

The Clinical and Community Psychology

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CONNECTING MEMBERS: SURVEY

The main purpose of this website is to promote activities and services to our members and to get know each other across the world.

To start with, in this section we have a proposal in which we would like to involve you as soon as possible...

Connecting members across the world!!



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

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



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

IAAP Division 6 Survey

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List of topics

- | | |
|-------------------------------------|---|
| 1. Addictions | 27. Family planning |
| 2. ADHD | 28. Health education |
| 3. Aging | 29. HIV & AIDS |
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| 23. Emotional Health | 49. Psychosis |
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| | |
| 53. Sport and Exercise | 57. Teens |
| 54. Stress | 58. Violence |
| 55. Suicide | 59. Women & Men |
| 56. Systemic therapy | 60. Workplace Issues |

EXPERTS ACROSS THE WORLD

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

ARTICLE

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

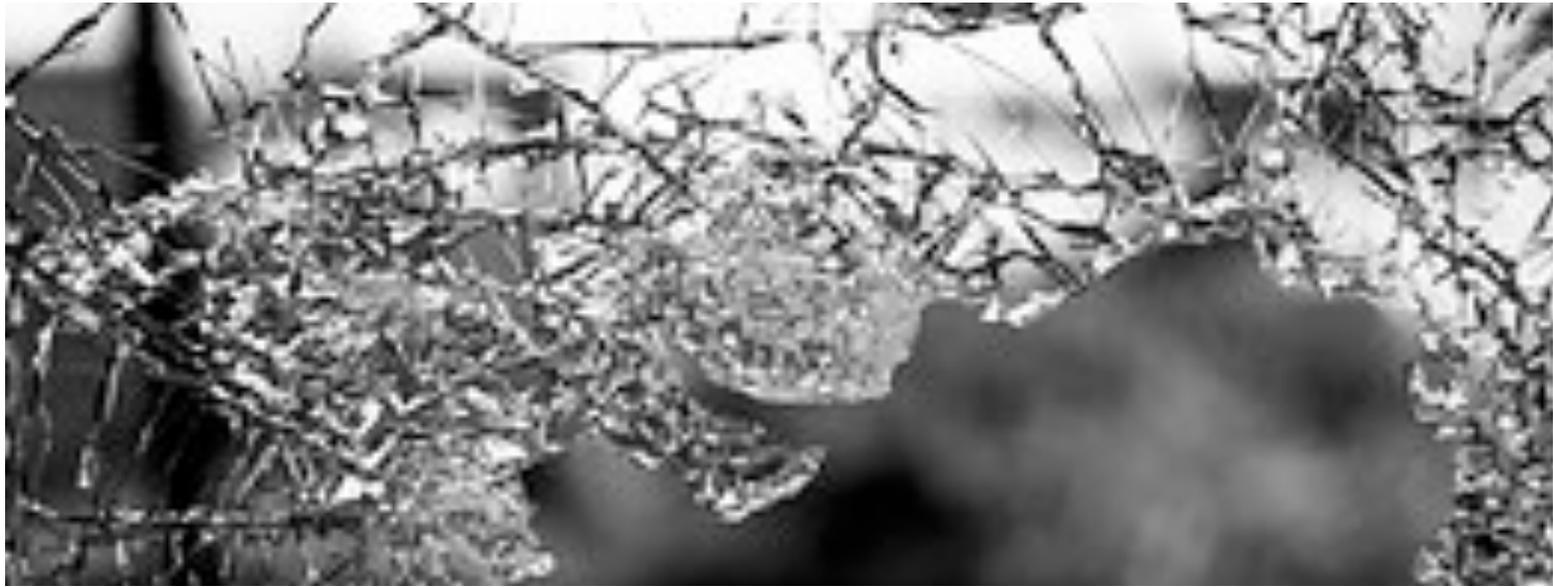
VIOLENCE TOWARD PARENTS

María González-Álvarez & Noelia Morán
Complutense University of Madrid

KEYWORDS: child to parent violence, parent abuse, adolescent violence, violence toward parents, psychological treatment

Violence toward parents has received an increased attention from society, public institutions and scientific community in recent years. Meanwhile violence against children or women have not only received a higher attention but also have generated a higher social awareness and in consequence promoted the creation of numerous resources and approaches, including legislation changes, aimed to solve these problems. However there is another kind of violence that has not received much attention, this is: the

violence toward parents. This form of domestic violence may seem an unusual and rare phenomenon, however, the data put us on the right track of social relevance that this phenomenon is taking in recent years. In fact there are numerous studies made in different countries that have shown that it is a widespread and serious problem with very negative consequences for all family members (Boxer, Gullan & Mahoney 2009; Calvete et al., 2013; Kennair & Mellor, 2007; Routt & Anderson, 2011). Therefore this form of



domestic violence is starting to be considered as a public health problem.

However this problem not always leaves the private sphere; many parents do not seek help from professional services, do not tell the problem to other relatives and friends, and do not take legal actions. This is because making publicly and visible that they are victims of abuse by their children makes them feel guilt, shame and humiliation, and they rather not to tell it. And this is usual due to the high emotionality caused by family problems. Very often these parents wonder what they did wrong, how they have failed as parents and why they are now victims of those who loves more, their children. Moreover, the society attitude has not always been the best with these parents. Often relatives, friends and even public

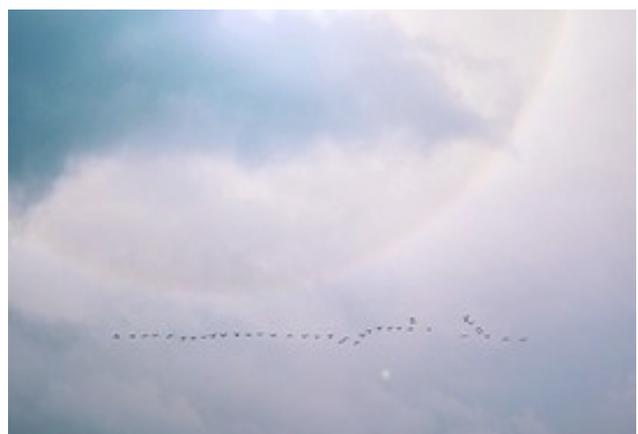
and social institutions have sent them a message of guilt and labeled them as "bad parents".

That is why psychologists who work with this kind of families need to know in depth this problem, its consequences and the steps needed to treat it. First of all, when we asked about how these adolescents are, we have to consider the following descriptive characteristics: we know that the presence of difficulties like the lack of self-control, low empathy, communication problems or thoughts that lead them to justify their behavior conceive violence as a legitimate way to resolve conflicts. These characteristics help us to know a profile and it must be considered in any intervention. However accountable only to a part of the problem lead us to fall into a reductionism that does not

conform the reality. In fact nowadays many studies have shown the influence that parents have on the appearance of this type of family violence. Of course while analyze and recognize parents contribution to the problem we must not fall into blaming them, because it is obvious that parents never seek to generate such reactions in their children. However, we know that violent behaviours used by the parents as a response to their children's violence, poor communication skills or a higher criticism are related to violence toward parents and on the same direction, negative parental discipline characterized by the lack of educational standards limits or on the other hand a too rigid educational standard can explain the abuse perpetrated by the children. And even the presence of hostile thoughts toward their children and justifying violence in interpersonal relationships can promote the development and maintenance or exacerbation of the problem.

Nevertheless, we can not forget the role of society in this type of problem and, more specifically, the role of social justification and normalization of aggressive behaviours and violence. In fact we are surrounded by violence, so we can see a lot of different

aggressive acts on social and mass media, at the school or in the family. And this exposure makes that behaviours such as yelling, insult or swear at somebody are considered normal, and frequently are not included on the concept of violence. However, we know that slaps or beatings do not appear spontaneously and the social attitudes of normalization of violence play an important role in the learning of these behaviours by any child. Moreover this family violence usually appears after a prolonged process that finally ends resulting in what is known as the phenomenon of escalation. But before punching or slapping a parent, any child and their parents during a conflict had shouted, insulted, threatened or even slammed the door. And if the society and parents consider this shouts or insults also as an aggression we are helping children and parents to act when these behaviours begin to appear, rather than wait for a chronic situation, turning family life untenable.



Whether due to the presence of verbal or physical aggression, it is clear that this family situation has consequences for all members. Sadness, anxiety, anger or fear, several emotions that can be present on both parents and children, making difficult to get out of this situation without professional help. Good news is that treatments exist to help these families, so it is important to encourage parents to seek help at the

first time when they detect the conflicts are arising and becoming violent, trying to leave behind guilt or shame. Any intervention needs to increase the motivation to change in adolescents and their parents, control the thoughts that promote anger and hostility, anger management, improve and recover the affective relationship between parents and children.



María González-Álvarez



Noelia Morán

SHARING RESOURCES

STEP-UP programme

STEP-UP Program building respectful family relationships and helping families to get over the violence toward parents

Violence toward parents or child-to-parent violence has garnered increasing attention due to the high rates of violence and the serious consequences that causes on parents victims of abuse by their children and on the perpetrators. So we can consider that violence toward parents it's starting to be a social and health public problem. In fact, the number of legal demands from parents victimized by this type of abuse in medical clinics, social services and psychological private clinics is growing day after day.

These data highlights the necessity of knowing more about the specific treatments in this area and particular treatments that act with all stakeholders on the problem, teenagers and their parents. In this review we are going to present the Step-Up Program, a recognized and specific intervention in

adolescent family violence, which was made in Seattle in 1997 in response to the high number of cases of violence toward parents detected during this year (King County, 1997). The main goals of Step-Up program are: 1) to stop violence and abuse toward parents and 2) to develop respectful family relationships in order to help family members to feel safe at home.

This multicomponent cognitive-behavioural approach is applied in a legal context and provides an integral therapeutic intervention developed in a group format, with children on one side, and parents on the other, and secondly they do a family intervention in order to restore adequate family relationships between members of the family unit. Structured in 21 weekly sessions and 90 minutes estimated duration (Buel, 2002; Routh and Anderson, 2011), the

program is completely voluntary and is offered to parents when they go to police office to denounce their sons or after the court appearance.

The First step of the intervention includes the real necessity for developing a safety plan with every family that is created after hazard assessment, mental health, and substances abuse. Afterwards, the intervention is aimed to give parents strategies in order to tackle the abuse perpetrated by their children.

Parental intervention focuses on the review of family history, especially in the detection of other familiar violence and the impact on children behaviour. In addition, parents receives a complete psychoeducation about the particularities of adolescence and the changes in their children during this stage, and the influence of punitive or violent parental styles on children behaviour. So parents are training on the establishment of appropriate rules and limits, and in the use of appropriate strategies such as time off, positive reinforcement, assertive communication and conflict resolution (Anderson y Routt, 2004a).The individual goals with children emphasize the necessity of holding the child responsibility for his/her abusive behaviour and

encourage the recognition of the effects of such behaviours on their parents and themselves (Anderson y Routt, 2004b). The intervention includes learning skills aimed to prevent violent behaviour, for which children learn assertion, conflict resolution, empathy, cognitive restructuring and learns to control anger. Finally, in family treatment, parents and their children are taught to detect signals and risk factors associated with violence, practice "time out" and enhance communication by using role-playing (Buel, 2002).

This intervention program has been evaluated three times by independent researchers, found promising results. If you want to know more about Step-Up program you can review following web site

<http://www.mincava.umn.edu/document/stepup/intro/stepupintroduction.html>

<http://www.kingcounty.gov/courts/clerk/step-up.aspx>

<http://www.kingcounty.gov/~media/courts/Clerk/stepUp/documents/TeenFacilitatorManual.ashx?la=en>

<http://www.kingcounty.gov/courts/stepUp/The%20Step%20Up%20Curriculum.aspx>

References:

Anderson, L. y Routt, G. . (2004a).

Step-Up: A consueling program



for teens who are violent at home. Parents group. Retrieved on <http://www.kingcounty.gov/courts/stepUp/The%20Step%20Up%20Curriculum.aspx>

Anderson, L y Routt, G. (2004b). *Step-Up: A consueling program for teens who are violent at home. Teen group. Retrieved on <http://www.kingcounty.gov/courts/stepUp/The%20Step%20Up%20Curriculum>.*

Buel, S. (2002). Why juvenile courts should address family violence: promising practices to improve intervention outcomes. *Juvenile and Family Court Journal*, 53(2), 1-16.

King County (2012). *About Step-Up*. Retrieved on <http://www.kingcounty.gov/courts/step-up/About.aspx>

CLINICAL CASE

PSYCHOLOGICAL REPORT

Judit García

Contributors: María Carmena

University Psychology Clinic, Complutense University of Madrid.

KEYWORDS: Report, child, clinical psychology

Judit García Jiménez (Collegiate number: M-24608) psychologist at the Complutense University's Psychology Clinic, presents this clinical report of "Juanito", at the request of their parents, in order to inform on the assessment and treatment performed with the patient on the Unit for Research and Teaching of the Masters in Clinical Psychology and Health.

IDENTIFYING INFORMATION:

NAME: "Juanito" (not real name)

AGE: 7 years old at the time of the assessment.

FAMILY STRUCTURE: "Juanito" lives with his parents.

START DATE: October 2011.

FINALISATION DATE: In Treatment Today.



ASSESSMENT PROCEDURES:

To objectively assess problematic behaviors observed in the child, as well as ruling out pathologies, besides following the diagnostic interview guide with children and adolescents (Ezpeleta, L., 2001) and Interview guide for adults, (Muñoz, M. 1997), I also interviewed the tutor and the child's speech therapist in order to obtain a more complete view of the situation.

The assessment included the following questionnaires: **CDI** (Kobacs, M. 1992), **CBCL** Child Behavior Checklist (Thomas M. Achenbach.,



1991), **EDAH** (Farré, A. Carbona, J. Madrid: TEA, 2003), **BASC** (C. R. Reynolds y R. W. Kamphaus), **CAS** (Guillis, J.S. Madrid: TEA, 1997), **WISC-IV** (Weschler, D. TEA, 2005), **CARAS** (Thurstone, L.L. Yela, M. Madrid: TEA, 1979).

* 8 sessions of evaluation were required due to individual characteristics of the patient. The child had difficulties in maintaining attention focused on the same test, and got up from the table several times; increasing the time to complete the tests.

REASON OF CONSULTATION:

The mother says, and insists, they come to consultation because the teacher has told them their child has a reading comprehension problem, staring off, and probably ADHD. Furthermore as we are told by the parents, the teacher textually says "is the kind of kid who is prepared for professional life. Your child is not like the others. "

The parents claim they are tired, and for that reason they come to consultation. After asking them, they admit his child may be "a little bit immature in the speech, and has difficulties to start making his homework." However, parents verbalize, they do not see his son different respect to other children of his age. They also insist on their dissatisfaction with the way the teacher treat them both (them and his child).

CASE BACKGROUND:

Parents mention that "Juanito" has had a normal development. Although we are told he had a series of illnesses

as a child. They say his son was born with a very open fontanel, so they attended to the neurologist until "Juanito" was 6-7 months old. They also inform us that he was born with retractile testicles, so he had to undergo three operations: the first operation at 15 months, the second at 2 years, and the third at 3 ½ years. "Juanito" will undergo another operation because he probably has an atrophied testicle. Finally they mention his child suffered of several ear infections.

As the parents told us, at the nursery school, when “Juanito” was 2 years old, they suggested them to see a speech therapist for delayed language acquisition. Later on he began to talking, so they decided not to take him to a speech therapist. Currently, it appears that the child's fluency that we observe during the interviews is not appropriate for his age; that was subsequently confirmed with the assessment tests.

Parents tell us the behavior of “Juanito” became worse when he was 3 or 4 years old. At this age the child starts having tantrums, contradicts his parents, disobeys, does not want to go to school and seems to be always angry. From age 4 “Juanito” refuses to go to school, trying to make excuses for not going, so they have to “drag him”. They report that tantrums occur anywhere every time they deny something “Juanito” wants. They explain us in these situations his son yells, hits his parents, cry and slams into the wall until he achieves his objective.

Parents mention that since he moved to primary school at the age of 6, his child “still hits more” when going to school. They believe this occurs because the teacher scolds him much.

Precisely that year, they received the first complaints from the teacher about the behavior and school performance of his child. As we could observe in his school grades, the child had suspended four subjects that academic year.

Currently in 2nd grade, the parents express that complaints from the teacher, have increased. According to the mother, the teacher tells her that “Juanito” is lagging far behind his classmates; he has comprehension problems, staring off, hits other children and is very restless. As the mother informed us the professor textually said: “I don’t understand why Juanito isn’t educated as a child with special needs, I believe he is below the children with special need of my class; if I had known how childish he is, I wouldn’t let him pass to primary. Parents says they don’t notice anything different in his child from other children; immaturity in the speech, and difficulties to start making his homework. However, because of the teacher's complaints, they decided to take “Juanito” to various specialits (psychologist, ENT specialist, pediatrician, oculist and neurologist).

Parents verbalize the school speech therapist tells them that “he believes Juanito presents ADHD and

should take medication", but as they inform us, he didn't applied his son not one assessment test. Subsequently, they take his son to a Social Security psychologist. We asked them to bring us a report, but till the date this one hasn't been provided. The psychologist told them he "only detected a possible developmental delay, but he didn't saw any other difficulty", and gave them appointment within three months. The pediatrician told them "Juanito's problems don't seem to have an organic basis, so it may be a developmental delay". According to the report of 17/10/2011 provided by the parents EEG results concluded that the bio-electrical brain activity is within the normal range for chronological age. Where problems were detected is in the oculist, who concludes, after the ocular evaluation, that "Juanito" should wear glasses because of a problem of farsightedness and astigmatism "AO" as indicated in the report dated 14/10/11. The first time the child comes with his glasses to the consultation was the 11/11/11.

Considering the history of ear infections that had the child during the first years of life, we recommend to attend a hearing test to dismiss hearing problems. Parents report that the results

of ENT "are positive, the child doesn't present hearing difficulties."

The school referred "Juanito" to the orientation team (November 2011), who studied the case and consider, both tutor and the speech therapist, "they cannot provide support to Juanito, as to be considered a child with special needs, he should have a delay of more than 2 years, and this is not his case". Currently they have appointment to see the neurologist.

ASSESSMENT RESULTS:

To carry out a comprehensive assessment of the problem, different questionnaires were applied in addition to the interviews; which were conducted with the child, the parents, the tutor, and his school speech therapist. We requested a complete medical checkup of the patient, where the vision problem was detected. On the other hand we dismissed organic causes that may be related to the present symptoms, as stated on the reports "Juanito" parents provided us, of the various specialists. The following table shows the results obtained in the different tests applied during different moments of evaluation.

For a more detailed assessment of the results see next board.

Table1

Data Sheet	Questionnaires	Results	Interpretation
Depression	CDI	Total: Pc 75	Not significant
		Esteem: Pc 90	Significant
Anxiety	CAS	Total: Pc 76	Significant
ADHD	EDAH	DA: PC 99	Significant
		H: PC 91	Not Significant
		TC: PC 98	Significant
		H + DA: PC 99	Significant
		H+DA+TC: PC 99	Significant
List of symptoms	BASC	Teacher: Hyperactivity, unusualness.	Clinically Significant
		Mother and Teacher: Aggressiveness, behavioral problem	Clinically Significant
		Fathers and Teacher: Attention problems.	Clinically Significant
		Mother: Social skills and leadership	Clinically Significant
		Mother: Depression, retreat and adaptability	At Risk
		Father and Teacher: Adaptative skills	At Risk
		Teacher: Learning disability	At Risk
		Fathers: F index	At Risk
		Teacher: F index	Extreme caution
Behavioral assessment	CBCL	Emotional problems	Pathological
		Anxiety problems	Limit
		Behavioral problems	Pathological

BEHAVIORAL OBSERVATION:

As part of the assessment, we asked the parents of “Juanito” to weekly register his son’s tantrums (insults, yells, slams against the wall, etc.), as well as the antecedents and consequences of such conducts. When the behavioral observations began (in November 2011) we found the patient had at least two tantrums every week when something he wants was denied, getting finally what he wanted. We could observe these tantrums during the consultations when we asked him to do something he didn’t want to do.



DIAGNOSE:

Based on data collected from interviews and questionnaires about symptoms presented, and in contrast with the diagnostic criteria of DSM-IV, we can make the following diagnosis to this patient according to DSM-IV-TR:

- AXIS I: F43.22 Adjustment disorder with mixed anxiety and depressed mood [309.28]. Chronic.
- AXIS II: Z03.2 No diagnosis [V71.09]
- AXIS III: Z03.2 No diagnosis

- AXIS IV: Problems with primary support group; Educational problems
- AXIS V: EEAG: 60 (current)

LIST OF PROBLEMS:

- Taking into account the results of the interviews, and the behavioral observation, we conclude “Juanito” had the following behavior problems: tantrums and swearwords, screams and hitting, high irritability, anxiety, low self-esteem, low mood and low frustration tolerance. Besides we

Table 2

TREATMENT GOALS	TECHNIQUES USED
<ul style="list-style-type: none"> • Return information 	<ul style="list-style-type: none"> - Returning information interview. - Psychoeducation.
<ul style="list-style-type: none"> • Improve mood • Regular activity levels 	<ul style="list-style-type: none"> - Psychoeducation about depression. - Planning enjoyable activities. - Thermometer mood.
<ul style="list-style-type: none"> • Decrease physiological arousal. 	<ul style="list-style-type: none"> - Diaphragmatic breathing training.
<ul style="list-style-type: none"> • Identification of erroneous beliefs and dysfunctional thoughts 	<ul style="list-style-type: none"> - Cognitive restructuring
<ul style="list-style-type: none"> • Encourage the development of coping skills: <ul style="list-style-type: none"> - Managing social situations. - Improve self- control - Anger Management . - Improve personal autonomy 	<ul style="list-style-type: none"> - Turtle technique. - Social skills training. - Self-instruction training. - Semaforo anger. - Troubleshooting.
<ul style="list-style-type: none"> • Explanation and emotional management 	<ul style="list-style-type: none"> - Psychoeducation emotions - Identification and emotional expression.
<ul style="list-style-type: none"> • Generalize what they learned • Maintain longterm achievements 	<ul style="list-style-type: none"> - Relapse prevention. - Review of the techniques learned. - Identifying risk situations.

found difficulty focusing, poor academic performance and social relationship deficits.

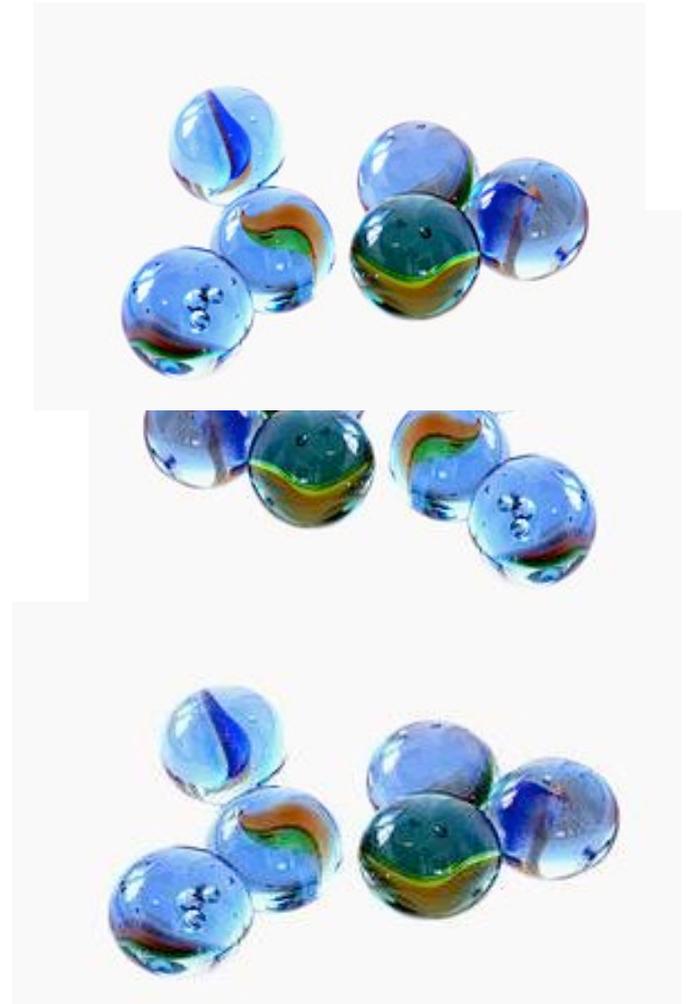
TREATMENT

RECOMMENDATIONS:

After carrying out the assessment process and clinical case formulation, based on data collected from interviews and questionnaires about symptoms presented; we considered the need of treatment. The therapeutic goals, and specific tasks to achieve them shown on table 2, were proposed and accepted by the family.

FINAL CONSIDERATIONS:

- After carrying out the assessment process, we consider necessary that the patient begins the treatment process



ACTIVITIES

EVENTS

Check here, next international congress of clinical and applied psychology.



January

- 14th Annual Meeting of the Society for Personality & Social Psychology; January 17th-19th, New Orleans, LA, USA. <http://www.spspmeeting.org>

February

- 12th World Congress on Stress, Trauma & Coping, February 19th- 26th, Baltimore, USA, www.icisf12thworldcongress.org
- 2nd Annual International Conference on Cognitive and Behavioral. Psychology (CBP), February 25th-26th, Singapore, Singapore. <http://www.cognitive-behavior.org/>

Abril

- International Psychological Applications Conference and Trends, April 26th-28th, Madrid, Spain. <http://www.inpact-psychologyconference.org/2013/>

June

- Third World Congress on Positive Psychology, June, 27th -30th, Los Angeles, USA, www.ippanetwork.org



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- Noelia Morán
- Judit García
- María Carmena