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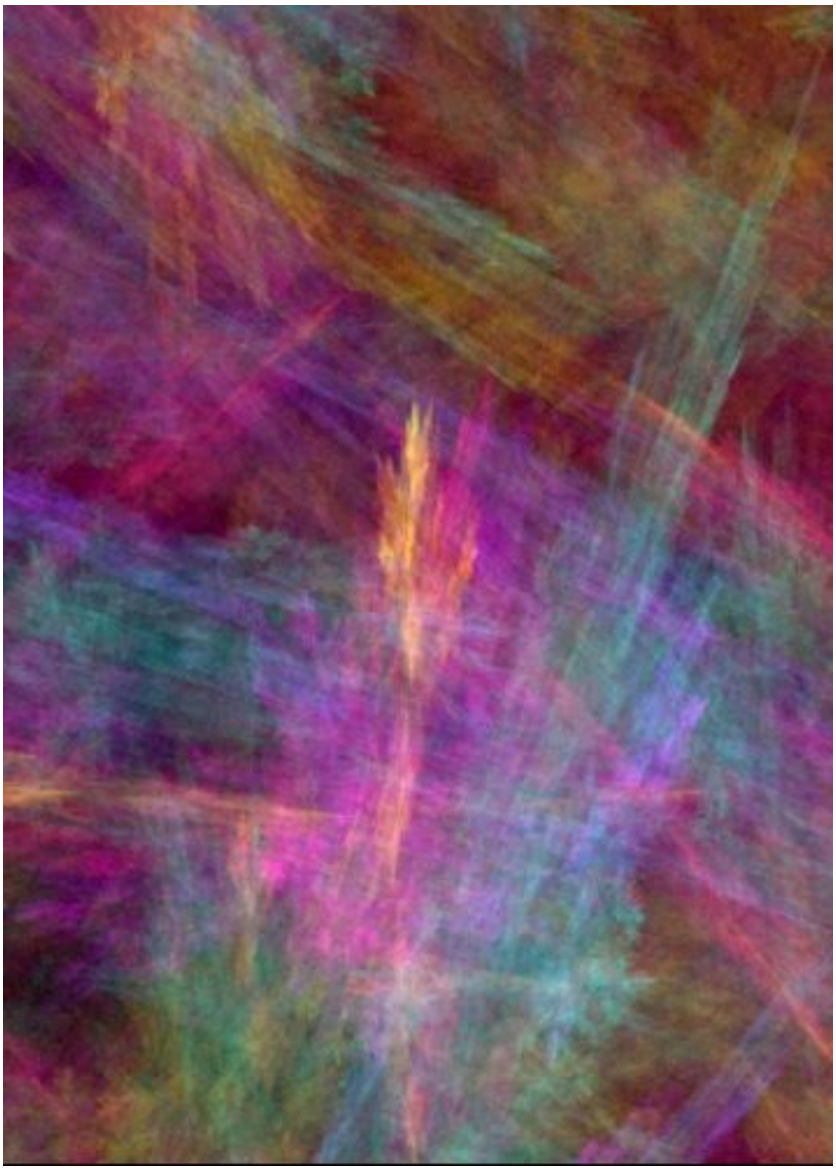

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Contents

Editorial *5*

Studies on personality and individual differences *7*

Balsamo M., Sergi A.R., Macchia A. (Italy) *Personality and depression: evidence of a possible mediating role for anger trait in the relationship between cooperativeness and depression.* *8*

Balsamo M., Romanelli R., Ciccarese G., Macchia A., Saggino A. (Italy) *The state-trait anxiety inventory: does it measure anxiety or depression?* *9*

Karaca S., Ünsal G., Onan N., Öz Can Y. (Turkey) *To study university students own family perception, family functions and interpersonal relationship style.* *10*

Charbonnier E., Bon M., Graziani P. (France) *Coping processes employed to face up to stress: study conducted with 400 homosexuals.* *11*

Studies on psychopathology 12

Çakir U., Gündüz N., Turan H., Güleş E., Tamer Aker A. (Turkey) *Comparison of cognitive schemas of women with sexual violence related PTSD with women with pure MD* *13*

Elizathe L., Murawski B., Scappatura M.L., Lievendag L., Diez M., Salaberry P., Barrios R., Grad Gut M.A., Keegan E., Rutsztein G. (Argentina) *Body image and risk of eating disorders in 9-12 years old children of Argentina* *14*

Elices M., Fernández C., Martìn-Blanco A., Feliu A., Soler J., Pascual J.C. (Spain) *Psysiological and self-reported assessment of emotional dysregulation in patients with borderline personality disorder: an emotional induction study using film clips* *15*

Dodig I., Acquistapace M., Baruffi M., Filipponi L., Galeazzi A., Pizzo S. (Italy) *Insight into eating disorders. Relationship between Anorexia Nervosa and the Psychotic Spectrum* *16*

Matsuda Eiko (Japan)
The association between sleep disturbance and depression: epidemiological survey of insomnia, hypersomnia and nightmare in japanese employee and adolescents: non pharmacological treatment for sleep disturbance may reduce a risk of a future mental disease *17*

Nieto L., Pousa E., Cobo J.V., Blas-Navarro J., Garcia-Parés G., Palao D., Obiols J. (Spain)
Insight and symptomatic dimensions of acute phase psychotic patients *18*

Szezeskiewiez Joanna (Canada)
"I am afraid I am going to kill myself": when fear of suicide and suicidal ideation coexist *19*

Roncero M., García-Soriano G., Belloch A., Perpiñá C. (Spain)
Ego-dystonicity and ego-syntonicity dimensions in obsessive intrusive thoughts subtypes. Study in a non-clinical population. *20*

Roncero M., García-Soriano G., Belloch A., Perpiñá C. (Spain)
Relationship between OCD & ED. How do patients interpret and manage their intrusions? *21*

Benita Chaves (Portugal)
Early Maladaptive Schemas: Relationship with aggressive and antisocial behavior *22*

Çankaya B., Aytürk E., Coşkun C. (Turkey)
Diatheses to Depression: The Interactions of Schema Propositions, Schema Structure and Negative Life Events *23*

Studies on assessment instruments *24*

Rodrigues S., Rijo D. (Portugal)
Expectancies and Attitudes towards Psychosocial Rehabilitation Scale – Prison Staff (EARPS-PS) *25*

Carvalho T., Pinto-Gouveia J., Cunha M. (Portugal)
Portuguese version of the Difficult Living and Working Environment Scale of the Deployment Risk and Resilience Inventory (DRRI): a study with Portuguese colonial war veterans *26*

Carvalho T., Pinto-Gouveia J., Cunha M. (Portugal)
Portuguese version of the Perceived Threat Scale of the Deployment Risk and Resilience Inventory (DRRI): a study with Portuguese colonial war veterans *27*

Miguel R.R., Rijo D., Lima L.N. (Portugal) *A Multidimensional Measure of Cognitive-Behavioural Variables Underlying School Underachievement* *28*

Petiz M., Vagos P., Rijo D. (Portugal) *PCS-Peer Conflict Scale. Validation studies in a sample of Portuguese adolescents* 29
Garcia-Soriano G., Belloch A., Roncero M., Carrió C., Cabedo E. (Spain) *Psychometric proporties of the Spanish version of the Obsessive-Compulsive Inventory-Revised (OCI-R) in a obsessive-compulsive disorder sample* 30
Soares T., Caminha R., Caminha M. (Brazil) *Deck of Emotions: Accesing child emotions* 31

Studies on intervention methods and programs 32
Peñacoba Puente C., Velasco Furlong L., Cigarán Mendez M., Ecija Gallardo C., Rodriguez Muñoz M. (Spain) *Effects of an interdisciplinary intervention (Cognitive-Behavioral Therapy+Occupational Therapy) in health outcomes in fibromyalgia* 33
Etchemendy E., Baños R.M., Felipe S., Castilla D., Botella C. (Spain) *The book of life: working positive reminiscence exercise with the elders through Positive Technologies* 34
Fatih Yavuz K., Ulusoy S., Karatepe H.T. (Turkey) *Preliminary results of 7-session cognitive group therapy for text anxiety* 35
Çelik F., Kirmizi-Alsan E., Tamer Aker A. (Turkey) *Grief focused cognitive behavioral therapy reduces grief symptoms in traumatic grief patients* 36
Rasal P., Botella C., Bretón J., Baños R., Agustí A. I. (Spain) *Treating small animal phobia in a 10 year old girl using images, a video game and augmented reality before in vivo exposure: A single case study* 37
Botella C., Herrero R., Vizcaíno Y., Molinari G., Baños R., Carcía-Palacios A. (Spain) T*he use of information and communication technologies supporting activity pacing in the psychological treatment of fibromyalgia* 38
Anisi Khoshlahje Sedgh (Iran) *The comparison of effects information Processing therapy and instruction of Communication skills in reducing depression* 39
Henriquez S., Farias A., Ramirez U., Piña A., McFarr L. (USA) *Cross Cultural Dialectical Behavioral Therapy (DBT): An Update on Acculturation; Treating Latinos with Borderline Personality Disorder with DBT and Culturally Sensitive Interventions* 40
Higier R.G., Benson L.A., Mallam S., Testerman L., Glenn D., Baucom K.J.W., Bedics J.D., McFarr L.M. (USA) *Predictors of Therapist Burnout in DBT: The role of Secondary Targets* 41
Jackson L.L., Higier R.G., Henriquez S., Baucom K.J.W., Bedics J.D., McFarr L.M. (USA) *Potential Links between DBT Skills Acquisition, Emotion Regulation and Length of Time in Comprehensive DBT Treatment* 42
Szezeskiewiez Joanna (Canada) *Psychotic disorders and physical health: enabling treatment collaboration* 43
Tahmasebi S., Fata L., Tahmasian K., Sadat Momenvaghefi M. (Iran) *Efficacy of parent skills training via TTT Model on Parent Stress and Behavior Problems of Preschoolers (A Preventive Community-Based Program)* 44
Fumika Kimura, Tateki Nakamura, Sora Hashimoto (Japan) *Effective summer camp programs for special support class students in the junior high school* 45
Özlem Yıldız, Ayla Yazıcı, Sibel Coşkun, Meltem Temiz, Şahap Erkoç (Turkey) *The effectivity of cognitive rehabilitation on the treatment of patients diagnosed with schizophrenia and on psychosocial functioning* 46
Özlem Yıldız, Ayla Yazıcı, Sibel Coşkun, Meltem Temiz, Cahit Keskinkılıç, Simge Tabakoğlu (Turkey) *The effectivity of cognitive rehabilitation on neurocognitive mechanism in schizophrenic patients* 47
Sibel Coşkun, Ayla Yazıcı, Meltem Temiz (Turkey) *Analysis of the changes in social functionality, BPRS and insight levels of chronic psychiatric patients treated in Day Hospital which apply patient-centered rehabilitation programme* 48
Marks I., Sibilia L., Borgo S., Sungur M. (International) *Common Language for Psychotherapy Procedures Project: An Update* 49

Next Conferences 50

Contributing to *Psychomed* 50

Editorial

Dear readers,

It is our pleasure to invite you to read this special issue of *Psychomed* containing a nice sample of the posters presented at the 7th International Conference of Cognitive Psychotherapy "Clinical Science" (ICCP 2011), jointly organised in Istanbul last June by the International Association of Cognitive Psychotherapy (IACP) and by the Turkish Association of Cognitive and Behavioral Psychotherapy (TACBP). This collection has been possible with the joint efforts of all the presidents of both Societies, and in particular M. Sungur, the generous president of TACBP and the Congress. More information about the 7th ICCP congress may be obtained from the website www.iccp2011.com

It is not the first time that *Psychomed* hosts a range of posters of an International Congress. We have started to publish posters just three years ago, in June 2008, when we proposed in the 6th IACP Conference Rome to let poster presenters to publish their work on our on-line journal. An idea which was a logical step in the publishing policy of *Psychomed*, which aims at providing an easy tool to be updated with current research literature in the area of medicine-psychology interface, in synthetic and more functional ways than the usual "journal" format. With a particular emphasis on the readability of articles, for example, we had already proposed the concept of "synthesis", an intermediate document between the "abstract", usually 200-300 words, and the "paper" (the scientific journal article) usually between a minimum of 6 and a maximum of 20 pages.

Moreover, we wished to give room to young researchers, whose work is often unjustly appraised as "second rate". Posters, often proposed by young authors who may not have the linguistic abilities or experience to present their work in oral congress sessions, very often have the same scientific quality of presentations which have a more prominent placement in congress programs. Moreover, posters may easily be reduced to a "computer screen" format and enlarged with no loss of information, a fact particularly adaptable to an on-line journal issue which can also be downloaded from the net, so that they may be read more comfortably rather than standing in a busy corridor of a conference venue.

Albeit the idea was an innovation in 2008, and the outcome not at all trivial given some technical difficulties we had to overcome, the success was immediate: we could publish 25 valuable posters, each published on one page, as very few had to be discarded of those received. The experience has been repeated so far and with growing success in other two occasions: the 2009 EABCT Conference in Dubrovnik and last year at the XL EABCT Conference in Milan, where a total of 43 posters were published.

The selection of posters, in previous as well as in current issue, has been performed on the basis of the relevance to the journal interests (but this rarely has been a problem, as posters had already been passed by conference organisers), the maintenance of minimum standards of scientific level, leaving to readers instead the appraisal of the scientific quality of the work and of readability. A particular effort has been made to preserve the graphic qualities of the authors' works, except when they reduced rather than enhance posters' readability. In these cases, some graphic element has been omitted, taking care not to skip any relevant information.

Of all the 46 files received to compose this issue, we regret that 7 had to be rejected, either because they were not received in time in the requested format, or because they were not received as "posters", but rather as ordinary papers, thus distributed on more than one page, a fact which

would have required further work on them. Perhaps the idea of publishing posters instead of papers is still too new to be understood. So, we regret for those Authors who will not see their work published in this special issue devoted to posters; however, the choice made was not to wait any longer, as one of the constraints (and promises) was to publish the current issue in a short time.

The 39 resulting posters accepted for this publication come from 11 different Countries and cover a wide range of clinical problems, assessment and intervention methods. They are grouped in clusters according to their large thematic areas, as follows: studies on personality and individual differences (4 studies), on psychopathology (11 studies), on assessment instruments (7 studies), on cognitive-behavioral or other intervention programs and methods (17 studies). Within each area, the posters are listed in their order of arrival.

This is really a sample of studies providing a sense of how international and active is clinical and experimental research in the area of cognitive-behavioral therapy; but also the clarification of new ideas and the exploration of new procedures, before they are submitted to empirical scrutiny, is part of the "Clinical science", so that these new ideas may, in the long run, challenge established assumptions.

The resulting file has a dimension of about 15 MB, so that it takes some time to be downloaded from the Net and loaded in a "reader" application, according to individual technical resources. This is certainly due to the great amount of information packed in each page, often coupled with a lot of graphics, a fact which does not allow, not invite, for a quick browsing. However, even so, we have noticed that we never had to wait more than a few seconds to read a new page on screen.

As a final note, we have realised just a few months ago that the idea of publishing posters on-line has been also implemented by other Colleagues, unknown and independently by us, in the occasion of a recent Italian conference of psychiatry, a fact which we take as a "reinforcement" of our initiative, a new way of communicating scientific literature, which *Psychomed* has initiated and is proud of.

Have a good and rewarding reading,

Lucio Sibilia, MD (Editor), Stefania Borgo (Co-editor) & Mehmet Sungur, MD (Guest Editor)



Studies on personality and individual differences

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PERSONALITY AND DEPRESSION: EVIDENCE OF A POSSIBLE MEDIATING ROLE FOR ANGER TRAIT IN THE RELATIONSHIP BETWEEN COOPERATIVENESS AND DEPRESSION

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INTRODUCTION

The aim of this study is to examine the relationship among domains of personality, anger and depression, because there has been no examination of the role anger plays in the personality factors-depression relationship. In fact, based on clinical observations, it could be hypothesized that anger trait maintains or exacerbates depression associated with some personality dimensions, for example with reduced cooperativeness, or with low self-compassion. Starting from these considerations, the goal of our explorative research was to conduct a more detailed investigation into the relationships among depression, anger trait and personality characteristics based on Cloninger's 7-factor personality theory (Cloninger, 1999), in a sample of healthy individuals. Depression and Cooperativeness were expected to have a negative and significant relationship and the trait anger was significantly associated with both cooperativeness and depression. Theoretically a new hypothesis was that the trait anger would mediate the relationship between depression and cooperativeness.

METHOD

INSTRUMENTS

State-Trait Anger Expression Inventory–2 (STAXI–2; Spielberger, 1999). This questionnaire is composed of 57 items and six scales: four anger ex-pression trait scales, a State-Anger scale, and a Trait-Anger scale. The Trait-Anger scale contains 10 items that assess the tendency to experience and express anger without any specific provocation. Participants score items using a four-point response scale from 1. The Cronbach coefficient α of the scale was .85.

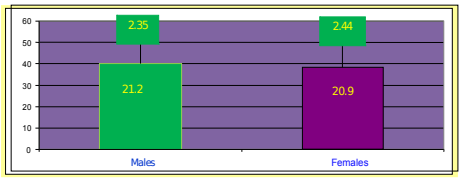
Beck Depression Inventory–II (BDI–II; Beck, A. T., Steer, R. A., & Brown, G. K., 1996).—The Italian adaptation (Ghisi, M., Flebus, G. B., Montano, A., Sanavio, E., & Sica, C., 2006) of the Beck Depression Inventory–II is a 21-item self-report inventory to assess the presence and severity of depressive symptoms in clinical and nonclinical samples. It is rated on a four-point Likert-type scale ranging from 0 to 3, based on severity of each item. Scores range from 0 (no symptoms) to 63 (very severe symptoms). In the present study the Cronbach's alpha for the total score α was .88.

Temperament and Character Inventory-Revised (TCI–R; Cloninger, 1999). It is 240-item self-administered questionnaire , rated on a 5-point Likert scale format ranging from 1 (*definitively false) to 5 (definitively true*). The TCI-R is composed of 7 scales. Four temperament traits (Novelty Seeking, Harm Avoidance, Reward Dependence, and Persistence) are considered expressions of basic emotional responses to novelty, anger or punishment, and reward. These traits manifest early in life, are stable throughout life, and are moderately heritable. Three character traits (Self-Directedness, Cooperativeness, and Self-Transcendence) are considered expressions of concepts about the self and personal relations. In the present study internal consistency reliabilities for the main TCI-R dimensions ranged from .48 (Harm Avoidance) to .88 (Persistence).

SUBJECTS

Participants were 230 Italian psychology undergraduates, recruited at the University of Chieti-Pescara. The sample was composed of 208 women (90.4%) and 22 men (9.6%). The sample's mean age was 20.9 yr. (SD = 2.43, range 19–37). The mean age for men was 21.2 yr. (SD = 2.35) and for women 20.9 yr. (SD = 2.44). The mean years of educa-tion were 13 yr. (SD = 1.2). All subjects were white. Finally, all respondents were asked to participate on a voluntary basis, and provided written informed con-sent before administration of the scales. Anonymity was guaranteed.

Figure 1. Mean and SD of age for sex in non clinical sample (*N*=230)



PROCEDURE

Zero order, partial correlation coefficients and a path analysis, based on Baron and Kenny's method, for calculating multiple regression analyses were calculated. In particular a path analysis was calculated to test for mediation by Anger trait between depression and the TCI-R dimension most related with depression (Harm Avoidance, a temperament domain, and Self-Directedness, a character domain).

RESULTS

Table 1 shows the obtained descriptive statistics and internal consistency reliabilities for the seven TCI-R scales, the BDI-II total score, and the STAXI-2 Trait Anger score.

Table 1. Descriptive statistics for the seven TCI-R scales, the BDI-II and the STAXI-2 Trait Anger scores (*N*=230).

Scales	M	DS	Range	Alpha
TCI-R Novelty Seeking	111.94	11.84	67-143	.63
TCI-R Harm Avoidance	103.64	8.74	73-122	.48
TCI-R Reward Dependence	94.46	9.92	63-113	.74
TCI-R Persistence	113.22	17.01	58-160	.88
TCI-R Self-Directedness	131.90	11.53	95-169	.68
TCI-R Cooperativeness	127.14	11.96	92-155	.80
TCI-R Self-Transcendence	70.72	15.35	41-122	.87
BDI-II	11.43	8.88	0-51	.88
STAXI-2 Trait Anger	19.74	6.58	10-39	.85

As can be seen in table 2 TCI-R harm avoidance , persistence, cooperativeness, and self-transcendence scales were found significant and negative correlations with Depression. Instead harm avoidance, reward dependence, self-directedness, and cooperativeness were found significant correlations with Trait Anger. However, we consider as "salient" only absolute correlations equal to or greater than .30, which explain 9% or more of the variance, as the probability value are influenced by the number of subjects (the probability values are also reported in the table 2). Therefore, only Cooperativeness character domain score is the TCI-R scale score most correlated with both Depression and Trait Anger._

Table 2. Bivariate Correlation Coefficients Among Temperament and Character traits (TCI-R scales), Trait Anger (STAXI–2), and Depression (BDI–II) (*N*=230).

TCI-R scales	Depression	Trait Anger
Novelty Seeking	-.04	.03
Harm Avoidance	-.16*	-.20**
Reward Dependence	-.12	.09*
Persistence	-.15*	.03
Self-Directedness	-.12	-.18**
Cooperativeness	-.30**	-.41**
Self-Transcendence	-.17**	.11

*$p < .05$. **$p < .001$

Table 3. Bivariate Correlation Coefficients Among TCI-R Cooperativeness subscales, Trait Anger (STAXI–2), and Depression (BDI– II) (*N*=230).

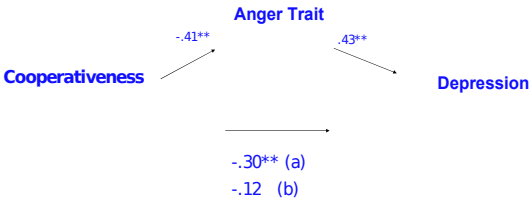
TCI-R Cooperativeness subscales	Depression	Trait Anger
Social Acceptance (CO1)	-.09	-.20**
Empathy (CO2)	-.11	.02
Helpfulness (CO3)	-.19**	-.09
Compassion (CO4)	-.23**	**-.47****
Pure-Hearted conscience (CO5)	-.07	-.11

** p < .001

The five subscale scores of the Cooperativeness domain, salient correlations were found only between Compassion subscale and the STAXI–2 Trait Anger score, as can be seen in Table 3.

Cooperativeness scale was correlated -.13 (p= n.s.) with Depression, controlling for Trait Anger, and .31 ($p < .001$) with Trait Anger, controlling for Depression. Depression was correlated .41 ($p < .00$) with Trait Anger, controlling for the Cooperativeness scale. Then the Cooperativeness was significantly associated with Depression ($\beta = -.30$; $t = -4.7$, $p < .001$) and Trait Anger ($\beta = -.41$; $t = -6.7$, $p < .001$). In the last equation, when controlling for Trait Anger, the relationship between Cooperativeness and Depression decreased ($\beta = -.12$; $t = -1.9$, p = n.s.), and become statistically not significant. Therefore, Trait Anger was concluded to mediate completely the Cooperativeness-Depression relationship (Fig. 2).

Figure 2. Path model. Values are β coefficients. (a) β coefficient without Anger Trait. (b) β coefficient after controlling for Anger Trait. Note **$p<.001$.



CONCLUSIONS

Consistent with our hypotheses, Cooperativeness character domain and Depression were strongly associated and both Cooperativeness domain and Depression were significantly and saliently associated with the trait anger. So the trait anger could help explain how or why Depression is related to reduced Cooperativeness (or low self-compassion). In terms of potential clinical implications, these findings, if replicated in clinical groups, suggest that self-compassion-based interventions may represent an effective approach for depressed individuals with anger attacks. Intervention to develop the inner compassion for the self and others may represent a parsimonious alternative to interventions that selectively target either anger or depression in treating depression. Thus, promoting self-compassion may be a promising approach as a cognitive "immunization strategy" against the development and/or maintenance of depressive symptoms with anger attacks.

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THE STATE-TRAIT ANXIETY INVENTORY: DOES IT MEASURE ANXIETY OR DEPRESSION?

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INTRODUCTION

Self-report instruments for measuring clinical variables are very useful in the clinical practice. Yet, many of these have several psychometric limitations. For example, for some of these, the validity construction has not been demonstrated. According to the most recent literature, the State Trait Anxiety Inventory (STAI; Spielberger, Gorsuch & Lushene, 1970), a well-known measure of trait anxiety and state, showed high correlations with the scores of depression scales the questionnaire, so it appeared to not strictly evaluate anxiety but, rather, negative affect (Bados, Gomez-Benito, Balaguer, 2010; Gros, Antony, Simms, McCabe, 2007; Ponciano, Rodrigues, Medeiros, Jardim, Cardoso, Spielberger, 2006). In contrast, much of the literature on the psychometric properties of assessment tools for anxiety and depression reports low or negative correlations between measures of depression and anxiety, so their divergent validity appears to be adequate in most cases (Bados et al., 2010; Gros et al., 2007). The aim of our study was to verify if the STAI can be considered a measure of pure anxiety symptoms by studying: 1) the relationships between two depression scales and the STAI form Y trait version (STAI-T) in a clinical sample and non clinical sample, and therefore its divergent validity; 2) the results of the confirmatory factor analysis of various models of the STAI-T.

METHOD

INSTRUMENTS

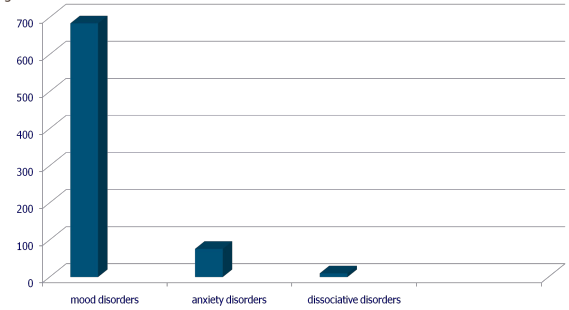
Beck Depression Inventory–II (BDI–II; Beck, Steer, Brown, 1996). It is a 21-item self-report inventory used to assess the presence and severity of depressive symptoms in clinical and nonclinical samples. It is rated on a four-point Likert-type scale ranging from 0 to 3, based on severity of each item.

Teate Depression Inventory (TDI; Balsamo, 2006). It is a new Italian self-report depression scale for adults, composed of 21 items, selected by the model of Item Response Theory on the basis of diagnostic criteria in the DSM-IV diagnosis of major depression. On 5-point Likert scale, the individual items measure how much of the time the symptoms have been present during the past 14 days. The scale form 0 (always) to 4 (never).

State-Trait Anxiety Inventory Form Y (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983).It is an instrument of self-report measure consisting of two sub-scales: STATE-A and TRAIT-A for the discovery of state and trait anxiety respectively. Each of the two sub-scales consists of 20 items rated on a Likert scale of four levels.

SUBJECTS

The total amount of partecipants was 1494; 726 of them were the non clinical sample while 768 were the clinical sample. The psychiatric outpatients were recruited from the hospital and mental health centers of the Italian country. Criteria of inclusion were: 1) a current diagnosis according to DSM-IV-TR diagnostic criteria axis I or/and II; 2) no treatment with antidepressant drugs or/and psychotherapy or, alternatively, presence of therapy in the preceding 3 months; 3) absence of severe medical illness; 4) at least 18 years of age.
The sample consisted of 521 females and 247 males. The mean age was 41.86 years (SD = 15.36, range 17-87). The average age of education was 12.01 years (SD = 4.10, range 0-24). All of the patients were diagnosed by experienced psychologists or psychiatrists according to DSM-IV-TR criteria. In Figure 1 Distribution of Axis I diagnoses have been shown.
Of the total clinical sample, 24.6% were in the initial phase of the pharmacological treatment (first 3 months), 32.4% were in the initial phase of the psychotherapeutic treatment, 34% were in the initial phase of both pharmacological and psychotherapeutic treatment, and 9% was free from treatment. Finally, all respondents were asked to participate on a voluntary basis. Anonymity was guaranteed.



Non clinical sample consist of 726 people (male=339; female=387). The mean age was 25.10 years (SD = 9.34, range 17-74). The average age of education was 14.19 years (SD = 2.63, range 1-27).

RESULTS

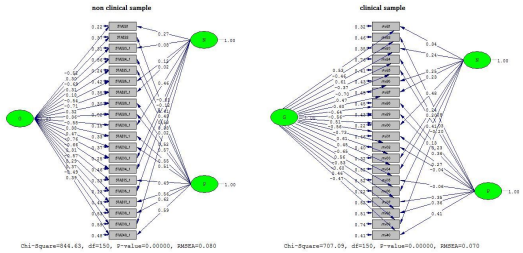
In Table 1, the intensity of the correlations between the TDI and the BDI-II on the whole sample was reported. It takes into account the total raw score obtained on each scale. Both the Trait-A of the STAI correlated significantly and positively with both measures of depression.

Table 1. Correlations between the scales of depression and the two subscales of the STAI *(N=1494)*

	STAI-T
BDI-II	*.76***
TDI	*.79***

We conducted a Confirmatory Factor Analysis throug LISREL 8.7 (Joreskog & Sorbom, 2004) of the STAI-T separately for clinical and non-clinical sample. Starting from Bados et al (2010), we tested three models: 1) a general Anxiety factor model; 2) Bifactor model with two specific factors (Depression and Anxiety); 3) one – construct, two – method model (Positive and Negative Polarity factor). In Figure 2 two path diagrams for clinical sample and non clinical sample of the one-construct two-method model have been shown.

Figure 2. One-construct, two-method model of the STAI-T. G = General factor; P = Positive Polarity Method factor; N = Negative Polarity Method factor.



In Table 2 goodness – fit indeces have been shown.

Table 2. Values of the fit indexes for the different models

	Tested Model	GFI	NNFI	CFI	RMSEA	RMSEA (90%CI)
Non clinical sample	One general anxiety factor	.55	.86	.87	.220	.21 - .22
	Bifactor model	.88	.96	.97	.088	.083-.093
	One-construct, two-method	.90	.97	.97	.080	.075 - .085
clinical sample	One general anxiety factor	.82	.95	.95	.11	.10 - .11
	Bifactor model	.92	.98	.98	.066	.061 - .071
	One-construct, two-method	.92	.97	.98	.070	.064 - .075

CONCLUSIONS

The fit indexes from the confirmatory factor analyses indicate that, of the three models considered, the bifactor model with two specific factors and even more the one-construct, twomethod model were those that showed the best fit, with acceptable fit indexes. The fit of the one-construct, two-method model is consistent with the findings of Bados at al. (2010) and supports the notion that the STAI–T may measure a substantive construct together with method effects due to item polarity. An alternative model is the bifactor model with two specific factors and one general factor. Thus, there is a general factor (Negative Affect, supposedly) that explains the item communality and two specific domain factors (Depression and Anxiety, supposedly), each of which accounts for the unique influence of the specific domain ahead of the general factor. Indeed, both models are plausible and can be regarded as alternative representations of the structure of the STAI–T. They both show the same pattern whereby all the items load strongly on the general factor, complemented by the presence of method or specific factors on which half of the items load. This raises concerns about the meaning of the general factor and the two specific factors. The data regarding the divergent validity of the STAI–T do shed further light on what it actually measures. The STAI-T in fact showed high correlations with measures of depression: BDI-II and TDI.
According to the current literature (Bados et al. 2010; Gros et al., 2007; Ponciano et al., 2006), these results suggest that the STAI does not strictly evaluate anxiety but rather the negative affect, represented by the general component.

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TO STUDY UNİVERSİTY STUDENTS' OWN FAMİLY PERCEPTİON, FAMİLY FUNCTİONS AND İNTERPERSONAL RELATİONSHİP STYLE

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Introduction

The individual within social relation communicates with many people; on the other hand, established close relationships with important people for him/her is in more dominant role in shaping personality(1). Each individual can use a different style for relationship and relationship style can also affect individuals' life satisfaction(2). Individuals are affected by relationships established in daily life and the established relationships with other people determine life quality in terms of communication skills. Communication style is closely related with perception style of himself, others and outside world. Formation of perception style is related with individual power to determine, messages which are received from his/her environment and interpretation of these messages. In addition, communication styles of individual's environment are important reference(4). Individual filters gained experiences from the environment outside the family through their parents(3). Famiy functioning can be related with how adolescent is percieved his/her family (3) and may affect adolescent problems(5). Accordingly, family function and perception have inevitable affects on communication style.
This descriptive study investigates own family perception, family functions and interpersonal relationship style of a group university students.

Method

The universe of this study is 105 first year students who attends Faculty of Health Sience of a university in the Turkey. The sample is 66 students who participated to this study. Structured Interview Form (SIF) , Family Evaluating Scale (FES) and Interpersonal Relationship Scale (IRS) are used to get data. The researcher prepared SIF from open-ended questions through literature (6,7) . The applied interview form to participants were grouped by evaluating. Percentage, mean and Spearman correlation analysis are used to evaluate the data in this study

Results

Table 1.Socıo-demographıc characterıstıcs

Socio-demographic characteristics		n	%
Age	17-20	63	95.5
	21-27	3	4.5
	Mean±Sd	19.12	1.35
Gender	Woman	50	27.9
	Man	16	8.9
Mother's Education Status	Literate	11	16.7
	Primary school	32	48.5
	Middle scholl	10	15.2
	High school	9	13.6
	Universty	4	6.1
Father's Education Status	Literate	5	2.8
	Primaryschool	21	31.8
	Middle scholl	12	6.7
	High school	15	8.4
	Universty	13	19.7
İncome Status	Sufficient	31	47.0
	Partially Sufficient	27	40.9
	Inadequate	8	12.1
Family Type	Nuclear family	64	97.0
	Large family	2	3.0
Number of Brothers	Single Child	4	6.2
	2-4 siblings	50	75.8
	5 and above	12	18.0
Which Sibling	The first	24	36.4
	Median	32	48.5
	Last	10	15.2
Pre-University Residence Region	Marmara	30	45.5
	Black Sea	12	18.2
	Aegean	6	9.1
	Mediterranean	3	4.5
	Central Anatolia	4	6.1
	Eastern Anatolia	6	9.1
	Southeastern Anatolia	7	7.6
living with other / place of residence	Living with family	14	21.2
	student dormitory	34	51.5
	Friend at home	14	31.3
	Living next to relative	4	6.10
	Total	66	100.0

The mean age of the students is 19.12±1.35. 27.9% of them is female and 35.8% of them have got nuclear family (Table 1). 90.9% of students think that their family relationship is reliable and 87.9% of them think that their family relationship is supportive. (description can be more than one statement). 83.3% of students think positive characteristics of their family is to value each other (Table 2).
The participants get lowest score on problem solving skills (1.95±0.61), highest scores on behavioral control (3.07±0.32) and exhibiting adequate attention (3.17±0.70) from sub-dimensions of FES. The sub-dimensions on SIF are campatible with the statements of "disallowance by own family on behavioural decision making" and "inefficiency on love and exhibiting attention ".

Table 2. Descrıptıon of the students on family relatıons

Family relations		n	%	Mean	Sd
Family Relations Perceptions	Interesting	57	86.4	0.90	0.35
	Supportive	58	87.9	0.88	0.32
	Provided by trust	60	90.9	0.90	0.28
	Respectful	50	75.8	0.75	0.43
	Clearly defining the responsibilities	23	34.9	0.34	0.48
The perceived positive features of the family	Problem solving	36	54.5	0.58	0.52
	Export value each other	55	83.3	0.83	0.57
	Express ideas	46	69.7	0.70	0.46
	Friendly Attitude of parents	16	24.2	0.24	0.43
	love is not expressed	26	39.4	0.40	0.50
The perceived negative features of the family	Failure to resolve conflicts	34	51.5	0.51	0.50
	Solid repressive attitudes of parents	49	74.2	0.74	0.44
	Feelings be tongue-tied with father	32	48.5	0.49	0.50
Communication Problems in the family	Not to listen each other	58	87.9	0.88	0.51
	Not to permit description of behavior	34	51.5	0.32	0.50
	Listen to their parents more	50	75.8	0.75	0.43
	Love to show	33	50.0	0.50	0.50
Circumstances that you want, changing it in the family	Parents can not be a fight between	27	40.9	0.40	0.49
	Relations parents have more soft and quiet	32	48.5	0.48	0.50
	Family members are aware of their responsibilities	13	19.7	0.19	0.40

Note:Participants stated that more than one definition

The mean value of feeding relationship score is 33.04±7.70 from IRS and the mean value of inhibitory relationship style score is 11.43±6.68 from IRS. Some statistical relations between sub-dimensions of SIF and IRS are found.

There is found negative direction and statistical relations between communication sub-dimension of FES and open (r= -.30; p<0.05) and respective(r=-.35; p<0.01) relationship of IRS. According to findings, while functionality of family communication skill increases, comminication style of adolescent increases in way of open and respective relationship too. There is found negative direction and statistical relations between problem solving sub-dimension of FES and open (r=-.38; p<0.01) and respective (r=-.31; p<0.05) relationship of IRS. According to findings, while functionality of family problem solving skills increase, comminication style of adolescent increases in way of open and respective relationship too. While problem solving(11.72±3.69) is best functionality of participants' family, behavior control (27.69±2.88) and exhibiting adequate attention (22.22±4.95) are worst functionality. It is found that there were statistical relationship between exhibiting adequate attention and inhibitory communication style (r=-.27; p<0.05) and between problem solving and feeding communication style (r=.-38; p<0.01).

Discussion

That is reported that love, respect and the democratic relationship between parents and children are in the basis of most appropriate family environment for psychosocial development of children and adolescents (8).It is obtained in this study that while problem solving was most healthy family function , behavior control and exhibiting adequate attention were worst family function. While the points of exhibiting adequate attention increases, inhibitory communication style decreases. While the points of problem solving and communication increases positively, feeding relationship style increases too(Table 2). It is emphasized that family environment of adolescent, parents relationship and parents' behavior affects positively or negatively their interpersonal relationship(8). 90.9% of students think that their family relationship is reliable and 87.9% of them think that their family relationship is supportive. A study with university students by Göçener (2010) found that while the level of secure attachment to parent decreases, students exhibits more inhibitory style on their interpersonel relationship(9). Inhibitory relationship style includes some characteristics like "to see himself/herself superior, to ignore the views of saying, to annoy people, easily lose himself/herself and deep end, to deride"(7). Because individuals have no functional interpersonal scheme to themself or to others, they develope behaviors to adopt inhibitory relationship style(10). The findings of this study are parallel with those in literature.

As a result, it is found that students think turkish family relationship as secure, supportive and "to not listen to each other" in terms of family communication. This finding can be interpreted as traditional structure of turkish family affects interpersonal relationship style positively.

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Coping processes employed to face up to stress: study conducted with 400 homosexuals

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Introduction & methodology

- Coping processes = strategies which the subject sets up during a stressful situation in order to resolve it *(Lazarus, 1984, 1987).*
- Homosexuals are confronted with stressing events that heterosexuals never meet, such as the announcement of their homosexuality (coming-out).
- Coming-out is one of the most stressful situation lived by homosexuals *(Savin-Williams, 2001; Willoughby et al., 2006).*
- Many young people delay their coming-out for fear of being rejected *(D'Auguelli, 2010).*
- This announcement leading to many suicide attempts *(D'Augelli, 1998).*

Aim of the study = understand how homosexuals young people deal with their coming-out and strategies used during this situation.

Population: 400 homosexuals (145 women and 255 men) aged between 16 and 26 years.

Two groups:

- Group 1: most stressful coming out (N= 252).
- Group 2: most stressful event in their life (except their coming-out) (N=148).

Questionnaire: french version of the "Way of Coping Check-list" *(Graziani et al., 1998)*

Results

Multiple factor analysis of « Way of Coping Check-list »

-9 factors with varimax rotation explain 39 % of variance

F1 = suicidal ideations and behaviors; **F2 = emotional control**; **F3 = personal growth**; F4= resolution of problem; F5 = search of assistance and support ; F6= addictives behaviors; **F7= avoidance** ; F8 = resort to imagination; F9 = confrontation

Coping strategies:

- Strategy the most employed = search of assistance and support (F5)
- Most stressful coming-out group (G1):
- Less emotional control (F2)
- Evaluate situation more positively (F3)
- More avoidance(F7)

Table 1: Comparison between groups on coping factors (mean, standard deviation and ANOVA)

	Group 1	Group 2	p
F1	.5 (.7)	.5 (.7)	NS
F2	1.3 (.8)	**1.6** (.7)	**.0001**
F3	**1.8 (.8)**	1.4 (.7)	**.0001**
F4	1.3 (.7)	1.4 (.6)	NS
F5	1.6 (.8)	1.6 (.9)	NS
F6	.6 (.7)	.7 (.7)	NS
F7	**1.3 (.6)**	1 (.7)	**.001**
F8	.8 (.7)	.8 (.8)	NS
F9	.6 (.7)	.7 (.8)	NS

Discussion

- CO = Primordial step allows personal growth and identity development *(Coursaud, 2002 ; Julien, 2001; Iwasaki & Ristock, 2007)*
- CO = stressful announcement which may be a source of pain (addictives behaviors, ...) and lead to avoidance strategies. Suffering is more important when the announcement results in rejection *(Willoughby et al., 2006)* or when coming-out is done early age *(Savin –Williams, 2000).*

☂ Complicated situation, both liberating and source of suffering.
☂ Multiple strategies are used but not habitually associated (for example avoidance and personal growth).
☂ Primordial to create a suitable care in order to prevent homosexuals suffering during coming-out.

Studies on psychopathology

COMPARISON OF COGNITIVE SCHEMAS OF WOMEN WITH SEXUAL VIOLENCE RELATED PTSD WITH WOMEN WITH PURE MDD

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SUMMARY

Introduction: We aimed to compare the cognitive schemas of women with sexual trauma realted PTSD with women without history of sexual violence.

Method: 32 women with sexual trauma related ptsd & mdd and 22 women with pure mdd participated the study. ATS, DAS and YSQ-90 were used to compare the beliefs, attitudes and schemas between two groups.

Results: Women with PTSD had the significantly higher scores of three early maladaptive schemas (EMS) those were failure, vulnerability and subjugation.

Discussion: It may be, excessive negative life events such as rape or other forms of sexual trauma may trigger more depressive schemas..

Conclusion: In this study sexual violence related PTSD has been found associated with early maladaptive schemas more than pure MDD. Cognitive therapist should consider this result in their treatment plans.

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INTRODUCTION

Sexual violence defined as: "Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work"(Jewkes, Sen &Garcia-Moreno, 2002). Rape defined as: "Physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object."(Jewkes, Sen &Garcia-Moreno, 2002) Sexual violence is a pervasive yet, until recently, largely ignored violation of women's human rights in most countries (WHO, 2005; KohsinWang & Rowley, 2007). Sexual violence is associated with negative physical, sexual and reproductive health effects and, as importantly, it is linked to profound long-term mental health consequences (Jewkes, Sen&Garcia-Moreno, 2002). Globally, between 7-36% of female and 5-10% of male children suffer from sexual violence (Finkelhor, 1994; Jewkes, Penn-Kekana & Rose-Junius, 2005). Amongst adults, estimated prevalence of sexual violence at the hands of their intimate partners is greater, falling between 10-50% of women (WHO, 2005). More specifically, roughly 24% of women will experience rape or attempted rape in their lifetime (Kohsin Wang&Rowley, 2007). Rape is a particularly traumatic violation of an individual that can have more severe negative sequelae than those following on from other trauma or crime (Kessler et al.,1995; Resnick et al, 1993; Koss et al, 2003). Not only that, but women are more commonly victims and are at a higher risk of posttraumatic stress as a result of traumatic episodes (Stevens, 2007; Tolin & Foa, 2006). Immediately post-assault, most victims will experience shock, intense fear, numbness, confusion, feelings of helplessness, and / or disbelief, in addition to self blame, hyperarousal and high levels of anxiety (Campbell, Dworkin & Cabral, 2009; Jewkes & Dartnall, 2008). One third of rape survivors will go on to develop Post Traumatic Stress Disorder (PTSD) (WHO, 2009; Yuan, Koss&Stone, 2006). Sexual violence related PTSD has high comorbidity with other psychiatric disorders such as major depressive disorder. (Breslau N, 2000)

Why do some rape victims recover and others develop chronic disturbances? Dalgleish (1999) argued that most cognitive theories of PTSD share the following core conceptualization: Individuals have preexisting cognitive representations (schemas, beliefs, etc.) of themselves, the world, and others that they have to somehow reconcile with the highly discrepant realities of trauma (annihilation, degradation, betrayal, shame, etc.). Such theories generally hypothesize that the difficulties in reconciling such discrepant information with preexisting mental representations underlie the avoidance and reexperiencing symptoms of PTSD. Dalgleish (2004) identified two main types of unirepresentational models of PTSD: schema-focused models (e.g., Horowitz, 1973, 1976, 1979; Janoff-Bulman, 1989,1992; Janoff-Bulman & Frantz, 1997; Janoff-Bulman & Frieze, 1983) and associative network models (Chemtob, Roitblat, Hamada, Carlson, & Twentyman, 1988; Creamer, Burgess, & Pattison, 1992; Foa, Steketee, & Rothbaum, 1989).

Horowitz's (Horowitz, 1973, 1976, 1979, 1986, 1997) formulation provides a more complex model of schematic processes and content involved in PTSD. Drawing on the work of Festinger (1957), Horowitz proposed that the completion tendency is the main driving force behind the processing of trauma-related information. This completion tendency involves the repeated matching of new, trauma-related information to preexisting cognitive beliefs, until the discrepancy between these two sets of representations is reduced. According to Horowitz (1986), immediately after the trauma, trauma-related information (e.g., thoughts, images, etc.) and preexisting mental beliefs cannot be reconciled. Moreover, despite the operation of defense mechanisms (e.g., numbing and denial) that strive to keep trauma related information out of consciousness, trauma-related information is kept in active memory because of the completion tendency, causing trauma- related content (e.g., flashbacks and intrusive thoughts) to break into conscious awareness. The gradual process of integrating trauma-related information with preexisting meanings is characterized by the conflict between defense mechanisms and the completion tendency, leading to the repeated oscillation between phases of intrusion and denial and numbing.

Foa and her colleagues have applied emotional-processing theory to address this question (e.g., Foa & Jaycox, 1999; Foa & Riggs, 1993). This theory proposes that special efforts are required to process the traumatic event and that the completion of this process is necessary for recovery. Chronic psychological disturbances have been seen as a sign that this processing has not occurred and that the representation of the traumatic experience in memory contains pathological elements, such as erroneous estimations about the potential for harm and about one's ability to handle the intense anxiety. Specifically, it is thought that victims with chronic PTSD conceive of the world as extremely dangerous and themselves as incapable of handling stress (e.g. "I am incompetent"). Pre-trauma conceptions of the world and oneself, the memory of the trauma itself, and the victim's interpretation of posttrauma experiences are implicated in the production and reinforcement of these erroneous elements, thus creating a vicious cycle that serves to maintain posttrauma psychopathology (Foa & Jaycox, 1999).

Beck's cognitive theory is based on cognitive perceptions and is considered a breakthrough in cognitive research. Beck's cognitive theory basically states that depression-prone individuals possess negative self-beliefs. They have a negative view of themselves, seeing themselves as worthless, unlovable, and deficient; they have a negative view of their environment, seeing it as overwhelming, filled with obstacles and failure; and they have a negative view of their future, seeing it as hopeless and believing that no effort will change their lives (Gonca & Savasir, 2001). These three factors were called the cognitive triad. The negative way of thinking guides one's perceptions, interpretations, and memory for personally relevant experiences, thereby resulting in a negatively based worldview and leading to depression (Gonca & Savasir 2001). Beck's Cognitive Model of Depression shows how early experiences can lead to the formation of dysfunctional beliefs, which in turn lead to negative self views, which in turn lead to depression. In this study we aimed to compare the cognitive schemas of women with history of sexual violence with women without history of sexual violence.

METHOD

Participants

Between October 2010 and May 2011, all female participants over age of 18 those have Major Depressive Disorder (MDD) and sexual violence related PTSD have been briefly informed about the study. Forty two women have met the criterias of sexual violence related PTSD and thirty of them have accepted to take part in the study. They were recruited from psychiatry outpatient unit or referred by forensic medicine. Twenty two women with pure MDD have accepted to take part in the comparison group.

Measurements

Sociodemographic form have been used to determine socio-demographic characteristics. Psychiatric diagnoses on Axis I were assessed with the Turkish version of Structured Clinical Interview for DSM-IV (Çorapçıoğlu, A. 1999). Authomatic thoughts scale (ATQ) was developed by Hollon and Kendall (1980) for objectively diagnosing the frequency of depressive automatic thoughts in patients. It is a likert-type self-report scale composed of 30 items. Scores range from 30 to 150 and higher scores indicate higher levels of depressive automatic thoughts. The validity and reliability of the Turkish version were studied by Aydın and Aydın (1990), and Şahin and Şahin (1992a). Dysfunctional Attitudes Scale(DAS), form A, was used to provide an explicit measure of maladaptive attitudes, including perfectionistic standards of performance, need for approval, and rigid ideas about the world (Weismann, 1979).

The DAS contains 40 items which participants rate from 1 (totally agree) to 7 (totally disagree). Higher scores on the DAS indicate greater levels of dysfunctional attitudes. The validity and reliability of the Turkish version were studied by Şahin and Şahin. (1992b) Young schema questionarie (YSQ-90) (Waller G, 2001) has been used to determine early maladaptive schemas. The validity and reliability of the Turkish version of YSQ-90 were studied by Karaosmanoğulları (2005)

Analyses

Independent samples t test has been used to compare the total scores. x^2 has been used to analyse descriptive properties of two groups.

RESULTS

The sample consisted of 52 participants. The sample distribution on socio-demographic variables is shown in Table 1. 18of 30 women with PTSD have self-destructive behavior at least once after the trauma. Only 2 of 22 for non traumatized women have self-destructive behavior. 23 of 30 women with PTSD have attempted suicide at least once after trauma. 19 of 30 women with PTSD have stated helplessness was the prominent feeling they have experienced during the trauma. 11 of them have experienced fear as prominent feeling. As shown table 2, women with PTSD had significantly higher ATS total scores compared to women with pure MDD. No differences were found in the total scores and in each subscale of DAS between two groups. Women with PTSD had the significantly higher scores of three early maladaptive schemas (EMS) those were failure, vulnerability and subjugation.

Table 1

	PTSD (n=30)	MDD (n=22)	Statistic
Age			t
Mean	25,10	30,91	
Standart Deviation	5,675	8,159	
Marital Status			x^2
Single	25 (%83,3)	7 (%31,8)	
Married	5 (%16,7)	15 (%68,2)	
Job			x^2
Employed	18 (%60)	7 (%31,8)	
Nonemployed	12 (%40)	15 (%68,2)	
Educational Status			x^2
Primary	3 (%10)	4 (%18,2)	
Secondary	3 (%10)	3 (%13,6)	
High School	11 (%36,7)	10 (%45,5)	
College	13 (%43,3)	5 (%27,2)	
Self-Destructive Behavior			x^2
No	12 (%40)	20 (%90,2)	
Yes	18 (%60)	2 (%9,8)	
Suicide Attempt			x^2
No	7 (%23,3)	16 (%72,7)	
Yes	23 (%76,7)	6 (%27,3)	
Prominent Feeling During Trauma			x^2
Fear	11 (%36,7)		
Helplessness	19 (%63,3)		

Table 2

		Mean	Std. Deviation	p
ATS* Total Score	ptsd	112,7233	22,09241	<0,05
	Mdd	97,4545	25,88018	
Failure EMS**	ptsd	16,4667	7,28595	<0,05
	mdd	12,5455	5,11512	
Vulnerability EMS	ptsd	20,2333	4,25630	<0,05
	mdd	16,7273	5,32900	
Subjugation EMS	ptsd	18,5667	6,17941	<0,05
	mdd	15,1364	5,41862	

* Automatic thoughts scale ** Early maladaptive schema

DISCUSSION

Young (2003) has described five schema domains and eighteen early maladaptive schemas (EMS). While failure EMS and vulnerability EMS are in the domains of impaired autonomy and performance, subjugation EMS schema is in the domain of other-directedness.

Impaired autonomy & performance is a schema domain described by Young (2003) as expectations about oneself and the environment that interfere with one's perceived ability to separate, survive, function independently, or perform successfully. Typical family origin is enmeshed, undermining of child's confidence, overprotective, or failing to reinforce child for performing competently outside the family.

Vulnerability to harm or illness is an early maladaptive schema described by Young (2003) as exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (A) Medical Catastrophes: e.g., heart attacks, AIDS; (B) Emotional Catastrophes: e.g., going crazy; (C): External Catastrophes: e.g., elevators collapsing, victimized by criminals, airplane crashes, earthquakes.

Failure is an early maladaptive schema described by Young (2003) as the belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc.). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.

Other-directedness is a schema domain described by Young (2003) as an excessive focus on the desires, feelings, and responses of others, at the expense of one's own needs -- in order to gain love and approval, maintain one's sense of connection, or avoid retaliation. Usually involves suppression and lack of awareness regarding one's own anger and natural inclinations. Typical family origin is based on conditional acceptance: children must suppress important aspects of themselves in order to gain love, attention, and approval. In many such families, the parents' emotional needs and desires -- or social acceptance and status -- are valued more than the unique needs and feelings of each child.

Subjugation is an early maladaptive schema described by Young (2003) as excessive surrendering of control to others because one feels coerced - - usually to avoid anger, retaliation, or abandonment. The two major forms of subjugation are:

A. Subjugation of Needs: Suppression of one's preferences, decisions, and desires.

B. Subjugation of Emotions: Suppression of emotional expression, especially anger.

Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out", substance abuse).

Joan P. Price (2007) have found four core schemas (defectiveness, dependency, enmeshment and failure) to be significant predictors in PTSD sympathology as a result of a study that has the sample of 77 helping professions such as police trainess, mental health nurse students, paramedic trainess and trainee clinical psychologists.

The question is that, why the rape exacerbates failure, vulnerability and subjugation schemas of females these are victims of sexual trauma. It is well-known, people with depression has negative schemas, beliefs and thoughts about themselves, their futures and environment. (Beck, 1979)

It may be excessive negative life events such as rape or other forms of sexual trauma may trigger more depressive schemas. We need more studies with the large number of participants.

CONCLUSION

In this study sexual violence related PTSD has been found associated with early maladaptive schemas more than pure MDD. Cognitive therapist should consider this result in their treatment plans.

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7th International Congress of Cognitive Psychotherapy
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The Harbiye Military Museum and Cultural Center

BODY IMAGE AND RISK OF EATING DISORDERS IN 9-12 YEARS OLD CHILDREN OF ARGENTINA

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While eating disorders have been traditionally studied in adolescents, in recent years these disorders are appearing at younger ages.

OBJECTIVE

The objective of this study is to compare body image and risk of eating disorders in children with overweight/obesity and normal range.

METHOD

Sample: 92 children (46 girls and 46 boys) between 9 and 12 years of age (Mean = 10.95; SD = 0.82).
Participants attend the fifth, sixth and seventh grade in a public elementary school in Buenos Aires.
Measures:
1) Sociodemographic questionnaire which inquires about symptoms of eating disorders.
2) Children's Eating Attitudes Test (ChEAT) (Maloney, McGuire, & Daniels, 1988).
3) Child/Adolescent Silhouette Rating Scale (Collins, 1991).
4) Children were weighed and measured by a nutritionist according to the norms of the Sociedad Argentina de Pediatría.

RESULTS

Anthropometric variables and Body Mass Index (BMI)

• The average BMI is 20.29 (SD = 4.35) for the boys and 19.59 (SD = 3.24) for the girls.

• 7.6% are at risk of underweight, 50% normal range, 26.1% overweight and 16.3% obese.

They were divided in two groups according to Body Mass Index: Overweight/obesity (O) and normal range (NR). Children at risk of underweight were excluded from this study.

Figure 1: Body Image "How do you looks?"

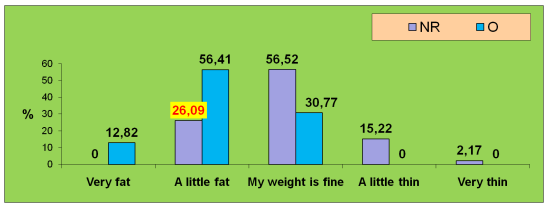

Figure 2: Body Image "How do you wish to look?"

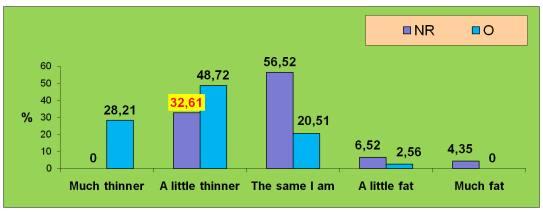

Table 4: ChEAT (Maloney, McGuire, & Daniels, 1988)

	NR Mean (SD)	O Mean (SD)	Mann-Whitney U z	p	Signif.
ChEAT	4,54 (4,68)	11,13 (10,91)	558,5	,003	**

*** p< 0.01*

Table 5: Risk of Eating Disorders

	NR (n=46) %	O (n=39) %	Proportion test z	p	Signif.
ChEAT >20	0 %	23,08 %	-3,09	,002	**

*** p< 0.01*

Table 1: Sample Characteristics

	Girls (n=46) Mean (SD)	Boys (n=46) Mean (SD)	Total sample (n=92) Mean (SD)
Age	10,80 (0,83)	11,11 (0,80)	10,95 (0,82)
Body Mass Index (kg/m2)	19,59 (3,24)	20,29 (4,35)	19,94 (3,83)

Table 2: Weight category based on Body Mass Index

	Girls (n=46) %	Boys (n=46) %	Total sample (n=92) %
Underweight	0 %	0 %	0 %
Risk of underweight	4,35 %	10,87 %	7,61 %
Normal range	63,04 %	36,96 %	50 %
Overweight	21,74 %	30,43 %	26,09 %
Obese	10,87 %	21,74 %	16,3 %

Body image

• 56.52% of NR group believe that his weight is fine, but 26.09% states that he's a little overweight

• 32.61% of NR group wish to weight a little less.

• On average, children of both groups wish to be thinner than they currently perceive themselves, (Mean $_{NR}$ = -0.13; SD $_{NR}$ = 0.81 vs. Mean $_{O}$ = -0.97; SD $_{O}$ = 0.75), but the gap between how they look and how they wish to look is greater in group O (U = 435; p = .000), indicating greater body image dissatisfaction.

Table 3: Body Image: Ch/ARS (Collins, 1991)

	NR Mean (SD)	O Mean (SD)	Mann-Whitney U z	p	Signif.
Current perception	3,86 (0,60)	4,79 (0,83)	347	,000	***
Ideal size	3,73 (0,55)	3,82 (0,57)	846	,594	NS
Difference between Ideal size and Current perception	-0,13 (0,81)	-0,97 (0,75)	435	,000	***

**** p< 0.001*

Risk of Eating Disorders

A score of 20 in ChEAT was used as a rough cutoff to identify risk of eating disorders (Maloney et al., 1988).

• Children in group O show higher rates in the ChEAT (Mean $_{O}$ = 11.3; SD $_{O}$ = 10.91 vs. Mean $_{NR}$ = 4.54; SD $_{NR}$ = 4.58) (U = 558.5; p = .003).
• 23.08% of children with O and none with NR show risk of eating disorders.

DISCUSSION

Overweight and obesity is associated with greater dissatisfaction with body image and increased risk of eating disorders. These results indicate the need to implement prevention programs to prevent the development of eating disorders, but also overweight and obesity.

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PHYSIOLOGICAL AND SELF-REPORTED ASSESSMENT OF EMOTIONAL DYSREGULATION IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER: AN EMOTIONAL INDUCTION STUDY USING FILM CLIPS.

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INTRODUCTION

Borderline Personality Disorder (BPD) is a serious and frequent disorder which afflicts 2% of the general population and is present in 10% of individuals seen in outpatient mental health clinics and in 15%-20% of psychiatric inpatients [1]. According to Linehan´s (1993) biosocial model, emotional dysregulation has been considered the core characteristic of the BPD and includes high baseline negative emotional intensity and high reactivity to emotionally evocative stimuli [2]. Baseline emotional intensity has traditionally been assessed by means of self-report instruments, and most studies have concluded that BPD patients report greater intensity of negative emotions in comparison with healthy controls (HC). In contrast, high reactivity has been studied using physiological measures, but to date results are still inconclusive [3].

The main aim of this study was to investigate the subjective and physiological emotional responses to a set of film clips with discrete emotions in a group of BPD patients in comparison with HC.

A secondary objective was to analyze differences between the patterns of emotional reactions to discrete emotion movies and to scenes tapping into BPD clinical characteristics, such as sexual abuse or abandonment (mixed emotions).

METHOD

Participants: 30 female subjects with BPD, diagnosed by SCID-II and DIB-R semi-structured diagnostic interviews, and 30 female age-matched HC were included.

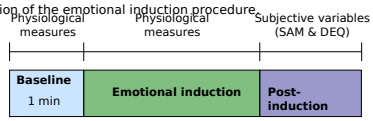
Measures:

- *Subjective variables:* Positive and Negative Affect Schedule (PANAS), Self-Assessment Manikin (SAM) and Discrete Emotions Questionnaire (DEQ).
- *Physiological measures:* Skin Conductance Level (SCL), Heart Rate (HR), Blood Volume Pulse (BVP) and Blood Volume Amplitude (PVA).

Procedure:

Each subject viewed a total of 9 film clips, previously validated in a Spanish sample, in 2 sessions: 5 of them elicited basic emotions (anger, fear, sadness, disgust, amusement), 1 neutral stimuli and 3 which unleashed mixed emotions clinically related to BPD [4]. Subjective emotional response and physiological measures were collected for each film clip throughout the experiment (Figure 1). Baseline emotional intensity was assessed prior to the procedure by means of the PANAS scale.

Figure 1: Schematic description of the emotional induction procedure.



RESULTS

Patient Demographics and Clinical Characteristics: The BPD sample had a moderate to severe clinical profile: mean DIB-R score was 7.9 (*SD*=1.2), 40% had been previously hospitalised, 77% had a history of self-injury and 23% a history of sexual abuse. Most of the patients (28 of 30 subjects with BPD) were taking pharmacological treatment: 86.7% antidepressants (mainly SSRIs), 73.3% benzodiazepines, 53.3% mood stabilizers and 26.7% antipsychotics.

Baseline emotional intensity:

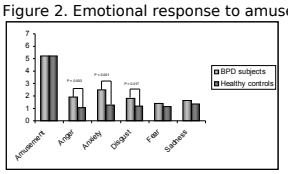
- BPD, in comparison with HC, presented significantly higher negative emotional intensity and lower positive emotional intensity, measured by PANAS.
- There weren't any differences in physiological data between groups, although a tendency to higher HR was observed in BPD group (78.7 (±14) vs. 71.8 (±13.2), F = 3.5, df= 1.55, p = 0.07). No influence of pharmacological treatment was observed.

Emotional reactivity to discrete emotions:

SAM: BPD patients presented lower dominance scores for neutral (p = 0.003) and disgust (p = 0.024) movies.

DEQ: Both groups showed a similar pattern of emotional response to neutral, sadness, anger and fear movies. For amusement film, ANOVAs results showed significant differences between groups and different pattern of emotional response (F = 9.22, df =1,57, p = 0.004) (Figure 2).

Figure 2. Emotional response to amusement film.

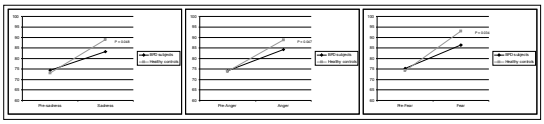


ANOVAs post-hoc analysis for amusement film. BPD subjects presented significant higher scores for anger (F = 9.56, df = 1,58, p = 0.003), anxiety (F = 11.62, df = 1,58, p = 0.001) and disgust (F =6.08, df=1,58, p = 0.017) labels of DEQ compared with HC.

Physiological measures: There were only significant differences on HR response between groups (Figure 3).

No influence of pharmacological treatment was observed.

Figure 3. Increase on heart rate from baseline to maximum frequency during sadness, anger and fear emotions elicitation.



One-way ANOVAs analyses for sadness (F = 4.1, df = 1,58, p = 0.048), anger (F = 4.11, df = 1,59, p = 0.047) and fear (F = 4.71, df = 1,58, p = 0.034).

Emotional reactivity to BPD related films:

SAM: BPD group showed significantly higher SAM arousal scores in films related with sexual abuse (p = 0.001) and emotional dependence (p = 0.003).

DEQ: BPD subjects presented a different pattern of emotional response in the three films (Figure 4). In the sexual abuse related film, there was an absence of influence of history of sexual abuse on subjective emotional responses.

Physiological measures: There were no significant differences between groups.

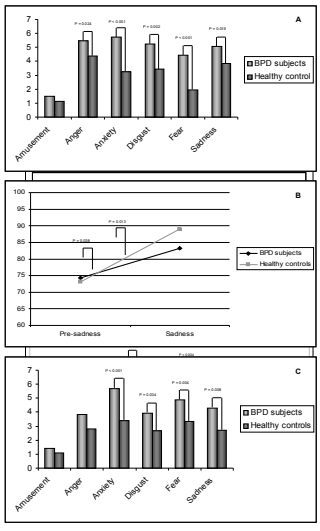


Figure 4. Emotional response to BPD related films.

ANOVA analyses. Post-hoc analyses were performed with one-way ANOVAs. a) For film clip related with sexual abuse (F = 21.46, df = 1,52, p < 0.001), b) for abandonment related scene (F = 4.9, df = 1,53, p = 0.03), and for film related with emotional dependence (F = 19.67, df = 1,52, p < 0.001).

CONCLUSIONS

1. Emotion-related film clips are a valid method to induce an emotional response in subjects with BPD.

2. BPD subjects showed a higher baseline negative emotional intensity than HC, but there were no differences in physiological measures.

3. Both groups showed a similar pattern of subjective emotional response for neutral, sadness, anger and fear movies, but there were significant differences for amusement film. Subjects with BPD had a lower increase in HR response in sadness, fear and anger films.

4. Film clips eliciting mixed emotions related to BPD, such as sexual abuse, abandonment and emotional dependence, induce a different pattern of subjective emotional response in BPD.

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INSIGHT INTO EATING DISORDERS

Relationship between Anorexia Nervosa and the Psychotic Spectrum

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Background

It's widely recognized that in Eating Disorders the subject shows a distortion in body image (Vocks, Legenbauer, Wachter, Wucherer e Kosfelder, 2007). In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR; APA, 2000) diagnostic criteria for anorexia nervosa emphasizes the presence of very strong beliefs in relation to weight, body shape and feeding. However, these criteria make no reference to the intensity of these beliefs. In some cases, they are extreme, the sense of reality and judgement are compromised, therefore patients are described as "almost delusional" or with poor insight. Eating Disorders, about body image themes, seem to be characterized by way of thinking that can be *delusional* or *not delusional* (Phillips, Kim & Hudson, 1995).

Aim

Systematic assessment of the irrational thinking in patients with AN will contribute to understanding the cognitive processes that characterize this illness. The aim of this study is to investigate whether, within the anorexia nervosa, we can provide for some subtype - eg., w*ith good insight, with poor insight and delusional* (or psychotic) *thinking.* The thought disorder, delusional disorder and dissociation are considered as disorder's index of severity.

Method

PARTICIPANTS

The sample is composed by 28 in-patients with anorexia nervosa and 20 in-patients with psychotic spectrum disorder. Diagnoses are made according to DSM IV-TR (APA, 2000). Participants' mean age was 35,25 years (SD = 12,6; range 18-62). Mean BMI (Kg/m^2) for subjects with anorexia nervosa was 14,46 (SD = 2; range 10,9-17,3) and for subjects with psychotic spectrum disorder was 27,29 (SD = 3,93; range 19,7-34,4). Written informed consent was obtained.

PROCEDURES AND MEASURES

Subjects are assessed by:

Brown Assessment of Beliefs Scale (BABS). The BABS (Eisen et al., 1998) is seven-item, semi-structured, clinician-administered scale that measures insight/delusional thinking in a variety of mental illnesses.

Millon Clinical Multiaxial Inventory-III (MCMI III). The MCMI-III (Millon, Davis & Millon, 1997) is 175 item clinical test of personality designed to measure personality disorders and major clinical sindromes.

Eating Disorder Inventory – 3 Referral Form (EDI-3 R). The EDI-3 RF (Garner, 2004) is self-report questionnaire. It contains 25 questions from the EDI-3 from the three scales that are specific to eating disorder risk.

Aggression Questionnaire (AQ). The AQ (Buss & Perrry, 1992) is 29 self-report questionnaire that measures an individual's aggressive responses.

Dissociative Experiences Scale (DES). The DES (Bernstein & Putnam, 1993) is 28 self-report measure of the frequency of dissociative experiences.

Results

The present research is a correlational study (Pearson's r). The comparison between subjects with Anorexia Nervosa and subjects with Psychotic Spectrum Disorder was carried out by t-test analysis for indipendent champions with Bonferroni's correction (Table 1). Analysis are made with SPSS/18.

We'll report only significant correlations, as follows.

As shown in Table 2, in subjects with Anorexia Nervosa drive for thinness and body dissatisfaction are both positively and significantly correlated with Insight.

In these subjects, with the decrease of insight we observe a reduction of verbal aggression. Further, in subjects with Anorexia Nervosa exists a positive correlated with majority of personality disorder identified through the MCMI-III.

In the group with Anorexia Nervosa 4 subjects (14,3%) has delusional (or psychotic) thinking, 6 subjects (21,4%) are with poor insight, and 18 subjects (64,3%) are with good insight (Fig. 1).

In the group with Psychotic Spectrum Disorder 7 subjects (35%) has delusional (or psychotic) thinking, 9 subjects (45%) are with poor insight, and 4 subjects (20%) are with good insight (Fig. 2)

"Delusional" is defined by receiving a BABS total score ≥ 18 and 4 on Item 1.

"Poor Insight" is defined by receiving a BABS total score ≥ 13 and 3 on Item 1.

Indipendent Samples t-test					
	Diagnoses	Mean	SD	t	p
BABS Total Score	Anorexia Nervosa	10,32	6,401	-3,722	,001
	Psychotic Spectrum	15,80	3,750		

Table 1. Indipendent Samples t-test

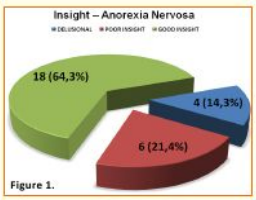

Figure 1.

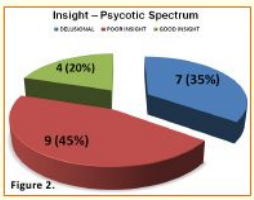

Figure 2.

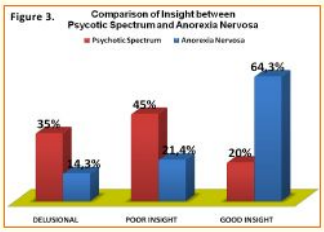

Figure 3.

Dominant beliefs in subjects with Anorexia Nervosa:

"I'm fat."
"If I eat, i'm fat."
"If I eat, I will lose control."
"My thighs are too big."

Dominant beliefs in subjects with Psychotic Spectrum Disorder:

"Other people want hurt me."
"Other people look at me and talk about me."
"Some people want to enter into my mind."
"They steal my thoughts."

Table 2.
Significant Correlations with BABS Total Score and Anorexia Nervosa

	BABS Total Score
Verbal Aggression AQ (VA)	,374*
Drive for Thinness EDI-III-RF(DT)	,466*
Body Dissatisfaction EDI-III-RF (BD)	,560**
MCMI-III X - Disclosure	,428*
MCMI-III Z - Debasement	,410*
MCMI-III 3 - Dependent	,419*
MCMI-III SS - Thought Disorder	,424*
MCMI-III 1 - Schizoid	,550**
MCMI-III 2A - Avoidant	,594**
MCMI-III 2B - Depressive	,594**
MCMI-III 4 - Histrionic	,506**
MCMI-III 5 - Narcissistic MCMI-III	-,579**
8B - Masochistic (Self-Defeating)	,552**
MCMI-III S - Schizotypal	,492**

Table 2. Pearson Correlation Matrix for the variable BABS Total Score (* p< 0.05; ** p< 0.01)

Conclusions

Comparison of AN's group and psychotic spectrum's group evidences a clear difference between subjects with good insight (74,3% AN vs 20% psychotic spectrum). In AN's subjects impairment of insight is found in 35,7% of total subjects, compared to 80% of subjects with psychotic spectrum disorder.

As pointed out in recent studies (Steinglass J. E., Isen J. L., at al., 2007), in AN subjects who were characterized as delusional thinking by BABS score are significantly correlated with drive for thinness and body dissatisfaction, but do not correlated with BMI and lowest BMI.

The current study, using a structured measure of irrational thinking, document that a significant minority of patients with AN exhibit distortions of thinking regarding shape and weight that can be considered delusional.

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The association between sleep disturbance and depression: Epidemiological survey of insomnia, hypersomnia and nightmare in Japanese employee and adolescents:

Non-pharmacological treatment for sleep disturbance may reduce a risk of a future mental disease

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1 Background...

- A. The morbidity rate of insomnia has been increased, with an estimated prevalence of over 20% in the Japanese adults, but few Japanese have medical examination and pharmacological treatment.
- B. Insomnia and stressor have been a risk of future psychiatric problems(i.e. mood disorder).
- C. Although insomnia is of great concern in sleep research, it is little known about hypersomnia and nightmare symptoms and mental health.

2 Aim

- Survey was conducted to explore
- (1)the relationship between was conducted to explore the relationship between the seriousness of sleep disturbance (insomnia, hypersomnia and nightmare) and depression,
- (2)comparison with demographic characteristics(Japanese employee VS university Students, Age,Sex) by multiple group Analysis.

3 Method

1 .Participants: 471employees & 774undergraduates.

2 . Measurement 1: Athena Insomnia Scale (Soldatoes et al., 2000) , Hypersomnia and Nightmare Disorder(DSM-4,2002)

3 . Measurement 2: Job Stress Scale for Japanese (Simomitsu et al., 2000)

4 . Measurement 3: BDI-2 for Japanese (Beck et al.,1996)

5. Duration of Survey: Jun-December , 2011

4

Figure1.1~4 showed comparison of employees and undergraduates. The seriousness of sleep disturbance in young adults case is more than one in middle age's case. However, neither they took pharmacological therapy.

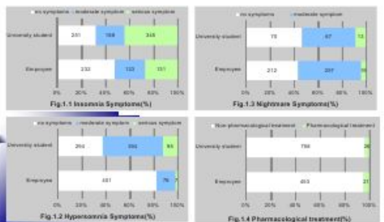

Fig.1.1 Insomnia Symptoms(%)

Fig.1.2 Hypersomnia Symptoms(%)

Fig.1.3 Nightmare Symptoms(%)

Fig.1.4 Pharmacological treatment(%)

5

Table1. The results showed that significant main effects of Age on 3 sleep symptoms and no significant interaction effects of Age and sex.

	Age	Sex		Main effect (Sex)	Main effect (Age)	Interaction effect
		Male (N=[illegible])	Female (N=[illegible])	F value	F value	F value
		M (SD)	M (SD)			
BDI-2	< 20 (N=[illegible])	[illegible]	[illegible]	8.79**	18.38***	n.s.
	20s (N=[illegible])	[illegible]	[illegible]			
	30s (N=[illegible])	[illegible]	[illegible]			
	40s (N=[illegible])	[illegible]	[illegible]			
	50s (N=[illegible])	[illegible]	[illegible]			
	60s (N=[illegible])	[illegible]	[illegible]			
	Total (N=[illegible])	[illegible]	[illegible]			
Insomnia	< 20 (N=[illegible])	[illegible]	[illegible]	n.s.	[illegible]***	n.s.
	20s (N=[illegible])	[illegible]	[illegible]			
	30s (N=[illegible])	[illegible]	[illegible]			
	40s (N=[illegible])	[illegible]	[illegible]			
	50s (N=[illegible])	[illegible]	[illegible]			
	60s (N=[illegible])	[illegible]	[illegible]			
	Total (N=[illegible])	[illegible]	[illegible]			
Hypersomnia	< 20 (N=[illegible])	[illegible]	[illegible]	n.s.	[illegible]***	n.s.
	20s (N=[illegible])	[illegible]	[illegible]			
	30s (N=[illegible])	[illegible]	[illegible]			
	40s (N=[illegible])	[illegible]	[illegible]			
	50s (N=[illegible])	[illegible]	[illegible]			
	60s (N=[illegible])	[illegible]	[illegible]			
	Total (N=[illegible])	[illegible]	[illegible]			
Nightmare	< 20 (N=[illegible])	[illegible]	[illegible]	n.s.	[illegible]***	n.s.
	20s (N=[illegible])	[illegible]	[illegible]			
	30s (N=[illegible])	[illegible]	[illegible]			
	40s (N=[illegible])	[illegible]	[illegible]			
	50s (N=[illegible])	[illegible]	[illegible]			
	60s (N=[illegible])	[illegible]	[illegible]			
	Total (N=[illegible])	[illegible]	[illegible]			

6 Fig.2.1 Japanese Employees(Total)

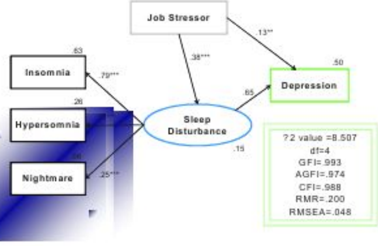

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Fig.2.2 Japanese Employees(Male)

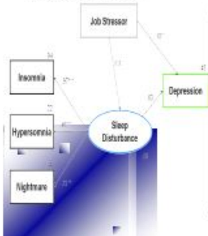
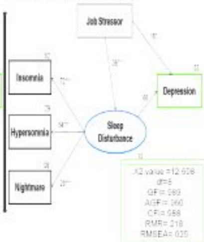


Fig.2.3 Japanese Employees(Female)



8 Fig.3.1 Japanese Undergraduates(Total)

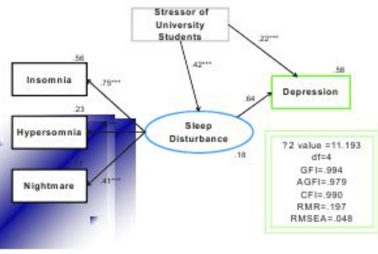


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Fig.3.2 Japanese Undergraduates (Male)

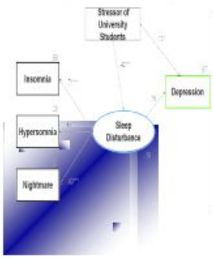
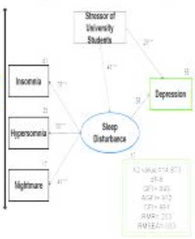


Fig.3.3 Japanese Undergraduates (Female)



10 Discussion

- 1. Sleep disturbance of Japanese undergraduates was significantly more serious than employees, especially in hypersomnia and insomnia. Oppositely, employees were more likely to complain about nightmare symptoms than undergraduates.
- 2.The research data indicated both seriousness of sleep disturbance was stronger predicting factor of depression than stressors.
- 3. This model was confirmed by multiple group Analysis(no differences among any attributes)

11 Conclusion

- Improvement of sleep disturbance is needed to prevent from depression for Japanese adults' resistance to pharmacological treatment.
- We can expect the effectiveness of non-pharmacological treatment (i.e. Cognitive Behavior Therapy for Insomnia) for sleep disturbance , because Japanese adults. The CBT-I intervention can positive effect to reduce symptoms of sleep (Morin, 1993) because coping ability and controllability for sleep was empowered.

12 Acknowledgments

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Thank you for your attention.

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Insight and symptomatic dimensions of acute phase psychotic patients

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INTRODUCTION

- **This study was designed to evaluate the relationship between the various dimensions of insight and the severity of psychotic symptomatology in a large sample of patients in the acute phase of psychosis, as well as to analyze the relationship between insight and the symptomatic profile of the patient. Also, we evaluated whether general cognitive abilities are involved in this relationship.**

METHOD:

- Transversal observational study of **96 patients**, older than 18 years, in the acute phase of psychosis, diagnosed by DSM-IV criteria.
- We evaluated the sample using the PANSS scale, for insight and its dimensions, the SUMD (Scale of Unawareness of Mental Disorder) and for general cognitive abilities, the SCIP (Screen for Cognitive Impairment in Psychiatry).

RESULTS:

- **Insight showed moderate significant correlations with positive symptoms but not with negative symptoms.**
- **When divided by subgroups, in the positive symptom profile subgroup, awareness of disorder and of the effects of medication were associated with severity of positive and general psychotic symptoms. Awareness of social consequences of disease was associated with the positive symptoms.**
- **In the subgroup with negative symptom profile, awareness of disorder and of the effects of medication were associated with severity of positive symptoms and general symptoms. Awareness of social consequences of the disease was only related to the somatic worry and anxiety.**
- **The cognitive skills played an important role in some of these last relationships.**

	POSITIVE SYMPTOM PROFILE GROUP						NEGATIVE SYMPTOM PROFILE GROUP					
	Awareness of disease		Awareness of the effects of medication		Awareness of the social consequences		Awareness of disease		Awareness of the effects of medication		Awareness of the social consequences	
	r	*r**	*r*	*r**	*r*	*r**	*r*	*r**	*r*	*r**	*r*	*r**
Positive Symptoms	0.401**	0.387**	0.382**	0.382**	0.380**	0.360**	0.514**	0.476**	0.422**	0.432**	-0.128	-0.260
Delusions	0.338*	0.356*	0.324*	0.350*	---	---	0.454**	0.479**	0.313*	0.306	---	---
Hallucinations	0.338*	0.292*	---	---	---	---	---	---	---	---	---	---
Suspiciousness	---	---	0.361*	0.377**	---	---	---	---	---	---	---	---
Hostility	---	---	0.336*	0.361*	---	---	0.365*	0.267	0.319*	0.260	---	---
Grandiosity	---	---	---	---	0.335*	0.375**	---	---	0.353*	0.387*	---	---
Negative Symptoms	0.276	0.229	0.279	0.252	0.204	0.163	0.162	0.109	0.062	0.065	-0.139	-0.193
Poor contact	---	---	0.285*	0.298*	---	---	---	---	---	---	---	---
Social withdrawal	---	---	0.324*	0.318*	---	---	---	---	---	---	---	---
Síntomas Generales	0.529**	0.528**	0.371**	0.375**	0.208	0.175	0.518**	0.422**	0.313*	0.249	-0.075	-0.253
Feelings of blame	-0.352*	-0.340*	-0.446**	-0.439**	---	---	---	---	---	---	---	---
Lack of cooperation	0.374**	0.372**	---	---	---	---	0.395*	0.322	0.409**	0.381*	---	---
Self-absorption	0.474**	0.449**	0.389**	0.368**	---	---	0.371*	0.346*	---	---	---	---
Active Social Avoidance	0.378**	0.360**	0.382**	0.375**	---	---	0.254	0.339*	---	---	---	---
Unusual thoughts	---	---	0.339*	0.356*	---	---	0.293	0.381 *	---	---	---	---
Disorientation	---	---	---	---	---	---	0.316*	0.283	---	---	---	---
Somatic Worry	---	---	---	---	---	---	---	---	---	---	-0.434**	-0.533**
Anxiety	---	---	---	---	---	---	---	---	---	---	-0.397*	-0.404*

Bivariate (r) and partial (r*) Pearson correlation coefficients between insight and psychotic symptomatology. The partial correlations were controlled using the TSCIP scale total; TPANSS= PANSS scale total. * $p \leq 0.05$, ** $p \leq 0.01$.

DISCUSSION

- **The severity of psychotic symptoms and the symptomatic profile of the subject is associated in different ways with the deficiency of insight and its dimensions.**

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3. Mintz, R.A., Dobson, S.K., Rommey, M.D., 2003. Insight in schizophrenia: a metaanalysis. Schizophrenia Research 61, 75-88.

"I AM AFRAID I AM GOING TO KILL MYSELF": WHEN FEAR OF SUICIDE AND SUICIDAL IDEATION COEXIST

PRESENTING PROBLEM:

"Lisa" is a person who experienced worry about suicide after a suicide attempt and whose safety strategies alienated her from her family and consequently refueled suicidal ideation.

Lisa's case raised two main questions:

1. What is the relationship between fear of dying by suicide and suicidal ideation?
2. Should worry about suicide be used to strengthen adherence to a safety plan or should worry about suicide and suicidal ideation be both considered as treatment targets?

OUTCOME:

- Experience of "suicide anxiety" was characterized by preoccupation with uncontrollability of own thoughts and actions.
- Suicidal ideation was associated with negative beliefs about self and a view that suicidal thoughts reflect true wishes.
- High "suicide anxiety" resulted in disorganized implementations of safety plans that in turn reinforced view of self as "untrustworthy failure" that was associated with client's desire to die.
- Decrease in suicidal ideation resulted in a temporary increase in "suicide anxiety."
- Lisa reported no instances of experiencing high suicidal intent in absence of anxiety. This allowed her to realize that she remained ambivalent about taking her life even when her suicide intent was rated as high.
- Client noted that the experience of not knowing if she wants tooodie was less distressing than not knowing if she could control her suicidal behaviour. Ambivalence implied a possibility of change in circumstances. Lack of control over own actions implied failure.

REVIEW AND EVALUATION:

Distinction between "suicide anxiety" and suicidal ideation may be of use for individuals whose safety behaviours result in alienation of potential supports and hence increase perception of loneliness and helplessness that are associated with risk of suicide.

CASE CONCEPTUALIZATION AND INTERVENTION:

1. Collaborative mapping [1]of Lisa's suicide mode [2].(Figure 1) enabled Lisa to:
   - appreciate the self-perpetuating nature of her difficulties,
   - differentiate between worries about suicide ("suicide anxiety") and suicidal intent (Figure 2), and
   - understand the relationship between suicide anxiety and suicidal intent.

Figure 1

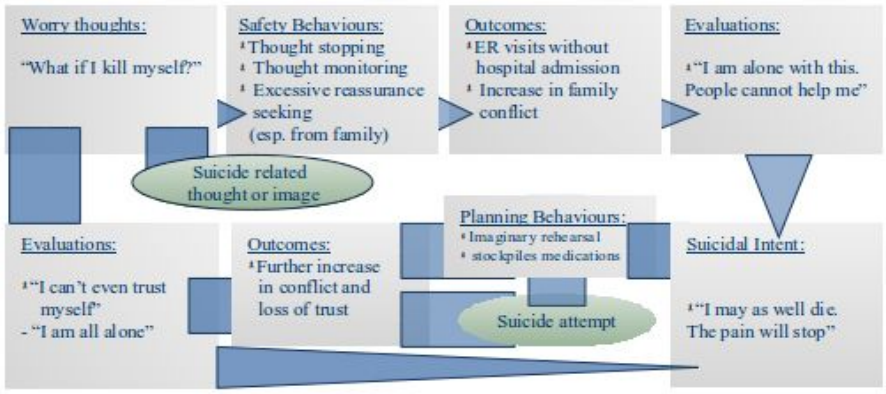

Figure 2.

DIFFERENTIATIG FACTOR	SUICIDE ANXIETY	SUICIDE INTENT
Internal triggers	• Avoid, distract, seek reassurance	• Focus, ruminate
Interpersonal triggers	• Argue, blame, accuse others of bringing up suicidal thoughts	• Confirmation of negative schema (eg. "It's no use")
Beliefs about thoughts and actions	• Uncontrollable, dangerous • Need to be protected against own actions and thoughts	• Within own control • Represent true wishes
Reactions to beliefs about thoughts and actions	• Thought stopping, thought monitoring, reassurance seeking	• Planning and imaginary rehearsal

2. Distinction between "suicide anxiety" and suicidal ideation was used to develop self-rating scales that rated these two dimensions as "low", "manageable" and "high". These ratings guided choice of intervention (Figure 3).

Figure 3.

Suicide Intent	Low	Manageable	High
High	• Focus on safety and ambivalence	• Focus on safety, ambivalence and affect regulation.	• Focus on safety, affect regulation and impulse control.
Med	• Review reasons for dying and reasons for living • Use progress log to appreciate the fluctuating nature of intention to die	• Remind self that anxiety can cause impulsive action that does not reflect desired intentions • Use self soothing but try not to escape the situation • Use progress log as reminder of a time limited nature of distress and of prior coping successes	• Have someone with you • Remind self that anxiety can cause impulsive action that does not reflect desired intentions • Use self soothing and remove self from situation if necessary • Use progress log as reminder of a time limited nature of distress and of prior coping successes
Low	• Work on core beliefs and perceived contingencies through thought records and behavioural experiments • Exposure work • Target anxiety using a protocol for generalized anxiety disorder • Keep a progress log	• Review function of worry and its impact on suicidal thoughts • Focus on difference between intent and anxiety and use the progress log to prove to self that coping is possible • Build emotion tolerance skills and disprove emotional thoughts by not escaping the situation	• Use self soothing but stay in the situation to build emotion tolerance and to disprove emotional thoughts • Use progress log as reminder of a time limited nature of distress and of prior coping successes

Suicide Anxiety

References:

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EGO-DYSTONICITY AND EGO-SYNTONICITY DIMENSIONS IN OBSESSIVE INTRUSIVE THOUGHTS SUBTYPES. STUDY IN A NON-CLINICAL POPULATION.

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INTRODUCTION

Ego-dystonicity is widely acknowledged as one of characteristics that define obsessions and postulated as a main criterion to distinguish obsessions from other modalities of negative and intrusive cognitions, e.g., negative automatic thoughts in depression, intrusive memories in post-traumatic stress disorder, or worries in generalized anxiety disorder . However, it has been suggested by some authors that ego-dystonicity varies according to the obsessions subtype.

OBJECTIVE

The aim of the present study was to evaluate ego-dystonicity and ego-syntonicity dimensions in Obsessive-related Intrusive Thoughts (OIT), taking into account the specific obsessional content: Type-I moral-based (i.e., aggressive, sexual, religious) and Type-II non-moral-based (i.e., ordering, doubts, contamination, superstition) contents.

METHOD

Participants:
349 community members (234 women) . Mean age: 23.34 (*SD* = 4.60) years old.

Instruments:

•The *INPIOS (Inventario de Pensamientos Intrusos Obsesivos, Obsessive Intrusive Thoughts Inventory*. Garcia-Soriano et al., 2011) evaluates frequency of 48 OITs.

•***Ego-Dystonicity Questionnaire-Reduced version****(EDQ-R;* Roncero et al., 2010) is the Spanish adaptation of the Ego-Dystonicity Questionnaire (Purdon et al., 2007). And ***Ego-Syntonicity Questionnaire*** *(ESQ;* Roncero et al., 2010), is a new questionnaire derived from EDQ to evaluate egosyntonicity.

Each instrument consist of 27 items grouped in 3 opposed factors (ESQ vs EDQ-R):

•Desirability of thought and for it to come true" vs "Undesirability of thought and rejection of it coming true"

•Rationality and coherence with personality" vs "Irrationality and incoherence with personality".

•Morality/consistency of thought with morals/ethics" vs "Immorality/inconsistency of thought with morals/ethics".

Procedure:

•. Participants were asked to select their most upsetting OIT and complete the *EDQ-R* and the *ESQ* with this thought in mind.

•Participants were divided into two groups depending on the content of the most upsetting OIT: Type-I (N=79)

Type-II (N=258)

RESULTS

Participants in the two groups (Type-I vs. II) were equiparable in: **Age** ($t_{(336)} = .68$), **Gender** ($chi^2 = 1.03$), and **Obsessionality** (CBOCI: $t_{(337)} = 1.32$).

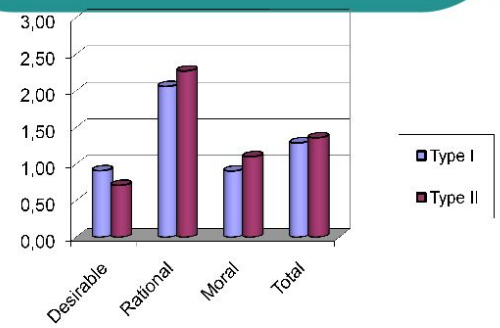
Differences were found in the **frequency** of OITs
(Type-I: $M = 3.49$ (1.38) vs Type-II: $M = 3.29$(1.23); $t_{(343)} = 2.3$, $p<.05$).

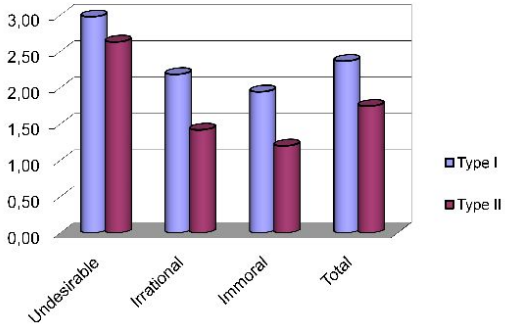
Scores in EDQ-R and ESQ were generally low, and only in "Undesirability" scores reached 2.5 "agree somewhat" in both groups (Figures 1 & 2).

•The two types of OIT did not differed on any of the ego-syntonicity dimensions (Figure 1).

In comparison with Type II, Type-I OIT were appraised as more: **Ego-dystonic** (EDQ-R total: $t_{(112.31)} = 3.99$; $p<.001$), **Irrational** ($t_{(106.25)} = 4.92$; $p<.001$) and **Immoral** ($t_{(109.6)} = 4.71$; $p<.001$). (Figure 2)

•ANCOVAs were calculated with frequency as covariable: Results did not change: EDQ-R total: $F_{(1,334)} = 18.16$, $p<.001$, Irrational: $F_{(1,334)} = 28.14$, p<.001; Immoral: $F_{(1,334)} = 28.12$, $p<.001$.





CONCLUSIONS

Even in non-clinical population it has been observed the importance of the OITs content in defining their ego-dystonicity, supporting other authors' suggestion that ego-dystonicity varies according to the obsessions subtype.

Moreover, results show that not every dimension of ego-dystonicity is equally relevant in the distinction of both types of OITs, since only "Irrationality" and "Immorality" were higher in Type I OITs.

ACKNOWLEDGMENTS : This study was supported by the Spanish Ministerio de Ciencia y Tecnología (CSI2009-10957) (PSI2010-18340), and CIBER Fisiopatología de la Obesidad y Nutrición. ISCIII

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Roncero, Belloch, & Perpiñá. (2010). Egodystonicity and egosyntonicity in eating disorder related intrusive thoughts. Póster. WCBCT (Boston).

Relationship between OCD & ED. How do patients interpret and manage their intrusions?

Roncero, M[1]; García-Soriano, G[1]; Belloch, A[1] & Perpiñá, C[1,2]

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INTRODUCTION

Intrusive and distressing thoughts, images, or impulses (IT) play an important role in the psychopathology of several clinical disorders, such as Obsessive-Compulsive Disorder (OCD) and Eating Disorders (ED). The current cognitive model of psychopathology has extensively researched the consequences of these intrusive cognitions on the development and/or maintenance of OCD, but less is known about their impact on ED.

OBJECTIVE

The purpose of this study is to compare the consequences of IT in 63 OCD, 47 Anorexia Nervosa (AN) and 36 Bulimia Nervosa (BN) patients.

METHOD

Participants:

-OCD patients (n=63;age=35.08±12.45)
-AN patients (n=47; age=24.09±7.33)
-BN patients (n=36; age=24.58±5.84)

Instruments:

•The INPIAS (Inventario de Pensamientos Intrusos Alimentarios, Eating Intrusive Thoughts Inventory. Perpiñá, et al., 2008) was designed to assess eating disorders ITs. INPIAS-Part 1 evaluates frequency of 50 ITs expressed as thought, image or impulse.

•The INPIOS (Inventario de Pensamientos Intrusos Alimentarios, Obsessive Intrusive Thoughts Inventory. Garcia-Soriano, et al., 2011) was designed to assess obsessional ITs. INPIOS-part 1 evaluates frequency of 48 obsessional ITs

•INPIAS/INPIOS-Part 2A evaluates appraisals, interference and emotional consequences of the most disturbing IT selected by subjects

•INPIAS/INPIOS-part 2B evaluates which strategies are used to control the most disturbing IT selected by subjects

RESULTS

Results indicate a similar frequency of IT among participants. AN=5,15±1.12; BN=4.94±1.26; OCD=5.27±0.09. (5="very often", *I have this intrusion daily*) $F_{(2,143)}$= 1.05; p=.35.

But OCD patients experience more emotional disturbance ($F_{(2,143)}$=5.15, p<.001) and BN patients more sadness ($F_{(2,143)}$=3.67, p<.05). (Figure 1)

OCD individuals appraised their IT more dysfunctionally: Thought Action Fusion-Morality ($F_{(2,143)}$=3.85, p<.05) , Responsibility ($F_{(2,143)}$=7.29, p<.001) , Importance of Thought Control ($F_{(2,143)}$=8.48, p<.001) and Overestimation of Threat ($F_{(2,143)}$=16.65, p<.001). (Figure 2)

Regarding thought control strategies, OCD patients made more use of repeating ($F_{(2,143)}$=7.97, p<.001) , whereas ED patients displayed more ordering ($F_{(2,143)}$=10.45, p<.001), Cognitive reestructuring ($F_{(2,143)}$=4.92, p<.01) and worrying strategies ($F_{(2,143)}$=8.5, p<.001). (Figure 3)

CONCLUSIONS

Although OCD and ED patients experience IT with the same frequency, these cognitions are more disturbing and dysfunctionally appraised by OCDs. This result is in agree with the cognitive theory of OCD.

There are no differences between OCD and ED patients in some of the appraisals and control strategies which have been usually associated to OCD (i.e., Overimportance of thought, Thought supression, or washing compulsions).

AN and BN patients showed the same pattern of appraisals and control strategies, pointing out the communalities between ED subtypes regarding these variables.

Fig.1. Emotional consequences

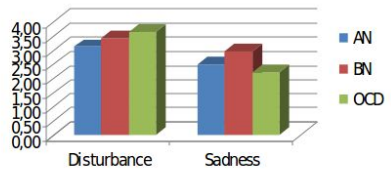


Fig.2. Disfunctional appraisals

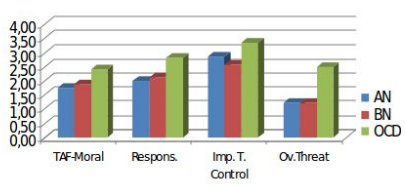
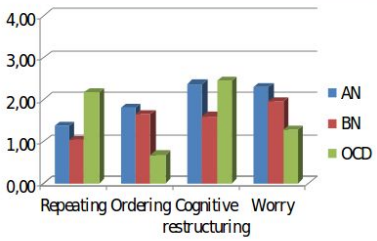


Fig.3. Control strategies



ACKNOWLEDGMENTS: This study was supported by the Spanish Ministerio de Ciencia y Tecnología (CSI2009-10957) (PSI2010-18340), and CIBER Fisiopatología de la Obesidad y Nutrición. ISCIII

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Early Maladaptive Schemas: Relationships with aggressive and antisocial behavior

C., Benita

Abstract

Early maladaptive schemas (EMS) refers to dysfunctional patterns of memories, emotions, cognitions, and bodily sensations about oneself and relationships with others developed in childhood and elaborated throughout life (Young, 1990, 1999; Young, Klosko, & Weishaar, 2003). Research on human aggression has been establishing significant relationships between EMS and aggressive behavior, related to the antisocial behavior (Tremblay & Dozois, 2009; Calvete, Estévez, López de Arroy-abe, & Ruiz, 2005; Rijo, Fernandes, Mota, & al., 2008; Young, Klosko, & Weishaar, 2003). The present research studies the relation among EMS Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame, Social Isolation/Alienation, Failure, Entitlement/Grandiosity and Insufficient Self-Control/Self-Discipline and aggression, anger and antisocial behavior, in a non-clinical sample of 301 Portuguese participants, through the Young Schema Questionnaire (YSQ-S3; Young, 2005; Portuguese Version of Gouveia, Rijo & Salvador 2005) with the aggression for all of the factors of the Aggression Questionnaire (AQ; Buss & Perry 1992; Portuguese Version of Vieira & Soeiro, 2002) and of the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1991; Portuguese Version of Silva, Campos & Prazeres, 1999).

The results indicate significant correlations between these EMS and aggression and all of its dimensions, with anger and antisocial behavior with most of its dimensions. For the EMS predicted the EMS of Mistrust/Abuse, Entitlement/Grandiosity and Insufficient Self-Control/Self-Discipline are those who present a higher endorsement in the explanation of aggression, anger and antisocial behavior.

Key words: Early Maladaptive Schemas, Aggression, Anger, Antisocial Behavior.

Introduction

Schema Therapy (ST) presents one of the most promising conceptual and therapeutic approaches for personality disorders. Early Maladaptive Schemas (EMS) refers to dysfunctional cognitive nuclear patterns postulated as the core of personality disorders (Young, 1990, 1999; Young, Klosko, & Weishaar, 2003; Bamber, 2004; Tremblay & Dozois, 2009; Lobbestael, 2008).

Literature about aggressive behavior set up significant relationships among EMS and aggressiveness related to antisocial behavior (Young et al., 2003; Beck, 2005; Dozois & Beck, 2008; Rijo et al., 2008).

The present research studies the relation among EMS Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame, Social Isolation/Alienation, Failure, Entitlement/Grandiosity and Insufficient Self-Control/Self-Discipline coping aggressive and antisocial behavior.

Method

Participants

301 Portuguese sample

33.71 ± 10.72 age

62% Female

38% Male

Instruments

General Identification Questionnaire, **QIG**

Young Schema Questionnaire, **YSQ-S3**

Agression Questionnaire, **AQ**

State-Trait Anger Expression Inventory, **STAXI**

Perception of Antisocial Behavior in the Childhood/Adolescence Scale, **EPCAIA**

Statistic Analysis

Pearson Correlation

Linear Multiple Stepwise Regression

HYPOTHESIS

EMS:
Abandonment/Instability
Mistrust/Abuse
Emotional Deprivation
Defectiveness/Shame
Social Isolation/Alienation
Failure
Entitlement/Grandiosity
Insufficient Self-Control/Self-Discipline

H1 significant and positive correlations with Aggression: Physical Aggression, Verbal Aggression, Anger and Hostility.

H2 significant correlations with Anger: positive correlation with State Anger, Trait Anger and Anger Expression, and negative with Anger Control.

H3 significant and positive correlations with Antiscocial Behavior: Persons or Animals Aggression, Property Destruction, Falsification or Theft, Serious Rules Violation, Drugs Abuse.

Results for Correlation Analysis

EMS	AQ Total	Physical Agression	Verbal Agression	Anger	Hostility
Emotional Deprivation	.38**	.35**	.33**	.22**	.37**
Abandonment/Instability	.44**	.40**	.35**	.30**	.44**
Mistrust/Abuse	.47**	.47**	.33**	.32**	.46**
Social Isolation/Alienation	.46**	.43**	.37**	.28**	.45**
Defectiveness/Shame	.43**	.42**	.34**	.26**	.41**
Failure	.40**	.39**	.32**	.22**	.40**
Dependence/Incompetence	.46**	.41**	.33**	.34**	.45**
Vulnerability to Harm or Illness	.45**	.43**	.29**	.38**	.40**
Enmeshment/Undeveloped Self	.42**	.41**	.30**	.31**	.38**
Subjugation	.48**	.45**	.37**	.33**	.46**
Self-Sacrifice	.29**	.27**	.18**	.24**	.28**
Emotional Inhibition	.36**	.38**	.26**	.21**	.36**
Unrelenting Standards/Hypercriticalness	.23**	.24**	n.s.	.22**	.23**
Entitlement/Grandiosity	.45**	.45**	.28**	.34**	.42**
Insufficient Self-Control/Self-Discipline	.45**	.46**	.33**	.24**	.44**
Approval-Seeking/Recognition-Seeking	.38**	.36**	.23**	.26**	.40**
Negativity/Pessimism	.47**	.46**	.32**	.33**	.45**
Punitiveness	.36**	.34**	.18**	.33**	.33**
YSQ Total	.59**	.56**	.41**	.41**	.57**

EMS	Sate Anger	Trait Anger	Anger Expression
Emotional Deprivation	.33**	.29**	.24**
Abandonment/Instability	.30**	.34**	.20**
Mistrust/Abuse	.31**	.36**	.35**
Social Isolation/Alienation	.28**	.35**	.28**
Defectiveness/Shame	.36**	.27**	.24**
Failure	.40**	.25**	.23**
Dependence/Incompetence	.38**	.26**	.20**
Vulnerability to Harm or Illness	.25**	.29**	.22**
Enmeshment/Undeveloped Self	.27**	.31**	.22**
Subjugation	.32**	.36**	.28**
Self-Sacrifice	n.s.	.20**	.13*
Emotional Inhibition	.22**	.28**	.27**
Unrelenting Standards/Hypercriticalness	n.s.	.25**	.32**
Entitlement/Grandiosity	.23**	.42**	.30**
Insufficient Self-Control/Self-Discipline	.24**	.38**	.29**
Approval-Seeking/Recognition-Seeking	.14*	.42**	.28**
Negativity/Pessimism	.21**	.36**	.30**
Punitiveness	.19**	.23**	.28**
YSQ Total	.35**	.45**	.37**

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

EMS	EPCAI A Total	Persons or Animals Aggression	Property Destruction	Falsification or Theft	Serious Rules Violation	Drugs Abuse
Emotional Deprivation	.16**	.15*	.13*	.19**	n.s.	n.s.
Abandonment/Instability	.23**	.14*	n.s.	.19**	.20**	.20**
Mistrust/Abuse	.21**	.19**	.14*	.22**	n.s.	.15**
Social Isolation/Alienation	.25**	.15**	.18**	.26**	.15**	.20**
Defectiveness/Shame	.26**	.20**	.21**	.29**	.15*	.18**
Failure	.23**	.15**	.16**	.20**	.16**	.19**
Dependence/Incompetence	.29**	.20**	.17**	.29**	.17**	.22**
Vulnerability to Harm or Illness	.20**	.16**	n.s.	.20**	.16**	.12*
Enmeshment/Undeveloped Self	.14*	.13*	n.s.	.17**	n.s.	n.s.
Subjugation	.19**	.14*	n.s.	.21**	.12*	.12*
Self-Sacrifice	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
Emotional Inhibition	.18**	.19**	n.s.	.14*	.12*	n.s.
Unrelenting Standards/Hypercriticalness	.15**	.17**	n.s.	n.s.	n.s.	n.s.
Entitlement/Grandiosity	.22**	.16**	n.s.	.14*	.18**	.17**
Insufficient Self-Control/Self-Discipline	.25**	.16**	n.s.	.22**	.19**	.21**
Approval-Seeking/Recognition-Seeking	.13*	n.s.	n.s.	.16**	n.s.	n.s.
Negativity/Pessimism	.16**	.14*	n.s.	n.s.	.17**	n.s.
Punitiveness	.27**	.20**	n.s.	.12*	.20**	.24**
YSQ Total	.27**	.21**	.14*	.25**	.18**	.19**

Discussion

The present research provides support for the EMS determinants of aggressive behavior.

Results indicate statistical significance between EMS and aggressive behavior dimensions.

EMS Mistrust/Abuse, Entitlement/Grandiosity and Insufficient Self-Control/Self-Discipline are those who present a higher endorsement contributing to aggressive behavior.

The findings suggests the importance of further studies on clinical and forensic samples.

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Diatheses to Depression: The Interactions of Schema Propositions, Schema Structure, and Negative Life Events

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INTRODUCTION

•Cognitive factors, particularly cognitive schemas as proposed by Beck are one of the most widely-studied vulnerability factors in depression.

•Most studies of the role of schemas in depression have focused exclusively on schema propositions/statements as measured by the Dysfunctional Attitudes Scale (DAS; Weissman & Beck, 1978), in spite of Beck's discussion of schemas in terms of both cognitive structure and propositions.

•A more detailed description of structural and propositional properties of schemas was explicated in the meta-construct model of cognition: Four elements of cognition are related to depression: structure, propositions, processes, and products (Ingram, Miranda, & Segal, 1998).
- •Structure is defined by the elements of internal organization, representations, and storage of information in memory.
- •Propositions are defined by the content of the information stored in memory as represented by self-statements,

•SELF-COMPLEXITY (SC) MODEL IN CONCEPTUALIZING SCHEMAS AS COGNITIVE STRUCTURES (Linville, 1985): The self is composed of multiple self-aspects that can have distinct meanings and implications for an individual's different life domains (e.g., interpersonal, academic, financial).
- •Self-aspects can be organized at various levels of self- perception, including roles (e.g., teacher, student) and attributes (e.g., hardworking, beautiful, worthless).
- •SC is defined by the number of different ways people describe themselves (i.e., self- aspects) and how these descriptions relate to each other.
- •When individuals have multiple self- aspects that are relatively independent in terms of their descriptions (i.e., high SC), individuals are better protected from events that threaten any one of their self-aspects. But, if SC is composed of negative attributes, then the reverse is true.

•The goal of the present study was to examine whether the structural (i.e., SC) and propositional components of schemas (DAS), independently and in interaction with each other and stressors, lead to changes in depressive symptoms.

•Hypotheses: If negative self-attributes across different self-aspects in a specific domain, interpersonal or achievement, are highly distinct (i.e., high negative SC) or if positive self-attributes across different aspects of self are redundant (i.e., low positive SC), then the DAS would be more likely to lead to higher levels of depression when domain-congruent stressors occur.

•To test the main effect, two-way interaction, and three-way interaction hypotheses, the present study used a two month longitudinal design involving three assessment periods, separated by one month.

METHOD

Participants

During the baseline assessment, a total of 189 students, participated in the study. Of these students, 86% (N = 163) and 64% (N = 121) participated in the first and second follow-ups, respectively. Two extra credit points were given for their participation in each of the three assessment periods. Characteristics of the participants at each assessment points are shown below in Table 1.

Table 1: Characteristics of baseline (N =189), One Month Follow-up (N = 163), and Two Month Follow-Up (N = 121) Samples

	Baseline		One Month		Two Month	
	N	%	N	%	N	%
Male	52	27.5	42	25.8	31	25.6
Female	137	72.5	121	74.2	90	74.4
Race (White)	154	81.5	137	84	102	84.3
	M	SD	M	SD	M	SD
Age	19.46	.96	19.59	.95	19.42	.93

Procedure

Design: The present study is longitudinal, involving three assessment periods, separated by one month.
- •**At the baseline (T1),** participants were group-administered the measures of schema variables, stressors, and depressive symptoms. The groups ranged between 2 and 20 participants at a time. Schema variables were measured only at T1. The T1 administration of questionnaires and mood manipulation lasted about 2 hours.
- •**At one month (T2) and two month (T3) follow-ups:** Participants filled out the stressor and depressive symptom measures online. The T2 and T3 measurements lasted about an hour.

Mood Manipulation: Before the administration of the DAS at the baseline assessment session, participants went through the mood induction procedure composed of both the autobiographical recollections method (ARM; Goodwin & Williams, 1982; Salovey, 1992) and sad music induction. Participants were asked to think about the saddest event in their lives while sad music was played for 5 minutes (i.e., Prokofiev's "Russia Under the Mongolian Yoke"). Participants were further instructed to imagine the event using Salovey's "relive" instructions (1992) while the music plays. Right after, participants took the DAS followed by the SC measure.
To remedy the effects of the mood manipulation, participants went through a neutralizing procedure (i.e., relive and write about a neutral experience that they recently experienced while listening to Vivaldi's "Spring" violin concerto op. 12). Participants were then debriefed about the study.

METHOD

•**Measures:** Cognitive structure measure: Self-Complexity (SC) measure (The Card- Sorting Task, CST; Linville, 1985), Schema propositional- content measure: Dysfunctional Attitudes Scale (DAS-A; Weissman, 1980), College Student Life Events Schedule (CSLES; Sandler & Lakey, 1982), The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977), The Brief Mood Introspection Measure (Mayer &Gaschke,1988), Control measure: Verbal Fluency Test (COWAT; Benton & Hamsher, 1976).

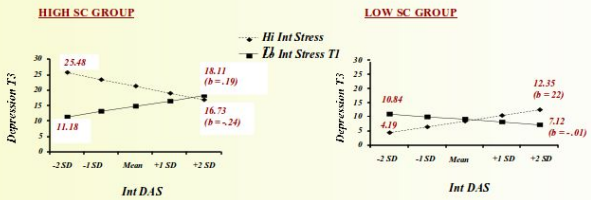
RESULTS

•**Manipulation Check:** A significant difference was found between the positive, negative, and overall mood ratings before and after the mood manipulation in the expected direction.

•**Control Variables:** Prior to testing the hypotheses, the effects of control variables (i.e., current status of psycho-medical interventions, level of verbal fluency, gender) on the DAS, negative SC, stressors, and depressive symptoms were examined. No significant relationships were found at any time period.

•**Hypotheses:** Multiple hierarchical regression analyses were used to examine two-way and three-way interactions.
- •Main effect: Strong support for the predictive power of negative SC with respect to depressive symptomatology. The DAS, on the contrary, was a concurrent factor related to depressive symptoms.
- •Two-way interactions: No supportive evidence for the diathesis-stress model.
- •Three-way interactions: There was a significant relationship between the interpersonal schema variables and stressors at T3 with respect to predicting changes in depressive symptoms at T3, without controlling for depressive symptoms at T1.

•Figure 1. Post-hoc analysis: Regression lines for relationships between interpersonal DAS (Int DAS) and depression at T3 as moderated by high/low (hi/lo) interpersonal stress and hi/lo interpersonal SC (Int SC) groups. b = unstandardized regression coefficient (i.e., simple slope).



DISCUSSION

This study is the first study attempting to explain the relationship of different components of schemas, stressors, and depressive symptoms.

•**Implications:**
- •Negative SC, but not the propositional DAS measure, may be a potential measure of cognitive vulnerability of an individual with respect to depressive symptoms.
- •If the three-way interaction between negative SC, DAS, and distal stressors is replicated in future studies, it may be important for therapists to focus on decreasing the discrepancy between how depressed individuals describe themselves across different roles in the interpersonal domain and what they say their beliefs are in terms of interpersonal relationships.
- •According to present results, even when individuals' negative SC and DAS are both high, the congruency, compared to discrepancy, would lead to lower levels of depressive symptoms.
- •Further, what individuals say they believe in and how they describe themselves are aligned, they may benefit more from cognitive restructuring work.

•**Future directions:**
- •Future studies need to be carried out to replicate the present findings, particularly the three-way interaction.
- •The interactions examined in the present study need to be studied with respect to predicting onset, persistence, and recurrence of clinical levels of depression.
- •Chronic stressors, need to be examined to determine whether such stressors have effects similar to those of acute stressors on levels of depression, when using the DAS and negative SC as diatheses.

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Studies on assessment instruments

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MINISTÉRIO DA JUSTIÇA
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Expectancies and Attitudes towards Psychosocial Rehabilitation Scale - Prison Staff (EAPRS-PS)

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Introduction

- Prisons should have an important role in reducing recidivism rates and promoting cognitive change in the inmates (Abrunhosa, 1998; Resende, 2006).
- Nevertheless, imprisonment frequently maintains and reinforces their anti-social behavior. (Liebling, Price & Elliott, 1999).
- In order to achieve an effective psychosocial intervention, all professionals working inside prisons should consider relationship as a true factor of change, using it to disconfirm the inmate's dysfunctional beliefs.
- This research project aims to validate a multidimensional self-report instrument, designed to assess cognitive and interpersonal factors underlying the behavior and attitudes of all professionals working inside prisons.

Goal

- To validate the Expectancies and Attitudes towards Psychosocial Rehabilitation Scale - Prison Staff (EARPS-PS).

Sample

N = 720 Portuguese Prisons System Staff

- 600 correctional officers
- 60 administrative
- 60 reeducation and rehabilitation technicians (psychologist, social workers, physicians)

Scale Description

Research version:
- 60 initial items.
- Derived from:
  - focus groups on the issue of dysfunctional behaviors and attitudes:
    a) prison staff members
    b) psychologist and health professionals working with staff training programs

Response scale:
- Likert like scale
- 1(Totally disagree) to 5 (Totally agree)

Theoretical Model to test

Hipothesized dimensions

Attitudes and expectancies towards

F.1. Inmates and their potential of change - 20 items
E.g. "I don't believe that any adult with criminal career can ever change"; "I believe that inmate's behavior change depends only on them"

F.2. Incarceration and prisons's role – 9 items
E.g. "The duration of imprisonment has little influence in the inmate's change, compared with the influence of their peer group"; "The role of prison is merely to ensure that inmates remain secluded from society"

F.3. Rehabilitation and social reintegration of inmates - 15 items
E.g. "Rehabilitation is an exclusive area of reeducation technicians"; "Rehabilitation aims are not compatible with the maintenance of security that is necessary inside prison"

F.4. Prison staff competencies and role - 16 items
E.g. "When I commit and push myself, I can actually modify the behavior of inmates"; "If an inmate recedes in his rehabilitation, I know how to increase his motivation to change"

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COMPETE
QREN QUADRO DE REFERÊNCIA ESTRATÉGICO NACIONAL
UNIÃO EUROPEIA
FCT Fundação para a Ciência e a Tecnologia
MINISTÉRIO DA CIÊNCIA, TECNOLOGIA E ENSINO SUPERIOR
(PTDC/PSI-PCL/102165/2008)

Portuguese version of the Difficult Living and Working Environment Scale of the Deployment Risk and Resilience Inventory (DRRI): a study with Portuguese colonial war veterans

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INTRODUCTION

The Deployment Risk and Resilience Inventory (DRRI, King, King, & Vogt, 2003; King, King, Vogt, Knight, & Samper, 2006) has been widely used as a self-report measure for the assessment of psychosocial risk and resilience factors. It was developed to be used military personnel and veterans involved in contemporary war. DRRI includes the Difficult Living and Working Environment Scale (DLWES) that addresses exposure to events or circumstances repeated or day-to-day environmental stressors.
The aim of this study is to present de development of the Portuguese version of the DLWES and its psychometric properties in a sample of Portuguese colonial war veterans.

METHOD

PARTICIPANTS:

Three hundred and six males from the general population of Portuguese colonial war veterans, recruited as a convenient sample, through personal contacts. The subsequent contacts were obtained by network, through indication from veterans previously contacted (snowball sampling). Sample characteristics are presented in Table 1.

INSTRUMENTS:

PTSD Checklist-Military Version (PCL-M; Weathers, Litz, Huska,, & Keane, 1994; Portuguese version by Carvalho Cunha, & Pinto-Gouveia, unpublished): composed by 17 items that measure, in a 5-point Likert scale, the severity of PTSD symptoms according with DSM-IV. The internal consistency in our sample was .95 for this self-report instrument.

Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Portuguese version by Vaz Serra & Abreu, 1973): is a 27-itens self-report questionnaire that assesses depressive symptoms. In this study we obtained an internal consistency of .92.

Anxiety and Stress Scales of DASS-21 (Lovibond & Lovibond, 1995; Portuguese version by Pais-Ribeiro, Honrado, & Leal, 2004): the DASS is a self-report measure composed of 21 items designed to assess three dimensions of psychopathological symptoms: depression, anxiety and stress. In the present study, we used the anxiety and stress subscales that showed good internal consistency (Cronbach's alpha=.85 for the anxiety subscale; Cronbach's alpha=.93 for the stress subscale).

Difficult Living and Working Environment Scale -Modified Version (DLWES-M; King et al., 2003, 2006; modified version by Carvalho, Cunha, & Pinto-Gouveia): This is a 20-itens scale that assesses the exposure to events or circumstances representing repeated or day-to-day irritations and pressures related to life in war zone (especially in combat zone at the stage of forces employment).
With previous permission of original authors, two more items (20 and 21) were added and items 17 and 19 was modified in order to apply to Portuguese colonial war context (see content items on Table 2).

PROCEDURES:

Translation was performed by two clinical psychologists, a NATO army officer and a native speaker. Linguistic and semantic equivalence aspects were considered.
Translated items were then analyzed concerning its adequacy to Portuguese colonial war. This task was held by two army officers who have completed several missions in combat zones on this theater of operations and by two psychologists with clinical experience in psychopathology related with combat exposure. The added items and the modified ones resulted from these experts agreement. The scale was subsequently administered to 30 war veterans to assess items adequacy and comprehensibility.
The assessment protocol was then administered to 306 veterans and 115 of these subjects completed the DLWES-M about three weeks after the first administration. Participation was voluntary, informed consent was given an research ethical principals were attained.

RESULTS

Demographic characteristics of the sample are presented in Table 1.

Table 1. Sample Characteristics (n=306)

	M	SD	
Age	63.06	4.96	(56-80)
Years of Education	7.88	4.33	(2-19)
Months of exposure to de combate zone	28.14	16.57	(2-148)

Exploratory Factor Analysis: The exploratory factor analysis through the Principal Component Analysis method (PCA) produced a five factors initial solution with eigenvalues greater than one that cumulatively accounted for 58,09% of total variance. Factor one (F1) explained 34.58% of variance, Factor two (F2) 7.85%, Factor three (F3) 5.73%, Factor four (F4) 5.27%, and Factor five (F5) 4.66%. Variance difference between F1 and F2 is considerably higher (26.73%) than the difference found concerning the other factors (F2-F3=2.12%; F3-F4=.46%; F4-F5=.61%). This results suggest a single component tendency confirmed by scree plot analysis. Nevertheless, theoretical interpretation and utility of the five factors were analysed. A decision for a single component solution was made based on these criteria.

Therefore, a second factor analysis, was conducted, forced at one factor. Items were retained based on factor loadings greater than .35. Item 16 "I had difficulties in using equipment and handling weaponry" was excluded due to a .29 factor loading. A subsequent PCA was carried out. Factor loadings ranged from .39 to .77, explaining 35.88% of total variance (see Table 2).

RELIABILITY ANALYSIS:

Concerning internal consistency, a Cronbach alpha of .91 was found.
Corrected item-total correlations ranged from r=.35 to r=.71.
Test-retest reliability was studied in a subgroup of 115 veterans who completed the DLWES-M about three weeks after the first administration. Pearson product-moment correlations showed to be .91.

Table 2. Factor loadings, Communalities, Mean, Std. Deviation and Item-Total Correlations for the DLWES-M Items

Items	Loadings	Communalities	Mean	Std. Deviation	Item-Total Correlation
12. I got the R&R (rest and relaxation) that I needed	-.77	.59	3.05	1.32	.71
8. I got as much sleep as I need	-.74	.55	2.77	1.35	.68
10. I was able to get enough privacy	-.73	.53	3.33	1.49	.66
3. I had access to clean clothing when I needed it	-.72	.52	2.60	1.39	.65
7. I had access to bathrooms or showers when I need them	-.72	.52	2.62	1.40	.65
4. I could get a cold drink (for exemple, water, juice, etc.) when I wanted one	-.70	.49	2.91	1.38	.64
21. It was unpleasant eating the same food for long periods of time*	.66	.44	3.36	1.36	.62
6. The conditions in lived in were extremely unsanitary	.65	.42	2.85	1.30	.60
13. I got my mail in a timely manner	-.62	.37	2.78	1.26	.56
5. The food I had I had to eat was of very poor quality (for example bad or old MREs)	.61	.37	2.59	1.30	.55
14. I was exposed to awful smells	.59	.34	2.38	1.18	.54
16. I had the equipment or supplies to what I needed to do	-.57	.33	2.41	1.28	.50
18. I felt comfortable living in the culture or cultures when I was deployed	-.55	.31	3.07	1.46	.49
15. I was exposed to loud noise	.55	.30	2.63	1.25	.49
17. My daily activities were restricted because of local lack of development and isolation**	.52	.27	3.13	1.36	.48
11. The workdays were too long	.52	.27	3.56	1.16	.48
19. I had difficulties in dealing with pressure for persuade natives not to supply logistical support to the enemy**	.48	.23	2.42	1.21	.44
2. I had to deal with annoying animals, insects, or plants during my deployment.	.44	.19	3.37	1.33	.40
1. The climate was extremely uncomfortable.	.42	.18	3.03	1.35	.39
20. I felt uncomfortable in living with local natives and not being sure which part (ours or the enemy) they were in favour of *	.40	.16	2.66	1.25	.36
9. The living space was too crowded	**.39**	.15	3.45	1.44	.35
Eigenvalues:	7.54				
Total of variance explained (%):	35.88				

* Items added
** Items modified

VALIDITY:

Significant and positive correlations between DLWES–M and PTSD symptoms, depression, anxiety and stress were found (see Table 3).

Table 3. Correlations between DLWES-M, PCL-M, BDI, and DASS-21

	PCL-M	BDI	DASS-21	
	PTSD Symptoms	Depression Symptoms	Anxiety Simptoms	Stress Simptoms
DLWES-M	.57**	.39**	.38**	.39**

** p<.01

DISCUSSION

Results suggest that the Portuguese version of DLWES is a reliable and valid measure tapping a single underlying component. The association found between the DLWES-M and psychopathology, particularly PTSD symptoms may indicate that environmental discomforts in a war context can function as risk factors for the development of psychopathological symptoms, supporting its discriminant validity.
Future studies may include a confirmatory factor analysis and explore whether the construct measured by this scale may be considered as a risk factor in the Portuguese colonial war veterans.

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Portuguese version of the Perceived Threat Scale of the Deployment Risk and Resilience Inventory (DRRI): a study with Portuguese colonial war veterans.

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INTRODUCTION

The literature and various empirical studies emphasize the threat perception during the exposure to military theatre of operations, particularly in a combat zone, as an important predictor of the development of physical and psychological symptoms in war veterans, among whom stand out those associated with Post-traumatic Stress Disorder (PTSD). This risk factor has been frequently measured by the Deployment Risk and Resilience Inventory (DRRI, King, King, & Vogt, 2003; King, King, Vogt, Knight, & Samper, 2006) that includes the Perceived Threat Scale (PTS). The DRRI is an inventory of psychosocial risk and resilience factors and is intended to be used within military personnel and veterans involved in contemporary war (King, King et al., 2006).

In Portugal, instruments to measure this variable in the Portuguese colonial war veterans population are unknown. These soldiers were deployed to Angola, Mozambique, Guinea and India for long period(s) (24 months each or more), were exposed to a guerrilla theatre perpetuated for 14 years (1961-1975).

This study presents a modified version of PTS adapted to Portuguese Colonial War and its exploratory validation.

METHOD

PARTICIPANTS:

The sample is constituted by 306 males from the general population of Portuguese colonial war veterans recruited as a convenient sample, through personal contacts. The subsequent contacts were obtained by network, through indication from veterans previously contacted (snowball sampling). Sample characteristics are described in Table 1.

INSTRUMENTS:

PTSD Checklist-Military Version (PCL-M; Weathers, Litz, Huska, & Keane, 1994; Portuguese version by Carvalho, Cunha, & Pinto-Gouveia, unpublished): composed by 17 items that measure, in a 5-point Likert scale, the severity of PTSD symptoms according with DSM-IV. The internal consistency in our sample was .95 for this self-report instrument.

Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Portuguese version by Vaz Serra & Abreu, 1973): is a 27-itens self-report questionnaire that assesses depressive symptoms. In this study we obtained an internal consistency of .92.

Anxiety and Stress Scales of DASS-21 (Lovibond & Lovibond, 1995; Portuguese version by Pais-Ribeiro, Honrado, & Leal, 2004): the DASS is a self-report measure composed of 21 items designed to assess three dimensions of psychopathological symptoms: depression, anxiety and stress. In the present study, we used the anxiety and stress subscales that showed good internal consistency (Cronbach's alpha=.85 for the anxiety subscale; Cronbach's alpha=.93 for the stress subscale).

Perceived Threat Scale-Modified Version (PTS-M; King et al., 2003, 2006; modified version by Carvalho, Cunha, & Pinto-Gouveia): 15-itens self-report questionnaire that assesses the perceived threat to security and personal well-being in a theatre of military operations, reflecting emotional or cognitive appraisals of situations that may or may not accurately represent objective or factual reality. With the previous permission of original authors, the content of items 3, 11, 12, 13 and 14 were modified due to the fact that they do not apply to Portuguese colonial war context.

PROCEDURES:

Translation was performed by two clinical psychologists, a NATO army officer and a native speaker. Linguistic and semantic equivalence aspects were considered.

Translated items were then analyzed concerning its adequacy to Portuguese colonial war. This task was held by two army officers who have completed several missions in combat zones on this theater of operations and by two psychologists with clinical experience in psychopathology related with combat exposure. The items modified content resulted from these experts agreement. The scale was subsequently administered to 30 war veterans to assess items adequacy and comprehensibility.

Finally, the 306 veterans completed the assessment protocol and a subgroup of 115 of them completed the PTS about three weeks after the first administration. Participation was voluntary, informed consent was given an research ethical principals were attained.

RESULTS

Demographic characteristics of the sample are presented in Table 1.

Table 1. Sample Characteristics (n=306)

	M	SD	
Age	63.06	4.96	(56-80)
Years of Education	7.88	4.33	(2-19)
Months of exposure to combat zone	28.14	16.57	(2-148)

Exploratory Factor Analysis:

The exploratory factor analysis through the Principal Component Analysis method (PCA) produced a initial solution with three factors with eigenvalues greater than one that cumulatively accounted for 55,52% of the total variance.

The Catell scree test suggested the retention of a bigger factor and one or two smaller. Its theoretical interpretation and utility were analysed and a decision for a final solution forced at two-factors through obliging rotation with Kaiser normalization was made. The first and second factors presented eigenvalues respectively of 5.38 and 1.78, corresponding to a percentage of total variance explained of 35.86 and 11.86 (Cumulative percentage of 47.72) (see Table 2). The correlation between these two dimensions was .44.

The first factor labelled **Threats Combat** consists of eight items that assess the perception of threats arising from the potential exposure to situations resulting directly from combat (employment of forces in combat zone). Factor loadings ranged between .82 and .55 (see Table 2).

The second dimension with 7 items was called **Non-Combat Threats**. It measures the fear in face of potential exposure to circumstances perceived by the Portuguese colonial war veterans as non-combat operations but may occur in the stages of preparation, deployment and employment of forces. The loadings factor range between .82 and .58 (see Table 2).

RELIABILITY ANALYSES:

The two subscales presented adequate internal consistency, with a Cronbach alpha of .82 each. Cronbach's alpha for the total scale was .87.

Corrected item-total correlations ranged from r=.72 to r=.42 for the Threat Combat Subscale and from r=.62 to r=.49 for the Non-Combat Threats Subscale. For the total scale these correlations ranged between .67 and .39 (see table 2).

Test-retest reliability was studied in a subgroup of 115 veterans who completed the PTS about three weeks after the first administration. Pearson product-moment correlations showed to be .89, which suggests an adequate temporal stability.

Table 2. Factor loadings, Communalities, Mean, Std. Deviation and Item-Total Correlations for the PST-M Items

Item	Load. F1	Load. F2	Communalities	Mean	Std. Deviation	Item-Total Correlation
Factor 1: Threats Combat (α=.82)						
4. I felt that I was in great danger of being killed or wounded.	**.82**	.41	.68	4.06	1.35	.72
5. I was concerned that my unit would be attacked by the enemy.	**.80**	.32	.64	4.26	1.31	.67
1. I thought I would never survive.	**.69**	.49	.52	2.93	1.67	.61
7. I was afraid I would encounter a mine or booby trap.	**.68**	.24	.47	4.38	1.39	.54
8. I felt secure that I would be coming home after the war.	**-.64**	-.25	.41	2.28	1.56	.52
3. I was worried about the possibility of the enemy to make progress in weaponry and mobility. *	**.59**	.38	.37	3.96	1.29	.48
2. I felt safe.	**-.55**	-.20	.31	2.70	1.49	.43
6. I worried about the possibility of accidents (for example, friendly fire).	**.55**	.28	.31	3.85	1.44	.43
Factor 2: Non-Threats Combat (α=.82)						
10. I was concerned that the tablets I took to protect me would make me sick.	.24	**.82**	.69	2.19	1.38	.62
9. I thought that vaccinations I received would actually cause me to be sick.	.18	**.79**	.65	2.15	1.34	.57.
14. I was worried about the possibility of being a victim of storms and cyclones during wet season.*	.36	**.70**	.50	2.94	1.59	.60
12. I felt that I could get sick due to ingestion of improper for consumption water.*	.51	**.67**	.51	3.54	1.47	.59
13. I felt threatened by animals, insects and dangerous plants.*	.36	**.62**	.40	3.74	1.38	.52
15. I worried about getting an infectious disease.	.57	**.68**	.36	3.96	1.39	.49
11. I was afraid of being attacked by maritime and air assets while traveling to and from Overseas.*	.43	**.58**	.37	2.47	1.59	.49
Eigenvalues:	5.38	1.78				
% of the variance explained:	35.86	11.86				
Total of variance explained (%):	**47.72**					

Notes: Items loading on each factor are in bold; * Items modified.

VALIDITY:

Significant and positive correlations coefficients at a .01 level between PTS (subscale and scale total) and PTSD symptoms, depression, anxiety and stress were found (see Table 3).

Table 3. Correlations between the PTS-M PCL-M, BDI and DASS-21

	PCL-M	BDI	DASS-21	
	PTSD Symptoms	Depression Symptoms	Anxiety Symptoms	Stress Symptoms
PTS-M - Treats Combat	.50**	.30**	.27**	.33**
PTS-M - Non-Treats Combat	.45**	.31**	.32**	.29**
PTS-M - Scale Total	.55**	.35**	.34**	.36**

** p<.01

DISCUSSION

The exploratory factor analysis of PTS-M reveals a two-dimensional factor structure. Concerning psychometric characteristics, it shows an adequate internal consistency (for the two dimensions and total scale) and a good temporal stability. The validity study suggests an association between the PTS-M and psychopathology, particularly with PTSD symptoms.

Further studies should be conducted in order to confirm these preliminary results and clarify the type of relationship between perceived threat and various forms of psychopathology developed by Portuguese colonial war veterans population.

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A Multidimensional Measure of Cognitive-Behavioural Variables Underlying School Underachievement

SSARF – Student Self Assessment of Risk Factors

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Introduction

Academic underachievement is a commonly studied topic, and yet, not fully understood.

Nevertheless, there is some lack of accuracy among researchers. Some of the studied risk factors seem to behave as precipitant factors (e.g. school size, rules, percentage of dropout, poor school performance, reduced attendance to school, negative school experiences, anti-social behaviour, addictive behaviours), while others are better conceptualized as vulnerability factors (namely family and individuals variables).

Goals

To develop a new multidimensional measure aiming to assess student's risk factors for school underachievement (failure and dropout), including cognitive, emotional and attitudinal variables

Characteristics

- Target population: students between 12 and 18 years old
- Experimental version: 117 items
- Answer: 5 points Likert-like scale (Totally true –Totally untrue)

Dimensions

F.1. Academic Self-efficacy - 16 items
E.g. "I know that if I push myself I am going to reach good results in school"; "When I don't understand a subject I no longer feel like reading anything else"

F.2. Self-regulation - 18 items
E.g. "I usually answer without thinking too much"; "I make mistakes because I don't read the questions carefully"

F.3. Causal attributions to success and failure at school - 11 items
E.g. "When I have good results it's because I worked hard for it"; "When I get bad grades it's because I was unlucky"

F.4. School attachment and social integration - 17 items
E.g. "I don't like the breaks because I am always alone"; "I am very popular in my school"

F.5. Academic self-concept - 14 items
E.g. "I often think I am dumb"; "Thinking about school grades makes me feel less smart than the others"

F.6. School routines - 11 items
E.g. "I always do my homework"; "I don't like to do homework; I only study if I am forced to do it"

F.7. Performance anxiety - 17 items
E.g. "Thinking about school tests makes me feel anxious"; "I usually avoid answering teachers questions because I am afraid to fail"

F.8. School Benefits Perception - 13 items
E.g. "School has no purpose"; "Attending to school improves the chance of finding a job"; "What I learn in school helps me to solve everyday problems"

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PCS – Peer Conflict Scale

Validation studies in a sample of Portuguese adolescents

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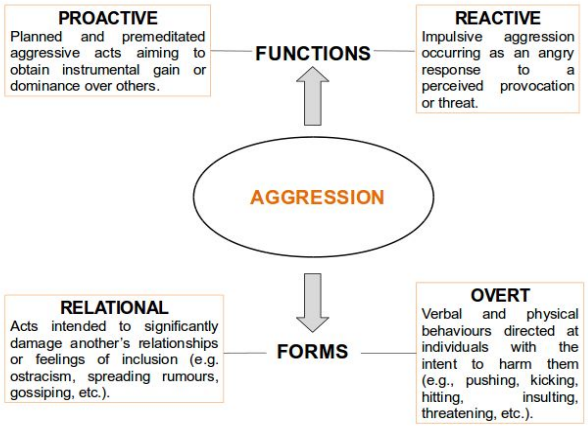
INTRODUCTION

· Peer conflict among adolescents is a problem that, although old, has become more and more a concern of modern societies. It has consequences at several levels: society, school, family and individual.

· Recent studies have shown that aggressiveness is a multidimensional concept and assessment instruments should differentiate the functions and the forms of aggression.

· The Peer Conflict Scale (PCS; Marsee, Kimonis & Frick, 2004) was created to overcome limitations of other aggression measures, assessing aggressiveness in four dimensions: open-proactive, open-reactive, relational-proactive and relational-reactive.

· The aim of this paper is to validate the Portuguese version of the PCS. We present some relevant preliminary results.



METHOD

· In this study, 120 adolescents between 15 and 18 years old answered a self-report measure of aggressiveness.

· This non-clinical sample was collected in High Schools of Coimbra Region (Portugal).

SAMPLE

Global Sample (n = 135)		
	M	SD
Age	16,34	1,01
Years of Education	9,60	,74
Number of holdbacks	.32	,62
	N	%
Gender		
Male	50	37
Female	85	63
Social Status		
Low	50	37
Medium	81	60
High	1	,7

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RESULTS

· Current sample presents a KMO of ,638; Bartlett's Test of Sphericity ($X2$ = 3307,43; p = ,000) which indicates sample adequacy for the following analysis.

· **Principal Component Analysis using Oblimin with Kaiser Normalization forced at four factors** (n = 135; total variance explained: 49,4%)

Items	FACTORS			
	F1	F2	F3	F4
26	,856			
34	,841			
28	,830			
29	,760			
19	,702			
23	,678			
7	,633			
35	,609			
5	,573			
20		,812		
14		,795		
11		,754		
3		,679		
1		,677		
37		,661		
8		,660		
36		,622		
16		,561		
18		,502		
2		,486		
13			,701	
9			,652	
24			,618	
27			,563	
40			,550	,479
31			,528	
15	,430		,480	
4			,406	
10	,314		,364	
21				,815
17				,728
39				,669
12				,628
6				,615
32				,499
22				,467

The highlighted items are those in common with the theoretical factors proposed by the scale's author.

· **Scale and Factors Reliability**

Factors	α
F1. Relational-Proactive Aggression	,844
F2. Open-Reactive Aggression	,864
F3. Relational-Reactive Aggression	,714
F4. Open-Proactive Aggression	,753
Scale	,859

CONCLUSION

· This exploratory study indicates that there is a considerable overlapping of theoretical factors with the empirical data collected so far.

· Scale and factors presents high reliability coefficients.

· Further research will be carried out to increase sample size and achieve final results.

Psychometric properties of the Spanish version of the Obsessive-Compulsive Inventory-Revised (OCI-R) in an obsessive-compulsive disorder sample

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INTRODUCTION

Obsessive-compulsive disorder (OCD) is described as a unitary nosological entity by current diagnostic classifications. However, OCD patients report a variety of symptom contents, and a great empirical effort has been devoted to the study of OCD dimensions.

The **Obsessive-Compulsive Inventory-Revised** (OCI-R; Foa et al., 2002) is a widely used 18-item self-report questionnaire that assesses the distress associated with OC symptoms, grouped in six subscales (washing, obsessing, hoarding, ordering, checking and neutralizing). The Spanish version has demonstrated excellent psychometric properties in non-clinical samples (Fullana et al., 2005), but no studies have examined OCI-R in clinical samples.

The **aim** of the present study is to explore the psychometric properties of the OCI-R in a Spanish OCD sample.

METHOD

Participants

68 Obsessive-compulsive patients (mean age 35.05±12.63; 51.50% men)
Number of patients classified in the basis of the content of their main obsession
14 contamination, 8 sexual/religious, 10 aggressive, 17 doubts, 14 superstition, 1 order

31 Anxious non-OCD patients (mean age 35.19 ± 11.14; 69.80% female)

Measures: patients completed a battery of questionnaires including: the Obsessive-Compulsive Inventory-Revised (OCI-R), measures of OCD severity (YBOCS), OCD symptoms (Clark-Beck Obsessive Compulsive Inventory, CBOCI), depression (BDI-II), anxiety (BAI, PSWQ)

RESULTS

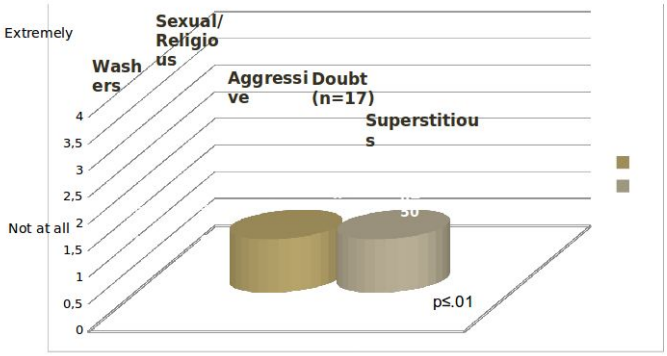
Internal consistency (OCD sample): OCI-R total and subscales showed good internal consistency

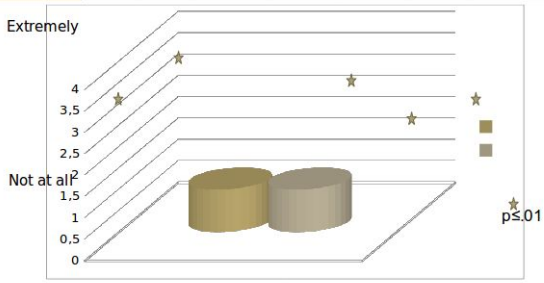
	OCI-R						
OCD sample	Total	washing	obsessing	hoarding	ordering	checking	neutralizing
α	.86	.88	.76	.75	.85	.92	.89

Convergent and divergent validity (OCD sample): OCI-R scores showed moderate-high associations with the CBOCI and YBOCS total and its corresponding subscales, low associations with non-corresponding CBOCI-scales, depression (BDI) and anxiety (BAI) and moderate with tendency to worry (PSWQ)

	OCI-R						
OCD sample	Total	washing	obsessing	hoarding	ordering	checking	neutralizing
CBOCI Total	.54***	.38**	.32*	.42***	.19	.36**	.30*
CBOCI obsessing	.37**	.17	**.54****	.21	.01	.29*	.16
CBOCI compulsion	.63***	**.47****	.11	**.51****	**.36****	**.37****	**.47****
YBOCS Total	**.32****	.36**	.23	.26*	.03	.12	.17
YBOCS obsessions	.244	.24	**.37****	.19	-.08	.04	.17
YBOCS compulsion	.37**	**.45****	.06	.30*	.17	.20	.18
BDI-II	*.19*	*.07*	*.29**	*.21*	*.04*	*-.005*	*.14*
BAI	*-.06*	*-.05*	*.08*	*.07*	*-.08*	*-.19*	*.009*
PSWQ	*.32**	*.001*	*.33***	*.37***	*.11*	*.32**	*.09*

Known groups validity: two different analysis were conducted: **(a) OCD** patients were grouped on the basis of the **content of their main obsession**. Then, OCD participants score on the OCI-R subscale with the same content as their main obsession was compared with the scores of other OCD patients on the same OCI-R dimension. Results showed that patients scored higher on the OCI-R subscales consistent with their main symptoms (e.g., OCD washers showed higher OCI-R-washing than non-washers) except the Aggressive patients. No analysis were conducted for the OCI-R ordering and hoarding subscales as there were not enough OCD patients (1 and 0 respectively) for conducting the t-test comparisons.





DISCUSSION The OCI-R Spanish version shows good psychometric properties (reliability, convergent, divergent and known-groups validity), thus supporting the use of the OCI-R Spanish version with OCD samples. The known-groups validity of the ordering and hoarding scales, as well as the obsessing scale related to aggressive obsessions need further examination.

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Deck of Emotions: Accesing child emotions

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Introduction

• Nearly one in every five children presents some sort of psychiatric disorder during childhood. If not treated, these bouts have high rates of continuity and lead to important future impairments (Costello, Mustillo, Erkanli, Keeler e Angold, 2003).
• Accordingly, cognitive-behavioral therapy (CBT) with children has gained strong impulse in the last decade. Nonetheless, treating children requires a specific approach and many therapists find difficulties in adequating its interventions.
• This poster presents the development of a tool called Deck of Emotions (DOE), which aims to help the clinic childhood practice. The DOE is composed by a series of cards containing illustrations of human faces expressing specific emotions, besides a ruler to measure the degree of the emotion (Caminha e Caminha, 2011).

Method

Extensive narrative review of the literature to identify emotions with transcultural facial e[illegible]ssions.

Six emotions identified (i.e. Fear and Sadness). The emotion "surprise" was excluded due to lack of clinical relevance.

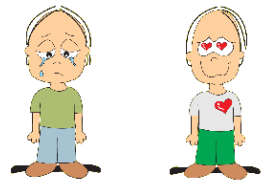
Data collection on the mentioned emotions by children in treatment over a 6 month period in a CBT train[illegible]enter.

Content analysis and grouping of the emotions not present in the review. Fifteen emotions identified (i.e. love and tire[illegible]ss).

A first version is designed, released and commercialized. Feedback from the professionals who used the first version of the DOE was used as a base for the release of a second version, with slight alterations in the cards themselves and several suggestions for clinical uses.

Results

Card samples



Sadness

Love

Happines s

Shame

Very strong
Strong
Medium
Weak
Very Weak

Possible uses

· Address emotions and the cognitive model in a ludic way.
· Play games, which can be useful in establishing Rapport and therapeutical alliance.
· Psychoeducation of both emotions and the cognitive model.
· Emotions monitoring (fulfilled by either the parents or the child. These data can be compared).
· Realize parental emotion socialization in-session or through parent-child playing homeworks.
· Working along adults with troubles in identifying, naming or accessing emotions.
· Evaluation tool for childhood research.

Discussion

· The emotion cards with transcultural facial expressions can be easily adapted and used in different contexts.
· Next research steps: systematic revision seeking to identify basic emotions without transcultural facial expressions, which will originate three card categories: transcultural facial expression basic emotions, basic emotions without transcultural facial expressions, and secondary/context-dependant emotions.

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Studies on intervention methods and programs

EFFECTS OF AN INTERDISCIPLINARY INTERVENTION (Cognitive- Behavioral Therapy + Occupational Therapy) IN HEALTH OUTCOMES IN FIBROMYALGIA

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Introduction

Fibromyalgia (FM) is a chronic pain condition of unknown etiology with few satisfactory treatment options. It is characterized by widespread pain, sleep disturbance, and fatigue that lead to extensive functional limitations in a high proportion. The multidimensional nature of the disease calls for a wide variety of treatment approaches including pharmacological and nonpharmacological but the lack of long term efectiveness of pharmacological treatments require other therapeutic modalities. Cognitive-Behavioral Therapy (CBT) constitutes one of the most successful treatments showing an improvement in the symptoms of the FM patients (Bernardy et al., 2010; Glombiewski et al., 2010). The biopsychosocial model considers that integrated treatments can be applied broadly and practically and there is evidence that support the use of these interventions for conditions such as FM (Rivera et al., 2004; Thieme et al., 2003).

Objectives

We evaluated the effect of an interdisciplinary intervention including Cognitive-Behavioral Therapy and Occupational Therapy in different health outcomes on 37 fibromyalgic female patients.

Methods

It was designed an interdisciplinary intervention including CBT and Occupational Therapy (OT) techniques with 12 sessions including control of pain techniques, symptom management, cognitive restructuring and activity pacing.

Participants were 37 women with FM (51 ± 10,79 years). Other sociodemographic variables are shown in Table 1.

The design was longitudinal (with pre-post and follow-up measures) with an equivalent control group.

Measures

- Pain Visual Analogue Scale (*VAS*)
- 12 Item Short Form Health Survey Scale (*SF-12*, Ware et al., 1996)
- General Self-Efficacy Scale (Jerusalem & Scharzer, 1992)
- Chronic Pain Self-Efficacy Scale (*CPSS*, Anderson et al., 1995)
- Fibromyalgia Impact Questionnaire (*FIQ*, Burckhardt et al.,1991).
- Rosenberg Self-Esteem Scale (*RSES*, Rosenberg, 1965)
- Positive Affect and Negative Scale, PANAS, Watson & Tellegen, 1985)

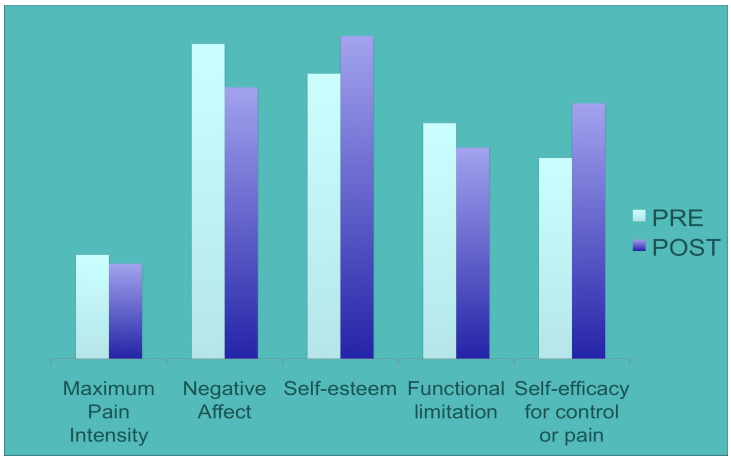
Results

Results showed that the intervention has positive effects on maximum pain intensity (t= 4,46; p <0.01) and on functional limitation (t= 4,66; p <0.01). However, there are no effects on quality of life and minimum and average pain intensity indicators. It is also observed a significant decrease in negative affect (t= 3,39; p <0.05) and a significant increase in self-esteem (t= -2,52; p <0.05) (Figure 1). Regarding pain self-efficacy, there are positive results near to significance in self-efficacy over control of pain (t= -1,81; p <0.09) but not with respect to pain self-efficacy for activities and for manage of symptoms.

Table 1. Sociodemographic variables

Variable		%
Marital Status	Married	81,8
	Single	12,1
	Separated/Divorce	3
	Widowed	3
Education level	None	16,3
	Primary	51,1
	High school	20,7
	Higher education	12
Employment status	Actually working	28,9
	Not working	60,8
	Disabled	10,3

Figure 1. Variables with significant differences



Implications

Interdisciplinary interventions turn out to be effective in patients with FM for the management of different illness outcomes through different self-management techniques. A change in pain intensity seems to be more difficult, which let us a point of reflection. Additional studies are needed to explore novel methods of delivering these interventions and make them available to the patients with FM.

El presente trabajo ha sido realizado con la financiación de dos artículos 83 de investigación entre la URJC-Grunenthal, y entre la URJC-AFIBROM con referencias internas A155, A163, A186.

Con la colaboración de GRUNENTHAL

The Book of Life: working positive reminiscence exercise with the elders through Positive Technologies

hemendy E.[1], Baños, R.M.[1-2], Felipe, S.[2], Castilla D.[1-3] & Botella C.[1-3]

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This study was funded in part by Ministerio de Educación y Ciencia Spain, Projects Consolider-C (SEJ2006-14301/PSIC), "CIBER of Physiopathology of Obesity and Nutrition, an initiative of ISCIII" and Probientic (PROMETEO/2008/157 Excellence Research Program PROMETEO Generalitat Valenciana. Conselleria de Educación).

- The disproportionate increase in the world's aged population, especially in developed countries, is one of the biggest challenges for developing health and social policies.
- The demographic change coincides with the S XX technological revolution.
- Developed countries are taking into consideration e-health applications in their health policies; these are effective programs that can reach large numbers of people at a much lower economic cost.
- The "Butler System" is an e-health application designed specifically for older people and the health professionals who work with this population.
- The "Butler system" is a multi-user platform with various levels of action, which includes resources that enhance elderly users' social integration, learning, socio-emotional networks, leisure and training in emotional regulation skills.

- The "Butler System" allows practitioners to continuously monitor older people's emotional states and offers various clinical resources and therapeutic activities
- Butler is a technology platform that uses Internet as a network linking for different types of users (Elderly User-Friends User-Clinic User) , and includes 3 applications:
  - *Diagnosis*: to detect symptoms of physical unease, anxiety and depression.
  - *Therapeutic*: it contains "Virtual Worlds" to generate positive emotions and the "Therapeutic Book of Life", a tool to apply a training program of reminiscence.
  - *Playful*: is aimed to increased social relationships, entertainment and learning new technologies. It include: E-mail, Videoconferencing, Search for Friends, Favorite Images and Melodies, (easy) access to web site search and **Book of Life.**

AIM: To test the efficacy of "Book of Life" to improve older users' mood and to analyze users satisfaction with this tool.

Book of Life (BL) works as a blog, where users can write and insert multimedia elements (including their own pictures and their favorite tunes); users can also decide which page can be read by other people and which of them are private.

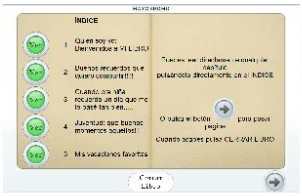
This tool is used by the elders with a psychologist, to work positive reminiscence.

In each session a psychologist to inform to users about a subject to work. For example, some subject are: *"Good moments that I want to share", "When I was child I remember a wonderful day", "My favorite holiday", "In my life I fell grateful for (10 reason)" , "Youth...that good moments! I remember a special day that...", etc.*

After session each user can elect a music and photography for to illustrate the page, furthermore he decide if he want to share this page with other people.

The reminiscence is a technique frequently used with the elders that use the positive personal memories.

It is related with the isolation decrease and the self-esteem and socialization increase (Haight & Burnside, 1993).



Sample:

- 6 participants aged from 63 to 79 (ME= 71.16 and DT= 6.30).
- All participants were recruited from nursing home and adult day care center.
- Participants did not have any psychological or cognitive

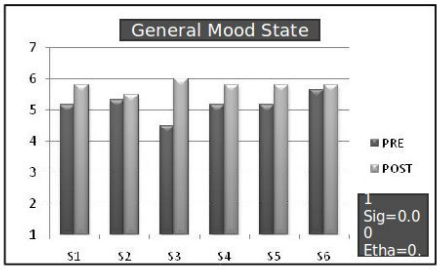
Measures:

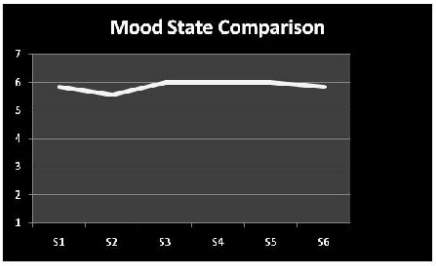
- *General Mood State (GMS):* a visual scale where users choose the facial expression that better represents their mood state before and after using the BL (Being 1 a face of maximum sadness and 7 a face of maximum happiness).
- *Mood State Comparison (MSC):* a visual scale where users indicate changes in their mood after using the BL. (Being 1 much worse and 7 much better)
- *Level Satisfaction (LS): a* visual scale where the users indicates the satisfaction with the BL after using it. (Being

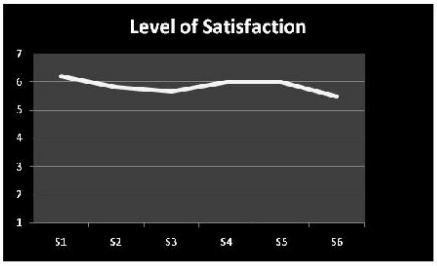
Procedure:

- Participants completed STAI-S and Yesavage-15 to detect high score for anxiety and depression (exclusion criteria).
- Participant used the BL once a week, an hour each day trough 6 sessions.
- In each session a therapist informed about a subject that the user had to remember. For example, one of the used subjects was "The life is wonderful because" or "I fell grateful for".
- The therapist helped them in the reminiscence work, guiding the positive memory through the story by recalling positive details and happy experiences.
- Before and after each session a researcher administered the measures (GMS, MSC and LS).

Results: in all session, all participants showed increase of mood and a higher level of satisfaction.







Conclusions: BL can be a useful resource to work reminiscence with elderly people, enriching the therapeutic technique of reminiscence, and providing resources that can enhance the professional work.

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PRELIMINARY RESULTS OF 7-SESSION COGNITIVE GROUP THERAPY FOR TEST ANXIETY

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Introduction

Because of achievement-oriented community of modern times, individuals expose much more evaluative processes in social situations. Experiencing of these testing situations may evoke anxiety reactions in many individuals. In early ages of life, many of children and adolescents (25-30%) are becoming test-anxious and this may interfere with educational or vocational success over time (1). In this paper we are presenting preliminary results of 7-session cognitive group therapy research for test anxiety. The data of this poster derived from first 2 completed group process.

Method

Participants were 24 test-anxious adolescents referred to Adolescent Outpatient Clinic of Bakirkoy Research and Training Hospital for Psychiatry and Neurology between January 2011 and March 2011. They were assessed according to application turn and instructed about group therapy research programme. Participants who accepted the conditions assigned into two groups and were attended in a 7-session cognitive group therapy program with weekly 90 minutes sessions. Therapy process executed by a supervised cognitive therapist. Therapy sessions configured as mentioned below:

Session 1: Acquaintance, explaining the rationale of group therapy, normalization of the emotions and anxiety

Session 2: Working on physiological, behavioral and cognitive aspects of anxiety , rationale of homework

Session 3: Realizing the automatic thoughts, rationale of cognitive distortions , homework

Session 4: Working on the negative automatic thought records,

Session 5: Other cognitive restructuring techniques , homework

Session 6: Working on the negative automatic thought records with cognitive restructuring techniques,

Session 7: Evaluation , blueprint

Participants were evaluated before and after each cognitive intervention by Text Anxiety Scale, Beck Anxiety Scale (BAI), State-Trait Anxiety Inventory, Ruminative Thought Style Questionnaire and Automatic Thought Scale. Statistical analysis performed by SPSS 13.0 version. Friedman and Wilcoxon singed ranks tests were used to assessing data.

Results

The mean age of participants was 17.3 (±1,4) years (age range: 14-20 years) and % 91.3 (21) were female. One participant in the first group hasn't completed the therapy process and evaluation was done over 23 participants. Compared with pre-treatment scores Test Anxiety Scale, Beck Anxiety Inventory, Automatic Thought Scale and Ruminative Thought Style Scale total scores significantly decreased (Sig. 0.00) at the end of the therapy (Figure 1,2).Even though it is not significant, declines were determined in all other scale scores.

Discussion

Cognitive-Behavioral Therapy is one of the few effective methods that used in test anxiety treatment (2). However there is a few psychotherapy research that use only cognitive techniques for test anxiety (3). Evaluation of clients after each intervention will realize an important function for development of evidence based treatment in test anxiety therapy. During the therapy process, participants have difficulties in comprehending and internalizing cognitive distortions was determined. This may be related to a possible deficiency of adolescents' abstract thinking skills.

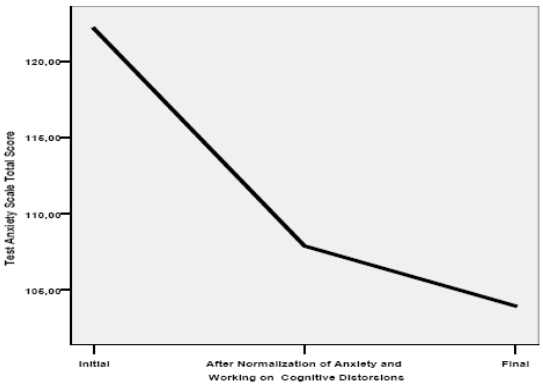

Figure 1. Course of Test Anxiety Scale mean scores .

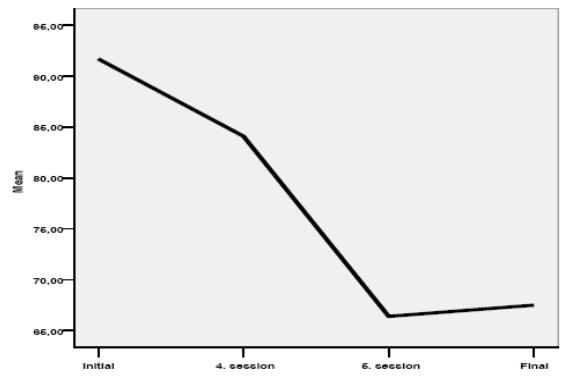

Figure 2. Course of Automatic Thought Scale mean scores .

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GRIEF FOCUSED COGNITIVE BEHAVIORAL THERAPY REDUCES GRIEF SYMPTOMS IN TRAUMATIC GRIEF PATIENTS

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Introduction: When death is unexpected, the interaction between grief and traumatic stress makes it difficult to process grief and traumatic grief (TG) is observed.[1] TG is a chronic and debilitating condition, which causes distress, worsens quality of life and has been linked to excess medical morbidity and suicidality. TG consists of the following symptoms that are observed beyond the first 6 months after the loss: yearning, confusion about one's role in life or diminished sense of self, disbelief, avoidance of reminders of the reality of the loss, mistrust to others, bitterness or anger, difficulty moving on with life, numbness, purposelessness and feeling stunned, dazed or shocked by the loss.[2] Both pharmacology and psychotherapy are used for the treatment of traumatic grief.[3] However it has been shown in traumatic grief patients that neither antidepressant medication nor interpersonal psychotherapy decreases grief symptoms. By contrast, randomized, controlled trials of psychotherapy designed specifically for TG have demonstrated efficacy for symptom reduction. The aim of this study was to present the results of grief focused cognitive behavioral therapy in 10 patients with traumatic grief, referred to treatment for symptoms of depression and anxiety because of unresponsiveness to medical treatment

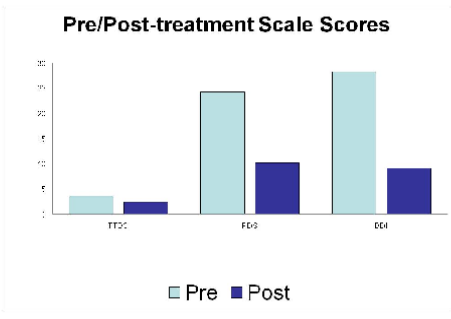
Method: The study sample consisted of 10 traumatic grief cases. Diagnostic assessments of the patients were based on the Structured Clinical Interview for DSM-IV. The patients received the Two-Track Model of Bereavement Questionnaire (TTBQ), the Posttraumatic Diagnostic Scale (PDS) and Beck Depression Inventory (BDI) before and after the treatment phase. The differences in pre- and post-treatment scores were analyzed with Wilcoxon Signed Ranks Test. 6 to 12 sessions of semi-structured grief focused cognitive behavioral therapy were administered to the patients. The patients continued with their standard treatment. The goals of traumatic grief treatment included reducing the intensity of grief, facilitating the ability to enjoy fond memories of the deceased, and supporting reengagement in daily activities and relationships with others. Intake interview included a detailed account of the death, as well as a chronicle of the relationship with the deceased and a review of current relationships. The symptoms of traumatic grief were described, along with the rationale for the treatment. Cognitive behavioral therapy techniques included repeated retelling of the story of the death (writing an essay and reading daily), working on confronting avoided situations (cemetery visits, cooking deceased's favorite dishes, working with the photographs and belongings of the deceased), imaginal conversations with the deceased and working on memories, scheduling pleasant activities to overcome numbing and purposelessness and behavioral-skills training to overcome the difficulties on daily tasks. Breathing exercises and relaxation exercises were used to facilitate therapy. At the end of treatment, progress was reviewed to ensure that the subjects were now able to access comforting memories about the deceased and hopelessness about the future, feelings of guilt and worthlessness and social isolation were reassessed.

Sample Case I: 28 year-old housewife
Loss: 82 year-old grandfather died of cancer within 4 months
Symptoms: depressive mood, feelings of guilt and being shocked by the unexpected death, talking excessively about the deceased, placing his photographs all over the house, not being able to visit her grandfather's community because of hallucinations about him, not being able to visit the cemetery because of the fear of pain .
Intervention: The period from the time of the diagnose to the time of the grandfather's death was reviewed with the patient and cognitive distortions were detected and cognitive restructuring was applied. Gradual desensitization was achieved through the task of writing a letter about the experience of loss and reading this letter regularly. An imaginary visit to the cemetery was conducted and cemetery visits were planned. At the end of therapy the patient was able to store away her grandfather's photographs and the feelings of guilt had subsided.

Sample Case II: 59 year-old widow
Loss: Lost a son 5 year ago due to an accidental stabbing
Symptoms: social withdrawal, loss of trust and love towards people other than relatives, yearning for the son, loss of meaning in life other than the desire to avenge his death, carrying a gun, thinking about her son all the time, avoiding downtown and their last meeting place, feelings of extreme distress when came across with the busses of the bus company that her son had been working at.
Intervention: An imaginal interview was conducted between the patient and her son about her feelings of revenge. Gradual desensitization was planned in the form of visits to the downtown at the end of which she visited their last meeting place where she said farewell to her son. At the end of the therapy she stopped carrying a gun and began to form meaningful relationships with other people.

Results: The mean age of the patients was 40.9 (SD=12,1, range=26-59) and eight of them were female. The mean time since the death associated with the grief was 5.9 (SD=5,22 range=9 month-14 year 9 month) years. Eight of the losses had been due to unnatural causes. Nine cases had lost a first degree relative and four had lost their children. All of the cases had received previous medical treatment for anxiety and/or depression. The subjects' mean number of current DSM-IV axis I diagnoses was 1.1 including major depressive disorder in 6 and posttraumatic stress disorder in 5 subjects. All the subjects met the traumatic grief criteria as described by Prigerson et al. Significant pre/post-treatment differences were found for the Two-Track Model of Bereavement Questionnaire, the Posttraumatic Diagnostic Scale and Beck Depression Inventory scores. (TTBQ: z=–2,803, p=0.005; PTDS: z=-2,809, p=0,05; BDI: z=-2,805, p=0,005)

Discussion: Although there is evidence that the symptoms, risk factors, clinical correlates and intervention responses of TG are distinct from MDB or PTSD, at present, grief is not recognized as a mental disorder in the DSM-IV or ICD-10 which causes difficulties in detection and treatment of TG patients by clinicians. In our study the co-occurrence of MDD and/or PTSD and the administration of antidepressants prior to therapy were in parallel with the literature. Antidepressant treatment had partially alleviated symptoms of depression and anxiety; however, traumatic grief symptoms were observed to be unresponsive to medication. At the end of the grief focused cognitive behavioral therapy significant improvement was observed in traumatic grief symptoms and a further improvement was observed with the depression symptoms. We present these results to draw attention to the importance of grief focused therapies in traumatic grief and to share the concept of traumatic grief focused cognitive behavioral therapy as an effective treatment strategy.



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Treating small animal phobia in a 10 year old girl using images, a video game, and augmented reality before in vivo exposure: A single case study

Paloma Rasal[1], Cristina Botella[1,3], Juana Bretón[3], Rosa Baños[1,2], Ana Isabel Agustí [3]

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The most effective treatment for specific phobias is in vivo exposure (IVE), however, not all patients benefit from it. Through the last years new ways of applying exposure using new information and communication technologies (ICT's), such as Virtual Reality (VR), have shown to be at least equally effective than IVE. Augmented Reality (AR) shares some advantages with VR, nevertheless it offers additional advantages over VR: it is not necessary to model the whole real environment, [1], it gives a greater feeling of presence and reality judgment than VR because the environments and the elements the patient uses to interact with the application are real. However its efficacy has not been studied with kids yet. Serious games (computer games) are another possibility that can be used to facilitate learning and psychological treatments.

OBJECTIVE

This work presents the results of an N=1 design to analyze whether the use of AR and a computer game can facilitate the treatment of small animal phobia for a kid.

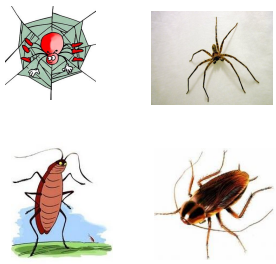


Figure 1. "Cockroach and Spiders images

Figure 2. Spider Game

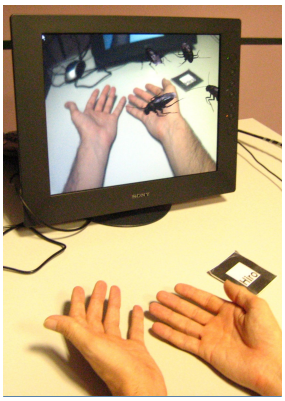


Figure 3. Augmented Reality System.

METHOD

Participant: A 10-year-old girl, diagnosed with small animal phobia (DSM-IV-TR).

Measures:

Subjective Units of Discomfort Scale (SUDs) [2]. The participant rated her level of anxiety on a scale from 0 ("No anxiety") to 10 ("Extreme anxiety") throughout the whole assessment and treatment stages. She also registered her level of avoidance and belief in the catastrophic thought on 0-10 scales.

Fear of Spiders Questionnaire (FSQ) [3]. It assesses the severity of spider phobia and consists of 18 items rated on an 8-point Likert scale ranging from 0 ("I totally disagree") to 8 ("I totally agree") for situations related to the fear of these creatures. For this study, an adaptation of this questionnaire (in which all items were referred to as cockroaches) was used.

Spider Phobia Beliefs Questionnaire (SPBQ) [4]. It is a self-report scale composed of 78 items rated on a 0 ("I do not believe at all") to 100 ("I absolutely believe it") scale. It includes two subscales: items 1-42 assess the strength of fearful beliefs about spiders; items 43-78 measure the strength of fearful beliefs about one's reaction to encountering spiders. For this study an adaptation of this questionnaire in order to assess fearful beliefs about cockroaches was used.

Behavioural Avoidance Test (BAT) [5]. It assesses the level of fear, avoidance and belief in the catastrophic thought related to the main target behaviour

Spiders and Cockroaches images: Images related with the feared animal were collected. The images were showed to the girl progressively, from cartoon to more realistic. Figure 1 shows some of the images selected.

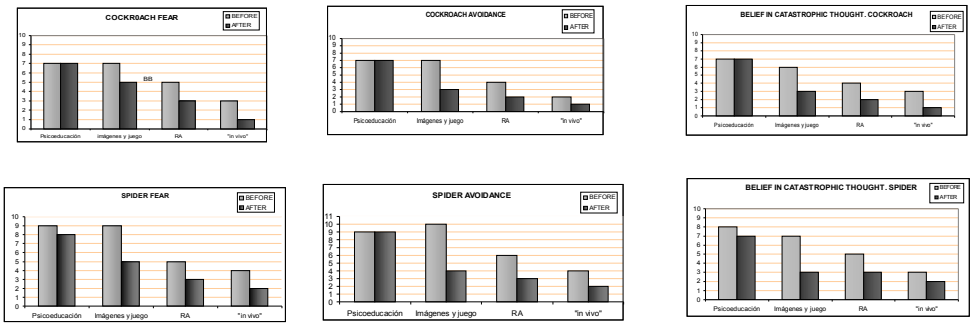
Spider game: A spider computer game was given to the girl to play with it. Figure 2 shows the spider from the game.

Treatment and Procedure: sessions the participant registered on a 0-10 scale her level of fear, avoidance and belief in the catastrophic thought in a 15-day base line period. The 1st treatment session was focused on psychoeducation. In the 2nd treatment session the child was exposed to images related to the feared small animals and she also used a spider game. During the 3rd and 4th sessions AR (figure 3) and in vivo exposure were applied. The girl was evaluated with the BAT before and after each session.

RESULTS

Results obtained for the level of fear, avoidance and belief in the catastrophic thought are presented in Figure 4. In the 1st session (psychoeducation) the clinical variables did no change except for spider fear and belief in catastrophic thought that decreased after the session. It is observed a significant decrease after the session in all clinical variables in the other three sessions both for cockroach and spider phobia. All therapeutic gains were maintained at the 1-month follow-up treatment

Figure 4. Fear, avoidance and belief along the case study design.



CONCLUSIONS

AR has showed its efficacy for the treatment of different phobias.

This study shows the importance and utility of reducing the levels of fear, avoidance and belief in catastrophic thought of other multimedia tools such as internet images and games, before exposing a girl to AR.

Graduating the therapeutic intervention in this way increases the sense of efficacy and the treatment is assessed as low aversive by the 10 year old girl. Also it opens a new way of applying psichological treatments that may be useful for kids.

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THE USE OF INFORMATION AND COMMUNICATION TECHNOLOGIES SUPPORTING ACTIVITY PACING IN THE PSYCHOLOGICAL TREATMENT OF FIBROMYALGIA

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INTRODUCTION

Fibromyalgia is a chronic pain condition which causes a negative impact in the patients' quality of life. Cognitive-behavioral interventions have been developed for the treatment of FM. Despite the good results achieved with these interventions, they are still scarce and there is room for improvement (Glombiewski, et. al., 2010). Information and communication technologies (ICTs) can help to improve the effectiveness of CBT interventions. Our research team has developed a virtual reality program using an adaptive display for the delivery of a behavior activation component. The idea is to use multimedia cues to induce a sense of vigor and energy in order to promote motivation and behavior activation. This component constitutes an adjunct to the activity pacing component.

OBJECTIVE

TO PRELIMINARILY TEST THE UTILITY OF A VIRTUAL REALITY (VR) COMPONENT FOR BEHAVIORAL ACTIVATION IN THE TREATMENT OF FIBROMYALGIA

METHOD

SAMPLE

Twelve women diagnosed with fibromyalgia according to the American College of Rheumatology (ACR, 1990), with an age ranging from 37 to 66 years (mean= 55.09 SD = 9.69). They have suffered from chronic pain for a mean duration of 12.36 years (SD = 7.46). Out of the 12 patients, 3 were active workers, 6 were housewives and 3 did not work. With regard to the educational profile of the participants, 4 had no education certificate, 4 had elementary education and 4 had high school education. Two participants dropped off because of medical issues not related with fibromyalgia.

MEASURES

In order to test the effect of the VR component, the participants rated several questionnaires before and after treatment:

- *Fibromyalgia Impact Questionnaire (FIQ, Bennet, 2005)*
- *Survey of Pain Attitudes (SOPA-32, Jensen & Karoli, 2006)*
- *Quality of Life Inventory (QLI, Mezzich, Cohen & Ruiperez, 1999)*
- *Profile of Mood State (POMS, Andrade, et al., 2008)*
- *General Self-efficacy (GSE, Sherer, et al., 1982)*

TREATMENT

The treatment program consisted of 6 two-hour therapy sessions administered in three weeks (2 sessions per week), to two different groups. As part of this program, a virtual reality component, designed by our team, was incorporated at the end of each session to induce positive emotions and increase behavioral activation (BA). The induction lasted approximately 20 minutes.

SESSION 1	Psychoeducation component
SESSION 2	BA training
SESSION 3	BA training. Mindfulness training. ***Induction of Positive Emotions***
SESSION 4	BA training. Mindfulness training. ***Induction of Positive Emotions***
SESSION 5	BA training. Mindfulness training. ***Induction of Positive Emotions***
SESSION 6	BA training. Mindfulness training. ***Induction of Positive Emotions***

VIRTUAL ENVIRONMENT´S DESCRIPTION

Emma's World is a Virtual Reality system (Adaptive display). There are five different pre-defined scenarios: a desert, an island, a threatening forest, a snow-covered town and a meadow. The environments have been designed to be related to different emotions in order to adjust the treatment to the characteristics and needs of each person or disorder. In this study we have used two of this five scenarios, the meadow and the island with specific music, sounds, colours, videos and images to induce a sense of vigour and energy in order to promote motivation and behaviour activation. This component constitutes an adjunct to the activity pacing component, which aim is to promote motivation and behavior activation with regard to meaningful activities.

RESULTS

A d-Cohen test for related samples was calculated to examine preliminarily the pre- post treatment results. They indicated an increase in quality of life (d= -0.7986). Regarding self efficacy an increase in behavioral initiation (d= -0.5206), effort (d=0.4582) and persistence (d= -0.5721) were found. In SOPA scale a decrease in disability (d= 0.8171), item 32 (d= 0.7213), a moderate decrease in solicitude (0.4629) and a moderate increase in medication (d= -0.4310) were observed. Finally, moderate effects were found in the POMS scale: an increase in vigour (d= -0.433) and a decrease in depression (d= 0.4407). Although it was a decrease in the FIQ it was marginal.

	n	PRE M (SD)	POST M (SD)	d Cohen
FIQ	10	59,96 (21.44)	55.67 (20.28)	0.2055
SOPA				
Control	10	2.11 (0.46)	2.32 (0.59)	-0.3973
Disability	10	2.99 (0.74)	2.30 (0.94)	**0.8171**
Harm	10	1.53 (1.18)	1.33 (0.86)	0.1943
Emotion	10	2.8 (1.03)	2.5(0.81)	0.3210
Medication	10	2.63 (0.71)	2.93 (0.68)	**-0.4310**
Solicitude	10	2.26 (1.38)	1.7 (1.01)	**0.4629**
Medical Cure	10	2.88 (0.66)	2.96 (0.65)	-0.1272
Item 31	10	2.8 (1.40)	2.4 (1.51)	0.2753
Item 32	10	2.5 (1.6)	1.35 (1.58)	**0.7213**
QLI	10	4.95 (0.92)	5.93 (1.47)	**-0.7986**
POMS				
Vigour	10	4.22 (4.6)	6.5 (5.83)	**-0.4333**
Depression	10	11.7 (9.7)	7.8 (8.2)	**0.4407**
Anger	10	14.5 (4.3)	16 (5.65)	-0.2867
Fatigue	10	11 (7.03)	10.1 (5.78)	0.1397
Confusion	10	8.22 (12.9)	6.7 (9.40)	0.1346
GSE				
Behavioral Initiation	10	8.6 (3.9)	10.2 (1.75)	**-0.5206**
Effort	10	13.2 (4.9)	10.7 (5.92)	**0.4582**
Persistence	10	11.7(3.83)	13.6 (2.71)	**-0.5721**

CONCLUSIONS

These findings are promising and indicate that the treatment with the designed ITC-based component provoked the expected effects in pre–post treatment evaluation: it improved perceived quality of life and self efficacy and reduced the disability feeling in patients. The VR system had an effect in the addressed issues. Although there were no big changes in pain interference, by increasing moderately positive emotions (vigour) and reducing negative emotions (depression), patients experienced a higher sense of self-efficacy, more positive attitudes towards fibromyalgia (decrement in linking chronic pain with disability and in the need of asking for help, SOPA), and an increment in their perceived quality of life. These results are encouraging in order to include this ITC- component as an adjunct to the activity pacing component in the psychological treatment of FM.

The comparison of effects information Processing therapy and instruction of Communication skills in reducing depression

Anisi Khoshlahje Sedgh
(Iranian psychologist)

Method:

Semi experimental method with pretest and posttest design was applied in this research. The variables like their grade and gender were kept the same in three groups. The sample was drawn from the all of the depressive women who have 20-35 old. The sample comprised 45 individuals who were sampled by multi-stage random sampling and randomly classified into three groups. All of subjects completed that the "BDI II Tests". The first experimental group received the information processing Therapy in 1:30 hours a week during 20 weeks and the second one were spent 20 sessions for instruction communication skills. Researcher made a package for therapy. The content validity of this package was checked and confirmed by experts. The sessions of information processing are made based on models of memory such as Atkinson-Schifrin's model and Baddeley-Hitch's models about memory. Second experimental group received the communication skills (1:30 hours a week during 20 weeks). Control group received nothing instruction and therapy and after 20 weeks was tested with posttest. The individuals in three groups used anti depression drugs across the research.

Results:

The information was analyzed with MANCOVA. The results showed that there were significant differences between 3 groups. The means of depression in the first group less than another experimental group and control group. In other word the information processing therapy leads to decreasing of signs of depression in comparison to the method of instruction of communication skills.

Discussion:

In this research the method of information processing therapy was applied in order to helping to depressed patients. Some of strategies were applied were:

1. Reconstructing of memories by story telling
2. Change of automatic processing to control processing by emphasizing on the role of short term memory as a central executive, and its control on information processing such as encoding of internal and external cues, change of method of interpretation of inputs, attention to and activation positive interpretation, and selection of appropriate response.
3. Attention to visual- spatial and phonological sketches, according to Baddly and Hich's theory about model of memory.

The results indicated that the information processing therapy respectively lead to reduction of symptoms of depression in comparison to instruction of communication skills and control group.

In this research, the results are adjusted to many of research, such as Williams and colleagues' research (1997) about the memory biases in depressed people and Li and Schafer's research (2004) about the differences between depressed people with normal subjects in information processing biases. And with Wenzlaff and Eisenberg' research (2000) about negative thinking biases in depressed patients.

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Results:

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Cross Cultural Dialectical Behavioral Therapy (DBT): An Update on Acculturation; Treating Latinos with Borderline Personality Disorder with DBT and Culturally Sensitive Interventions.

Suhadee Henriquez, Aurora Farias, Ulises Ramirez, Amilcar Piña, Lynn McFarr

Harbor-UCLA Medical Center

Overview

We examined the therapeutic efficacy of a culturally adapted form of Dialectical Behavior Therapy (DBT) with the Latin American (Latino) population at Harbor-UCLA in Los Angeles, California. This poster focuses on Latinos' emotion regulation in DBT skills group. DBT identifies emotion dysregulation as central to the dangerous impulsivity of an individual with borderline personality disorder (BPD). The research indicates significant changes in clients reported emotional regulation between constructs (e.g., depressed, sad (hopelessness), anxious, calm, and happy) adult psychological adjustment (e.g., behavioral problems, social competence, and academic achievement) in the Latino population. These findings suggest that there are cross-cultural similarities in the developmental processes underlying behavioral problems with Latinos.

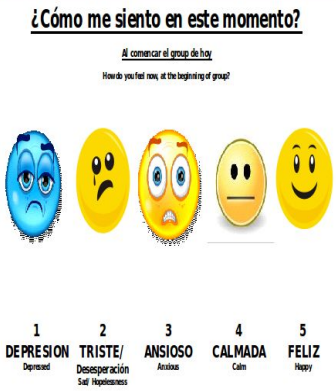
Patient Selection

All patients treated in the Spanish DBT program are initially referred to the AOP clinic where cases are opened when criteria for medical necessity is determined. Patients must have an Axis I diagnosis and exhibit impairment functioning at work, school, and/or interpersonally. Our client population are from mainly from Latin America and Brazil. This community is made up of people from many different nationalities, races, educational and socioeconomic levels.

Methods

The description of "Emotion Regulation" was calculated using a 5-item scale that assesses self-perceived ability to identify, manage, and adaptively use a variety of negative to positive mood states. Individuals used a 5-point scale (e.g., depressed face (1), sad (hopeless) face (2), anxious face(3), calm face (4), and happy face (5)) to respond to the statement, "When I arrive to skills group, "I feel "depressed (1), sad (hopeless) (2), anxious (3), calm 4), happy (5). Before leaving group individuals complete the scale in response to the statement "When I am leaving skills group I feel " depressed (1), sad (2), anxious (3), calm (4), and happy (5).

Methods/Scales



Cultural Adaptation

Several cultural adaptations have been made in order to provide culturally sensitive DBT treatment.

•*Cuentos* **(short stories)** are used as a part of mindfulness exercises or serve the function of metaphors.

•*Dichos* **(proverbs)** are incorporated in order to facilitate the understanding of a DBT skill. Interpersonal effectiveness sample: *Quien pide con timidez, invita a negar* (he that asks timidly, asks for a rejection response).

•"*La Loteria Mexicana*" **(Mexican Bingo)** was used as a culturally relevant token system designed to increase attendance, Diary Card completion, and homework compliance.

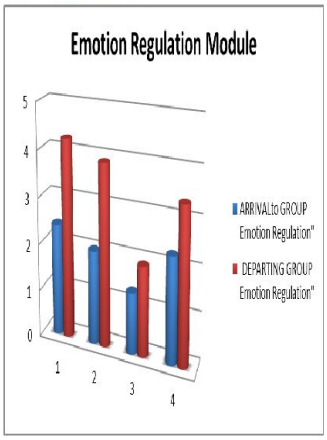
•*Personalismo* **(Personalism)**: this concept refers to the value of treating people with respect and dignity. It is demonstrated by communicating kindness, fairness, and personal interest in the clients.

•*Respeto* **(Respect)** implies deference to authority or a more hierarchical relationship orientation. *Respeto* emphasizes the importance of setting clear boundaries and knowing one's place of respect in hierarchical relationship (Santiago-Rivera et al., 2002).

•*Valores* **(Values)** Traditionally, the Hispanic family is a close-knit group and the most important social unit. The term *familia* (Family) usually goes beyond the nuclear family. The Hispanic "family unit" includes not only parents and children but also extended family. In most Hispanic families, the father is the head of the family, and the mother is responsible for the home.

Findings

Our findings suggest that clients reported a significant change in there emotions between time of arrival and time of departure of the Spanish DBT Skills group. Clients ability to regulate emotions appears to improve significantly from the time the client arrived to group session and the time the session was over. However, there is a growing need to continue research in culturally sensitive interventions targeting the Latino population. Understanding the varied processes involved in cultural adaptation is imperative to the success of these services.



Summary of the Program

Our culturally supportive DBT program considers whether the clients' goals support assimilation, acculturation, or biculturalism. It is unknown what is in the best interest of Latinos or how to best balance their positive cultural traditions with those of the U.S. mainstream culture while teaching them DBT Skills. To address some of these issues, we try to provide psychoeducation about mental health and stigma, innovative research data and the most accurate information about the traditions of Latino and how they inform and support healthy patient and family relationships. Questions still remain about these cultural traditions and how they vary by country, religion, and rural/urban living. Further acculturation also needs to be disentangled from issues of poverty, socio-economic status, ethnicity, and culture. This poster suggested that clients regulated their emotions during the course of the group meeting. Data does not indicate causal pathways of emotional regulation changes, however the goal for the therapist and the client is for the client to learn to regulate their emotions, practice and learn the DBT skills.

Harbor-UCLA DBT Spanish Program

Questions and further information please contact : harboruclaspanishdbt@yahoogroups.com

Predictors of Therapist Burnout in DBT: The Role of Secondary Targets

Rachel G. Higier1,2, Lisa A. Benson1,2, Sravya Mallam1, Laura Testerman2,3, Daniel Glenn1,2, Katie J.W. Baucom1,2, Jamie D. Bedics2,4, and Lynn M. McFarr2

1 University of California, Los Angeles, 2 Harbor-UCLA Medical Center, 3 Loma Linda University, 4California Lutheran University

INTRODUCTION

- Treating individuals with borderline personality disorder (BPD) is thought to place increased demands on the therapeutic resources, which in turn may result in high risk for burnout (Cleary et al., 2002).
- Linehan (1993) proposed six maladaptive behavioral patterns known as secondary targets that characterize BPD patients (see Figure 1). Given that secondary targets represent maladaptive response patterns in interpersonal interactions, it seems likely that these behaviors would also play out in therapeutic interactions and may consequently result in therapist burnout.

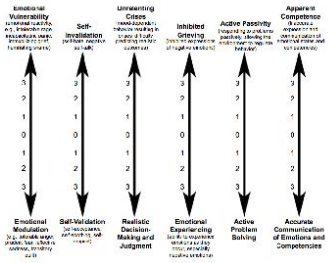


Figure 1. Secondary treatment targets adapted from Linehan (1993).

- To date, there is no established measure for assessing secondary targets. We created a continuum measure of each individual secondary treatment target ranging from healthy to unhealthy behavioral patterns.

Study Goals

- To determine the extent to which secondary treatment targets are intercorrelated, as previously theorized (Linehan, 1993).
- To explore how patient behavioral response patterns are associated with therapist burnout.

METHODS

Participants

- Pilot data was collected from N = 71 DBT therapists currently treating individuals with BPD polled from the international DBT listserv (https://lists.duhs.duke.edu/mailman/listinfo/dbt-l).
- Additional data were collected from N = 26 DBT therapists treating individuals with BPD working at a community mental health clinic in Southern California.

Measures

- Secondary Targets Scale
  - A 6-item Likert scale was adapted from Linehan's (1993) original description of secondary treatment targets (see Figure 1). Therapists were asked to rate each target ranging from unhealthy to healthy behavioral patterns based on the peak response of the unhealthy behavioral pattern. Behavioral anchors were provided, including a rating of zero to indicate no evidence for a given target. Ratings were based on patient reported behaviors or behaviors observed in-session.
- Therapist Burnout
  - A 1-item measure assessed overall level of burnout on a Likert scale ranging from one to seven.

Procedures

- Ratings were completed on a weekly basis over a six-week period.

RESULTS

	Emotional Vulnerability	Self-Invalidation	Unrelenting Crises	Inhibited Grieving	Active Passivity	Apparent Competence
Emotional Vulnerability (*M* = 4.32, *SD* = 1.49)		**0.580***	0.515*	0.238*	0.236*	0.312*
Self-Invalidation (*M* = 4.30, *SD* = 1.55)			0.522*	0.412*	0.433*	0.339*
Unrelenting Crises (*M* = 4.41, *SD* = 1.51)				**0.442***	0.604*	0.534*
Inhibited Grieving (*M* = 4.43, *SD* = 1.53)					0.521*	0.599*
Active Passivity (*M* = 4.28, *SD* = 1.55)						**0.531***
Apparent Competence (*M* = 4.31, *SD* = 1.51)						

Table 1. Intercorrelations between the secondary treatment targets. Correlations were calculated using Spearman's rho. Internal consistency of the secondary targets scale was shown to be good (Cronbach's α = 0.85). Analyses were conducted on N = 158 data points collected from 26 therapists over 6-weeks. Bold type indicates predicted intercorrelated patterns following Linehan (1993). *p < .05.

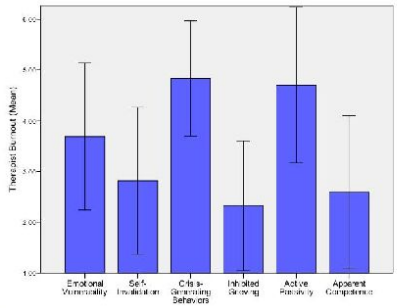


Figure 2. Pilot data from a secondary targets survey administered to N = 71 DBT therapists on an international listserv. Participants were asked to rank-order the secondary targets according to level of burnout (1=least burnout, 6=most burnout). Error bars represent +/- 1 standard deviation.

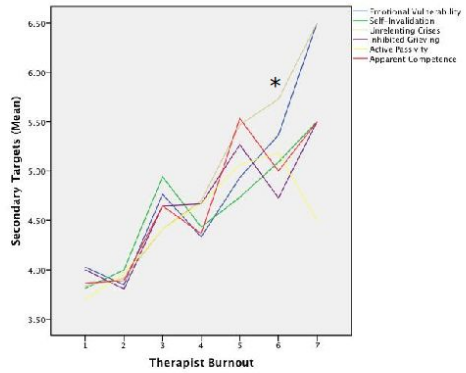


Figure 3. Analyses were conducted on N = 158 data points collected from 26 therapists over 6-weeks. Patient secondary treatment targets significantly predict therapist burnout ($F(6,151) = 6.57$, $p < .001$). Secondary targets explained 20.7% of the variance in therapist burnout ($R2 = 0.21$). In particular, unrelenting crisis significantly predicted burnout after controlling for the other secondary treatment targets ($R2 = 0.19$, $p = .008$). No other secondary target uniquely predicted burnout.

DISCUSSION

This study aimed to identify the extent to which secondary treatment targets were associated with therapist burnout. We created a continuum measure of secondary targets. Preliminary analyses indicate that crisis-generating behaviors and active passivity are associated with the highest levels of burnout. Additional data corroborate these results, showing unrelenting crises as the strongest unique predictor of therapist burnout. These results suggest that secondary treatment targets are an important consideration in addressing burnout in DBT therapists.

Limitations

- Preliminary analysis did not account for dependency of data nested within patients and therapists and across time. Final analyses will employ mixed modeling data analytic techniques.
- Participants included therapists treating BPD patients across different stages of treatment. It is possible the relationship between secondary targets and burnout changes across treatment.
- This study assessed therapists' perceptions of secondary targets. Future analyses will provide construct validity to the secondary targets scale, for example using patient data or coded therapy sessions.

Future Directions

- This study is part of a larger on-going study examining the association between secondary treatment targets and therapy-interfering behaviors and therapist burnout across the course of DBT.
- Measurement development and construct validation for the assessment of dialectical dilemmas in individuals with BPD.

Acknowledgements

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Potential Links Between DBT Skills Acquisition, Emotion Regulation & Length of Time in Comprehensive DBT Treatment

Lauren L. Jackson[1], Rachel G. Higier[1, 2], Suhadee Henriquez[1], Katherine J.W. Baucom[1, 2], Jamie D. Bedics[1, 3] & Lynn M. McFarr[1, 2]

[1]Harbor-UCLA Medical Center; [2]UCLA; [3]California Lutheran University

Abstract

In recent years Dialectical Behavior Therapy (DBT; Linehan, 1993) has been found to effectively reduce self-harm and suicidal behavior in people with Borderline Personality Disorder (BPD). Although the efficacy of DBT is well-established and there is some support for its effectiveness, little is known regarding the mechanisms of change for this treatment model. Researchers have theorized that emotion regulation and use of DBT skills may mediate changes in symptoms of BPD (e.g., Lynch et al., 2006). In the present study, researchers assess potential links between skills acquisition, emotional regulation, and length of participation in comprehensive DBT treatment. Therapists serving on an outpatient DBT Team at Harbor UCLA Medical Center will complete a self-report questionnaire evaluating their patients' perceived ability to regulate emotions and make regular use of DBT skills. Regression analyses will be used in order to investigate the relationship between these variables for individuals diagnosed with BPD receiving DBT in a community-based, outpatient setting.

Introduction

Recent research has estimated the lifetime prevalence of Borderline Personality Disorder (BPD) to be 5.9%, evenly distributed across genders (Grant et al., 2008). This makes BPD one of the most commonly seen personality disorders in the clinical population. According to the Biosocial Model of BPD, the central underlying cause of behaviors frequently demonstrated by those with BPD is a pervasive difficulty regulating one's emotions. Furthermore, theorists suggest that individuals diagnosed with BPD demonstrate significant skills deficits in the areas of emotion regulation, distress tolerance, interpersonal effectiveness as well as their ability to effectively redirect their attention. Given these skills deficits as well as the pervasive dysregulation experienced by those with BPD, the Dialectical Behavior Therapy (DBT) treatment model aims to increase the use of both acceptance and change-based skills in order to help individuals diagnosed with BPD "build a life worth living." Despite the importance of skills acquisition and emotion regulation in the DBT model, mechanisms of change have yet to be identified. The current study was conducted in order to collect pilot data assessing the feasibility of carrying out a larger study involving patient self-report of skill acquisition and emotion regulation over the course of comprehensive DBT Treatment.

Methods

Setting

The DBT Program in the Department of Psychiatry at Harbor-UCLA Medical Center is housed within an outpatient psychiatry clinic that serves a county hospital population. It includes all features of standard DBT and comprises about 30 therapists/patient pairs. Therapists range in experience from supervised graduate students to licensed clinicians.

Measures Used

The Therapist Perception of Emotion Regulation and Skills Use (TPERS) is a 28-item measure that assesses therapists' perception of patient emotion regulation in the following domains: mindfulness of emotions, emotional labeling, acceptance of emotions, judgment of emotions, validation of emotions, ability to skillfully refrain from mood-dependent behavior, and ability to regulate emotions through use of general DBT skills. These domains of emotion regulation were modeled off of the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004). This measure also assesses patient endorsement of regular DBT skills use, with "regular use" being defined as engaging in a particular skill one or more times per week.

Implementation of Measures

20 therapist-patient pairs were assessed at a single time-point. Patients were all diagnosed with BPD and receiving comprehensive DBT treatment at Harbor-UCLA Medical Center. Length of engagement in treatment ranged from 2 weeks to 2.5 years, with a mean of 11.55 months.

Results

Simple linear regression were conducted in order to determine if 1) total time in treatment predicts skill acquisition 2) total time in treatment predicts emotion regulation and 3) skill acquisition predicts emotion regulation. Furthermore, researchers also completed repeated measures analyses to see if there are differences in skill acquisition per module according to treatment time. Findings were as follows:

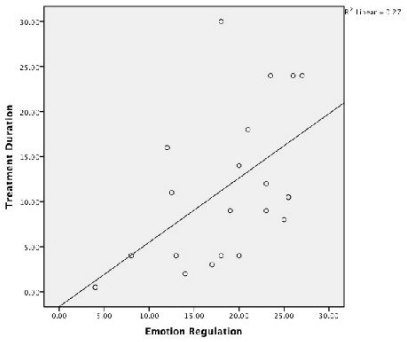

Figure 1: Total treatment duration does predict emotion regulation ($p < .02$) with treatment duration explaining 27% of the variance in emotion regulation.

Researchers evaluated whether DBT skill acquisition predicts emotion regulation after controlling for treatment duration. Results demonstrated that, for each extra skill learned, emotion regulation increased 1.057 points on the emotion regulation likert scale over and above time in treatment. There are no differences in types of skills acquired ($p = 0.868$), and there is no interaction between skill module and duration of treatment ($p = 0.953$).

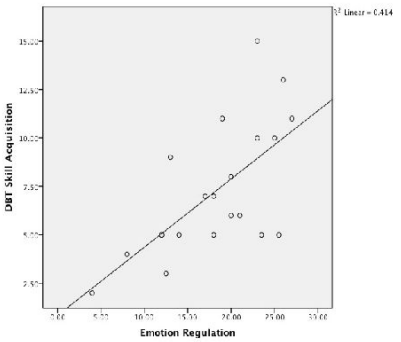

Figure 2: Skill acquisition predicts emotion regulation ($p < .002$) with DBT skill acquisition explaining 41% of the variance in emotion regulation.

Discussion

The purpose of the current study was to collect pilot data assessing the feasibility of carrying out a larger study evaluating potential mechanisms of action in DBT. Findings suggested that time spent in treatment significantly predicts emotion regulation; however, duration of treatment was not shown to be a predictor for skills acquisition. The lack of relationship between treatment duration and skills acquisition may suggest that individuals with longer treatment duration enter DBT with lower functional baselines or barriers to skills acquisition, such as cognitive deficits. An additional explanation for this finding may be that some DBT patients are more effective in shaping their individual DBT therapists out of emphasizing skills acquisition during individual therapy sessions.

Data from this study also suggested that skills acquisition is a significant predictor for emotion regulation. Furthermore, emotion regulation was shown to significantly increase the more DBT skills a patient has in their behavioral repertoire. Interestingly, findings did not point to a specific DBT skills module that increases the likelihood of emotion regulation. Rather, these data suggest that the more general DBT skills that an individual has, the more likely they are to be able to regulate their emotions. The clinical implications of these findings highlight the importance of emphasizing DBT skills acquisition across all modes of DBT therapy.

This study has limitations including rater bias, in which therapists may have over or underestimating patients' level of skill acquisition and/or emotion regulation abilities. Other limitations include the use of an unvalidated measure as well as a lack of baseline data.

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References available upon request.

PSYCHOTIC DISORDERS AND PHYSICAL HEALTH: ENABLING TREATMENT COLLABORATION

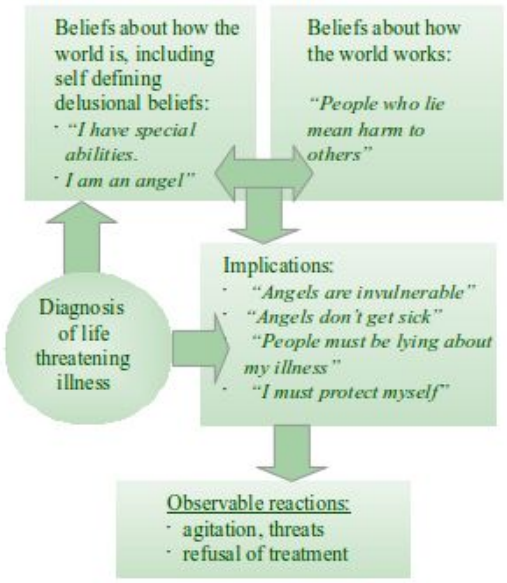
PRESENTING PROBLEM:

- Persons with psychotic disorders have higher incidence of physical health problems yet access treatment less frequently than general population.
- Consent to treatment may be obtained from a substitute decision-makers but treatment success depends on the affected person's ability and willingness to collaborate with the proposed plan of action.

"Sam" has a history of paranoid schizophrenia and lives in community where is supported by an assertive community treatment team. Sam has a long standing belief that he is an angel and that others want to experiment on him to study him. He generally has a good rapport with his workers but tends to become agitated whenever there are changes in his treatment regimen as he regards any treatment as unnecessary hassle that he has to put up with. His worker finally convinced Sam to attend his first physical in years and now Sam has to attend more appointments and take blood thinners due to diagnosis of deep vein thrombosis.

CASE CONCEPTUALIZATION AND INTERVENTION:

Figure 1. Sample Conceptualization



1. Understanding:
Developing a simple case conceptualization, like the one depicted in figure 1, assists with understanding Sam's reasons for treatment refusal. It also shows that focus on behaviour management and health education is not likely to promote treatment adherence while forced treatment with substitute consent is likely to reinforce beliefs of hidden agendas and unique physiology.

2. Selecting target cognitions
Sam attaches great value to being an Angel and it is not necessary for him to change this belief in order to accept treatment. Instead, the target cognition is a belief that "angels do not get sick". This can be tackled by discussing client's prior experiences (flu, headache) while also taking care to monitor what belief is formed to replace the original delusional assumption.[2] Some typical obstacles to treatment compliance along with specific intervention strategies are listed in Table 1.

3. Clarification of treatment preferences
Some clients have very hard time discussing treatment preferences when it comes to their own illness. Presenting them with examples of people in similar circumstances and asking what choice would they make if they were the person in the example tends to produce good discussions.

4. Implementation as desensitization and renegotiation process
Implementation of treatment plan can still be difficult and should be treated as a desensitization process. Many clients have hard time tolerating medical settings and need to be familiarized with the environment. Such exposure exercises can be used to demonstrate trustworthiness of staff as the person is not detained against their wishes and has an opportunity to talk to other patients about their reasons to attend appointments.

Table 1. Typical Obstacles to Treatment Compliance

	Impaired awareness of physical changes	Understanding of Body Functions	Beliefs about purpose of illness	Beliefs about treatment	Life philosophy
Presentation	· Long term persistent sensations may become unnoticeable · Pattern of self-neglect leaves the person unresponsive. · Presence of cognitive impairment may add to the person's inability to respond.	· Somatic delusions · Health anxiety and panic · Bizarre explanations and meanings may be attributed to routine body functions. · Belief in having unusual physiology	• Clients may attach special meanings to the purpose of the illness. • The meaning and purpose of the illness may be influenced by the experience of voices	· Treatment providers may be viewed as having hidden agendas; · Unusual treatment methods may be requested by client.	· Impact of spiritual or religious beliefs and practices on understanding of death, illness and pain · Personal preferences and values
Intervention	· Assist with monitoring of physical health status · Provide rationale for monitoring · Assist client with developing baselines · Implement strategies that compensate for cognitive or functional deficits	· Develop awareness of client's perceptions, including vocabulary used by client. · Present health information as alternative explanations that can be tested together with client	· Self-punitive attributions: negotiate what can be done to get a justified reprieve from the punishing forces. · Self-enhancing attributions: target contingency between self-respect and illness. · Voices: address the predictive nature of voices and the power they are perceived to have.	· Explore and tests beliefs about providers' intentions. · Clarify treatment plan. Ensure predictability. · Can client's requests be incorporated without negative impact on health?	· Find out client's belief system (including "religions of one") · Explore preferences · Use vignette method if personal questions cannot be tolerated

OUTCOME:

- Attempts at health education and work with self-defining delusional beliefs had little impact on unwillingness to participate in treatment.
- Interventions that allowed for regarding of medical procedures as justified without challenging the overarching beliefs increased collaboration and reduced frequency of behavioural escalations.

REVIEW AND EVALUATION:

- Case reviews hint that barriers to collaboration can be attributed to: (1) beliefs about own physiology and powers, (2) beliefs about meaning of the illness; (3) insistence on special cures, (4) distrust of others, (5) inability to recognize physical symptoms, and (6) inability to follow the organizational rules while receiving care.
- This area requires more investigation - it offers an opportunity to decrease unnecessary distress and confrontations between treatment recipients and providers, and may increase access to needed medical care among persons with psychotic illnesses.

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Efficacy of Parent Skills Training via TTT Model on Parent Stress and Behavior Problems of Preschoolers (A Preventive Community-Based Program)

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INTRODUCTION

Prevalence of behavior problems in preschoolers is reported 24/4 % which 9/1% of those have severe behavior disorders (Lavigne et al., 1996).

Parent Skills Training (PST) program used in this project is a community-based program that aims to prevent the development of conduct problems by promoting positive parenting and child developmental competence. Based on cognitive-behavioral parent and child programs with demonstrated effectiveness, skills training includes a 10-week parenting package which has 18 skills in 6 domains and instruction guideline which is applicable for children with and without behavior problems (Bloomquist, 1996, 2006).Since this program has not been validated in a randomized controlled trial and our preschools have not a systematic prevention program, the authors decided to implement this project via a Train-The-Trainer(TTT) model.

METHOD

Participants

The 14 preschool of welfare organization were initially randomly assigned to participate in one of the two groups. Randomization within area was done to ensure that equal numbers from each area were assigned to each group.PST group included 7 preschools with 160 mothers and waitlist group included 7 preschools with 130 mothers.43 children Of training group and 41 ones from control group got the score above the CBCL cut-off points. Each preschool introduced one to three educators for participation in training program.

Measures

1) **Demographic & Distal Risk Factors Questionnaire for Children** (Tahmasebi, et al., 2005).

2) **Child Development Questionnaire** (Bloomquist, 2006): which includes 60 items & 6 domains. Each domain assessed with 10 questions. Cronbach's alpha reliability coefficients were .86 (self-control), .82 (social), .88 (emotional), .89 (academic), .82 (wellbeing) and .84 (family relationships). In previous research, the CDQ subscales were found to correlate significantly with the CBCL (Tahmasebi et al., 2008).

3)**CBCL**: The Iranian norm of CBCL for preschoolers provided by Tahmasebi, Fata, Tahmasian, Asgarnejad(2008)which showed significant reliability(above .80).

Procedure

Two 5-day workshops which included educators training program performed for educators. Because of facility in training generalizability, location of workshops were in the kindergartens. Informed consent was obtained from all participants (mothers, preschool headmistresses and educators) in accordance with human subjects research guidelines. It is considerable that according to the APA ethic codes educators of waitlist control group same as PST group trained but after follow up assessment.

RESULTS

Confounding demographic and pretest variables based on their measurements set as fixed factors or covariates in MANCOVA to moderate their effects. All of the CDQ scales of PST excepting emotional and academic development decreased at post-test and maintained this reduction at follow up. Emotional and academic development started their reductions from follow up. In CBCL scales of PST only somatic complaints and thought problems did not decrease. CDQ and CBCL scales of control group did not change markedly at post and follow up test. There were significant differences between the two groups at post and follow-up tests on wellbeing, family relationships, self-control, and social scales of CDQ. Significant differences between conditions at post-intervention and follow up were found for all measures of CBCL other than somatic complaints, delinquent behavior and thought problems. The eta-square effect size estimate indicated that the group factor accounted for 20-97% of the variance in dependent variables which decreased significantly.

DISCUSSION

The results of this study support the notion that dysfunctional parenting practices play a central role as a final conduit for multiple risk factors known to be associated with the etiology and maintenance of disruptive disorders (Sanders et al., 2000). Patterson (1995) has demonstrated the vital relationship between ineffective parenting practices and antisocial outcomes(i.e., when parents are taught effective discipline strategies, there is close covariance with the magnitude of change in child antisocial behavior).Improvement of developmental knowledge and attitude of parents, parent wellbeing and family relationships produce a developer context for parent-child system to utilize evidence-based strategies for teaching and learning self-control and social skills which accounted for PST effect on self-control, social and behavior problems.

Overall the results obtained in this study support the use of PST in TTT model for preschool children with development and behavior difficulties and shows that educators and teachers can transmit mental health materials effectively and inexpensively, provided, policy makers supply relevant rules and financial resources.

Effective summer camp programs for special support class students in the junior high school

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Sora Hashimoto (Department of psychology and humanities, College of sociology, Edogawa University, JAPAN).
KEY WORDS: developmental disorder; summer camp; group dynamics; junior high school.

Introduction:

After 2002, Japanese school reform includes establishing systems to support students with developmental disorders. Now, less support classes do summer camp than from 1980s to 1990s. But many students, their family and teachers actually feel the effect to attend the summer camp. The main purpose of our study is to examine the effects of the summer camp program on them and to develop the program for support class students.

The main purpose of our study is to examine the effects of the summer camp program on them and to develop the program for support class students.

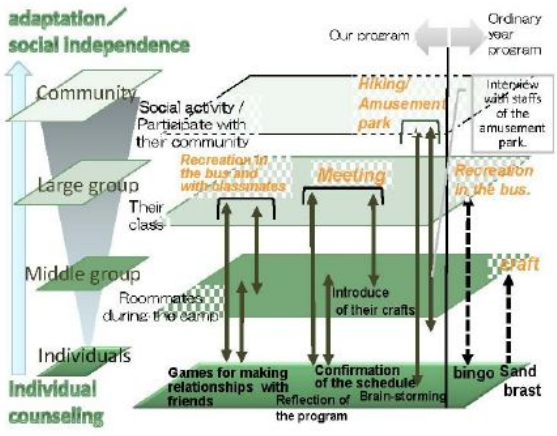
Method:

We investigated the questionnaire as a pre-test before the camp program, and as a post-test after the camp program. And we observed them concerning their behavior during the camp program.

Participants:

16 students (8 boys and 8 girls) from a support class. They were 7th to 9th grade. Their support class was set up in a public school and located in metropolitan area of Tokyo.

Figure 1. Structure of our camp program:



When? : The summer camp program and 2 times questionnaires were held in September 2010.

The questionnaires included 78 items.

1. Their reasons why go to school.
2. Their behavior and their emotion.

Results:

During the camp program, we noticed:

1. None of participants of the camp program dropped out.
2. The participants hardly used the school nurse's room.

And it was showed that the reasons to go to school were different later before the camp program. Before the camp, they went to school by the obligation, and after the camp, they went to school because they feel happy at their class and they were looking forward to seeing their friend at their class.

Discussion:

In this summer camp at the ordinary year, some students dropped out and returned to home in Tokyo. And the availability of the school nurse's room was very high. But in this summer camp program, such a phenomenon was not seen. It is thought as these three reasons.

We intended making to the program contents structure.
We intended making to staffs' role structure.
We did to consider the group management.

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THE EFFECTIVITY OF COGNITIVE REHABILITATION ON THE TREATMENT OF PATIENTS DIAGNOSED WITH SCHIZOPHRENIA AND ON PSYCHOSOCIAL FUNCTIONING

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INTRODUCTİON: Improvement in cognitive deficits must be one of the most important treatment goals in schizophrenia. Cognitive impairments are the core feature of chronic schizophrenia since the time of Bleuler and Kraepelin. These deficits are present at disease onset, stable over time. Cognitive deficits are thought to play a central role in the social disability and other problems in daily living experienced by patients with schizophrenia. Although there is evidence that atypical antipsychotic drugs may produce some improvement in selected areas of cognitive performance, antipsyhotic medications do not eliminate cognitive deficits. Thus, amelioration of neurocognitive deficits has been posited to be an important treatment goal in schizophrenia. To address the problem of cognitive impairment in schizophrenia, a range of cognitive remediation programs has been developed and evaluated over the past 40 years (1,2). Cognitive remediation aims to rehabilitate impaired cognitive functions. A variant of the cognitive process targeting approach is included as acomponent in a more comprehensive psychosocial treatment modality, Integrated Psychological Treatment for Schizophrenic Patients (3).

OBJECTİVE: The aim of the present study is to assess the effect of cognitive differentiation and social perception sub programs of "Integrated Psychological Treatment for Schizophrenic Patients (IPT)" on symptom control and psychosocial functioning among patients with schizophrenia.

RESULTS: There was no difference socio-demographic datas between the patients in the study and the control groups. At the end of the study, PANSS scores were found to have been declined for both groups. The decline was statistically significant in the study group. There was statistically significant increase in the study group in terms of the Quality of Life Scale ($p<.05$) (see Table 2). The evaluation of Social Functioning Scale scores were higher in the study group and the difference was statistically significant ($p<.05$). Likewise, the improvement in Global Assessing of Functioning Scale in study group after treatment was found to be statistically significant ($p<.05$), (see Table 1).

METHOD: 60 schizophrenic outpatients who were in remission participated to the study. 30 patients assigned to the study groups and 30 patients assigned to the control groups randomly. The aim of the study was shared with all of the participants and written informed consent was obtained. IPT was carried out twice weekly for three months in the study group along with other therapies running in day hospital (Psychiatric Rehabilitation Center) and in Schizophrenia Association. The patients in the control group recieved only the routine therapy modalities held in either of the two settings.The following forms were used: a sociodemographical data form, Postive and Negative Syndromes Scale (PANSS) to assess the symptom. Functioning Scale, The Quality of Life Scale and Global Assessment of Functioning were used to evaluate psychosocial functioning. Five patients leaved from study group and three patients leaved from control group in the duration of research.

DİSCUSSİON: We found statistically significant improvement in psychosocial functioning, in symptom (severity), and in cognition and the improvement in the symptom severity and psychosocial functioning was particularly more significant. The changes observed in sypmtom severity, psychosocial functioning may be correlated with the effects of cognitive differentiation and social perception subprograms included in IPT and the improvement may also be due to the other treatment modalities running in the rehabilitation center. The results from our study suggest that cognitive rehabilitation should take place in the long run with frequent and systematic course in rehabilitation practice along with the other methods.

Table-1 Global Assessing of Functioning Scale

		Study Group n	Study Group %	Control Group n	Control Group %	
Pre test score	61-70	4	16.0%	7	25.9%	χ^2:0.767
	51-60	21	84.0%	20	74.1%	p: 0.381
Post test score	61-70	21	84.0%	8	29.6%	χ^2:15.5
	51-60	4	16.0%	19	70.4%	p: .0001
Mc Nemar's		.0001		.598		

Table 2

		Study Group x±Ss	Control Group x±Ss	t	p
The Quality of Life Scale Total Point	Pre test	60.60±12.90	61.56±13.01	0.27	.792
	Post-test	69.08±11.97	59.63±13.53	2.56	.011
	t	-6.08	1.07		
	p (2)	.0001	.290		

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THE EFFECTIVITY OF COGNITIVE REHABILITATION ON NEUROCOGNITIVE MECHANISM IN SCHIZOPHRENIC PATIENTS

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Introduction: Cognitive deficits are thought to play a central role in the social disability and other problems in daily living experienced by patients with schizophrenia. Improvement in cognitive deficits must be one of the most important treatment goals in schizophrenia. Furthermore, cognitive appears to be associated with negative symptoms of schizophrenia. Impaired cognition may be a "rate-limiting factor" in the succes of psychological interventions for schizophrenia. Although there is evidence that atypical antipsychotic drugs may produce some improvement in selected areas of cognitive performance, antipsyhotic medications do not eliminate cognitive deficits (1,2, 3). Cognitive remediation aims to rehabilitate impaired cognitive functions. A variant of the cognitive process targeting approach is included as acomponent in a more comprehensive psychosocial treatment modality, Integrated Psychological Treatment (ITP) for Schizophrenic Patients (4). IPT is a highly structured group theraphy approach that is conducted in 30 -to 60-minute sessions two or three times per week in groups of five or seven patients. It includes five subprograms. The first three subprograms are the cognitive component of IPT. They are named Cognitive Differentiation, Social Perception and Verbal Communication, and they target cognitive abilities thought to be prerequisites to effective social interaction. The fourth and fifth subprograms, Social Skills and Interpersonal Problem Solving, target the more behavioral level of social interaction (5).

Objective: The aim of the present study is to assess the effect of cognitive differentiation and social perception sub programs on symptom control, psychosocial functioning and cognitive domains among patients with schizophrenia.

Method: 60 schizophrenic outpatients who were in remission participated to the study. 30 patients assigned to the study groups and 30 patients assigned to the control groups randomly. But, five patients leaved from study group and three patients leaved from control group in the duration of research. The study groups attended to 24 therapy group sessions of 45-60 min each over a 12-week period. The following forms were used: a sociodemographical data form, Postive and Negative Syndromes Scale(PANSS) to assess the symptom and Neurological Evaluation Scale (Digit Span Test, Trail Making Test A-B, WMS Visual -Reproduction Test, Rey Auditory Verbal Learning Test Stroop Test, Wisconsin Card Sorting Test). These neurocognitive tests were used at entry to the study and after the intervention. Moreover, Functioning Scale, The Quality of Life Scale:, and Global Assessment of Functioning were used to evaluate psychosocial functioning. NCSS 2007 packed program was used for statistical analysis were performed with.

Results: There was no statisticly difference regarding age, sex, education level, marital status, access to social security systems, accommodation and household features, duration of the illness and the number of hospitalization between the patients in the study and the control groups (Table 1). Improvement in verbal and particularly in visual memory and in simple and complicated attention in the study group was found by assessing the attention tests after termination of the program. At the and of the study; the attention scores showed to improvement in the study group. The placement and arrangement of information were improved (recording process). While there was no change in recall the information encoded. There was a minimal improvement in executive functions in both groups (Table 2). The decline in the PANSS total score and subscale score was more high in the study group, though both groups had lower total and subscale scores at the end of the study (Table 3). The improvement in both of the groups was adressed to psychoeducation, personal therapy, occupational therapy covered in rehabilitation services; and the particular exceeding improvement in the study group may be due to better benefit from the rehabilitation methods provided by the improvement in cognitive functioning in this group. The asessment of social functioning scale, quality of life scale and global assessment of functioning scale revealed statisticly significant better functioning in the study group. The improvement in the cognitive domain may have contributed to minimize the disabilities in functioning.

We found statistically significant improvement in psychosocial functioning, in symptom (severity), and in cognition and the improvement in the symptom severity and psychosocial functioning was particularly more significant (p<.05). We found significant difference in symptom severity in the control group but not in the cognitive domain. The changes (improvement) observed in sypmtom severity, psychosocial functioning and cognitive domains may be correlated with the effects of cognitive differentiation and social perception subprograms included in IPT and the improvement may also be due to the other treatment modalities running in the rehabilitation center.

Discussion: As a result of the study, we found statistically significant improvement in attention and memory in the study group but executive functions's improvement was not statically significant. The results from our study suggest that cognitive rehabilitation could be make changes on the neurocognitive domains.

Table 1 ***Socio-demographical Datas***		Study Group (n:25)	Control Group (n:27)
Age X:35.96±5.0			X:37.28±4.4
Year of disease		X:19	X:15
Gender	Women	7 (%28)	4 (%14.8)
	Men	18 (%72)	23 (%85.2)
	Primary School	9(%36)	10(%37)
	High School	13(%52)	13(%48.2)
	University	3(%12)	4(%14.8)
	Single	23(%92)	26(%96.3)
	Maried	2(%8)	1(%3.7)
	Jobless	12(%48)	18(%66.7)
	Worker	6(%24)	5(%18.5)
	Study	1(%4)	1(%3.7)
	Housewife	3(%12)	1(%3.7)
	Self-employment	5(%20)	4(%14.8)

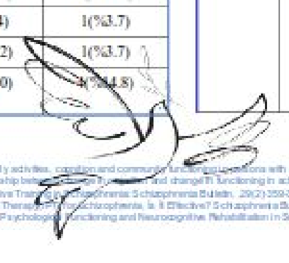

Table 2 ***Neurological Evaluation Scale Scores***			Study Group (n:25)				Control Group (n:27)				T	P
			Before	After	t	p	Before	After	t	p		
Attention	Trail Making Test	TMT-A Time	59.1±20.5	49.3±14.72	3.72	.001	55.7±26	53.7±20.0	0.47	.645	-0.43	.667
		TMT-B Time	156.1±80.6	100.5±30.8	4.18	.0001	142.3±68.0	121.2±59.1	2.07	.049-	0.75	.458
	Digit Span Test	Direct	5.5±1.2	5.8±0.9	-2.57	.017	5.3±0.7	5.4±0.7	-0.9	.376	0.24	.809
		Advers	3.8±0.9	4.6±0.8	-4.32	.0001	3.8±1	4.1±0.9	-2.6	.015	0.39	.702
		Total	9.3±1.7	10.5±1.6	-5.24	.0001	9.1±1.5	9.6±1.5	-2.47	.021	0.46	.644
Memory	Verbal Memory Test	Sort	4.2±1.8	5.3±1.5	-4.42	.0001	5.0±1.6	4.7±1.5	0.71	.484	1.35	.183
		Optimum reading	11.6±2.1	12.4±2.0	-2.47	.021	11.7±2.1	11.0±2.8	1.75	.092	2.07	.044
		Learning	86.0±16.7	91.3±16.8	-2.16	.041	87.1±18.4	83.7±19.8	1.3	.204	1.49	.142
		Long time recall	8.3±2.8	8.3±1.8	0.07	.946	7.8±3.2	6.7±2.9	1.98	.058	2.31	.025
	WMS-Visual Reproduction Test	Short time	9.3±3.3	11.8±2.2	-4.43	.0001	9.5±2.9	11.1±2.4	-3.69	.001	0.99	.329
		Long time	7.4±3.2	9.1±3.2	-3	.006	8.2±2.9	7.8±3.4	0.53	.6	1.32	.193
		Long time recall	10.5±3.0	12.8±1.7	-4.05	.0001	10.8±2.7	11.8±2.6	-2.35	.027	1.66	.103
		Total wrong	64.8±20.8	55.8±25.5	2.47	.021	60.8±22.0	46.2±25.8	3.72	.001	-0.58	.562
		Cathegory	2.6±1.7	3.2±2.1	-2.24	.035	2.8±2.0	3.4±2.2	-2.63	.014	0.31	.76
		Time 1	18.4±8.4	15.0±5.24	2.73	.012	16.7±5.2	17.5±6.9	-0.67	.508	-1.51	.136
		Time 5	39±12.3	31.8±10.37	4.03	.0001	35.9±15.1	33.0±14.4	1.47	.154	1.6	.116

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ANALYSIS OF THE CHANGES IN SOCIAL FUNCTIONALITY, BPRS AND INSIGHT LEVELS OF CHRONIC PSYCHIATRIC PATIENTS TREATED IN DAY HOSPITAL WHICH APPLY PATİENT-CENTERED REHABILITATION PROGRAMME

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INTRODUCTION: *People with a variety of serious mental illnesses can benefit from psychiatric rehabilitation services. The most common diagnoses of the people in psychiatric rehabilitation programs are from the schizophrenia and mood disorder categories. The goals of psychiatric rehabilitation is to help individuals recover from the catastrophe of serious mental illness and teaching skills needed for persons with psychiatric disabilities to function at their highest level possible in their environments (1,2). The ideas of recovery, wellness, and resiliency embody a functional model of what it means to be person-centered; they simultaneously address both process and outcome. Treatment goals such as symptom reduction, decreased hospitalization, treatment compliance, increase social and physical functionality or the elimination of behavior problems. Providing person-centered services requires endorsement and support at the level of organized systems of care. The expectations of quality care need to be aligned with the resources and supports required by providers in order to realize a person-centered approach (3). Case management model is used to in person-centered services and rehabilitation units currently. Case management was designed to be the glue of the system, serving the centralized and coordinating functions of ensuring that persons with psychiatric disabilities received the services and supports that they needed when they needed them. Case managers work with persons with psychiatric disabilities to negotiate for the services and resources they want and need and to develop the personal skills and environmental supports they need to overcome environmental and personal barriers in order to achieve their own identified goals (2).*

Objective:

The purpose of the experimental research is to analyze the changes of social functionality, BPRS and insight levels of chronic psychiatric patients involved in a psychiatric rehabilitation programme that is based on patient-centred approach.

Material and Methods:

Approved by the required ethics committee, the study was undertaken on 60 chronic psychiatric outpatients being treated in the patient-centered rehabilitation program in Istanbul between January and June 2009. Prior to the rehabilitation programme, the patients were applied to the tests of Social functionality, insight and BPRS scales to be re-applied six months later. The results of the both tests were compared and evaluated. In addition to the weekly individual counseling and behavioral homework assignment, rehabilitation programme concerned the participation of 36 patients into to psyco-education group/social skills group, 18 patients into interaction group. Moreover, all the patients were encouraged to be involved in occupational therapy in the rehabilitation center.

Results:

70% of patients were male and 30% of the patients were female. 63.3% of the patients were single and their average age was X:35.5±9.5. Duration of the disease period was X:14.93±9.12. 66.7% of the patients were diagnosed with schizophrenia or atypical psychosis and 86% of the patients were compatible with the pharmacological treatment. Prior to the treatment; the average insight scale score was X:14.48±5.47, BPRS scale score was X:56.51±16 and social functionality scale score was X:100.46±26.48. Six months later, the average insight scale score was X:16:45±2.17, BPRS scale score was X:44.3±14.5, social functionality scale score was X:119.96±21:42. Difference between the first and last measurements is to be statistically significant ($p<.01$), see the table.

Conclusion:

As a result of the six-month rehabilitation programme based on patient-centred approach, statistically significant difference has been noted in psychiatric symptoms, level of insight and social functionality of the patients. The fact that there was no control group inthe research is considered to be a significant limitation of the analysis.

Table . Difference Between the First and Last Measurements

SCALES	(First) X±Sd	(Last) X±Sd	t	p
İnsight Scale	14.48±5.47	16.45±2.17	-2.91	.005
Brief Psychiatric Rating Scale (BPRS)	56.51±16.00	44.30±14.50	9.41	.000
Social Functionality Scale	100.46±26.48	119.96±21:42	-6.09	.000

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COMMON LANGUAGE FOR PSYCHOTHERAPY PROCEDURES PROJECT: AN UPDATE

The CLP Task Force Group

7th International Congress of Cognitive Psychotherapy
"Clinical Science" June 2-5 2011 – Istanbul, Turkey

Common language for psychotherapy procedures project: an update

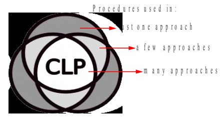
Summary

Isaac Marks, King's College London, for CLP Task Force

CBT is maturing into a science whose shared forms of practice can be defined and tested operationally. This is seen in the website www.CommonLanguagePsychotherapy.org which shows work of the ongoing CLP project Common Language forPsychotherapy Procedures.
A Task Force to run the CLP was set up by the EABCT and ABCT and has won further sponsorship by 10 more psychotherapy organisations with diverse orientations. The CLP hopes to reduce confusion which arises when different therapists give the same procedure different names or give different procedures the same name. Confusion can be cleared by making freely available therapists' short empirical descriptions in plain practical language, without theory, of how they use a particular procedure with patients, including a brief Case Illustration of how they do that. Each CLP entry depicts what a therapist actually does when applying that procedure, not why s/he does it. So far the website has 89 entries with Case Illustrations from 104 therapists around the world detailing how they use given procedures. Rather like the voyages of discovery 500 years ago which brought new flora and fauna from around the world to scientific attention, the CLP gives ready access at one site to brief practical accounts of a huge variety of therapy procedures. This facilitates the teaching of students and an empirical classification of therapists' actions..

Common Language for Psychotherapy (CLP) procedures

www.commonlanguagepsychotherapy.org



CLP Task Force

Begun by EABCT & ABCT to develop a **Common Language** to understand terms for **Psychotherapy procedures**

CLP entries describe **what** therapists do, not why they do it

CLP Task Force members

EABCT: Stefania BORGO, Pim CUIJPERS, Miquel Angel FULLANA (deputy co-ordinator), Isaac MARKS (co-ordinator), Lucio SIBILIA, Mehmet SUNGUR

ABCT: Marvin GOLDFRIED, Michelle NEWMAN, George STRICKER

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Classification Consultant: Miquel TORTELLA

Psychodynamic Editor: Jeremy HOLMES

Website: www.commonlanguagepsychotherapy.org

Dynamic designer: Marco BENARD

Manager: Lorena FERNÁNDEZ DE LA CRUZ with Toni RIERA & Alberto PERDUSA

Sponsoring Organisations

The Problem

Therapists often

1. give similar procedures different names e.g. to "*grief*":
   a. guided mourning, b. exposure, c. working through
2. give different procedures similar names e.g.
   in *diary keeping* ask patient to record:
   a. irrational thoughts, or
   b. relaxation exercises without exposure, or
   c. live-exposure homework tasks, or
   d. times of praise by spouse

The Problem (continued)

Lack of a common language for procedures leads to:

- misunderstandings among professionals and patients
- slowing of psychotherapy's maturing into a science

CLP **aims** to:

- describe therapy procedures in plain language, each with a brief real **Case Illustration**
- be ecumenical, with entries from therapists from **any** school
- get **international** acceptance by a broad range of therapists

CLP project so far

(May 2011)

- **89** accepted **entries** for procedures (more due) from 104 **authors** from 14 **countries**: Australia, Canada, Finland, France, Germany, Greece, Israel, Italy, Japan, Netherlands, Sweden, Switzerland, UK, USA
- entries from many **orientations**: CBT, cognitive analytic, interpersonal, psychodynamic, systemic …
- **classification & indexing** of procedures in train
- **teaching** aid for students *(Tortella)*: expanded their knowledge of procedures, classified those reliably

89 entries on clp website so far

Examples:

anger management; attention training; becoming the other; behavioral activation; cognitive defusion; cognitive restructuring; community reinforcement; compassion-focused therapy; decisional balance; empathy expression; experiment; expressive writing therapy; family work for schizophrenia; fixed-role therapy; guided mourning; habit reversal; harm reduction; imagery rehearsal; imago relationship therapy; internalised-other interviewing; interoceptive exposure; interpersonal therapy; interpreting defenses; life review; metaphor use; method of levels; morita therapy; motivational interviewing; nidotherapy; problem-solving; promoting resilience; reciprocal role procedures; repairing rupture; repertory grid; ritual prevention; socratic questioning; speech restructuring; stimulus control; task concentration; time-in management; token economy; transference interpretation; triple-P parenting; two-chair dialogue; well-being therapy

PSYCHODRAMA

Adam BLATNER, Georgetown, TX 78633, USA

Definition: Improvised role playing to reveal and help a client's problems.

Elements: Directed by therapist, client role-plays interactions with significant others, done with group members (trained or volunteers) who act other people important in that role play. Client role-plays in a special area in the room. Others witness, share, and encourage. Facilitating techniques include: role reverse, double (another person expresses the client's unspoken thoughts; mirror (client stands to the side and watches someone replay the scene, to see how his behaviour looked from the outside; exaggerate (a phrase or behaviour so the client discovers underlying feelings); concretize (physically act out what was said e.g. "feeling torn apart" - group members pull the client's arms in different directions).

Related procedures: Action methods; becoming the other; drama therapy; internalized-other interviewing; rehearsal; role-play; sociodrama, two-chair dialogue;

Application: Explore role conflicts - intra- or inter-personal or between groups in psychotherapy, sometimes in education, business, or community-building.

1st use? Moreno (1937)

References: 1. Blatner A (1999). Psychodrama (Chapter). In D. Wiener (Ed.), *Beyond Talk Therapy: Using Movement and Expressive Techniques in Clinical Practice.* Washington, DC. Am Psychol Associat Press. 1999.
2. Blatner A (2000). *Foundations of Psychodrama: History, Theory, Practice* (4th ed.) NY: Springer.
3. Blatner A (2007). Morenean approaches: recognizing psychodrama's many facets. *J. of Group Psychotherapy, Psychodrama & Sociometry*, 59,159-170.
4. Moreno JL (1937). Interpersonal therapy and the psychopathology of interpersonal relations. *Sociometry, 1*, 9-76.

PSYCHODRAMA (continued)

Case illustration (Blatner 1999)

18 professionals had psychodrama training in a 2hr session. Director began **warm-up**: *'Tell us your names---how you came by and feel about it.'* Members told their stories for 30':*'Who wants to explore parts of your life? Can you each put your hand on the shoulder of whoever's story resonates with you?* Most chose Zoe, who'd spoken about unresolved losses (10'). Therapist began a 30' **action** phase by asking Zoe about losses through death, moving away... He had her place a chair on stage for each loss named - 5 to begin with. "*Let's fill these chairs. Who could be your uncle Don?*". Zoe pointed to a gp member. Director:"*Please come up as uncle Don?*" Cousin Ronald etc were chosen similarly. "*Zoe, tell Don something you shared together.*" Zoe: "We'd go walking & you'd show me plants." She did this with each of the 5 people playing lost others. "*Change parts*". Zoe took the lost person's place in the chair while that person took Zoe's position. Zoe (as "Uncle Oscar") said "Yes, little Zoe, you'd say the name of the plant again & again, to practice", & described more memories to each person represented by each empty chair. To aid grieving, the director asked: 1. about a shared memory, as above. 2. *'Tell* (that person) *what s/he meant to you'*. 3. After Zoe role reversed with the lost other, to that other (played by Zoe): *'Tell Zoe what she meant to you'*. Zoe did this for 5' each with 2 people whose losses had hurt most. She cried while role-playing talking to, rather than "about", them. Th: *'Name all the other losses in your youth'*. For another 5' she placed more chairs handed to her from the audience: "My friend Jane who moved away; my kitty who died when I was nine… " (middle "action" phase 40'). The session ended with **sharing**: *'Please come off the stage, out of role play, back into the group circle, and say your real names'*) e.g. one member said "I'm no longer Uncle Don, I'm Arnie again." Then, director to the group: "*Zoe shared with you. Please give back to her, say what in her role play touched you, what you felt from your own experience*". Over 40' group members shared this with Zoe and often cried too.

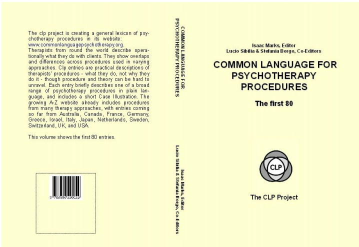
ANY THERAPIST CAN CONTRIBUTE TO

www.commonlanguagepsychotherapy.org

1. email suggested term for a procedure to isaac.marks@kcl.ac.uk & mafr@copc.es
2. if term is suitable for clp entry, therapist submits its draft-entry description in a clp format
3. entry is edited & published on clp website with **therapist's name highlighted as author**

A first publication of clp project

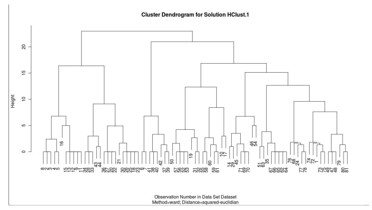
(already available in all main bookshops on-line)



Classification of procedures: 16 Domains

Attention-Focusing: attend to & accept external stimuli or own thoughts, sensations, feelings
Body Skills Training: train to monitor and change habits and sensations.
Contingency Management: reward desired, and ignore or penalize undesired, behavior
Distraction: divert attention from feelings, thoughts & images
Education: formally explain what maintains a problem and how to overcome it
Empathy Expression: express understanding of & accept another's feelings
Environmental Change: planned non-contingent change of the environment
Exposure: guide patients into facing frightening/avoided situations/feelings/imagery/thoughts
Externalize Feelings & Thoughts: help patients uncover hidden feelings & thoughts
Goal Planning & Attainment: help pts define problems, goals to reduce them, steps to goals
Homework: help pt plan to carry out and record tasks between sessions, in natural environment
Interpersonal Skills Training: train appropriate social behaviors
Modeling: show clients what to do by watching it being done by others or by imagining it
Reframing: help patients see things differently by discussion/written method
Rehearsal & Role Play: rehearse behavior to improve skill in performing it or to understand it from one's own or another perspective
Therapist's Self-Instruction: therapist uses own feeling, memo or action to help patient

A possible tree for classifying procedures



Next Conferences

- 41st Eabct Annual Congress

  31 August - 3 September 2011 - Reykjavik, Icelan
  http://www.congress.is/eabct/

- I° Congresso della Società Italiana di Psicoterapia (SIPSIC)
  La psicoterapia in evoluzione. Nuove idee a confronto.
  21-24 Settembre 2011 - Roma, Italia
  http://www.sipsic.it/jo/attachments/article/63/Programma%20provvisorio.pdf

- 8th International Congress of Cognitive Psychotherapy "*The New Frontiers*"
  24-17 June 2014 - Hong Kong, Cina
  http://www.iccp2014.com/

Contributing to Psychomed

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