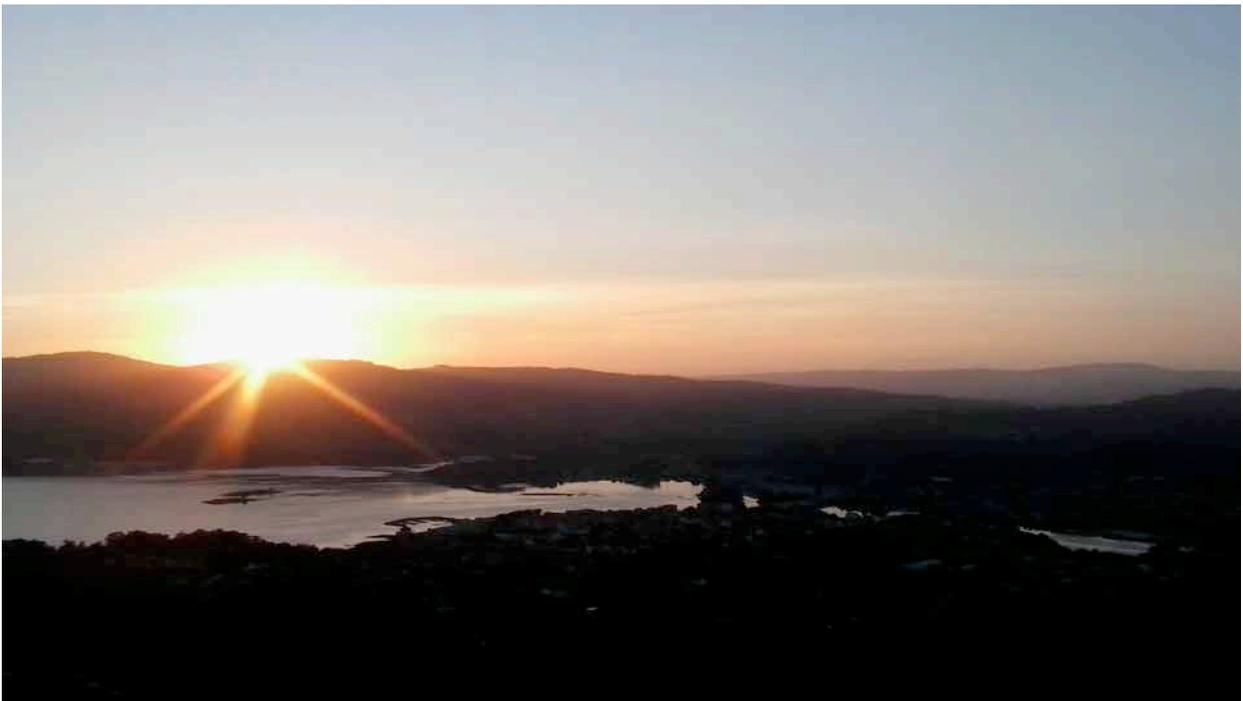


# **The Clinical and Community Psychology**

A Publication of the Division 6 of the  
International Association of Applied  
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*of the **IAAP**!!*

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## CONNECTING MEMBERS: SURVEY

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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 colleagues 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](mailto:mpgvera@psi.ucm.es)

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**List of topics**

- |                                     |   |
|-------------------------------------|---|
| 1. Addictions                       | 27. Family planning                         |
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| 4. Alzheimer's and dementias        | 30. Human Rights                            |
| 5. Anger                            | 31. Hypnosis                                |
| 6. Anxiety                          | 32. Immigration                             |
| 7. Assessment                       | 33. Intelligence                            |
| 8. Autism                           | 34. Interpersonal therapy                   |
| 9. Affective disorders              | 35. Kids & the Media                        |
| 10. Biofeedback                     | 36. Law & Psychology                        |
| 11. Bullying                        | 37. Learning & Memory                       |
| 12. Burnout                         | 38. Military                                |
| 13. Cancer                          | 39. Natural Disasters                       |
| 14. Children                        | 40. Obesity                                 |
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| 16. Couples                         | 42. Psychophysiological disorders           |
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| 18. Diagnosis                       | 44. Personality                             |
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| 21. EMDR                            | 47. Terrorism                               |
| 22. Emergencies                     | 48. Trauma / Post-traumatic Stress Disorder |
| 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

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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

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

### **EFFICACY OF A LONG-TERM TRAUMA FOCUSED CBT IN PTSD, MAJOR DEPRESSION AND ANXIETY DISORDERS IN VICTIMS OF TERRORISM**

#### **A pilot study**

Clara Gesteira

This article briefly examines the preliminary results of a pilot study about the efficacy of trauma-focused cognitive-behavioral therapy (TF-CBT) with an exposure component in victims of terrorist attacks with a longstanding history (> 5 years after terrorist attacks) of posttraumatic stress disorder (PTSD), anxiety, or depressive disorders. Thus, it aims to augment the limited scientific knowledge on the efficacy of treatments in this particular population.

127 direct and indirect victims of terrorist attacks committed in Spain, an average of 18.20 years ago, that presented separately or concurrently

post-traumatic stress disorder (PTSD, 52%), major depressive disorder (MDD, 42.5%), and other anxiety disorders (75.8%) were randomized into either a 16 session CBT (cognitive behavioral therapy) focused in trauma (treatment group), or a 16 weeks waiting list (control group). The trauma-focused CBT was based in the prolonged exposure protocol of Foa and Rothbaum (1998) with specific techniques for mood disorders, and anxiety disorders, highlighting psychoeducation about posttraumatic reactions, cognitive restructuring and adding some other motivational strategies, emotional

regulation and narrative therapy. Of the 63 people who were assigned to the experimental group, 25 (39.7 %) rejected the therapy and 9 (23.7 %) dropped out once it started.

People in the treatment group who finished the treatment ( $n = 23$ ) had significantly lower average scores in post-traumatic (PCL), depressive (BDI-II) and anxiety (BAI) symptomatology than those obtained in pre-treatment, and none of them presented PTSD nor MDD post-treatment. These results were significantly better than those of the control group. The pre/post effect size was large ( $d$  PCL = 1.69;  $d$  BDI-II = 1.25;  $d$  BAI = 1.31), and the effect sizes across groups were large and medium ( $d$  PCL = 0.78,  $d$  BDI-II = 0.64,  $d$  BAI = 0.83). The results of this study, similar

to those of other previous efficacy studies, suggest that this trauma-focused CBT, adapted for victims of terrorism who suffer from PTSD or anxiety or depression disorders many years after the terrorist attacks, is effective. Although it is recommended to improve motivation techniques, and to investigate with larger sample sizes, with specific analysis of the components of treatment, with reliability and adherence to protocol analysis and according to different groups of victims and risk factors, the results of this thesis strongly support the idea that cognitive-behavioral therapy focused on trauma should be the preferred treatment for victims of terrorism with PTSD, MDD or other anxiety disorders, even when they are comorbid and chronic.



Clara Gesteira Santos

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

### **Professor James Michael Shultz**

1. As an expert on disaster health, you are the creator of a new methodology related to trauma which is called “trauma signature”. Can you explain how this new approach works and what is it used for?

*Trauma signature (TSIG) analysis is an evidence-based method that examines the interrelationship between population exposure to a disaster, extreme event, or complex emergency and the interconnected physical and psychological consequences for the purpose of providing timely, actionable guidance for effective mental health and psychosocial support (MHPSS) that is organically tailored and targeted to the defining features of the event (Shultz & Neria 2013).*

Each disaster has distinguishing characteristics, a singular “signature.” This is important to recognize because the particular constellation of psychological risk factors that the disaster-affected community will

experience is uniquely defined by the nature of the disaster event. MHPSS response needs to be adapted to the situation and to the stressors.

TSIG was initially developed in the process of conducting a detailed case study of the prominent psychological risk factors during the 2010 Haiti earthquake (Shultz et al. 2011). During that event, there was widespread population exposure to earthquake hazards, losses, and life changes – known risk factors for psychological distress and psychopathology. Also, many international disaster responders experienced potentially traumatizing exposures. However, the MHPSS response was initially non-existent for months and later, psychological support was feeble and inconsistently implemented. As we examined the gaps in MHPSS support, it occurred to us that it would be optimal to be able to

conduct a rapid assessment of psychosocial needs in the immediate aftermath of a disaster in a manner that could guide the MHPSS response.

To this point, TSIG has been used to conduct a series of retrospective case studies. In the short-term future, several researchers are interested in mapping TSIG onto to the Inter-Agency Standing Committee guidelines for psychosocial support in emergency settings. Others

## 2. What kind of traumatic events are appropriated for trauma signature?

To date, TSIG case studies have been conducted on large “mega-disaster” events that have significantly impacted large populations and have generated a national or international disaster response. These events frequently are of such scale that they are designated as complex emergencies and/or humanitarian crises. As an important real-time data source, events of this nature are often tracked on ReliefWeb where regular situation reports from multiple sources - including the United Nations Office for the Coordination of Humanitarian Assistance (OCHA) - can be retrieved and used in the analysis.

As part of doing the TSIG analysis, a “trauma signature summary”

want to strengthen the focus on resilience. The ultimate goal is to create a real-time TSIG analysis capability that will assess incoming data from an evolving disaster and generate guidance for responder “force protection” and for the initial MHPSS response for disaster survivors. Hopefully this capability can be staffed and coordinated with international disaster response operations, perhaps in conjunction with the World Health Organization.

is developed that ranks the disaster event on an “exposure severity” scale for a range of psychological risk factors. So far the severity ratings are based on absolute numbers of deaths, injuries, affected persons, displaced persons and other measures regarding costs and needs for emergency supplies. These absolute numbers can be compared to data on more than a century of major disaster events compiled by the Centre for Research on the Epidemiology of Disasters (CRED), Brussels, Belgium. We do not yet have the data to examine severity in terms of rates, which would be desirable epidemiologically; hopefully this will be a future enhancement that will allow TSIG analysis of smaller scale disaster events.

3. What kind of traumatic events have you tested with trauma signature methodology?

2010 Haiti Earthquake (Shultz et al. 2011)

2010 *Deepwater Horizon* oil spill (Shultz et al., in review)

2011 regional flooding in the U.S. Midwest (Shultz et al. 2013a)

2011 Great East Japan Disaster (Shultz et al. 2013b)

2012 Superstorm Sandy (Neria & Shultz 2012)

2014/2015 West Africa Ebola outbreak (Shultz, Baingana, & Neria, in review)

Decades of conflict in Colombia: Conflict-displaced persons (Shultz et al. 2014)

4. Which are the main results you have obtained with trauma signature?

Each disaster is unique. That is the basis for conducting trauma signature analysis. MHPSS response can be tailored to the situation and better targeted to meet the novel psychosocial needs of the disaster-affected population. When the TSIG summary tables – that enumerate major psychological risk factors that are common to many disasters and rank the “exposure severity” to each of these risks – are compared, it is clear that each disaster

has a novel constellation of psychological risks.

5. Is there any variable specially related to a specific type of trauma? Under your point of view, which are the most important variables? Do external variables have more impact in people than internal ones? Or is it just on the contrary?

TSIG analysis is grounded on the Disaster Ecology Model. That model focuses on three types of exposures: to hazards, losses, and life changes. These exposures are psychological stressors known to elevate risks for distress and common mental disorders in persons exposed to disasters. So the ability to 1) define the unique and distinguishing features of the disaster event – the “signature” descriptors, and 2) comprehensively document the exposures to hazards, losses, and life changes by disaster phases serve as the primary variables upon which the TSIG analysis is based. The resulting description can be used to prepare responders for what to expect for the purpose of their own “force protection” and to create a data-based approach to organizing the MHPSS response.

6. How much predictive power do you think this tool of trauma signature is going to have in the future?

Based on the case studies conducted to date, TSIG analysis should have considerable predictive power at the level of the disaster-affected population. There has been recent discussion about whether TSIG can be “beamed down” from a population to an individual level of application; currently it is too early to know this.

7. What type of clinical implications will trauma signature have?

TSIG is currently a tool designed for community-level application. However, if TSIG analyses are conducted during impact or immediately post-disaster, and MHPSS support is timely and focused, there should be detectable improvements in population mental health. By extension, this would be based on having more individuals maintaining or regaining function, exhibiting resilience, and recovering from disaster-related common mental disorders.

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**psychological consequences of the Haiti 2010 earthquake.**

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Neria Y, Shultz JM. **Mental health effects of Hurricane Sandy: characteristics, potential aftermath, and response.**

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**the affected population.**

*Disaster Medicine and Public Health Preparedness*. 2013b; 7(2):201-214.

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Shultz JM, Baingana F, Neria Y. **The 2014 Ebola outbreak and mental health: current status and recommended response.** *JAMA*. In review.

Shultz JM, Walsh L, Garfin DR, Wilson FE, Neria Y. **The 2010 Deepwater Horizon oil spill: the trauma signature of an ecological disaster.** *Journal of Behavioral Health Services and Research*. In review.



James Michael Shultz

## SHARING RESOURCES

### *List of some of the main guidelines for good clinical practice in trauma*

Some prestigious organizations, such as the American Psychiatric Association (APA, 2004, 2009), the American Psychological Association (2015), the Australian Centre for Posttraumatic Mental Health (ACPMH, 2013), the Cochrane (Roberts, Kitchiner, Kenardy, and Bisson, 2010; Stein, Ipser and Seedat, 2006); the Department of Veterans Affairs and the Department of Defense of the USA (VA / DoD, 2010) or the National Institute for Health and Clinical Excellence (NICE, 2005) have launched their proposals on how is the best approaching to the post trauma intervention. All these interventions are based, of course, on the empirical evidence available at the time and based therefore on treatments that have been proven more effective. Here are some of the most important guidelines about trauma intervention.

- American Psychiatric Association (2004). *Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder*. (2015, October 8) Retrieved from [http://psychiatryonline.org/pb/assets/raw/sitewide/practice\\_guidelines/guidelines/acutestressdisorderptsd.pdf](http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd.pdf)
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- Australian Centre for Posttraumatic Mental Health (2013). *Australian guidelines for the treatment of acute*

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[858.CD007944.pub2](http://dx.doi.org/10.1002/14651858.CD007944.pub2)

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# ACTIVITIES

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## *EVENTS*

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



### **May, 2015**

- **168th Annual Meeting American Psychiatric Association (APA).** May 16th-20th, Toronto, Canada.  
<http://www.psychiatry.org/psychiatrists/meetings/annual-meeting>
- **ICAP 2015: 17th International Conference on Applied Psychology.** May 28th-29th, Tokyo, Japan.  
<https://www.waset.org/conference/2015/05/tokyo/ICAP>

**June, 2015**

- **IV 4th World Congress on Positive Psychology.** June, 25th-28th Lake Buena Vista, florida, USA. <http://www.ippanetwork.org/wcpp2015/preliminary-program/>



## **ACKNOWLEDGMENTS**

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- **James Michael Shultz**