The Clinical and Community Psychology

A Publication of the Division 6 of the International Association of Applied Psychology (IAAP)

Vol. 6, Issue 2, October 2017

ISSN: 2308-6394

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

The Clinical and Community Psychology is the Official Newsletter of the Division 6 of the International Association of Applied Psychology (IAAP)

Publisher: Division 6 of the International Association of Applied Psychology (IAAP)

Editor: Rocío Fausor,

Associate Editor: Pedro Altungy Clara Gesteira, Noelia Morán, Ashley Navarro

Translation reviewer: Ashley Navarro

Design: Rocío Fausor

Collaborators: Roberto Navarro, Belen Reguera, Sara Liébana

Photos and illustrations: Chosen by Rocío Fausor from a free copyright website.

Vol. 6, Issue I1, October 2017
ISSN: 2308-6394

CONTENTS

EXECUTIVE COMITTEE

PRESIDENT
María Paz García Vera
Department of Personality,
Assessment and Clinical Psychology
Complutense University of Madrid
Campus de Somosaguas
28223 - Pozuelo de Alarcón (Madrid)
Spain.
E-mail: mpgvera@psi.ucm.es

PRESIDENT ELECT
Daniel Dodgen
Director,
Division for At-Risk Individuals,
Behavioral Health and Community Resilience,
ASPR
Unites States.
E-mail:
Daniel.dodgen@hhs.gov


The best preparation for tomorrow is doing your best today.
H. Jackson Brown Jr.

CONNECTING MEMBERS: SURVEY

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

Connecting members across the world!!

Because our organization has more than four hundred members worldwide, the first aim of this website will be to connect us, to know where our colleagues are working from in the aim topics of Clinical and Applied Community Psychology, their diverse functions and different areas of expertise, and the world centres where we are performing psychological interventions and research. We ask you to complete this questionnaire that will allow 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 at.

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 research programmes in any part of the world, and so on.

Please, complete the following 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: _____

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

Country: _____

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

Phone number: _____

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

Fax: _____

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

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)

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

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

ARTICLE

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

1st Pan-African Psychology Congress
18-21 September 2017
Durban, South Africa

Invited Symposium

Sponsored by IAAP

and

Submitted on behalf of the

IAAP Task Force on Terrorism

Last September the 1st Pan-African Psychology Congress took place in Durban. Both Division 6 president and president elect were invited to participate. It is with great pleasure we emphasize the great success obtained in this symposium both in assistance of the guests as well as in their participation.

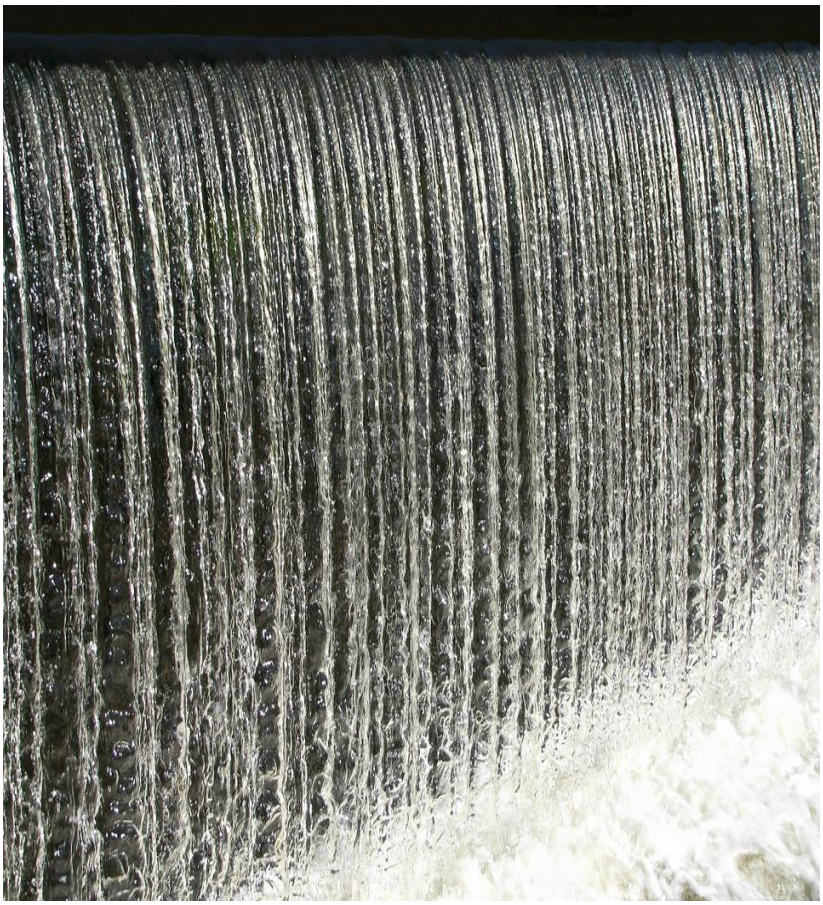
Here you´ll be able to read the abstract of the symposium oral conferences.

Psychology applied to terrorism and violence: Advances and challenges

Janel Gauthier, Ph.D. (President, International Association of Applied Psychology) janel.gauthier@psy.ulaval.ca

Terrorist attacks resulting in human casualties have become a common occurrence. Nowadays, a day hardly goes by when we do not hear of another violent terrorist attack somewhere in the world. Some are widely covered by media, but many go unnoticed. According to the data of the National Consortium for the Study of Terrorism and Responses to Terrorism (2016) of the United States, during 2015,

11,774 terrorist attacks occurred in 92 different countries, resulting in a total of more than 28,300 deaths, 35,300 injured victims, and 12,100 kidnappings. Of these attacks, 597 caused more than 10 deaths. These data alone clearly indicate that, in recent years, terrorism has become one of the most severe and concerning problems worldwide. The purpose of this invited symposium is to report on the contributions of psychological research to the understanding of terrorism, and reflect on the strategies used to thwart violence and terror in the world. Four speakers from four different countries (Colombia, Spain, Uganda and the U.S.A.) will each address one of the following topics: (1) the long-term consequences of terrorist attacks on the mental health of victims of terrorism; (2) the need for human resources, expertise, training, funds, equipment, mortuaries, hospital beds, and national policies to provide a better psychosocial response to terrorism; (3) the planning tools and other resources available online that can be used and modified for the needs of different nations and communities to prepare for the psychological aftermath of a terrorist attack; and (4) the role of media in the legitimization of violence. Each presenter will provide example of actions that psychology can take to move the agenda forward and help build a better world for all.



Terrorism in Africa: A case of the twin bombings in Kampala, Uganda

James Kagaari, Ph.D.(Kyambogo University, Kampala, Uganda)
jmskagaari@gmail.com

The African continent has had its share of global terrorism. In 2014, the African continent experienced a peak of 16,840 attacks (Institute for Economics & Peace, 2015: 37-46). However, terrorism in Africa became a reality in 1998 with the bombings of the United States embassies in Dar es salam (Tanzania) and Nairobi (Kenya), in which over 16 Americans and 200 Africans were killed (Nwolise, 2005). This paper narrates a case of the terrorist attack in Kampala, Uganda. During the FIFA cup finals in 2010, Uganda was woken up with twin bombings at two locations in the capital city, Kampala. One bombing occurred at Kabalagala-Kansanga in a restaurant popularly known as the “Ethiopian village” and another at Lugogo Rugby play grounds, leaving 64 dead and 70 injured. Counseling psychologists felt an impulsive need to intervene and visited hospitals. At the National referral hospital administration-Mulago Hospital, Counseling Psychologists convened to answer a professional calling.

Multidisciplinary teams were deployed to key hospitals in Kampala where victims had been admitted. The psychosocial intervention team organized a debriefing session for Mulago Hospital emergency workers after 14 days, the psychologists organized a debriefing session on anniversary of the critical incident for survivors, family, media, public. Unfortunately, a follow up of the survivors from the psychosocial team remains unknown.

Best Practices and Planning Tools to Improve the Mental Health Response to Terrorism

Daniel Dodgen, Ph.D. (U.S. Department of Health and Human Services, Washington DC, U.S.A.) Daniel.Dodgen@HHS.Gov

In mass casualty events, particularly terrorist attacks, the mental health consequences are significant and pervasive. However, most planning efforts focus primarily on acute medical care and law enforcement concerns. In the United States, more attention has been given in recent years to planning for the mental health consequences of terrorism and other mass casualty events. This presentation will focus on planning tools, mental health response teams, and online resources that can be used to prepare for psychological needs in such events. Participants will learn about tools developed in the United States and discuss how they have been used in recent events, such as the Orlando Pulse nightclub shooting and Boston Marathon attack. The panel will also talk about how these tools might be adapted for use in other nations to address psychological needs following a terrorist attack. The focus will be on four tools: The Disaster Behavioral Health Concept of Operations, The Disaster Mental Health Coalition Guidance, The Community Self-Assessment for Disaster Behavioral Health Capacity, and the Rad Resilient City project (a tool for local planning for a nuclear detonation). The purpose and development of each tool will be discussed, along with how the resources can be used or modified for the needs of different nations and communities.

Time does not heal all wounds: prevalence of psychological disorders in victims of terrorism 6-39 years after terrorist attacks

Maria Paz Garcia-Vera, Sara Gutierrez, Clara Gesteira, Noelia Moran, & Jesus Sanz (Complutense University of Madrid, Madrid, Spain) mpgvera@psi.ucm.es

Nearly all previous research on the psychopathological repercussions of terrorist attacks has focused on the consequences at short term or at medium term, but their true magnitude in the long term, after 5, 15, 25 years, or more, is unknown. This study is aimed to examine long-term prevalence of posttraumatic

stress disorder (PTSD), anxiety disorders, and depressive disorders in victims of terrorism. The Association of Victims of Terrorism of Spain assisted in obtaining a sample of 507 adults who had suffered a terrorist attack or who were direct relatives of someone who had died or had been injured in a terrorist attack. Terrorist attacks had occurred between 6 and 39 years ago. All participants completed the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-CV). After an average of 21.5 years since the terrorist attacks, 50.3% of victims showed a mental disorder. The most prevalent mental disorder was PTSD (26.8%), followed by major depressive disorder (17.9%), specific phobia (15%), panic disorder (13.4%), and generalized anxiety disorder (11.8%). Binary logistic regression analyses revealed that the time elapsed since the attack had no significant effect on the prevalence of mental disorders, but they had the following factors: type of victim,
gender, age, and type of terrorist attack. Results are discussed in terms of the need of providing psychological attention at the short, medium, and long term to direct and indirect victims.

From left to right: James Kagaari, Janel Gauthier, Daniel Dodgen and Maria Paz Garcia-Vera. Participants in the symposium at the 15th European Congress of Psychology.

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

In the current number we will have the pleasure of reading an interview of Professor María Paz García Vera, president of division 6. The interview took place on 31st of October 2017 by videoconference and it was carried out by a group of students of the psychology program from the National University of Colombia. It was validated by Juan Guerrero, expert teacher.

The interview is the result of an investigation on Psychology of peace, violence and armed conflict. It was developed by students who thought of Professor María Paz García-Vera for her knowledge and experience in the care of victims of terrorism in Spain.

INTERVIEW PROF. MARÍA PAZ

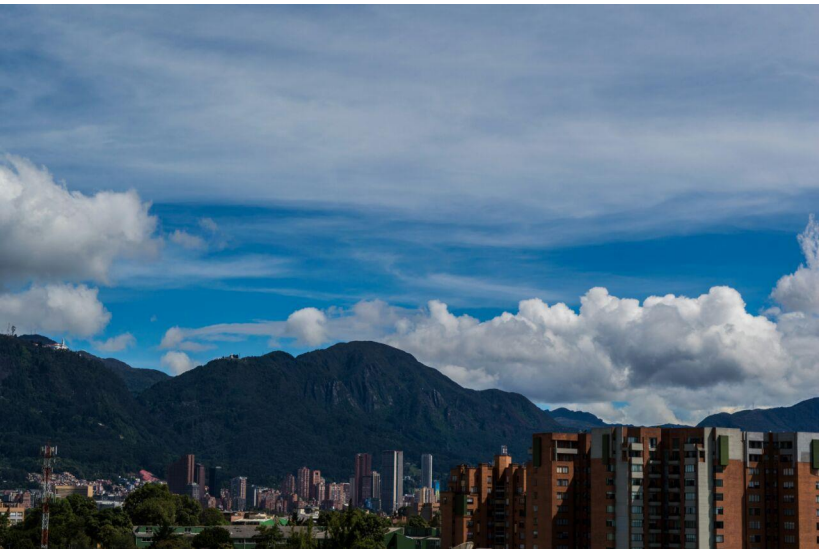
Pablo A. *Reyes Velásquez, Jennifer A. Malaver Toloza, Ingrid C. Bernal Riveros, Ángela R. Guevara López, Juan S. Niño Zambrano, Sebastián Sanjuan Castañeda* and Nataly Ballesteros Vargas, from National University of Colombia

Could you tell us about your academical background?

I'm a professor in the clinical psychology department at the Faculty of Psychology at the Universidad Complutense de Madrid (UCM). I was director of the Clínica Universitaria de Psicología of the UCM for 16 years. I am the director of Complutense Extraordinary Chair of Psychology Applied in Emergencies and Disasters, that we have in tandem with the Emergency Military Unit of the Spanish Armed Forces. I have worked in the Psychologist' Society for many years, I have collaborated in tasks related to professional ethics and international relations. Now, I am the president of the Division 6: Clinical and Community Psychology of the IAAP - International Association of Applied Psychology, also, I'm representing the General Council of the International Union of Psychological Science (IUPsyS)

Currently, together with Professor Jesús Sanz, who is a professor in the department, and in collaboration with the Asociación de Víctimas del Terrorismo (AVT), we are directing a project to assist terrorism victims throughout Spain. We are trying to have

an information about how the terrorism victims in our country are, which has suffered terrorist attacks for more than 40 years. In our research, we wanted to know how these people are, if they are well, or if they have psychological disorders because of the attacks, or if the symptoms have disappeared over time, or if we can do intervention to help these people. We are working with a team of 15 people: some doctors (Ph. D) who have specialized in this field, other professors of the department, other doctoral students and collaborators of the AVT.



Since when can we talk of attention to victims of terrorism in Spain?

Although Spain has been suffering terrorist attacks for 40 years, that studies on the attention of terrorism victims began to develop after the attack of the 11-S., that is, around 2001. This does not mean that before there weren't terrorist attacks or intervention, this does mean that the data about the effectiveness of treatments can begin to develop only after these years. This is the time when society and, principally, psychology was interested in this issue and started the treatments to determine its effectiveness. Until then, some treatments had been carried out but there was no body of knowledge as we have it now.

What has been your role as psychologist in the intervention?

I have worked with the victims from the applied field. In this regard, I have worked from the accompaniment in the first moments with psychological first aid. I have worked in the psychological accompaniment during the tributes or moments of examination of body, sanatoriums or massive attacks like the 11-M (the 2004 Madrid train bombings). Besides, I have also worked in later moments, weeks later and even 40 years after the attacks. We have done psychological care tasks, psychological treatments for the victims and we try to reduce their problems and difficulties. These symptoms not only have to do with PTSD also with depressive disorders, post-traumatic stress disorders related to the attack, generalized anxiety disorders or agoraphobia.

In addition, we built a self-help guide to try to get people to have basic notions about the reactions that occur when a terrorist attack takes place. In the guide, we explained what are the reactions that being present in an attack, when the help is necessary for the people. This guide also served for the relatives because it was taught to recognize the symptoms, to give them guidelines on how to support the victims. With the guide, we wanted to help people to be stronger, that is, to make people more resilient. Although, it is normal that at

first, they suffer some symptoms, the important thing is that these symptoms are reduced. It is necessary to know how to interpret what is happening to them and that they can be supported by others. The guide also included some guidelines for professionals from the prevention in case of a terrorist attack, the attention in the middle of an attack or after the event occurred. I have worked in all these stages in the training of professionals such as the Spanish Civil Guard, the Red Cross and emergency personnel.

It also includes what we can do when the attack occurs: How to give psychological first aid, how to give related information, how to make society help victims to support them, how to give more personalized support to the most affected people, how the media should address the news about terrorist attacks, how we can track the people who may have the greatest risk of being affected and what kind of intervention to give them until there is a recovery from normal life. It is quite obvious that people do not forget an attack, and that it changes the people's lives of they have suffered it, but the best thing is that people can recover, and they can lead a normal and peaceful life.

What does the psychologist assess, and which instruments does he use?

What we assess depends very much on the moment in which we are. If, for example, an attack had occurred right now, the first thing that the psychologist evaluates would be if people have risky behaviors for themselves or for others such as drinking alcohol, using psychoactive substances or drugs. We must make people able to use all family support. The best thing is that they are with their relatives.

The psychologists will be able to tell them "we are going to be at your disposal and we are also going to respect your privacy", because some victims at the beginning do not want to be with a psychologist although, in fact, they require it. We must evaluate if the victims have who supports them or if they were left alone. It is necessary to favor the meeting with relatives and with the closest people and if possible, we should seek to establish other artificial supports for people.

If people have hopelessness or self-destructive behaviors, they would be people at risk that we cannot lose sight of and we must keep close and control what they do. If they become aggressive with others, we should try to make them feel understood and at the same time we should find an adequate way to canalize the emotions. In other words, during the first moments of the attack we would have to reduce the risk behaviors with respect to personal injuries and to other people. We would have to give you contact information of the psychologists who can help the victims.

After a few hours or days, we should have some instrument to assess if the person has symptoms that require help from a professional. In general terms, the people who have had the most intense reactions are those who are going to need more help because we observe that they have no contact with reality or are not motivated to move forward. These people would need psychological help from the first moments.

We have a series of questionnaires that can assess the severity of symptoms such as the PCL-R or Post-Traumatic Stress Disorder Checklist, PCL, even in the self-help guide that we developed there is a small questionnaire. In brief, we must know if people are okay, if they work normally or if they are in danger. These questions help us know if people do require psychological attention

However, there are people who once past time have not recovered. Here the term disorder appears, understood as a set of symptoms that do not allow people to live normally and that generate a lot of discomfort. The work of psychological evaluation is to know if these people have disorder, that is, a series of symptoms that do not allow them to live normally and that generates discomfort. In these cases, we can apply a diagnostic interview to detect if these people need treatment.

Is there a problem related with the use of terms to label people, for example "mental disorders"?

With the victims we must be very careful with the labels. The psychologists use the labels among us to understand each other, in that sense, that is not a problem. In the field of victimology, the problem is that victims often need to be diagnosed to be recognized or to receive some support. Then they end up believing that the label is part of their life or their identity.
For example, in the case of PTSD with more than three months, we say that it is a chronic post-traumatic stress disorder. This for psychologists does not have much relevance, it only means that it has more than three months. But for victims 'chronic' may mean that you will have PTSD for a lifetime. It is very important that the psychologist clarify that it is only a label and that there are treatments that are effective for people to stop having PTSD even when it has been present 15, 20, 30 or 40 years. 'Chronic' only means that the person has been with a problem for a long time and that it is time to solve it with an adequate psychological treatment.

What other psychological consequences can be found in victims of terrorism?

When a person has been the victim of a terrorist attack different reactions can occur that are normal to threatening situations. Many of these reactions are only survival, triggered to survive, as the arousal of the attention to stimuli and avoidance of other stimuli, fight or flight. All these reactions are normal and many times we are not aware of what happens to us. As time passes, we have other kinds of reactions that help us move forward. For example, in the case of a victim who has lost his/her family in a terrorist attack, he/she takes refuge in his/her home, although others may think that he/she is not connected to reality. This reaction that psychologists call avoidance is a survival response because it allows us to measure the degree to which you expose yourself to what has happened. The fact of approaching little by little to reality, makes people capable of facing these painful and traumatic events. Many times, avoiding help to survive.

What psychologists must do is monitor that the responses that people have of arousal, if avoidance and re-experimentation are good, that is, they are adaptive. What we do is monitor that these types of responses return to

normal. They cannot be activated or avoidable after one year. There is no evolution in the process of people. So, psychologists have treatments that help these survival reactions return to normal. The important thing is that they are adaptive for the traumatic moment and not that they remain 10 or 20 years later.

After an attack, people changes their beliefs. In the terrorism victims there is an adjustment to the new reality because of what they have had to live, they re-adapt and re-adjust their justice beliefs. People stop believing that they live in a fair world. where good things happen to good people and bad things happen to bad people. They find it hard to believe that bad things happen to good people and that bad things do not happen to bad people. Therefore, they break the beliefs of security and of trust in others. Then, people build other beliefs. They believe that since they are victims now, the world must provide them with everything. As they never have it all they live in bitterness because of the belief. The work that we can do be done with the terrorism victims is to try to make them have beliefs that allow them to live without feeling constantly disillusioned.

We would like to ask you about the program of attention to terrorism victims that you have. Also, I would like to ask you if these attention programs are efficient even when the victims have been having a disorder for 30 or 40 years.

The treatment we do is to call each one of the terrorism victims. We call them by phone and we do a short psychological screening interview not to see if they have disorders, but to see if they have symptoms like anxiety, symptoms of posttraumatic stress, and symptoms of depression.

What we do with the people we detect from the phone call is to summon them to a personal way interview. We try to determine if those symptoms are interfering in their life and are generating a high degree of suffering.

To the people to whom we apply this structured diagnostic interview and we find that they have a disorder, we offer a free treatment based on the scientific data we have today. Actually for the terrorism victims the treatment of choice trauma-focused cognitive behavioral therapy, where we have also incorporated some extra elements that have to do with cognitive therapies that allow them to better process the information and also some narrative techniques, and of course, techniques of behavioral activation to help them to increase their operational capacity. In addition to this, we also use exposure techniques that are part of trauma-focused cognitive behavioral therapy.

It is a treatment that is not directed only to people who have post-traumatic stress, but also to people who have depression or other anxiety disorders; because we have found that many victims have other types of disorders besides post-traumatic stress or that they do not have post-traumatic stress but have these disorders. It is a treatment that is applied in 16 sessions although in a flexible way because what we mark in our treatment guide are some goals and there are older people who need more time to meet those goals and others who do not.

In the theme of the exposure, we make people expose to external stimuli that generate fear, such as get back on a train, go back to a Civil Guard barracks, go to the place where the attack occurred, see to people related to what happened, such as comrades in the army, comrades in the civil guard or companions of the town where the event occurred and also to internal stimuli such as memories.

In fact, one of the most interesting parts of the treatment I think it can be the exposure to memories, we make an exposure of memories in which the person remembers everything that happened to him/her, in the present, with her eyes closed, following the exposure model of Foa and with a tape recording. This is our treatment and we observe after the writing of its own history, how it is evolving, how they are now and how they feel facing the future and what we have found is that the treatment is effective to reduce the symptoms of post-traumatic stress and also the depressive symptomatology and other anxiety disorders, because we have done some randomized studies, that is, we have compared the victims who had already received the treatment with those who had not yet received it. We also have studies of utility, that is, not only has efficacy, but effectiveness, utility, and in which we have seen that treatment also works, because reduce the symptoms in people, that these people no longer have disorders, that is to say, that these people could no longer be diagnosed with disorders and that they have also recovered their well-being in their daily lives.

Therefore, I believe that there are two very important conclusions of our research work worldwide that would be, first that the treatments work and not only work for victims who have PTSD but also for victims who have other disorders such as depression or anxiety, and second, perhaps the most important, is that they work in people who have been suffering from these symptoms for 20, 30 or 40 years, which is a very important fact for psychology. I think it is a fact that should encourage everyone to follow up on people who suffer from this type of problem and not only those who have just suffered, but in people who have experienced this type of traumatic event, as it also happens in Colombia, which in many cases are faced with truly very traumatic situations and that may feel bad after a while and perhaps what I could add in a bit in the face of the situation of Colombia, that is not the one of Spain and that we can have perhaps approximately ten or fifteen thousand victims at the most, you have many more victims and I think that there are things that could be done differently and that would be very interesting. For example, the screening situation could not be called by telephone to all the victims but it can be formed, as the representatives can be trained, you can train them, you can train key people of the communities to be able to identify which people of each community who feel bad, they can be given guides so that with them many people can improve and if that still does not work they can be those people who are not well refer to specialized services, but maybe there would be a lot of people that only with the guides and with the support of other people who were trained could move forward.

So the situation, what would be the psychological screening could be done, I think that in Colombia it could be done

by training key informants from the communities, it could be done through psychologists who said how to do it in programs of radio, television, that is, to identify the victims helped by the media, by apps that can be had on mobile phones, that is, there were many ways to do this screening, which is an initial screening, and then it were the psychologists who really determined which identified people need help. Of course, group interventions could be made, interventions could be made through communication media, and only those people, let's say, in a situation of greater risk or more difficult had to go to a more personalized intervention.

Are there typologies of victims?

Typologies of victims there are many. We work with the "direct victims", that is, the people who were in the traumatic situation, and "indirect victims", which would be for example their relatives, those people who have been affected in some way, not because they were in the place of the scene; they can also have post-traumatic stress. So we work with victims who suffered the attack or people who were in the attacks and then with the relatives of the injured and the deceased. In our work we have found that both family members and the injured are very affected and that in some cases injured people are more affected than family members. In fact, the injured are in many cases more affected. However, if we classify the victims as has been usual in the field of emergencies (people who had suffered directly in an attack, neighbors, emergency personnel), it should be taken into account that, for example, emergency personnel may be the more affected because they were present when an event occurred, as in the case of the attack in Madrid. That is, the degree of exposure to the traumatic event is one of the variables that has been most related to the psychopathological consequences of the victims. It is not the same when the emergency personnel arrive when the traumatic event has already passed, that when the emergency personnel, as in the attacks in New York in 2001, were the firemen inside the World Trade Center. In this case, they are both emergency personnel and victims.

So, one very interesting thing that has been studied in recent years when determining the degree to which something is going to affect the victims of terrorism is to what extent these people have been exposed to traumatic events. When the victims of terrorism have been exposed to many traumatic events, bombings, attacks, they are more affected. For example, when we talk about situations of violence like the one in Colombia or Spain, we find that people have suffered from these situations of violence throughout their lives. For that reason, sometimes people say that they are already used to violence or terrorism but what we find is the opposite, people who live in constant violence are more affected psychologically.

We have talked about the treatment to victims but have you worked specifically in attention to victimizers?

In the field of the terrorism, the closest i have worked has been with adolescents and young people who have aggressive behaviors and sometimes they are in the institutes for juvenile of of the Agencia de la Comunidad de Madrid para la Reeducación y Reinserción del Menor Infractor. There are many young

people who have behaviors of violence and they need some kind of help. I have worked from viewpoint of clinical psychology. Indeed, the treatment for victimizers are very important because we must work in the beliefs they have and the cleverness they have to get the things that they want. People have the desire to get things, satisfy their needs, to have success, to have a role in the society and sometimes that we have in the victimizers are self-esteem problems, reduced social groups, they justify the violence as a mean to get things. There is where the psychologist must work in order to change this behavior.

In this way, this knowledge can be applied in other fields of the violence. Right now I am leading an international group of work into the International Association of Applied Psychology (IAAP) and we tried to determine the contributions of psychology in the field of terrorism. In fact, one of the works that we are seeing is about the efforts to reduce the radicalization of terrorists. It develops with the terrorists families in the jails, community and society. At last, is wide field of work. I really know more about the field of words of victims. However, the studies with victimizers is a necessary field, in this moment there are many resources to international level to work in these programs of radicalization, reduction of risks of extremism, reduction and prevention of violence.

What ethical considerations should a psychologist have regarding the treatment of terrorism victims?

To work with them, I believe that in the ethical considerations that must have are, basically, very similar to those we have with other types of treatments or interventions, I think that psychologists somehow know clearly about where our limitations are, I believe that this is one of the important ethical considerations, that is to say, we do not all come from home with the same ethics, then we must study that ethics in the universities, we must study it in the Psychologists' Societies, because there are many things that we think we are doing well, but we are not doing well, then, that would be my first consideration, that ethics must be learned.

In the field of terrorism victims, it is very important that although we are, of course, under the principles of confidentiality with the victims, we must also inform them when those principles no longer matter because there are other things more important, both when you work with the victims, and when you work with terrorists.

All the principles we work on are important, perhaps, I would like to emphasize one that worries me especially, and that is that terrorism victims, like all patients, have the right to have the best possible treatment, and therefore, if there is something that I see ethically important and essential is that we give them the best possible treatments, that is, it is inadmissible doing anything with them, it is inadmissible saying "I'm going to apply this treatment with music because I find it very interesting" , one has the ethical and professional obligation to apply the treatment that we know works best with them, and in this sense, I think we have a lot of work to do, because nowadays in many occasions any treatment is applied, the treatment the psychologist knows better, but, the

treatment to which the victim has right is to the best of the possible treatments, that is, to the one that we know works at this moment, and that implies that pharmacological treatments are not the treatments of choice in post-traumatic stress, they are the psychological treatments, the trauma-focused cognitive behavioral therapy, and therefore it is the treatment that we should apply.

Another thing that also seems very important to me, is that we cannot let these treatments last forever, therefore, part of our ethics has to be that when we see that a patient does not improve with us in a reasonable time, let's say, 2 months seeing him weekly, let's not say that maybe it's all right, but that it's evolving in the right direction, we would also have the ethical obligation to refer it to someone else.

Finally, I would like to emphasize that psychologists who work with victims should not fall into the ethical error of agreeing on everything with them so you put themselves on their side and you make them feel understood, because the best help often is that we are able to generate dissonances about what are being the pillars of his life so that a change can really be generated, and I think it is very important, not to agree on everything with the victims, otherwise sometimes we become a kind of cronies, where they trust us because we agree with them, but not because we really generate a change in their lives. And of course, another thing that seems fundamental to me is that when we say something we can differentiate between what we say as experts because we have learned it through clinic practice and what we say because we really have data. I think that is very important, if I tell a patient "*most people recover*", it is a fact, "*and most people recover without help*", it is a fact, but, if I tell people, "*people need to see their son's body to recover*" that's not a fact, it's my opinion and there may be another psychologist who thinks otherwise, in fact sometimes we make those kinds of mistakes, we say to the people "*it is necessary that you see the body of your child to be able to mourn*", and that is not true, there are many people who begin to mourn, which is a symbolic process, without having seen the body of their son, maybe because sometimes the body of your child has been torn apart or is missing.

So, we must be very careful with the things we tell them that are not based on data, which are our opinion, because sometimes we give opinions that people actually end up making of them as if they were absolute truths, and they are not. And sometimes we hurt people, for example, with the corpses, of having to see the corpse to start the mourning, we are doing a lot of damage to all those victims who cannot have the corpse of their children or their relatives, and that is not a fact, it is not true, this may be the opinion of a professional that I personally would refute, therefore, I think another very important thing is to differentiate the data from the opinions of experts, and in this field unfortunately many times we talk about opinions as if they were data and they are not.

What other disciplines work in the intervention in the field of psychology?

Well, for example, the study that we are doing right now in the IAAP is a research where we are trying to find everything

in which psychology could contribute to approach the challenge that the issue of terrorism has raised us, so, there is the psychology, of course, there are other disciplines as well, for example, there would be involved the politicians, in fact, what our task force wants is finally give recommendations to the politicians about the field of psychology and terrorism. We are watching what contributions, the psychology, could make to the challenge of terrorism, from prevention, approach, until the process of reconciliation and peace, anything the process would be. In fact, the professor Wilson López, who works with you all, there in Colombia, he is collaborating as well, he is one of the members of our task force, and we want to explain how psychology could contribute to this field of terrorism, but, undoubtedly when we finish, we will make some conclusions that we want to give to politicians, because they are social agents, and mass media, somehow, has to absorb that knowledge from psychology to act and to be efficient in terrorism.

We work hand in hand with a lot of professionals, sometimes, we work close to social workers, personal of emergencies and lawyers. For example, lawyers would have to consider psychologists as well when they are going to do laws, because sometimes the laws help to maintain the victimism, because they really reinforce a lot of the victim's behaviors, but the laws are not able to reinforce behaviors like communities or individuals' resilience.

The professions which are really involved are medicine, social work, politicians, journalists, those who work on mass media and practically the whole society. We would have to include the society because the people who go to the protest marches to support the no-violence and to support to the victims, they are playing a function of support to the victims and against terrorism, therefore, I think that the whole world is involved in this problem.

Finally, in what can a specialized psychologist in intervention to victims of terrorism work?

Well, in Spain, for example, what happens is that the law obliges in some way that victims of terrorism recognized as such have money for their own psychological treatment and they can come to any Psychologist they want, so in Spain, where private practice is in some way the predominant manner to apply Psychology, many of the victims come to private centers; others, for example us that we are making this treatment in all Spain, have also treated many victims. Ours is a program of treatment in the framework of a collaboration agreement between Universidad Complutense de Madrid (UCM) and the Asociación de Víctimas del Terrorismo (AVT) in which the victims don't have to pay anything, but there are other victims that in another time have gone to other treatments. On the other hand, Ministry of Interior recently have created a network of attention to victims of terrorism. This is an idea that, in some way, we gave them some years ago because in our first project we want to create this network and what we do now with the Complutense Team, that is going to all of the autonomous communities in Spain, because we initially thought in create a network of Psychologist, and that they could face those treatments and become a part of our research, but

they don’t gave us enough money to do so and include all those psychologists, so what we did was leave the idea of the network and work with our team of psychologist from the Complutense University that were going to the communities. The Interior ministry, I think that with good judgement, it took that idea on the network and what it has done is an agreement between Colegio de Psicólogos de España and Consejo general de la Psicología; the Consejo General de la Psicología choose, from across the country, all those people who have training in caring for victims of terrorism, a lot of them have been our students, of the diplomas we offer in training in psychological assistance to victims of terrorism, others have attended to summer courses and others have been trained in other colleges.

Author Carlos Acuña
Members of the group: Psychology of Peace, Violence and Armed conflict at Colombia

Author: David Camargo
From left to right: Ingrid Bernal, Alejandro Reyes, Jennifer Malaver, Sebastián Sanjuan, Nathaly Ballesteros, Sebastian Niño

SHARING RESOURCES

Recommended Bibliography

The Phd Noelia Moran, has shared with us bibliography on how to work with adolescents who attack their parents.

- Boxer, P., Gullan, R.L. y Mahoney, A. (2009). Adolescents' physical aggression toward parents in a clinic-referred sample. *Journal of Clinical Child and Adolescent Psychology, 38*(1), 106-116. doi: 10.1080/15374410802575396

- Brezina, T. (1999). Teenage violence toward parents as an adaptation to family strain. *Youth y Society 30(4)*, 416-444. doi: 10.1177/0044118X99030004002
- Browne, K. D. y Hamilton, C.E. (1998). Physical violence between young adults and their parents: Associations with a History of Child Maltreatment. *Journal of Family Violence, 13*(1), 59-79. doi: 10.1023/A:1022812816957
- Calvete, E., Orue, I. y Sampedro, R. (2011). Violencia filio-parental en la adolescencia: Características ambientales y personales.*Infancia y Aprendizaje, 34*(3), 349- 363. doi: 10.1174/021037011797238577

- Calvete, E., Gámez-Guadix, M. y Orue, I. (2014). Características familiares asociadas a violencia filio-parental en adolescentes. *Anales de Psicología, 30(3)*, 1176-1182. doi: 10.6018/analesps.30.3.166291
- Calvete, E., Orue, I., Gamez-Guadix, M., y Bushman, B. J. (2015). Predictors of child-to-parent aggression: A 3-year longitudinal study. *Developmental psychology*, *51*(5), 663. doi: 10.1037/a0039092
- González-Álvarez, M., Gesteira, C., Fernández-Arias, I. y García-Vera, M. P. (2010). Adolescentes que agreden a sus padres. Un análisis descriptivo de los menores agresores. *Revista de Psicopatología Clínica, Legal y Forense*, *10,* 37-53.
- González-Álvarez, M., Gesteira, C., Fernández, I. y García-Vera, M.P. (2009). Programa de Adolescentes que Agreden a sus Padres (P.A.P.): Una propuesta específica para el tratamiento de problemas de conducta en el ámbito familiar. *Revista de Psicopatología Clínica, Legal y Forense*, *9,* 149-170.

- Ibabe, I. y Bentler, P. M. (2016). The Contribution of Family Relationships to Child-to-Parent Violence. *Journal of Family Violence*, *31*(2), 259-269. http://dx.doi.org/10.1007/s10896-015-9764-0

- Ibabe, I., Jaureguizar, J. y Bentler, P. M. (2016). Risk factors for child-to-parent violence. *Journal of family violence*, *28*(5), 523-534. doi: 10.1007/s10896-013-9512-2Lyons, J., Bell, T., Fréchette, S. y Romano, E. (2015). Child-to-parent violence: Frequency and family correlates. *Journal of family violence*, *30*(6), 729-742. doi: 10.1007/s10896-013-9512-2
- Margolin, G. y Baucom, B. R. (2014). Adolescents' aggression to parents: longitudinal links with parents' physical aggression. *Journal of Adolescent Health*, *55(5),* 645-651. doi:10.1016/j.jadohealth.2014.05.008
  - Muñoz-Rivas, M.J., Andreu, J.M., Graña, J.L, O'Leary, D.K. y González, M.P. (2007). Validación de la versión modificada de la Conflicts Tactics Scale (M- CTS) en población juvenil española. *Psicothema, 19*(4), 693-698.
  - Nock, M.K. y Kazdin, A.E. (2002). Parent-directed physical aggression by clinic- referred youths. *Journal of Clinical Child Psychology, 31*(2), 193-205. doi: 10.1207/S15374424JCCP3102_05
  - Omer, H. (2001). Helping Parents Deal With Children's Acute Disciplinary Problems Without Escalation: The Principle of Nonviolent Resistance. *Family Process, 40 (1)*, 53-66. doi: 10.1111/j.1545-5300.2001.4010100053.x
  - Pagani, L.R., Tremblay, R.E., Nagin, D., Zoccolillo, M, Vitaro, F. y McDuff, P. (2004). Risk factor models for adolescent verbal and physical aggression toward mothers. *International Journal of Behavioral Development, 28(6)*, 528-537. doi: 10.1080/01650250444000243
  - Walsh, J. A. y Krienert, J. L. (2007). Child–Parent Violence: An Empirical Analysis of Offender, Victim, and Event Characteristics in a National Sample of Reported Incidents. *Journal Family Violence, 22,* 563-574. doi: 10.1007/s10896-007-9108-9

Noelia Moran Rodriguez

ACTIVITIES

Division 6 member activities

In this section we will summarize the activities that members of division 6 have done. As all members know Division 6 works to spread knowledge and the initiatives on psychology and we would like to invite our members to share with all of us what are they doing in community and clinical psychology.

- Maria Paz Garcia-Vera, President Division 6 & Daniel Dodgen, Elect President Division 6, participated in the 1st Pan-African Psychology Congress. The Congress was held 18-21 September 2017 in Durban, South Africa. They participated in the Symposium: Psychology Applied to Terrorism and Violence: Advances and Challenges, Chaired by Janel Gauthier https://twitter.com/IAAP_Division6/status/910408493957599232

- Division 6 members, Pedro Altungy, Belen Reguera, Roberto Navarro, Sara Liébana, Rocio Fausor, Clara Gesteira and Noelia Morán, have been continuously working to assess and to provide treatment for all the victims of terrorism who need it. This program is a Complutense University attention program in which the Division 6 members are involved. The regions visited along the past month have been Basque Country, Navarra, Cantabria and Asturias. http://avt.org/docs/revista/AVT%2027%20abril_2017%20.pdf (pages 42-43).

- Participation in the SEPCyS (Spanish Society of Clinical and Health Psychology) Conference "Beyond the diagnostic models: new approaches to the psychological treatment" Madrid October 27th 2017. University Camilo José Cela. http://www.sepcys.es/index.php?mact=News,cntnt01,detail,0&cntnt01articleid=20&cntnt01origid=15&cntnt01returnid=64.

- Maria Paz Garcia-Vera & Jesus Sanz, members of the Division 6, have received a special mention in the III edition Awards of Technology Transfer and Knowledge by the Universidad Complutense de Madrid. Modality: Biomedical and health sciences, for their psychological programs with the victims of terrorism in Spain

- Clara Gesteira, member of Division 6, participated in an international teaching experience. Some Division 6 members had the opportunity of giving different lectures and workshops on the topic of the evidence-based treatments for victims of terrorism to undergraduate and graduate Psychology students from several European universities. Specifically, the following courses took place:
  - Evidence-based treatments for victims of terrorism (8 hour course). Universidade da Beira Interior (Covilha, Portugal). 3-5 May 2017
  - Evidence-based treatments for victims of terrorism (8 hour course). Justus-Liebig-Universität Giessen (Giessen, Germany):9-5-June 2017
  - Evidence-based treatments for victims of terrorism (8 hour course). Eberhard Karls Universität Tübingen (Tübingen, Germany): 12-14 June 2017
- Division 6 members, Pedro Altungy, Belen Reguera, Roberto Navarro, Sara Liébana, have been travelling around Spain in order

to continue with the Complutense University Association of Victims of Terrorism psychological attention program. In this program, the Complutense University team assessed and treated psychologically people who have suffered from terrorism in the country. The regions visited along the current year have been País Vasco, Ciudad Real, Navarra, Cantabria and Asturias.

- Division 6 members have been participating in several TV programs and in Social Media with the objective of disseminating psychological help to victims of terrorism after the Barcelona terrorist attacks

- Maria Paz Garcia-Vera, participated in the **Colombian Congress of Psychology 2017 (August 30 to September 2)** with the following forums and conferences:

    - Conference: "Psychopathological Repercussions of the terrorism and their treatment: State of the Art".
    - Emergency Forum: Psychological contributions in the attention to the victims of natural disasters and armed conflicts.
    - Ethics forum: challenges and lessons of ethics applied to psychology.

- Media activity. We keep working on Twitter and Facebook. Please, Follow us @IAAP_Division6.

Colombian Congress of Psychology 2017 (August 30 to September 2)

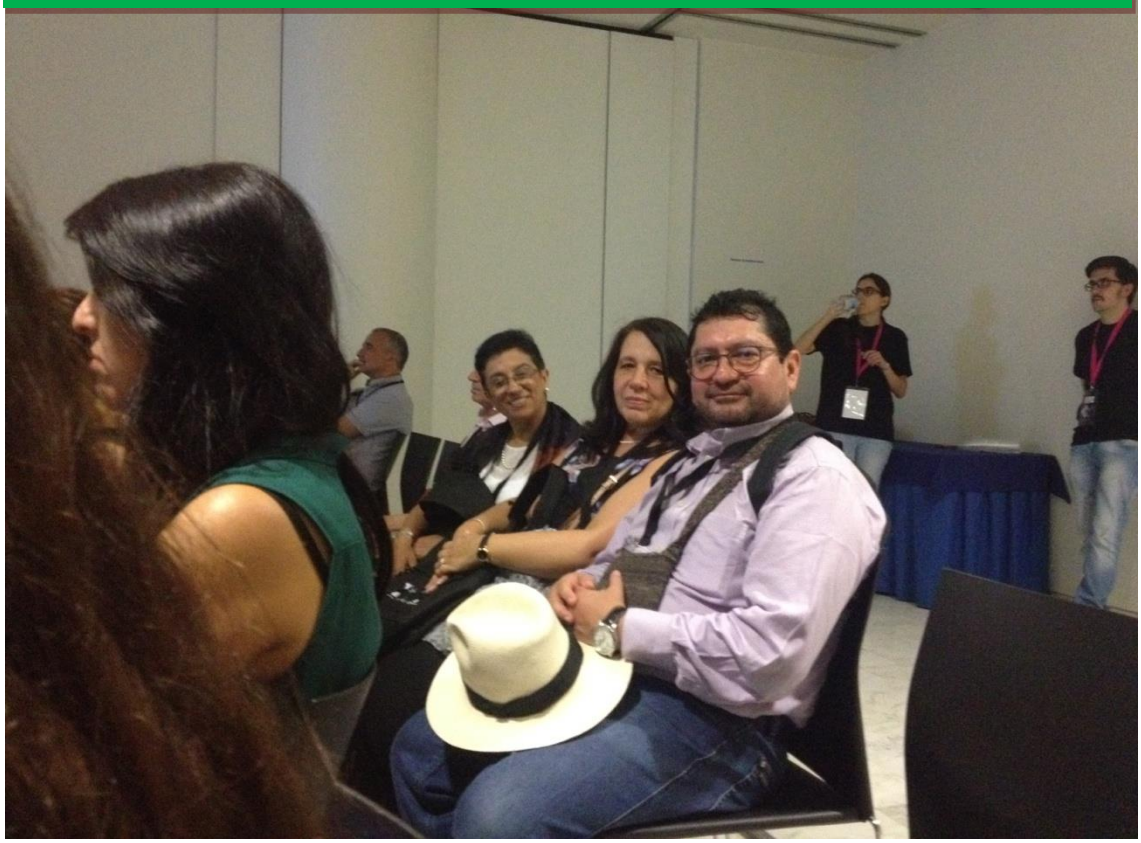
Forum about emergencies and catastrophes during Colombian Congress of Psychology 2017 (August 30 to September 2)

Forum about emergencies and catastrophes during Colombian Congress of Psychology 2017 (August 30 to September 2)

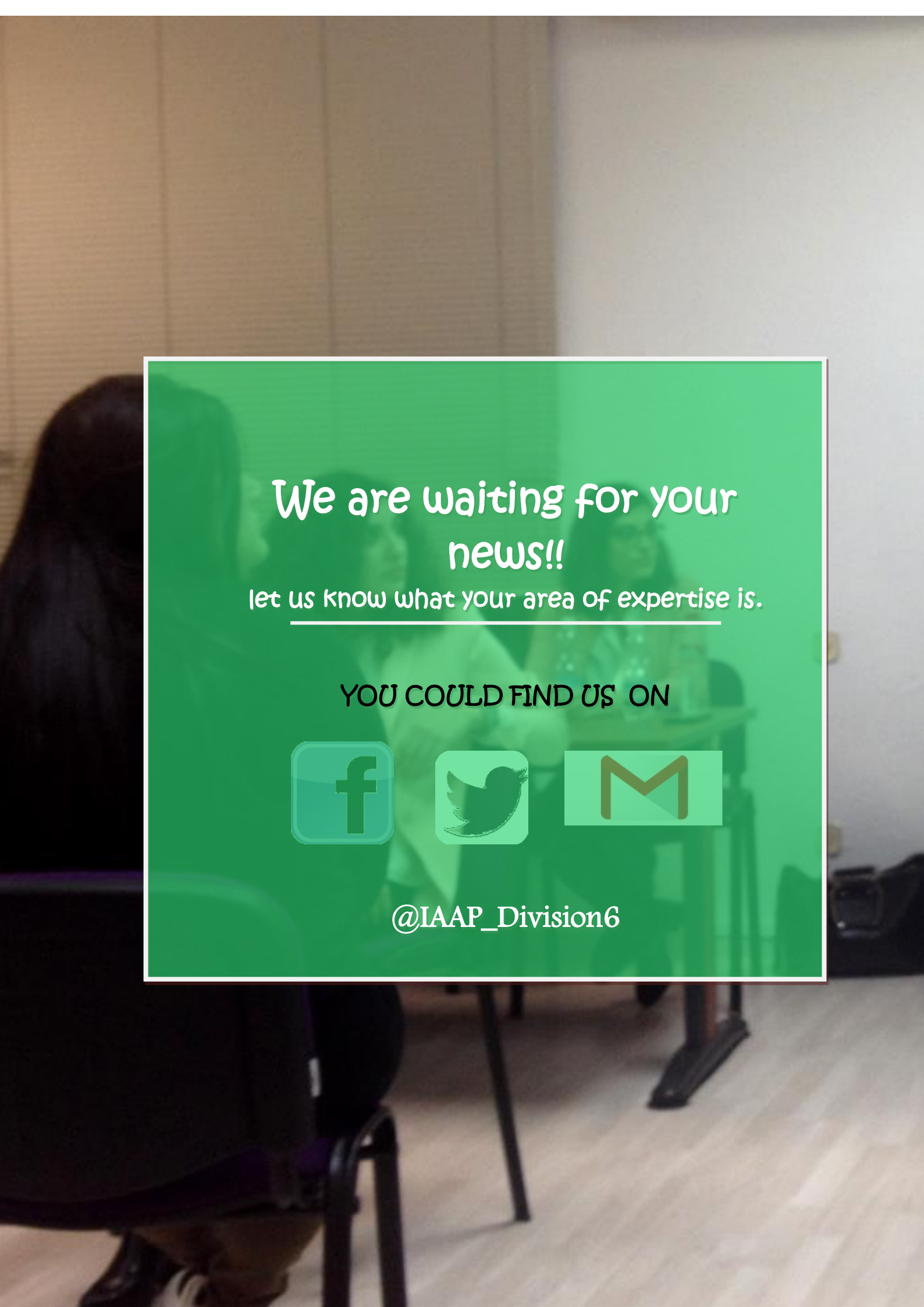
Team work for international relationship, during Colombian Congress of Psychology 2017 (August 30 to September 2)

Opening of III National Congress of Psychology at Oviedo, Spain

Official Association of Psychologists of Colombia President and other representatives at the Oviedo III National Congress of Psychology, Spain.



Author: Alejandro Reyes
From left to right: Sebastian San Juan, Jennifer Malaver, Alejandro Reyes, Ingrid Bernal, Nathaly Ballesteros


We are waiting for your news!!
let us know what your area of expertise is.
YOU COULD FIND US ON
@IAAP_Division6

EVENTS

July – December 2017

- 19th International Conference on Attitudes and Cognitive Organization in Social Psychology (ICACOSP). July 04-05, 2017. Singapore, Singapore.
- 15th European Congress of Psychology (EPC). July 11-14, 2017. Amsterdam, The Netherlands.
- 19th International Conference on Personality Psychology, Development, Health and Personality Change (ICPPDHPC). August 14-15, 2017. Mestre, Italy.
- 19th International Conference on Applied Psychology and Behavioural Science (ICAPBS). August 17-18, 2017. Copenhagen, Denmark.
- 19th International Conference on Personality Psychology and Humanistic Theories (ICPPHT). August 28-29, 2017. Paris, France.
- 18th European Conference on Developmental Psychology. August 28 – September 01, 2017. Utrecht, The Netherlands.
- 21st International Conference on Psychology & Language Research (ICPLR). September 07-08, 2017. Nusa dua, Bali. Indonesia.
- 19th International Conference on Abnormal Psychology and Posttraumatic Stress (ICAPPS). September 14-15, 2017. Saint Petersburg, Rusia.
- 19th International Conference on Psychology (ICP). October 09-10, 2017. Osaka, Japan.
- Australian Psychology Society (APS) 16th Psychology of Relationships Interest Group (PORIG) National Conference. November 16-17, 2017. Melbourne, Australia.
- 19th International Conference on Individual Psychology and Compensation (ICIPC). November 16-17, 2017. Kyoto, Japan.
- 6th World Conference on Psychology and Sociology. November 23-25, 2017. Barcelona, Spain.
- 19th International Conference on Health Psychology (ICHP). December 07-08, 2017. Surry Hills, New Zeland.
- 4th World Conference on Psychology Sciences. December 07-09, 2017. Thessaloniki, Grece.
- 19th International Conference on Forensic Psychology (ICFP). December 11-12, 2017. Kuala Lumpur, Malaysia.
- 19th International Conference on Clinical and Counselling Psychology (ICCCP). December 18-19, 2017. London, England.

ACKNOWLEDGMENTS

To all of those who built this project and want to share knowledge.

- **To our President** *María Paz García-Vera* **and president elect** *Daniel Dodgen*
- To Pablo A. *Reyes Velásquez, Jennifer A. Malaver Toloza, Ingrid C. Bernal Riveros, Ángela R. Guevara López, Juan S. Niño Zambrano, Sebastián Sanjuan Castañeda* and Nataly Ballesteros Vargas, from National University of Colombia for their contribution to this newsletter number with their interesting interview to *María Paz García-Vera.*
- To Noelia Moran for sharing with us recommended bibliography.
- To Clara Gesteira, Rocío Fausor and Pedro Altungy for their help and ideas to develop this newsletter.