INTERNATIONAL ASSOCIATION OF APPLIED PSYCHOLOGY (IAAP)

Division 6: Clinical and Community Psychology

Welcome to the homepage of Division 6 of the IAAP!!

Volumen 1, Issue 1, July 2012

Contents:

President's Message

To all members of IAAP Division 6

Kia ora, Greetings,

It gives me great pleasure to participate in the inauguration of the Division website. This has come about as a result of the excellent initiatives and untiring work of Dr María Paz García-Vera, President Elect of the Division.

Once launched the website becomes a resource that we can all share and benefit from. This will only be the case, however, if we each contribute to it as well as gaining information from it. If we do this it will become a very special attribute of the Division, and indeed of the IAAP.

Applied Psychology, and indeed the basic science that underpins applications, in all its aspects, has immense and under-valued contributions to make to humanity. Clinical and Community Psychology is especially relevant to many of the challenges we face, and this will only become more apparent and urgent with time. In addition to the problems with which individuals and communities have contended for all of history – war, violence, civil unrest, criminal assault, sexual abuse, material privation, discrimination, and the problems of disabilities and physical and mental ill-health, etc – our generation, and the generations of our children and grandchildren will contend with a new set of difficulties arising from global climate change. This is not something that humankind has confronted for millennia, and when we last did so, our numbers were small and our impact on the ecosystem slight. Now our numbers and our impact strain the resources of a planet.

My recent experience of living through a natural disaster has sharpened my sense of urgency about marshalling our resources as applied psychologists to identify and meet these imminent challenges. I hope that the website can become a place where our collective wisdom, creativity, and efficacy can be displayed to the benefit of all. Through it we can "think globally, act locally, and share globally" (Munoz, Beardslee, & Leykin, 2012).

Kia kaha
(Remain strong and committed)

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Reference: Munoz, R.F., Beardslee, W.R., & Leykin, Y. (2012). Major depression can be prevented. American Psychologist, 67(4), 285 – 295.

Executive Committee

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Connecting Members

The main purpose of this website is to promote activities and services to our members and to get known 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 posible.....

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 main 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

IAAP Division 6 Survey

Personal Information

Reset Submit

Name: _____
☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Surname: _____
☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Age: ____
☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Gender: ○Male ○Female
☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Academic information

Academic degree: _____
☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Master´s degree: ○No ○Yes Please, specify Master's degree titles(s):

_____
☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Doctor´s degree ○Yes ○No Please, specify Doctor's degree titles(s):

_____
☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Specialization area

(list a maximum of 6 choices in order of preference by selecting the number of the correspondig topic. You can add other 2 topics if you want)

Topics: ___, ___, ___, ___, ___, ___
Others: _____, _____
☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Areas of interest/research

(check up a maximum of 6 choices in order of preference by selecting the number of the correspondig topic. You can add other 2 topics if you want)

Topics: ___, ___, ___, ___, ___, ___
Others: _____, _____
☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Work

Current job position: _____

☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Current institutions or workplaces (enter up to 3):

_____

_____

_____

☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Workplace address: _____

☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

City: _____

☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

State:_____

☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Zip code: _____

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Country: _____

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Phone number: _____

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Fax: _____

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Email address: _____

☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Website: _____

☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Career resumes (500 words max):

☐ *"Please, mark the following box if you agree to share this information with other IAAP members"*

Most relevant publications (500 words max)

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List of topics

1. Addictions
2. ADHD
3. Aging
4. Alzheimer's and dementias
5. Anger
6. Anxiety
7. Assesment
8. Autism
9. Affective disorders
10. Biofeedback
11. Bullying
12. Burnout
13. Cancer
14. Children
15. Cognitive-behavioral treatments
16. Couples
17. Death & Dying
18. Diagnosis
19. Disability
20. Eating Disorders
21. EMDR
22. Emergencies
23. Emotional Health
24. Environment
25. Ethics
26. Evidenced-based treatments
27. Family planning
28. Health education
29. HIV & AIDS
30. Human Rights
31. Hypnosis
32. Immigration
33. Intelligence
34. Interpersonal therapy
35. Kids & the Media
36. Law & Psychology
37. Learning & Memory
38. Military
39. Natural Disasters
40. Obesity
41. Psychology and Health
42. Psychophysiological disorders
43. Parenting
44. Personality
45. Prevention
46. Psychoanalysis
47. Terrorism
48. Trauma / Post-traumatic Stress Disorder
49. Psychosis
50. Sexual Abuse
51. Sexuality
52. Sleep
53. Sport and Exercise
54. Stress
55. Suicide
56. Systemic therapy
57. Teens
58. Violence
59. Women & Men
60. Workplace Issues

Experts Across the World

You can find articles and interviews with the aim of presenting experiences and professional challenges from the diverse countries.

Articles

This is a menu to share articles about professional topics, experiences, up-to-date topics, etc., with experts from diverse countries. The articles will be arranged by alphabetical order of the country, then the date, the author, and lastly the article title.

Indonesian Clinical Psychologists in brief history

Monty P. Satiadarma

Psychology in Indonesia started around 1953 and was introduced by Slamet Iman Santoso, a professor in psychiatry, soon after he returned from Holland. The University of Indonesia started the program of psychology as a division in the medical department of the University of Indonesia. The first graduate of the program was Fuad Hassan (later he became the National Minister of Education), and his diploma was from the Medical Department. Later Fuad Hassan obtained his PhD from Toronto, Canada, and he became the first Dean of Psychology of The University of Indonesia.

Between the years of 1960s to 1990s the educational program in psychology in Indonesia was based on European educational program, primarily Dutch program in preparing the students to be clinician. The influence from the medical program was very strong with great numbers of biology and neurology classes, besides great emphasis on psychoanalytical approach. The undergraduate program was conducted in 4 years, followed by 2 years graduate program including internships. Once they graduated they will be licensed as psychologists. The degree was called "doctorandus" (candidate for doctor), thus they were eligible to pursue the doctorate program. Three main Indonesian universities, The University of Indonesia, The Pajajaran University, and The Gajah Mada University, developed the programs and get connected with Dutch universities such as Nijmegen, etc.

However, only a small numbers of psychologists work in hospitals as clinicians, and few others had private practice. Most of them work in companies and industries, and even private practice psychologists often conducted psychological testing for the sake of recruitment or doing vocational counseling. Providing services for the sake of industrial and organizational matters gives more financial support for the practitioners rather than being employed in hospitals which became more adjunctive therapists to assist medical doctors or psychiatrists.

Starting around early 1990s, the minister of education changed the policy. Graduate students in psychology do not have to have undergraduate psychology degree unless they want to be clinical psychologists. Meanwhile, psychology graduates became some of the mostly looked for being employed in numbers of companies.

Undergraduate psychology programs were booming in numbers of universities, primarily for employment reasons, but also for having eligibility

to attend clinical program which make them also eligible to have private practice after obtaining the degree. Those who do not continue to be clinicians remain having great opportunities for employment besides also allowed to take further educational program in different fields.

Limited numbers of universities provide training in clinical psychology. It may still be the priority of the program, but also considered the most challenging program with rather tight selection process, besides requirements of undergraduate in psychology. During the final year of the program, students are required to write a research paper (thesis) based on treatment on mental disorders, and to work in hospital settings. These are considered the most challenging requirements that may cause the students to cancel attending the clinical program and to change their mind to attend other programs that has no such requirements.

Borobudur, Java, Indonesia

The benefits of being clinical psychologist in Indonesia are the eligibility to work on various different settings besides the eligibility of having private practice and conducting psychotherapeutic treatments with various different modalities. However, those who have interests to be industrial psychologists do not need to take education in clinical settings anymore and working as industrial psychologists may give better financial support than being clinicians. Also those who have more interests in educational psychology do not need to take clinical traineeship for secure employment in education settings; and as schools and universities are growing fields, the employment for psychology graduates are growing as well. In the mean time, the requirements for being clinicians remain high and considered challenging as well as difficult for number of students.

The role of clinical psychologists in Indonesia is not as strong as in many other countries. Although they have various forms of eligibility to practice, they are not yet mandated to determine for example whether a person is suppose to be hospitalized, rehabilitated or being charged in court. Those decisions are based on psychiatrist referral. The psychologist may give suggestion based on psychological diagnosis, but referral is supposed to be more based on psychiatric considerations.

Recently, the social department and health department of the Indonesian government have accepted the role of clinical psychologists in a better position in various government institutions such as in numbers of rehabilitation centers besides in hospital settings. Also, as a part of educational programs, numbers of schools regulate that students entering their programs must also submit clinical evaluation indicating their mental concerns.

We are hoping that the role of clinical psychologists in Indonesia is increasing in the near future, and indeed the training quality and research concerns must also well developed. The Indonesian Psychological Association routinely conducts meetings, annual congresses and conferences for the quality development of the clinicians. They also invite speakers and experts from abroad besides sending delegates to attend international congresses and conferences. The progress may be rather slow associated with limited financial supports, yet Indonesian Clinical Psychologists remain positive on keeping their attitudes to participate in improving better living conditions for the society, domestically and internationally.

Monty P. Satiadarma.

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Former Vice Rector – Tarumanagara University (2006-2008)
Former Dean of Psychology, Tarumanagara University (1997-2006)
Indonesian Area Chair –International Council of Psychologists
Co-founder – Asian Psychological Association

Psychology and the Canterbury (NZ) earthquakes (Part 1)

Neville M Blampied

In the early hours of the morning of 4th September, 2010, residents of the Canterbury region in New Zealand's South Island, and its major city, Christchurch (regional population ~400,000), were woken by the noise and shaking of an earthquake. Earthquakes are not unfamiliar to us. NZ lies on the Pacific "ring of fire" and a major fault-line – the Alpine Fault – runs down the western side of the Island, marking where the Pacific tectonic plate grinds past the Australian plate. As the shaking grew in severity most of us assumed that this was the long-predicted "big one" – an overdue release of seismic energy on the Alpine Fault. We soon learned, however, that we had experienced a 7.1 magnitude quake on a previously unknown fault lying under rural land about 30kms west of the city.

Canterbury has been occupied by humans for about 700 years. The indigenous Maori used the swamps where the modern city of Christchurch now stands for food-gathering but it was not until European settlers arrived in 1850 that the swamps were drained and a city built. Christchurch retained many of its late 19th – early 20th C heritage buildings, constructed of stone and unreinforced masonry. Such buildings suffered extensive damage, and huge areas of the city were covered with liquefaction silt, as the vibration of the quake turned previously swampy soil to liquid. Despite the extensive damage, however, there were no deaths and only two serious injuries – truly remarkable given the severity of the earthquake.

The widespread reaction in the days afterwards was that, first, we had been extremely lucky, and second, that we had discovered (or rediscovered) a new sense of community, as folk checked on neighbours, helped dig out the liquefaction, and assisted with the social and economic repair that quickly got underway. But this sense of community was soon to be tested to a new level. At 12.51pm on Tuesday, 22 February, 2011, a catastrophic 6.1 magnitude aftershock struck, at shallow depth, on another unknown fault, this time within 10kms of downtown, and with an orientation that funnelled energy into the centre. The vertical accelerations, at >2gravities and among the largest ever recorded for a modern earthquake, greatly exceeded the building code. The centre of the city was devastated, severe damage was widespread across the region, liquefaction was worse in depth and extent than in the September quake, more than 6000 people were injured, and 185 died. Among the dead was a leading clinical psychologist (and her client).

The city was without power, water, and sewage, although the telephone system continued to operate, as did emergency services and the main hospitals, despite damage. Roads were badly damaged, many bridges unusable. A state of emergency was declared, the central city area was cordoned off by the NZ armed forces, and Urban Search and Rescue (USAR) teams from all round NZ flew in. They were soon joined by teams from Australia, Singapore, Japan1, the UK and USA, and we remain profoundly grateful for that assistance, and other assistance by way of financial aid that has been offered from around the world.

Over the next days, weeks and months emergency welfare centers were set up across the city, homes and businesses throughout the city were checked for casualties and welfare needs, basic services restored, and some semblance of social and business life resumed. One remarkable story of volunteer response is the "Student Army". Since all the city's universities, polytechnics and schools were closed, a group of student leaders at the University of Canterbury set up a system through which student volunteers could be despatched to different parts of the city armed with shovels and wheelbarrows to help dig properties out from the liquefaction silt. At its peak several thousand Student Army helpers were organised daily, using the social media Facebook. Other volunteer groups were modelled on this, such as the "Farmy Army" which involved farmers from nearby rural communities. All told,

Debris crushed a car outside the Christchurch Catholic Cathedral after an earthquake rocked Christchurch, New Zealand, Tuesday, Feb. 22, 2011.

more than 500,000 tonnes of silt has been removed from Christchurch since the earthquakes began. However, one year on and 10,000+ aftershock later, the centre of the city remains cordoned off, almost all heritage buildings have been or will be demolished (including our iconic cathedrals), most high-rise buildings, major art venues, libraries, and sports facilities are closed and many are waiting for demolition, more than 6000 homes have been condemned, tens of thousands of homes are damaged but habitable, and large tracts of city land are deemed too dangerous to build on again.

What was the response of psychologists to this extreme experience? Among affected psychologists were clinical psychologists employed in the public health system (the Canterbury District Health Board, CDHB); clinical psychologists employed in private practice; some other private practitioners, mostly in the industrial-organizational area; educational psychologists serving the public school system, NZ Defence Force psychologists, and academic psychologists and their students, mostly at the University of Canterbury. All experienced some level of personal distress and disruption from the earthquake, including the destruction of homes and places of work. Nevertheless, within days most were back functioning in some professional role. In this part of the account I will focus on clinical, industrial-organizational, and educational psychologists' roles and responses. In the second part I will discuss the response of academics, especially their research.

For many organizations and the individuals within them, the initial September earthquake provided a rehearsal of the responses that were required on a much larger scale following 22nd February. For the CDHB psychologists, following both quakes, they provided professional psychological support to the Emergency Welfare Centres that were set up as refuges for displaced people. This provided advice and support to the emergency management personnel, helped to monitor and deal with growing stress and distress among such staff, and provided direct clinical services to individuals using the Emergency Centres, for instance by monitoring those with pre-existing mental health conditions who were experiencing exacerbation of their symptoms, and dealing with distress and anxiety arising from events such as continuing aftershocks, or the necessity of returning home. The professional challenges faced were much greater after the February quake, both because of the severity of the disaster

and the fact that many of the mental health services lost access to their buildings and therefore to their professional records and resources. Despite continuing losses and difficulties two leaders of this group concluded "The magnitude of these events has also forced a 'shake-up' … of the boundaries and silos that people have traditionally worked in. This has led to improved communication between key agencies and more collaborative and flexible ways of working than was the case before September, 2010." (Chanbers & Henderson, 2011).

In the immediate aftermath of the February event, CDHB psychologists, private practitioners, and academics were involved in providing direct support to rescue workers, family members, and survivors particularly at the two sites where the collapse of multi-story buildings resulted in many casualties (116 at one site alone). This support later extended to personnel of the Disaster Victim Identification team established at a nearby military base. It quickly became clear that different organizations had quite different levels of understanding of the benefits of and the capacity to engage with psychological input in such a situation. For instance, the NZ military has its own psychologists (Sutton & Fourie, 2011) and the NZ Police force, nationally and locally, has a long-standing system for calling on psychologists to help with staff distress and trauma. At the other extreme, it took some time to realise that the men operating the cranes and diggers that were being used to recover bodies from the wreckage (mostly employees of private contractors) had no support system. Some ingenuity was called on to arrange appropriate support for these indispensible workers. For many private practitioners their workplaces were damaged or inaccessible behind the city cordon, and so for a time a number volunteered to assist with counselling at the Canterbury Charity Hospital. This is a fully volunteer hospital which, prior to the February quake, provided day-surgery treatment for those not qualifying for public or private health services. Following the quake the hospital's management realised the need for counselling services, recruited volunteer counsellors, and found premises for the work. During 2011 it is estimated to have served approximately 1200 clients. Among the psychologists volunteering were the staff and trainee clinical psychologists of the University's Psychology Clinic who unable to access their university facilities for three months.

The coordination of all this work was assisted by an informal weekly meeting attended by a diverse group of psychologists. This group (assisted by CDHB and academic psychologists) also arranged for public information statements to be distributed in various media, designed to help the public understand normal responses to stress and trauma, deal with anxiety, recognise when family members, especially children needed help, and know where to locate help when it was needed. This was greatly assisted by material generously supplied by the NZ Psychological Society (NZPsS), the NZ College of Clinical Psychology, and the Australian Psychological Society. Later, the Association for Psychological Science made a useful document available (Bonnano, Brewin, Kaniasty, & La Greca, 2010). Underlying much of this public education was a desire to moderate references in the news media to "trauma" and "post-traumatic stress disorder" (PTSD) etc. Our fear was that this would set up an expectation that everyone was going to suffer PTSD or similar, and to some extent create a self-fulfilling prophecy.

Industrial-Organizational psychologists, almost all of whom are private practitioners, tell a similar story (Black & McLean, 2011) of the need to provide educational resources for managers and workers that counteracted myths about "trauma", that facilitated coping, and that helped identify those who needed more specialist support and help. Among other communication channels, podcasts on company intranets were used to disseminate such information. These authors also discuss "Community Divergence" which occurred in a number of contexts, but in particular reflected that the most seriously affected parts of the city were the centre and the east, and the east is industrial and working-class, while professionals and managers tended to live in western suburbs that were not as badly affected. This posed a challenge for management and leadership in some organizations. Equally, however, phone or text messages from managers checking on workers' welfare and situation, similar mutual contacts between employees, and rapid organization of work, such as clearing up, rescuing equipment, and helping with business relocation, all helped with personal recovery and resilience.

In NZ Educational (School) Psychologists are employed by the government Ministry of

Members of Canterbury University volunteer army clean up liquefaction mud on February 24, 2011 in Christchurch, NZ.

Education, and provide services from pre-school to high school levels. Schools, however, are autonomous entities, each with its own Board of Trustees, and a Principal (as CEO and professional leader of the teaching staff). It is much to the credit of Christchurch schools that no school pupils or staff were killed or seriously injured in the February earthquake, and the general experience of parents after they had fought their way through gridlocked traffic and damaged streets to pick up their children was to find them in well-organised class groups waiting in relative calm on the school's open spaces – notwithstanding constant and often major aftershocks. After the September earthquake schools were closed for only a short time, but from February onwards, schools were closed for weeks or more, some schools were forced to relocate, and others had to shift their daily schedule so that two schools could use the same facilities, one in the morning the other in the afternoon. So in addition to the disruption of life that everyone experienced, many pupils and teachers also faced dealing with unfamiliar places and routines. Educational Psychologists worked within a Ministry-devised psychosocial support framework described as Respond, Recover, Renew (Brown, 2011). Again, provision of information through websites and face-to-face presentations was a key task. While deeply cognizant of safety issues, schools were encouraged to open as soon as possible, recognizing that getting back to familiar routines and social relationships was very important for child and family wellbeing. An Education Welfare Response Team was formed to provide more specialist help to school staff and students. The most seriously affected schools had their own team while other schools worked through liaison staff. As was the case with CDHB psychologist, educational psychologists typically worked in multi-disciplinary teams, and this seems to have been a positive experience (Gilmore & Larson, 2011).

In part 2 I will discuss the response to the earthquake of the academic community, and also say more about how psychologists' organizations, especially NZPsS, have engaged with the aftermath. Some of this research will be presented at the International Congress of Psychology, Cape Town, July, 2012.

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Footnotes:

1. When the devastating earthquake and tsunami struck Japan on 11th March, 2011, the Japanese USAR team returned to Japan. We were able to reciprocate their help, and sent a NZUSAR team to help with their much larger disaster.

The development of the profession of general health psychologist and the master´s degree in General Health Psychology: challenges, opportunities and threats for Clinical and Health Psychology in Spain

Maria Paz Garcia-Vera

In the past 30 years, the basic structure of the profession of psychologist in Spain, insofar as professional practice within the sphere of clinical and health psychology, has advanced notably but is still incomplete.

On the one hand, the generic practice of the psychologist profession for all areas (clinical, social, work/organizational, educational, etc.) is acknowledged with the sole requirements of having a title of Licentiate's/Bachelor's degree in Psychology and being registered in the Official Associations of Psychologists (in Spanish, Colegios Oficiales de Psicólogos or COP). In Spain, both degrees are undergraduate university degrees with curricula composed of courses exclusively in Psychology that entail access to the professional license, that is, the practice of the profession of psychologist.

On the other hand, in 1998, the official title of Psychologist Specializing in Clinical Psychology was established by law. This involves a higher level of theoretical-practical training and specialization in diagnosis, assessment, treatment, and rehabilitation of mental, emotional, and behavioral disorders. Psychologists can access this title only through a specialized training in clinical psychology via the residency system in the National Health System (training program for the Intern-Resident Psychologist or PIR training1), although, when this law was passed, there began an extraordinary and temporary process that the psychologists who had been practicing their profession in the clinical sphere before the law was passed could request and obtain the title without having to undergo the PIR training, if they met minimum criteria of theoretical-practical training and years of practice in professional activities within the specialty of clinical psychology. Subsequently, a law was passed in 2003 to regulate health professions, which included among the certified and regulated health professions that of the psychologist who had the title of Specializing in Clinical Psychology, but not the licentiate/bachelor in Psychology who did not have this title. Lastly, also in 2003, another law established that only health professionals could work in health centers and health services, either public or private, of any type and nature.

Leaving aside the debate about whether or not the profession of psychologist without a specialist title can be considered a health profession (Duro Martínez, 2004), these legal regulations have led to the consolidation of clinical psychology in Spain. Moreover, the demand of a high level of training and specialization to practice clinical psychology is no doubt a guarantee of quality for society.

Nevertheless, these laws have also caused a series of problems and conflicts that have affected an large number of psychologists who work in the clinical sphere, Psychology students who graduated after 1998, and the future of psychological care of the Spanish population, and they have also confronted the COP, representatives of the academic institutions, and the delegates of the Psychology students with the diverse Spanish governments.

Up to 2003, Psychology graduates without a specialist title could open a consulting office, clinics, or clinical psychology center and register it without any trouble in the health center registry. After passing these laws, these psychologists were put in a difficult situation regarding work and juridical insecurity, because these laws affected both the centers and services of the public health system, as well as the private consulting offices, clinics, and centers, where 80% of the Spanish psychologists who practice their profession in the clinical sphere are estimated to be working (Santolaya Ochando, Berdullas Temes, & Fernández Hermida, 2001).

Of course, a large number of these psychologists had undergone the extraordinary process to obtain the title of Specializing in Clinical Psychology (more than 14,500 requests were presented) and, therefore, their work situation was regulated insofar as they achieved the title (more than 7,000 until now) and, as health professionals, they could continue to work in health centers as they had before. However, the Psychology students who had finished their studies after 1998 were even worse off because, although most of them were interested in working in the clinical sphere, the only possibility to do so was through access to the PIR training, the only pathway as of that year to obtain the title of Specializing in Clinical Psychology and, therefore, to be considered health professionals and be able to work legally in consulting offices, clinics, and health centers. Currently, there are more than 56,000 students enrolled in the Psychology faculties and, in those that provide specific curricular itineraries, 40-50% of the students choose the curricular itinerary of clinical and health psychology. However, from 1998 to 2012, only between 60 and 141 places to access the PIR training have been convoked yearly. This high student-to-place ratio could be interpreted in terms of a misfit between the high number of Psychology students and the actual possibilities of labor insertion in Spain. In fact, this misfit is quite real, but it is also obvious that such a low number of PIR places cannot ensure either the generational takeover of the clinical psychologists or the psychotherapeutic care of a population that already exceeds 47 million inhabitants.

Therefore, although at short term the high number of psychologists who until now have passed the extraordinary process to obtain the title of Psychologist Specializing in Clinical Psychology ensures that the psychotherapeutic care of the Spanish population is taken care of, at medium and long term, the scanty number of places for the PIR training, the only official pathway to practice in the clinical sphere as a health professional, places such care at serious risk. In this sense, it is important to point out that most of the psychologists who work in the clinical sphere do so in private consulting offices, clinics, and centers, and that there is a scarce number of psychologists who work in the Spanish public network of mental health care. Thus, although the employment of the clinical psychologists in the public sector has not ceased to

grow in the last 25 years, it is still far from the standards of other developed countries that, like Spain, have an important public health system. In 2003, the Spanish public network of mental health care had 4.3 clinical psychologists for every 100,000 inhabitants (Salvador, 2005), whereas the median for high income countries was 14 psychologists for every 100,000 inhabitants in 2005 (World Health Organization, 2005).

To solve those problems caused by the 2003 laws aimed to regulate health professions and centers, in 2006 and, later, in November 2011, the Spanish Government passed two laws which allowed psychologists to open or work in clinical psychology consulting offices, clinics, and centers even if they did not have the title of Specializing in Clinical Psychology (and were therefore not officially considered health professionals), inasmuch as they accredited having studied Psychology following a curricular itinerary qualified by its link with the teaching area of personality, assessment, and psychological treatment or clinical and health psychology, or they accredited having complementary postgraduate training in these areas of not less than 400 hours, of which at least 100 should be practice supervised by psychologists specialized in clinical psychology, in centers, institutions, university psychology services, clinical psychology consulting offices or clinics accredited as health centers.

The November 2011 law is currently in force, but it is a temporary solution (until 2014) while a more appropriate solution can be implemented. This

solution was also proposed by the November 2011 law and implies the development of a new health profession or health professional title named General Health Psychologist, that requires a specialized training in clinical and health psychology via an official university Master's degree in General Health Psychology within the framework of the European Higher Education Area2. Thus, this Master's degree extends the possibility of being legally recognized as health professional and will ensure higher training in clinical and health psychology than does the Licentiate's/Bachelor's degree in Psychology.

This Master's degree, to which only the licenciate/bachelor in Psychology would have access, would last 1.5 years (90 ECTS credits; see footnote 2) and would have national guidelines about the minimum of hours required of supervised clinical practice and theoretical-practical training in certain subjects such as, for example, psychopathology, psychological assessment, psychotherapy, and so on. In fact, to obtain the title of General Health Psychologist, students should have taken a minimum of 180 ECTS credits on health and clinical psychology taking into account both the credits of the Bachelor's degree in Psychology and the Master's degree in General Health Psychology. The Ministry of Health, the Ministry of Education and the professional and academic representatives of Spanish Psychology are collaborating and working on the outline of those guidelines and, in fact, the November 2011 law requires that those guidelines are set by April 2012. Later, based on those guidelines, Spanish universities should develop the curricula of their Master's degrees in General Health Psychology and submit them to an assessment process by a State agency that assesses the quality of the Spanish higher education (the National Agency of Assessment of the Quality and Accreditation: ANECA). This agency is in charge of verifying and accrediting that the university curricula meet the pertinent training goals, for example, the acquisition of the basic competences in health and clinical psychology set by the national guidelines for the General Health Psychologist.

Therefore, the Master's degree in General Health Psychologist could begin to be implemented, at the earliest, in the 2012-2013 course, but in any event, its development and the development of the profession of General Health Psychologist pose some challenges that could become threats or opportunities to the Spanish psychology depending on the actions, not only of the politicians in charge, but also of the academics and professionals.

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Notes:

1. The PIR training is regulated by the Spanish Ministry of Health and the Spanish Ministry of Education, and to access it, students must have a licentiate's/bachelor's degree in Psychology and have passed the selective test held at the national level. The PIR training program lasts 4 years and is based on the occupational integration of the resident in hospitals and health centers of the National Health System through an occupational training contract to provide health care and simultaneously receive training.
2. The European Higher Education Area (EHEA) is a policy commitment endorsed by 47 European states to improve the quality, mobility, diversity, and competitiveness of university education. This is done by adopting a series of common instruments, for example, a comparable degree system with three cycles (Bachelor, Master, and Doctorate) and a learner-centered system for academic credit accumulation and transfer (European Credit Transfer and Accumulation System or ECTS) based on student workload, that is, the time students typically need to complete all learning activities (such as lectures, seminars, projects, practical work, self-study and examinations) required to achieve the expected learning outcomes of the study program (one ECTS credit corresponds to 25-30 hours of work). Typically, the first cycle includes 180-240 ECTS credits, while the second cycle comprises 60-120 ECTS credits.

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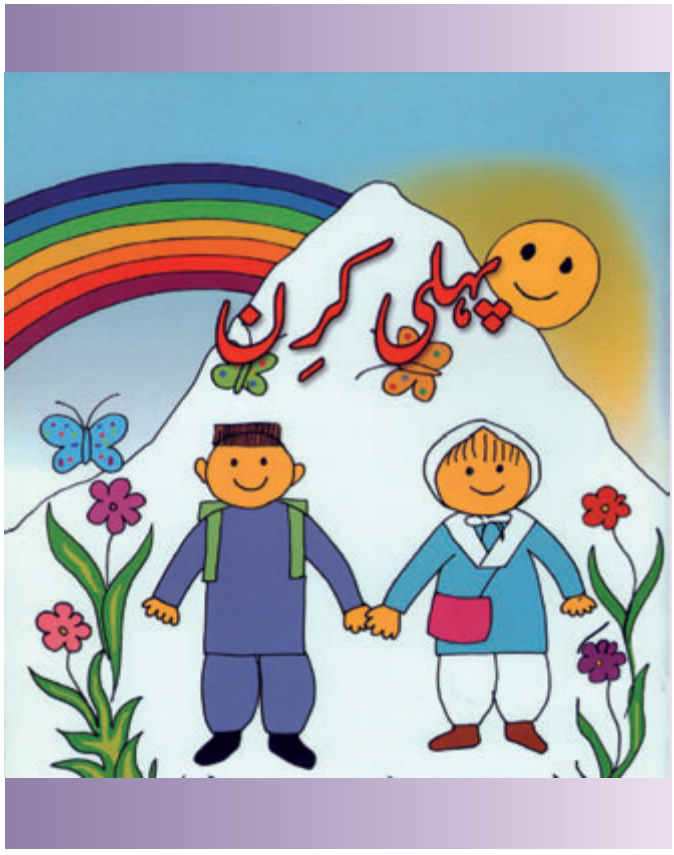
Research and Professional Challenges of a Pakistani psychologist

Prof. Dr Najma Najam

As a psychologist, living and working in one of the most turbulent regions of the world where disasters and trauma have become a part of everyday life our professional capacities are challenged continuously. Pakistani Psychology has emerged to meet these challenges in different ways, through conferences, workshops, specialized training, research, aimed at understanding and helping the communities, as well as the professionals who deal with these challenges.

Applied Research:

a) Active research has been carried out on issues related to victims of trauma, (earthquakes, floods, bomb blasts, migration, etc). Several papers have been presented at national and international forums. The papers range from studies on dreams and nightmares of child earthquake survivors to psychological issues of displaced persons, and refugees (especially women and children).



b) Assessment of trauma victims for PTSD and intervention. Also assessment of security personnel placed on high security risk duties for screening of those who may be psychologically at risk.

c) Pehli Kiran: (First ray of Sunshine): Booklet to help children in distress was prepared by a team of Psychologists, Behavioural Scientists at Fatima Jinnah Women University, supported by Kinder Hof Germany(through the Doer Trust). This was based on children's own stories, and experiences. The booklet also contains incomplete sentences and stories to assess the level of children's distress. Further, it has children's games, some hygiene tips, also cautionary stories (to stay away from strangers etc.).

The following is the list of the work carried out by me and my colleagues. There is much to be done and is being done. Psychologists around the country are working at research and on applied issues. However we need to incorporate the research findings into our courses, our trainings and even outreach services. The impact of the trauma, (terrorism, naural disasters etc.) are going to be a part of our lives -days and years to come, as people live through these traumas everyday.

Prof. Dr Najma Najam
Vice-Chancellor of
Karakoram International
University Gilgit-Baltistan
(KIU) Pakistan.

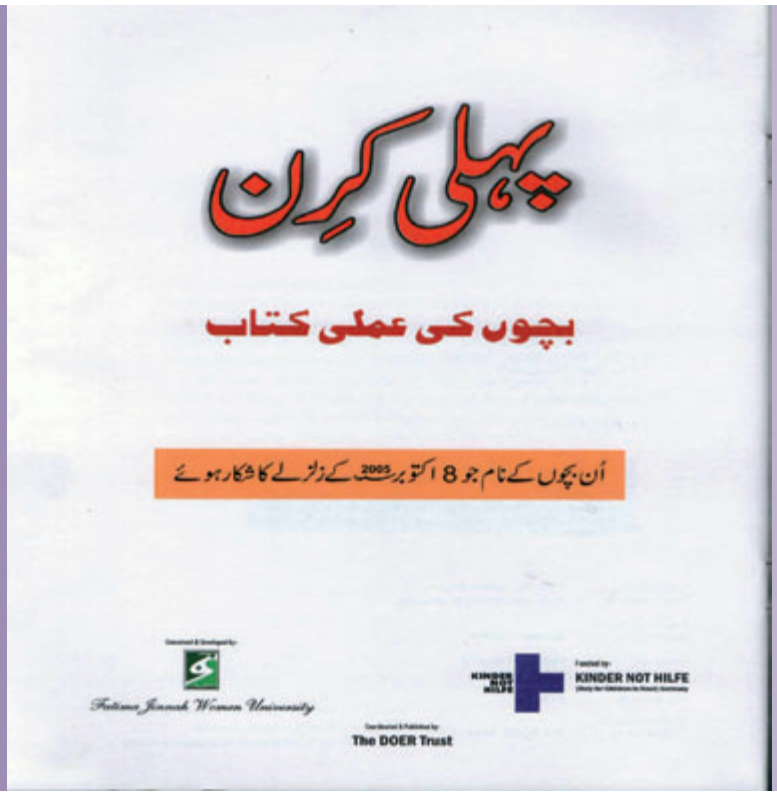
Listing of work carried out:

a) Sept 2004-2005: Assessment and Evaluation of Personalities of Security personnel (for sensitive postings/duties).

b) Oct-dec 2005: A team of Psychologist / professional led by Dr Najma Najam prepared Children's Comfort booklet for Use in Earthquake survived children.

Publications/ proceedings:

c) *Najam, N. Mansoor,A. and Gul,I (2007) Assessment of Security Personnel in Pakistan. In International Perspectives in Psychology. Comunian, A,L. and Roswith, R. (Ed.s) Proceedings of the 64th Convention of the International Council of Psychologists (ICP), 10-13 July



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3. Najam,N (2010) Women's resilience and Reconstruction of Keynote address at the one day conference on Women's resilience, Coping and reconstruction. Organized by the department of AppliedPsychology Punjab university Lahore, Pakistan, March 11th 2010.
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Student's experiences

Experiences of studying Psychology in different countries, Erasmus scholarships, or sojourns in other universities or research centers.

The real life of an exchange student in Madrid (Spain)

For students describe their experiences of studying Psychology in different countries. Erasmus scholarchips, or sojourns in other universityies of research centers.

Sabrina van Dijk Student of the Amsterdam 'Vrije universiteit'

The past couple of months I've been living the beautiful life of an exchange-student, getting to know a new country, meeting new people, even learning a new language! I am a dutch student and now for exchange in Madrid, a pretty big culture difference from Holland going to Spain.

Even more than I expected but I love it, until 2 o'clock you are allowed to say good morning and the evening doesn't start until 9 o'clock. Twice a day a hot meal and the discotheques are usually open until 6 o'clock in the morning! To not even begin about the weather, sunny! And of course there is also the Complutense University, which is, besides the fact that there's never toilet paper, also pretty nice!

As an enthusiast student I signed up for 6 courses, of which I dropped one right away when I realized that studying in Spanish (6 months after you've had your first Spanish lessons) isn't as easy as it seems. And now the exams are getting closer and closer I figured that it would be best dropping another course because the Spanish really does slow you down! But even now, before knowing if I will pass any of my exams or not, I can say that I would do it all over again!

It has been such a great experience, you get to know people from all over the world because you really can't escape all the other Exchange students that are all around. To really live and study in another country gives you the chance to really get to know another culture, and the weird thing is that it really does feel like home here!

I love my Spanish roommates, there's always something to do or somewhere to go and I really feel like this is also my city. And I have to admit that, although I love my friends and family at home I cannot say that I'm looking forward to going home again. I fell in love with the Spanish people, the weather, the food and their way of enjoying life! Being an exchange student really enriches you as a person, it really is an unforgettable experience.

Oukje Verkerk Student of the Amsterdam 'Vrije universiteit'

Here you are, the airport of your home country. Just said goodbye to your friends and family and excited to start a new adventure. You have just one suitcase and tried to fit everything in that you'll need for the next 5 months.

Of course this didn't work. A mixture of feelings pass by in the plane: fresh courage and excitement, but at the same time sadness of leaving everything behind.

Probably the most Exchange students recognize this situation. For me it was no different. The first week is always hard. For me it was staying in a hostel where I could barely get sleep, trying to find a room using a language I definitely was not yet well versed in, and at the same time attending Spanish classes.

I didn't really knew anyone yet so I was left to my own devices. It's only the first part, but for me that is the essence of the Exchange experience: to encounter that you can do it on your own. It is amazing how you can built up a life in a few weeks. A complete new social life, learning a new language, and of course get used to a new university. It was really surprising how different the university in Madrid is form my university in Amsterdam: the building, the students, the classes. In Amsterdam my classes are in big lecture-halls, here in Madrid they are more like class rooms.

Furthermore the lessons are more personal with a lot more practical assignments than I'm used to, and the subjects are approached in a different way. The students here wear different style of clothes, and seem a lot more politically involved: everywhere around the university you can find banners and graffiti with political slogans.

I can tell a lot more differences I encountered since I arrived here: the days schedule, family culture, food. But I think the most important is that in spite of all the differences, it takes only a few weeks to start to feel at home. And that's the moment you know you are extending your horizon.

Federico Taretto Estudiante de Psicología de la Universitá degli Studi di Milano Bicocca

The one who told me that I wouldn't regret doing an exchange program was right, I don't regret it, and if I could I would do it all over again and again. It's true that for me, being an Italian, going to spain has been like visiting your cousins who you haven't seen for a long time and you have a lot of things in common.

I came to Madrid the first of June, 2011, three months before the official start of the Exchange period. I went here to enjoy the heat of Madrid in summertime. Besides that it was for learning the language, because I never studied or talked spanish before. And I can honestly say that still today, I never opened (and never had) a single book about spanish, but being almost exclusively around spanish people has helped me a lot with the language.

Exchange, for someone who doesn't know, it also means attending classes! And I have to say that also the universal ambiance I liked a lot. One of the differences with Italy are the papers that you have to turn in with every course. Another difference is the amount of exam periods that you have in wich they can give an exam: in Italy you have 6 possibilities for every course while here…

Well, you know that! And always talking about the exams while here they have a 'tipo-test' or 'multiple choice', in Italy they are almost all oral exams and/or written exams. The first day of class here at the UCM I discovered that there are some teachers who do not appreciate if a student enters or leaves the classroom while he is explaining something… Well, I had a fought the first day!

My only advice to the boys and girls who decide to do an exchange program, wherever you decide to go, is to live this months being around the people from this country, although it might seem difficult in the beginning, it will definitely be worth it!

Karla Nahuat Herrera Estudiante de Psicología de la Universidad Autónoma de Yucatán, México.

At the goodbye at the airport there were no tears, just good wishes and encouragement. For me the adventure started at the boarding gate, in this moment I realized that it was going to be a big challenge and that I would have to face it alone.

There were a lot of emotions, I was excited and scared at the same time but I had hope that everything would be fine. The first days weren't that easy, I think that things like this happen to everyone who decides to live this experience; I needed to find a room soon and because of the stress and the time difference, I found it impossible to sleep well. Individual differences make that some are able to adjust easier than others, and in my case it turned out to be quite difficult.

I had hoped that it was a little easier to make friends at the university, fortunately I managed to find the right people, who helped me a lot, and everything turned out great. So I understood that all of this was a part of the exchange program, you have to develop greater confidence in yourself and in what you can do.

But there will come a moment in which you start to enjoy, to accept the new culture, yes! The party begins, you will make great friends and in my case, there will be a lot of journeys, that allow you to expand your knowledge about other lifestyles. Also (even though some don't believe it) there is time for study and schoolwork.

My courses I've liked from the beginning and luckily I didn't have any problems with the language, because my mother tongue is also Spanish. That made it a lot easier to keep up with all the classes. Now there are just a couple of weeks left before this adventure is over and in the meantime... I continue enjoying it!

Sharing resources

Free Instruments

INTERACTION ANXIOUSNESS SCALE (IAS)

IDENTIFICATION

Original name: Interaction Anxiousness Scale (IAS)

Name in Spanish: Escala de Ansiedad a la Interacción (IAS)

Author: Mark R. Leary

Year: 1983

Versions: There are a Japanese adaptation (Okabayashi, & Seiwa, 1991), a Chinese adaptation (Chun-zi, Yao-xian, & Xiong-zhao, 2004; Wei, Ping-Ging, & Li-Ying, 2006), and two Spanish adaptations, one developed for Chileans (Pérez & Sepúlveda, 1991) and another one developed for Spaniards (Sanz, 1994).

CHARACTERISTICS

Type of instrument: A self-report inventory with a paper-and-pencil format.

Aim: The IAS is aimed at assessing the general tendency for people to experience anxious feelings (the subjective or affective component of social anxiety) in situations involving contingent social interactions ("face-to-face interactions"), that is, situations wherein a person needs the feedback from the others.

Population: The IAS was developed with samples of university students and has been widely researched and validated in that kind of samples. Only a few studies have used the IAS in other kind of samples, for example, in patients with schizophrenia (Chien et al., 2003) and in police recruits (Wei et al., 2006).

Number of items: 15

Description: The IAS is composed of items describing subjective responses of anxiety (feeling tense, nervous, anxious, or uncomfortable) when confronting a variety of situations involving contingent social interactions, that is, situations in which an individual's responses are contingent upon the responses of other persons with whom he or she interacts (e. g., a job interview, a conversation with a person of the opposite sex, talking to a teacher or a boss, talking on the telephone). To control acquiescence, the IAS is also composed of 4 reversed items, that is, items describing subjective responses of calmness (feeling relaxed, at ease) in social situations or items describing the absence of anxiety or shyness in those situations (items 3, 6, 10, and 15). The assessed person has to answer, on a 5-point Likert scale, the degree to which the item describes him or her. Thus, a higher score indicates a higher tendency to experience subjective anxiety in social situations. The IAS tries to separate "social anxiousness" (the proneness to experience anxious feelings in social situations) from behavioral reactions of social anxiety (e. g., avoidance of social situations, reluctance to participate in social situations, inhibition in verbal behaviors, gestures o movements). The IAS supposes that, although both components (subjective and overt behavioral) of social anxiety are often associated, there is no necessary a direct relationship between them.

Therefore, the IAS is an instrument suitable for measuring the subjective components of social anxiety experienced in contingent interactions, but it is not an instrument appropriate for measuring the overt behaviors of social anxiety or other components of social anxiety (e.g., cognitive and physiologic components), or for measuring social anxiety in noncontingent interactions (e.g., speaking in public) or in more specific anxiety-provoking social situations (e.g., intimate relationships).

Psychometric properties:

Reliability: Internal consistency reliability indices (Cronbach's alpha coefficients) ranging from .87 to .89 have been reported for the original version in a variety of samples of US university students (Leary & Kowalski, 1993). With that version and with that kind of sample, Leary (1983) obtained an 8-week test-retest reliability index of .83. Sanz (1994) reported that the internal consistency of the Spanish version of the IAS, as measured by the Cronbach's alpha coefficient, was .90 in a sample of Spanish university students.

Validity: A notable number of studies have found good convergent validity indices for the IAS in samples of university students. These studies have showed that the IAS is moderately correlated to other measures of social anxiety (see data reported by Leary & Kowalski, 1991, concerning the correlations of the IAS with 7 valid instruments of social anxiety). For example, taking Watson and Friend's Social Avoidance and Distress (SAD) scale as reference, Leary and Kowalski (1993) reported a correlation of .71 for the IAS, whereas, examining the Spanish version of the IAS, Sanz (1994) reported correlations of .75 and .71 with the subscales of distress and avoidance of the SAD, respectively. Several studies have also found good discriminant validity indices for the IAS concerning to instrument measuring constructs different to social anxiety (see data reported by Leary & Kowalski, 1991). For example, concerning to depression measures, Leary and Kowalski (1991) found a correlation of .34, whereas Sanz (1994) found correlations of .36 and .43. However, other data provided by Leary and Kowalski (1991) and Sanz (1994) also point out that the IAS, in spite of having appropriate discriminant validity indices, is significantly, although moderately, correlated to other instruments closely related to social anxiety (nomological network validity), such as extraversion and sociability (r = -.47 and -.39, respectively; Leary & Kowalski, 1991) or negative and positive self-statements during social interactions (r = .61 and -.45, respectively; Sanz, 1994). There are also data supporting IAS scores' criterion validity, since those scores allow one to predict the degree of anxiety that university students will experience when they participate in dyadic social situations, for example, after interacting with a person of the opposite sex (r = .48) or during an interview with a researcher (r = .48). Finally, data concerning factorial validity for the IAS are also good since they consistently indicate either the existence of only one factor that, supposedly, reflects the construct of subjective social anxiety in contingent social interactions, or the existence of two highly related factors: a large general social anxiousness factor on which most of the items would load, and a small factor on which items related to interaction with authority figures (e. g., professor, boss). This small factor would reflect a more specific factor of subjective social anxiety in contingent social situations with authority figures, which are particularly problematic for people with social anxiety (Leary & Kowalski, 1987; Sanz, 1994).

ADMINISTRATION

Estimated administration time: Less than 5 minutes.

Norms for administration: For each IAS item, the assessed person is asked to indicate the degree to which the item describes him or her on a 5-point Likert-type scale from 1 ("Not at all characteristic of me") to 5 ("Extremely characteristic of me").

Scoring and interpretation: Each item is scored between 1 and 5 points as a function of the answer of the person being examined. After reversing the score of items 3, 6, 10 and 15, all scores are summed and a total score is obtained. The range of this total score is between 15 and 75. With the original version and US university students, Leary and Kowalski (1991) obtained means ranging from 38.6 to 40.6, with standard deviations (SD) varying between 9 and 11.1. However, Sanz (1994), after assessing a sample of 338 Spanish university students (85% females; mean age = 22.6, SD = 2.7), obtained a similar SD of 10.7, but a mean of 44, slightly higher than that obtained by Leary and Kowalski (1991). If replicable, this difference

would suggest an important cultural difference between US and Spanish university students. There are no established cutoff points that may guide the interpretation of IAS scores, but, since IAS scores are close to a normal distribution, a score higher than two standard deviations above the mean (e.g., equal to or greater than 65 according to normative data provided by Sanz, 1994, for Spanish university students) would indicate that the assessed person has a higher level of social anxiety than 98% of the appropriate population (that cutoff point is the 98th percentile and is the equivalent of a 70 T-score).

Time of administration: The IAS has received widespread use for research purposes in personality and social psychology areas. From a clinical viewpoint, it should be used mainly during initial assessment. It could be also administered during the course, ending and follow-up of a treatment for social anxiety, however there no published data on its sensitivity to therapeutic change.

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IAS webpage:
http://www.duke.edu/~leary/scales.htm or
http://www.duke.edu/~leary/socanx.rtf

Spanish adaptation:
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Personal webpage:
http://www.ucm.es/info/psclinic/profesores/jsanz.htm

Interaction Anxiousness Scale

(Leary, 1983)

Indicate how characteristic each of the following statements is of you according to the following scale:

1 = Not at all characteristic of me.
2 = Slightly characteristic of me.
3 = Moderately characteristic of me.
4 = Very characteristic of me.
5 = Extremely characteristic of me.

_____ 1. I often feel nervous even in casual get-togethers.

_____ 2. I usually feel comfortable when I'm in a group of people I don't know.

_____ 3. I am usually at ease when speaking to a member of the other sex.

_____ 4. I get nervous when I must talk to a teacher or a boss.

_____ 5. Parties often make me feel anxious and uncomfortable.

_____ 6. I am probably less shy in social interactions than most people.

_____ 7. I sometimes feel tense when talking to people of my own sex if I don't know them very well.

_____ 8. I would be nervous if I was being interviewed for a job.

_____ 9. I wish I had more confidence in social situations.

_____ 10. I seldom feel anxious in social situations.

_____ 11. In general, I am a shy person.

_____ 12. I often feel nervous when talking to an attractive member of the opposite sex.

_____ 13. I often feel nervous when calling someone I don't know very well on the telephone.

_____ 14. I get nervous when I speak to someone in a position of authority.

_____ 15. I usually feel relaxed around other people, even people who are quite different from me.

Case 1: The importance of the family in children's problems.

Authors: Fausor R., and García, J.,(2012). University Psychology Clinic. Complutense University of Madrid. Spain

The following psychologists from the Master's Degree of Clinical and Health Psychology of the Complutense University of Madrid collaborated in this work: Alonso, A., Casanueva, P., Díaz, P., Galilea, I., Hernández, N., Gómez, A. Lozano, D. Martín, M. C., Martínez, D., Martínez, Morón, E., Núñez, M.E., Núñez, I., and Rodríguez, A.
Illustrations: Morón, E.

KEYWORDS: Clinical psychology, child case studies, family formulation.

In most cases of children who come to consultation for psychological problems, we find that they present problems that cannot be understood or modified without taking the parents into account and, sometimes, the entire family.

As an example of the need to perform a family formulation of children's problems, we present the case of two brothers (Antonio and Juan), who came to consultation independently and separately, due to problems considered unrelated by their parents. The analysis of the relation between the two cases and the importance of the parents' behaviors were the key to explain the problem and, therefore, to discover where we had to work to solve it.

1. Antonio

♦ Patient's name: Antonio (fictitious)
♦ Sex: male
♦ Age: 11 years
♦ Occupation: student
♦ Family Structure: he lives with his parents and his younger brother, who is also in therapy.

The first day, Antonio came to the consultation with his father because his mother could not come. The father commented that his son needed help because he had behavior problems, although what worried him the most was that Antonio was very fearful.

• CASE DESCRIPTION: Evolution of the problem and historical analysis.

The parents describe a normal development, but comment that he had a hard time staying in class with the other children. When he was 6, the parents say that the tutor (who is still the child's tutor) humiliated Antonio, calling him a "baby and a midget" in front of the whole class because he could not do something that all the other children of the class did.

According to his parents, after this event, Antonio began to take refuge with the girls of the class because they were always more understanding of his behaviors, which the parents describe as "childish".

In an interview with both of Antonio's parents, they tell us that since his teacher insulted him that time, he is not as happy as he used to be and his behavior at home has worsened.

However, when his parents are not present, Antonio tells us that although he remembers this event with his teacher, his experience of it was not so bad and he does not feel any ill will towards this teacher who, incidentally, is still his teacher. What really worries him is that his parents want to change schools because they "cannot stand this teacher". Antonio does not like his teacher, but he realizes that she treats all the children badly and it is not something “personal” against him, so he doesn't worry about it. He doesn't feel bad in that class where he says he has friends and he doesn't want to change schools.

The parents describe Antonio as a cry-baby and fearful, a boy who has never defended himself and who always solves problems by crying. The father says he cannot stand that behavior and he lets the boy know it, even by calling him a "sissy”.

When we ask the parents about his behavior problems, they say they usually occur because they tell him to do something and he disobeys, or because of his studies. The parents explain that Antonio "thinks he's smart", he is confident, and he doesn't get better grades because he does not make enough effort. When he behaves like this, the parents say they get angry, especially the father, and he even punishes Antonio by forbidding him to use the video console or the TV. Antonio reacts by screaming at them, and sometimes he runs to his room, bangs the floor, or slams his door shut.

Although the parents assure us that they never argue about punishments in front of the children, the father explains that Antonio's clashes with him are worse than with his mother because he demands more, he often insults Antonio, and even smacks the children once in a while.

The mother comments that she is usually the one who stops her husband when she realizes that he is losing control, by nudging him with her elbow or looking at him. The father explains that, when faced with those situations, he loses his temper and has a hard time controlling himself, and later he realizes he has gone too far. Therefore, he feels bad and tries to lessen the punishments because, upon analyzing the situation in cold blood, he considers them excessive.

When we ask about any other kind of consequences they use to deal with their son's behaviors, they comment that there is only one punishment that is any good and that is to forbid using the console. "At the beginning, we get very angry and forbid it for 3 months, but actually, after a few hours or at the most, the next day, they are playing with them again."

Antonio says he has no problems and does not need to see a psychologist. He doesn't like his parents to scold him, or when his father spanks him, but what bothers him the most is that his father won't let him talk and explain why he doesn't want to do some things. He also complains that the punishments are always the same, no matter what he has done: it doesn't matter whether he refuses to set the table or whether he refuses to enter a place that scares him; he disagrees with this and thinks the punishments should be different.

He describes himself as a fearful child, and says that's why his father is ashamed of him. He is frightened of many things, especially of Halloween.

• ASSESSMENT INSTRUMENTS AND RESULTS

To complement the information about Antonio's behaviors obtained in the interview and to rule out possible problems that were not mentioned, we applied the following questionnaires:

Children's Depression Inventory (CDI) (Kovacs, 1992), which seemed appropriate because of its briefness and validity to estimate the intensity and evolution of depressive symptoms in children and adolescents. The questionnaire is divided into two scales: dysphoria and negative self-esteem.

State/Trait Anxiety Questionnaire in Children (STAIC). (Spielberger,1973), which seemed adequate to appraise transient state and latent trait anxious symptomatology.

Behavior Assessment System for Children (BASC). (Reynolds & W. Kamphaus, 1992) to assess the more or less adaptive behaviors of the child with his family and at school, as it collects information from the parents, the teachers, and from the child himself.

Children's Attributions and Perceptions Scale (CAPS) (Mannarino, Cohen & Berman, 1994). This is a self-report questionnaire for children which assesses two dimensions of perfectionism: self-oriented and socially prescribed.

After analyzing the results of the diverse assessment instruments, we found no significant scores in any of them.

• FUNCTIONAL ANALYSIS

Analyzing the present data and the specific behavior sequences, we considered that the hypothesis of the origin and maintenance of the behavior problems is the father gives in to these tantrums (crying, screaming, and complaining) and the child learns to get what he wants by throwing temper tantrums, even though the father scolds him for his complaining and screaming.

We think the origin and maintenance of this behavior are very similar, because if Antonio uses tantrums in different situations, it is because they work.

In the case of Antonio's anxiety, we will go into a little more detail. We observed that the child is afraid in situations that produce normal fear, like going into the House of Terror, or people who are disguised. His parents press him to face up to events that produce excessive anxiety. He may have begun to use the same behavior that always served to get what he wanted in order to leave these situations, and, of course, it seems that it also worked here, because he could avoid these situations and, in the short run, he reduced his anxiety even though his father reproached him. Therefore, when currently faced with situations that produce normal fear, such as Halloween, the child thinks, "I won't be able to do it, they're going to force me", which produces excessive anxiety. In these situations, he also cries, complains, and screams, behaviors that served to avoid facing the above-mentioned events. Thus, he manages to reduce his anxiety in the short run, but his father reproaches him, and this will probably increase his anticipatory thoughts in other situations.

We got the impression that the anxiety generated by others' pressure has become generalized to other situations in which he feels he is negatively appraised. In these situations, the child has negative thoughts that provoke anxiety and, once again, he resolves them with these avoidance behaviors, such as crying and tantrums, with the result of a short-term anxiety reduction, but it does not solve the problem, so the negative thoughts will increase, and this behavior is maintained in similar situations, reducing anxiety in the short run.

• BEHAVIOR PROBLEMS

On the one hand, Antonio has negative thoughts like "I should have more male friends and not so many female friends", " I shouldn't be so fearful", "I should not enjoy SpongeBob", which generates anxiety; this anxiety is provoked by these thoughts about what should be but is not and by the avoidant behaviors. It is particularly noteworthy that he down plays some things and he even denies them, such as the avoidance behavior.

Another issue is the behavior problems, that is, his tantrums and disobedience.

• DIAGNOSIS

After collecting all the information, we began to establish the diagnosis, which generated a strong debate in the Tutorship. On the one hand, because we found no pathological behaviors in the child that really interfered with his functioning and generated a high degree distress in him. As we found no depressive or anxious symptomatology, despite some normal sadness because of the disillusion he provokes in his parents, we did not want to assign

the category of symptoms to his behaviors, because they seemed normal behaviors in the face of the pressure he suffers. This may provoke a negative self-image, but we could not confirm that these behaviors had the entity of psychopathological symptoms in the child's life, either through the interviews or the questionnaires, because they do not seem to provoke a high degree of distress in the child or to generate any interference in his normal functioning. Therefore, with regard to the behaviors of anxiety and the negative self-image, we do not consider we should refer to symptoms or to psychopathology, or even diagnose a disorder of a residual category, such as a nonspecific depressive disorder. Therefore, after much debate, our opinion is that he does not meet the criteria for any diagnosis.
With regard to the behavior problems, we think his disobedience is fairly habitual at his age and, moreover, very conditioned by the parents' poor contingency management. We do not think that this problem has a diagnostic entity.

Therefore, we were finally inclined not to diagnose this child in Axis I, although we decided to include problems concerning the primary support group of Axis IV. GAF (global asessment of functioning) was 70 at the time of assessment.

Diagnostic and Statistical Manual of Mental Disorders IV-TR
AXIS I: Z03.2 No diagnosis [V71.09]
AXIS II: Z03.2 No diagnosis [V71.09]
AXIS III: No diagnosis.
AXIS IV: Problems with primary support group
AXIS V: GAF: 70 (Current)

2. Juan

- ♦ Patient's name: Juan (fictitious)
- ♦ Sex: male
- ♦ Age: 9 years
- ♦ Occupation: student
- ♦ Family Structure: he lives with his parents and his older brother, who is also in therapy.

When Juan comes to consultation, he displays bad behavior at school, according to his parents, who are worried because they get many complaints from the school because of "disproportionate anger" and "disobedience in these anger situations". The parents say they feel overwhelmed. Moreover, the father explains that he is concerned to see how this is interfering with his son's social relations.

• CASE DESCRIPTION: Evolution of the problem and historical analysis
The parents mention that they had also wanted to have their second child. They comment that the child reached all the developmental milestones successfully and has had no remarkable illnesses.
The mother comments that the behavior problems and consequential punishments began ever since Juan began to crawl. She says, "he has always been a very naughty child and by the time he arrived at the kindergarten, he was almost always punished". According to her, these punishments were because Juan hit the children to get the toys he wanted.
The parents say they don't consider these behaviors bad because "he's a child with a strong character" and that "when he had to defend himself, it didn't matter whether the other child was smaller or bigger than him". In this sense, the father compares his two sons, explaining that "the little one has always been braver because he never cried even if there was a reason to cry; whereas the older solved everything by crying". Even so, the mother emphasizes that they punished him by "scolding him, making him sit down to think in a chair, or spanking" because she "was ashamed when she heard other mothers tell their children not to play with him because he was a bully". She says that, in general, before the scoldings, the child got what he wanted.
The mother explains that the child is also punished at school, and they tell her, "he arrived at school and the teachers continued to punish him, and this is still going on currently".

According to the current teacher, in 1st and 2nd grade of primary school, when Juan's classmates didn't want to play what he wanted, he threw tantrums in the school yard, which she defined as "intense anger" and subsequently “he turned away from the children and played by himself”. According to his tutor, all the teachers had heard about Juan because of his behavior in the school recess.

His parents explain that in 2nd grade of primary school, they noticed a change in Juan's behavior: "he no longer hits but instead the others hit him and he cries whenever anyone does anything to him at school”. They also comment that he does not have a group of friends and he spends his time playing with a child who has an intellectual incapacity. The father thinks that Juan is friends with this child because he always does what Juan wants and he admits that he doesn't like this friendship because he doesn't want others to think that Juan is "weird”.

According to the tutor, at the beginning of 3rd grade of primary school, Juan threw his desk after getting angry and one month later, he arrived at the classroom kicking a classmate's coat, which was on the floor.

The teacher gave him a "black star", he was punished with no recess, no excursion, and his mother says she also scolded him and was very upset. The parents say they "no longer know how to correct Juan's behavior, they have even gone so far as to remove all his toys and they still get complaints about him from the school."

With regard to his social relations in this course, the father notes that "his classmates reject him because of his behavior”. In the same vein, the teacher says he is not a "rejected child but his classmates don't seek his company" and that ”nowadays, if his classmates don't want to play with him, Juan is alright playing by himself." This is confirmed by the child in the individual sessions with him, and he adds that he has no problems to seek out other children to play with (who are almost always younger than him because, as he notes, they play the games he wants to, and the older ones do not).

Juan comments that other children think he is bad because, for a long time, he used to hit them; however, he says he is not bad and would like to prove it. Currently, with regard to his brother, he says they have a good relationship and they usually play what he wants. About his parents, Juan thinks he prefers his mother to punish him instead of his father, because his father imposes harsher punishments: no TV and no consoles, and his mother, only no TV.

Currently, the mother says he is a collaborative child, he doesn't confront them and at home, he has his assigned household tasks that he does. The father comments that Juan knows how to get his way, he tells us literally that "he seems to obey but in the end, he does what he wants”. They give us an example: the child wanted to watch TV and his parents wouldn't let him because it was bedtime, but they let his older brother watch TV. Juan began to complain so they wouldn't let his brother watch TV either. Then the mother sent them both to bed, winking at Antonio, and when Juan was asleep, she got Antonio out of bed to watch TV. This gave us the impression that they teach the child to get what he wants even when he is not dominating the situation because, by fooling him, the mother made him believe that he had won.

• ASSESSMENT INSTRUMENTS AND RESULTS

In addition to the interviews to obtain informa-

tion, we wished to use objective tests that would allow us to monitor the variables we consider relevant in this case. We used the following tests:

-Child Anxiety Scale, CAS (Gillis, 1980). This instrument psychologically explores anxiety processes in children during the first school years (6-8 years).
-Child Depression Inventory, CDI (Kovacs, M., 1992).
-State-Trait Anger Expression Inventory in children and adolescents, STAXI-NA (Spielberger, 2005). This accurately assesses the diverse components of anger (Experience, Expression and Control) and its facets as State and as Trait.
-Behavior Assessment System for Children BASC. (Reynolds & Kamphaus; 1992).

After analyzing the results obtained from the above assessment instruments, we found significant scores in all of them, which will be explained below.

• BEHAVIOR PROBLEMS

We found that Juan's behavior problems occurred with his peers and with his teacher. Feelings of sadness linked to thoughts like "I'm bad" and social isolation.

• FUNCTIONAL ANALYSIS

With the information gathered by the questionnaires and assessment interviews, and after analyzing the chains of behaviors presented by Juan, we proposed that, in principle, when Juan wanted something from his parents and he didn't get it for some reason, he complained, he got angry, or he sought a way to get what he wanted. Thus, he always got what he wanted and, therefore, the child had learned to find a way to get whatever he wanted at home, without needing to confront his parents, as noted by his mother. As this worked, he continued to emit these behaviors currently, and, as we saw in one of the most recent sequences, Juan is capable of complaining to make his brother go to bed, and he achieves his goal.
What was happening at school? When Juan wanted something that he did not get, he would complain, but in this setting, he did not achieve his goal but instead they scolded him, they gave him "black stars", and he was not allowed to go on excursions. As these responses did not serve him, he began to decrease them. Then he started emitting other behaviors, such as throwing ball-point pens. The teacher says she ignored him. At that point, the logical process of extinction began, and the response topography varied, becoming more intense, and Juan would throw books, and even his desk. This is when they brought him to consultation for bad behavior.
We found that, at home, Juan gets his way with his inappropriate responses, but at school, they do not work. In fact, now he is quiet, he doesn't know what to do… neither do these behaviors help him to get his way. We think this is generating dissonance in Juan about what he must do to get his way, because at school, they explained to him that if he hits others or gets angry to get his way, he is being bad, whereas at home, he gets whatever he wants with this type of behavior. Moreover, his parents consider him "a little rascal", which has no negative connotations for them.
At this point, we think the teacher used the extinction technique correctly because there are no current complaints of disruptive behavior in the classroom. However, it is important to note that she did not apply any reinforcement to adequate alternative behaviors, so, as a consequence, symptoms of sadness and disillusion emerge because Juan doesn't know how to manage these situations at school.
Lastly, we also analyzed his interactions with his peers, finding that one of the behaviors he presents is crying but, according to his teacher, the children ignore him; however, he does get his educators' and parents' attention, so he continues to emit this behavior currently. Nowadays, when he doesn't get what he wants, he gets angry and he goes off to play with younger children, with whom he plays what he wants; thus, he partially achieves his goal, but he does not manage to play with children of his age. This generates sadness and isolation, and a negative self-image, as the child reflected in the tests.

Diagnostic and Statistical Manual of Mental Disorders IV-TR
AXIS I: Adaptive disorder with depressive symptomatology
AXIS II: V71.09 no diagnosis
AXIS III: no diagnosis
AXIS IV: Problems with primary support group and educational problems
AXIS V: GAF: 65

• DIAGNOSIS

With all the information of the case, we decided that Juan presents depressive symptomatology measured both in his self-report and the reports presented by his parents and teachers. Likewise, he presents anxious symptomatology that interferes with his life, as his academic achievement is decreasing, he has no friends of his age, and he is aware of this.

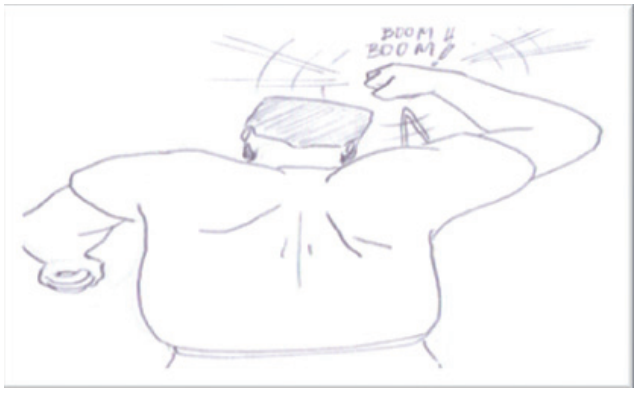
Upon analyzing his symptomatology, he did not meet the criteria for any anxiety disorder such as social phobia, because of this his lack of skills to interact with his peers that leads him to play with smaller children and to have the feeling that he does not fit. Nor did he meet the criteria for mood disorders, such as depression, because, according to his parents, he has no sleeping problems and his appetite has not changed in the past two weeks, he still plays the games he likes although he has switched from building to his Play Station Portable. They point out that he does not act nervous or sluggish, and he has no death-related thoughts.

Given the distress the child reflects and the social interference it is generating, we conclude that Juan presents an adaptive disorder with depressive symptomatology on Axis 1. No diagnosis on Axes II and III, and, represented on Axis IV, problems related to the primary support group and to schooling generated by the lack of coping and problem-solving skills. His GAF (global asessment of functioning) at the time of assessment was 65.

3. Parents

As we had both brothers in our tutorship, we could share the two cases, which is when we began to have our first doubts that, little by little, led us to the conclusion that the case required a more exhaustive assessment of the parents, because we intuited that the family dynamics, and more specifically the parents, could have a great influence on their children's problems.

With the information gathered till now and seeing the parents' influence on their children's behavior, we decided to dedicate two assessment sessions to perform a more detailed analysis of the complete family functioning. This way, we could reach a more adequate hypothesis of the origin and maintenance of the behavior problems presented by the children.



• BEHAVIOR PROBLEMS

As mentioned, one was inadequate contingency management of the children's behaviors ...because the parents give way when their children throw tantrums, so the children get their way and their behavior is reinforced. Moreover, when they imposed some negative consequence in a situation, it was sometimes so intense or inappropriate that they could not carry it out.

The second problem and, we think, the main one, is the parents' inappropriate ideas that generate so much anxiety. We will also examine the father's anger when his expectations are not met.

• FUNCTIONAL ANALYSIS

Now, when examining the children's chains of inadequate responses and analyzing the parents' behavior, we found: The child wants to get something from his parents. When they refuse, he complains and gets angry, in the case of the older brother, he throws a tantrum, in the case of the younger one, he finds a way to get what he wants. The father, in order to eliminate the negative stimulus of the tantrum, ends by giving the child what he wants.

Both children emit behaviors that lead to their getting their way, so these behaviors are maintained, although their topography varies. In both cases, the father gives in so that the negative stimulation (complaints, confrontations) will decrease. So the father learns to give in. And, in all these situations, the mother remains in the background.

4. Clinical Family Formulation

At this point, we will try to formulate this family case, emphasizing what we consider are the main treatment target behaviors, and therefore, where we would have to work so the situation will change.

We think that the main behaviors involve the parents, especially their deficient skills to manage their children's behavior, but also their numerous inadequate beliefs about "what their children should be like", that is, "the older one is a sissy; the little one is more of a rascal, so he is more manly…"

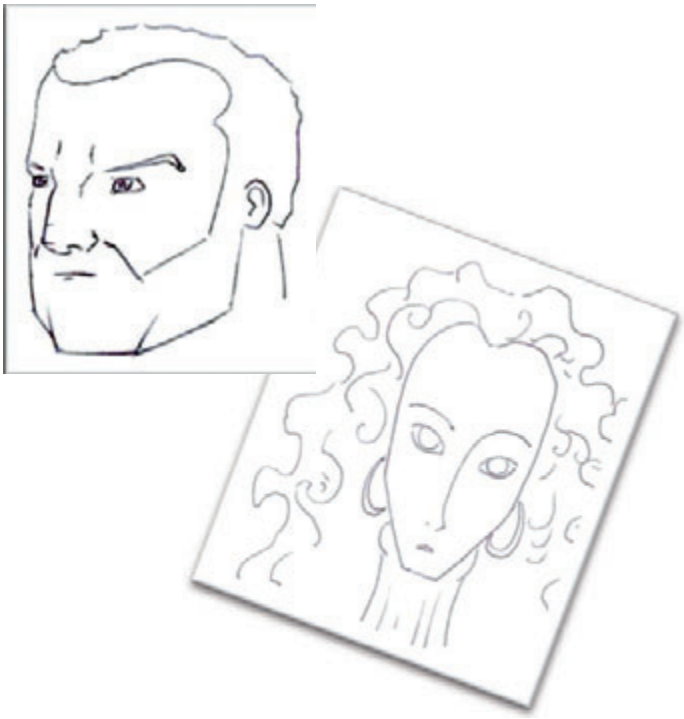
This generates intense anxiety in the parents and a series of behaviors to attempt to control what they fear and to reduce their anxiety. The parents' deficits in the contingency management of their children's behaviors has made them behave inadequately with them, and their concerns about how their children should behave have turned into real pressure for the older child, which generates great anxiety in him and problems in their relationship with him, because he knows that he disappoints them by the way he acts and by behaving the way he does.

With regard to the younger brother, the main problem is that his habitual behaviors to get his way serve his purpose at home but not at school, and this provokes not only sadness, isolation and a negative self-image, but also cognitive dissonance related to the fact that what he normally does to get his way is "being bad", so now he also worries about being bad. And the worst is that doesn't know how to get his way by any other means.

5. Treatment

On the basis of the above and the analysis of the family formulation, we decided that the treatment that best met the needs of this family consisted of focusing on the parents' behavior problems, on the family interaction and, separately, on both children's behaviors, which are influenced by the former.

For the intervention with the parents, we provided them with adequate guidelines for contingency



management. With regard to the parents' inadequate beliefs, the proposed treatment plan consists of decreasing their concerns, which we consider essential for them in order to reduce their control behaviors. This is a possible hypothesis, but it should be considered that not just by changing beliefs (which have been in place for years) will the concerns automatically decrease and, therefore, the control behaviors will also decrease.

As changing the beliefs is a long and difficult undertaking, we shall start simultaneously with a program of behavioral control to modify the control behaviors the parents carry out, for example, in the case of the older brother, not making him do something when he doesn't want to, not pressing him to do something he is afraid of, not performing checking behaviors such as, for example, asking him if he is gay (as they have sometimes done), not making fun of his fears…

When we tell parents they should not say anything that goes through their heads to their children, we do so within a cognitive program, as psychoeducation, so they will understand that they should not always try to influence their children so they will comply with their wishes.

The belief system is a central element, but not the only one, because the control behaviors, besides causing much harm, do not disappear just by modifying the beliefs.

Another aspect we shall work on with the parents,

following the Socratic method, is the negative image they have of their children, making the parents tell their children that they are neither better nor worse nor less than others because they have mannerisms, like they are doing with Antonio. In fact, we think that the parents could be great allies to facilitate change when we start the intervention with them.

Another thing we would deal with and we think is necessary—due to the deterioration of the father-older son relationship—is the family interaction, planning from the start pleasant activities in which contingency management can also be worked on. This was one of the behavior problems we described first.

Parents' treatment:

Goals	Techniques
Make them aware of the problem of the family dynamics	Feedback interview
Improve the father-son relationship and family climate	Pleasant activities in the family
Eliminate the control behaviors	Stimulus control
Increase emotional control in anger situations	Emotional regulation Techniques of self-control
Modification of beliefs	Cognitive restructuring
Develop a better way to manage their sons' behavior	Contingency management

Then what occurs with their sons' behaviors? A possible hypothesis could be that by making the parents' behavior problems disappear, the sons' would also disappear, but we think we should help them at the beginning with their problems, because we think they are, up to a point, at risk (specifically, the older boy).

Case 1: Older brother

After analyzing all the data, we proposed the treatment. We think that we would perform the feedback interview with Antonio and with his parents, separately. To manage anxiety, we would teach him the relaxation technique, because one of his problems are his tantrums and his difficulty to control himself, which would be complemented with techniques for self-control. To learn this, we would ask him to practice at home and we would also train him in session. We would also explain the function of anxiety to him. Another of the main goals is to deal with his thoughts using the ABC model, because Antonio has many negative thoughts as well as concerns related to his family, especially to his father. We would also teach him social skills to improve his social integration

Lastly, after working on all the goals, we would introduce relapse prevention.

Treatment of the older brother:

GOALS	TECHNIQUES
Inform about the problem and its main components.	-Feedback interview Psychoeducation
Modification of negative thoughts, particularly negative anticipations and thoughts about his personal worth.	-Explanation of the ABC Model ABC Record -Cognitive discussion about the validity of thoughts -Game "The planet of the Psimons".
Promote the development of Social Skills	-Psychoeducation of social skills Self-instructions -Training in self-instructions. Modeling and behavioral rehearsal
Strengthen the achievements Generalize the learnings and maintain achievements at long term	-Relapse prevention -Reviewing the techniques learned -Identification of risky situations

Case 2: Younger brother

The treatment designed for Juan, the younger brother, includes information feedback with the child so he will understand his problem and the work we shall carry out during the sessions. Thereafter, we shall start by normalizing his current coping responses and differentiating inadequate, unacceptable and adequate responses, through psychoeducation. Likewise, we shall intervene in his belief that he is "bad", and if psychoeducation alone is not sufficient, we shall use cognitive restructuring. The next goal we propose is to increase his adequate coping skills by means of a contingency program, which his parents will manage with token economy, and training in social skills training and in emotional regulation. Thereafter, so he will perceive that his peer relations as less aversive and so we can thereby increase his interactions with peers, we propose a program of pleasant activities with peers that would also involve exposure in which Juan could practice the skills he acquired.
Lastly, we would use overlearning exercises and we would review the learnings to prevent relapses.

Treatment of the younger brother:

GOALS	TECHNIQUES
Inform about the problem and its main components.	Feedback interview
Normalize the current coping responses	Psychoeducation to differentiate inadequate - unacceptable-adequate responses Psychoeducation of the concept of "being bad"
Decrease cognitive distortions	-Cognitive restructuring
Increase adequate coping skills	-Contingency program Social Skills -Emotional regulation
Increase the time he enjoys being with his peers	Pleasant activities with peers
Relapse prevention	Overlearning exercises Review the learnings

6. Discussion

After analyzing all the information, we concluded that we need information from different sources when examining the children's behavior, because their diverse settings substantially complement the assessment. The case presented herein helped us to reflect about:

♦ The fact of finding apparently contradictory information between what the child tells us and his self-reports can reveal his contradictions, concerns, and ambivalences, thus enriching our explanatory hypotheses.

♦ When applying techniques to extinguish inadequate behavior, it is very important to guarantee the learning and installation of adequate alternative behaviors in order to avoid generating behavioral helplessness and the resulting sadness and negative self-image in the child.

♦ Functional analysis of the family's behaviors—and not just those of the child—is of great importance because the information obtained allows us to perform a good assessment and consequently the best possible treatment.

♦ Many of the behaviors that the parents consider to be pathological are really not so, and it is this belief that generates pathology.

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