V World Congress of Behavioural & Cognitive Therapies

Barcelona '07

11th-14th July 2007

Barcelona International Convention Centre (CCIB)

World Associations for Behavioural and Cognitive Therapies

Association for Behavioural and Cognitive Therapies (ABCT) USA
Australian Association for Cognitive and Behaviour Therapy (AACBT)
La Asociación Latinoamericana de Análisis y Modificación del Comportamiento (ALAMOC) South America
International Association of Cognitive Psychotherapy (Worldwide)
Japanese Association of Behaviour Therapy (JABT)
South African Behaviour Therapy Association (SABTA)
European Association for Behavioural and Cognitive Therapies (EABCT)

- Austrian Association for Cognitive and Behaviour Therapy
- Association for Behaviour Modification in Austria
- Association for Behaviour Modification in Germany
- Association for Behaviour Modification in Switzerland
- Association for the Study, Modification and Therapy of Behaviour (Belgium)
- Association Francophone de Formation et de Recher en Therapie Comportementale et Cognitive
- Association of Behavioural Therapy and Cognitive Therapy (The Netherlands)
- Association for Cognitive and Behavioural Therapies (Montenegro)
- British Association for Behavioural and Cognitive Psychotherapies
- Bulgarian Association for Cognitive Behaviour Psychotherapy
- Catalan Society of Behaviour Research and Therapy
- Croatian Association for Behavioural-Cognitive Therapies
- Czech Society for Cognitive Behaviour Therapy
- Danish Association of Behavioural and Cognitive Therapy
- Estonian Association for Cognitive Behaviour Therapy
- Finnish Association for Cognitive and Behaviour Therapy
- Finnish Association for Behavioural Analysis and Cognitive Behaviour Therapy
- Flemish Association of Behaviour Therapy
- French Association of Behaviour and Cognitive Therapy
- German Association for Behaviour Therapy
- German Professional Association for Behaviour Therapy
- Greek Association for Behavioural Modification and Research
- Greek Association for Cognitive and Behavioural Psychotherapies
- Hungarian Association for Behavioural & Cognitive Therapies
- Icelandic Association for Cognitive and Behavioural Therapies
- Irish Association of Behavioural And Cognitive Psychotherapy
- Israeli Association For Behavioural-Cognitive Therapy
- Italian Association for Behavioural Analysis & Modification, & Behaviour & Cognitive Therapies
- Italian Association for Behavioural and Cognitive Therapy
- Lithuanian Cognitive Behaviour Therapy Association
- Norwegian Association for Cognitive Therapy
- Polish Association for Cognitive and Behavioural Therapy
- Portuguese Association of Behaviour Therapy
- Rumanian Association of Hypnosis and Cognitive Behavioural Psychotherapy
- Rumanian Association for Behavioural and Cognitive Therapy
- Serbian Association for Behavioural and Cognitive Therapies
- Slovene Association for Behaviour and Cognitive Therapies
- Swedish Association of Behaviour Therapy
- Swiss Association of Behaviour Therapy
- Swiss Association for Cognitive Psychotherapy
- Turkish Association for Cognitive and Behavioural Psychotherapy

Internet-delivered cognitive-behavioural self-help treatment for insomnia; a randomised controlled trial
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Chronic insomnia - difficulty initiating and/or maintaining sleep - is a prevalent mental disorder affecting around 8-12% of the general adult population (Ford & Camerow, 1989; Ohayon, 2002). It has been associated with daytime fatigue, limitations in cognitive functioning and with mood and anxiety complaints. Primary insomnia is a prevalent condition, but insomnia also frequently occurs in affective disorders, and is a risk-factor for the development of post-traumatic stress disorder (Koren et al., 2002) and depression (Chang et al., 1997; Foley et al., 1999). Although insomnia receives little attention in the mental health care, it is a persistent disorder that does not resolve without specific treatment. This also applies to insomnia occurring during the course of another disorder, e.g. insomnia seems resistant to PTSD treatment (Zayfert & DeViva, 2004). While the use of pharmacological agents for chronic insomnia is questionable due to tolerance and dependency, specific cognitive-behavioural treatment for insomnia, typically administered in 6-8 (group) sessions, does show long-term sleep improvements (Morin et al., 1999). However, it is questionable as to how much can be added to the already high volume of work of mental health professionals. It seems warranted to study less intensive treatment delivery methods, such as self-help interventions. As cognitive-behavioural treatment for insomnia mainly consists of psycho-education and exercises, the effects of self-help interventions for insomnia are positive and promising (Mimeault & Morin, 1999). Moreover, self-help can be delivered using novel multi-media approaches, such as TV or internet. One previous study (Ström, Pettersson & Andersson, 2004) found modest but significant improvements in sleep after internet-delivered self-help treatment with minimal therapist interaction. The current study aims to evaluate the effects of internet-delivered cognitive-behavioural self-help treatment for insomnia, without any therapist interaction. As part of a larger sleep programme adult persons of a company were invited to fill out an online sleeptest - the SLEEP-50, a validated sleep questionnaire that has shown good predictive validity for diagnoses obtained in a sleep clinic (Spoormaker et al., 2005). Participants with insomnia complaints could register for inclusion in the current study. 74 participants did and were randomised into the treatment group (n = 38) or waiting list (n = 36). The treatment group received a self-help treatment in PDF-format. This self-help treatment employed stimulus control (re-associating the bed and bedroom with sleep compatible activities), sleep hygiene education (improving health behaviours or environmental factors affecting sleep), cognitive restructuring (changing faulty beliefs about sleep) and progressive muscle relaxation. Participants were measured twelve weeks later with the SLEEP-50 (online) to evaluate insomnia complaints, sleep quality and duration, and psychosocial functioning. 43 participants completed the online sleep questionnaire at follow-up (treatment group n = 23). The effects of cognitive-behavioural self-help treatment on SLEEP-50 variables will be presented. Conclusions, clinical implications and limitations will be discussed.

Impulsivity as a Risk Factor for Insomnia
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There is considerable evidence that individuals suffering from insomnia experience unwanted intrusive and worrisome thoughts during sleep onset and that they attribute their sleep disturbances to a "racing mind" (for a review, see Harvey, 2005). There is also growing evidence that thought suppression might fuel the experience of negative cognitive arousal during sleep onset, thereby contributing to the maintenance of insomnia (for reviews, see Espie, 2002; Harvey, 2002). Research has, for example, shown that insomniacs report using suppression during the presleep period more than good sleepers do (Harvey, 2001), and that the more frequent use of suppression is associated with more frequent sleep-interfering thoughts and poorer sleep quality (Ree et al., 2005). Comparatively little is known about personality factors that might predispose people to suppress unwanted intrusive thoughts when trying to fall asleep. Despite its prominent status in psychopathology, impulsivity has rarely been considered as a potential risk factor for insomnia in previous research, and the few studies that have done so produced equivocal evidence (Dorsey & Bootzin, 1997; Ireland & Culpin, 2006; Lundh et al., 1995). Meanwhile, indirect evidence continues to hint at a possible link between impulsivity and insomnia, for example, well-documented sleep disturbances in impulsivity-related disorders such as borderline personality disorder (de la Fuente et al., 2001; Lindberg et al., 2003). The purpose of the present study was to investigate the relationship between impulsivity and insomnia based on the comprehensive approach to impulsivity proposed by Whiteside and Lynam (2001). According to these authors, four facets of impulsivity can be distinguished: urgency, lack of premeditation, lack of perseverance, and sensation seeking. The present study involved 233 undergraduate students who completed Whiteside and Lynam's UPPS Impulsive Behavior Scale, Morin's (1993) Sleep Impairment Index, and a short questionnaire on hypnagogic and dreamlike mentation. The main findings were that both urgency and lack or perseverance was related to insomnia severity. Furthermore, urgency was associated with frequency of aggressive suppression of unwanted thoughts, and with frequency of upsetting thoughts at sleep onset. Critically, the effect of urgency on difficulty in falling asleep was partially mediated by frequency of upsetting thoughts and images at sleep onset. To our knowledge, the present study is the first to provide clear evidence for a link between two facets of impulsivity (urgency, lack of perseverance) and insomnia, and for a link between urgency and sleep-interfering cognitive activity. The specific relations between facets of impulsivity and aspects of insomnia might open up new avenues for modeling the development and maintenance of insomnia and for clinical interventions.

The application of accaptance and commitment therapy to chronic pain
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ACT has been shown to be a potentially effective alternative to traditional CBT for treatment of chronic pain. ACT is conceptually more compatible with accepted theories of chronic pain. Specifically, ACT targets experiential avoidance; promotes the view that suffering is inevitable; and advocates a refocus on life direction and values. These factors are relevant because people with chronic pain try to avoid the inescapable experience of pain; fail to accept their pain and suffering; and focus on pain at the expense of living a fulfilling life. ACT has been shown to be a potentially effective alternative to traditional CBT for treatment of chronic pain. ACT is conceptually more compatible with accepted theories of chronic pain. Specifically, ACT targets experiential avoidance; promotes the view that suffering is inevitable; and advocates a refocus on life direction and values. These factors are relevant because people with chronic pain try to avoid the inescapable experience of pain; fail to accept their pain and suffering; and focus on pain at the expense of living a fulfilling life. Aims: To evaluate an ACT based intensive pain programme (PMP-I). Methods: An intention to treat analysis was conducted on the first 60 participants in the PMP-I. Standardised outcome pain measures included self efficacy (PSEQ); acceptance (CPAQ), catastrophising (PRSS), self reported disability (MRM), depression, anxiety and stress (DASS); pain-related anxiety (TSK-11). Follow ups were conducted at 1, 3 and 6 months post-treatment. Results: Clinically significant improvements were shown post-treatment and these outcomes were maintained at follow-up. Conclusions: (a) ACT appears to be effective for addressing chronic pain; (b) outcomes were indicative of sustainable improvements in long term functioning; (c) the conceptual compatibility between ACT and theories of chronic pain suggests potential enhanced outcomes when applying ACT to chronic pain.

Open Paper Symposium 10

CBT for Pain and Fatigue

Hypervigilance as a predictor of outcome in acute pain patients: Clinical Implications
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Theories of chronic pain suggest that hypervigilance to pain following an acute injury has a causal role in the development of chronic pain. Although there is emerging evidence that hypervigilance is associated with chronic pain, there is no evidence that hypervigilance precedes the development of chronic pain. The present study aimed to determine: a) whether acute pain patients who are hypervigilant to pain-related stimuli are more likely to develop chronic pain; and b) whether hypervigilance predicts chronicity and indices of disability. One hundred and thirty patients with acute low back pain were assessed at their second physiotherapy appointment and completed measures of hypervigilance (Dot-Probe) and other demographic and clinical variables. Participants were followed-up at three and six months to ascertain subsequent pain status and disability. At six months, participants were re-administered the Dot-Probe. Those participants who subsequently developed chronic pain had significant biases towards affective pain, threatening and disability related stimuli at baseline compared to those who recovered. The reverse was true for sensory pain words. That is, those who became chronic were more likely to avoid the sensory aspects of pain. Subsequent pain status (ie whether chronic, recurrent or recovered) was independently predicted by baseline fear of pain and hypervigilance. Indeed, when controlling for other demographic and clinical features, hypervigilance accounted for nearly 15% of the variance in pain status. Significant correlations were also found between baseline hypervigilance and other indices of disability, including the highest and average pain ratings, days in pain, time off work, the number of visits to health professionals. This study suggests that during an acute injury, patients attend to the emotionally salient, rather than sensory aspects of pain. These biases were found to differ significantly between those who subsequently recovered and those that did not. Strong relationships were also found between indices of hypervigilance and subsequent pain status. These findings support the claim that attentional biases do have a causal role in the development of chronic pain.