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CONNECTING MEMBERS: SURVEY

The main purpose of this website is to promote activities and services to our members and to get know each other across the world.
To start with, in this section we have a proposal in which we would like to involve you as soon as possible...

Connecting members across the world!!



Because our organization has more than four hundred members worldwide, the first aim of this website will be to connect us, to know where our colleges are working in the aim topics of Clinical and Applied Community Psychology, their diverse functions and different areas of expertise, and the world centres where we are performing psychological interventions and research. We ask you to complete this questionnaire that will permit us to build a database and to give you information about which members of the Division are close to you, their areas of expertise, and the psychological centres where they are working.

We think this information will be useful to support you in many professional situations, for instance, when you are preparing a professional trip, when you need collaboration to develop some research programmes in any part of the world, and so on.



Please, complete the questionnaire and send it to mpgvera@psi.ucm.es

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Most relevant publications (500 words max)

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EXPERTS ACROSS THE WORLD

In this section you can find articles and interviews from *experts across the world*, with the aim of presenting experiences and professional challenges from the diverse countries.

ARTICLE

This is a menu to share articles about professional topics, experiences, up-to-date topics, etc., with experts from diverse countries.

Beyond Numbers

Belén Reguera and Pedro Altungy
Complutense University of Madrid.

KEYWORDS: Assessment, depression, anxiety, questionnaire, functional analysis.

In the currently practice of psychology, it is widely spread the use of questionnaires, test and scales, in order to get more clinical information about the patient. These instruments are composed by several questions related to the symptomatology that is being studied. They can be used in any part of the psychotherapy (assessment, diagnosis, treatment and therapy results). How are these instruments used? Usually, the figures of each question are added up and the final score that is obtained is compared to normative scales proposed by the authors of the instruments. Those normative scales

give information about the severity of the symptomatology that the patient present.

As it has been said, it is common for the therapist to only pay attention to the final score obtained in the questionnaire, and the information that it provide but, is this all the information that we can get form them? If so, the therapist would only be paying attention to the quantitative information of the test but, is there any information beyond the figures? Can qualitative information be obtained from these very same tools as well? If it would be possible, very useful information for the understanding

of the patient and its problem could be used for the therapist. Should not be forgotten that a fundamental part of any psychological intervention (framed into cognitive-behavioural therapy) is the functional analysis and case formulation. These clinical tools help psychologists to understand and explain the patient problem in an analytical, visual and schematic way. We have considered that the qualitative information given by the questionnaires would be very helpful for filing both clinical tools. Therefore, what we purpose is how can be this task achieved.

Thanks to the collaboration between Universidad Complutense de Madrid (UCM) and the *Terrorism Victims Association* (AVT), we have been able to work with a wide sample of people who, sadly, have experienced a terrorist attack, in a direct (injured and witnesses) or indirect (relatives or partners) way. More accurately, the present collaboration between the two institutions was made with the aim of creating a “*Following of the psychological and social necessities of terrorism victims*”. Thanks to it, diagnostic assessment interviews, psychological treatment and results tracing have been carried out in victim’s behalf. In those interviews, several

questionnaires have been used by the therapists, among which the most relevant ones are the *Beck Depression Inventory Second Version* (BDI-II), the *Beck Anxiety Inventory* (BAI) and the *Post-traumatic Check List Civil Version* (PCL-C) (Table1). In addition, *Structured Clinical Interview for DSM-IV Axis I Disorders* (SCID-I) was used as a diagnostic interview. Other questionnaires were used in the process, but we have chosen BDI-II, BAI and PCL-C for the present study because they are the ones who assess the symptomatology of the three more frequent diagnoses in our sample (Major Depressive Disorder, Anxiety Disorders and Post-Traumatic Stress Disorder respectively). In the frame of the collaboration, therapists had mainly paid attention to the final scores of the test (to the quantitative information) so far, but recently it has arisen the idea of paying more attention to the information given by the questionnaires’ items themselves, in order to have more comprehensive information about the patient and its problems. That information, as explained in the previous paragraph, could be also used in the functional analysis and case formulation. Thus, our aim has been to try to find a common answer pattern in victims with the same

diagnosis, looking for a relationship between those diagnosis and the higher

scores in the questionnaires' items.

Table 1: Questionnaires' description.

	QUESTIONNAIRE		
	BDI-II	BAI	PCL-C
AIM	Asses the presence and severity of depressive symptomatology	Asses the presence and severity of anxiety symptomatology	Asses the presence and severity of post-traumatic stress disorder symptomatology
DESIGNED FOR POPULATION...	Clinical and no clinical over 13 years old	Clinical and no clinical over 13 years old	Clinical and no clinical over 18 years old
NUMBER OF ITEMS	21 (scores between 0-3)	21 (scores between 0-3)	17 (scores between 1-5)
SIGNIFICATIVE SCORE	≥14	≥8	≥44

- **Table 2: items per symptomatology manifestation.**

	COGNITIVE	MOTOR	PHYSIOLOGICAL	EMOTIONAL
BDI-II	Item 2: Pessimism Item 6: Punishment feeling. Item 8: Self-criticism. Item 9: Suicide thoughts/desire. Item 13: Indecision. Item 19: Concentration problems. Item 21: Decrease in sexual arousal.	Item 10: Crying. Item 11: Agitation	Item 15: Loss of Energy. Item 16: Changes in Sleeping Pattern. Item 18: Changes in Appetite. Item 20: Tiredness or Fatigue.	Item 1: Sadness Item 3: Past Failure. Item 4: Loss of Pleasure Item 5: Guilty Feelings. Item 7: Self-Dislike. Item 12: Loss of Interest. Item 14: Worthlessness Item 17: Irritability

BAI	<p>Item 4: Relaxation incapacity.</p> <p>Item 5: Fear of the worst.</p> <p>Item 14: Fear of losing control.</p> <p>Item 16: Fear of dying.</p>	<p>Item 3: Wobbly.</p> <p>Item 12: Hands trembling.</p> <p>Item 13: Trembling.</p> <p>Item 15: Difficulty breathing.</p>	<p>Item 1: Numbness</p> <p>Item 2: Hot sensation.</p> <p>Item 6: Dizziness</p> <p>Item 7: Heart pounding or racing.</p> <p>Item 8: Restless.</p> <p>Item 11: Feeling of suffocation.</p> <p>Item 18: Indigestion or discomfort in the abdomen.</p> <p>Item 19: Fainting.</p> <p>Item 20: Red face.</p> <p>Item 21: Sweating (not due to heat).</p>	<p>Item 9: Terrified.</p> <p>Item 10: Nervous.</p> <p>Item 17: Frightened.</p>
PCL-C	<p>Item 1: Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?</p> <p>Item 3: Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?</p> <p>Item 6: Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?</p> <p>Item 8: Trouble remembering important parts of a stressful experience from the past?</p> <p>Item 12: Feeling as if your future will somehow be cut short?</p> <p>Item 15: Having difficulty concentrating?</p> <p>Item 16: Being “super alert” or watchful on guard?</p>	<p>Item 7: Avoid activities or situations because they remind you of a stressful experience from the past?</p>	<p>Item 2: Repeated, disturbing dreams of a stressful experience from the past?</p> <p>Item 5: Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?</p> <p>Item 13: Trouble falling or staying asleep?</p> <p>Item 17: Feeling jumpy or easily startled?</p>	<p>Item 4: Feeling very upset when something reminded you of a stressful experience from the past?</p> <p>Item 9: Loss of interest in things that you used to enjoy?</p> <p>Item 10: Feeling distant or cut off from other people?</p> <p>Item 11: Feeling emotionally numb or being unable to have loving feelings for those close to you?</p> <p>Item 14: Feeling irritable or having angry outbursts?</p>

Our first step for getting the qualitative information has been to assign each questionnaire item to one of the four main symptomatology expressions: *cognitive, motor, physiological and emotional*. The assignation has been done following the test's instructions and the clinical opinion of the collaboration programme research team (UCM-AVT). This assignation can be seen in Table 2.

As it can be regarded in table 2, almost all the items ask for different symptomatology, either cognitive or motor or physiological or emotional. Very few of them ask for the same symptom, which means that a great deal of information can be obtained for our functional analysis and case formulation from the three questionnaires.

With the information given so far, therapists could have a better frame before treating their patients, but we wanted to go further. Thus, we decided to look for which items scored higher in the more prevalent disorders that our sample presented. For it, we run a statistical analysis which consisted on a partial correlation study between the questionnaire items and its final score and the different diagnosis, using as control variables: *sex, age, civil status,*

working status, studies level, injured during the attack, physical consequences, and the final score of the questionnaires left. The sample size was of 644 people, victims directly or indirectly of terrorist attacks. We chose those partial correlations which were statistically significant ($\text{sig} \leq 0.05$) and with *Pearson correlations* (ρ) over 0.2. The results obtained are shown in Table 3



First thing we would like to highlight is that those results are merely for helping the therapist when approaching the patient problem, and do not intend to create a sophisticated response pattern of our sample. Therefore, when assessing terrorism victims with questionnaires like PCL-C, BDI-II and BAI, therapist should pay special attention to the responses on the items which appear in the table. In case that the patient score in those items were over the half score, the probabilities of that person of having a certain disorder would be higher, and further assessment in that direction would be recommendable. Finally, the squares

highlighted in green mean that the final score of those questionnaires are significantly related with the diagnosis of the disorder. Mention that the results in our sample in that sense are in agreement with the scientific literature about those same questionnaires.

• **Table 3: partial correlations.**

	PCL-C	BDI-II	BAI
PTSD	Ítem 1 (0,24); Ítem 6 (0,26); Ítem 7(0,38); Ítem 11 (0,22); Ítem 12 (0,21); Ítem 14 (0,27)		
MDD	Ítem 6 (0,22)	Ítem 2 (0,27); Ítem 3 (0,25); Ítem 6 (0,25); Ítem 10 (0,23); Ítem 15 (0,24)	
T. ANGUSTIA		Ítem 9 (0,27)	Ítem 7 (0,2)
OCD			Ítem 17 (0,2); Ítem 18 (0,2)
AGORAPHOBY			
SOCIAL PHOBY	Ítem 12 (-0,21)		Ítem 11 (0,21)
GAD			Ítem 15 (-0,26)
NON-SPECIFIED ANXIETY			

In conclusion, we want to remark that questionnaires give therapists a lot of information, not only quantitative but qualitative as well. Any of them should be forgotten, because each one gives very valuable information for different but fundamental parts of the assessment. The final score will surely be used as a support for the diagnosis; meanwhile the items themselves will bring key information for the functional analysis and case formulation. Furthermore, insisting in the idea of the value of the qualitative information, when using different questionnaires together

therapist will get a very wide range of information about the manifestations of the patient's problem in its four mean spheres (cognitive, motor, physiological and emotional). Finally, but nonetheless important, it seems that cognitive symptomatology is the most relevant one when distinguishing between one or other disorder, being the other three more common among the different disorders, so more attention should be put in the items related to cognitive symptomatology. After all, Aristotle already said so: *"The whole is bigger than the mere addition of its parts"*.



Belén Reguera and Pedro Altungy

In this part of the section, interviews to professionals of the clinical psychology will be shared. The aim of this section is to provide the reader a deepest understanding of our profession and its development through the eyes of the psychologist who are currently at the forefront of the clinical psychology.

Professor Doctor Specialist in Psychiatry Zelde Espinel

1. As it is a common practice in your country, you have spent an entire year of your medicine studies doing what it is called “a rural year” (“año rural”). Concretely you have spent this period of time in the south of Colombia, in the department of Amazonas, where the indigenous community is still present and numerous. Can you tell us where have you been and what communities of indigenous do you have work with?

During my social service year (“año rural”) I was one of 2 community physicians based in Puerto Nariño, in Amazonas, Colombia’s most southerly department (state). Puerto Nariño is the second municipality of the Amazonas department of Colombia, located in an estuary along the shore of the Amazon River. The municipality has about 2,000 residents but the hospital serves the larger surrounding area, a catchment area of about 6,000. Puerto Nariño is an experimental ecological community that is entirely pedestrian and no motorized vehicles are permitted. Travel to the capital of Amazonas, Leticia, the

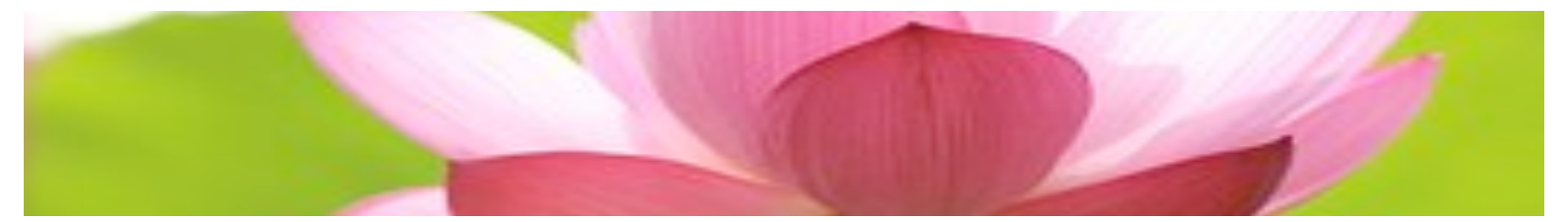
only other Colombian municipality in the region takes place by motorized boats, traveling along the Amazon River.

At the time I was there, there was no municipal water system; the copious tropical rains provided the fresh water needs. Also, electrical power was available only sporadically, usually for about 2 hours per day. The hospital was equipped with its own gas-powered generator to maintain the electrical needs around the clock.

The indigenous peoples in the area were primarily Ticunas, Yagua and Cocama.

2. Which are the main differences in the practice of medicine in this kind of indigenous communities? Have you found anything blocking your interventions, such as some general rooted beliefs?

One of the most interesting differences is the cultural tradition of childbirth, women prefer to have their children at home, delivering



them in a traditional squatting position, often in the company of a midwife. During my social service year, I only delivered one baby at the hospital. Another difference is the preference for using traditional herbal remedies rather than prescription pharmaceuticals. One of the most remarkable differences from urban practice in Colombia and especially different from medical practice in developed nations is the almost complete absence of chronic diseases. The population is lean, physically active and their substance is rich in fish and complex carbohydrates. However, what was very prevalent was parasitic diseases and much of our work had a public health focus, emphasising childhood immunizations and pre-natal care.

3. Even when we guess that your experience there was based on general medicine, have you observed any specific mental problem in this kind of people? What sort of interventions in mental health have you done?

There was very minimal expression of mental illness in the community during my time in Amazonas. There was a single episode of a psychotic break requiring referral to the capital of Leticia. Regarding substance use, there were occasional cases of alcohol abuse. However, this was limited due to the low level of income (most people could not purchase hard liqueur) and the most prevalent form of alcohol consumption involved locally produced fermented beverages (e.g. yucca wine). Only the small population of non-indigenous “colonos” (“whites” who had

relocated to the area) had a slightly higher level of alcohol use.

4. We don't know if the armed conflict in Colombia has impacted the indigenous settlements, but if it did, have you notice any kind of posttraumatic reactions in them?

Throughout Colombia indigenous populations in some areas have been targeted for displacement and subjected to many atrocities. In our studies with (Internally Displaced Persons (IDPs) who have resettled Bogota, we find very high rates of common mental disorders in internally displaced women with highest rates in those who are indigenous. However, during my time in Puerto Nariño the local population had fortunately not been affected by the armed conflict.

5. How about the resilience? Do you think indigenous people are more resilient?

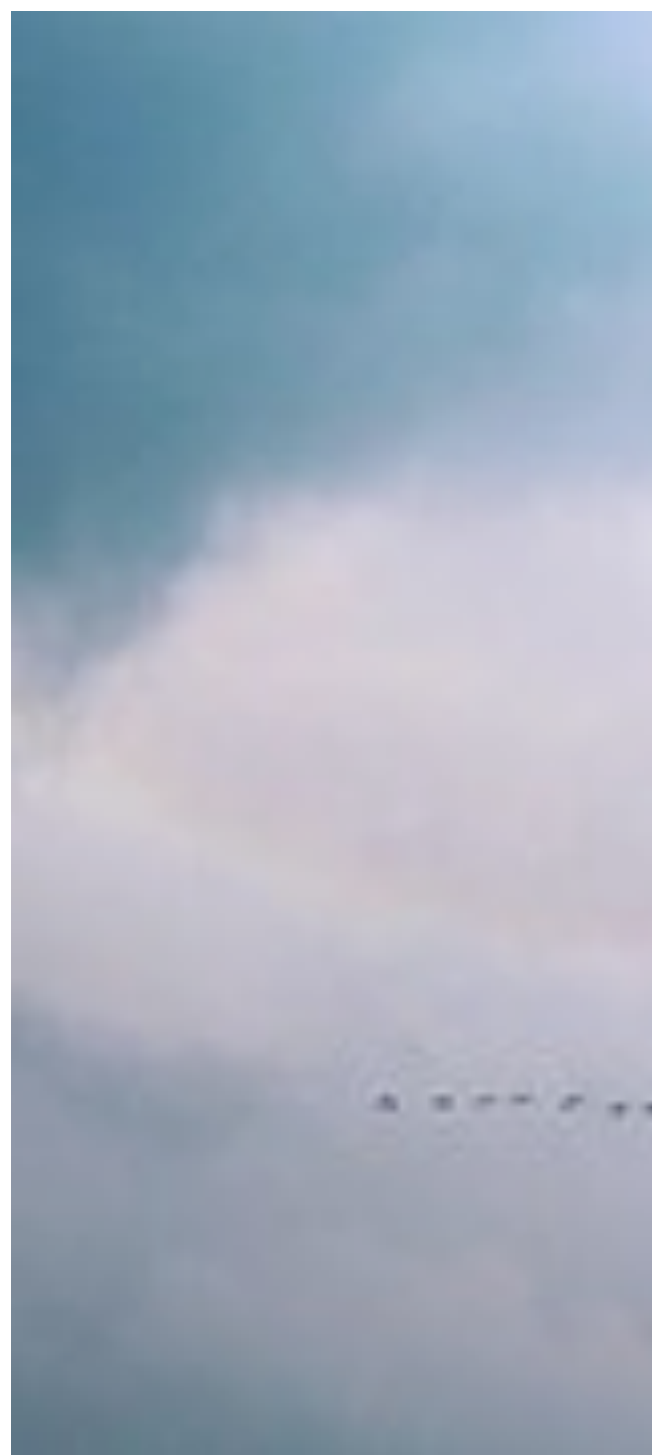
It's difficult to apply resilience terminology to this population. These populations represent last vestiges of the traditional hunter-gatherer populations and they are maintaining lifestyles that have endured for millennia. However, it would be appropriate to describe these indigenous people as resilient based on their abilities to maintain their traditional lifestyles (including native language, rituals, and cultural art forms) despite more than 400 years of contact and exploitive conquest by European conquistadores.

6. Do you identify any distinctive ability that therapists should have in their approach to indigenous people? What kind of personal benefits have you achieved with your work with this specific population?

The most important qualities that health practitioners should have when approaching indigenous people is respect for cultural traditions and appropriate humility, acknowledging that professional preparation in Western medicine is insufficient to fully understand their lifestyles and worldview. My experience during my social service year immediately following medical school helped to form my decision to specialize in psychiatry – in a curious way. Living and working in this indigenous community provided the opportunity to observe a population free from chronic disease that exhibited robust mental health in contrast to urban populations elsewhere in Colombia. This influenced my desire to work both clinically and from a public health vantage on promotion of mental wellness.



Zelde Espinel



SHARING RESOURCES

Psychological Self-Help Guide for Traumatic Events Guide developed after March 11th terrorist attacks in Madrid

On the early morning of March 11th of 2004, several bombs exploded almost simultaneously in different trains in Madrid. It is the second most important terrorist attack, second only to the New York attacks of September 11th. 192 people, in their daily way to work, were killed that morning, and more than 2.000 people were injured. Those attacks tested the response, not only of the public Administration, but also the response of the security forces, firemen, doctors, nurses, social workers, psychologists... as well as all the citizens of Madrid. Their individual and collective response to such tragic event was checked that day.

Psychologists also had a prime role in the development of the events of that day, in the helping tasks and health assistance of the people involved in the attacks, as direct victims or as helpers. As it is widely known, the first moments after a traumatic event are the

most decisive ones in order to prevent future severe psychological injuries. Thus, it was necessary to take care of all the people who were involved, so more than 2.000 psychologists offered themselves in order to collaborate in this fundamental labour. Many of them phoned to the Universitarian Psychology Clinic of the *Universidad Complutense de Madrid*, asking for information about how they could help. It was then when a fundamental issue arose, which was to establish some general action rules, a textbook for guiding all the people affected by the attacks, a guide which led all the psychologists in their actions, and led the people who faced the injured, their relatives and friends. This guide had to be an essential guide for all the psychologists, and had to be based in all the available knowledge about effective interventions after traumatic events. Thus, an agile, simple and accurate self-

help psychological guide, which could be easily handled and accessible by anyone who wanted to use it, started to become a prime necessity.

That very night a first guide was freely uploaded to the Internet, and people immediately started to download it. Thousands of people downloaded it in the days which followed the 11-M., which meant a wide success and proved

the importance and the desire of the population of having resources in order to deal with the psychological consequences that an event of those characteristics doubtlessly generates.

This guide is freely accessible on the following link:

<http://www.ucm.es/estres/ayuda-victimas>

References:

- Guía de autoayuda tras los atentados del 11 de marzo. En M. P. García-Vera, F. J. Labrador y C. Larroy (Eds.), *Ayuda psicológica a las víctimas de atentados y catástrofes. Guía de autoayuda y pautas de intervención elaboradas tras los atentados del 11-M* (pp. 35-68). Madrid: Editorial Complutense [<http://biblioteca.ucm.es/ecsa/36254.php?id=33>].



ACTIVITIES

EVENTS



July, 2013

- **71st Annual Convention, International Council of Psychologists**, July 4-7, Jakarta. <http://www.icpweb.org/>
- **V Congreso Internacional de Psicología-X Taller Internacional de Psicología Latinoamericana y del Caribe**. July 17-21, Santiago Cuba, Cuba. <http://isdfundacion.org/2013/06/21/v-congreso-internacional-de-psicologia-y-x-taller-internacional-de-psicologia-latinoamericana-y-caribena-julio-2013-cuba/>
- **7th World Congress of Behavioral & Cognitive Therapies**, July, 22-25, Lima, Perú. <http://www.wcbct2013.pe/site/es/bienvenida>
- **5th International Conference on Licensure, Certification, and Credentialing in Psychology**. July 9-13, Sweden, Stockholm. <http://www.ecp2013.se/>
- **13th European Congress of Psychology (ECP) Stockholm, Sweden** 9-12, Sweden, Stockholm. <http://www.ecp2013.se/>

- 34th Interamerican Congress of Psychology. July 15th-19th, Brasilia, Brasil.
<http://www.psaude2013.org>.

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+ Belén Reguera

+ Pedro Altungy