Special Issue:
“Bridging the gap between science and practice”
Selected Posters from the 44th Annual Congress of the European Association for Behavioural and Cognitive Therapies (EABCT)
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Editorial

Dear readers,

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

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it became soon evident that posters exhibited in Conferences were already implementing that idea, albeit they remained unpublished on scientific journals, for obvious reasons, the main one being that they were too large to be compressed in a journal page.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

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

In the current special issue, the 36 resulting posters accepted for this publication come
from 18 different countries (new entry: Cyprus), grouped according to their large thematic areas. Among them, you will find one of the nominates for the poster prize: A brief cognitive-behavioral therapy for the breast reconstruction decision-making. Psychological effects of the breast reconstruction, by MªJosé Gallego (Spain).

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

Again, we leave the final word to you,

Dimitra Kakaraki
Lucio Sibilia
Rome, December 2014
The Posters

Adolescents
Why are students absent?
The predictive role of risk-health behaviors and symptoms of psychopathology for boys and girls

Serena V. Bauducco*, Maria Tillfors, Steven J. Linton, and Metin Özdemir
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BACKGROUND

- Adolescents skipping school are at risk for poor present and future outcomes.
- Presence of the same boys and girls.
- Students skip school... - are anxious and depressed - have low self-esteem and poor peer interactions - engage in delinquency outside school - they do not sleep well

- Problems:
  - Few studies have looked at all three issues together, but they should
  - Impaired and anxious students are not seen in the same at-risk group (Peterson, 2005).
  - Risk of school absence is a new area of research, but it is assumed that the reasons are the same. (Bittner, 2005)
  - Different patterns of absenteeism.
  - Different coping strategies that may lead to avoiding school.

- Questions:
  - How many students report risk factors for absenteeism?
  - Do they really contribute to risk factors for absenteeism over and above internalizing problems?
  - Does this matter for both boys and girls?

METHOD

- Longitudinal study
- Participants:
  - 442 (51% girls)
  - Age range 9-10
  - Wave 1: grade 1-3 - Wave 2: grade 1-4
- Measures:
  - Absenteeism T1 (1)
  - Risk factors (at school and home) for missing school in the last three months
  - Social anxiety (1)
  - School social phobia (1)
  - Social phobia (1)

RESULTS

Table 1. Binomial logistic regression - girls

<table>
<thead>
<tr>
<th>Variable</th>
<th>B (SE)</th>
<th>Wald</th>
<th>p</th>
<th>Exp(B)</th>
<th>95% CI for Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absenteeism T1 (1)</td>
<td>1.52 (0.54)</td>
<td>5.44</td>
<td>0.02</td>
<td>0.73</td>
<td>1.29</td>
</tr>
<tr>
<td>Alcohol intolerance (1)</td>
<td>0.04 (0.01)</td>
<td>1.70</td>
<td>0.19</td>
<td>1.06</td>
<td>0.84-1.34</td>
</tr>
<tr>
<td>Bullying victimization (1)</td>
<td>0.15 (0.02)</td>
<td>7.28</td>
<td>0.01</td>
<td>1.16</td>
<td>1.07-1.25</td>
</tr>
<tr>
<td>Social phobia (1)</td>
<td>0.13 (0.03)</td>
<td>4.65</td>
<td>0.03</td>
<td>1.07</td>
<td>1.00-1.15</td>
</tr>
<tr>
<td>Depression symptoms (1)</td>
<td>0.90 (0.06)</td>
<td>126.89</td>
<td>5.02</td>
<td>1.09</td>
<td>1.09-1.10</td>
</tr>
<tr>
<td>Social Anxiety (1)</td>
<td>0.02 (0.01)</td>
<td>1.98</td>
<td>0.15</td>
<td>0.89</td>
<td>1.06-1.65</td>
</tr>
<tr>
<td>Somatic symptoms (1)</td>
<td>0.10 (0.02)</td>
<td>3.17</td>
<td>0.04</td>
<td>1.01</td>
<td>0.98-1.05</td>
</tr>
<tr>
<td>Somatic stress (1)</td>
<td>0.20 (0.10)</td>
<td>3.71</td>
<td>0.05</td>
<td>1.21</td>
<td>1.00-1.47</td>
</tr>
<tr>
<td>Sleep complaints (1)</td>
<td>0.52 (0.10)</td>
<td>17.17</td>
<td>1.00</td>
<td>1.01</td>
<td>1.00-1.02</td>
</tr>
<tr>
<td>Sleep complaints (2)</td>
<td>1.46 (0.50)</td>
<td>6.57</td>
<td>0.01</td>
<td>1.01</td>
<td>1.00-1.03</td>
</tr>
</tbody>
</table>

Note: Step 2 model: R² = 0.49 (Exp. & Soc.): 0.46 (Exp. & Soc.); Model (p<0.01): 0.34 (Exp. & Soc.)

Table 2. Binomial logistic regression - boys

<table>
<thead>
<tr>
<th>Variable</th>
<th>B (SE)</th>
<th>Wald</th>
<th>p</th>
<th>Exp(B)</th>
<th>95% CI for Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absenteeism T1 (1)</td>
<td>0.28 (0.05)</td>
<td>2.09</td>
<td>0.15</td>
<td>1.30</td>
<td>0.67-2.51</td>
</tr>
<tr>
<td>Alcohol intolerance (1)</td>
<td>1.10 (0.06)</td>
<td>7.67</td>
<td>0.01</td>
<td>3.00</td>
<td>1.96-4.58</td>
</tr>
<tr>
<td>Bullying victimization (1)</td>
<td>0.30 (0.03)</td>
<td>11.14</td>
<td>0.01</td>
<td>1.35</td>
<td>1.02-1.79</td>
</tr>
<tr>
<td>Social phobia (1)</td>
<td>0.07 (0.02)</td>
<td>1.38</td>
<td>0.24</td>
<td>1.07</td>
<td>0.88-1.31</td>
</tr>
<tr>
<td>Depression symptoms (1)</td>
<td>0.12 (0.02)</td>
<td>6.97</td>
<td>0.01</td>
<td>1.13</td>
<td>1.06-1.20</td>
</tr>
<tr>
<td>Social Anxiety (1)</td>
<td>0.05 (0.01)</td>
<td>4.89</td>
<td>0.03</td>
<td>1.05</td>
<td>1.01-1.08</td>
</tr>
<tr>
<td>Somatic symptoms (1)</td>
<td>0.15 (0.03)</td>
<td>6.42</td>
<td>0.01</td>
<td>1.16</td>
<td>1.03-1.31</td>
</tr>
<tr>
<td>Somatic stress (1)</td>
<td>0.22 (0.10)</td>
<td>3.94</td>
<td>0.05</td>
<td>1.27</td>
<td>1.00-1.62</td>
</tr>
<tr>
<td>Sleep complaints (1)</td>
<td>0.82 (0.14)</td>
<td>17.07</td>
<td>1.00</td>
<td>1.01</td>
<td>1.00-1.02</td>
</tr>
<tr>
<td>Sleep complaints (2)</td>
<td>0.09 (0.02)</td>
<td>3.51</td>
<td>0.06</td>
<td>1.09</td>
<td>1.00-1.19</td>
</tr>
</tbody>
</table>

Note: Step 2 model: R² = 0.49 (Exp. & Soc.): 0.46 (Exp. & Soc.); Model (p<0.01): 0.34 (Exp. & Soc.)

CONCLUSIONS

- Sleep complaints in an important risk independently of sex.
- By targeting sleep hygiene and schedules, one would not only improve school attendance directly but also through an improvement in overall psychological health.
- Girls with social phobia had more problems attending school as compared to boys with the same scores.
- By testing the model separately for boys and girls, different reasons for school absenteeism emerged.
- These differences are important when planning a preventive intervention.
Explicit memory bias and eating disorders: evaluation among young French women with high body dissatisfaction or suffering of eating disorders.

Gasperini, C., Rousseau, A.
Université Lille Nord de France, Ltexts, PSCIC, Villeneuve d'Ascq, France

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

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

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

Participants:
42 young women, college students
mean age: 20.96 ± 2.03 (min = 18; max = 25),
mean BMI: 21.8 ± 4.16 (min = 17; max = 39).

Questionnaires:
Body Shape Questionnaire (BSQ) (Cooper et al., 1987)
self-report measure of body dissatisfaction
Eating Attitudes Test (EAT-26) Garner et al. (1982):
self-report measure of symptoms and concerns characteristic of eating disorders
Questionnaire for Eating Disorder Diagnosis (QEDD) (Mintz et al., 1992):
questionnaire assessing the diagnostic criteria for AN, BN, BED, EDNOS and subclinical disorders

Procedure:
Women watched target and control words.
They performed a self-referent encoding task (imagination task) during the exposition on a computer to experimental material.
Then, memory recall of words was subsequently assessed.
Finally, self-report measures were taken.

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

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

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

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

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

Aim

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

Method

A total of 949 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:

- The Depression Scale for Children and Adolescents (Vulić-Pršćan, 2003).

- Each participant separately assessing mother and father on a four level scale.

Results

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

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

<table>
<thead>
<tr>
<th>CRITERION VARIABLE</th>
<th>SOCIAL ANXIETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>autonomy (from the mother)</td>
<td></td>
</tr>
<tr>
<td>mother’s monitoring</td>
<td></td>
</tr>
<tr>
<td>father’s negative discipline</td>
<td></td>
</tr>
<tr>
<td>mother’s acceptance</td>
<td></td>
</tr>
<tr>
<td>mother’s psychological control</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CRITERION VARIABLE</th>
<th>DEPRESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>mother’s acceptance</td>
<td></td>
</tr>
</tbody>
</table>

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

Conclusion

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

44th Annual EABCT Congress, The Hague e-mail: marja.lebedina.manzoni@erf.hr
Although social anxiety may not be disabling of social functioning per se, in an excessive level, it may be uncomfortable, emotionally exhausting and highly disabling, from which point it is designated social anxiety disorder (SAD). Concerning information processing of SAD patients, post-event processing (PEP) is pointed out as a crucial maintenance factor of the disorder (Clark & Wells, 1995). Thus, research on this subject is imperative to better understand and assess SAD and improve clinical practice. One of the widely used questionnaires to assess post-event processing is the Post-Event Processing Questionnaire (PEP; Fehm et al., 2008). Since in Portugal, there was no measure to assess this construct, the aim of this study was to validate the PEP both in adolescents and adults. The psychometric properties of both versions were good. The factor structure of the Portuguese version, regardless of the sample, revealed a 3-factor structure (unlike the 4-factor original version): Persistent Ruminating, Specific Ruminating and Control Attempts. The PEP has demonstrated good internal consistency and reasonable validity, thus becoming a valuable asset in clinical evaluation and research of SAD in general, and of PEP, in particular.

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

**ABSTRACT**

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

**METHOD**

**RESULTS**

**CONCLUSION**

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

**References**

Regulation of Shame and Pride in Adolescents with Collectivistic Migration Background
Iryna Struina, Annabelle Starck, Ulrich Stangier

Introduction
According to Matsumoto, Yoo & Le Roux (2004) the capacity to regulate emotions effectively is crucial for successful intercultural adjustment. Particularly self-conscious emotions pride and shame play an important role in the accommodation process of immigrants and development of their children’s (experiences of discrimination, conflicts between the culture of origin and receiving culture etc.). They also contribute significantly to the development of mental disorders such as depression or social phobia (Pfohlmann, Anu-Ansvari & Hinton, 2020). Cultural comparative studies could show that social-engaged emotions like shame are experienced more often and shown more overtly in cultures with more collectivistic background as compared to those with a stronger individualistic orientation. Whereas social disengaged emotions such as pride are experienced and shown less in collectivistic cultures (Tracy & Matsumoto, 2008). At the same time studies conducted on emotion regulation in general and on other emotions (e.g. anger) have shown that participants with collectivistic orientation tend to suppress their emotions more than those with individualistic orientation (Matsumoto, Yoo & Nakagawa, 2008; Novin, Banaji & Kieff, 2012).

The objective of the present study is the investigation of the experience and regulation of experimentally-induced shame and pride in adolescents considering the cultural orientation.

Hypotheses
1. Migration background (MB) and emotion intensity:
1.1 Pride: Adolescents with MB report less intensity of pride than adolescents without MB.
1.2 Shame: Adolescents with MB report more intensity of shame than adolescents without MB.

2. Migration background and emotion regulation:
2.1 Pride: Adolescents with MB suppress pride more & accept less than those without MB.
2.2 Shame: Adolescents with MB suppress shame less & accept more than those without MB.

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

Assessment
- Interview on socio-demographic data
- SDQ - Strengths and Difficulties Questionnaire (Goodman, 1997)
- Habitual affective style: ASQ-Kilo - Affective Style Questionnaire for children and adolescents (Böls, unpublished, Munich & Koblenz, 2008)
- FEEL-KI: Questionnaire for Assessment of Emotion Regulation in Adolescents (Gröb & Smirnoff, 2005)
- FRANK 11-18 R: Frankfurt Acculturation Scale for Adolescents (Kohlbrenn, Hupper & Gröb, 2013)
- CQS: Cultural Orientation Scale (Kohlbrenn, Mayer & Weltz, 1994)
- Intensity of shame and pride: SSQS: State Shame and Guilt Scale (Marchall, Isomvii, & Tangy, 1990)
- PANAS: Positive and Negative Affect Schedule (Watson & Clark, 1994)
- Emotion regulation strategy being used: ASO-Kilo-State (6 items from ASO-Kilo, 2 for each scale)
- Suppression, Reappraisal, Acceptance
- Physiological assessment: EDA, ECG

Procedure
- Assessment of control variables
- T1: Written report of pride-evoking autobiographical event
- T2: Oral report of pride-evoking autobiographical event
- T3: Written report of shame-evoking autobiographical event
- T4: Oral report of shame-evoking autobiographical event

Results
Differences in intensity of pride (PANAS) Differences in intensity of shame (PANAS) Differences in ER after pride induction Differences in ER after shame induction

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

Yulisha Byrow & Lorna Peters
Centre for Emotional Health, Department of Psychology, Macquarie University, Australia.

Introduction:
Attention is implicated in the major theoretical models of social anxiety disorder (SAD).
- Clark & Wells (1995): individuals with SAD avoid focusing attention on threat signals.
- Rapee & Heimberg (1997): SAD individuals are initially vigilant to threat cues. Once threat is detected these individuals have difficulty disengaging from threat.

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

Method:
Thirty three clinical participants with a primary diagnosis of SAD (DSM-IV).
Eye tracking task (difficulty to disengage (DDE)) at pre-treatment, measures of social anxiety (SIAS), adult attachment (ECR-R) & depression (DASS) completed at pre and post treatment.

Statistical Analysis: A hierarchical linear regression was conducted with social anxiety severity scores measured at post treatment as the dependent variable. Independent variables (attachment anxiety, attachment avoidance, angry DDE Scores, neutral DDE Scores, happy DDE Scores).

Results:

<table>
<thead>
<tr>
<th>Model</th>
<th>R Square Change</th>
<th>Sig. F Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>.44</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Pre-treatment Social Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attachment Avoidance</td>
<td>.15</td>
<td>.142</td>
</tr>
<tr>
<td>Attachment Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Happy DDE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neutral DDE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry DDE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Att Avoidance × Angry DDE</td>
<td>.29</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Att Avoidance × Neutral DDE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Att Avoidance × Happy DDE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Att Anxiety × Angry DDE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Att Anxiety × Neutral DDE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Att Anxiety × Happy DDE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Summary & Conclusions:
Attachment moderates the relationship between attention and treatment outcome.
- Those who are high on attachment anxiety and were quicker to disengage from the angry face at pre-treatment had lower SAD severity at post-treatment.
- Those who are high on attachment avoidance and were slower to disengage from the angry face at pre-treatment had lower SAD severity at post-treatment.

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

INTRODUCTION

Anxiety disorders are among the most prevalent problems during childhood. In many cases, they have a huge impact on children and family lives and are associated with important health and social costs (Bieden, Ekstein, & Bogies, 2007). Theoretical models and research have highlighted the role of certain parental factors in children’s anxiety (e.g., Barlow, 2003) and have identified the bidirectional influence of parents and child’s behaviors in the development of childhood anxiety problems (e.g., Rapee, 2001). Few studies were capable to identify and measuring these reciprocal and interactional processes. Furthermore, the differences between fathers and mothers behaviors in interactions with anxious children remain unclear. The present study pursued these purposes, using time window sequential analysis in order to explore parent-Child interactions in the context of anxiety.

OBJECTIVES

The study examined the role of children’s anxiety and parental behaviors during parent-child interactions and attempted to:

1. Compare parenting behaviors of parents from anxious and non-anxious children.
2. Analyze the co-occurrence of negative parent-child practices, such as overinvolvement and rejection, and children anxiety manifestations.
3. Compare mother’s and father’s behavior towards the children.

METHOD

Participants: Thirty-three children (ages 9-12 years) and their parents (fathers; mothers) were recruited. The anxiety disorder group consisted of children with a primary diagnosis of anxiety disorder (Generalized anxiety, 17.1%; social phobia, 17.1%; specific phobia, 14.3%; separation anxiety, 8%). The control group (n = 13) included non-anxious children. Children were recruited in Portuguese public schools through a multilevel screening method.

Measures: Children’s anxiety was evaluated by the Screen for Child Anxiety-Related Emotional Disorders—Modified (SCARED-M; Muris, Merckelbach, & Merckelbach, 1999). Children’s version) and by the Anxiety Disorder Interview Schedule—Parents and Child—adapted version (A-DISC-P; Albano e Silverman, 1995).

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

Procedure: Design: 2 task (speech preparation) × 2 (dyad father-child/child-child) was used. Each task took 3 minutes long.

Data Analysis: Sequential analysis was used to code observations according to discrete events and to practice time units. Using individual content codes, a priori categories were created based on theoretical definitions, namely overinvolvement (McLeod, Wood & West, 2007).

RESULTS

Mothers from anxious children are more likely to be overinvolving compared to children from non-anxious children (e.g., emotional overinvolvement; anxiety symptoms; request for assistance and reassurance). Mothers from non-anxious children are overinvolving only when children verbalize their anxiety feelings. Fathers of anxious children are more overinvolving when children request their assistance, showing lesser overinvolvement than fathers from non-anxious children.

Mothers and fathers from anxious children are more likely to reject their offspring in specific ways (e.g., verbal rejection, derisory child’s feelings; negative affect) when children manifest anxiety symptoms (e.g., verbal and nonverbal anxiety), whereas parents from control group express rejection in fewer situations.

DISCUSSION

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

References:

Are Police applicants particularly resilient to trauma?

Background

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

Methods

Population and control subjects characteristics

<table>
<thead>
<tr>
<th></th>
<th>Police applicants (N=100)</th>
<th>Control individuals (N=130)</th>
<th>Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Age</td>
<td>29.293</td>
<td>3.189</td>
<td>24.834</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>M women</td>
<td>M men</td>
<td>M women</td>
</tr>
<tr>
<td>Prof training</td>
<td>8</td>
<td>48</td>
<td>9</td>
</tr>
<tr>
<td>Educ degree</td>
<td>3</td>
<td>32</td>
<td>3</td>
</tr>
</tbody>
</table>
| Note: n.s. = non-significant

Results

Aggression is significantly predicted by social desirability, even after having accounted for happiness/depression and anxiety (Step 2: ΔR²=.120; F(1,207)=43.578; p=.000). Regression in Step 3 indicates that sensitivity to punishment and sensitivity to reward make an additional contribution to predict aggression attitude (ΔR²=.089; F(2,205)=18.926; p=.000). Individuals more sensitive to reward tend to be more aggressive (β=3.262; p=.013; p=.000) independently of their social desirability, happiness/depression and anxiety levels. Some findings have also been described within the Police applicants subsample.

Conclusion

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

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ALCOHOL USE AS AN EXPERIENTIAL AVOIDANCE STRATEGY IN SOCIAL ANXIETY

Maria do Céu Salvador & Fabiana Tomé | 2014
cesusalvador@gmail.com & fabianatome@live.com.pt

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

INTRODUCTION
Herbert & Cardaciotto’s model (2010) for Social Anxiety Disorder (SAD), in line with the Acceptance and Action Therapy (Hayes et al., 1999), postulates that reduced acceptance promotes the use of experiential avoidance strategies that will paradoxically lead to an increase of the symptoms and to a disruption of behavior. Alcohol consumption is widely associated to SAD (Cattaneo & Randall, 2005), while, on the other hand, individuals with alcohol abuse frequently exhibit social anxiety (Lepine & Pellecchio, 1998). Given alcohol’s pharmacological effects reducing anxious symptoms and other negative emotions, alcohol consumption could then be considered an experiential avoidance strategy. However, the literature linking SAD, alcohol and acceptance is scarce.

PARTICIPANTS
Individuals aged between 18 and 65 years old

Table 1. Participants by gender

<table>
<thead>
<tr>
<th>GENDER</th>
<th>DIAGNOSIS</th>
<th>STRESS</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>143 (47.4%)</td>
<td>169 (52.6%)</td>
<td>312</td>
</tr>
<tr>
<td>Female</td>
<td>7 (21.9%)</td>
<td>25 (78.1%)</td>
<td>32</td>
</tr>
</tbody>
</table>

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

STUDY 1
The Exploratory Factor Analysis performed to explore the SA-AAQ dimensionality revealed a bifactorial structure - acceptance and action - explaining 68.76% of the variance. The SA-AAQ showed good internal consistency, a good test-retest reliability, a 4.6 internal consistency, and discriminant validity, and sensitivity to differentiate subjects with SAD.

STUDY 2
Table 2. Pearson correlations between all variables

<table>
<thead>
<tr>
<th>GROUP</th>
<th>SIAS</th>
<th>IPBEA-4</th>
<th>IPBEA-6</th>
<th>SIAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>-26</td>
<td>-22</td>
<td>-47</td>
<td></td>
</tr>
<tr>
<td>SA-AAQ ACCEPTANCE</td>
<td>37</td>
<td>-32</td>
<td>-46</td>
<td></td>
</tr>
<tr>
<td>ACTION</td>
<td>-01</td>
<td>-00</td>
<td>-47**</td>
<td></td>
</tr>
<tr>
<td>SIAS</td>
<td>-16</td>
<td>-15</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>GROUP AUD</td>
<td>IPBEA-4</td>
<td>IPBEA-6</td>
<td>SIAS</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>-49**</td>
<td>-52**</td>
<td>-34**</td>
<td></td>
</tr>
<tr>
<td>SA-AAQ ACCEPTANCE</td>
<td>-54**</td>
<td>-56**</td>
<td>-30</td>
<td></td>
</tr>
<tr>
<td>ACTION</td>
<td>-12</td>
<td>-06</td>
<td>-25</td>
<td></td>
</tr>
<tr>
<td>SIAS</td>
<td>-38</td>
<td>-42</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

Note: IPBEA = Escape from Negative Emotional States, IPBEA = Decrease in Feelings of Self and Anxiety Evaluative

DISCUSSION & CONCLUSION
The SA-AAQ proved to be a valid and reliable measure of acceptance in social situations.

- In the sample PAS, contrary to expectations, there were no significant associations between variables of social anxiety (SIAS) and expectations regarding the effects of alcohol (IPBEA), thus hindering mediation analysis.

- In the AUD sample, acceptance completely mediated the relationship between social anxiety and expectations regarding alcohol effects.

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

Further research is needed to investigate this relationship in individuals with SAD.

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

Chrysanthi Leonidou, Georgia Panayiotou, Aspa Bati, & Maria Karekla
University of Cyprus

Introduction
Clinical levels of somatization and hypochondriasis (or severe health anxiety) influence the individual's functioning in the psychological, social, professional and other domains, mostly due to avoidance of daily activities in order to prevent worsening of symptoms, frequent health care visits and high comorbidity with other psychological disorders. (APA, 2000; Zohar 

Prevalence in general population reported in DSM-5 (APA, 2013) was 6.7% for somatic symptom disorder (somatization) 1.2-10% for illness anxiety disorder (hypochondriasis)

Previous studies reported associations of somatization and hypochondriasis with demographic characteristics, such as gender and age, personality traits, such as anxiety sensitivity and experiential avoidance, social support and coping strategies, (Leonidou et al., 2018). High comorbidity is especially presented between somatization and hypochondriasis with anxiety disorders such as generalized anxiety disorder and panic disorder (Kim, Yoon, Kim, 

Further examination of the links of the two somatoform disorders with the factors mentioned above and the comorbid conditions might better explain the onset and maintenance mechanisms of the disorders, and provide guidance on the improvement of the prevention and therapeutic interventions.

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

Results

### Predictors of somatization

<table>
<thead>
<tr>
<th>Step</th>
<th>Predictor</th>
<th>$\beta$</th>
<th>SE</th>
<th>t</th>
<th>$p$</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Severity of health condition</td>
<td>0.35 **</td>
<td>0.16</td>
<td>2.17</td>
<td>0.03</td>
<td>0.06, 0.54</td>
</tr>
<tr>
<td>Step 2</td>
<td>Anxiety sensitivity</td>
<td>0.26 **</td>
<td>0.09</td>
<td>2.91</td>
<td>0.00</td>
<td>0.06, 0.46</td>
</tr>
<tr>
<td>Step 3</td>
<td>Panic symptoms</td>
<td>0.19</td>
<td>0.09</td>
<td>2.06</td>
<td>0.04</td>
<td>0.02, 0.38</td>
</tr>
<tr>
<td>Step 4</td>
<td>Anxiety symptoms</td>
<td>0.18</td>
<td>0.09</td>
<td>2.02</td>
<td>0.04</td>
<td>0.02, 0.38</td>
</tr>
<tr>
<td>Total R²</td>
<td>0.63</td>
<td>0.05</td>
<td>0.05</td>
<td>0.01</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Excluded variables: Social support (β=0.03), Negative affect (β=0.02), Social support total (β=0.08), Social support composite (β=0.08), Social support perceived (β=0.00)

### Predictors of hypochondriasis

<table>
<thead>
<tr>
<th>Step</th>
<th>Predictor</th>
<th>$\beta$</th>
<th>SE</th>
<th>t</th>
<th>$p$</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Severity of health condition</td>
<td>0.67 **</td>
<td>0.18</td>
<td>3.71</td>
<td>0.00</td>
<td>0.30, 1.04</td>
</tr>
<tr>
<td>Step 2</td>
<td>Anxiety sensitivity</td>
<td>0.26 **</td>
<td>0.09</td>
<td>2.91</td>
<td>0.00</td>
<td>0.06, 0.46</td>
</tr>
<tr>
<td>Step 3</td>
<td>Anxiety symptoms</td>
<td>0.19</td>
<td>0.09</td>
<td>2.06</td>
<td>0.04</td>
<td>0.02, 0.38</td>
</tr>
<tr>
<td>Step 4</td>
<td>Social support</td>
<td>0.18</td>
<td>0.09</td>
<td>2.02</td>
<td>0.04</td>
<td>0.02, 0.38</td>
</tr>
<tr>
<td>Total R²</td>
<td>0.63</td>
<td>0.05</td>
<td>0.05</td>
<td>0.01</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Excluded variables: Avoidance (β=0.06), Social support total (β=0.08), Social support perceived (β=0.00)

### Comparisons between clinical and typical groups

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Somatization</th>
<th>Hypochondriasis</th>
<th>Both Diagnoses</th>
<th>Typical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case-control</td>
<td>Adjusted M (SD)</td>
<td>Adjusted M (SD)</td>
<td>Adjusted M (SD)</td>
<td>Adjusted M (SD)</td>
</tr>
<tr>
<td>Physiological</td>
<td>59.47 (4.97)</td>
<td>57.38 (3.98)</td>
<td>58.90 (4.77)</td>
<td>50.00 (4.77)</td>
</tr>
<tr>
<td>Psychological</td>
<td>57.77 (5.59)</td>
<td>55.34 (3.56)</td>
<td>56.57 (5.29)</td>
<td>50.00 (4.77)</td>
</tr>
<tr>
<td>Social Que.</td>
<td>63.07 (6.75)</td>
<td>61.23 (4.50)</td>
<td>62.20 (6.27)</td>
<td>50.00 (4.77)</td>
</tr>
<tr>
<td>Environmental Que.</td>
<td>57.61 (4.51)</td>
<td>52.60 (3.01)</td>
<td>54.61 (4.19)</td>
<td>50.00 (4.77)</td>
</tr>
</tbody>
</table>

Note: *P<0.05, **P<0.01, ***P<0.001

### Comorbidity with anxiety and panic symptoms

<table>
<thead>
<tr>
<th>Condition</th>
<th>Typical</th>
<th>Clinical</th>
<th>Typical</th>
<th>Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic Symptom</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Anxiety symptoms</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Somatization</td>
<td>0.10</td>
<td>0.10</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>Hypochondriasis</td>
<td>0.10</td>
<td>0.10</td>
<td>0.10</td>
<td>0.10</td>
</tr>
</tbody>
</table>

### Discussion

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

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Social Anxiety and Violence Among Peers: The Role of Attachment

Joana Filipa Nascimento & Maria do Céu Salvador 2014

Abstract

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

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

Introduction

For some adolescents, the transition from family support to peer support can be problematic due the important role that those last ones play in the emotional development of the adolescent (La Greca & Harrison, 2005). Due to the psychological, interpersonal and social modifications that are characteristic of this stage, the influence of parents in the adolescent’s daily life tend to decrease and peer relationships become progressively a more important source of support and values (Bersoff & Leidheister, 2004). Few studies approach the relation between attachment and violence among peers in adolescence. Associations have been found between insecure attachment and a higher risk of being victimized by peers (Jinayang et al., 1998). Anxious adolescents show submissive behaviors compared to other adolescents, show less group acceptance and higher levels of peer’s rejection (Spera et al., 1999). Recently, Kokkinos (2013) concluded that pre-adolescents that report an insecure attachment (to parents) revealed a greater tendency to be victims of peer violence.

Method

Participants

Adolescents aged between 14 and 18 years old.

Table 1. Distribution of the samples by gender.

<table>
<thead>
<tr>
<th>Sample</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-clinical</td>
<td>20</td>
<td>27</td>
<td>47</td>
</tr>
<tr>
<td>n (45.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Measures

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

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

Results

Intragroup Analyses

<table>
<thead>
<tr>
<th>Table 2. Means (M) and standard deviations (SD) of the variables under study for both groups. t-test to analyze differences between groups.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>SAS-A</td>
</tr>
<tr>
<td>CON</td>
</tr>
<tr>
<td>IPPA Mother</td>
</tr>
<tr>
<td>IPPA Father</td>
</tr>
<tr>
<td>IPPA Peers</td>
</tr>
<tr>
<td>PRQ Bully</td>
</tr>
<tr>
<td>PRQ Victim</td>
</tr>
<tr>
<td>PRQ Prosocial</td>
</tr>
</tbody>
</table>

Conclusions

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

Attachment to parents was a predictor of the tendency to be victimized in the absence of peers attachment. However, when attachment to peers was introduced this was the only variable behaving as a predictor of the tendency to be victimized by peers. In adolescents with SAD (total mediation). These data suggest that the presence of secure relationships to peers may attenuate the tendency to be victim that characterizes SAD.
BRIDGING THE GAP BETWEEN INFORMATION PROCESSING AND EVOLUTIONARY VARIABLES IN SOCIAL ANXIETY DISORDER

Daniel Seabra (daniel.seabra@hotmail.com) | Filipa Fernandes (filipa.fernandes119@gmail.com) | Maria de C. Salvador (maria.desalvador@gmail.com)

ABSTRACT

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

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

BACKGROUND

Social Anxiety Disorder (SAD) is characterized by a marked fear or anxiety in situations where the individual might be exposed to the possible scrutiny of others (APA, 2013). Two typical information processing strategies implicated in the maintenance of SAD (Clark & Wells, 1995) are Self-Focused Attention (SFA) and Post-Event Processing (PEP). SFA is an abstractive bias for the subject’s own thoughts, emotions and bodily sensations (Cerwagner & Scheier, 1981). These information will be used in post-mortem rumination (PEP) where the subject reviews critically and with detail what went wrong in the social event. Self-Criticism (SC) is a pervasive form of self-evaluation involving feelings of inadequacy and guilt (Batt, 1976). Inernal Shame (IS) is related to negative self-perception and External Shame (ES) is related to the way people think they exist in the other’s mind (Gilbert, 1998).

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

RESEARCH QUESTION:

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

METHOD

Participants
32 Portuguese subjects with SAD (978.10%; c 21.90%)

Measures
ADIS-IV (Anxiety Disorders Interview Schedule-IV; Di Nardo et al., 1994)
SIAS (Social Interaction Anxiety Scale; Mattick & Clark, 1995)
SFA (Self-Focused Attention Scale; Bögels et al., 2006)
PEPOQ (Post-Event Processing Questionnaire; Fehr et al., 2003)
FSCRS (Forms of Self-Criticism/Attacking & Self-Reassuring Scale; Gilbert et al., 2004)
IIS (Internalized Shame Scale; Cook, 1994, 2001)
OAS (Other As Shamer Scale; Goss et al., 1964)
OSS-21 (Depression, Anxiety, and Stress Scale 21-Items Version; Lovibond & Lovibond, 1995)

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

Clinical implications: Once these two SAD’s maintenance processes are mainly related to internal shame, intervention between SFA and PEP processes. This result seems to indicate that both SFA and PEP are demoted by inferiority issues related to the self and that is this characteristic of SAD that is responsible for these processes.

REFERENCES

Correlations Pearson correlations were computed for all variables (Table 1).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>7</th>
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<th>9</th>
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<tbody>
<tr>
<td>SFA</td>
<td>1.00</td>
<td>.53**</td>
<td>1.00</td>
<td>.64**</td>
<td>.49**</td>
<td>1.00</td>
<td>.51**</td>
<td>1.00</td>
<td>.53**</td>
<td>.49**</td>
<td>1.00</td>
</tr>
<tr>
<td>SFA (behavior)</td>
<td>.53**</td>
<td>1.00</td>
<td>.53**</td>
<td>1.00</td>
<td>.51**</td>
<td>.53**</td>
<td>1.00</td>
<td>.53**</td>
<td>.53**</td>
<td>.51**</td>
<td>.53**</td>
</tr>
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<td>.64**</td>
<td>.53**</td>
<td>1.00</td>
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<td>1.00</td>
<td>.53**</td>
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<td>SFA (total)</td>
<td>.49**</td>
<td>.49**</td>
<td>.49**</td>
<td>1.00</td>
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<td>.51**</td>
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<td>1.00</td>
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<tr>
<td>IS</td>
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<td>.53**</td>
<td>.53**</td>
<td>.53**</td>
<td>1.00</td>
<td>.53**</td>
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<td>.53**</td>
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<td>.53**</td>
<td>1.00</td>
</tr>
<tr>
<td>SC</td>
<td>.49**</td>
<td>.49**</td>
<td>.49**</td>
<td>.49**</td>
<td>.53**</td>
<td>.53**</td>
<td>1.00</td>
<td>.53**</td>
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<td>.53**</td>
<td>.53**</td>
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<tr>
<td>PEP</td>
<td>.49**</td>
<td>.49**</td>
<td>.49**</td>
<td>.49**</td>
<td>.53**</td>
<td>.53**</td>
<td>.53**</td>
<td>1.00</td>
<td>.53**</td>
<td>.53**</td>
<td>.53**</td>
</tr>
</tbody>
</table>

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

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

a: β = .58*  

b: β = .53*  

c: β = .60  

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

a: β = .58*  

b: β = .55*

c: β = .35  

d: β = .60  

e: β = .02

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

Discord:

Psychomed 2014 n. 1-2 Special Issue: 44rd Annual Congress EABCT Selected Posters 21
CBT Interventions
CBT of hearing voices; a case study of IDD client

Esa Chydenius
Senior Psychologist, psychotherapist, Rinnekoti Research Centre, Espoo, Finland

Aim: To diminish auditory hallucinations.

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

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

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

Results
First session intervention: Behavioural analysis of the situation. Intervention: the shouting angry man must fear for you, if he doesn’t dare to speak to you properly. -> Big relief and long lasting laugh. The situation was much better in group home.

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

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

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

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

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

esa.chydenius (at) rinnekoti.fi
A brief cognitive-behavioral therapy for breast reconstruction decision-making. Psychological effects of the breast reconstruction.

Provincial Hospital of Castellon (Spain)

INTRODUCTION

Psychosocial factors associated with decision regret in the context of breast reconstruction are low satisfaction with preparatory information, decision anxiety, and regret (Chabhoras et al., 2007). Hence, it is important to assess the effectiveness of a brief cognitive-behavioral therapy group, on the breast reconstruction decision making in mastectomy-treated breast cancer.

METHOD

PARTICIPANTS

Forty-eight oncology patients that were waiting for breast reconstruction after mastectomy participated in the study. The mean age was 51.69 (SD=17.83), with the range from 35 to 69 years old.

Graph 1: Level of education

INSTRUMENTS

3. The Hospital Anxiety and Depression Scale (Zung, 1983)
4. Body Image Scale (Hopwood, 1995)
5. Rosenberg Self-Esteem Scale (Rosenberg, 1965)
6. Pearsons Social Support Scale (Zimet, Dahlem, Zimet & Farley, 1988)
7. Questionnaire of Couple Relationship and Sexuality (Toms & Gallegos, 2013)
8. Attractive satisfaction with breast reconstruction (Alderman, McShan & Wilkins, 2003)
9. Motivations Satisfactions with the psychological treatment (Noor & Boekeer, 1972)

TREATMENT

The brief cognitive-behavioral group therapy for breast reconstruction decision-making (CBTBR) was conducted by two clinical psychologists and the length was 6 sessions of 90 minutes. The treatment components were: techniques to improve the self-esteem and body image, anxiety, positive thinking, information about breast reconstruction, psychological support, the surgery and immuno-revulsive-based techniques for depression and anxiety. One plastic surgeon who was to perform the reconstruction also collaborated in the treatment, increasing patients' confidence. Two women who had already undergone breast reconstruction talked about their experiences.

PROCEDURE

Participants were randomized to:
1. A brief cognitive-behavioral therapy for breast reconstruction decision-making (N=24)
2. A waiting list control condition (N=24)

Assessments:

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

RESULTS

There were no significant differences between both experimental groups in the pre-test.

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

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-treatment</th>
<th>Post-treatment</th>
<th>6 months after reconstruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>(5.67)</td>
<td>(3.69)</td>
<td>(2.67)</td>
</tr>
<tr>
<td>Depression</td>
<td>(3.18)</td>
<td>(2.61)</td>
<td>(2.58)</td>
</tr>
<tr>
<td>Body Image</td>
<td>(5.74)</td>
<td>(5.81)</td>
<td>(5.48)</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>(3.18)</td>
<td>(3.27)</td>
<td>(3.36)</td>
</tr>
<tr>
<td>Social support</td>
<td>(2.18)</td>
<td>(2.18)</td>
<td>(2.18)</td>
</tr>
<tr>
<td>Aesthetic satisfaction</td>
<td>(2.18)</td>
<td>(2.18)</td>
<td>(2.18)</td>
</tr>
</tbody>
</table>

CONCLUSIONS

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

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

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

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

The present work is the first randomized controlled study in breast cancer patients that uses a cognitive-behavioral therapy to support breast reconstruction decision making.
An Internet-based treatment to quit smoking vs. a smoking cessation group therapy: A controlled Trial

Gallego, M. J., Modesto, M., Peris, C. P., Muñoz, M. A., Almajano, M. J. and Emmelkamp, P.M.G.

Smoking has a huge impact on human health, disease like chronic obstructive disease (COPD), cardiovascular disease, stroke and lung cancer have a strong relationship with cigarette use. In Spain, 68% of people died from smoking-related diseases (Egger & Claxton-Finch, 2012). The best way to prevent these diseases is smoking cessation, but it is extremely difficult for many individuals and requires commitment. In the Treatment of Tobacco Use and Dependence Clinical Practice Guideline (Fries, Bickel & Cohen, 2009), describes nicotine dependence as a chronic disease. However, there is a wide range of effective smoking cessation treatments available for smokers who are ready to quit (Gorodetzky & Langer, 2012). The treatment of choice for giving up smoking is the combination of cognitive-behavioral therapy with pharmacological treatment (Wise & Naccarelli, 2008). A recent review by Clevick et al. (2015) affirmed that Internet-based treatment for smoking cessation at six months or longer, particularly those which are interactive, are effective for individuals.

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

**Method**

**Participants N = 70**

**Gender**

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>%</th>
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<tbody>
<tr>
<td>Male</td>
<td>36</td>
<td>51.4</td>
</tr>
<tr>
<td>Female</td>
<td>34</td>
<td>48.6</td>
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**Level of education**

<table>
<thead>
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<th>Primary school</th>
<th>Secondary</th>
<th>University</th>
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</thead>
<tbody>
<tr>
<td>32</td>
<td>26</td>
<td>12</td>
</tr>
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**Age**

<table>
<thead>
<tr>
<th>Range</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-65</td>
<td>42.87 (9.44)</td>
</tr>
</tbody>
</table>

**Attempts to give up smoking**

<table>
<thead>
<tr>
<th>Number of cigarettes/day</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.58 (9.09)</td>
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**Carbon monoxide test**

<table>
<thead>
<tr>
<th>Fagerström</th>
<th>Mean (SD)</th>
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<tbody>
<tr>
<td>4.05 (2.15)</td>
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**Stages of change**

<table>
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<th>Preparation</th>
<th>Encounter</th>
<th>Action</th>
<th>Maintenance</th>
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<tbody>
<tr>
<td>38.3%</td>
<td>38.3%</td>
<td>13%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Procedure**

**GROUP TREATMENT (6 sessions)**

1. PNEUMLOGIST
2. MEDICAL EXAMINATION & PHARMACOLOGICAL PRESCRIPTIONS
3. Psychological assessment pre-treatment

**INTERNET TREATMENT (6 weeks)**

1. N = 33
2. GROUP TREATMENT (6 sessions)
3. N = 37
4. PSYCHOLOGICAL ASSESSMENT POST TREATMENT
5. 1 YEAR FOLLOW UP

**Results**

**Table 1. ANOVAs pre-test. Means and standard deviations**

<table>
<thead>
<tr>
<th>Internet treatment Group treatment</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Time effect</th>
<th>Intervention effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Internet</td>
<td>Group</td>
<td>Internet</td>
<td>Group</td>
<td>Internet</td>
<td>Group</td>
<td>Internet</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Post-treatment</th>
<th>One year follow-up</th>
<th>Internet</th>
<th>Group</th>
<th>Internet</th>
<th>Group</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internet</td>
<td>Group</td>
<td>Internet</td>
<td>Group</td>
<td>Internet</td>
<td>Group</td>
<td>80.1</td>
<td>83.3</td>
<td>50%</td>
<td>34.5%</td>
<td></td>
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</table>

**Table 3. Means and standard deviations of the acceptability variables**

<table>
<thead>
<tr>
<th>Internet</th>
<th>Group</th>
<th>M</th>
<th>SD</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internet</td>
<td>1</td>
<td>1.25</td>
<td>0.40</td>
<td>0.66</td>
<td>0.40</td>
</tr>
<tr>
<td>Group</td>
<td>2</td>
<td>0.62</td>
<td>0.65</td>
<td>0.57</td>
<td>0.62</td>
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</table>

**Table 2. Participants that start treatment and drop-outs**

<table>
<thead>
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<th>Internet</th>
<th>Group</th>
<th>N</th>
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</thead>
<tbody>
<tr>
<td>Start treatment</td>
<td>16</td>
<td>48.5</td>
<td>29</td>
</tr>
<tr>
<td>Do not start treatment</td>
<td>17</td>
<td>51.5</td>
<td>8</td>
</tr>
</tbody>
</table>

**Table 2. Pharmacological treatment**

<table>
<thead>
<tr>
<th>Internet</th>
<th>Group</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No medicine</td>
<td>12</td>
<td>35.3</td>
<td>12</td>
</tr>
<tr>
<td>Medication</td>
<td>18</td>
<td>51.4</td>
<td>24</td>
</tr>
</tbody>
</table>

**Conclusions**

The present controlled study shows that an Internet-based cognitive-behavioral treatment to quit smoking is as effective as a group cognitive-behavioral therapy at one year follow-up, which is used under health professional guidance and combined with pharmacological treatment as usual. Participants were motivated to start both psychological treatments in quitting smoking, moreover at post-test, they were satisfied and they trusted the treatment, they thought that it was logical, useful and they would recommend it to a friend.

Future studies are needed to find methods to increase the number of participants that start the Internet treatment. Besides is essential to implement tools that use medicines as a stable variable.
The Use of Cognitive Behavioral Therapy in the Recovery of Patient After Undergone Encephalitis - Case Study

Jasińska Agnieszka
Pomeranian Centre for Infectious Diseases and Tuberculosis Ltd., Gdańsk, Poland

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

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

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

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

References:
1. Jmor, F.; Emsley H.C., Fischer M. et al. (2008); The incidence of acute encephalitis syndrom in Western industrialised and tropical countries, Virology Journal, 5 (134), 134
5. Steady Project Intervention Manual, Clarke i in., 2002
Cognitive Behavioral Therapy for Depression among Adult HIV-Infected Patients - Case Series

Jasińska Agnieszka¹, Sawicz Joanna², Jakubowski Paweł² & Dręczewski Marcin³
¹Pomeranian Centre for Infectious Diseases and Tuberculosis Ltd., Gdańsk, Poland,
²Medical University of Gdansk, Infectious Diseases Department, Gdańsk, Poland

Human Immunodeficiency Virus (HIV) is a retrovirus responsible for suppression of CD4 lymphocytes resulting in immunological deficiency linked with multiple opportunistic infections and non-infectious comorbidities such as HIV-associated neurocognitive disorders (HAND) or depression. The prevalence of major depression in HIV-infected populations is reported to be up to 20-40% versus 7% in general population.

Specific stressors may include: stigmatization, disruption in relationships with a partner and family, life-style disruptions, sexual dysfunction and decreased self-esteem.

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

Patients’ mood was monitored with a Beck Depression Inventory and Mood Questionnaire.

CBT applied in all observed cases showed satisfying efficacy. The beneficial effect of CBT was not only immediate but also sustained at post-treatment evaluation, what is crucial not only for the patients’ psychological quality of life, but also for their somatic condition.

Based on cases reported in this paper, we have noticed better response for CBT for depression in the group of MSM. These are preliminary observations from our clinical experience, which need to be confirmed and developed in further studies.

References:
Positive Psychology vs. CBT for clinical depression: Results from a 6-month follow-up study
Lopez-Gomez, I., Chaves, C., Vazquez, C., & Hervas, G.
Complutense University of Madrid (Spain)

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

Over the past decade, research in the field of positive psychology has supported the efficacy of happiness-promoting exercises in clinical problems like depression (Sin & Lyubomirsky, 2005; Bolier, et al., 2013). Positive psychotherapy delivered to depressed individuals significantly boosts well-being, decreases depression and it can be especially effective for treating residual symptoms and preventing future relapse (Seeligman et al., 2006).

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

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

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

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

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

Results
PPI is as effective as CBT

Improvements are clinically significant

PPI is also effective for severe depression

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

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

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

Method

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

- The Symptom Checklist 90 (SCL-90; Arrindell & Ettema, 2005), a multidimensional screening checklist for psychological and physical symptoms.
- The Dutch version of the Buss-Durkee Hostility Inventory (BDI-D; Lange et al., 1995), self-report measure for direct and indirect aggression.
- The Utrecht Coping Lijst (UCL; Schruers, de Willigte, Brosschot, Tellegen, & Graus, 2003), a Dutch self-report questionnaire that measures different coping styles.

Pre- and postmeasures were compared using GLM repeated measures ANOVAs in SPSS.

Results

<table>
<thead>
<tr>
<th></th>
<th>Pre Treatment</th>
<th>Post Treatment</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score Mean</td>
<td>Score Mean</td>
<td>SD</td>
<td>SD</td>
</tr>
<tr>
<td>Psychopathology</td>
<td>204.9 (57.62)</td>
<td>192.6 (49.25)</td>
<td>2.98</td>
<td>0.09</td>
</tr>
<tr>
<td>Aggression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostility</td>
<td>16.26 (5.72)</td>
<td>13.14 (4.71)</td>
<td>16.26</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Direct Aggression</td>
<td>13.12 (2.07)</td>
<td>12.69 (2.15)</td>
<td>1.93</td>
<td>0.17</td>
</tr>
<tr>
<td>Indirect Aggression</td>
<td>12.62 (4.34)</td>
<td>11.62 (4.98)</td>
<td>3.09</td>
<td>0.06</td>
</tr>
<tr>
<td>Coping styles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td>16.20 (4.28)</td>
<td>16.73 (3.82)</td>
<td>1.27</td>
<td>0.28</td>
</tr>
<tr>
<td>Social support</td>
<td>11.18 (3.22)</td>
<td>11.42 (3.55)</td>
<td>0.40</td>
<td>0.53</td>
</tr>
<tr>
<td>Expression of emotions</td>
<td>8.24 (2.05)</td>
<td>7.78 (2.67)</td>
<td>4.10</td>
<td>0.05</td>
</tr>
<tr>
<td>Passive</td>
<td>16.59 (4.46)</td>
<td>15.72 (4.26)</td>
<td>2.86</td>
<td>0.10</td>
</tr>
<tr>
<td>Palliative</td>
<td>17.61 (4.05)</td>
<td>18.11 (3.98)</td>
<td>1.37</td>
<td>0.25</td>
</tr>
<tr>
<td>Avoidant</td>
<td>16.93 (3.57)</td>
<td>17.63 (3.63)</td>
<td>0.26</td>
<td>0.60</td>
</tr>
</tbody>
</table>

Discussion

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

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

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

A Case Report

Doke C. van der Ven, University Center for Psychiatry, University Medical Center Goningen, The Netherlands

Corresponding author: d.c.vander.ven@umcg.nl

INTRODUCTION

- MORE THAN HALF OF THE DEPRESSED PATIENTS SUFFER FROM CONCURRENT ANXIETY (DISORDERED AND DEPRESSIVE MOOD) VS. ANXIETY
- ANXIETY IN DEPRESSION IS CHALLENGING AS IT RESULTS IN HIGHER SEVERITY, POORER RESPONSE TO TREATMENT, MORE RESIDUAL SYMPTOMS AND MORE SUICIDALITY
- GUIDELINES OFFER LITTLE TO NO INFORMATION ON TREATMENT
- FROM A CBT PERSPECTIVE: INTERACTION OF DEPRESSIVE AND ANXIETY SYMPTOMS CAN BE SEEN AS ‘GORDIAN KNOT’ WHERE:
- DEPRESSIVE AVOIDANCE BEHAVIOUR DEPRIVES THE PATIENT OF POSITIVE KEENFORCES, LOWERS MOTIVATION FOR SELF-DIRECTED EXPOSURE AND WHERE ANXIOUS AVOIDANCE BEHAVIOUR LEAVES INCOMPLETE ASSUMPTIONS INTACT AND NARROWS THE BEHAVIOURAL REPertoire EVEN MORE.

TREATMENT PROTOCOL - 32 WEEKLY SESSIONS

- CASE CONCEPTUALISATION: MAIN TREATMENT TARGET: DEPRESSIVE AND ANXIOUS AVOIDANCE BEHAVIOUR
- MOTIVATIONAL PHASE: PSYCHEDELICATION ON THE ‘GORDIAN KNOT’ AND FALLING (ACT) AS MOTIVATIONAL TECHNIQUE
- TREATMENT PHASE: BEHAVIOURAL ACTIVATION IN SERVICE OF EXPOSURE AND BEHAVIOURAL EXPERIMENTS WITH PREFEATED AND VALUED ACTS.

OUTCOME

- AVOIDANCE BEHAVIOUR: MORE ACTIVE ENGAGEMENT WITH HER SON AND SOCIALLY; SHE STARTS WORK AND SPORTS.
- SYMPTOMS: DEPRESSIVE SYMPTOMS:
  - IDS-SR: 31 (MODERATE) → 15 (MILD)
  - SCL-90 REP: 45 → 32 (RCS: 4.77)
- ANXIETY:
  - SCL-90 ANX: 36 → 17 (RCS: 6.74)

DISCUSSION

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

REFERENCES

The Effectiveness of Inquiry-based Stress Reduction (IBSR) on Irrationality, Dysfunctional Attitudes and Maladaptive Schemas -The Work of Byron Katie in Learning Therapy-

MarieOdie van Rhijn¹ & Michaela Schok²

¹ ICTEL, Instituut voor Cognitieve Therapie en Levenskunst, S.B. de Messines, Portugal
² Psychological scientist/consultant, Houten, the Netherlands

Introduction

In 1988 Ms. Byron Katie developed a technique ‘The Work’, a meditative process with self-inquiry on cognitions connected to stressful circumstances. As a tool in therapy it is called Inquiry-based Stress Reduction (IBSR). IBSR incorporates elements from CBT and Mindfulness approaches. The focus is not on changing the beliefs, but on becoming aware that they are incorrect and counteracting on emotions and behaviours. From this awareness the result can be a spontaneous letting go of the beliefs, resulting in a positive change in emotion and behaviour. In IBSR the inner wisdom ‘Wise Mind’ is addressed rather than the rationality and objectivity as in classical CBT.

IBSR is deceptively simple: 4 questions and turnarounds.

Results

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

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

<table>
<thead>
<tr>
<th></th>
<th>Pre intervention</th>
<th>Post intervention</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAS-A</td>
<td>128.25</td>
<td>78.25</td>
<td>9.06</td>
</tr>
<tr>
<td>BS</td>
<td>85.38</td>
<td>82</td>
<td>53.31</td>
</tr>
<tr>
<td>YSQ</td>
<td>38.69</td>
<td>38.77</td>
<td>38.77</td>
</tr>
</tbody>
</table>

Method

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

Intervention

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

Participants (n=64)

CBT trainees, who choose this method of learning therapy age range from 26 to 58, mean age 38.16 years (SD 8.57)
59 women (92.1%) and 5 men (7.8%)
50 living together (78.15%) and 14 single (21.9%)

Measurements

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

Conclusion

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

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References


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BROADENING OUR SCOPE BEYOND THE INDIVIDUAL: TRAINING IN COGNITIVE BEHAVIOURAL COUPLES THERAPY

Dr Michael Worrell, Prof. Sarah Corrie, Effie Molyva

Central & North West London Foundation NHS Trust
Central London CBT Training Centre
www.central-london-cbt.com

BCT and IPT Background

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

Overview of the Training

WHAT WAS COVERED?

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

Day 2: Interventions with patients ‘Sharing thoughts and feelings’ Strategies to improve relational understanding and expression Cognitive interventions: attributions


Assessment for BCT Processes and therapy The use of individual sessions Concentration Feedback sessions

Day 4: Developing couple-based interventions Research on couples and depression Targets for intervention Psychodynamic Emotional expressive training Addressing negative cognitions Successful interventions

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

Training Methods

Didactic presentations with handouts Videos of specific demonstrations of key BCT skills and interventions Live role plays by the programme leaders of different therapeutic situations Role plays in small groups by the participants as therapists, with direct feedback from the programme team Assessed readings

Post-training clinical activity

END OF TRAINING FEEDBACK

Therapists’ experiences transitioning from individual to couple therapy

Focus group superordinate themes

Theme no. 1: The intensity of having two people in the room,

Theme no. 2: Managing multiple therapeutic relationships

Theme no. 3: Having more experience in couple therapy

Theme no. 4: Therapists facing different models and the therapists

Theme no. 5: More directive in couple therapy

CONCLUSIONS

The high ratings of trainees satisfaction immediately at the end of training has been followed by very good ratings from trainees, 12 months post training, and over prepared for the rest of their work. Training has been reported by trainees as having been challenging and enjoyable, without experiencing challenges we would have to continue. It is this improvement in their competence to these challenges.

BCT is experienced by trainees as qualitatively different from individual CBT and involves the acquisition and development of new set of clinical skills for working with couples.

From the results obtained it appears that trainees experience the training to have successfully prepared them with these skills.
Depression
Comparison of Personality Related Core Beliefs in Acute and Chronic Depression

Sedat BATMAZ 1, Sibel KOÇBİYİK 2, Semra ULUSOY KAYMAK 2 & Mehmet Hakan TURKÇAPAR 3

1Merzifon State Hospital, Psychiatry Clinic, Merzifon, Turkey, 2Atatürk Training and Research Hospital, Psychiatry Clinic, Ankara, Turkey, 3Hasan Kalyoncu University, Department of Psychology, Gaziantep, Turkey

Objectives:

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

Methods:

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

Results:

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

Conclusions:

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

References:

Reversal learning of negative self-thinking in depressive individuals

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²KU Leuven, Center for the Psychology of Learning and Experimental Psychopathology, Belgium.
³The University of Tokyo, Graduate School of Arts and Sciences, Japan.

Introduction

Depressive individuals experience negative self-verification, that is, they willingly gather information consistent with their negative self-concept (Giese, et al., 1996).

Moreover, depressive individuals regard negative self-thinking as useful, and these positive beliefs about negative self-conscious thoughts have been characterized to promote rumination about such individuals (Fisman et al., 2001).

Thus, it is suggested that this preference for negative information is one of the fundamental issues underlying depressive symptoms.

Modifying these preferences could lead to symptom reduction.

Against this background, we examined whether depressive individuals can break away from the positive beliefs associated with negative self-thinking and rewards, using a probabilistic reversal learning task.

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

Probabilistic reversal learning task

1. The association between “negative” topics and reward is learned.
   - This manipulation could experimentally simulate the preference for negative information.

2. Conversely, the association between “positive” topics and reward is learned.
   - This preference for positive information would be produced.
   - Can depressive individuals choose positive topics in reversal phase?
   - How long does the learning the association between positive topics and reward take for them?

Method

Participants

A total of 38 undergraduates (23 females; mean age: 19.6 years; SD = 2.8; range: 19–35 years) agreed to participate in our experiment.

Measures

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

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

Procedure

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

Results and Discussion

Figure: The association between the number of trials required for participants to learn the association and depressive symptoms.

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


Introduction. Baseline severity is a crucial moderator of trial outcomes in adult depression. Mixed-age studies have shown that the mean differences between groups treated with antidepressant medication and placebo become larger as baseline severity increases. Kirsch et al. (2008) argued that the increased benefit of drug treatment for severely depressed patients is related to a decrease in responsiveness to placebos. However, two meta-analyses have shown that initial severity predicted symptom improvement in adult patients who took antidepressant medication(12). Yet, baseline severity has not been examined as a moderator of antidepressant and placebo outcomes in late-life depression.

Methods.

Outcome. Mean change in depressive symptoms (HDRS scores)

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

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

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

Results.

Overall Effect Size for Antidepressant and Placebo Treatment. 22 studies provided relevant data for the meta-analysis. Patients in the treatment groups showed a significantly higher mean change in HDRS score than patients in the placebo group (Hedges’s g = 0.26; 95% CI: 0.25 - 0.47; p < .001). Studies exhibited moderate, yet significant between-studies heterogeneity ($I^2 = 64.24; I^2 = 56; p = .001$).

Baseline Severity and Mean Change in Depressive Symptoms. Significant increase in antidepressant trials ($Z = 2.67, p = .008, R^2 = .40$)
- Significant increase in placebo trials ($Z = 4.46, p < .001, R^2 = .90$)
- No significant severity x group interaction ($R^2 = 0.27, p = .987$)

Discussion. With increasing baseline scores, change in depression symptoms increased in both interventions (see Figure 1). Our results indicate that placebo effects are important in the treatment of elderly people with different severity grades of depression.

Limitations. Limited to published data
- Only one study of severely depressed patients
- Possible regression to the mean effect
- Stable physical illness and comorbid disorders were common

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

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


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

Jonathan Remue, Rudi De Raedt and Nuria Romero

Department of Psychology, Ghent University (Belgium)

Introduction

Rumination is a repetitive negative style of thinking about one's problems or negative experiences that is difficult to disengage from (Nolen-Hoeksema, 1991). Although past research has shown the consequences of acquiring a rumination style (e.g. poor problem solving, maintenance of negative affect), there is less clarity on the mechanisms underlying rumination (Koster, et al. 2013).

According to self-regulation theories of depression (e.g. Carver & Scheier, 1989), rumination is initiated by perceived discrepancies between one's current state and a desired state. Moreover, cognitive vulnerability models (e.g. Beck, 2005) postulates that rumination would involve a maladaptive reflective processing triggered by negatively biased associative processing.

In the present study we aimed to evaluate actual and ideal implicit self-esteem in dysphoric individuals, and to evaluate the associations between rumination and actual vs. ideal implicit self-esteem discrepancy.

Method

Participants:

The sample was composed by 44 undergraduate students:

- Low BD group (BD ≤ 18) 19 (54.5% female). Mean age: 20.08 (SD: 4.40).
- High BD group (BD > 24) 25 (20% Female). Mean age: 28.85 (SD: 2.94).

Measures:


- Actual and ideal Implicit self-esteem. We used two self-esteem variants of the Go/No-go Association Task (GNAT) (Neave & Bousfield, 2003) to evaluate automatic associations between actual and ideal self and positive and negative attributes. The actual self GNAT with the stimuli “I am,” “I am not” (see table below) and the ideal self GNAT with the stimuli “I want to be”, “I don’t want to be”.

Table 1:

<table>
<thead>
<tr>
<th>Item</th>
<th>Press Key</th>
<th>Keep Press Key</th>
<th>Category</th>
<th>Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1</td>
<td>Positive self-esteem (I am)</td>
<td>YES</td>
<td>SAMPLE</td>
<td>POSITIVE</td>
</tr>
<tr>
<td>Item 2</td>
<td>Negative self-esteem (I am not)</td>
<td>YES</td>
<td>SAMPLE</td>
<td>NEGATIVE</td>
</tr>
<tr>
<td>Item 3</td>
<td>Positive self-esteem (I want to be)</td>
<td>YES</td>
<td>SAMPLE</td>
<td>POSITIVE</td>
</tr>
<tr>
<td>Item 4</td>
<td>Negative self-esteem (I don’t want to be)</td>
<td>YES</td>
<td>SAMPLE</td>
<td>NEGATIVE</td>
</tr>
</tbody>
</table>

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

- Consistent actual SE: Sum Reaction time (RT) “I am Positive” block and RT “I am Not Negative” block divided by 2.
- Inconsistent actual SE: Sum RT “I am Negative” block and RT “I am Not Positive” block divided by 2.
- Consistent ideal SE: Sum Reaction time (RT) “I want to be Positive” block and RT “I don’t want to be Negative” block divided by 2.
- Inconsistent ideal SE: Sum RT “I want to be Negative” block and RT “I don’t want to be Positive” block divided by 2.

Results

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

A 2 (Group: high BD group, low BD group) x 2 (Task: actual, ideal) x 2 (Condition: consistent, inconsistent) mixed design ANOVA revealed a significant three way interaction, F(1,42)= 4.16, p< .05, η² = .09. Two separate 2 (Group) x 2 (Task) ANOVAs were conducted.

- For the consistent condition, analyses revealed a significant Group x Condition interaction, F(1,42)= 3.10, p< .05, η² = .07. Low BD group did not differ in their reaction times for actual and ideal consistent SE. However, high BD group showed longer reaction times across idealizing than actualizing consistent SE, p< .05, indicating a higher actual vs. ideal implicit SE.
- For the inconsistent condition, analyses revealed a non significant Group x Condition interaction, F(1,42)= 1.1, p>.20. (See table 2)

<table>
<thead>
<tr>
<th>Task</th>
<th>Actual Consistent SE</th>
<th>Actual Inconsistent SE</th>
<th>Ideal Consistent SE</th>
<th>Ideal Inconsistent SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low BD group</td>
<td>398.88</td>
<td>33.56</td>
<td>467.14</td>
<td>54.62</td>
</tr>
<tr>
<td>High BD group</td>
<td>513.24</td>
<td>69.91</td>
<td>1007.04</td>
<td>52.86</td>
</tr>
</tbody>
</table>

Correlations

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

Conclusions

- Our findings showed that dysphoric individuals are characterized by an actual vs. ideal implicit self-esteem discrepancy, showing higher levels of actual than ideal self-esteem. Non-dysphoric individuals, however, did not show differences between their actual and ideal self-esteem.
- Our findings support the idea that rumination, and more specifically its maladaptive brooding component, is associated with discrepancies between the current self and the desired self (e.g. Carver & Scheier, 1989). And also support the idea that rumination could be generated by a negatively biased automatic processing (Beckers, 2003), as showed by this actual vs. ideal implicit self-esteem discrepancy.
- Our findings provide a better understanding about the possible mechanisms underlying rumination, and open an interesting line of research which may be important to develop new strategies of prevention and intervention of depressive rumination.

References


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

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

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

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

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

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

Aurélie Wagener*, Céline Baeyens & Sylvie Blairy*
* University of Liège, Belgium; ** University of Liège, Belgium; *** University of Liège, Belgium

BACKGROUND

According to Kinderman (2013), biological factors, social factors, and other environmental factors can lead to mental health problems through their separate effects on psychological processes, and these are the four common pathways to mental ill-health.

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

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

METHODS

To investigate the influence of these psychological processes on the behavioral avoidance.

To find the psychological processes which have a positive influence on the behavioral activation.

To present an integration of our results with Kinderman’s psychological model of mental health (2013).

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

RESULTS

According to Kinderman (2013), psychological processes are the four common pathways to mental ill-health.

The four common pathways are:

1. Biological factors
2. Social factors
3. Other environmental factors
4. Psychological processes

These factors are influenced by depression severity and the level of behavioral activation.

DISCUSSION

The evidence is highly influenced by:

- Negative self-concept
- Poor environmental networks
- Maladaptive emotion regulation strategies
- Avoidance

The evidence is highly influenced by:

- High environmental reward
- Positive affect
- Adaptive emotion regulation strategies

According to these factors, the evidence is important to understand the role of environmental reward and the emotion regulation strategies in the treatment of depression.
Trans-diagnostic Dysfunctions
Stressing Emotions: Emotion Focused Transdiagnostic Treatment for Work Stress

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Örebro University, School of Law, Psychology and Social Work, Örebro, Sweden

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BACKGROUND
- People with work stress often present with multiple problems within the matrix of emotional disorders.
- Although stress and emotional problems are often comorbid, most evidence-based CBT treatments are disorder specific.
- This presents a challenge for clinicians in assessment and in selecting treatment targets.
- There is a need for more panemotional and flexible treatments to effectively address work stress.
- Clinical research has been an increased focus on shared etiological and maintenance processes across disorders - transdiagnostic treatment approaches.
- Targeting these may treat several disorders with one protocol.

METHOD
- Single-subject multiple baseline design.
- Baseline (2-3 or 4 months).
- Treatment (3-4 or 5 months).
- Post-treatment follow-up (3 months).
- Treatment and post-treatment graphs.

RESULTS
- If individuals with work stress (HSCE > 30%) = elevated levels of anxiety or depression (HADS > 10 in 3 subgroups).
- Recruited from an inpatient health care facility.
- Treatment (Unified Protocol).
- Sessions to 8 sessions.
- All modules included.

AIM
- Test the feasibility of treating work stress with the Unified Protocol.
- Is an unified treatment approach for emotional problems preferred by patients with work stress?
- Is it effective in decreasing levels of work stress?
- Is it effective in decreasing generalized symptoms of anxiety and depression?

CONCLUSIONS AND FUTURE DIRECTIONS
- Work stress patients scored the treatment acceptable.
- 64% of patients decreased in levels of anxiety.
- 64% of patients decreased in levels of emotional symptoms.
- Changes in stress and emotional symptoms were evident at about the same time (start of treatment).

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

Figure 3. Pre- and post-range of all participants.

Figure 4. Evaluation of treatment

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

<table>
<thead>
<tr>
<th>Unified Protocol Modules</th>
<th>Time point</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work stress</td>
<td>Pre-post</td>
<td>LUE: Krasnitch &amp; Ollack, 2010</td>
</tr>
<tr>
<td>Personali stress</td>
<td>Pre-post</td>
<td>PES: Heffner, 1995</td>
</tr>
<tr>
<td>Anxiety &amp; Depression</td>
<td>Pre-post</td>
<td>SAS: Zung, 1963</td>
</tr>
<tr>
<td>Depression</td>
<td>Pre-post</td>
<td>CDSS: Birge, 2014</td>
</tr>
</tbody>
</table>

References

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The Role of Cognitive Behavioural Therapy Scales in Predicting Personality Disorder

Sedat BATMAZ, Sibel KOCBIYIK, Semra ULUSOY KAYMAK & Mehmet Hakan TURKCAPAR

College of Medicine, Psychiatry Clinic, Mersin, Turkey; Ataturk Training and Research Hospital, Psychiatry Clinic, Ankara, Turkey; Hasan Kalyoncu University, Department of Psychology, Gaziantep, Turkey

Objectives:

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

Methods:

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

Results:

For the diagnosis of personality disorder according to the total score of core beliefs related to personality, the duration of illness, number of hospitalizations, frequency of automatic thoughts, dysfunctional attitudes related to need for approval, total score of dysfunctional attitudes, adaptive emotional schemas and rigid emotional schemas; for core beliefs related to cluster A personality disorders, the duration of illness, being unemployed, frequency of automatic thoughts, dysfunctional attitudes related to perfectionism, total score of dysfunctional attitudes, adaptive emotional schemas and rigid emotional schemas; for core beliefs related to cluster B personality disorders, the duration of illness, being married, being unemployed, number of hospitalizations, the severity of depression, frequency of automatic thoughts, dysfunctional attitudes related to need for approval, total score of dysfunctional attitudes, adaptive emotional schemas and rigid emotional schemas and for core beliefs related to cluster C personality disorders, the duration of illness, frequency of automatic thoughts, dysfunctional attitudes related to perfectionism, total score of dysfunctional attitudes, adaptive emotional schemas and rigid emotional schemas were found to be statistically significant predictors.

Conclusions:

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

References:

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

Nathalie Claes\textsuperscript{a,b}, Geert Crombez\textsuperscript{b}, Johan W.S. Vlaeyen\textsuperscript{a,c,d}

Background
- Fear-Avoidance models propose that a catastrophic reappraisal of a painful experience may give rise to pain-related fear and consequently avoidance behavior, resulting in the development and maintenance of chronic pain problems \cite{1,2}.
- The experience of pain might install the salient goal to avoid pain, whilst other life goals might be simultaneously pursued \cite{3,4}. Moreover, both types of goals might possibly compete with each other, often resulting in withdrawal from the non-pain goals \cite{5}.
- Little is known about the effects of goal competition on pain-related fear and associated avoidance behavior in clinical situations as well as in experimental situations \cite{6}.

Therefore, we conducted fundamental, experimental research in healthy volunteers
Aim 1: To investigate whether a competing goal (a concurrent reward) is capable of diminishing both pain-related fear and avoidance of a movement that predicts pain (CS+).
Aim 2: To investigate how goal preference impacts pain-related fear and avoidance behavior in a context of competing goals.

Methods

Participants
- 65 healthy volunteers, after exclusion: 57.
- Male, M age = 22.62 years (SD = 1.64).
- Categorized in three groups, based on preferred goal (self-report, a priori):
  - Pain-avoidance (n = 19).
  - Reward-seeking (n = 21).
  - Equally important (n = 17).

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

Design
- Within-subjects crossover design.
- Control condition: CS+ accompanied by pain-US (i.e., CS+ no US).
- Reinforcement rate in acquisition and test phase: 50%, in choice phase: 100%.

Results
- Repeated Measures ANOVA:
- Successful acquisition in both conditions and all groups:
  - Expectancy of the pain-US was higher for the CS+ than the CS- movement, F(1,56) = 84.26, p < .001, irrespective of condition and group, F(1, 43). Pain-related fear.
- Participants reported to be more afraid of the painful movement compared to the safe movement, F(1,56) = 84.26, p < .001. Adding the concurrent reward did not result in changes in pain-related fear. There were however small differences between groups in overall reported pain-related fear, F(2,54) = 4.33, p = .018.

Choice behavior
- Participants choose to perform the painful movement more often when a concurrent reward was presented compared to when it was absent, F(1,56) = 160.03, p < .001. This effect was influenced by goal preference, Group × Condition: F(2,54) = 11.53, p < .001.
- All groups show an increase in the number of painful movements performed.
- When a concurrent reward was presented, the pain-avoidance group performed less painful movements than the equally important group, which in turn performed less painful movements than the reward-seeking group.

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

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dianascoelho@gmail.com & cesusalvador@gmail.com

ABSTRACT

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

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

INTRODUCTION

Unlike other phobic disorders, social anxiety in social anxiety disorder (SAD), does not decrease through exposure to the phobic stimulus in day to day life. PEP, a process that feeds on information coming from self-focused attention, has been pointed out as one of the explanatory factors for this fact and, consequently, as an important factor for maintaining SAD (Clark & Wells, 1995).

On the other hand, Herbert and Cardaciott (2005) postulated that lower levels of acceptance would increase levels of SFA and experiential control, and inevitably social anxiety.

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

METHOD

Participants

65 adolescents aged between 14 to 18 years

34 with SAD

31 without psychopathology

N = 7

27

N = 14

17

With comorbidity : N = 10 (29.4%)

In treatment : N = 2 (6%)

DIAGNOSTIC INTERVIEW:


Self Report Questionnaires:

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

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

Post-Event Processing Questionnaire for Adolescents: PEPPQ-A (Jeem et al., 2008; Conha & Salvador, 2014)

Focus of Attention Questionnaire: FAQ (Wood & Whid, 1997; Fonseca & Salvador, 2014)

Children’s Depression Inventory: CDI (Kovacs, 1985; Menoja, 1994)

RESULTS

Table 1. Significant differences between groups

<table>
<thead>
<tr>
<th>Medidas</th>
<th>P</th>
<th>χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAS-A</td>
<td>108.7***</td>
<td>63</td>
</tr>
<tr>
<td>FAQ-Pepp</td>
<td>47.6**,*</td>
<td>41</td>
</tr>
<tr>
<td>PEPPQ-A Total</td>
<td>52.9**,*</td>
<td>46</td>
</tr>
<tr>
<td>SA-AAQacceptance</td>
<td>48.1**,*</td>
<td>43</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>SAS-A</th>
<th>FAQ-Pepp</th>
<th>SA-AAQacceptance</th>
<th>CDI</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEPPQ-A</td>
<td>-42**</td>
<td>-57**</td>
<td>-.68**</td>
</tr>
</tbody>
</table>

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

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

CONCLUSION

The data seem to suggest that:

- The problem is neither the levels of social anxiety experienced neither the level of SFA but the way the individual is available to accept these internal experiences. Acceptance can be seen as a protective factor of PEP and consequently of PAS.

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

REFERENCES


Self-Efficacy in People with Mild Dementia and their Carers

BACKGROUND
Self-efficacy is the belief in one’s own ability to complete tasks and reach goals, and can influence how a person cope with a severe disease (1). New research demonstrates that self-efficacy is important for how a person with dementia cope with memory decline (2, 3). However, few studies have examined the correlation between self-efficacy and other psychiatric symptoms of people with dementia and their carers.

METHOD AND MATERIAL
The study is based on the German Cordial-study (4), which is a manual based approach that consists of cognitive behavioural therapy. The aim is increase self-efficacy in persons with mild dementia (MMSE ≥ 20). Sixty patients with dementia (52 females, mean age (SD) 70.6 (8.0), mean MMSE (SD) 23.3 (3.0)) and their caregivers (62 females and 89 males, mean age (SD) 67.0 (12.7)), which are included in the study, completed standardized measures of self-efficacy (GSE) (5), depression and anxiety (HAD) (6) and quality of life (ADGQL) (7). Thereafter, descriptive analyses, T-tests, correlation analyses and linear regression were completed in SPSS.

RESULTS
When controlling for age and gender, we found a negative significant correlation between patients’ self efficacy and depression/anxiety (R² = 40%) and between carers’ self-efficacy and quality of life (R² = 25%).

CONCLUSION
The aim of this study is to increase self-efficacy. We found:
- Low self-efficacy was associated with increased depression and anxiety in people with dementia.
- Low self-efficacy resulted in low quality of life in carers.

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

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

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

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

Brailovskaja, J., Bieda, A., Schönfeld, P. & Margraf, J.
Mental Health Research and Treatment Center, Ruhr-Universität Bochum, Germany

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

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

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

Results

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

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>USA</th>
<th>Russia</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) res*depression</td>
<td>-46**</td>
<td>-40**</td>
<td>-29**</td>
</tr>
<tr>
<td>(2) res*anxiety</td>
<td>-36**</td>
<td>-33**</td>
<td>-20**</td>
</tr>
<tr>
<td>(3) res*stress</td>
<td>-33**</td>
<td>-33**</td>
<td>-22**</td>
</tr>
<tr>
<td>(4) soc sup*depression</td>
<td>-37**</td>
<td>-37**</td>
<td>-29**</td>
</tr>
<tr>
<td>(5) soc sup*anxiety</td>
<td>-29**</td>
<td>-28**</td>
<td>-19**</td>
</tr>
<tr>
<td>(6) soc sup*stress</td>
<td>-24**</td>
<td>-28**</td>
<td>-22**</td>
</tr>
</tbody>
</table>

Note: res = resilience, soc sup = social support; **p ≤ .001

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

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>USA</th>
<th>Russia</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) res*dep</td>
<td>-32**</td>
<td>-45**</td>
<td>-25**</td>
</tr>
<tr>
<td>(2) res*anxiety</td>
<td>-21**</td>
<td>-38**</td>
<td>-20**</td>
</tr>
<tr>
<td>(3) res*stress</td>
<td>-26**</td>
<td>-32**</td>
<td>-25**</td>
</tr>
</tbody>
</table>

Note: res = resilience, soc sup = social support; **p ≤ .001

Means

Depression, Anxiety and Stress

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>USA</th>
<th>Russia</th>
</tr>
</thead>
<tbody>
<tr>
<td>stress</td>
<td>33</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>anxiety</td>
<td>33</td>
<td>28</td>
<td>25</td>
</tr>
</tbody>
</table>

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

Resilience and Social Support

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>USA</th>
<th>Russia</th>
</tr>
</thead>
<tbody>
<tr>
<td>soc sup</td>
<td>26</td>
<td>28</td>
<td>26</td>
</tr>
</tbody>
</table>

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

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

References

Contact: Julia.Brailovskaja@rub.de
The Disgust Scale - Revised (DS-R): Preliminary Reports of the Psychometric Properties in Greek Population
Chalimourdas T.1, Gonidakis F.1, Matsouka E.1, Sotiropoulou P.1, Efstratiadou K.1, Stachta X.1, Mourikis I.1, Vaidakis N.1 & Papadimitriou G.1
1 Athens University Medical School, Euthenia Hospital. Department of Psychiatry. Athens, Greece

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

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

Method
Participants
The participants were 251 students (170 women, 81 men)
The age range was from 18 to 36.

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

Material
1. The DS-R consists of 27 items, each item is rated on a 5-point scale ranging from 0 to 4.
   15 of the items rate the agreement with the statements, on a 5 point scale:
   0 = Strongly disagree (very untrue about me)
   1 = Slightly disagree
   2 = Neither agree nor disagree
   3 = Slightly agree
   4 = Strongly agree (very true about me)
   Next 10 items rate the degree of disgust on a 5 point scale:
   0 = Not disgusting at all
   1 = Slightly disgusting
   2 = Moderately disgusting
   3 = Very disgusting
   4 = Extremely disgusting
   Moreover, the DS-R includes 2 "catch" questions (identification of people who are not paying attention or are not taking the task seriously).
2. Demographic data was collected for each participant (sex, age, education, work status, family income, religion/religiousness).

Results
1. Preliminary results showed that the Greek version of the DS-R possesses satisfactory psychometric properties (sensitivity and specificity) as compared with published results from other countries.
2. The three factors model that is proposed by the creators of DS-R (core disgust, reminder of animals and contamination disgust) has also been confirmed for the Greek version of DS-R as the results indicated that there was satisfactory reliability of the model, medium relation among the three factors and strong relation with the total scale.

<table>
<thead>
<tr>
<th>Core disgust</th>
<th>Animal Reminder</th>
<th>Contamination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson r</td>
<td>p-value</td>
<td>Pearson r</td>
</tr>
<tr>
<td>Animal Reminder</td>
<td>0.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Contamination</td>
<td>0.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Total</td>
<td>0.9</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

3. Women had higher measurements of disgust than men.

<table>
<thead>
<tr>
<th>DS-R</th>
<th>Men</th>
<th>Women</th>
<th>Independent samples test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean value</td>
<td>Standard deviation</td>
<td>Mean value</td>
</tr>
<tr>
<td>Core Disgust</td>
<td>23.6</td>
<td>7.7</td>
<td>29.5</td>
</tr>
<tr>
<td>Animal Reminder</td>
<td>15.6</td>
<td>6.4</td>
<td>17.8</td>
</tr>
<tr>
<td>Contamination</td>
<td>8.2</td>
<td>3.8</td>
<td>9.1</td>
</tr>
<tr>
<td>Total</td>
<td>47.3</td>
<td>15.4</td>
<td>56.5</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Age</th>
<th>Income</th>
<th>Religiousness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>rho</td>
<td>p-value</td>
</tr>
<tr>
<td>Core Disgust</td>
<td>-0.012</td>
<td>0.889</td>
</tr>
<tr>
<td>Animal Reminder</td>
<td>-0.156</td>
<td>0.065</td>
</tr>
<tr>
<td>Contamination</td>
<td>-0.137</td>
<td>0.031</td>
</tr>
<tr>
<td>Total</td>
<td>0.001</td>
<td>0.985</td>
</tr>
</tbody>
</table>

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

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

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

Reference
Mental Health and Mental Illness Across the Lifespan: Transnational Comparison in Germany and Russia

Schönfeld, P., Brailovskaia, J., Bieda, A., Zhang X. C. & Margraf, J.
Mental Health Research and Treatment Center, Ruhr University Bochum

Introduction
Independent but correlated concepts of psychological symptoms and well-being (e.g., Keyes, 2007)
Inconsistent evidence for age differences in mental health and illness:
Increased mental health (Happel, 2011) in Australia
Unchanged mental health (Hammer et al., 2006) in USA
Decreased mental illness (Westerhof & Keyes, 2009) in Netherlands

Methods
Two representative cross-sectional samples:
- Germany (N=7583, Min_age=18, Max_age=99, M_age=47.64, 49.9% female)
- Russia (N=2606, Min_age=18, Max_age=100, M_age=44.02, 54.5% female)
Self-report questionnaires:
- Depression Anxiety Stress Scales (DASS-21)
- Positive Mental Health Scale (P-Scale)
- Marital Status
- School education

Data collection:
- Face-to-Face
- Online
- Offline Panel

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

Results
Overall differences:
Mental health is higher for Russians (M=20.90, SD=5.24) than for Germans (M=20.00, SD=6.18; p<.001)
Mental illness (including the subscales depression, anxiety and stress) is higher for Russians (M=11.18, SD=10.56) than for Germans (M=12.05, SD=11.11; p<.001)

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

- Age remains a significant positive predictor of mental health in Germany (β=.074, p<.001) even after controlling for gender, school education and marital status; by contrast age is a negative predictor in Russia (β=.167, p<.001)
- Both in Germany (β=.050, p<.001) and Russia (β=.059, p<.01) the relationship between age and mental health is curvilinear
- Age has a negative effect on mental illness in Germany (β=-.132, p<.001), even when sociodemographic variables are included in the model while it has a positive effect in Russia (β=.054, p<.06)
- The same results arise for depression (β=-.107, p<.001), anxiety (β=.062, p<.001) and stress (β=-.170, p<.05) in Germany and for anxiety (β=.103, p<.001) in Russia

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

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

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

References
Next Conferences

Terzo Convegno
La Psicoterapia in Evoluzione
Disagi Emozionali: Regolazione e Disregolazione degli Affetti nel Tempo della Crisi

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Dr. Richard Gevirtz
Heart Rate Variability Biofeedback: Principles and Applications

Dr. Diana Martinez
Optimization Therapies: Quantitative EEG Analysis, Bio & Neurofeedback in Combination with Noninvasive Brain Stimulation

Lothar Niepeth, Dipl. Psych.
Biofeedback in the Treatment of Insomnia

Dr. Erik Peper
Building Hope: Integrating Biofeedback and Somatic Feedback with Self-healing Skills Resolving Chronic Disorders from Test Anxiety to Severe Chronic Pain

Dr. Paul G. Swingle
Clinical and Braindriving: Neurotherapeutic Treatment of Depression ClinicalQ and Braindriving: Fundamental Neurotherapy for Professionals

Dr. Lindsay Thornton
Applied Work with Athletes in Peak Performance and Sports

Edna Tune, B.Sc., MA
From Disabilities to (Learning) Differences: Over to Abilities & Control and Learning Gains in Correlation With the Frontal Lobe

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A cura di
Lucio Sibilia e Stefania Borgo

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Stefania Borgo, neurologa e psichiatra, direttrice delle due maggiori associazioni di psicoterapia cognitivo-comportamentale (STDC e AVAMC), direttore del Centro per la Ricerca in Psicoterapia e della Scuola di Specializzazione in psicoterapia cognitivo-comportamentale a intervento psicocinetic. È autrice di numerosi libri e articoli in diverse riviste scientifiche e parabibliografie.
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The works will be shortly read by the Editorial Committee and the sending Author will receive a prompt feedback.