.
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**INTRODUCTION**

Paranoid Delusions are present in many mental disorders and are a frequently observed clinical phenomenon. Paranoid Delusions constitute a key clinical manifestation of psychosis, having a particular significance for the diagnosis of Psychotic Schizophrenia. The vulnerability to experience Paranoid beliefs has been associated with high levels of shame (Gillibrand et al., 2005), where an individual’s self-perception of being inferior (in a low rank position), odd/strange, unreliable, and unloved may then give rise to shame feelings and to the subsequent activation of defensive strategies, in order to minimize harm from others, avoid rejection, and protect oneself (Pfohl et al., 2009). Hence, a preconceived sense of threat to the self is felt which is felt vulnerable, inferior, or unnatural, and a view of others as dangerous, hostile and dominating, which may harm, reject, exclude or persecute the self could compromise the access to feelings of sadness and security, elevating the vulnerability to experience Paranoid symptoms (Pfohl et al., 2015). Paranoid symptoms might be understood if patients use avoidance as a method of regulating emotional conflict (Booth & Voysey, 2002). So, a process of Experiential Avoidance (EA) of current shame feelings might operate as a form of protecting the self from damages against one’s self-image, possible criticism and attacks from others.

Thus, this study sets out to explore the nature of Paranoid Delusions as a process of Experiential Avoidance of external shame. We are interested in investigating if the effect of shame on Paranoid Delusions is generated by Experiential Avoidance. So, in other words, we hypothesized that individuals with Paranoid Schizophrenia who believe they have a deeply depressive and fractional by others and also have higher levels of Paranoid Delusions will present more frequent, evoking and disturbing Paranoid Delusions.

**METHOD**

Participants and Procedures

Participants in this study were 30 patients with Paranoid Schizophrenia (25 men and 5 women) recruited from the Psychiatric Services of the “Caminho Hospital” in the city of Coimbra. The diagnoses of all the participants were given by experienced psychiatrists, who worked in the service and followed the cases. Participants ranged in age from 18 to 64, with a mean of 43.4 years. Regarding the education level, 11 participants had a primary school education, 13 had a secondary school education (vocation or general), and 6 had a university degree. Participants were excluded if they had a past history of any type of psychiatric disorder or if they had a history of substance abuse. All participants provided written informed consent prior to participation.

The assessment of Experiential Avoidance was conducted using the Acceptance and Action Questionnaire (AAQA). The AAQA is a self-report measure that assesses the degree to which individuals tend to act in ways that reduce experiential avoidance. The AAQA consists of 28 items that assess the likelihood of engaging in experiential avoidance on a 5-point scale. The higher the score, the greater the degree of experiential avoidance.

The assessment of shame was conducted using the Shame Sensitivity Scale (SSS). The SSS is a self-report measure that assesses the individual’s sensitivity to feelings of shame. The SSS consists of 10 items that assess the frequency and intensity of shame feelings. The higher the score, the greater the shame sensitivity.

**RESULTS**

Descriptions

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

Correlation analysis

All of the analyzed variables showed a positive relation between them (Table 1). The correlations were between external shame (Shame Sensitivity Scale), experiential avoidance (Acceptance and Action Questionnaire), and paranoid delusions (Psychiatric Comorbidities Questionnaire). All of these variables were highly correlated, especially the frequency of (Shame Sensitivity Scale), the conviction in Paranoid thoughts (Psychiatric Comorbidities Questionnaire), and the dimension associated (Psychiatric Comorbidities Questionnaire).

**CONCLUSION AND LIMITATIONS**

Our study adds to previous research on the relation between shame and Paranoid Schizophrenia, by suggesting that experiential avoidance and particularly shame avoidance have a significant mediator effect on the relationship between shame and Paranoid Schizophrenia. These are interesting results for clinicians, as they highlight the importance of addressing experiential avoidance and shame avoidance in the treatment of Paranoid Schizophrenia. ACT focuses on promoting psychological flexibility by directing clients towards acceptance of unpleasant thoughts and emotions (e.g., shame), and a commitment towards the achievement of valued life directions. This might be useful in reducing the use of a psychiatric treatment as ACT focuses specifically on reducing EA and enhancing psychological flexibility, as an alternative psychotherapeutic treatment for psychiatric symptomology.

**REFERENCES**


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Children and adolescents
The impact of Traumatic Shame Experiences in Social Anxiety - the moderating role of Emotional Intelligence

Maria da Luz Antunes & Maria do Côa Salvador & Alexandra Alves | 2013
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ABSTRACT
Adolescents whose traumatic shame experiences (TSE) reveal traumatic characteristics tend to develop a sense of self as shameful. Social anxiety (SA) can be influenced by current and pervasive feelings of shame and since emotional intelligence (EI) may enhance the ability to effectively cope with traumatic experiences, TSE may perform an important role in the association between the impact of TSE and SA. This study explored the associations between the impact of TSE, SA, and EI, in 1018 adolescents. Although the association between the impact of TSE and SA was weak, the impact of TSE had a significant predictive effect on SA. The relationship between the impact of TSE and EI was also statistically significant. Furthermore, EI had a moderator role in the predictive effect of the impact of TSE on SA.

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

INTRODUCTION
The centrality of Event Theory (Berntsen & Rubin, 2006; 2007) postulates that trauma memories or emotional negative events become central in the individual’s life history and identity, and create internal stable global attributions associated with post-traumatic stress reactions, depression and anxiety. Adolescents whose TSE reveal traumatic characteristics and regard shame events as key to identity and as turning points in their life story, tend to develop a sense of self as existing negatively in the eyes of others and in their own eyes, and the impact of shame memories operates through their influence on fostering shame feelings (Cunha et al., 2012). Nevertheless, adolescents with high EI report fewer psychological symptoms resulting from traumatic experiences (Toljendal et al., 2012).

Furthermore, socially anxious individuals are particularly prone to interpret a variety of experiences as distressing or traumatic (Carleton et al., 2011) and demonstrate re-experiencing, avoidance and hypervigilance at intensities that interfere with their processing (Erwin et al., 2006). Will EI moderate the association between the impact of TSE and SA?

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

TABLE 1. Sample’s distribution by gender

<table>
<thead>
<tr>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>436</td>
<td>582</td>
<td>1018</td>
</tr>
</tbody>
</table>

INSTRUMENTS

SELF-RESPONSE QUESTIONNAIRES:
Social Anxiety Scale for Adolescents (SAS-A; La Greca & Lopez, 1999); The Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997); Trait Meta-Mood Scale (TMMS; Salovey et al., 1995); Children’s Depression Inventory (CDI; Kovacs, 1985).

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

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

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

Future research

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

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

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

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

DISCUSSION

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

CORRELATIONS and REGRÉSSION

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

| TABLE 2. Partial Pearson correlations of SA, the Impact of TSE and EI. |
| TSE (IES-R) | SA (SAS-A) | .36*** | .20*** |
| FNE (SAS-A) | .35*** | .20*** |
| SDON (SAS-A) | .25*** | .24*** |
| SADG (SAS-A) | .32*** | .34*** |
| TSE (IES-R) | -.20*** |

<p>| TABLE 3. Independent effects of Gender, Depression and the Impact of TSE on SA, in the last model. |</p>
<table>
<thead>
<tr>
<th>Model</th>
<th>R²</th>
<th>R²</th>
<th>β</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 3</td>
<td>.329</td>
<td>.016</td>
<td>165,492***</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.040***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDI</td>
<td>.077***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES-R</td>
<td>.145***</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MODERATION ANALYSIS

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

REFERENCES

**Specific and generalized social phobia: differences and similarities in shame, self-criticism and impact**

Cátia Garcia & Maria da Cunha Salvador | 2013
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**ABSTRACT**

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

**Key words**: Social Anxiety, Specific Social Anxiety, Internal Shame, External Shame, Self-criticism, Quality of Life

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**INTRODUCTION**

Turner, Beidel and Townsey (1992) defend the inclusion of individuals with high anxiety in social interaction situations in the generalized subtype, and the inclusion of people with only fear of performance situations in the specific subtype. McNeil (2001) considers that generalized social phobia and specific social phobia are two different disorders, despite having phenotypical similarities. Individuals with generalized social phobia diagnosis present more precocious symptomatology, higher levels of introversion, more severe symptoms and higher rates of associated psychopathology (Turner et al., 1992). In the specific subtype, studies are scarce, namely in children and adolescents.

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

**METHOD**

**PARTICIPANTS**

Adolescents aged between 14 and 18. Generalized social phobia (GSP) N=85 Specific social phobia (SSP) N=34 Other anxiety disorder (OAD) N=44 Adolescents without psychopathology (N) N=68

**INSTRUMENTS**


**RESULTS**

**INTER-GROUP STUDY**

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

<table>
<thead>
<tr>
<th>Measures of depression, quality of life, shame and self-criticism</th>
<th>Differences</th>
<th>Effect size (Cohen’s d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDI</td>
<td>GSP&gt;SSP</td>
<td>0.55</td>
</tr>
<tr>
<td></td>
<td>GSP&gt;OAD</td>
<td>0.79</td>
</tr>
<tr>
<td></td>
<td>GSP&gt;N</td>
<td>1.18</td>
</tr>
<tr>
<td></td>
<td>SSP&gt;N</td>
<td>0.69</td>
</tr>
<tr>
<td>KidScreen-27</td>
<td>GSP&gt;N</td>
<td>0.99</td>
</tr>
<tr>
<td>Physical well-being</td>
<td>SSP&gt;N</td>
<td>0.71</td>
</tr>
<tr>
<td></td>
<td>OAD&gt;N</td>
<td>0.70</td>
</tr>
<tr>
<td>KidScreen-27</td>
<td>GSP&gt;SSP</td>
<td>0.57</td>
</tr>
<tr>
<td>Peers &amp; Social Support</td>
<td>GSP&gt;N</td>
<td>0.62</td>
</tr>
<tr>
<td>KidScreen-27</td>
<td>GSP&gt;N</td>
<td>0.66</td>
</tr>
<tr>
<td>School Environment</td>
<td>OAD&gt;N</td>
<td>0.68</td>
</tr>
<tr>
<td>ISS- Internal Shame</td>
<td>GSP &gt; OAD</td>
<td>0.79</td>
</tr>
<tr>
<td></td>
<td>GSP &gt; N</td>
<td>1.13</td>
</tr>
<tr>
<td></td>
<td>SSP &gt; N</td>
<td>0.81</td>
</tr>
<tr>
<td>OAS- External Shame</td>
<td>GSP &gt; OAD</td>
<td>1.28</td>
</tr>
<tr>
<td></td>
<td>GSP &gt; N</td>
<td>0.86</td>
</tr>
<tr>
<td></td>
<td>SSP &gt; N</td>
<td>0.70</td>
</tr>
<tr>
<td>FSCRS – Self-Criticism</td>
<td>GSP&gt;OAD</td>
<td>0.55</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>1.08</td>
</tr>
</tbody>
</table>

Only statistically significant differences are presented.

**CONCLUSIONS**

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

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

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

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

**REFERENCES**

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

MARTINA LOTAR RIFATARIC
University of Zagreb, Croatia

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

There are different approaches to measure the susceptibility to peer pressure so this study will compare results from correlational and experimental approach.

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

METHOD
Self-reported Susceptibility to peer pressure (first part of the study)
- Participants: 477 second grade high school students participated (41% boys and 59% girls) with average age M=16.02 (SD=0.33)
- Instruments:
  - Sensitivity to Peer Pressure was measured as self-report with Susceptibility to Peer Pressure Questionnaire (SPQP; Lotar, 2012)
  - descriptives of seven hypothetical situations concerning peer pressure to misconduct (smoking, alcohol consumption, smoking marijuana, stealing, cutting classes, breaking parents’ rules, impudent sexual behaviour)
  - participants needed to imagine themselves in each situation and choose one of the four answers that would describe their reaction in given situation
  - Attachment to friends (Anxiety and Avoidance) - Modified Experiences in Close Relationships Inventory (Kamenov & Jelić, 2003)
  - Cooperation - International Personality Item Pool (IPIP)
  - Desirability of risk behaviours from hypothetical situations – Desirability of Risk Behaviors Scale (Lotar, 2012)

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

RESULTS
The results of ANOVA have shown that boys are more prone to conform to peers’ behaviour than girls. Also, the adolescents are more susceptible when they were exposed to real peer pressure in experimental situation then they report in pen and paper questionnaire.

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

Hierarchical regression analysis have shown that higher percentage of variance is explained by included predictors when susceptibility to peer pressure was operationalized as self-report (95% vs. 24%). It seems that adolescents’ behaviour in the situation of pressure is more determined by different situational than individual factors.

DISCUSSION AND CONCLUSION
Adolescents report about their intention to behave in pen and paper questionnaire. However, in situation of peer pressure, they are more prone to meet their friends’ expectations. It can be concluded that in real life situation adolescents’ reaction to peer pressure is determined by other factors that were not included in this research.

Results indicate that in real situation adolescents do not think much about how they want to behave and what behaviours are acceptable to them, so it is not enough to teach them ‘just say no’ to socially undesirable behaviours. It is important to examine motivation for conformation to peers’ behaviour and to teach adolescents how to resist peer pressure in different situations but in, for adolescent, acceptable way.
Self-perception and anxiety as predictors of depression symptoms among Croatian adolescents

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

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

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

Method
A total of 938 elementary and high school students aged from 12 to 18 (M_age=14.82; SD_age=1.476) participated in the study (55% girls and 45% boys). The following instruments were applied:
- Depression Scale for Children and Adolescents (Vulic-Prtonic, 2003),
- Worry and Social anxiety subscales from Fear and anxiety scale for children and adolescents (Vulic-Prtonic, 2004),
- The Self-perception Profile for Adolescents (Harter, 1985), which measures general self-worth and following self-perception domains:
  - academic-scholastic competence, athletic competence, physical appearance, social acceptance, romantic appeal, behavioral conduct and close friendship (job competence was excluded from data analysis because content of this domain is not suitable for adolescents in Croatia)

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

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

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

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

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

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SOCIAL ANXIETY IN ADOLESCENCE: THE ROLE OF SHAME

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

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

Key-Words: Experience of Shame Scale (ESS), Social Anxiety Disorder (SAD), Shame and Adolescence

INTRODUCTION

Adolescence seems to be an important period to the development of both shame and social anxiety. It is a period in which we assist to a rapid magnification of shame, in the way that great changes take place such as the pubertal process, identity formation and emerging sexuality (Reiner, 1999). All these changes call attention to the Self and to its exposure, as well as to all the inherent social comparison processes (Kaufman, 1996).

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

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

METHOD

PARTICIPANTS

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

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

INSTRUMENTS

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

RESULTS

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

Table 1. Significant differences between groups

<table>
<thead>
<tr>
<th>Measures</th>
<th>F</th>
<th>Post-Hoc</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESS TOTAL</td>
<td>8.899*</td>
<td>SAD&gt;OAD, NCG</td>
</tr>
<tr>
<td>ESS CHARACTEROLESHAME</td>
<td>9.181*</td>
<td>SAD&gt;OAD, NCG</td>
</tr>
<tr>
<td>ESS BEHAVIORAL SHAME</td>
<td>8.355*</td>
<td>SAD, NCG</td>
</tr>
<tr>
<td>ESS BODILY SHAME</td>
<td>3.359</td>
<td>SAD, OAD, NCG</td>
</tr>
</tbody>
</table>

*p<.05

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

The only significant difference found between genders was in Factor 3 of the ESS (F = 8.128, p = .035), where girls scored higher than boys. Therefore, gender was not controlled for in any of the following analyses.

REFERENCES


DISCUSSION

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

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

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

Regression Analysis: Social Anxiety independent effects of Characterological Shame and Behavioural Shame

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

<table>
<thead>
<tr>
<th>Predictors</th>
<th>R</th>
<th>R²</th>
<th>B</th>
<th>β</th>
<th>F</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1</td>
<td>.606</td>
<td>.369</td>
<td>.1238</td>
<td>.097</td>
<td>2.209*</td>
<td></td>
</tr>
<tr>
<td>Characterological Shame</td>
<td>.366</td>
<td>.474</td>
<td>2.096*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Shame</td>
<td>.135</td>
<td>.525</td>
<td>5.71</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Table 2. Correlations between Shame and Social Anxiety

<table>
<thead>
<tr>
<th>Group</th>
<th>SAD (N=45)</th>
<th>SAS-A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FNE</td>
<td>SAD-N</td>
</tr>
<tr>
<td></td>
<td>.61**</td>
<td>.30**</td>
</tr>
<tr>
<td>Characterological Shame</td>
<td>.58**</td>
<td>.38**</td>
</tr>
<tr>
<td>Behavioral Shame</td>
<td>.58**</td>
<td>.36**</td>
</tr>
<tr>
<td>Bodily Shame</td>
<td>.39**</td>
<td>-.13</td>
</tr>
</tbody>
</table>

PNE=Fear of Negative Evaluation; SAD-N=Social Avoidance and Distress Specific to New Situations; SAD-G=Generalized Social Avoidance and Distress; SAS-A Total=Social Anxiety Scale for Adolescents; ESS=Experience of Shame Scale

To test for the role of shame on social anxiety, a hierarchical regression analysis was performed.
Behavioural medicine
Preventing side effects of adjuvant endocrine treatment in breast cancer?
Design and first results of a randomized controlled trial.


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Background
Adjuvant endocrine therapy (AET) considerably improves disease free survival and time to recurrence in women with breast cancer. However, AET is associated with considerable side effects that reduce patients’ quality of life and might result in non-adherence. (Eggermont, 2013). The majority of side effects is considered unspecific (nocebo effects), thus their development depends more on the treatment context and individual expectations rather than on the pharmacological action of the drug (Braam, 2013). Psychological interventions might be promising to prevent side effect burden and treatment discontinuation.

Aim of Study
To evaluate a cognitive behavioral Side Effect Prevention Training (SEPT) in a randomized controlled trial that
- optimizes patients’ response expectations before starting endocrine therapy and
- prevents nocebo side effects during longer term drug intake.

Sample: Pilot data of n = 75 patients:

<table>
<thead>
<tr>
<th>Variable</th>
<th>AETM</th>
<th>Supportive Therapy</th>
<th>TAU</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>26</td>
<td>28</td>
<td>24</td>
</tr>
<tr>
<td>Mean age (SD; range)</td>
<td>54.7</td>
<td>55.5</td>
<td>55.6</td>
</tr>
<tr>
<td>Type of surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast conserving</td>
<td>80.5</td>
<td>92.0</td>
<td>87.5</td>
</tr>
<tr>
<td>Mastectomy</td>
<td>11.5</td>
<td>8.0</td>
<td>12.5</td>
</tr>
<tr>
<td>Type of AET</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aromatase inhibitor</td>
<td>24.6</td>
<td>40.0</td>
<td>42.1</td>
</tr>
<tr>
<td>Tamoxifen</td>
<td>76.4</td>
<td>60.0</td>
<td>57.9</td>
</tr>
<tr>
<td>Staging</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage I</td>
<td>61.5</td>
<td>56.9</td>
<td>66.7</td>
</tr>
<tr>
<td>Stage III</td>
<td>26.9</td>
<td>36.9</td>
<td>20.9</td>
</tr>
<tr>
<td>Stage III and IV</td>
<td>7.6</td>
<td>4.1</td>
<td>8.3</td>
</tr>
</tbody>
</table>

Results
Patients’ needs
84.2% of the patients expressed their need to talk about their expectations. 67.2% expressed their need to talk about their emotions.

Evaluation of interventions

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

References:

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

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

Methods
Patient education
- Measures
  - Comprehension and recall
  - Perceived relevance and threat of information
- Mechanisms
  - Benefit
  - Side effects

Sample
N=95 postoperative patients with breast cancer
N=95 matched healthy controls
Age in both groups: M=56.44 (SD=10.82)

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

Results: Patients
Predictors and moderators of recall:
- R²=.46, F(5,88)=15.17, p<.001

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

Contact:
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Outcome and process research
INTRODUCTION
Perfectionism is characterized by the pursuit of excellence and an intolerance to imperfection. It is often accompanied by self-evaluative hypervigilance and anxiety about making mistakes. Local studies have shown an incidence of perfectionism in psychology students of more than half of respondents (60% of 761 evaluated subjects). Perfectionism has been considered a factor of causality in the maintenance of various mental disorders such as depression, social phobia, generalized anxiety disorder, obsessive-compulsive disorder, and anorexia nervosa. The need to develop preventive transdiagnostic treatments, as well as psychoeducational interventions aimed at reducing the impact of dysfunctional aspects associated with this trait has been raised in the fields of clinical and prevention psychology. To this end, our research team has designed a psychosocial intervention (PI) on perfectionism oriented to Argentine college students.

OBJECTIVE
- To evaluate the impact of a psychosocial intervention on clinical perfectionism.
- To prevent the emergence of clinical perfectionism in college students (Psychosocial Intervention).

METHOD
The study design is quasi-experimental, longitudinal and two repeated measures (pre- and post-intervention). Two measurements were taken: at the beginning (pre-intervention assessment) and at the end of the intervention (post-intervention assessment). The intervention was conducted in a group setting over four weeks. A significant reduction of perfectionism was observed at the end of the program. Effect size was large for all variables (from 0.88 to 2.09). Data at follow-up suggested that the intervention continued to have a positive effect. Complete data are available for follow-up.

METHOD
Participants
A total of 30 university students were randomly assigned to the intervention group (n=15) or the control group (n=15) using a 1:1 ratio. The intervention group received a four-week psychosocial intervention, while the control group did not receive any intervention.

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

RESULTS
Significant differences were found at pre-post PI for both perfectionism and clinical measures. Discrepancy score and Depression score decreased significantly after the intervention. Anxiety score also decreased, but the effect size was smaller. The intervention had a significant effect on reducing perfectionism, depression, and anxiety levels.

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

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

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

INTRODUCTION

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

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

GROUP TREATMENT

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

The three parts of the group programme focus on:
- understanding relationships (sessions 1-4)
- understanding the principles of self-management in relationships (sessions 5-8)
- skills for self-management in relationships (sessions 9-12).

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

RESULTS

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

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

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

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

DISCUSSION

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

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

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

A charity leading innovation in mental health

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Young psychotherapists today: the impact of a four years training in an Italian CBT school.

Colombo P., Di Berardino A., Bizzozero A., Pagenuzzi P., Raffognato C. e Meneghelli A. (ASIPSE, ITA)

OBJECTIVE
The study aims to investigate the impact on trainee psychotherapists of four years postgraduate specialist training in a Cognitive-Behavioral school. Although the Cognitive Behavioural approach has a strong evidence-based orientation, we have very few, almost zero, data about the effects that the training received by future psychotherapists has on on the psychotherapists themselves. We should to ask not just:
- Does he/she knows all the things a therapist should know?
- Has he/she developed the personal characteristics that he/she promotes?
This work goes in the direction of being the first step in answering those two questions, starting from

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

A survey of variables such as self-esteem, assertiveness, explanatory style and quality of life
dimensions investigated by standardized self-report questionnaires

Satisfaction with Life Scale - Attributional Style Q. - Basic SE (Self-esteem Scale) - SIB (Scale for Interpersonal Behavior)

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

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

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

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

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

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

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

The average age of entry at Asipse is 30 years (from 25 to 60 years old)
The time between graduation from university and the entry at Asipse varies from 1 year to 23 years.

The average age at the time of Graduation is 26,5 years
(the youngest at 24 years old, the oldest 37)

The average age of entry at Asipse is 30 years (from 25 to 60 years old)
The time between graduation from university and the entry at Asipse varies from 1 year to 23 years.
RESULTS FROM A PILOT TRIAL USING COMPASSION AND LOVING KINDNESS PRACTICES IN A GROUP SETTING WITH PATIENTS SUFFERING FROM CHRONIC DEPRESSION

Johannes Graser, Volkmar Höfling, Charlotte Weßlau & Ulrich Stangier

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

THEORETICAL BACKGROUND

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

METHOD

Sample

- N = 11 Patients suffering from chronic depression (Dysthymia: recurrent depressive disorder without sufficient remission for at least 2 years or double depression; Diagnosed with SH ODD, PDD in Psychiatric Status Rating (PSR) instrument for assessment of chronic depression)
- 7 female patients, 4 male patients
- Age between 31-55 years (M = 41.84 Range 24-55)
- Average duration of chronic depression 6.3 years (SD = 5.16 Range 2-17)
- Mostly no medication experience
- Patients with acute addictions, manic or psychotic symptoms, PTSD or odd/dramatic personality disorders were not included
- Included patients were allowed medication but no current psychotherapy

Program structure

- 9 weekly group sessions (8 x 100 minutes, 1 x 200 minutes = Retreat)
- 1 main meditation exercise every week:
  - 3 Min: Mindfulness exercises: Mindfulness of a stone / breath / feelings
  - 2 Self-Compassion exercises: Self-Compassion Break (2 weeks), Self-Compassion to my feelings
  - Loving-kindness meditation (3 weeks)

- The sessions started off with the practice of last weeks homework exercise, afterwards group discussion: How was that exercise for you and how did the practice go at home?
- Theoretical input on Mindfulness / Self-Compassion / Loving-kindness
- Introduction of a new exercise and group discussion
- Sometimes informal practices
- Discussion of homework, 30 minutes of daily practice with provided taped exercises were recommended.

RESULTS

Depression

BDI II

Correlations: Practice time = Difference depressive symptoms

<table>
<thead>
<tr>
<th>Practice time (minutes)</th>
<th>Difference BDI II (no. n = 4)</th>
<th>Practice time (minutes)</th>
<th>Difference BDI II (no. n = 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice time during 9-week program to 0,13</td>
<td>43.30 (9.43)</td>
<td>43.30 (9.43)</td>
<td></td>
</tr>
</tbody>
</table>

Other Scales


Self-Reported Changes (Pre / Post / Follow-up 12 weeks)

Discussion

The main outcome measure, the BDI II, did not reach a significant decrease in the pilot study. Participants who practiced more, experienced a stronger decrease in depression. Self-Esteem was increased significantly with a medium sized effect at 12-week follow-up. This overall Self-Compassion Scale did not significantly increase, the subscales Self-Kindness (post) and follow-ups and Mindfulness (follow-up) showed medium sized increases.

Next, post and follow-up set reports comparing the patients current state with the state before therapy showed mostly slight improvements in the inquired areas. The majority of the patients evaluated the program as (rather) helpful, though the results on depression are not satisfactory yet. In a second trial we will reduce the size of the exercises to allow more practice for each exercise. We also decided to prolong the treatment from 9 to 12 weeks. In addition, we want to address issues with the exercises that caused problems for some patients such as ‘fear of compassion’ (Gilbert, 2011) and other problems we came across with these exercises (e.g., ‘don’t deserve / feel compassion’).

References


PsycroCom 2013 n. 2-3 Special Issue: 43rd Annual Congress EABCT Selected Posters 37
Dialectic Behavioural Therapy –based skills training in group for adults with ADHD

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

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

Fig 1. Treatment components (in the middle) are applied on different ADHD-related themes.

STUDY 1: RCT effectiveness study
In a Swedish outpatient psychiatric context we evaluated effectiveness (feasibility and efficacy) of Dialectical Behavioural Therapy (DBT) -based skills training groups for adults with ADHD (Hesslinger, Philipson & Richter, 2004; Philipson et al, 2007).

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

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

Fig 2. The RCT study was published 2011.

STUDY 2: Predictors of treatment effects and drop-out

Fig 3. Study 2 was performed according to the Swedish version of the treatment manual, published 2010.

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

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

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

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

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

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

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

Preliminary results
Approximately 85% of participants have completed the treatment; an acceptable feasibility in the compulsory care context.
Changes in Thought-Action Fusion and Inferential Confusion Scores with Cognitive-Behavioral Group Therapy for Obsessive-Compulsive Disorder

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4Hasan Kalyoncu University Department of Psychology
E-mail: drgusafak@yahoo.com

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

<table>
<thead>
<tr>
<th>Socio-Demographic Features</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>9</td>
<td>24.3%</td>
</tr>
<tr>
<td>Women</td>
<td>28</td>
<td>75.7%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-24</td>
<td>8</td>
<td>21.6%</td>
</tr>
<tr>
<td>25-40</td>
<td>24</td>
<td>66.7%</td>
</tr>
<tr>
<td>41-65</td>
<td>5</td>
<td>13.5%</td>
</tr>
<tr>
<td>Mean</td>
<td>32.13 ± 9.85</td>
<td></td>
</tr>
<tr>
<td>Education in years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 years</td>
<td>12</td>
<td>32.5%</td>
</tr>
<tr>
<td>9-11 years</td>
<td>14</td>
<td>37.8%</td>
</tr>
<tr>
<td>12 years</td>
<td>11</td>
<td>29.7%</td>
</tr>
<tr>
<td>Mean</td>
<td>10.59±3.58</td>
<td></td>
</tr>
<tr>
<td>Age at Onset</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>23.24 ± 5.89</td>
<td></td>
</tr>
<tr>
<td>Disorder Duration (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>8.89±0.99</td>
<td></td>
</tr>
</tbody>
</table>

Alterations in YBOCS, BAI, BDI, TAFS and ICQ were shown in the table 2. We found CBGT is effective. Hence, statistically significant difference between the initial and final scores (YBOCS, BDI, BAI) of the patients was detected. Also, alterations in TAFS and ICQ are both statistically significant at the level of p<0.001.

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

<table>
<thead>
<tr>
<th></th>
<th>Average Difference</th>
<th>Average</th>
<th>Std. D</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial YBOCS – Final YBOCS</td>
<td>13.72</td>
<td>6.04</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Initial BAE – Final BAE</td>
<td>8.65</td>
<td>9.98</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Initial BIDE – Final BIDE</td>
<td>7.37</td>
<td>6.37</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Initial TAF-Final TAF</td>
<td>16.13</td>
<td>15.55</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>InitialICQ-FinalICQ</td>
<td>9.72</td>
<td>13.82</td>
<td>.001</td>
<td></td>
</tr>
</tbody>
</table>

CONCLUSION:

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

References

1Ruscio, E. (2001) The contribution of thought-action fusion and in the development of obsession-like intrusions in normal participants, Behaviour Research and Therapy, 39, 1023-1032
7Purdon, C. (1999) and psychopathology. Behaviour Research and Therapy, 37, 1023-1034

RESULTS:

Socio-demographic variables and disorder duration were shown in the table-1.
An experimental study of “written emotional expression”: mechanisms and effectiveness

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Anna Rita Colanelli, Faculty of Educational Sciences, Universita Pontificia Salesiana, Roma
Margherita Cirillo, Center for Research in Psychotherapy (CRP), Rome, Italy

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

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

Method
120 undergraduate students were enrolled and randomly divided into 3 groups of 40 SS each. The first underwent three EWT sessions about their own traumas, the second underwent three sessions of a mood enhancing writing technique (according to the method of Laura King), and the third was invited to write about neutral experiences. Both at baseline and 40 days after the end of the experimental period, the scores of Well-Being were gathered with the Ryff Scale (RS) and of Depression with the Beck Depression Inventory (BDI).

All the written reports about the traumatic experiences were gathered, and were assessed for the frequency of emotional words (positive, negative) as a measure of emotional expression, and total word count as a measure of descriptive detail.

Assessment procedure
Instruments used:
- HWV - Ryff Scales of Psychological Well-Being (Ryff)
- Depression: Modified Beck Depression Inventory (Mod. EBDI)
- Emotional expression: Linguistic Inquiry and Word Count (LIWC)

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

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

Results
Only 55 in the first group (EWT) exhibited both a significant reduction in BDI scores (depression level) and an improvement in PWB scores (well-being), as compared either to the second group (L. King’s technique) and to the control one. The 55 in the second group did not show any significant improvement in the two outcome measures.

In the written reports, the number of positive emotions was not significantly correlated with the outcome in neither technique, and the number of negative words was significantly correlated with the outcome in EWT, but inversely as expected, whereas it was rather the total number of words to be associated with increases of well-being in EWT.

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

References
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