Clinical and Health Psychology:

An international perspective

Joseph Wolpe y Hans J. Eysenck
Granada 1995

G. Buela-Casal
(Ed.)

Dykinson, S. L.

CLINICAL AND HEALTH PSYCHOLOGY: AN INTERNATIONAL PERSPECTIVE

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G. Buela-Casal

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Granada 2025

Dykinson, S.L.

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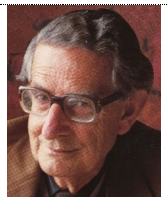
IN MEMORIAM

We dedicate this book to six great psychologists who were important in the consolidation of the Asociación Española de Psicología Conductual (AEPC).

	Hans Jürgen Eysenck (Berlin, 1916 – London, 1997) AEPC Congress Granada, 1995		Joseph Wolpe (Johannesburg, 1915 – Los Angeles, 1997) AEPC Congress Granada, 1995
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	Frank J. S. Donker (Utrecht, 1946 – Arnhem, 2015) AEPC Congress Jaén, 1989, 1990		Vicente Pelechano (Algemesí, 1943 – Tenerife, 2016) AEPC Congress Granada, 2000

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	Alan E. Kazdin, President APA		Nadine J. Kaslow, President APA
	Suzanne Bennett Johnson, President APA		Antonio Puente, President APA

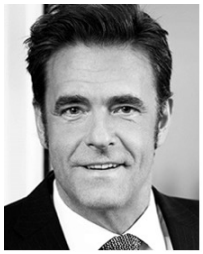
	Susan H. McDaniel, President APA		Rosie Phillips Davis, President APA
	Jennifer F. Kelly, President APA		Merry Bullock, Director International Relations APA
	Amanda Clinton, Director International Relations APA		Thema S. Bryant, President APA
	Frank C. Worrell, President APA		Cynthia de las Fuentes, President APA

To the Consejo General de la Psicología de España for its continuous support to the AEPC's International Congress of Clinical Psychology, and in particular to:

Francisco Santolaya, President of the Consejo General de la Psicología, for his continuous institutional support of the Consejo and for his multiple participations as a speaker at the congress.

José Ramón Fernández Hermida, Director of INFOCOP of the Consejo General de la Psicología de España, for his collaboration in providing the interview material published in INFOCOP.

To the Director of the Classification of Mental and Behavioral Disorders of the ICD-11



Geoffrey M. Reed, Director of the Classification of Mental and Behavioral Disorders of the International Classification of Diseases-11 of the World Health Organization (WHO), for his important contribution to several AEPC congresses.

INDEX

ACKNOWLEDGEMENTS **9**

LIST OF AUTHORS **17**

FOREWORD **25**

INTRODUCTION: THE PAST AND PRESENT OF THE AEPC **27**

Gualberto Buela-Casal and Juan Carlos Sierra

PSYCHOLOGY PERSPECTIVE **33**

Suzanne Bennett Johnson and Gualberto Buela-Casal

CLINICAL PSYCHOLOGY **41**

Alan E. Kazdin and Gualberto Buela-Casal

REFLECTIONS ON PSYCHOLOGY **45**

Alan E. Kazdin and Gualberto Buela-Casal

FOSTERING PSYCHOLOGICAL SERVICES IN PRIMARY CARE **51**

Susan H. McDaniel and Wenceslao Peñate

ICD-11 OR DSM-5 WHICH ONE SHOULD WE USE? **57**

Geoffrey M. Reed and Gualberto Buela-Casal

MOVEMENT TOWARDS TRANSDIAGNOSTIC APPROACHES **67**

Andrea Ashbaugh

FROM THE MOST CURRENT RESEARCH IN MENTAL HEALTH TO CLINICAL PRACTICE 71

Jürgen Margraf and Juan Preciado

CLINICAL GUIDELINES AND SCIENTIFIC EVIDENCE..... 79

John C. Norcross and Gualberto Buela-Casal

MINI BRAINS: APPLICATIONS FOR CLINICAL PSYCHOLOGY AND ETHICAL CONSIDERATIONS..... 85

Oscar F. Gonçalves and Wenceslao Peñate

NEUROPSYCHOLOGY AS A HEALTH SPECIALIZATION 91

Antonio Puente and Gualberto Buela-Casal

FUNCTIONAL ANALYSIS OF BEHAVIOR 97

Stephen N. Haynes and Juan Carlos Sierra

QUALITY CONTROL IN ONLINE PSYCHOLOGICAL ASSESSMENT ...107

Merry Bullock and Wenceslao Peñate

ANXIETY DISORDERS.....113

Michael W. Eysenck and Wenceslao Peñate

FROM ANXIETY DISORDERS TO SOCIO-EMOTIONAL DISORDERS: THEIR PREVENTION AND INTERVENTION.....119

Ronald M. Rapee and Juan F. Rodríguez-Testal

SUICIDAL TENDENCIES IN DEPRESSIVE PATIENTS 127

Nadine J. Kaslow and Gualberto Buela-Casal

UNDERSTANDING AND TREATING HOARDING DISORDER: AN EXCESSIVE ATTACHMENT TO OBJECTS 135

Melissa Norberg and Ana I. Rosa Alcázar

COMMUNICATING WITH DIFFICULT PATIENTS 141

Dmitrii Kovpak

CULTURAL ADAPTATION OF PSYCHOTHERAPIES 151

Shin-ichi Ishikawa

HOW TO SELECT THE MOST APPROPRIATE TREATMENT FOR EACH PATIENT 159

Larry E. Beutler and Gualberto Buela-Casal

EVIDENCE-BASED PSYCHOLOGICAL TREATMENTS 173

Michael Kyrios

WRITING THERAPIES FOR POST-TRAUMATIC STRESS DISORDER 181

Arnold Van Emmerik

PSYCHOLOGICAL TREATMENTS FOR CHILDREN AND ADOLESCENTS BASED ON EMPIRICAL EVIDENCE 185

Carmem Beatriz Neufeld and Juan Carlos Sierra

PARENT-CHILD INTERACTION THERAPY FOR CHILDREN WITH EMOTIONAL AND BEHAVIORAL PROBLEMS 193

Amanda Clinton and Wenceslao Peñate

ONE-SESSION TREATMENT OF PHOBIAS: REFLECTIONS IN CLINICAL CHILD PSYCHOLOGY 199

Thomas H. Ollendick and Juan Preciado

ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD) IN CHILDREN 205

Joanne Hands and Juan Carlos Sierra

CYBERBULLYING IN ADOLESCENTS 211

Carlos P. Zalaquett and Juan Carlos Sierra

INCLUSIVE PSYCHOLOGY FOR ALL 225

Cynthia de las Fuentes and Saúl Neves de Jesus

THE EDUCATIONAL CONTEXT OF MENTAL HEALTH INTERVENTIONS WITH CHILDREN AND ADOLESCENTS 233

Frank C. Worrell and Cristián Oyanadel

OVERCOMING FEAR AND TRAUMA AND THE 'DECOLONIZATION' OF PSYCHOLOGY 239

Thema S. Bryant and Carlos Del Río

APPENDIX A. CONGRESSES AND TRAINING ACTIVITIES ORGANIZED BY THE ASOCIACIÓN ESPAÑOLA DE PSICOLOGÍA CONDUCTUAL (1990-2025) 247

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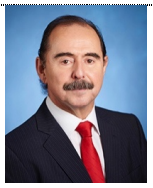	Carlos P. Zalaquett, Ph.D., is a Professor at The Pennsylvania State University (United States of America), Co-coordinator of the Clinical Mental Health and Rehabilitation emphasis, and Director of the Brain Focus Lab. He is the President of the Pennsylvania Mental Health Association (PAMHCA) and former president of the Inter-American Society of Psychology (SIP) and is the Chair of the 2024 Annual Conference of the American Psychology Association (APA)'s Division 52 – International Psychology. United States of America.
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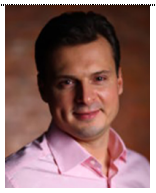	Dmitrii Kovpak is a Professor of Psychology at North-Western State Medical University Mechnikov in St. Petersburg. President of the Association for Cognitive and Behavioral Psychotherapy. Russia.
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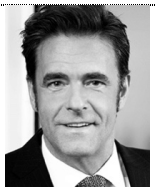	Geoffrey M. Reed is a Professor of Medical Psychology at Columbia University. Director of the Classification of Mental and Behavioral Disorders of the International Classification of Diseases-11 (ICD-11) of the World Health Organization. He is one of the most influential scientists in the world according to the Stanford University Ranking. United States of America.
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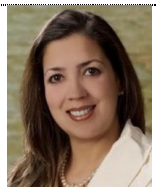	Joanne Hands is the Clinical Director of Kuwait Counseling Center and the President of the Middle East Psychological Association. Kuwait.
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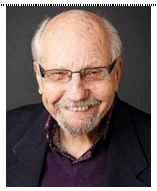	Larry E. Beutler is a Professor at the University of California at Santa Barbara. He is a past president of the Psychotherapy and Clinical Divisions of the American Psychological Association (APA). He is one of the most influential scientists in the world according to the Stanford University Ranking. United States of America.
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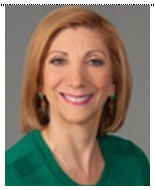	Nadine J. Kaslow is a Professor of Psychiatry and Behavioral Sciences at Emory University. She is a past president of the American Psychological Association (APA). She is one of the most influential scientists in the world according to the Stanford University Ranking. United States of America.
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FOREWORD*

Rubén Ardila is a Professor of Psychology at the National University of Colombia. He obtained the Distinguished Contributions to the International Advancement of Psychology Award from the American Psychological Association (APA). He is also a Professor at the BBVA Foundation at the University of Granada and Founder of the Latin American Association for Behavior Analysis and Modification (ALAMOC).

* During the editing of this book, we received the sad news of the death of Dr. Rubén Ardila. This posthumous publication serves as a tribute to his brilliant academic career, which will undoubtedly occupy a relevant place in the History of Psychology at an international level.

Edited by Gualberto Buela-Casal, this book features a series of interviews with leading psychologists, mostly clinicians, about the major current challenges and perspectives of Clinical Psychology worldwide.

Among the interviewees in this book are many of today's most prominent figures in Psychology, including Alan E. Kazdin, Antonio E. Puente, Michael W. Eysenck, Suzanne Bennett Johnson, Stephen N. Haynes, Amanda Clinton, G. Reed, Carlos P. Zalaquett, John C. Nor-cross, Merry Bullock, Oscar F. Gonçalves, and Nadine J. Kaslow, among others. Coming from many different countries (e.g. the United States of America, Australia, United Kingdom, Germany, Japan, Portugal, Russia, Kuwait, and the Netherlands), these professionals broadly represent psychology (mainly but not exclusively Clinical and Health psychology) from an international perspective.

The professionals featured in these interviews are international leaders in Clinical and Health Psychology and were interviewed by Spanish colleagues who are also prominent in their respective fields, including the editor of the book, Gualberto Buela-Casal, along with Juan Preciado, Wenceslao Peñate, Ana I. Rosa Alcázar, Juan Carlos Sierra, Juan F. Rodríguez-Testal, Carlos del Rio, and Cristián Oyanadel.

The interviews touch on ideas, concerns, challenges, and the potential of Clinical and Health Psychology from a global perspective, as well as Psychology's integration into society, relationships among professionals, the health systems

across countries, and the recognition that psychologists receive as health professionals. It is important to bear in mind that the field of Psychology that attracts the most psychologists and peaks the greatest interest from students, professionals, and society, is Clinical Psychology. Despite the great diversification and growth of other fields of Psychology, which is illustrated by the 54 Divisions of the APA, the Divisions and working groups of the International Association of Applied Psychology (IAAP) and in the Interamerican Psychological Society (IPS) and many other societies across continents, Clinical Psychology continues to be the area with the largest recognition and visibility.

This book analyzes and discusses in detail topics such as the training of psychologists, perspectives in health, the effectiveness of evidence-based therapies, neuropsychology, functional analysis of behavior, "mini-brains", the use of information technology and the Internet, phobias, problems of childhood and adolescence, classifications of psychopathological disorders (DSM-5, ICD-11), catastrophes, corruption, sleep disorders, eating disorder, and many others. Psychology's role in understanding and solving the problems associated with Covid-19 could not be left out, of course, due to its relevance at this time.

Several of the interviewees have served as presidents of the APA in recent years. Another interviewee was the president of the IPS. Together, they are all internationally recognized individuals who have dedicated their lives to work at the institutional, scientific, social and/or individual level. They have held and continue to hold positions of great responsibility across fields in Psychology. They are also colleagues whose research and publications contribute to shaping the current state of the psychological discipline.

This book undoubtedly offers a deep analysis of the current state of Clinical Psychology and its future perspective. It also examines the vision that the leaders of the discipline have about this important field of research aimed at improving the quality of life of individuals, families, groups, and societies.

Rubén Ardila

Universidad Nacional de Colombia

INTRODUCTION: THE PAST AND PRESENT OF THE AEPC

Gualberto Buela-Casal and Juan Carlos Sierra

Gualberto Buela-Casal is a Professor of Clinical Psychology at the University of Granada (Spain). Founder of the Professorship of Sleep Research at the University of Granada. President of the Asociación Española de Psicología Conductual (AEPC). He is one of the most influential scientists in the world according to the Stanford University's Ranking.

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*One could say that this book was started over thirty years ago when a group of young university professors, including the editor of this book, decided to establish the Spanish Association of Behavioral Psychology (AEPC) and organize a symposium on Clinical Psychology at the campus of the University of Jaén, which at that time belonged to the University of Granada. The location was not optimal as it lacked resources, was poorly located, and at the time only offered first-year undergraduate classes and thus lacked graduate students. However, motivation was the driving force that allowed them to overcome these difficulties.

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The I and II Symposium of Applied Clinical Psychology were organized in Jaén in 1989 and 1990, respectively, with the help of first-year undergraduate psychology students and the collaboration of important Spanish professors and two foreign specialists (Frank J. S. Donker from Holland and Esteve Freixa i Baqué from France). Financial resources were so scarce that each speaker gave four-hour lectures to make up for the reduced number of speakers. Despite the numerous obstacles, the meeting proved to be a triumph, with more than 650 people attending each of the events. This was a historic milestone as these were the most attended scientific meetings in the field of Clinical Psychology in Spain. After this success, it was essential to create a young and small scientific association that could continue to organize future events: the AEPC. In 1991, the AEPC organized the I National Symposium of Behavioral Psychology. In addition to distinguished Spanish specialists, this symposium included the participation of several international speakers: Marc Richelle (Belgium), Leonor I. Lega (USA), and Esteve Freixa i Baqué (France). Nearly 700 people attended the event.

Given the great acceptance of the events organized by the AEPC, it was decided to transform the symposia into congresses with an international scope. Thus, in 1991 the I Iberoamerican Symposium of Behavioral Psychology was organized in Costa Rica. In 1992 the Iberoamerican Symposium on Sleep and Hypnosis was held in Granada, with the participation of Jaime Monti from Uruguay. In 1993, the AEPC organized the II National Congress of Behavioral Psychology in Palma de Mallorca, as well as the Symposium on Sleep and its Disorders in Malaga, with the presence of René Drucker-Colín from Mexico, the Symposium on Clinical Actuality in Behavioral Psychology in Córdoba (Argentina), and collaborated in the organization of the *I International Meeting of Cognitive-Behavioral Therapy* in Rio de Janeiro, chaired by Bernard Rangé. In the following year, 1994, the II Iberoamerican Symposium on Sleep and Hypnosis, the Symposium on Human Sexuality, both in Granada, and the I International Congress of Behavioral Psychology in A Coruña were held, with the important participation of Alan E. Kazdin (USA), Rubén Ardila (Colombia), Oscar Gonçalves and Pinto Gouveia (both from Portugal), and Frank E. Donker (the Netherlands), as well as outstanding professors of Clinical Psychology in Spain. In the same year, the AEPC collaborated in the organization of the *I Ibero-American Conference on Health and Behavior* in New York chaired by Juan Preciado, which was the first Clinical Psychology congress organized in the USA with Spanish as the official language.

Regarding specialized postgraduate training, the AEPC created the International Master's Degree in Clinical and Health Psychology in 1993, which was referential at the European level due to the presence of more than thirty internationally renowned international professors. The Master's program produced eighteen graduating classes of psychologists, of whom several are

currently prestigious clinical psychologists and professors. Among the faculty who participated in the Master's program, the following names stand out: Alan E. Kazdin (Yale University, USA), Stephen N. Haynes (University of Hawaii, USA), Michael Mahoney (University of North Texas, USA), Steven C. Hayes (University of Nevada, USA), Larry E. Beutler (University of California at Santa Barbara, USA), Arnold A. Lazarus (Rutgers University, USA), David H. Barlow (Boston University, USA), Charles D. Spielberger (University of South Florida, USA), Arthur Freeman (University of Pennsylvania, USA), Thomas H. Ollendick (Virginia Polytechnic Institute University, USA), Robert Sternberg (Yale University, USA), Antonio Puente (University of North Carolina, USA), Daniel O'Leary (State University of New York, USA), Leonor I. Lega (St. Peter's College, USA), Juan Preciado (University of New York, USA), Luis Montesinos (Montclair State University, USA), Freddy Paniagua (University of Texas at Galveston, USA), Carlos Aparicio (University of Mississippi, USA), Oscar F. Gonçalves (Universidade do Minho, Portugal), Paulo Machado (Universidade do Minho, Portugal), Rubén Ardila (Universidad Nacional de Colombia, Colombia), and Jorge A. Grau (Instituto Nacional de Oncología y Radiología, Cuba), among others.

Five years after its foundation, the AEPC further gained an international reputation in the field of Clinical Psychology with the organization of the II International Congress and the III National Congress of Behavioral Psychology, held in Granada (Spain) in 1995. This congress was a milestone in the history of clinical psychology due to the participation of two of the founding fathers of Behavioral Therapy, namely Hans Jürgen Eysenck and Joseph Wolpe. It was such an honor for the AEPC to have them, especially considering that this would be the last time they would be together in a scientific meeting. Two years later, they both passed away, leaving behind a legacy that will endure forever in the history of Psychology[1]. Both Alan E. Kazdin and David H. Barlow, two of the most important authorities in Clinical Psychology, participated in this event as speakers, among others. This congress broke national attendance records, being the first scientific meeting in the field of Psychology with more than a thousand attendees. This all resulted in the consolidation of the AEPC at the international level. In fact, the association was asked to join the European Association for Behavioral and Cognitive Therapies (EABCT) and subsequently selected as the venue for their iconic congress in Granada in 2000. That year marked the turn of the century and millennium, and the venue was hotly contested between Stockholm, Helsinki, and Granada. It was the second time that this important congress was held in Spain; the first took place in Palma de Mallorca in 1975, chaired by Vicente Pelechano, who was a pioneer in Behavioral Therapy in

[1] As a tribute, we have dedicated the cover of this book to the two of them by including a photo taken while they were talking during a break at this congress, held at the Palacio de Exposiciones y Congresos de Granada in 1995.

Spain. Indeed, he founded the first scientific society related to Behavioral Therapy in Spain in 1979, namely the Sociedad Valenciana de Análisis y Cambio de Conducta (SVACC).

Between 1996 and 1999, several national congresses were held in Granada (1997), Vitoria (1998), and Madrid (1999). Additionally, several international congresses were held, including the III International Congress of Behavioral Psychology (Granada, 1997), IV International Congress of Cognitive/Behavioral Psychology (Valencia, 1999), IV Iberian Congress of Cognitive/Behavioral Therapy (Salamanca, 1998), II Iberoamerican Congress of Health and Behavior (Granada, 1996), III Iberoamerican Congress of Health Psychology (Torremolinos-Malaga, 1998), and IV Iberoamerican Congress of Health Psychology (Granada, 1999). Simultaneously, important symposia were organized, including the I International Symposium on Anxiety Disorders (Granada, 1998), with the participation of Michael W. Eysenck and Charles D. Spielbeger, and the I International Symposium on Depression (Granada, 1999), again with Charles D. Spielberger as special guest. A comprehensive list of all the events held during these and subsequent years can be found in Appendix A.

In 2000, the *XXX Congress of the European Association for Behavioral & Cognitive Therapies* (EABCT) was held in Granada. Vicente Pelechano was the honorary president and distinguished international specialists participated, including Alan E. Kazdin, David H. Barlow, Michael Mahoney, Stephen N. Haynes, Steven C. Hayes, Arthur Freeman, Charles D. Spielberger, Keith Dobson, Thomas H. Ollendick, Larry E. Beutler, Juan Preciado, E. Thomas Dowd, Kim Halford, Don Beal, K. Gunnar Gotestam and Jurgen Margraf, among others. For the first time in thirty editions of the Congress, there were two official languages: Spanish and English. It could be said that it was a world congress rather than a European congress. More than 1,700 participants from 50 countries participated. In the history of the EABCT, no congress had reached a thousand participants. In the same year, the V Ibero-American Congress of Health Psychology was organized in Cartagena de Indias.

Within a decade after its inception, the AEPC had established itself as a scientific society with international recognition. We would like to express gratitude for the collaboration of important international and national speakers who were significant authorities in the field of psychology at the time. Certainly, this rapid evolution occurred thanks to those partnerships[2]. In the

[2] Thanks to all the speakers who made these first congresses possible: Hans J. Eysenck, Joseph Wolpe, Alan E. Kazdin, David H. Barlow, Stephen N. Haynes, Steven C. Hayes, Arthur Freeman, Frank J. S. Donker, Rubén Ardila, Antonio Puente, Charles D. Spielberger, Michael W. Eysenck, Keith Dobson, Thomas H. Ollendick, Michael Mahoney, Larry E. Beutler, Juan Preciado, E. Thomas Dowd, Kim Halford, Don Beal, K. Gunnar Gotestam, Jurgen Margraf,Oscar F. Gonçalves, Paulo Machado, Pinto Gouveia, Luis Montesinos, Freddy A. Paniagua, René Druker-Colín, Jaime Monti, Esteve Freixa

following years, AEPC congresses continued to be organized both nationally and internationally at different emblematic venues, including the Palacio de la Magdalena (Santander), the Palacio de Miramar (San Sebastián), and the Monasterio San Martín Pinario (Santiago de Compostela), among others. Appendix A includes a chronological listing of the various venues.

In 2001, professors Juan Carlos Sierra and Gualberto Buela-Casal founded the International Journal of Clinical and Health Psychology. Initially, the journal was published in two official languages, Spanish and English. Later, per the recommendations of Eugene Garfield[3], the journal was renamed exclusively in English, and this language was designated as the sole official language of the journal. *The International Journal of Clinical and Health Psychology* was expeditiously included in the *Journal Citation Reports* (JCR), reaching the first quartile during its inaugural year in the JCR (2007). The journal held this position through 2021, the year in which Juan Carlos Sierra and Gualberto Buela-Casal left their role as editors. This journal has undoubtedly been made possible because of the important international authors that have contributed with their articles: Stephen N. Haynes, Larry E. Beutler, Jorge E. Hirsch, Eugene Garfield, Keith Dobson, Charles D. Spielberger, Robert Sternberg, Thomas H. Ollendick, E. Thomas Dowd, Oscar F. G. G. Beutler, Jorge E. Hirsch, Eugene Garfield, Keith Dobson, Charles D. Spielberger, Robert Sternberg, Thomas H. Ollendick, E. Thomas Dowd, Oscar F. Gonçalves, James N. Butcher, Frank Dattilio, Philip E. Kendall, Rudolf H. Moos, Juan José Sánchez-Sosa, Jurgen Margraf, Geoffrey Reed, Paulo Machado, Esteve Freixa i Baqué, Annette M. La Greca, Manuel Bobenrieth, or Vicente Pelechano, among others. Since its founding in 2001 until 2012, the journal was edited by the AEPC and from that year until today, it has been edited by the prestigious publisher Elsevier. Over the past two decades, the *International Journal of Clinical and Health Psychology* has established itself as the journal of Clinical Psychology with the highest impact factor in JCR in Europe.

Over the past decade, the AEPC Congresses have become increasingly international. The international scope has been enhanced through the support and participation of the *American Psychological Association* (APA), the General Council of Psychology of Spain, and more than fifty scientific and professional associations that have acted as collaborators. During this period, additional

i Baqué, Guillermo Argueta-Bernal, Leonor I. Lega, Wayne Wardwell, María Corsi, Laura Hernández, Bernard Rangé, Héctor Fernández-Álvarez, Jorge Grau, Paulo Moderato, Vicente Pelechano, Amparo Belloch, Cristina Botella, Xavier Bornas, Eduardo García-Cueto, Miquel Tortella, Mateu Serverá, Arturo Bados, Juan José Miguel-Tobal, Wenceslao Peñate, José Cáceres, José Santacreu, Miguel Ángel Verdugo, Ramón Bayés, José Olivares, DiegoMaciá, Francisco Javier Méndez, Marino Pérez, Francisco Labrador, Luis Fernández-Ríos, Enrique G. Fernández Abascal, Bonifacio Sandín, Francisco Revuelta, Javier Rodríguez, Luís Rodríguez-Franco, Alfonso Blanco Picabia, Carmen Luciano, Jesús Gil Roales-Nieto, José Luis Graña, Francisco Santolaya, among others.

[3] Eugene Garfield was the president of the Institute for Scientific Information (ISI).

official languages were added to the congress. While only Spanish and English were originally included, Portuguese, French, and Russian were subsequently added. Currently, these are the five official languages of the congress, which has become the global standard in Clinical Psychology with the participation of experts from the five continents.

This book is one of the results of these international congresses. In recent years, a series of interviews were conducted with prominent speakers at the congresses. These interviews have been carried out by experts and published in the INFOCOP journal of the General Council of Psychology of Spain and on the AEPC website. The interviews have generated a great deal of interest, both among professionals and academics, prompting several queries as to how the interviews should be cited. This discussion, in part, led to the idea of compiling them into this book. The outcome is, in our opinion, a more enjoyable material. Authors (both interviewees and interviewers), approach the topics more informally than a traditional textbook while maintaining a high level of expertise and contemporary discourse on the subjects covered. Photographs of the authors are incorporated, thereby bringing the readers closer to them. This novel format makes it possible to address the current topics in clinical psychology in an international context, with a different approach. A more informal presentation is not incompatible with the extensive level of specialization and analysis of the topics addressed and explained by specialists who are world-renowned experts in their fields, and who have generously waived their copyrights to facilitate the free reading of the content (*open access*).

This book is formatted to be an enjoyable experience for the reader and addresses current topics in Clinical Psychology. The authors offer their distinguished knowledge, backed up by many high-level scientific publications. To summarize, this book features ten APA leaders, along with exceptional professionals, specialists, and researchers who have published more than 4,000 articles in scientific journals indexed in the *Web of Science* (WoS), yielding nearly 140,000 citations. Twelve of the authors are part of the prestigious ranking of the world's most influential scientists by Stanford University published annually since 2020. Altogether, this illustrates the quality of the work you are holding in your hands.

PSYCHOLOGY PERSPECTIVE

Suzanne Bennett Johnson and Gualberto Buela-Casal

Suzanne Bennett Johnson is a Professor of Psychology at the Florida State University College of Medicine (USA). She was president of the American Psychological Association (APA) in 2012. She is one of the most influential scientists in the world according to the Stanford University Ranking.

Gualberto Buela-Casal is a Professor of Clinical Psychology at the University of Granada (Spain). Founder of the Professorship of Sleep Research at the University of Granada. President of the Asociación Española de Psicología Conductual (AEPC). He is one of the most influential scientists in the world according to the Stanford University Ranking.

**On behalf of the Spanish Association of Behavioral Psychology (AEPC for its initials in Spanish), let me begin by thanking you for your participation in the V International Congress of Clinical Psychology, which will be held in the most emblematic place, the Magdalena Palace in Santander on April 26 to 28. Indeed, it is an honor for our Association and psychologists in Spain to have the President of the American Psychological Association (APA) in this Congress, which has one thousand registered participants from fifteen different countries and seven hundred presentations.*

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* This interview was originally published in *Infocop Online*.

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It is a great honor to participate in this important conference.

From its inception, the APA has been regarded as the most influential scientific and professional organization worldwide not only because of its membership size, but also because of its historical contributions to the development of psychology. As President of APA since January of this year, what are the main objectives that you would like to accomplish during your tenure?

APA has a strategic plan with three goals: 1) maximize organizational effectiveness; (2) expand psychology's role in advancing health; and (3) increase recognition of psychology as a science. As APA President, I am committed to this strategic plan and selected my presidential initiatives with these strategic goals in mind. Attracting the next generation to psychology and to the APA, is my first presidential initiative and is directly relevant to APA's goal of maximizing organizational effectiveness. Interdisciplinary science and practice is my second presidential initiative and is directly related to APA's second and third strategic goals – expanding psychology's role in advancing health and increasing recognition of psychology as a science. Obesity is my third presidential initiative, and this too is directly related to APA's second and third strategic goals – expanding psychology's role in advancing health and increasing recognition of psychology as a science. You can read more about my presidential initiatives at http://www.apa.org/about/governance/president/index.aspx.

> *The International Journal of Clinical and Health Psychology recently published a study of the H index (an indicator of scientific production of articles and citations) of APA presidents from its foundation up to 2010 http://www.aepc.es/ijchp/articulos_pdf/ijchp-372.pdf. The study in question shows how APA has been presided over by presidents with research profiles, as well as presidents with a more practitioner orientation. You undoubtedly represent the former with an impressive production of hundreds of articles and books, editor of Prevention and Treatment and Health Psychology. And this why I would like to ask if you believe that future presidents of APA would be more likely to fit a researcher profile than a practitioner one? Or does the orientation or profile of the candidate have any bearing on selecting the president of APA?*

Both science and practice are important to APA and its members. In fact, most clinical psychologists in the US are trained in the science- practitioner model – they are skilled clinicians who are also very well trained in the science of psychology. Of course, many APA presidents are not clinicians and only conduct research. However, many – like Alan Kazdin – are scientist-practitioners. They both see patients and conduct research on how best to help these patients. I am a scientist- practitioner who has devoted her career to the application of

psychological principles to the care of patients who have diabetes or other serious health problems. So, I may appear to be primarily a researcher but in fact, I am both a researcher and a practitioner. Although psychologists who engage only in research and psychologists who engage only in practice are certainly eligible to be APA President, I think there is some advantage to being both a scientist and a practitioner since your experience and skills resonate with all the APA membership.

The Collegiate of Psychologists of Spain, with its 55,000 members, it is the second largest professional organization after APA in terms of membership. Should there be more international collaborations between the two organizations? Is it something you perhaps might like to pursue during your presidency?

I am very enthusiastic about increasing collaborations between our two organizations and would definitely like to pursue this as part of my APA presidency.

Over the last few years, we have had lengthy discussions about whether or not to consider psychology as a health profession in Spain. Prior to this debate, psychology was considered part of the social sciences which had important repercussions for the practice of psychology. More recently, psychology has been part of the health sciences in academia; and last year, psychology is regarded as a health profession by law in terms of its practice. As an expert in health psychology, what is your opinion about this issue?

Since psychology is the study of human behavior, it is a science that should have broad impact. In my view, the practice of psychology should not be limited to mental health issues. Psychological science is relevant to health promotion, disease prevention, and the management of illness when it does occur. Restricting psychological services to the "mental health" arena only promotes mind-body dualism and unfairly limits the application of psychological science to all patients' health and well-being.

In this Congress, we are having a roundtable discussion entitled, "Should psychologist prescribe medications?" As I understand it, some states already allow prescribing privileges for psychologists in the US. What is your opinion about this?

There are 2 states - out of 50 states in the United States - that permit psychologists to prescribe medications, and this prescriptive authority is

limited to psychotropic medications. This is a controversial area both within psychology and in the larger health care community; most US physicians oppose giving psychologists prescriptive authority. Many psychologists oppose it either on principle or because of the cost in resources and negative impact on psychologists' relationship with their medical colleagues. My own view is that psychologists are very intelligent and could be readily trained to prescribe psychotropic medications safely and effectively. However, this requires extensive additional training – with its inherent costs in time and money – that most US psychologists are not interested in pursuing. For those that do want to pursue this type of training, there are other avenues (nurse practitioner, physician assistant) that would permit psychologists to be trained to prescribe all types of medications – not just psychotropic medications – in about the same time frame with no opposition from the medical community. Certainly, there could be countries or jurisdictions across the world where there would be little or no opposition to training psychologists to prescribe psychotropic medications. In fact, some places might welcome it. In that political context, it makes sense to pursue training for practicing psychologists to prescribe psychotropic medications as part of their treatment armamentarium. In those places where the existing health care community opposes this increase in psychologists' scope of practice, the psychology community will need to decide if it wants to spend its resources pursuing this issue.

> *Another topic which sparks great interest in Spain is the current status of the DSM V and ICD -11, both of which will be addressed in two presentations in Santander. In terms of classification and diagnosis of psychological disorders, APA has traditionally been in favor of the DSM, which is also utilized by most of Spanish psychologists. However, it is my understanding, and please correct me if I am wrong, that APA may now be in favor of promoting the use of the ICD over the DSM? If this is the case, what are your thoughts on this issue?*

As you know, the DSM is the product of the American Psychiatric Association. Although many US psychologists have participated in the development of some aspect of the DSM or its revisión, the American Psychological Association (APA) has no formal relationship with the development or revisión of the DSM. However, US clinical training programs used the DSM in their training curriculum and this historical precedent has continued until the present. Because American psychiatry was also influential in developing the ICD, historically there was little difference between the DSM and ICD. As a consequence, many US psychologists were unfamiliar with the ICD and were trained only in the DSM. This is changing for several reasons. First, the expansion of the practice of psychology into the larger health area, has meant that psychologists working in clinical

health psychology became familiar with the ICD – which is used by the rest of medicine in the US and around the world. Second, the ICD-11 has provided an opportunity for full psychological participation in this revision. Through the International Union of Psychological Science, APA has been able to support a psychologist – Dr. Geoffrey Reed – in a leadership role in the development of the ICD-11. As a consequence, the ICD-11 will not be a modified version of the DSM-V. Third, the US government has stipulated that all US providers, including psychologists, must use the ICD for billing purposes in the coming few years – although there are efforts by some groups within the US to delay the exact date of this requirement. For all these reasons, the APA sees this as an ideal time to provide training opportunities for practicing psychologists in use of the ICD. The ICD has additional advantages including its development by the World Health Organization and its dissemination free of charge. In contrast, the DSM is developed and promoted by a single organization from a single country – the American Psychiatric Association - for profit. Personally, I strongly favor moving our training and practice to the ICD. I am delighted to see that Dr. Reed will be at the conference to discuss this issue with you in more detail.

> *Doctoral level training in psychology is a topic of special interest here in Spain. Contrary to the high selectivity and small cohort of students accepted in the most prestigious Ph.D. programs in the US, the Spanish have a tendency to offer many slots for doctoral training. In fact, in some cases, some universities offer up to 100 slots per year, which some of us believe is a mistake in terms of the quality of training of doctoral level students. What are your thoughts about this issue?*

Similar controversy occurs in the US with the development of free-standing PsyD programs in the US that admit very large numbers of students. Large numbers of students per se is not necessarily a problem. For example, most programs that train physicians in the US admit 100+ students per year. The issue is whether a program has the resources to train that number of students well. US medical education is extremely expensive because so many resources are brought to bear on providing the necessary training. In addition, students must pass a series of difficult exams before they can be licensed to practice. In US psychology, we have attempted to address this issue through the accreditation process. Programs must meet certain standards – including sufficient resources – to be accredited. In my view, prospective students should only attend accredited programs, so they are assured some basic standard of training. I should point out that these large PsyD programs are only training practicing psychologists. In the US, PhD programs in other areas of psychology (e.g., experimental, cognitive, social) are all small and admit only a few students each year.

An important contrast between the US and Spain is faculty mobility through institutions for education and professional employment. For instance, I see that you were trained and worked in different universities through your professional life (Cornell University, State University of New York, University of Florida, and Robert Wood Johnson Health Policy Fellow ...). In Spain, faculty mobility is usually limited such that we have faculty who are educated and spend their professional working lives in the same city in which they were born. We even have a term for such individuals: "faculty with roots." On the contrary, in the best universities of the US, there seems to be a preference for hiring faculty who were trained in other institutions over those who were trained in-house. What are advantages do you see in faculty mobility?

I believe you are quite right about the preference in the US for faculty members who have been trained in an institution other the one hiring the applicant. This preference comes from at least three sources. First, there is a strong cultural preference to have a student attend the very best university to which he or she has been admitted. Although location plays a part in a student's selection of a university, the prestige of the university is very important. Consequently, it is very common for top students to attend universities outside of their local area. Top students are used to moving and living away from their hometown during their college and graduate training. Second, universities have a policy of open transparent hiring, and hiring the very best applicant is the goal. Of course, there are exceptions to this general policy, but culturally it is widely accepted as the preferred hiring method. Third, there is a general belief that new ideas and approaches are good for a faculty and training program. There is concern that hiring individuals who were trained by existing faculty is too insular and will create a faculty of very similar individuals who - as a faculty – will not be as innovative as a faculty of individuals trained in many different institutions.

As an expert in child health psychology, you have written seminal works on this topic and have published multiple articles, particularly about obesity in children, which is the topic of your opening address. Spain is one of the European countries with high child obesity rates, even though we adhere to the Mediterranean diet, which is presumed to be healthy. What is your opinion of the origins of childhood obesity? Is it a problem related to healthy habits? Is it a lack of physical activity or exercise? Or is a high caloric diet the problem? What is your opinion about children's use or abuse of computers, videogames, TV and related technologies? Do they promote sedentary lifestyles and thus increase obesity?

The obesity epidemic occurring in the US is not a product of changing genes or biology. It is in fact, a product of a changing socio-cultural environment that has massively affected human behavior. These changes involve many aspects of our culture and include both reduced activity levels and changes in what we eat and the amount we eat. Sedentary lifestyles are very common. We are entertained by more and more opportunities that place no activity demands on us (e.g., movies can be streamed to our TV or iPad, home theatres, video games, texting with friends, never ending opportunities on the internet). We live in suburbs and must drive everywhere by car. Most mothers work and children are asked to come home from school and stay in the house for safety reasons (we call these children "latch-key children"). Efforts to integrate our schools led to long bus rides rather than short walks or bike-rides to the local school. High stakes testing in our schools has resulted in more and more time spent teaching academics in an effort to get good test scores and less and less time is spent on physical education. Both parents working has resulted in fewer meals at home and more meals eaten out. The fast-food industry became very popular and attracted customers by low price and large portions (e.g. you can supersize this drink for only 25 cents more). The food industry often targets children on TV programs, so they request certain high calorie, low food-value products of their parents. Many have referred to all of this as an obesogenic environment. Unfortunately, this obesogenic environment is being re-created worldwide.

Given that you are a highly regarded researcher and the APA President, you are, no doubt, in high demand and with an extremely busy schedule of professional engagements. May I ask, if was there any particular reason(s) for accepting our invitation?

There are several reasons I was happy to accept this invitation. In December, right before I became APA President, I had the opportunity to spend some time at a meeting of the Mexican Psychological Association (SMP). APA and SMP have developed a Memorandum of Understanding, and it was very exciting to discuss ways in which both organizations can successfully collaborate. I am very committed to developing stronger collaborations with other psychological associations worldwide and hope that we can develop some important collaborations between APA and AEPC. Second, I am very committed to expanding psychology's role beyond mental health, to the larger health care and health research arena. This is the direction we are moving in the US, and I think it is an important direction for all psychologists worldwide; I look forward to discusing this shift in focus with you. Third, I feel passionately about the obesity epidemic. My particular area of expertise is childhood diabetes and when I saw children with type 2 diabetes – a disease of overweight older adults – I felt that I must do something about this travesty. Obesity is an epidemic in the US and

is likely to bankrupt our health care system unless we can successfully address it. Increasing psychologists' awareness and potential role in addressing obesity may help prevent it from becoming an epidemic in your own country.

> *Lastly, I want to take this opportunity to thank you once again for your contributions to this Congress, and if you feel like adding any comments to this interview, feel free to do so. In any event, I look forward to personally welcoming you in Santander.*

I am very much looking forward to my visit and your convention. I am sure it will be a wonderful learning experience for me, and I am hopeful that we can develop plans for collaborations between our two organizations that will last far into the future.

CLINICAL PSYCHOLOGY

Alan E. Kazdin and Gualberto Buela-Casal

Alan E. Kazdin is a Professor of Psychology at Yale University. He was the Director of the Yale Parenting Center and Child Conduct Clinic. He is a past president of the American Psychological Association (APA). He is one of the most influential scientists in the world according to the Stanford University Ranking.

Gualberto Buela-Casal is a Professor of Clinical Psychology at the University of Granada (Spain). Founder of the Professorship of Sleep Research at the University of Granada. President of the Asociación Española de Psicología Conductual (AEPC). He is one of the most influential scientists in the world according to the Stanford University Ranking.

**Professor Kazdin, tell me why you decided to study psychology and why you oriented your activity towards clinical psychology?*

I have been mainly interested in philosophy and psychology. Through the relationship with some very dynamic and stimulating professors, I became interested in clinical psychology. Also, when it came to choosing a career, clinical psychology gave me the opportunity to work in different areas and I felt that studies in philosophy were more limited. During my undergraduate studies, I became interested in clinical practice and therapy, but I quickly understood

* This interview was originally published in *Papeles del Psicólogo*.

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the importance of research and the need to answer questions that could help clinical work.

You have been training clinical psychologists for many years, so I would like to get your opinion on what would be the ideal training for a good clinical psychologist.

I think it is important to be aware of different theoretical and therapeutic approaches, but not to commit to one too early, and to know the importance and limitations of research. We have learned from extensive research that we tend to have great confidence in the opinions we form, the decisions we make, and the judgments we make in clinical work, but these are neither very reliable nor valid. I think an important step in the clinical process is humility about what we know, even if we want to help a particular patient and be sensitive to their needs, we do not know how to do it well. I also think it is very important for a clinical psychologist to learn assessment, not only for research purposes, but also to monitor a patient's progress during therapy. In my opinion, good clinical practice is very similar to research. You start by formulating hypotheses, test them, and then make changes based on the information you gain. This process is even more important in clinical practice because we need to monitor the patient's progress to ensure that the goals of therapy are being met and that the decisions we make are informed. Assessment and treatment monitoring are very important to me as a clinical psychologist.

What do you think about the importance of clinical practice in the training of clinical psychologists? Do you think it is as important as good theoretical training, or only complementary?

Clinical practice is very important for training, but experience is very limited unless it is guided by knowledge. Much of the knowledge we have in our field about learning, motivation, and cognition could be applied in practice, but this is generally not the case. Also, most of the basic knowledge is based on the general population, which may or may not be applicable to an individual case. Therefore, I believe that clinical experience should include experience in developing better ways to assess patient characteristics and progress in therapy. Training and experience are very important, but all clinical experience should be carefully reviewed.

As Director of the Clinical Psychology Training Program at Yale University, could you briefly tell me how your doctoral program in clinical psychology works, how many spots are offered, how people are selected, and what your training consists of?

Each year at Yale University, approximately 250 to 350 students apply to the doctoral program in clinical psychology. Of these, we accept two or three students. In general, the applicants are excellent; as we review the applications, it is clear to the faculty that the vast majority are outstanding, well-trained individuals who would make contributions to our field. Among the few who are ultimately selected, we look for special training experiences, research experience, accomplishments or excellence in various fields or on graduate examinations, and we also consider the qualitative information we get from an interview, usually conducted by telephone. We also look for a match between what applicants want to do in their research and what we can offer in terms of opportunities. This application process is somewhat frustrating for both faculty and applicants. The reason for this is that there are many excellent students who apply to the Ph.D. program who ultimately cannot be admitted.

You have participated in the last two congresses organized by the Asociación Española de Psicología Conductual (AEPC), so you have had the experience of meeting and exchanging opinions with Spanish psychologists. What is your opinion about clinical psychology in Spain? What do you think about the level of Spanish clinical psychologists and their publications?

The level of work in clinical psychology in Spain is, in my opinion, excellent. The professors and their work are at the level of the best in the world. I would like to see more exchange in terms of publications. I would like to read more about the work of Spanish psychologists in journals published in the United States of America, so that the audience for this excellent work would be even wider. I would also like to see more U.S. psychologists publishing in Spanish journals to strengthen this exchange. In addition to Spanish psychology in general, the University of Granada deserves special mention; its Faculty of Psychology, and the Department of Clinical Psychology in particular, have made a very important contribution to the field of psychology.

During your classes, I noticed that you repeatedly told the students: "it is not the techniques that fail, it is usually the therapist that fails". Can you explain to me what you were trying to convey: that we should have more confidence in the techniques, or that the clinician should self-evaluate and try to find out why they don't work in some cases?

I have always been concerned about some of our inconsistencies as therapists. When we talk about therapeutic success, we often give ourselves more credit than we really deserve. When a patient does not improve, gets worse, or drops out of treatment, we usually attribute this to the patient; we

say to ourselves, "they were resistant, did not follow our instructions," or we think that they were not motivated to change. In fact, the psychologist's job is to understand the behavior, to use psychological findings to understand the behavior, and to evaluate what we have done. It may be true that the patient is not motivated; however, it seems that this conclusion is not certain until we use our knowledge. To blame the patient is to miss the point of our task. Therapy requires the solution of a complex problem of a particular patient. Given the limitation of our knowledge, what can we do? The answer, I believe, is first of all to extract, to take advantage of all that we know about how to change emotions, cognition, and behavior. We have a great deal of knowledge, but only a small part of it is applicable to the context of clinical work. We know a lot about how to assess change and, in clinical work, what is clinically meaningful change, but very little of it is translatable to practice. For my part, I feel that patients are not receiving optimal care.

Finally, what are your future research interests?

I would like to continue my work with children as it will be important for our research group to study young children and also adolescents. The goal is to better understand the pathways that lead to deviance, the changes that occur over the course of development, and the means of intervening at each stage to improve functioning. The work of our group will focus on these issues, in addition to continuing the development of effective treatments.

REFLECTIONS ON PSYCHOLOGY

Alan E. Kazdin and Gualberto Buela-Casal

Alan E. Kazdin is a Professor of Psychology at Yale University. He was Director of the Yale Parenting Center and Child Conduct Clinic. He is a past president of the American Psychological Association (APA). He is one of the most influential scientists in the world according to the Stanford University Ranking.

Gualberto Buela-Casal is a Professor of Clinical Psychology at the University of Granada (Spain). Founder of the Professorship of Sleep Research at the University of Granada. President of the Asociación Española de Psicología Conductual (AEPC). He is one of the most influential scientists in the world according to the Stanford University Ranking.

**Alan Kazdin can be considered a person with a great deal of experience in managing departments, journals, committees, and scientific societies, as evidenced by the fact that he has held numerous leadership positions in the American Psychological Association (APA), the Society for Experimental Analysis of Behavior (SEAB), and the presidency of the Association for Advancement of Behavior Therapy (AABT). Do you think this experience will be enough to lead the APA and to meet the expectations that so many people have for you?*

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* This interview was originally published in *Infocop Online*.

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These experiences will undoubtedly help me in the position. Some of the administrative work I have done has involved strategic planning and implementation of plans, which will also be helpful. However, I still have a lot to learn about how APA is moving forward in areas such as research, training, policy, clinical services, and others. I also want to know what is of interest to the members of the organization and to psychologists around the world.

In any case, it would not be the first major challenge, as managing The Encyclopedia of Psychology, published by Oxford University Press and the APA, was perhaps the largest publishing project in the field of psychology to date. I know the pressure was intense at times, and now that a few years have passed, do you think it was worth the effort?

Undoubtedly. The publications are read by other professionals, which is essential for the advancement of science and clinical work. However, the public that reads the Encyclopedia is much broader (since it includes students and the general public), and for that reason it is an important opportunity to show what psychology is and what makes it important in the world. I have been very fortunate to be involved in the preparation of the Encyclopedia and to work with so many professionals from around the world.

It is possible that the name of the APA may cause confusion, because while some consider it to be an American association, it can actually be considered an international association, since many of its members come from different countries around the world. In fact, some of its congresses have been held in Canada. What is your vision in this regard?

In fact, APA is in many ways an international organization because it has members from other countries. However, I would like to see psychology have more contact with the international community and work with other countries to apply psychology to significant human problems. What do we need to learn from other countries in order to solve significant problems? We need to learn from each other and work together. For example, obesity and malnutrition are global problems that occur simultaneously in some countries. What can psychology do in this case? Psychology has also contributed to the fight against HIV and to practices that reduce the incidence of AIDS, but what else can we do? Our contribution should focus on what psychology can do rather than what the APA can do.

In 2001, a study published in the International Journal of Clinical and Health Psychology showed that Alan Kazdin was the most productive and most cited psychologist in the field of behavioral assessment. More

recently, another paper was published in Research in Developmental Disabilities confirming this in the context of clinical psychology. Just this month, I conducted a comparative study of the article and Web of Science citation production of the five candidates running for election to the APA. The result showed that not only was Alan Kazdin one of the top authors in the Web of Science in terms of productivity, but he was also cited 9,758 times in that database alone; in other words, he received almost as many citations as he received votes in the APA presidential election. Do you think that being so highly cited had an important weight in getting so much support for the presidency? By the way, how does it feel to be quoted so often?

It is very kind of you to mention my work and the citations you have received. I am surprised that my work is cited. Even my relatives don't read my work, so I didn't expect anyone else to.

Among those who have supported your candidacy are some of the most respected psychologists, such as Albert Bandura, Aaron Beck, David Barlow, and our mutual friend Michael Mahoney, whom, sadly, we recently lost. In the 1990s, Michael and you co-edited a book (Cognitive and Behavioral Interventions) that was a huge success. He was considered by many to be one of the most important psychologists of the last few decades, I don't know if you want to comment on that.

Michael Mahoney was very creative. When we were at Pennsylvania State University together and our offices in the Psychology Department were next door to each other. He was a constant source of ideas and had an excellent sense of humor. It was a pleasure and a learning experience to have him as a colleague. He was very influential, and his loss has saddened many of us.

In your campaign for the presidency of the APA, you emphasized the application of psychology to health and gave the example of all that can be done through behavior change in the case of HIV/AIDS. Do you see health as one of the challenges for psychology? What other challenges do you foresee for your term as President?

I would like to expand a bit on the topic of health. Research continues to show that psychological problems have a huge impact on physical health and that physical health has a huge impact on psychological problems. Both physical and mental health problems are very costly in terms of economic and human resources. One of the implications of this is that both psychological services and clinical work should play a more central role in physical health and disease

prevention and management. Clinical psychology should play a much larger role than it does in the world and should not be limited to mental health alone. In terms of initiatives for this period, I would like to see particular emphasis on understanding culture and ethnicity, childhood and family, and international work. This challenge translates into a question: what can psychology do to help the world, and how can we partner with other organizations and countries to achieve greater impact? These are key questions for my presidency.

> *It is well known that the APA is the most important association of psychologists in the world and therefore has an enormous influence in many areas, but it is also true that the Consejo General de Colegios de Psicólogos de España (with about 40,000 members) is a large association in terms of its numerical importance. Given your proximity to Spain and psychology in Spanish, do you think it would be interesting to develop joint projects? What kind of projects might be interesting?*

I look forward to developing some kind of collaboration. I believe that international collaboration is important to maximize the impact of psychology. You know how much I have enjoyed professional collaboration. I expect that collaboration between our countries and, more generally, collaboration at the international level, will be essential to achieve a greater impact of psychology. This impact includes everything from the care, education and training of the next generation of psychologists to research, clinical work and care services.

> *In Spain, as you know, there has been an important debate about whether psychology is a health science. As in any debate, there are conflicting opinions, but the fact is that recently the Consejo de Coordinación Universitaria del Ministerio de Educación y Ciencia approved the classification of psychology as a health science (it was previously classified as a social and legal science). What is your opinion on this change and its consideration as a health science?*

Psychology is central to health and can contribute in two ways. First, basic scientific research helps to understand critical aspects of health. For example, we now know that the eating habits or smoking patterns of a person's parents and grandparents can influence the development of physical and psychological health problems in children and grandchildren. This is very important. Second, we now know that adherence to medical treatments, diet, exercise, smoking, and other lifestyle habits affect health. Psychology is essential for understanding and addressing these habits. There is no room for debate, the key aspects and issues of psychology influence health and the use of health services.

Your research interests have been diverse, ranging from research methodology, behavioral assessment, psychological treatments, and the effectiveness of treatments for antisocial behavior, but perhaps it is the latter topic that you have worked on the most in recent years and in which you are a world reference. Will you continue to prioritize this area of research in the future?

My research continues to focus on antisocial behavior and aggression in children and adolescents. As you know from our collaborations, we have developed effective treatments. An ongoing difficulty we face is the dissemination of these treatments to professionals in clinical practice. The most effective and best studied treatments are still not being applied in clinical practice. In this sense, my priority objective now is to better disseminate what we know, although this does not mean that I will stop my research work.

More than a decade ago I interviewed you during an international congress held in Granada. In that interview you insisted on two pieces of advice for young psychologists: one is that professional experience, if it is not guided by theoretical knowledge, is very limited, and the other is that "techniques do not fail, what fail are the therapists", do you still think the same way?

Theory is a good guide to research, but we must be careful. In psychology, on some occasions, theory has been assimilated with very global perspectives on a problem, whether that perspective is behavioral, psychoanalytic, humanistic, or other. Such broad perspectives constitute a type of theory that, in my view, is not very useful. They are far removed from the actual data. Specific models of how a particular phenomenon works are very important. I encourage young researchers to work closely with the phenomenon they are studying and to develop detailed and very careful descriptions. Detailed descriptions, done very carefully, are the best way to get a deep understanding and to develop a theory.

At the beginning of the 21st century, a book was published in Spain under the direction of Professor Rubén Ardila entitled "La Psicología en el Futuro". In this book you wrote a chapter in which you stated that the progress of psychology in the future will also be related to the connection between psychology and biology, with the progress of technology and robotics, and with the knowledge of the map of the human genome. Do you still maintain this approach?

I believe that psychology still has a lot to contribute on its own. At the same time, collaboration with other fields is essential. For example, research in

genetics and proteomics has made psychology more important than ever. Work in epigenetics illustrates this. Epigenetic research shows how parenting and nurturing (psychology) can affect gene expression across multiple generations. This work is amazing and shows the importance of collaboration between two disciplines. Similarly, neuroimaging and molecular biology are critical in addressing issues such as modeling and empathy. Collaboration is essential to reach new levels of understanding.

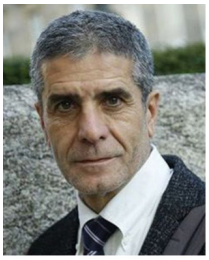
Is there anything else you would like to say to Spanish psychologists?

I hope that we will have the opportunity to cooperate and work with Spanish psychologists. We can learn a lot from them. Also, together we can make an impact that will not only bring improvements for both countries, but also help people around the world. Mental and physical health, education, family life, and the rights of groups suffering from discrimination, abuse, and violence are just some of the issues. I would like to think that together we can do more for our countries than we could ever do separately.

FOSTERING PSYCHOLOGICAL SERVICES IN PRIMARY CARE

Susan H. McDaniel and Wenceslao Peñate

Susan McDaniel is a Professor of Family and Health at Rochester University and Director of the Family Institute at Rochester University. She is a past president of the American Psychological Association (APA). She is one of the most influential scientists in the world according to the Stanford University Ranking.



Wenceslao Peñate is Professor of Clinical Psychology at the University of La Laguna. He is a member of the Instituto Universitario de Neurociencia.

** How is a 'normal' labor day in your life now (president of APA)?*

What a great question! no one has asked me that! My days are very long. I have a half-time sabbatical from my leadership jobs at University of Rochester Medical Center where I am a Division Chief in the Department of Psychiatry and Associate Chair of the Department of Family Medicine. The half-time sabbatical gives me the time to do the traveling I need and want to do as President of APA, including coming to Spain. Last week, I gave a talk on integrated care in

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San Antonio Texas to the Veterans' Administration Psychologists' Leadership Conference, then I went to San Francisco to give a talk on integrated care to the American College Health Association. The days before were spent preparing the talks and slides and going to the Medical Center to do the work I need to do there. With healthcare reform in the United States, there is much work to do to change our healthcare system and integrating behavioral health into primary care is a big initiative. So, there is a lot going on! This week I will be working hard at the Medical Center from Monday-Wed. Thurs-Sun I will be running a Board of Directors meeting for APA in Washington DC. So, this week I will be doing my Medical Center work full-time at the beginning of the week. The Internet makes for wonderful connections, but it is also true that I average about 500 emails/day, and these are the ones that staff can't answer. But it is the email, phone, and (best) in person contact with people that makes being President so interesting and meaningful.

You will participate in the IX International Congress of Clinical Psychology at Santander, Spain (November 2015), among other contributions, with a conference about a topic that you had had developing by several years: medical family therapy. The first question, for our readers, is about the concept of Medical Family Therapy (MFT), and to what extent is different from traditional family therapy.

MFT is a meta-framework within which one can practice any kind of family therapy. The framework is founded on a biopsychosocial systems approach that recognizes that mind and body are inextricably intertwined. Medical family therapy, then, involves asking people about their physical as well as emotional experiences, and collaborating with other health professionals to provide comprehensive care to people and their families, especially when faced with an illness or health challenge.

From the point of view of professional psychology, which advantages provide MFT to health systems (customers, professionals, organizers ...)?

I think it provides an amazing range of possible contributions: care for patients that addresses the whole person in the context of their family and community; attention to wellness of the workforce and consultation to improve the effectiveness of healthcare teams since systemic approaches work as well for teams as they do for families; I also have trained a team of psychologists to join me in doing leadership and communication coaching for the physician faculty in our medical center. We focus on communication with patients, families, and the rest of the healthcare team, and the physicians find it very supportive and useful.

Can we know some examples of good practice MFT in your country?

There are so many good examples involving patients and health professionals of all kinds—in primary care, alzheimer's, epilepsy, fertility, family medicine, genetics, obstetrics, general pediatrics, pediatric rheumatology, and surgery—The faculty from the Institute for the Family that I direct in Psychiatry are placed in each of these departments—providing care to patients and families, and assisting physicians and other health professionals to learn about the behavioral health issues of their patients.

Very close to MFT are your interests in fostering psychology at primary care, and I think these interests have a special place because your APA presidency. In Spain, our professional organization (Consejo General de la Psicología de España/General Council of Psychology of Spain) together with others psychological associations (such as AEPC, organizer of this congress in clinical psychology), is trying to include clinical psychology in primary care. In that sense, in your opinion, which are the main advantages of psychology in primary care, not only for costumers, but for the whole health system?

Primary care is the foundation for all healthcare (and finally we are getting there in the US). It is where people bring their health problems when they or their family or friends haven't been able to solve them. The problems are undifferentiated, and often involve a mix of physical and emotional issues that need attention (sometimes one more than the other). Having a psychologist on the primary care team ensures that any behavioral or psychological issue will be noted so that intervention can be early. It also ensures patients and families who are stressed by serious illness will get the support they deserve, and hopefully prevent their relationships from becoming skewed in a permanent way as a result of the illness. Additionally burn-out is a major problem for primary care physicians in this country. Having a psychologist on the team helps with sharing the burdens of care and providing a supportive work environment.

What kind of competencies is needed for psychologists in primary care? Are there special or specific competencies?

Definitely. We wrote a very long paper published in the American Psychologist about all the competencies that are needed (see McDaniel et al., 2014). Some of the most important are understanding how common chronic illnesses have comorbid mental health problems—such as diabetes and depression, or cardiac disease and anxiety. It is also very important to understand systems theory—in order to understand the patient in context, the healthcare team, and the

healthcare system. Learning to collaborate and work on a team on behalf of a patient is also a very important skill. These are just a few that are not always taught in psychology graduate training.

> *That means an epistemological change? Because it would be necessary a new formative curriculum...*

Absolutely! I have been talking about that lately in my talks. It does require systemic thinking, respect for other disciplines (knowing what they are good for and how we fit in). And psychology students need to have inter-professional education early in their career. So psychology, medicine, nursing, social work, pharmacy students can all take a seminar early taught by a multidisciplinary faculty on Integrated Care with topics such as: population health, payment methodologies, collaboration, what predicts effective team functioning, new models of leadership, etc.

> *Two steps that could be relevant: (i) how we move from a provider-centered health model to a patient-centered model?*

Yes, we are organized for the convenience of the clinicians not the patients. That needs to change, and we are working on that to improve access to care, less time waiting, and especially a focus on the patient and family's concerns and what they are willing to do in terms of change or treatment. This is a big and multi-faceted issue.

> *And (ii) how can we persuade, how we can convince politicians and health economists that psychology at primary care is both social and economic profitable? Has APA some 'seductive' plan for that?*

We are working hard to demonstrate our worth, and I hope it will be "seductive." There are now a number of outcome studies showing comprehensive care is both less costly and more effective. Sometimes the politician has to have his or her own experience with healthcare before it really sinks in. Sometimes stories that bring the statistics to life are what convinces them.

> *What extent the Accountable Care Act ("Obamacare") can facilitate transition psychology to primary care? What is your point of view about this law?*

I am VERY in favor of the Affordable Care Act. The incentives in our healthcare system have been perverse, rewarding clinicians for procedures and visits

rather than for keeping people healthy. It is a major step in the right direction. And behavior (=psychology) plays a huge role in keeping people healthy.

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ICD-11 OR DSM-5 WHICH ONE SHOULD WE USE?

Geoffrey M. Reed and Gualberto Buela-Casal

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Gualberto Buela-Casal is a Professor of Clinical Psychology at the University of Granada (Spain). Founder of the Professorship of Sleep Research at the University of Granada. President of the Asociación Española de Psicología Conductual (AEPC). He is one of the most influential scientists in the world according to the Stanford University Ranking.

**Your lecture at the V International Congress of Clinical Psychology will deal with the current status of the Classification of Mental and Behavioral Disorders in the future ICD-11, undoubtedly a highly topical issue and one that I would like us to focus on in this interview. You are a clinical psychologist trained at the University of California (UCLA) and at the University of Washington and you are currently working in Geneva at the WHO, being the person in charge of the Classification of Mental and Behavioral Disorders in the ICD-11. This is undoubtedly a recognition for Psychology, but could you explain to us the criteria for*

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choosing a psychologist for this important function that has classically been in the hands of Psychiatry?

I began working with the World Health Organization (WHO) on international classification systems more than a decade ago, when I was Assistant Executive Director for Professional Development at the American Psychological Association. At that time, there was a discussion about whether psychology should develop its own classification system rather than continuing to be dominated by the DSM and by psychiatry. I was asked to look into this and concluded that an independent diagnostic system developed by U.S. psychology faced many obstacles and would be subject to many of the same criticisms as the DSM. My judgment was that it would be better for us to join forces with the WHO. At that time, WHO was working on what would become the International Classification of Functioning, Disability and Health (ICF), and I became intensely involved in that effort. This was because many of the interventions provided by psychologists can be seen as attempting to improve the functional status of the person receiving services, regardless of the person's diagnosis. Through my work on the ICF, I developed an expertise in health classification systems and gained a great deal of experience in collaborating with the WHO and its many partners and constituencies. So, it was natural that I would be considered to work on the ICD-11 when the WHO began that process. The WHO Department of Mental Health and Substance Abuse already had a commitment that the revision of mental and behavioural disorders chapter of the ICD would be multidisciplinary, so there was no reason that they would not consider a psychologist for the position. It was also very important that I had the support of the International Union of Psychological Science.

Recently in another interview I conducted with Dr. Suzanne Bennett Johnson, current President of the American Psychological Association, she told me that from now on the APA will recommend the use of the ICD-11 instead of the DSM-5, but this will undoubtedly have a greater or lesser acceptance depending on the frequency of use of these diagnostic systems in different countries. What is the situation in the European Union regarding the use of the ICD and the DSM? To what do you attribute the greater use of one or the other?

Just last year, we published the results of a major survey that we did in collaboration with the World Psychiatric Association (WPA). This was the largest survey on diagnostic classification by psychiatrists ever conducted (Reed et al., 2011). The WPA-WHO global survey of psychiatrists' uses and attitudes towards mental disorders classification. World Psychiatry, 10, 118-131.) Nearly 5000 psychiatrists in 44 countries, in every global region, participated.

Worldwide, 70% of participating psychiatrists said that the ICD-10 was the diagnostic system that they used most, and only 23% reported most often using the DSM-IV. In Europe, this was even more pronounced: more than 80% of over 2700 European psychiatrists participating in the survey used the ICD-10 most, and only 13% used the DSM-IV more frequently. We have conducted a similar survey of psychologists and are analyzing the data now, and I will be able to present it at the Congress next month. In terms of Europe and the ICD, the mental and behavioural disorders classification in ICD has traditionally been led by Europeans. We have a series of 14 international Working Groups that are currently collaborating with us to develop ICD-11 mental and behavioural disorders classification, and fully half of them are chaired by Europeans, including psychologists. WHO Member States, which include all EU countries, are obligated by international treaty to use the ICD as a framework for the collection and reporting of health information. The DSM, in fact, uses ICD diagnostic codes in order to comply with this requirement, but the United States is still using the ICD-9, even though ICD-10 was approved by the World Health Assembly over 20 years ago. There is no reason to expect that European countries would adopt a system that is a proprietary, commercial product of a single US professional association rather than the international classification of WHO. We expect that in European countries, the ICD will continue to be the standard, and that these countries will be major and early users of the ICD-11 when it comes out.

> *In Spain, as you surely know, the use of the DSM is almost exclusive in the training programs for psychologists (undergraduate, graduate, and specialty) and also in professional practice, what reasons could you argue for advising the use of the ICD-11 instead of the DSM-5?*

I think this may partly reflect a developmental phenomenon within psychology and in science more broadly. Psychology has traditionally been dominated by psychiatry and has been willing to accept and even abet this situation. As training standards have improved throughout the world and psychological science has flourished, psychologists increasingly question whether products and processes designed by psychiatrists will meet their needs.

Similarly, the international community is less and less willing to accept automatically that U.S. scholarship is better, or that its scientific products are superior and that U.S. conceptualizations will be suitable to their needs. Similarly, WHO Member States want to see their own priorities for health care and their own cultural and linguistic specificities reflected in the classification system. As you know, the nature and values of health care systems in Europe are very different from those in the United States, and it is not clear that a product base on US concepts will be the best fit. For this reason, WHO is engaging a global and multidisciplinary process in developing the ICD-11. With ICD-11, WHO will also

work to do a better job than it did with ICD-10 of making ICD-related projects, such as the Clinical Descriptions and Diagnostic Guidelines for Mental and Behavioural Disorders, available and affordable in Spanish and other languages. Spain and Latin America are very well represented in all of our working processes in the ICD revision, and all of our revision activities are being conducted in Spanish and English simultaneously. We will conduct activities in other languages as possible, but we are committed at least to these two. As a part of this, we have completed a detailed analysis of Spanish-language classification systems for mental disorders, which we published last year in the Revista Panamericana de Salud Pública (Rivas Rodríguez et al., 2011). Aportaciones de dos clasificaciones psiquiátricas latinoamericanas para el desarrollo de la CIE-11. Revista Panamericana de Salud Pública, 29, 130-137). We also collaborated on a supplement in the Revista Brasileira de Psiquiatria on 'The Latin American contribution to the revision of ICD-10', which can be access online at: http://www.scielo.br/scielo.php?script=sci_issuetoc&pid=1516-444620110005&lng=en&nrm=iso. All field studies for ICD-11 will be conducted in Spanish. Spanish psychologists can participate directly in the development of the ICD-11 by signing up to participate in our Global Clinical Practice Network at the following website:

http://kuclas.qualtrics.com/SE/?SID=SV_9B7R6myjIIPPgoI&SVID=Prod&Q_lang=ES

Currently in Spain, we have more than fifty thousand psychology students and more than fifty thousand professionals, most of them, both students and professionals have a foundation in cognitive-behavioral training, do you think this may favor the use of the future ICD-11 or on the contrary may be an obstacle, and by the way, do you have any training program planned for the use of the ICD-11?

The ICD is designed to be neutral with respect to the type of treatment approach that will be used. We are specifically mindful of making sure that it will be clinically useful for a wide range of health professionals. Worldwide, only a tiny proportion of people with mental disorders will ever see a psychiatrist. We also want to make sure that the ICD will help to support non-pharmacological forms of treatment. This is one area where I think it makes a difference that I am a psychologist, in that I don't think about treatment automatically in terms of drugs. A big part of the reason we have done the large surveys I referred to earlier is that we want to pay attention to what front-line clinicians tell us that they need. What they are saying is that they want a simpler system with fewer categories, and one that is sufficiently flexible to allow for clinical judgment and cultural variation, rather than one that is based on complex formulas of large numbers of pseudo-precise criteria.

Despite its frequent use, the DSM is criticized for its high and unjustified cost. Do you think that in the DSM-5 and ICD-11 editions, costs will be another differential element?

Most definitely. The ICD is intended as a public good, and WHO will make ICD-11 as widely available as possible, including for free on the internet. ICD-11 products for mental and behavioural disorders in book form will be available low cost, and WHO will make them available at a large discount in low and middle income countries. This was something that was not handled well with ICD-10, particularly in relation to translated versions of products related to mental and behavioural disorders, but WHO is committed to doing a much better job of this with ICD-11.

If we consider that Psychology is a health science, something much broader than mental health, then it is evident that the ICD is better suited to the professional activity of the psychologist, however, this does not correspond to its use, what are the reasons why in different countries, such as Spain, it is hardly used?

Based on the information that we have, I think this question reflects an underestimation of the extent of the use of the ICD globally. Certainly it is true that the DSM has been more widely used in research and is therefore has greater representation in publications. But in clinical practice, the opposite is true. The government of Spain is obligated to report health statistics to WHO using the ICD. If the activities of health professionals occur largely outside the government health system or if they are not responsible for assigning or coding the diagnosis, they may not be fully aware of this. I think you are exactly right in mentioning the issue of health viewed more broadly as an important reason that psychology should consider the ICD as its core diagnostic system, and I think you are quite right about this. In all other areas of health, the ICD is the internationally accepted standard for diagnosis and classification, and there is no competitor system. WHO works with many international and national professional societies on the development of ICD, and all of them are collaborating with WHO to improve the ICD. Mental disorders is the only area in which a national professional association has established and maintains a directly competitive system.

In your opinion, as the person in charge of this topic, what are the most important novelties in the ICD-11, especially in the field of mental and behavioral disorders, how will personality disorders finally be included, and will the changes in the ICD-11 make it more in line with the training and professional activity of psychology?

In revising the ICD, we are particularly focusing on improving the clinical utility and global applicability of the classification, and most of the changes that are currently being considered relate directly to these priorities. In most areas, proposals are still under development, but will be made available for public review in May. I will provide additional information about this at the Congress. I do think that the new system will fit better with the practice of psychology. For example, there has been a major reconceptualization of what was previously called Mental Retardation, and is now called Intellectual Developmental Disorders (Salvador-Carulla et al., 2011). Intellectual developmental disorders: Towards a new name, definition and framework for 'mental retardation/ intellectual disability' in ICD-11. World Psychiatry, 10, 175-180.) As you mention, the area of personality disorders will be substantially changed, and the new classification will emphasize the severity of personality disturbance but also make possible the coding of prominent traits, rather than having many artificial and reified specific diagnostic entities. This represents a much more psychological view of personality and personality disturbance (Tyrer et al., 2011). The rationale for the reclassification of personality disorder in the 11th Revision of the International Classification of Diseases (ICD-11). Personality and Mental Health, 5, 246-259.

> *Regarding the correspondence or equivalence between the diagnostic categories of DSM-5 and ICD-11, are they already closed or is there still work to be done? On the other hand, could ICD-11 be considered to be more independent of cultural differences, i.e., adaptable to different cultures?*

There is a recognition that it would be beneficial to the world if the ICD-11 and the DSM-5 were as consistent with one another as possible. WHO has indicated that there may be substantive differences in the two classifications based on their different purposes and constituencies. One type of difference that may exist is in fact based on the need for cross-cultural applicability of the ICD-11. For example, most eating disorders in non-Western countries may end up being classified under current diagnostic systems as 'unspecified' because they do not fit the pattern of eating disorders in the U.S. and Western Europe. But the fact is that most of the existing differences between ICD-10 and DSM-IV are arbitrary and not based on evidence supporting either approach. Both WHO and the American Psychiatric Association would like to avoid these types of differences, and we have a process of 'harmonization' in place with the American Psychiatric Association that is still ongoing. On the other hand, it must be pointed out that if there were complete harmonization there would be no reason to buy the DSM when you could get the ICD without charge on the WHO website.

The DSM-5 is receiving important criticisms, thousands of professionals are complaining that this classification system is psychopathologizing everyday life, for example, shyness, apathy, introversion, etc., could be considered disorders.

I think there are two aspects to this criticism. The first is based on a more general discourse about the nature of mental illness, along the lines of the work of Thomas Szasz, that questions the existence of mental illness and sees mental health treatment as an instrument of social control. I think this is an important discussion, but if this is your perspective the ICD is not likely to make you much happier than the DSM. This second aspect of this criticism concerns the designation as mental disorders of much more common, high base rate, low threshold conditions that have been previously seen as variations in normal functioning or as aspects of normal experience. In this respect, I think there there will be an important difference between the ICD-11 and the DSM-5. Examples of DSM-5 proposals about which this concern has been raised include 'attenuated psychosis syndrome', 'mild neurocognitive disorder', and the removal of the bereavement exclusion for major depression. WHO views proposals of this nature as problematic for several reasons. First, these high base rate, low threshold conditions represent major targets for drug development and marketing, which is more than anything in the interests of pharmaceutical companies. Second, when every country in the world is faced with increasingly difficult choices about the allocation of health care resources, these proposals have the potential to divert resources from more serious conditions that do have effective treatments. Third, they are likely to result in people who really do not need them being given serious medications with potentially serious side effects. Fourth, they are likely to result in huge increases in the estimated prevalence of mental disorders, which will make it even more difficult for WHO to encourage member countries to make mental health a priority because it will seem that much more overwhelming to do so. So, there is very little public health justification for such proposals, and it is highly unlikely that they will be incorporated into the ICD-11. WHO does not see how the addition of such categories would help move us toward our goal for the ICD-11 of helping WHO member countries to reduce the disease burden associated with mental and behavioural disorders.

Surely you know that in Spain for some years now Psychology has been considered a health science at the academic level and since last year it is regulated by law as a health profession, what is your opinion on this?

As you mentioned, I was trained in the United States. My training was according to the scientist-practitioner model of psychology, so it is comfortable

to me to think about psychology in both ways. Psychology is hugely important as a science, and in my opinion it is the strong scientific training of psychologists that gives psychologists a special place among health disciplines. On the other hand, this is obviously not to say that every psychologist will provide health services or will do basic research. To me personally, the most valuable thing about my training is that it has given me the skills and the flexibility to do many things, and both our profession and our professional organizations should work to preserve this breadth.

> *Finally, in a few weeks we will meet in Santander, from here I want to thank you for your participation in this congress, and if you want to add any more comments you can do it. I would like to reiterate that it is a source of pride for Psychology that a psychologist holds such an important position as yours, which is undoubtedly important for this profession.*

I am very much looking forward to meeting more of my colleagues from Spain and around the world in Santander. I am grateful for the invitation, and look forward to more collaboration in the future. Thank you!

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MOVEMENT TOWARDS TRANSDIAGNOSTIC APPROACHES

Andrea Ashbaugh

Andrea Ashbaugh is an Associate Professor at Ottawa University (Canada). She is on the Editorial Board of the Journal of Behavior Therapy and Experimental Psychiatry, and a member of the Training and Accreditation Committee of the World Confederation of Cognitive and Behavioural Therapies.

**As an introduction, much of your research has focused on anxiety disorders. Could you explain how your interest in studying in this field arose?*

Anxiety is a nearly universal experience. We can all identify with just how uncomfortable anxiety can be and yet anxiety is an extremely important state that enables us to interact in our world effectively. However, it is apparent that some people are able to manage anxiety with little difficulty and others become debilitated by anxious experiences. Extreme distress from anxiety is common. Disorders in which anxiety or fear play an important role (including the anxiety disorders but also disorders like OCD and PTSD) as a group have very high prevalence rates, and many more individuals experience significant distress as result of anxiety but don't necessarily have diagnosis. Studying anxiety disorders is the perfect intersection between my interest in studying individual human differences and hopefully one day improving the lives of individuals suffering from anxiety disorders.

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The classification systems and the debate between categorical and dimensional systems are very relevant issues in psychopathology today. What is your opinion of the current DSM-5 and ICD-11 classifications? What do you think of the transdiagnostic approach, in which anxiety plays an important role?

Issues of diagnosis and the definition of anxiety have been an interest of mine for quite sometime, and I recently had the pleasure of co-authoring a chapter on this very issue with a colleague of mine, Dr. Cary Kogan. In my opinion, the DSM-5 and ICD-11 are valuable tools that enable us to identify people in distress, to study and to provide estimates on the prevalence of psychological problems. However, disorders in DSM-5 and ICD-11 are constructions. The constructions are made based upon the most up-to-date synthesis of research, but the more we understand psychological phenomena the more we are coming realize that many of the "disorders" identified in these diagnostic systems are much more dimensional in nature. I think the movement towards transdiagnostic approaches to understanding phenomena, for example identifying cross-cutting beliefs such as perfectionism, will help move clinical psychology forward as field and ultimately may improve our interventions for mental health problems. I'm looking forward to seeing whether new classification systems, such as the Hierarchical Taxonomy of Psychopathology (HiTOP) prove to be clinical useful.

We know that in the coming month of November you will give a conference talk entitled "Hopes for Improving Psychological Treatments: Recent Advances in Experimental Psychopathology", within the framework of the XII International and XVII National Congress of Clinical Psychology, which will be held in Santander between the 13th and 16th. Could you tell us what your talk will consist of and what topics it will address?

We currently have pretty good psychological treatments. However, many people still don't get better and others relapse after treatment. My talk is going to explore how some refinements of current interventions that are based upon experimental psychopathology research may be helpful towards improving our outcomes. Furthermore, my talk will propose taking a transtheoretical approach towards improving treatment. Much discussion on clinical outcome research has focused on debating which type of intervention is better (CBT or psychodynamic for example) or on whether common factors, such as the therapeutic alliance that is important outcome. I think clinical psychology as a science can advance much further in improving outcome by working collaboratively. My talk is going to focus on some examples different key areas of the science of human behaviour and emotion can be applied to clinical psychology. For example research on individual differences and the clustering of various personality

traits has resulted in dimensional models of psychopathology (e.g., HiTOP) which may more accurately represent the nature of psychological problems compared to categorical models of psychopathology. Advances in inhibitory learning theory have refined how we understand the mechanisms underlying exposure therapy. I hope that my talk will highlight how a more collaborative approach to understanding psychological treatment may help improve outcome in the future.

Given the previous question, what are the lines of action that are proposed to improve the outcomes in existing treatments, and what can Psychology professionals do in this area?

I think both clinicians and researchers have an important role to play in improving the outcomes of our patients. Our field is young and evolving. Clinicians should make every effort to stay up to date on current evidence-based practices, attend workshops and conferences regularly, seek supervision to facilitate keeping clinical skills up-to-date, and be skeptical of the latest a panacea. Researchers need to be careful not to get attached to their pet theories and instead focus on the goal of understanding human behavior and improving outcome, and focus on conducting high quality, powerful research rather than publishing quickly. Involvement in open science and replication are two ways to help facilitate this. Finally, researchers need to do a better job of disseminating research findings to clinicians in a way that is easily accessible and has clinical relevance.

As an expert in the field, could you point out the additional benefits that psychological intervention can provide in comparison with other types of intervention?

Medication and psychological interventions both have their place in treatment. The research is pretty clear that they are about equivalent with regards to outcome, but that the effects of psychological interventions are longer lasting. It is my personal opinion, but I do think that psychological interventions teach individuals tools to help manage strong and difficult emotions that may arise later down the road after treatment.

In the current world in which we live immersed in new technologies, what role does the Internet can play in the study and approachment of mental disorders, as well as in the improvement of psychological treatments?

I think the Internet is a powerful tool that Clinical Psychology has not fully taken advantage of yet. With regards to research there are many exciting ways

that the Internet can be used to study psychological phenomena. In my own lab we have very simply incorporated smartphone technology to monitor people's emotions and thoughts using ecological momentary assessment. Our participants get notifications on their phone to complete survey items within a specified period of time. We can track their experiences randomly and in the moment. Other labs are actually using information collected about how and where smartphones are used to better understand clinical phenomena.

I think the Internet will be and is becoming a valuable tool for improving psychological treatments. First, the use of treatment apps has the potential to improve accessibility to psychological treatments. This important especially in big countries like Canada where we have individuals who are probably the most in need of help living in very remote areas of the country. Second, I think the Internet, especially smartphone technology, has the potential to improve treatments by providing "online" "immediate" access to psychological tools. For example, the ability to complete a thought record using an app may enable a client to complete it as soon as the uncomfortable thought or emotion arises, providing more accuracy in tracking thoughts. This is just a basic example of who technology might be used going forward, the field is just starting to explore all the potentials this technology has to offer. I do think there are ethical issues that need to be considered and certainly research on the efficacy of using technology for treatment needs to continue to be researched.

Finally, would you like to add any other comments?

I don't have any final comments, except to say I do think we are at a crossroads with regards to the field of Clinical Psychology. I am looking forward to seeing how the field of Clinical Psychology evolves with our expanding understanding of human behaviour and the introduction of technological innovations. I hope that more careful attention to scientific rigor and a more collaborative approach to studying treatment outcome will help facilitate our evolution.

FROM THE MOST CURRENT RESEARCH IN MENTAL HEALTH TO CLINICAL PRACTICE

Jürgen Margraf and Juan Preciado

Jürgen Margraf is a Professor of the Clinical Psychology and Psychotherapy Department at Rhur-Universität Bochum (Germany). He was the first psychologist to receive the Alexander von Humboldt professorship.

Juan Preciado is a Professor of Health Education at Hostos Community College of the City University of New York (United States of America).

**Congratulations on being the first psychologist to receive the Alexander on Humboldt-Professorship. Let me just mention the size of the award for those readers who might not be familiar with this most meritorious recognition. You were awarded 5 million euros, which is five times larger than the Nobel Prize. How did the prize change your professional life? And what were the funds directed at?*

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The prize officially aims to enable its winners to enjoy a high degree of freedom in creating their own working conditions and thus creating an internationally com-petitive basis for a long-term academic future in Germany. And this is what it did for me. It allowed me to set up the Mental Health Research and Treatment Center (MHRTC), which offers a unique infrastructure for research, practice and training in Clinical Psychology and Psychotherapy. It also allowed me to establish several lines of research aimed at long-term outcomes rather than having to pursue the typical short-term perspectives as we are all too often forced to. I was able to start projects for which there would have been no funding under normal conditions, such as the cross-cultural longitudinal investigation of positive mental health, the influence of macrosocial factors on mental health or the study of mental health across the lifespan by simultaneously looking at children and adults.

Allow me to follow-up on the Mental Health Research and Treatment Center (MHRTC) that you created. Could you briefly comment on its current status and future plans?

Thanks to the support of the Alexander von Humboldt-Foundation and other funding agencies, the MHRTC at Ruhr-Universität Bochum unites under a single roof a comprehensive clinical, experimental psychological, psychophysiological, and psychometric/biostatistical infrastructure. It includes the professorships for Clinical Psychology and Psychotherapy, for Clinical Child and Adolescent Psychology and for Clinical and Behavioral Neuroscience as well as their associated postgraduate training programs. In addition to our many B.Sc., M.Sc. and Ph.D. students we currently have more than 110 therapists who are completing a three-year full-time training program for CBT in children, adolescents and adults. This requires large outpatient clinics in which each year over 2000 children, adolescents, and adults with the whole range of mental disorders are treated using evidence-based methods. This patient flow is very important for the center´s research, which combines etiological and treatment studies in order to contribute to a better understanding of the interplay of psychological, biological and social factors as well as to sustainably ameliorate mental health care across the lifespan. After the initial funding by the Humboldt-Foundation has run out early in 2017, the center now supports itself by generating over 4 million Euros annually in Third Party money in addition to the university´s substantial regular funding. Future plans focus on the development of innovative psychological treatment approaches, embedding psychotherapy into the social context and addressing neglected disorders in children and adolescents. In our research, we will tighten the interlocking of etiological and therapeutic research strategies and of the bio-, psycho-, and social levels of analysis of mental disorders. Strategically, therapy is a prime

example of the fact that humans are active, information-processing beings, able to change their world and their brains. Causal effects between the biological, psychological and social factors of health and disease do not represent a one-way street, but rather a two-way street with multiple dynamic interactions between local and distant neighbors, as well as systemic effects. In addition, we will pursue both a broad and a narrow focus. While we will not give up investigating clearly defined and measured biological processes ("narrow focus"), we are complementing this by a "broader" focus on psychological and social processes. We will have more infant studies in our lab work, and we will keep looking at neglected fields such as the pitfalls and failures in diagnostics. Simultaneously, we will continue to investigate how psychological factors mediate the strong influence of macrosocial factors such as justice, wealth and freedom on mental health. And finally, we have already begun to shift our attention from the classic pathology-based focus on negative, pathogenic factors to a broader view that incorporates the study of positive mental health together with salutogenic and protective factors which is at the core of our "BOOM" project.

I wonder if you could comment on your current project: the BOOM. What is this project about? Why did you decide to get into this particular area? Could you discuss one or two of its major findings so far?

The main aim of BOOM ("Bochum Optimism and Mental Health studies") is the identification of causal protective and risk factors for both positive mental health (PMH) and depression, anxiety and stress symptoms (negative mental health, NMH). A theoretical basis is the dual-factor model of mental health, which describes PMH and NMH as two interrelated but separate unipolar dimensions. PMH is more than the absence of mental disorder: Elements of both can coexist - they are correlated, but partially independent. Combining cross-sectional and longitudinal designs, we investigate predictors of PMH as well as depression, anxiety and stress in a transcultural research program (China, Germany, Russia, USA, and lately Pakistan, total N≈40000). Preparatory methodological groundwork has established which scales and constructs show cross-cultural measurement invariance, i.e. can be compared meaningfully across cultures. We were able to establish good measurement invariance for the main outcome variables for PMH and NMH in BOOM. Based on that, our subsequent results so far show that across cultures, PMH is a major buffer against the pathogenic effects of daily stress and negative social influences and a strong predictor of the remission of emotional disorders and suicidal behavior above and beyond all other variables. Substantial cross-cultural differences point to divergent trajectories of mental health across the lifespan (e.g., increasing in Germany, decreasing in Russia). Moreover, several differences in personal values are related to mental health in meaningful ways. Overall, longitudinal analyses show

that salutogenic factors (overall PMH as well as resilience, optimism, happiness, social support, self-efficacy) positively influence both overall well-being and mental problems. Positive mental health thus clearly deserves more attention. It can be assessed reliably and validly across groups, cultures and time; it is relatively independent of mental illness (69-84% non-shared variance in our studies); it shows significant cross-cultural differences; it has high predictive validity (especially for remission of mental problems) and it mediates the effects of stress, social support, resilience etc. Moreover, mental health is strongly related to social factors and psychological mechanisms such as sense of control, mental activity or delay of gratification appear to mediate the effect of social class and education. Perhaps most importantly for therapists: all of this can be influenced by our lifestyle choices, behaviors and cognitions!

As I understand, you have done research on pharmacological augmentation in therapy. What are some of the reasons you got involved in research looking at augmentation therapies via medications? What are the benefits of doing so?

Augmentation studies are relevant not primarily because of potential therapeutic gains for clinical practice, but mainly for advancing our knowledge about the basic processes underlying therapeutic change. They represent a true translational para-digm shift that recognizes learning, memory and neuronal plasticity as the basis for psychological treatments and for new interventions that specifically target some of these mechanisms as potential enhancers of CBT. The thinking behind traditional drug treatments assumes an unproven or even falsified pathophysiology of neuro-transmitter systems. As such, drugs that target monoamines or gamma-aminobutyric acid (GABA) such as benzodiazepines, tricyclics or SSRI´s have been applied in rather chronic, non-specific ways. It is therefore not surprising that treatment effects vanish once drugs are withdrawn. More importantly, in order to qualify as a causal factor, the assumed pathophysiology would have to have existed before the onset of the disorder. In contrast to various psychosocial risk factors, this has not been shown con-vincingly. Classic drug treatments thus rely on a shaky model of pathology to give patients relatively unspecific medications for prolonged periods of time while side effects, potential abuse and negative long-term effects further impede the cost–bene¬fit ratio. Moreover, traditional approaches to combining pharmacological and psycho-logical treatments have relied on a simple additive model: You put two things to-gether and hope that the result gets better. Remarkably, this has not been the case in many studies. In fact, for several classes of drugs—such as benzodiazepines or tricy-clics—the combination has been less successful than CBT alone. The new augmenta-tion paradigm is much more specific than earlier pharmacotherapy since it relies on a sound understanding

of learning and memory, gives substances only briefly and aims at ameliorating processes which, at least in principle, should create lasting ef¬fects. Successful augmentation of exposure in human patients has been shown for agents such as DCS, methylene blue and cortisol. In addition, behavioral augmenta¬tion via physical exercise and sleep has also been demonstrated. These interventions may work by enhancing the consolidation of newly learned inhibitory memory con-nections, or by updating threat-related memories during reconsolidation. Notwith-standing these advances, it is important to realize at least two major limitations. First, the observed augmentation effects are so far rather small. Second, the psychological treatments applied were often of "mild-to-moderate" intensity. Thus, augmentation for full "gold standard" treatments remain yet to be shown.

> *You have completed several international research studies related to mental health treatment and disorders across various geographical contexts. How does culture expand our understanding of the way we conceptualize and treat mental disorders? Are we doing enough research on cultural factors in clinical psychology in Europe and elsewhere?*

There are very important cross-cultural differences with respect to clinical phenomena. Examples for this include the much better long-term outcome of psychosis in Third World countries, the much higher proportion of the burden of disease due to depression in Western societies or the epidemic of medication induced drug dependence in industrialized countries. All of these effects stand in strong contrast to the much higher financial investment in mental health care in industrialized countries, especially into drug treatments. And yet, very little effort is made towards a better understanding of these large cross-cultural effects. This is at least partly due to fashions that affect science just as other fields of human activity. Half a century ago we attributed mental health problems much more on social factors, today we focus on individual factors and lately these are primarily construed as biological and genetic. Funding for psychosocial research is much more difficult to obtain than for biomedical studies. This contrasts with the fact that there is much more evidence for a strong influence of social factors on most mental health problems than for an influence of specific biological and genetic factors. Culture is a prime example of social factors and cross-cultural research thus offers a great way of studying social factors. Moreover, we live in an increasingly global age and need to realize that psychology and psychotherapy cannot be based almost exclusively on studies in North America and Western Europe, typically done in psychology undergraduates and with a heavy Anglo-Saxon emphasis. It is remarkable that the typical study in major psychology journals makes universal claims but is almost never backed by cross-cultural data. Less than 2% of

psychological studies claiming universal validity are supported by cross-cultural data, and even in the Journal of Cross-Cultural Psychology this is true for less than 20% of publications! These figures clearly show that we do not do enough research on cultural factors in Europe and North America. As the cultural psychologist Qi Wang has recently stated in the APS Observer (VOLUME 30, ISSUE 1, JANUARY 2017, see https://www.psychologicalscience.org/observer/five-myths-about-the-role-of-culture-in-psychological-research) "a cultural psychological perspective helps us recognize, reduce, and eliminate biases, uncover new mechanisms and develop new theories, and understand human cogni-tion and behavior as a constructive process that takes place in the interaction be-tween a person and her or his environment."

As you acknowledged in your writings, exposure therapy has proven success¬ful in clinical psychology. Still, you decided that much needs to be done in this area. What led you to focus on exposure therapy in your research?

At the university I received basic training in both client-centered therapy and CBT. When I then started to work at the Palo Alto VA Hospital with schizophrenic, severely depressed and agoraphobic patients back in 1983, I quickly realized the lim-its of the client-centered approach and the value of CBT, especially exposure and cog-nitive approaches. A few years later, after having returned to Germany, my own sub-sequent work underlined the relevance of exposure in treating not only anxiety and especially with respect to long-term stability or even further improvement of out-comes after the end of treatment. Exposure is the best-known active ingredient in psychological treatments. In my opinion, this means that understanding its underly-ing processes offers us the most promising opportunity for really advancing our knowledge of helping and healing processes. And in spite of all its successes, there is still room for improvement.

At the IX International CP Congress, you plan to talk about the Triple E, and so I don't want to spoil your presentation. However, was this a concept you developed? Without getting into much detail, what are some of the major clinical implications of your work?

Over the years, it has become increasingly clear that extinction learning is a core active ingredient of exposure. In addition, my team was able to show as early as 2007 that patients with Panic Disorder or Post-Traumatic Stress Disorder are characterized by delayed extinction even in standard fear conditioning paradigms without disorder-specific stimuli. Unfortunately, most research in Clinical Psychology is correlational with respect to the disorder variable, i.e. we

typically do not manipulate the disorder experimentally. This is to a large part due to ethical limitations, to another part due to practical limitations. In order to draw causal inferences about the etiology and treatment of clinically relevant disorders, however, we need to conduct true experiments. Systematically enhancing exposure and extinction offers a scientifically promising and ethically justified pathway to a mechanistic understanding of lasting therapeutic change. For instance, we were recently able to show that enhancing self-efficacy leads to better extinction in standard fear conditioning. This is true not only for subjective measures, but also for the classic psychophysiological measure of fear extinction, namely electrodermal activity which directly reflects sympathetic nervous activity. Together with other studies, our work has clinical implications: Patients benefit most from an optimal rather than a maximal treatment. Focusing treatment underscores the relevant points and generates a better signal-to-noise ratio in treatment contents. In the treatment of anxiety problems, exposure and extinction should be the focus of therapy. Focusing on these facilitates patient self-efficacy and empowers them for effective coping. Together with the results of augmentation experiments, long-term follow-up studies support the relevance of measures aimed at increasing inhibition learning, context generalization and self-efficacy. Optimal therapy then shares a basic point with good cuisine: The best result is not achieved by adding more and more good ingredients and cooking them longer and longer, but rather by the optimal combination of a limited number of well-matched ingredients that are cooked to the minute.

CLINICAL GUIDELINES AND SCIENTIFIC EVIDENCE

John C. Norcross and Gualberto Buela-Casal

John C. Norcross is a Distinguished Professor of Psychology at the University of Scranton and Clinical Professor of Psychiatry at SUNY Upstate Medical University (USA). He is a past president of several practice divisions of the American Psychological Association (APA). He is one of the most influential scientists in the world according to the Stanford University Ranking.

Gualberto Buela-Casal is a Professor of Clinical Psychology at the University of Granada (Spain). Founder of the Professorship of Sleep Research at the University of Granada. President of the Asociación Española de Psicología Conductual (AEPC). He is one of the most influential scientists in the world according to the Stanford University Ranking.

**I do not know if you will agree with us that we are at a crucial moment for the field of psychotherapy. On the one hand, a cycle of confrontation between schools seems to be closing, but not completely, and no other better or more integrative alternative has emerged. On the other hand, the implementation of clinical psychology in public and private health systems, where psychiatry and its reductionist biomedical approach are clearly showing their limits, is becoming more and more widespread. This situation creates great interest in psychotherapy and its potential contribution to the improvement of health and well-being. Do you think we are at a particularly important moment in the field of psychotherapy?*

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What do you think are the most salient features that define this current moment in psychotherapy?

This is a crucial moment for the discipline of psychotherapy. You have correctly linked the conflicting forces. Globally, the use of psychotherapy has increased, the outcome research is extensive and compelling, and it is entering the mainstream of medical care. Undoubtedly, psychotherapy is now considered effective, safe, and health-promoting. Also, the misleading distinction between mind and body, mental health, and physical health, is disappearing. On the other hand, pharmacotherapy has expanded at the expense of psychotherapy. Taking a pill is often quicker, cheaper, and less stigmatizing, and provides a short-term solution compared to psychotherapeutic intervention. However, research shows that psychotherapy is more cost-effective in the long term. In this regard, we should direct our efforts to the promotion of our profession, of psychotherapy and, sometimes, of combined therapy (psychotherapy plus pharmacotherapy). The only part of your summary with which I disagree is the part about integration in psychotherapy. Such integration is the normal route that any mature profession would follow, and, in most countries, integration or eclecticism represents the predominant orientation. In fact, integration in psychotherapy has shown a high differential efficacy compared to other independent schools. Therefore, in my opinion, integrative alternatives are more effective and comprehensive. While our discussion so far has focused on psychotherapy, we should not forget that clinical psychologists provide much more than this wonderful service. Among mental health professionals, psychologists are trained to apply psychological tests -neuropsychological, personality, health, learning disability, etc.-, as well as to conduct empirical research, teach and supervise, develop programs, and the like. We are much more than the simple generic term "therapists".

The struggle between schools is part of the teaching and practice of psychotherapy. However, there seems to be considerable evidence that many types of psychotherapy achieve similar results for different mental disorders or problems. The idea that arises from this evidence is that there are universal, non-specific mechanisms that account for these results. Much of the literature supports this idea. However, clinical guidelines continue to prioritize certain forms of psychotherapy and do not mention common mechanisms. In this regard, what would you say to Pim Cuijpers when he states in an article published in 2013 that "therapies, not mechanisms, deserve a section in treatment guidelines"?

It is a cruel irony. Most clinical guidelines do not follow the scientific evidence! A sad review of 50 years of research shows that the success of therapy is due to the following factors, in the following order: the patient, the therapeutic relationship,

the individual therapist, and the specific methods used. The latter accounts for only 5 to 10% of the variance in outcomes. However, the large volume of guidelines focuses on specific treatment techniques and ignores more consequential factors. This is precisely why we decided to create an intradivisional task force of the *American Psychological Association* (APA) aimed at determining what relationship behaviors and adaptive treatments work. I am confident that the next generation of clinical guidelines will have an evidence base and will include, for the most part, therapist-relationship behaviors and therapeutic adaptations that take into account the whole person, not just the diagnosis.

I would raise two other points here. First, while we agree that there is ample evidence that most psychotherapies produce similar results for most disorders, there are clinically important exceptions. For example, some form of exposure for severe anxiety disorders, conjoint therapy for relationship dysfunction, cognitive-behavioral therapy for panic disorders, and insight therapies for clients seeking self-awareness. Second, most of the comparative outcome research refers to particular mental disorders, as opposed to transdiagnostic patient characteristics. There are, of course, treatments of choice for different stages of change, levels of reactance, different cultures, patient preferences, and coping styles. We should therefore be cautious about claiming that everything works equally well for everyone.

> *Returning to the mechanisms common to all successful psychotherapies, one of them seems to be the therapeutic relationship. Establishing a therapeutic bond seems to be essential to the success of therapy. However, there is research that supports the efficacy of "forced" therapies with adolescents in the field of drug use, in which control is sought rather than rapport. There are also "distant" interventions in which there is no contact with the therapist. You yourself are the author of an important self-help book. How do these findings fit with the idea that the quality of the therapeutic relationship is an essential part of treatment?*

The therapeutic relationship has a large and compelling body of research to support it. Of course, there will be exceptions among the thousands of process and outcome studies. However, meta-analytic research generally demonstrates that confrontation is discredited. In a review of a dozen randomized clinical trials for the treatment of addictions, confrontation showed no results or negative results in all trials. Nevertheless, it should be noted that there are urgent clinical situations that require involuntary treatment to protect a person from suicidal or homicidal behavior. However, beyond saving a life or averting an immediate crisis, there are generally fewer long-term benefits when a person is "forced" into psychotherapy. In fact, accumulated evidence shows that precontemplators who are forced into therapy often drop out prematurely

and are less successful. As for computerized interventions, I attribute their generally positive outcomes to an implicit but powerful relationship. There is no distant intervention without a relationship (involving empathy, support, cooperation, self-disclosure, etc.). Program developers are well aware of the important power of the relationship and intentionally build these elements into their psychoeducational and therapeutic modules. Otherwise, distance and self-help therapies would consist largely of checklists or encyclopedic articles. Psychotherapy is, at its core, a human relationship. Even when "delivered" at a distance or by computer, psychotherapy is an irreducibly human encounter.

> *The "great debate" between empirically supported techniques and therapeutic relationships has been raised in psychotherapy. Those who emphasize the power of techniques do not fail to recognize the importance of relationships in their functioning, but don't working relationships themselves imply a technique, a "know-how"? Or are we simply talking about a good relationship that anyone with empathy and common sense could apply without further psychotherapeutic training? To what extent is the debate about techniques and relationships artificial?*

For historical and research purposes, the field has distinguished between relationships and techniques. Words such as "relationship" and "interpersonal behavior" are used to describe how the therapist and client act toward each other. By contrast, the terms "technique" or "method" are used to describe what the therapist does. We often treat the "how" and the "what" (the relationship and the method, the interpersonal and the intervention) as separate categories. In reality, of course, what is done and how it is done are complementary and inseparable. In other words, the value of a treatment method is inextricably linked to the relational context in which it is applied. Hans Strupp, one of my early research mentors, offered an analogy to illustrate the inseparability of these constituent elements. Suppose you want your teenager to clean his room. Two methods of achieving this goal would be to set clear rules and to state possible consequences; this would be a reasonable approach, but the effectiveness of these two evidence-based methods will vary depending on whether the relationship between you and the adolescent is characterized by warmth and mutual respect or by anger and distrust. This does not mean that the methods are useless, but simply that how well they work depends on the context in which they are used. As for the other question, is psychotherapy trivialized by characterizing it as "just a good relationship with a caregiver"? Research shows that an effective psychotherapist employs specific methods, builds strong relationships, and personalizes both the treatment methods and the nature of the relationship to the individual characteristics of the client in his or her context. This requires considerable training, self-awareness, and

experience, which is the antithesis of "anyone with common sense and empathy" can do psychotherapy well.

> *Regarding transdiagnostic treatment as an alternative to specific treatments, there is a proliferation of "unified protocols" that seem to increase the number of psychotherapies instead of unifying them properly. Do you think there is a solution to the plurality of psychotherapeutic approaches that populate clinical psychology? Since Prochaska and DiClemente's transtheoretical model, as well as yours, is one of the first and most important proposals in this sense, you will see that it is only one among others. Why doesn't the scientific community adopt this model, since it integrates the most effective processes of the different theoretical approaches?*

I often laugh out loud when people present transdiagnostic treatments as "new" when in fact they have been around for about 40 years. Thank you for your kind words about the transtheoretical model. It is supported by 40 years of research and thousands of studies conducted worldwide. The transtheoretical model is one solution for integration, but it is certainly not the only one. While a single coherent universe would be more desirable, clinical evidence points to the existence of multiverses. There are many paths to integration (technical eclecticism, theoretical integration, common factors, assimilative integration), and each brings something unique and valuable to clinical practice. The mental health, behavioral medicine, and public health scientific communities have widely embraced the transtheoretical model. Its extensive evidence base, effective sequence of stages, proactive population outreach, and flexible formats (in-person therapy, telephone counseling, software, etc.) have attracted a large and loyal following around the world. Finally, while it would be most remarkable to have a single grand unifying theory of psychotherapy, it is not yet clinically or empirically possible. Human beings are infinitely more complex and indeterminate than the contents of physics or chemistry. For now, we will have to be content with evidence-based pluralism and various avenues of integration.

MINI BRAINS: APPLICATIONS FOR CLINICAL PSYCHOLOGY AND ETHICAL CONSIDERATIONS

Oscar F. Gonçalves and Wenceslao Peñate

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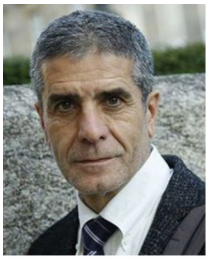

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**Going directly into the topic of your conference (Mini brains: implications for Clinical Psychology and ethical considerations), the topic is as intriguing as it is stimulating. What are mini brains?*

Brain organoids, known as mini-brains, are in vitro individualized 3-D models of the brain, derived from cultures of human pluripotent stem cells. Summarizing in few words what it is a complex technological process, we can say that mini brains can be generated from an individual biological sample.

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From that sample, we can in the lab, induce pluripotent stem cells. During the course of several weeks, these progenitor cells give rise to neurons and later neuronal networks, recapitulating brain development.

Does this mean that they are 'representative' brains of the original brain, and also capable of accurately representing brain connectivity?

These mini brains are miniature models of the human brain, not real brains per se. A good metaphor is to state that brain organoids are for the human brain as a sophisticated train electric toy is for the actual train. Most of the structures and functions are there, but they are miniatures. The average 15 centimeters length of the human brain is miniaturized into a 4-mm-diameter size mini-brain, and 100 billion cells are reduced to 2 million mini-brain cells. However, it is important to note that mini brains are able to express a diversity of brain regions (forebrain, midbrain, hindbrain) with already a rudimentary cortical differentiation into, for instance, sensorial and cortical regions. Madeline Lancaster published in Nature in 2013 the first paper describing how cerebral organoids can be effective in mimicking human brain development (Lancaster et al., 2013). Since then, the field has increased in research sophistication combining the potentialities of self-organizing cultures with bioengineering tools in order to generate specific brain structures and modeling its functioning (Lancaster et al., 2017). After the initial technological sophistication, mini-brain research is moving fast to mimic brain structure and functioning in both, normal and abnormal conditions.

A relevant aspect is the ethical implications...

As I just mentioned, the research is moving fast and the methods are increasing in sophistication, suggesting that mini brains are able to establish self-organized patterns of activity. They seem to gain a life on their own; and because we are, in this case, talking about the brain, this life may be, in the limit, a psychological life. It may very well be the case that brain organoid researchers will start experiencing soon, the paradox of having found a dreaming tool that may turn into a nightmare. As in Mary Shelley's novel, we may soon feel like in Dr. Victor Frankenstein experiment: creating a sapient but a hideous uncontrolled creature. This outstanding scientific advancement started already raising some ethical concerns among the scientific community, are we about developing a sentient organoid with not only sensory but also cognitive dimensions? Can brain organoids in the near future start evidencing consciousness? These are, indeed, important ethical questions that psychologists are called to address. At the end of the day that's up to us, up as psychologist, to come with new methods

to study if mini brains have internal sentient states, and as such defining the potentialities and limits of cerebral organoid research.

Undoubtedly, minibrains represent a very significant advance in basic research. To what extent do you think neuropsychology and clinical psychology can benefit from this research resource?

I believe that mini brains are challenging the frontiers of clinical psychology research. Mini brains are opening new windows for clinical psychology with the opportunity to study the system as well as cellular and molecular mechanisms associated with different psychological and brain disorders. We can find important breakthroughs already in mini-brain research modeling conditions such Autism Spectrum Disorders to Alzheimer's Dementia. The most interesting thing is that we can develop specific models within each disorder. For instance, in OCD, an area where I've been researching, it would be possible in the near future to come up with mini brains clustered along different OCD subtypes (e.g., checkers, cleaners, hoarders, etc.) and to characterize them from the molecular to the system levels. We can even move further and develop individualized brain models for a specific patient. This would be instrumental in overcoming some of the limitations of our current psychiatry diagnostic systems and opening the door to design individualized treatments previously modeled in the organoid "dish". That is, mini brains open the door for personalized treatments by modeling the mechanism of different clinical interventions and its effects on plasticity (e.g., epigenetic level) or regeneration (e.g., systems level). Of course, this would be more immediate for pharmacological intervention. However, given that we are progressively moving into proto-sentient mini-brains, psychologists are challenged to come up with "in vitro" models of psychological therapies.

Another topic within your interests in cognitive neuroscience is the use of Virtual Reality and its application in clinical settings. In this regard, could you tell us what his research group is working on?

Exactly. Let me now briefly move from "in vitro" to "in virtuo" therapies. As you are guessing, there is a continuity in this process with the overall aim of moving into more science-based treatments. I believe that psychotherapy needs to move from just an empirical based approach to a science-based approach. Neuroimaging research from our team suggests that OCD difficulties in cognitive regulatory control result from an emotional imbalance between a hyperactive defensive system (e.g., threat) and a hypoactive appetitive system (e.g., pleasure). Clinically, were researching more effective ways for improving regulatory control (inhibitory/excitatory) while restoring the balance between the defensive and appetitive systems. In the process, we are developing a virtual

reality (in virtuo) closed-loop human-machine interaction platform – NoOCD City - for improving autonomic and cognitive regulatory control in response to triggers of defensive (threat stimuli-inhibitory regulation) and appetitive systems (pleasant stimuli-excitatory regulation). NoOCD City was awarded in the 2018 Bial Award of Clinical Medicine and is now a top 10 finalists in the Roche pharmaceutics' Open Innovation competition: Building Tomorrow Together.

> *We are finishing the interview. I would now like to know a little about your academic life, which is as exciting as mini brains. For some time now you have been combining your time in Europe with your stay at prestigious research centers and universities in the USA and Brazil, where you lead and have leaded powerful psychology departments. How do you adapt to such an intense work pace?*

It has been both exciting and fun. I was led to move back and forth across continents very early in my career. In 1983 I got a Fulbright Award to pursue my Doctorate in the USA. I ended up graduating from the University of Massachusetts in Amherst. Then took a faculty position at the University of California Santa Barbara when Michael Mahoney was still there. I moved back to Portugal, invited to help in launching a new psychology program at the University of Minho. In few years we went from being the "new kids" in the block to the top psychology program in Portugal. Along the way I decided to pursue my studies and went, first, to the Faculty of Sciences (University of Vigo) to complete a DEA in Biology-Neurosciences and later a Doctorate in Neurosciences at the Faculty of Medicine (University of Santiago de Compostela). In the process, I moved from clinical to clinical-neurosciences research establishing the Neuropsychophysiology Lab at the University of Minho (now "Psychological neurosciences lab"). Few years ago, I went back to USA as a chair of Applied Psychology at Northeastern University in Boston and holding a research position at Neuromodulation Center from the Spaulding Rehabilitation Hospital, Harvard Medical School. Now I'm back to Portugal, maintaining my research appointment in Boston and about doing a new move to another university and starting a new research program that will help in this translation from the bench (e.g., mini brains) to the bed side (e.g., clinical treatments). These are just some snapshots illustrating what has been probably the central leitmotiv of my academic life: leading change and networking across cultures and knowledge domains, from in vivo, to in vitro and in virtuo contexts bringing together the clinic, science and technological advances.

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NEUROPSYCHOLOGY AS A HEALTH SPECIALIZATION

Antonio Puente and Gualberto Buela-Casal

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Gualberto Buela-Casal is a Professor of Clinical Psychology at the University of Granada (Spain). Founder of the Professorship of Sleep Research at the University of Granada. President of the Asociación Española de Psicología Conductual (AEPC). He is one of the most influential scientists in the world according to the Stanford University Ranking.

**It was a pleasure for me when the result of the final vote in which you were elected President of the American Psychological Association (APA) was announced, and for several reasons. We have known each other for decades, when you were a visiting professor at a postgraduate program organized by the Asociación Española de Psicología Conductual in the city of Granada, where you taught clinical neuropsychology. In addition, you were a visiting professor at the University of Granada. On the other hand, it is a very positive thing that a psychologist of Hispanic origin*

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becomes president of the APA, being the only one to date, in an association with more than one hundred years of history.

Yes, I think we have known each other since 1988. I have visited the University of Granada almost every year, including this year and next. For many years I taught courses in neuropsychology, but lately I have been sitting on dissertation committees, often as chair. I have also had about ten students from the university as fellows. Several of them are now professors at the University of Granada. I consider the University and Granada as my second home.

Tell us why and when you decided to specialize in neuropsychology, as this is a discipline that is not usually in high demand by psychology students.

As an emigrant from Cuba, I have always been interested in analyzing how some people adapt, and others do not. For many years I observed family, friends, and others struggling with cognitive and emotional processes. During my early years at university, I began to think that perhaps it was the brain that directed and controlled these processes. I dedicated myself to studying the problem in a serious and systematic way. During those years, I had the great opportunity to study with Roger W. Sperry, the first psychologist to receive a Nobel Prize (Medicine, 1981) for his work on the cerebral hemispheres. Later, I also studied with Luria's group in Moscow. I continued to work in the lab and have spent nearly 25 years archiving and writing Sperry's story.

What training and professional qualifications does a neuropsychologist need to have to practice in the United States? Is it necessary to have a Ph.D. in psychology? Is it considered a health profession? Are there differences from one state to the next? How many years of training does a psychologist need to practice clinical neuropsychology?

Clinical neuropsychology is one of the oldest specialties in psychology and one of the six oldest specialties, starting in 1996. I was one of the members of the board that developed what the specialty was at its inception. Of course, it has changed tremendously and continues to do so. First, you need a license, which is required after a Ph.D. and two years of training in clinical processes, mostly focusing on diagnosis. To obtain the license, one must pass a standardized written and oral examination. In addition, you must have formal clinical training to be accredited in the discipline. During this process, you must pass a written neuropsychology exam, present a case, and defend it orally before a committee. We have about five thousand neuropsychologists in the United States of America and about 10% are certified. Personally, I am

certified in general neuropsychology and in child neuropsychology. In total, it's around ten years of university (to the end of the Ph.D.) and then one year of general clinical and two more years of clinical neuropsychology. And yes, it is a health profession, but also an academic and scientific one. It is the largest of the psychology specialties.

> *As a connoisseur of psychology in Spain, you know that clinical neuropsychology does not currently exist in this country as a profession or as an academic field. In the university context, some subjects are taught in the field of clinical psychology. In the professional field, it can be practiced in the public health system only by those who have the title of Health Specialist in Clinical Psychology. And in the private sector, only those psychologists who are considered health professionals, either through accreditation or through the Master's Degree in General Health Psychology, which enables psychologists to work in the private sector. In fact, the Consejo General de la Psicología de España has recently created the accreditation of Expert in Clinical Neuropsychology, for which it is necessary to be considered a healthcare professional beforehand. Tell me, how do you see the situation of clinical neuropsychology in Spain? Is it very different from other countries? What advice could you give to improve it, or do you think it is well established as it is?*

The model that exists in Spain exists in Latin America, but not in other countries. In Russia, for example, the system is more like that of the United States of America. It seems to me that in a country with such a large population, it does not make sense to have only health psychologists within such a small system as the Psicólogos Internos Residentes (PIR). The PIR needs to grow, or neuropsychology needs to be developed as a specialty within the Colegio de Psicólogos. There is too much need and not enough staff.

> *Now let's focus on the APA. In other interviews with past presidents (Alan Kazdin, Suzanne Bennett, Nadine J. Kaslow, or Susan H. McDaniel), we have asked them some questions that I would like to share with you. The first has to do with the profile that an APA president should have: is it better for them to be an academic/researcher or a psychology professional, or a mixed profile, as in your case, a professional and a researcher? APA has had presidents with these three profiles; what do you think is best?*

We have had two types of presidents: academics with a very broad curriculum like Kazdin and others more clinical like Anton. It is not typical to have one who is both clinical and academic at the same time. The fascinating thing about APA

is that we have more than 50 divisions or areas of psychology, from humanistic and psychoanalytic to experimental and educational; other areas in which only training is given, plus there are those who see patients and those who do research with rats. In all of this we also have the politician who is dedicated to the development of the field and the profession of psychologist, like De León. In my case, I have tried to fulfill the three fields: academic, clinical, and political. I am very fortunate to be able to do all three at such a time of great change in society and in APA.

> *ICD-11 is scheduled to be published in 2018; in fact, Geoffrey M. Reed, Director of the Classification of Mental and Behavioral Disorders at the World Health Organization (WHO), will give a lecture at this congress announcing the main changes in the new version. Do you think psychologists should use the DSM or the ICD? I know you will be able to tell me that if they want to, they should use neither; however, there are cases in which it is necessary to make diagnoses according to an international classification, so in your opinion, which system do you recommend to use and why?*

The DSM is a system that describes mental disorders, while the ICD is a diagnostic system. The DSM is a small part of the ICD. In the United States of America, the DSM is used as something that helps or supports the ICD. Insurance companies and the government system prevent the use of the DSM, although it is still used by people who work only with mental disorders. In neuropsychology, the ICD has historically been used, largely because the disorders of interest to us are health disorders, not just mental disorders.

> *Finally, as you know, the Consejo General de la Psicología de España is the second largest professional psychology society in the world, after the APA. I know that the past presidents of APA have had several contacts and collaboration plans with the Consejo. I believe that now, since you are a good connoisseur of Spanish psychology, a greater collaboration can be consolidated. What are your plans for academic and/or professional collaboration?*

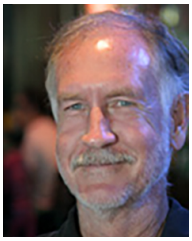
It is true that we are the two largest and perhaps the two most important societies. For now, my interest is to have a good relationship, the best possible relationship, between the two societies. At the same time, I would love to collaborate more in whatever way I can. Perhaps the first step would be to see how we can have a health system for psychologists that is more universal.

I do not want to take up any more of your time, at the congress in Santiago de Compostela the participants will be able to talk with you informally in the "hour of conversation with A. Puente". I do not know if you have anything else to add, for my part I thank you for your collaboration and I will see you in Santiago de Compostela.

I would like to tell you that the future of psychology will have to include not only our countries, but also a universal psychology that has the local as its focus. At the moment, we have developed a psychology that has had a great impact only in developed countries and with processes that are affected by culture. It would be interesting in the future to dedicate ourselves to a more global psychology, without losing the important thing that defines who we are within a more national framework. There is much to discover and much more to apply to a world that is becoming more complicated and interesting every day.

FUNCTIONAL ANALYSIS OF BEHAVIOR

Stephen N. Haynes and Juan Carlos Sierra



Stephen N. Haynes is Emeritus Professor of Psychology at the University of Hawaii at Mānoa, United States of America. He has published 10 books and 150 articles, mostly on clinical assessment, was Editor of the American Psychological Association Journal Psychological Assessment, has been a member of several editorial boards, and is an Honorary Member of the Spanish Association of Behavioral Psychology (AEPC).

Juan Carlos Sierra is a Professor of Psychological Assessment and Human Sexuality at the University of Granada (Spain). Director of the Human Sexuality Laboratory at the Mind, Brain, and Behavior Research Center in Granada. Editor of the International Journal of Clinical and Health Psychology since its foundation until 2021.

**Your presentation at the VI International Congress of Clinical Psychology in Spain focused on clinical case formulation and you proposed the functional behavior analysis as the most effective approach to understanding and treating a client's behavior problems. What is functional behavior analysis and why do you recommend it?*

Good question! Answering it would require an entire book. I will try to reduce my answer to a few paragraphs. First, this assessment and treatment strategy is also known as functional analysis and functional behavioral assessment.

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These terms have been used interchangeably and defined in many ways. The term "functional analysis" was introduced by B.F. Skinner in the 1950s. Hanley et al. (2003), in a comprehensive review, defined functional analysis as "the identification of variables that influence the occurrence of behavior problems" (p. 147). We defined it in our 2011 books (with Drs. Willian H. O'Brien, Joseph Keaweʻaimoku Kaholokula, and Antonio Godoy) Behavioral Assessment and Case Formulation and our 2019 book (with Drs. John Hunsley and Greg Smith) Scientific Foundations of Clinical Assessment as the identification of important, controllable, causal and noncausal functional relations relevant to specified behaviors for an individual. The term "functional behavioral assessment" includes functional analysis but encompasses a wider array of assessment strategies, as we can discuss later.

We know from thousands of studies that many clients who seek help have multiple behavior problems and that these problems can differ in their importance to the client. Further, a client's problems can affect each other in complex ways – consider how the intensity, duration, and frequency of a client's anxiety or depressive symptoms can affect, and be affected by, the client's social relationships, sleep, life stressors, substance use and many other factors. Making it even more challenging for the clinician's clinical assessment and intervention decisions, each of a client's multiple behavior problems can be affected by multiple casual factors that can vary in their strength across time and settings and also interact in complex ways. Importantly for a clinician's assessment and intervention strategies, there can be important differences between clients in the characteristics of similar behavior problems, the causal relations that affect them, and in the contexts in which they occur.

These individual differences emphasize the challenges in clinical assessment and in selecting the best interventions to help a client. The clinician is often faced with difficult decisions – "how can I best help this person." This clinical decision-making challenge emphasizes the importance of a pre-treatment, individualized functional behavioral assessment to select the interventions that would most likely help the client achieve their goals enhance their quality of life (the term "client" can refer to individuals, couples, families, groups, or organizations).

The outcome of a functional behavioral assessment is an integration of these complex behaviors, events, and functional relations into a behavioral clinical case formulation. The process of developing a behavioral clinical case formulation using evidence-based assessment strategies is discussed at length in our 2011 books and in books by Sturmey and Tarrier (e.g., Clinical Case Formulation; Case Formulation…).

In our books, we promote the utility of Functional Analytic Clinical Case Causal Diagrams (we abbreviate this to "FACCD") as a way to visually organize

and communicate about a client's behavior problems, goals, and associated functional relations – the clinical case formulation. The overall goal of a FACCD is to guide the clinician's intervention efforts with the client. There are also many nonbehavioral models for clinical case formulation (see books by Eells), but they are often less evidence-based than those associated with behavioral analysis and behavioral assessment.

Interventions that are not guided by the outcome of a functional behavioral assessment, for example, those that are guided only by a psychiatric diagnosis or only by a clinician's personal biases, may not be optimally effective because they may miss important characteristics of the client, target less important functional relations, and ignore more important functional relations that influence the client's behavior problems and goals.

The benefit of a functional behavioral assessment is strongly supported in a research review article by Hurl and others in 2016 that found significantly better outcomes for interventions based on, compared to interventions not based on, a pre-intervention functional behavioral assessment.

As you can see, the challenge for clinicians in making the best intervention decisions is that behavioral problems and their causes are complex, dynamic, setting-specific, and vary across persons. It is particularly challenging for clinicians to collect and integrate this large amount of assessment information, integrate it with extant research, and then to select the best intervention for their clients. It is at this point where the behavioral case formulation provides a strong guide.

> *We know that in addition to the functional analysis of behavior, there are other behavioral models for clinical case formulation. For example, the one based on the Problem Solving strategy of Nezu and Nezu or Linehan's Dialectical-Behavioral Therapy. Would these share some of their principles with functional behavioral assessment? Could you tell us what are the advantages of functional behavior analysis compared to these other approaches?*

All behavioral models of clinical case formulation share some important assets. They emphasize: (a) the importance of a comprehensive, evidence-based pre-intervention assessment, (b) the uniqueness and individuality of each client, (c) the importance of clearly identifying and specifying a client's behavior problems and goals and the factors that influence them, (d) that clients often have multiple behavior problems, and (e) that behavior problems and causal variables can be multimodal; that is, they can involve behaviors, cognitions, social and environmental and health-related factors that can have complex interactions. They particularly stress the importance of a behavioral

science-grounded case formulation to help select the best interventions to help a client reduce their problems and achieve their goals.

As we discuss in our books, chapters, and articles, functional behavioral assessment strategies include these important attributes and emphasize additional aspects of a client's behavior problems and goals – all designed to help a clinician better understand a client and select the best ways to help them with their problems and goals. Some additional foci of a functional behavioral assessment include (a) identifying which of the client's behavior problems and goals are most important to the client and which of the multiple causal variables most strongly influence them, (b) identifying how a client's behavior problems can interact and influence each other in important and complex ways, (c) specifying the unidirectional, bidirectional, linear or nonlinear, nature of causal relations, (d) recognizing that behavior problems, goals, and causal relations and can change over time, (e) estimating the degree to which causal variables can be modified, that is, their "clinical utility," (f) identifying the multiple paths through which behavior problems and causal variables can influence each other, (g) identifying the variables that moderate or mediate causal relations for a client, and (h) recognizing that causal relations for a client's behavior problems and goals can be conditional – they can vary across settings and contexts.

> *As you noted earlier in our discussion, one of your contributions to this field is the proposal of Functional Analytical Clinical Case Diagrams, FACCD, to help organize, describe, and communicate about the outcome of a functional behavioral assessment. Could you briefly describe what this methodology consists of and how useful it is for the clinician?*

Thank you for asking this question -- this is one of my favorite topics. The FACCD is a way to visually integrate and communicate all those complex aspects of a functional behavioral assessment, the behavioral clinical case formulation, that I mentioned earlier. The challenge for the clinician is how to organize and communicate those complex behavioral assessment-based judgments to others, how to explain your treatment suggestions to the client so that they understand the rationale for the proposed intervention, and how to integrate all these data to make the best treatment decisions for a client. Our recommended strategy is to present the results of the clinical assessment in a visual causal diagram, the FACCD, to integrate and communicate complex information.

There are hundreds of examples of causal diagrams in many fields, such as economics, physics, medicine, and sociology. We describe the construction of FACCDs in our books. Articles with Drs. O'Brien, Godoy, and Fries also discuss ways to mathematically analyze the causal paths in a FACCD to identify the most important causal relations associated with a client's behavior problems and goals.

In you Conference presentation you emphasized the use of FACCDs for complex cases. Does this mean that you recommend FACCD only in certain types of clinical cases or do you think it is a useful tool for all clients?

Another good question! Although it may seem surprising to you because I have been promoting functional behavioral assessment and FACCDs for many years, a formal behavioral clinical case formulation may not always be the first and best way to help a client. The problem with all clinical case formulation strategies is that they are time consuming and can delay the start of an intervention. If your client comes to you hoping that you can quickly help with a well-defined and circumscribed behavior problem such as depressed mood, autism spectrum problems, panic episodes, or relationship difficulties, why not attempt to help them with an evidence-based intervention, if one is available, rather than delaying treatment and spending additional hours constructing a complex case formulation? Of course, a behavioral assessment is still necessary to define and specify a problem or goal, even if it is limited.

Pre-treatment behavioral assessments and case formulations are especially important in four situations: (a) with complex cases in which clients are experiencing multiple, important, and complexly interrelated behavioral problems, (b) when there multiple problems and it is difficult to decide where to initially focus an intervention to best help the client, (c) when a well-established, empirically supported, and standardized intervention program has failed for a client, and (d) when the goal is to teach students or clinicians to think carefully and critically about their clients and promote evidence-based assessment and case formulation strategies.

In reference to "c" above, when a client is first referred to an empirically supported intervention program, the clinician should carefully monitor its effects to evaluate if the intervention is effective after several sessions. If the treatment does not seem to help a client, there may be a mismatch between the treatment mechanisms, the causal relations addressed in the treatment. and the causal relations that are affecting the client. Of course, this assumes that the therapy has been applied correctly. In the case of therapy that is not helping a client, a more intensive behavioral assessment and clinical case formulation is necessary to identify additional causal relations that may be operating for the client's problems or goals.

We start from the assumption that human behavior can be very complex, but some of the FACCDs that appear in publications give the impression that we are dealing with a complex assessment methodology. Is this a methodology that any clinician can put into practice or is training required to be a good functional analyst and successfully construct FACCDs?

The cases I present in my books and other publications meet the conditions I just mentioned: They are complex cases that have not been successfully treated. As I commented earlier, conducting a functional behavioral assessment can be difficult and takes time. With these demanding cases I have spent many hours collecting data from many sources using multiple methods and sometimes I am still unsure about the client's specific problems and the causal relations associated with them.

A valid and clinically useful functional behavioral assessment requires a science-oriented well-trained clinical assessor. First, the clinician must understand psychometric principles of assessment and measurement and rely on empirically supported methods of assessment. Second, the clinician must focus more on identifying important functional relations relevant to their client's behavior problems and goals than on the client's psychiatric diagnosis. Third, the clinician must be sensitive to the importance of the client's dimensions of individual differences, such as their sex and gender, age, ethnicity, economic status, religion, disability, sexual orientation, and life circumstances. Dr. Kaholokula, Junko Tanaka-Matsu and I wrote a chapter that emphasized the importance of sensitivity to diverse cultures in clinical assessment. Fourth, integrating these data into a meaningful clinical case formulation requires careful critical judgments. Finally, to conduct a valid and useful functional behavioral assessment, a clinician must be a good interviewer and observer of human behavior, be familiar with multiple methods of evidence-based assessment, know the relevant literature relevant to the client's behavioral problems and goals, and understand evidence-based interventions and how they work.

In sum, acquiring valid and useful data from a functional behavioral assessment and integrating it with extant clinical research into a behavioral clinical case formulation, and FACCD, is major challenge for any clinician. It takes lots of training and a strong commitment to applying evidence-based assessment and treatment strategies!

> *As you have noted in your books and other publications, the success or failure of a functional analysis, that is the degree to which it leads to valid and clinically useful information, is strongly influenced by the validity of the measures used in the clinical assessment. Traditionally, the functional analysis has emphasized careful observation under controlled environments, such as in A-B-A-B designs. Are there other assessment methods that would be useful in developing a functional analysis of complex cases?*

Yes. Behavioral assessment offers the most effective paradigm to guide clinical evaluation. It is a strongly evidence-based approach that include many methods

in addition to structured analog and naturalistic behavioral observations. As we review in our books, functional behavioral assessment can also include interviews, self-monitoring, momentary ecological monitoring in the natural environment, self- and other-report questionnaires, and psychophysiological and cognitive assessment methods. The most important requirement for an assessment method and instrument is that it be psychometrically sound and help to identify important functional relations associated with the client's behavior problems and goals.

In my clinical assessments, I use behavioral interviews and self-report questionnaires with almost all clients, along with self-monitoring and behavioral observation in analogue and natural situations. Of course, behavioral assessment, compared to other assessment strategies, focuses more on behavioral interactions, functional/causal relations, environments, situations, and contexts.

> *In relation to this last question, what are the most relevant advances in clinical assessment today and what challenges must this area of psychology face in the near future?*

Another difficult question. I have been Editor and Associate Editor of assessment journals, I serve on multiple editorial boards, and I still read a lot -- being Professor Emeritus helps in this regard. I see both negative aspects and positive advances in the psychological assessment. I will mention just a few. First I see advances in science-based strategies for assessment instrument development and validation. Assessment researchers are more often adopting psychometrically sound methods of developing and testing new assessment instruments. Second, there is an increasing focus on using technology to collect information in the natural environment at the time of its occurrence. Examples would be biomonitoring or ecological momentary assessment. Third there is an increase in the recognition of the conditional nature of psychometric evidence: validation indices for a measure and instrument may apply to some people, situations, and contexts, and not to other. Fourth, there is an increasing recognition of the importance of individual differences, such as ethnicity, age, and gender, in the development and application of assessment instruments and interpreting their results.

On the negative side, many practicing clinicians continue to use poorly supported assessment instruments and many do not engage in pretreatment assessment at all. The consequence is that they are likely to make clinical decisions that are not in the client's best interest.

Many health professionals continue to emphasize psychiatric diagnosis, such as DSM and ICD. I would like to know what you think about this. You have pointed out that many psychological problems that a health professional faces do not have a formal diagnosis and that too often treatment decisions are based only on a diagnosis.

Psychiatric diagnosis can sometimes be a useful guide for a clinician. However, here are hundreds of articles criticizing the methodology used for the development of formal diagnostic systems. There are concerns about the imposition of categorical labelling systems applied to essentially non-categorical behaviors, the heterogeneity of some categories, the unreliability of some diagnostic judgments, and the failure of some diagnostic categories to be associated with clinically useful treatments. In functional behavioral assessment, diagnosis can be a starting point because it can suggest an array of possible causal factors for some persons. However, diagnosis, the imposition of a psychiatric label on a client, is less important than identifying causal relations affecting the client's behavior problems and goals. We suggest that to make the best treatment decisions, a clinician should not stop with a diagnosis and also to treat diagnoses cautiously. It is best to focus on the behavioral problems and goals of clients, their contexts, and associated functional relations, regardless of the diagnosis.

The objective of clinical case functional analysis is to identify and suggest the best possible treatment for a particular client. In recent years, much has been written about the importance of empirical evidence for treatments. Some have suggested that clinicians often do not apply psychological treatments based on empirical evidence? What do you think about these guides?

Good question, but complex. Note, for example, that a recent review on evidence-based treatments for children with externalizing or internalizing disorders has reported more than 100 treatment manuals. Most of these have little empirical support so it is not clear how effective many of them are.

I frequently encounter therapists who administer treatments that have no empirical support. They treat clients based on their hunches, orientations, experiences with previous clients, and theoretical biases, with little attention to research findings. They are not applying clinical science-based treatments. It is embarrassing for the profession of clinical psychology and other health care professionals, and they do not offer their clients the best treatments available.

Well, I would like us to also address some issue outside of your conference. You travel to Spain with some frequency, to participate in conferences, master's degrees, teach courses, so you have a more or less formed

images of the situation of psychology in our country. How would you describe it in comparison to other countries that you know and, more specifically, in relation to the situation in the United States of America? Have you noticed substantial changes since your first trips to Spain?

I have taught courses or classes at six different Spanish universities and in several postgraduate programs, probably for close to 25 years. I probably have a biased vision of psychology in Spanish universities because only those programs with a science-based vision similar to mine invite me. However, I am impressed by the increasing dominance of science-based, cognitive-behavioral principles and methods in Spanish psychology departments. This has been the most striking change over time and university psychology programs in Spain are comparable to many that I have known in the United States of America and other parts of Europe. I see increasing standardization among Spanish universities, a growing interest in science-based approaches to evaluation and treatment, and stricter requirements when it comes to practicing as a psychologist. All of this seems like positive progress.

In addition, I have spent many months living in Spain. Megumi, my wife, and I love the people, culture, food, music, history, vibrant city and country life, and physical beauty of the country. We consider it our second home.

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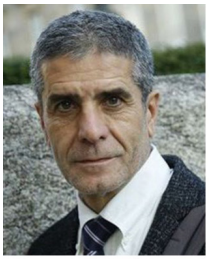
QUALITY CONTROL IN ONLINE PSYCHOLOGICAL ASSESSMENT

Merry Bullock and Wenceslao Peñate

Merry Bullock was head of the Office of International Affairs of the American Psychological Association (APA). She was general secretary of the International Union of Psychological Science (IUPsyS).



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**You will participate in the VIII International Congress of Clinical Psychology at Granada (November 2015), among other contributions, in a panel discussion on the use of new information technologies in psychology, and its implications. In this sense, we would like to know your opinion about the impact of new technologies in psychology tasks, especially those derived from informational technologies and Internet. Do you think that Psychology is adapting quickly?*

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There have always been new technologies in psychology, and they have changed the way we do our work. Information technologies and the internet have produced a watershed change – influencing how we gather information, run experiments, teach and collaborate – they have expanded our scope, reach and vision. That said, there are always challenges to be addressed in the adoption of new technologies, and the internet is no different. As a society, we are grappling with these issues – from annoying spam to invasions of privacy and identity, but I doubt that many of us would want to return to a time of letter correspondence and very expensive long-distance calling. I actually don't think that psychology as a discipline has adapted quickly. I think that the use of information technologies as tools in our work is just in its infancy. Their promise is that they will expand the scope, breadth, range and utility of our toolkit. For example, we can use technology to enhance learning, especially if we apply our expertise in learning principles and cognitive science. Similarly, there are enormous possibilities in using new technology as research tools. For applied psychology, the use of new technologies and the Internet can help remove some barriers of access, and allow information gathering, monitoring, and behavioral interventions and follow-up that have never before been possible. Just imagine a world in which people can have their "therapist in a pocket" or where a therapist can monitor mood swings remotely – this has the potential to greatly enhance the work that we do. It also has the potential to vastly increase access to mental health care for those who live in remote places, or places with few mental health care workers. Of course there are challenges in adapting to these new possibilities, but they are not insurmountable. We already know some of these (privacy concerns, validity concerns, and affordability…), and are thinking of ways to meet these challenges through modifications to our tools, through user education, or through policy changes to ensure equitable access to internet technologies.

> *This growth of new technologies has reached to practically all psychological labors (information, psychoeducational, assessment, counseling, psychotherapy…). As an expert, how are you observing this fast-growing?*

Actually, I am observing that psychology is somewhere in the middle in adapting new technologies. Some fields, such as Medicine, have adapted more quickly. There are systems for monitoring almost every biomarker remotely, training takes place remotely, and even virtual surgery occurs. Psychology has begun to develop some tools, but we are not using even current technology as broadly as we could. That said, of course, there are some great examples of technology use in psychology – virtual worlds, virtual classrooms, interesting monitoring systems, and self-help (one example is "MoodGym" from the Australian National University, it attempts to provide online empirically supported training in CBT), but they are not generally widespread or publicized.

In terms of applications, I suppose one issue is that we need even more research on effectiveness. For psychology it's important to document that internet-based therapies, for example, are as effective as in-person therapies, or that virtual classrooms can provide hands on skills and competencies. These challenges may not exist for rapidly growing areas in Medicine.

> *For our interest, Internet has had a special impact in clinical psychology. We would like to know your point of view about two areas: psychological assessment and psychological treatment. With respect to assessment, what do you think that several resources (mental tests, questionnaires, inventories…) are free available in Internet? What is your opinion that some websites supply these instruments, without professional control?*

Let me begin quite generally: a lot of the progress in the information technology area is prompted by growing patient demand for online services and growing practitioner demand for online tools. The technology is clearly in place to facilitate electronic tools and telehealth practice through a variety of modalities. What is lagging are the legal and regulatory policies that guide providers in how to navigate in this space, especially with regards to virtual practice across traditional boundaries or jurisdictions, or with ethical discussions to help practitioners think through new challenges. To your specific question, quality control is, of course, an enormous issue in assessing psychology-relevant materials online. We all have learned that being on a website does not make information true or valuable. For assessment I would like to differentiate psychologists' assessment tools and self-assessment tools for the public.

a. Assessment and treatment tools. Generally speaking, it is not appropriate to make professional psychological test instruments publicly available online. Most test instruments are copyrighted so posting them online (free or not) would run afoul of the test user's obligation not to violate the publisher's copyright. That said, making tools appropriately available to professionals online has many benefits, it is easier for professionals to access and use such tools, especially if scoring or analysis of data is built into the online internet host. There are some good compendia of tests available (PsyCTests is one) and there are terrific guidelines on test use from the International Test Commission (https://www.intestcom.org/). One of the issues with making such tests available online to non-professionals is how they are used. With any sort of assessment tool, an interpretation is necessary to understand the results. While many non-medical personnel might have some understanding of medical results such as blood pressure readings or temperature, the same is not true for psychological tests. Most non mental health experts will not be familiar with how to interpret assessment scores with respect to normative

values and their meanings. Posting tests of IQ, or depression, or Self-esteem online without some sort of explanation of results or appropriate referrals for follow-up could pose a problem, and many are concerned that posting test content could render some tests invalid. It's hard to fake a blood pressure result but it's easier to fake responses on a Self-report tool, especially if one has some idea of what scores "mean". I think that it is crucially important to emphasize education – for professionals on the opportunities and challenges of online tests and testing, and for the public on an understanding of testing, how to evaluate what is available online, and how to find appropriate interpretations. I say that it is important to emphasize education because we can't change what is already available online. Like it or not, we do have and will continue to have a robust selection of online tests for all manner of psychological constructs.

b. Self-Assessment Tests online. Any Internet search will yield literally hundreds of online tests and self-help tools. There is no regulation of these, and the caution "caveat emptor" applies (a business expression indicating that the buyer is responsible for what was purchased). Many of the self-help tools are similar to "get to know yourself" scales in popular magazines, but others are empirically based, well described guided self-help tools and explanations. It is very hard for users to navigate their way through these and few know that there is good guidance on choosing and using internet resources. Again, here public education is important to help users know criteria for judging whether the materials they find online are sound, empirically based self-help guides or more pseudo-tests.

The growth of Internet-based psychological treatments (IPT) has been so impressive that today we have over 20 systematic reviews and meta-analyses about the use of internet as a treatment tool. What do you consider are the major advantages of these therapeutic resources?

Meta-analyses generally show that internet-based therapies are equivalent to interpersonal therapies for some diagnoses. To the extent that they continue to be shown to be effective, I would say the major success of these tools is in increasing access to mental health care. Any such tools are really a public health initiative, weather they realize it or not. Naturally, some will be more effective than others, but the fact remains that now more than ever people have better access to mental health resources. I think the jury is still out on whether internet-based treatments will be better than in-person treatments, but to my mind this will depend in how we incorporate monitoring, self-guidance, and the possibilities on real-time interactions into our tools.

> *Despite these advantages, there are many both scientific and legal doubts about IPT. For example, not all treatments via Internet are based on treatments empirically derived….*

I think these are the challenges of an emerging field. We are seeing an explosion of possible technologies and applications that are relevant to psychology, but we have just begun to evaluate the benefits – we need to encourage research in this field, and we need to encourage innovation. There are a number of important questions to ask – have IPTs been developed using good psychological science? Have they been evaluated for use with a specific problem or specific populations? Are there any special practical or ethical concerns (for instance, security of Information, ability to respond in emergencies)? I think that we need to temper the immense possibilities with health evaluation – but of course, we don't want to be so cautious that psychologists are discouraged from exploring this area of research and application!

> *Also, we do not know who is "behind" these treatments: are they professional psychologists? Clinical psychologists? Have they an official license to act professionally?*

Again, I think we need to focus on public education. This is not just an issue for internet applications – in those countries without strong regulation of mental health care providers, the same is true for in-person treatment. Just as it takes time for legislative acts to catch up with practice, it will take time for us to understand the appropriate regulatory and oversight mechanisms for internet-based treatments. As yet there are no accreditation or certification requirements or possibilities. This is an important area for professional associations to champion – to advocate for resources for internet treatment development (think of something like "grants for apps that work") and to advocate for thoughtful discussion about what kind of regulation is important and useful.

> *Because Internet is a global network, do we need an international license for psychological practice? And an international ethical code? If that, which problems can generate an international license, and an international ethical code with the respect to cultural and ethnic diversity?*

This is an important issue. In most jurisdictions, practitioners are licensed to practice in a specific geographical area. In the United States, practitioners are licensed by the state (or states) in which they practice, not by the federal government. In other countries, it is at the federal level, but still for practice within the country. In general, licensing bodies see their first responsibility as protecting the public that they serve, which means the psychologist is expected

to be licensed where the patient is located. This raises huge issues for internet practice where geographical boundaries are not relevant. But I think I would focus rather on international discussion of the competencies needed for internet practice, including ethical issues than on global licensing. We do have broad international ethical principles in the Universal Declaration of Ethical principles for psychologists. These can help form the basis for discussion of specific ethical issues with internet treatment. It would be great to have similar discussion on the competencies needed for Internet treatment.

> *We are finishing the interview, and I would like to know your point of view related with one of the most relevant results of systematic reviews on IPT. This result outstands how the efficacy of IPTs depends especially of some type of contact with a therapist (e-mail, video-conference, face-to-face…). Can mean it, even though today we have more precise and systematic psychological treatments via internet, the therapist presence is still essential?*

Psychologists work at many levels of care, from public health to individual psychotherapy, with varying levels of contact. I think many of the things that take place in treatment can be augmented by automated information technologies, but many of these augmentations also include personal contact. Although apps and IPT may reduce the need for one-on-one therapy by improving public health education and awareness of strategies to improve one's mental health, there is still, I believe, a need for more nuanced care. Generally, the research seems to suggest that apps and IPTs are usually helpful for mild to moderate difficulties. In some way they are a form of stepped care. More severe mental illness may always need more complex tailored care that is difficult to achieve without personal assessment and review of individual factors.

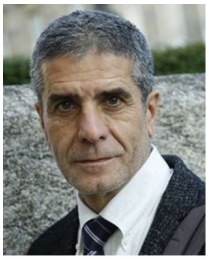
The psychological treatment will always be an interpersonal relationship?

I am not sure that psychological treatment is always an interpersonal relationship even now. Treatments that focus on infrastructure or organizational or systemic change are not necessarily interpersonal. I look to changes in medicine, where even the most exquisite moves toward "precision medicine" still have an important role for expert clinical judgment, and to changes in community-based treatment where interpersonal dynamics are equally important in successful implementation. So, at the extreme, I do not expect to see psychologists replaced by information systems!

ANXIETY DISORDERS

Michael W. Eysenck and Wenceslao Peñate

Michael W. Eysenck is a Professor Emeritus at Royal Holloway, Uni-versity of London (United Kingdom). He was Founding Editor of the European Journal for Cognitive Psychology. He is one of the most influential scientists in the world according to Stanford University Ranking.



Wenceslao Peñate is Professor of Clinical Psychology at the Universi-ty of La Laguna. He is a member of the Instituto Universitario de Neurociencia.

**An initial question is for knowing about your current scientific and academic interests. Your research curriculum has especially dealt with anxiety (state and trait), and the mechanisms underlying this psychological feature. Why that interest in anxiety? How it arises? And why your interest in the underlying processes (instead other theoretical perspectives)?*

I have always been a cognitive psychologist. In view of the importance of individual differences in cognitive functioning, I found it perplexing that until comparatively recently there was so little interest in individual differences

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among cognitive psychologists. Anxiety is an extremely important individual difference and one that lends itself to a cognitive analysis. In essence, I simply found it fascinating to try to identify cognitive processes and structures that help us to understand differences in cognitive performance between individuals high and low in trait anxiety.

We would like to highlight your contribution with an initial theory: processing efficiency theory. What is the status of that theory, and why it has been necessary to move it into a new theory (Attentional Control Theory)?

If we consider citation evidence, then processing efficiency theory (proposed by Manuel Calvo and myself in 1992) is still highly influential. Unusually, the number of citations of the theoretical article on processing efficiency theory was initially fairly low but increased considerably more than 10 years after it was published! It still attracts many citations every year. However, in spite of its success, processing efficiency theory was limited in some respects. Its main limitation is that it was put forward at a time when we had a relatively unsophisticated theoretical understanding of attentional processes. The single most important reason for the development of attentional control theory is that theoretical advances in the understanding of attentional processes made it possible to provide a more detailed account of the ways in which anxiety affects attention. In addition, advances in cognitive neuroscience also facilitated the advances found in attentional control theory compared to processing efficiency theory.

According to your research findings, people with anxiety are characterized by deficient information processing, especially linked to attentional processes (impairment in inhibition functions, impairment in shifting/adaptation functions, deficiencies in working memory). To what extent these findings represent a significant advance in the understanding of anxiety phenomenon?

My general strategy has been to consider the effects of anxiety on cognitive processes to the development of theories of attention and working memory within cognitive psychology. We now know that there are several executive processes (e.g., inhibition function; shifting function), and so I have progressively developed and expanded my understanding of anxiety to incorporate these theoretical developments.

A central aspect of attentional control theory contradicts the initial proposal by Irvin Sarason about that anxious individuals are characterized by the presence of both feelings and thoughts of worry,

which interfere with the performance of these individuals (as task irrelevant thoughts). Until the publication your research work, we believed that people with anxiety had worse performance because their attentional capacity was diminished by having to address internal states such as worry. What is the current status of the traditional relationships between anxiety and performance?

The first point to make is that I mostly agree with what Irvin Sarason and others had to say about the ways in which anxiety causes negative effects through worry and other task-irrelevant thoughts! My views differ from those of Sarason in two main ways. First, I think that worry often leads anxious individuals to exert more effort and so its effects are not entirely negative. Second, we should relate worry to cognitive theories much more than Sarason did. We can think of worry as making use of processes within the working memory model such as the central executive and the phonological loop. That offers the prospect of a more detailed understanding of what worry is doing to the cognitive system.

What can be the psychological meaning that people with anxiety are more characterized by deficient information processing, rather than poor performance (compared to non-anxious people)?

Traditionally, it was believed implicitly or explicitly that there was essentially a one-to-one relationship between cognitive performance and internal processes. Thus, for example, if high-anxious and low-anxious individuals performed comparably on a cognitive task, it was assumed there were no significant differences in internal processing between the two groups. In contrast, I believe strongly that high-anxious and low-anxious individuals can achieve comparable levels of performance through very different underlying processes. As you say, high-anxious individuals have "deficient information processing" but matters are more complex than that. I argue that they try to compensate for that deficient processing by using various compensatory processes. At the risk of over-simplification, the argument is that high-anxious individuals are highly motivated to prevent their deficient processing from impairing performance. This accounts for the common finding that high-anxious individuals report using more effort during tasks than do low-anxious ones.

The findings of Sonia Bishop about anxiety, attentional processes, and performance, reflect an apparent contradiction with your theory, pointing out that anxious persons are characterized by a failure in attentional control mechanisms. What is your opinion about these findings?

Personally, I am totally unimpressed by Bishop's theory and research for numerous reasons. Here I will briefly mention two. First, Bishop has emphasized the notion that individuals high in trait anxiety typically have lower activation in the dorsolateral prefrontal cortex (associated with attentional control) than those low in trait anxiety. However, most of the available research indicates that precisely the opposite is the case! Bishop (2009) found a strong positive correlation between trait anxiety and dorsolateral prefrontal cortex activation in one of their conditions but mysteriously fail to admit that this finding is inconsistent with her theoretical approach but entirely consistent with attentional control theory! Second, an in-press article by Bishop and colleagues identifies several reasons why high trait anxiety impairs performance: high worry levels, impaired attentional control, high mind wandering, and reduced activation in the dorsolateral prefrontal cortex and anterior cingulate cortex. Within this theory, it seems certain that high anxiety would always impair cognitive performance which of course is not actually the case.

> *Changing now to clinical implications, in your lecture in the 7th International and 12th National Congress of Clinical Psychology, you will address the implications of these and other processes in the treatment of anxiety disorders. Without revealing the main content of the conference, can you give us some examples of these implications?*

As you imply, it would not be appropriate to say too much about the content of my forthcoming talk in Seville! However, what I can reveal is that I increasingly believe that cognitive mechanisms are even more important in understanding therapeutic improvements than has generally been thought. For example, it has traditionally been believed that the mechanisms underlying the effectiveness of exposure therapy do not include cognitive ones. In fact, however, there is increasingly evidence that cognitive change often precedes (and seems to be causally related to) therapeutic change in the treatment of anxiety disorders.

> *As it is well known, the cognitive approach to anxiety has allowed the development of several models, some of them very fruitful. For example, Michel Dugas and his group have developed a process model (intolerance to uncertainty, cognitive avoidance, worry...), especially related to generalized anxiety, but applies to other anxiety disorders, with clear therapeutic implications. In central concept is that of intolerance of uncertainty. To what extent the proposals of this model can be consistent with the theory of the attentional control?*

I fully accept that an extremely important characteristic of anxious individuals is their intolerance of uncertainty. This is seen most clearly in

patients with obsessive-compulsive disorder but is also apparent in the other anxiety disorders. Overall, I am generally supportive of the theoretical ideas of Michel Dugas and his colleagues but am not sure at present how well those ideas could be combined with those contained within processing efficiency theory and attentional control theory.

> *Speaking about therapeutic implications, we would like to know your opinion on so-called third-wave therapies, and their role in controlling anxiety. We would like to know your opinion because of we think (and we are sorry if this is so daring) that some of your basic research findings can support some statements of those approaches. For example, Acceptance and Commitment Therapy emphasizes the independence between thoughts (private events) and manifest behaviors (actions). Do you think the fact that anxiety affects to information processing but not (especially) to performance is a support to that independence?*

I am flattered that you suggest that some of my ideas may be of relevance to 'third wave' therapies. You are certainly correct that I have always emphasized that there can be important discrepancies between internal processes and external behaviour. However, I would not wish to go so far as to argue that internal processes and external behaviour are independent of each other. What I feel most strongly is that it is of vital importance within clinical psychology to focus more directly on the underlying mechanisms responsible for beneficial therapeutic change. For too long there has been a tendency to assume that we know much more about the underlying mechanisms than we actually do.

> *Finally, we would like to know your opinion on a current topic, such as the controversy over the quality of scientific publications. In recent years it has begun to question the Impact Factor as a criterion of scientific quality of publications (including the opinion of recognized Nobel prize winners), pointing out that some relevant journals can be manipulating the scientific knowledge. What do you think about it? And what do you consider about the current priority of the journal papers and the decreased production of handbooks and scientific collections?*

There are several inter-related issues here. First, it is obvious that journal Impact Factors are a relatively poor measure of the scientific quality of publications. It is important to note that a journal's Impact Factor is based on the number of citations of articles published in that journal over the preceding two years divided by the number of articles. This method of calculation may work well in science such as physics and chemistry but is not very appropriate in psychology. The reason is that articles in psychology achieve 50% of their

total citations on average about 5 years after publication! As a result, citations over the first two years since publication can be very unrepresentative of an article's ultimate impact. Second, the value of Impact Factor based on citations within two years of publication varies greatly within psychology. Cognitive neuroscience journals typically publish articles within a much shorter time period of submission than is the case with more traditional journals in psychology. As a consequence, cognitive neuroscience journals typically have much higher impact factors than other psychology journals because a higher proportion of an article's citations occur rapidly. Third, journals increasingly distort their impact factor by making articles generally available several months (or even a year) before the start of the 2-year rule beginning with the official publication date. Fourth, I think there is an excessive focus on journal articles at the expense of other means of reporting theoretical and empirical research. For example, I have produced two influential research monographs, but these monographs were regarded as virtually irrelevant when the research of British researchers has been evaluated formally in successive research assessment exercises!

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FROM ANXIETY DISORDERS TO SOCIO-EMOTIONAL DISORDERS: THEIR PREVENTION AND INTERVENTION

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**In one of your publications (Spence & Rapee, 2016), you suggest: "There is insufficient evidence, as yet, to determine whether SAD is a cause or effect of such comorbid problems, or whether these patterns of comorbidity reflect common underlying causal factors" (pp. 52). Would you say that social anxiety, or more exactly, Social Anxiety Disorder (SAD), due to its relationship with depression, its relationship to drinking alcohol (as a way to alleviate emotional distress), especially due to its*

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relationship with the possibility of being rejected by others, not seeming competent doing something, etc., is really a depressive phenomenon? Might social anxiety be the alarm that this is a vulnerable identity, perhaps of depressogenic construction?

I'm not sure I would put them down to any single problem – e.g. saying they are all manifestations of depression or that depression is a manifestation of social anxiety is perhaps too specific. We recently published a hypothetical model of ways in which emotional disorders might be influenced by adolescent developmental characteristics. In that model we talked about social anxiety, generalized anxiety, depression, and disorders of body image as highly related and we referred to them as the "social-emotional" disorders. When we reviewed the evidence about their onset, the vast majority of risk factors appear to be more or less common across these disorders. In other words, I wouldn't say that one is a manifestation of another, but rather that these disorders share more in common than their differences. This perspective is consistent with a body of literature (e.g. Krueger, Lahey, and others) on the hierarchical classification of mental disorder, that points out that the common (or shared) variance across all internalizing disorders is far greater than differences between them. Having said that, this doesn't mean that one is not an "alarm" as you put it for another. In other words, precisely because they share so many of their characteristics and risks, when an individual experiences one of these problems, we know that they are at greatly increased risk for another. Because social anxiety most commonly begins before depression, it can indeed act as an "alarm".

In Rapee et al. (2020), you carried out an excellent review and updated an explanatory model of emotional disorders, giving social relations and cognitive processes, such as social comparison, enormous importance. What is the role of social media in the context of this model? Understanding that they are part of the reality we live in, what do social media enable us to anticipate as facilitating and disturbing in the child and adolescent's development?

The paper you are referring to was our recent theoretical model of the development of social-emotional disorders during adolescence. The purpose of this model wasn't to describe a comprehensive developmental account, but to specifically highlight the characteristics of the adolescent period that makes them a high-risk window for these disorders. In this context, there is no doubt that social media is a critically important medium for adolescents. One of the most critical changes that occurs in adolescence is the dramatic increase in the importance and influence of peers. In this way, social media takes on vital importance.

It is very important to point out that social media is not necessarily "bad". Social media can increase the focus, intensity, and immediacy of peer relationships. But peer relationships themselves can be both good and bad. In the same way, using social media can have many strengths, as well as potential risks – it all comes down to what is done on social media and how it is used. For adolescents who use social media to connect with their friends, obtain social support, and share normative information, using the internet is a positive experience and has the potential to protect from mental disorder. However, for adolescents who use social media to make frequent upward social comparisons, who don't engage in mutual online chats, and who are victimized online, social media can be a very lonely place that can increase anxiety and depression.

> *Two very interesting recent studies (Forbes et al., 2019; Forbes et al., 2020) might infer that much of the symptomatology observed, especially in childhood and adolescence, are actually general ways of reacting, for example, to adversity, traumatic situations, or maladjusted development, where emotional manifestations and/or alterations in behavior dominate, more than specific syndromes for specific causes. Is that right? At these ages, would general intervention approaches directed precisely at dominating internalizing or externalizing characteristics make more sense than a diagnostic approach?*

This work follows on from some of the comments I made earlier about shared variance. To give some quick background: there is some moderately new research on the classification of mental disorders by a growing group of researchers, including Bob Krueger and others. What these researchers have done is to apply a purely empirical view to the classification of mental disorders by looking at their patterns of comorbidity. What they repeatedly find (which makes complete clinical sense to me) that the largest amount of variation between all forms of mental disorder is actually shared. In other words, when you look at the factor structure of all disorders in the DSM, you find that most of the variation is common across these disorders and the researchers have labeled this, "general psychopathology". Once you statistically control or remove the variance accounted for by general psychopathology, the remaining variance usually falls into two broad groups – internalizing disorders and externalizing disorders (sometimes psychosis forms an additional spectrum). So, what this means is that when you look at someone with an internalizing disorder, most of their characteristics are very similar to the characteristics of anyone who has any mental disorder. Then there is an additional set of characteristics that is similar to anyone with another internalizing disorder. And finally, there are some unique characteristics of the specific DSM disorder that the person has – but these are quite minimal. This has two treatment implications: First, it

suggests that the biggest treatment effects will come if you address the largest components, which are actually transdiagnostic; but second, it suggests a more nuanced idea in which treatment and prevention can be organized hierarchically so that the first thing you treat are the very broad components (general psychopathology), then if a problem remains, you address the next largest component (internalizing), and only if a problem remains do you need to focus on the specific characteristics of a particular disorder.

> *In line with what is particularly mentioned in Forbes et al. (2019), would it make sense that precisely the study of at-risk mental states (ARMS) of psychosis should be nonspecific, as shown in the literature and the clinic, starting out from that non-differentiation depending on their development and then going on from there specifying toward schizophrenia, toward bipolar disorder, or toward emotional disorders, as they progress to adulthood? Would an approach directed too much toward a specific diagnosis then be a risk for an adolescent, especially the earlier it is made, with respect to the development of the person being assessed?*

Based on the hierarchical classification models that I described above and based on our clinical and empirical knowledge of comorbidity, we know that a person diagnosed with one particular disorder at one stage of their life is very likely to present with a different disorder later in life. Clinically you often see this with psychosis – young people suffering their first episode of psychosis, often have a history of earlier diagnoses of generalized anxiety, social anxiety, depression, and so on. The paper you refer to, Forbes et al. (2020), was aimed at addressing the idea of prevention from very early childhood. What we suggested there, was that in very early childhood, it is extremely difficult to know the specific mental disorders that a person is going to experience across their life. Therefore, the most cost-effective focus of early intervention might be to try and reduce characteristics of general psychopathology. If this is done successfully, according to theory, it should prevent the development of all other forms of disorder.

> *Another of your studies (Rapee et al., 2020) suggests some questions in the same direction: Certain cognitive processes, such as social comparison (comparison of appearance, self-rated attractiveness, comparison on social media) and other processes more related to social activity or affiliation, for example, could have to do with social anxiety, probably also depression, or eating behavior disorders. Would it not be more useful to make classifications of cognitive processes that have a demonstrated mediating role rather than diagnoses or disorders, as in*

the diagnostic classifications in use? And therefore, would it not be more advantageous to design intervention more toward cognitive processes than toward concrete diagnoses? Would these processes not really be transdiagnostic?

Yes, I fully agree. As per my earlier comments, in that paper we tried to highlight some characteristics of normal adolescent development that might increase risk for mental disorders in some youth. The way we began was by looking at which mental disorders show a strong increased prevalence during the teenage years. It turns out that there are four: generalized anxiety, social anxiety, depression, and eating disorders (substance use also increases but for a range of reasons, we excluded this). So at the very least, these four disorders share a lot of common risk factors. On this basis, I completely agree – if we can develop programs to reduce these broad risk factors, then these programs should reduce the prevalence of a range of different disorders, rather than focusing specifically on one single disorder.

In the same sense as the previous question, in an excellent study on perfectionism, more exactly, socially prescribed and self-orientated perfectionism (Magson et al., 2019), the importance of this process, probably linked rather to very stable styles of functioning (personality) is drawn perfectly. How should preventive work be focused in this type of process?

Perfectionism is another of the broad, transdiagnostic processes that characterizes several disorders. There is some excellent work from people like Roz Shafran in the UK and Sarah Egan and Tracy Wade in Australia that shows how reducing perfectionism can have downstream benefits for a range of mental disorders. Their interventions utilize many standard CBT strategies – cognitive restructuring, problem solving, and exposure to errors and imperfection. In a prevention context we might also want to focus on expectations and modeling from parents. There is no doubt that there is a strong inherited component to perfectionism. But young people can be taught very clear strategies to successfully manage their perfectionistic tendencies.

In some of your recent studies, you suggest intervention by telematics, for example, analyzing adherence to these procedures (Titov et al., 2013). What is the future of intervention in emotional disorders? How could preventive procedures be developed, and who should be responsible for their development? And if I may, what is the future of clinical and psychopathological research, where should efforts be directed?

Cognitive behavior therapy is based on educational principles of training people in practical, sensible skills. In the same way that any new skill can be taught in a variety of ways, CBT skills are very open to being learned through self-motivated methods. For many years we have shown that treatment can be very successfully delivered through printed materials (such as books). More recently of course, this information is now delivered via computers and smartphones. This should be no surprise and no threat to CBT therapists. What is disappointing however, is the number of people who try and create an "us vs them" mentality – either saying that treatment has to be done over the internet or in person. In reality the future of clinical research and therapy will be a blend of strategies. In some circumstances online treatments are the only answer, in other cases, some people only want to speak to a therapist in person. In Australia for example, some people live in areas where the nearest therapist may be more than 1,000 km away. For these people, internet treatment programs are a lifesaver. However, the complexity of some problems may require an individualized approach. We recently completed a study of stepped care for anxious young people. At the first step all participants did a self-help program and 40% needed no further intervention. The remaining 60% then went to manualized, face to face therapy and another 40% got better from that. The final 20% saw an experienced clinical psychologist for an individualized intervention. So in answer to your question, I think the future of clinical intervention is to work out the best combinations of blending and merging the various choices for treatment. We will need to balance, access, costs, people's preference, and the type and complexity of their disorder.

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SUICIDAL TENDENCIES IN DEPRESSIVE PATIENTS

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**You studied at the University of Pennsylvania (Philadelphia), received your PhD from the University of Houston (Texas), and completed postdoctoral studies at the University of Wisconsin (Madison). Subsequently, you worked at Yale University (Connecticut) and, currently, at Emory University (Atlanta). Undoubtedly, this is a career path that guarantees a high professional qualification, but it involves several changes of residence, which can make it more difficult to combine with family life. As we know, this is very frequent in professors in the United States of America, unlike in Spain, where most professors are usually trained and work in the same University, which in many cases is in the*

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city where they were born, so we could say that they are "professors with roots", which model do you consider better and what are the advantages?

I can see benefits and disadvantages in both approaches and, of course, I am more familiar with what is common in the United States of America. The advantages of moving are the opportunity to meet and learn from a broad and diverse group of people, to get the best possible training/education, to work in a context that you choose and that is a good fit, to get to know different cultures in our country (for example, the northeastern part of the United States of America is very different from the southern states), and to take advantage of the strengths of different communities. I also think it is easier to move from the role of student/trainee to that of university/academic staff, if one moves to a different location. The opportunities of this model are that it is often personally difficult for one to uproot oneself. It is hard to leave friends and colleagues one knows well. Also, displacement because of one's career path can be difficult for other family members (partner, children). In contrast, it seems that the advantages of being a "teacher with roots" is that it allows for considerable personal and professional stability, building and maintaining long-term networks, not needing to uproot oneself or one's family, and being close to one's family of origin. The disadvantages, I imagine, are less opportunity to learn a greater diversity of perspectives, make new collaborations, potentially advance one's career or be in a position that is the best fit.

You are currently the president of the American Psychological Association (APA), but you have also been linked to the APA for two decades now, collaborating and holding positions of responsibility in different divisions, so it is an institution that you know very well and as is well known, it is an academic and professional association with great influence in the training of psychologists. However, even in the United States of America, as in other countries, there are great differences in the training curricula of psychologists. Don't you think that there should be more consensus in the training curriculum of psychologists, especially now that we live in a more globalized world?

I am a strong advocate of a competency-based approach to educational and training psychology. I believe it is optimal to have a common understanding of key competencies and their essential components. Efforts have begun to develop an international agreement on competencies, and I fully support this project. However, I also believe that institutions should have some flexibility in their approach to base education/training on the strengths and areas of focus of their faculty, student interest, etc.

The controversy over diagnostic systems for mental and behavioral disorders continues with the publication of the DSM-5. More and more psychologists identify with the ICD of the World Health Organization (WHO). But there is currently a strong controversy about whether to use classifications of psychological disorders, and these movements are supported by the Division of Clinical Psychology of the British Psychological Association. However, in an interview two years ago with Suzanne Bennett Johnson (President of the APA in 2012), she clearly defended the use of the WHO ICD. And, along the same lines, in the interview published in this book, Geoffrey M. Reed, director of the Classification of Mental and Behavioral Disorders of the International Classification of Diseases, ICD-11 of the WHO argues the advantages of using the ICD system. What is the official position of the APA and what is your personal position on this?

The APA does not have an official position on this issue. However, there is much support for the development, dissemination, and use of ICD. Through the *International Union of Psychological Science*, APA has supported a leadership role for psychologists in the ICD-11 process. APA has planned to create training materials for psychologists in the use of ICD-10 and, eventually, ICD-11. There are sessions on ICD at the annual APA convention. Through my own research on understanding diagnoses in a relational context, I have been actively involved in an international working group with the ICD-11 team to integrate relational diagnoses into this document. Field studies for this work are underway. Over the next decade, I recommend that psychology students be trained using both ICD and DSM-5. Depending on the occupation, they may use only the ICD (e.g., in private practice, non-psychiatry oriented medical occupations) or they may need to use both (e.g., in Departments of Psychiatry).

In your professional activity you have dedicated much time to academic management, both in the APA and in the universities in which you have worked. Nevertheless, you are a reference in research, in fact, you have more than 200 articles published in Web of Science journals, your articles have received more than 5,000 citations and you have an h-index of 38, being one of the seven highest of all the presidents that the APA has had (see Buela-Casal et al., 2011), How can you be so productive in research having so much activity in academic management?

To be honest, I had no idea that my h-index was so high compared to that of other APA presidents. When I look at my position on the list, I must admit that I am quite honored to know that. I have prioritized juggling research productivity, teaching and supervision, clinical practice, advocacy and public interest, and

administrative work, because I enjoy all of these. The following are some of the reasons I think I am as successful as you point out. I work extremely hard, long hours, every day of the week, on plane rides, etc. While I definitely prioritize producing high quality work, I also recognize the importance of being efficient doing the work. I typically write in work groups and very rarely publish alone, which means I share the writer's workload. However, in virtually every team, I act as a final editor to ensure the quality of the article. I am fortunate that writing well comes relatively easily to me, and this makes producing the work easier. Finally, I have had wonderful role models with respect to publishing scholarly work, including my mother (Florence Kaslow, PhD), my undergraduate tutor (Marty Seligman, PhD former APA president, fourth on the list), and my graduate tutor (Lynn Rehm, PhD).

> *Let's talk now about one of the topics in which you are a specialist, suicide and its prevention. Suicide continues to increase in recent years; for example, in Spain it is already the leading cause of unnatural death, surpassing by far deaths due to traffic accidents. In Spain, suicides increased by 11.30% between 2011 and 2012, with a total of 3,539 cases (7.50 per 100,000 inhabitants) recorded during 2012. In the European Union, the suicide rate has increased most in Ireland and Greece, which are the countries most affected by the economic crisis. Do you consider that these increases may be due to the effects of the economic crisis and unemployment?*

The loss of job or economic support may influence an individual person and may lead to the deterioration of their closest relationships, but suicide may also be linked to the economic recession on a systemic level. There has been recent research indicating that the financial crisis is being felt in many countries, including both Spain and the United States of America, which has been associated with a relative increase in suicides.

> *On the other hand, we know that almost one million people commit suicide every year, which is a mortality rate of 16 per 100,000, or one death every 40 seconds, but this is the result of an almost constant increase. Thus, in the last 45 years, suicide rates have increased by 60% worldwide. How can this significant increase be explained and on what basis?*

There are many factors that can contribute to suicidal behaviors, including biological, environmental, and psychological variables, so it is difficult to identify one or two risk factors that may be increasing the rate of suicide. However, as mentioned above, the changing economic climate around the world has been found to be related to increased risk. In addition, new technologies may also

contribute to the suicide rate. For example, children and adolescents now have new methods of communication through avenues such as Facebook, and they may be using social media to bully other kids, which has been shown to increase the risk of suicide. There is also evidence that increases in suicide rates are due to specific populations. For example, in the United States of America there are dramatic increases in rates in middle-aged individuals, particularly in men, which has been attributed to both the economic downturn and increased access to prescription drugs.

> *In a study just published in JAMA Psychiatry (see Vyssoki et al., 2014), analyzing 70,000 suicides that occurred in Austria over the last 40 years, it is shown that there is a relationship between daily hours of sunshine and the number of suicides; something similar occurs between depression and the amount of sunlight. Can this make us think that in suicide, apart from psychological causes, there are also biological factors that manifest themselves in the interaction with the physical environment?*

I think the research on the effects of sunlight on suicide is interesting. However, much more work is needed in this area to identify the underlying mechanisms that might explain this relationship. Some researchers have suggested that sunlight interacts with serotonin neurotransmission triggering increased impulsivity to promote more violent suicidal acts; while others have proposed that sunlight is a natural antidepressant that first enhances motivation, which improves mood, thus generating a potential increase in suicide risk, albeit short-term from its initial application. Again, further research is needed to clarify the role of sunlight in triggering neurobiological, behavioral, and psychological changes, which may contribute to suicidal behavior.

> *There are studies conducted by the University of San Francisco and the University of Warwick that link higher suicide rates with higher happiness rates and demonstrate this by analyzing different countries ranked according to their prosperity indexes. What is your opinion on this?*

There is a growing body of research suggesting that the happiest states in the United States and countries around the world also have the highest suicide rates, which seems to be contradictory. This surprising finding may be explained by the fact that individuals compare themselves and judge their own good mental health against others. Thus, although one's own happiness protects one from suicide on an individual level, the happiness of others may be a risk factor when a sad or depressed individual is surrounded by those who are relatively content with their lives.

Continuing from the above, what is the relationship between depression and suicide? In what types of depression are there more risks of suicide and how can clinicians identify the risk of suicide in these patients? Is the cause of suicide in these cases very different from that of suicide due to terminal illness?

Research has consistently shown that depression and other mood disorders significantly increase the likelihood of an individual having suicidal thoughts, engaging in suicidal behaviors, and potentially dying by suicide. In fact, Bipolar Disorder Type 1 has the strongest association with death by suicide of all the psychological disorders identified in the DSM-5. Individuals with non-bipolar Major Depressive Disorder are at increased risk for death by suicide if their illness is more severe or they have been hospitalized. Clinicians should routinely assess for suicidality among patients diagnosed with a mood disorder or who present with mood disorder symptoms.

What relevance does culture have on suicide rates? It is well known that the number of suicides varies greatly from one culture to another, and even the type of suicide; for example, in Western culture it would be difficult to understand the cases of suicide kamikazes or suicidal Islamists.

Culture and suicide have been researched for years and different cultures view suicide differently. It is important to consider these cultural values when working with people at risk for suicide. It is also important to consider that, although each culture has its own collective perspective of suicide, there may be differences between individuals in how they identify with the cultural values and beliefs of their country, with some identifying with more than one culture, such as immigrants. The more we understand the role of culture, the more effectively we can prevent suicide and treat people who experience the continuum of suicidal behavior. People from one culture are likely to find it difficult to understand culturally compelled suicidal behavior associated with another culture; Westerners may find it challenging to understand the cases of suicide kamikazes or suicidal Islamists. However, there is no evidence to be sure of the veracity of this claim.

You are a member of the Research Advisory Committee of the American Foundation for Suicide Prevention. It is undoubtedly important that such a Foundation exists, but what are the mechanisms of action to be able to contribute to suicide prevention? Can suicide really be prevented and to what extent?

This is a critically important and thought-provoking issue. Suicide is a major public health problem worldwide, with devastating effects on individuals and communities. While it is unlikely that all suicide deaths can be prevented, every effort should be made to prevent them or to reduce the contributing risk factors (mental illness, substance abuse, etc.) outright. It is true that an increasing number of evidence-based strategies have been developed and have had positive results, but rates are increasing. There is no doubt that this is discouraging and has raised questions about whether or not suicide can be prevented. I firmly believe that there are effective biopsychosocial strategies and interventions that help reduce the risk for continued suicidal behavior, and these need to be more widely disseminated. In addition, we have a moral responsibility to the public to develop, evaluate, and disseminate more integrative preventive intervention approaches, as well as approaches targeted to specific high-risk groups. While debatable in some cultures, including in the United States of America, the finding that restricting access to lethal means (e.g., firearms) is an effective approach to suicide prevention should be taken into account when making national and local policy decisions regarding firearm regulations.

> *Finally, you will give the inaugural lecture at the VII International Congress of Clinical Psychology on "Current situation in the prevention and intervention of suicide", can you tell us briefly the content of your presentation?*

I will discuss psychosocial interventions aimed at reducing risk factors and increasing protective factors. The categories of risk and protective factors that will be discussed are interpersonal, social/situational, and cultural/environmental. I believe that such interventions should be administered in a culturally informed manner.

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UNDERSTANDING AND TREATING HOARDING DISORDER: AN EXCESSIVE ATTACHMENT TO OBJECTS

Melissa Norberg and Ana I. Rosa Alcázar

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**You were born in Nebraska, completed your undergraduate education at the University of Nebraska-Lincoln, your Master's degree and PhD in Clinical Psychology at the University of Wisconsin-Milwaukee, and are currently working in Australia. Have you found relevant differences in Clinical Psychology in the US compared to Australia?*

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Yes, the most obvious difference is that in the United States you must obtain a PhD to be a clinical psychologist, but Australia only requires a master's degree. The PhD training programs in the USA tack on another two-three years of training, which allows students to obtain more training in statistics and research methods, as well as in the biological, developmental, social, and cognitive/affective bases of behaviour.

You are currently the President of the Australian Association for Cognitive and Behaviour Therapy. What are this association´s goals? What is your vision for the Association and more broadly for the field of clinical psychology?

The objectives of the Australian Association for Cognitive and Behaviour Therapy are to 1) provide high quality professional development; 2) publish and disseminate evidence-based practice; 3) increase the use of behavioural and cognitive therapies in Australia; and 4) partner with the international community. Personally, I would like to see a greater focus placed on the science of clinical psychology. There has been a disconnect between theory and clinical practice, such that we have been focused on what works rather than why it works. This has led to a proliferation in the number of treatments disseminated. Because we also haven't been concerned enough with ensuring that new treatments work better than what currently exists, therapists are stretched, becoming a jack of all trades, rather than experts in a few key treatments. Thus, I'd like to see more of a focus on linking models of psychopathology to treatment processes. Many models overlap (e.g., avoidance is a key feature in models of anxiety and depression), and we need to figure out which treatment techniques target these overlapping features the best, and then work on disseminating and training clinicians to deliver these techniques to the best of their abilities. Likewise, if psychopathology models or particular tenets of models do not have scientific support, we should not be using them to guide treatment. Inherent in this process is ensuring clinicians are capable of interpreting research findings so that they can figure out which models and interventions have enough support to warrant their attention.

We have found that your field of research is wide, but focuses heavily on OCD and related disorders. As you know, in 2013, a new classification of the disorder emerged, forming a new grouping together with "related disorders", what is your opinion of this change?

My interpretation of research findings is that OCD and body dysmorphic disorder are similar, whereas trichotillomania and skin picking are similar to each other. Hoarding disorder seems to differ quite a bit from OCD. Individuals

who meet criteria for hoarding disorder tend to enjoy possessions. They collect them because it makes sense to them, what is difficult is parting with them. Saving is the absence of a behaviour (i.e., discarding), which to me is different from the compulsive behaviour associated with OCD. But what is similar is the fear produced by thoughts associated with each disorder and a profound belief that distress cannot be tolerated. With all of the OCRDs, clinicians need to help individuals realise that they can tolerate distress. After all, they do it every day.

> *One of your lines of research is to discover what factors and processes contribute to the aetiology and maintenance of anxiety, obsessive-compulsive and related disorders, and substance use problems. In addition, you are interested in the role of both general and disorder-specific factors, would we be talking about looking for factors common to these disorders? Would this fall within the so-called "trandiagnostic or transtreatment"?*

Yes, this falls in line with researching transdiagnostic factors. Emotion dysregulation appears to be a problem underlying many disorders. This entails becoming overly distressed by certain cues and the perception that one cannot tolerate distress. Transdiagnostic treatment, like the one developed by Prof Peter Norton and colleagues, can help individuals suffering from excessive anxiety regulate their emotions, regardless of which cues trigger their anxiety and belief that anxiety cannot be tolerated. My own research has highlighted that emotion dysregulation and poor interpersonal functioning underlies hoarding disorder.

> *One interest in your research is hoarding disorder. You have published numerous papers on attachment style, including a systematic review. What conclusions have you reached in regard to attachment style and hoarding disorder?*

It seems likely that hoarding disorder develops, at least in part, because individuals rely on possessions for emotional support. This may happen when individuals have not learned how to emotionally support themselves or others. According to attachment theory, when primary caregivers inconsistently respond to their infant's needs and emotional states, children do not learn how to support their own emotional needs or the emotional needs of others. As a result, these infants grow up looking for signs of rejection, which may heighten their negative emotion and lead to engagement in strategies meant to gain support and love, but which often fuel interpersonal problems because they are carried out with resentment and anger. This style of interpersonal functioning is referred to as an anxious attachment style. Much of my research

has shown a link between an anxious attachment style, emotion dysregulation, poor interpersonal functioning, and hoarding disorder. As a result, I believe that treatment for hoarding disorder must target these factors.

Your conference in the Congress is titled: "Understanding and Treating Hoarding Disorder", could you tell us what would be the main elements to take into account when designing a treatment for hoarding disorder?

During my keynote, you'll learn that I think modules targeting emotion dysregulation and interpersonal functioning are missing from current treatment for hoarding disorder. These two facets seem to underlie many people's excessive attachment to objects, and we need to reduce object attachment if we want people to be able to part with their possessions.

Focusing on the effectiveness of OCD in children and adolescents, and taking into account your training as a clinical researcher, what ingredients should treatment for resistant cases have or whose relapses are frequent in the short and medium terms?

Basic research has taught us that extinction learning is context dependent. Thus, we must realise that exposure and response prevention is not a cure for OCD. We need to use treatment strategies that help reduce context-dependent relapse (e.g., the passage of time, being in different environments) and inform clients of this up front. This way we can help reduce the chance of relapse and teach our clients how they can help in this regard. As for treatment resistant cases, we need to be looking into how we can enhance exposure and response prevention. For example, we know that sexual and harm obsessions are more difficult to treat. Research also has indicated that sexual and harm obsessions trigger shame, in addition to anxiety, but research has not explored whether ERP reduces shame. If exposure to feared events does not reduce shame, we need to figure out which strategy does.

Finally, and focusing on this moment in time during the COVID-19 Pandemic, how do you think this virus is affecting OCD and related disorders? Will it have more of an effect on patients with symptoms of contamination?

It seems that COVID-19 has had variable effects. Some, even those with contamination concerns, haven't been too concerned with contracting COVID-19. For others, COVID-19 has supported their belief that they should be overly concerned with contamination. This highlights the idiosyncratic nature

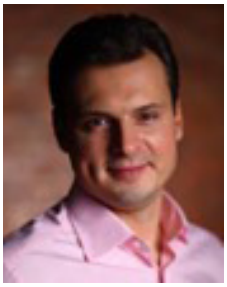
of OCD and the need to fully understand each person's underlying beliefs and how those beliefs fuel avoidance.

What about hoarding disorder during the COVID-19?

The same goes for hoarding disorder. It really depends on an individual's circumstances. Discarding is always hard and COVID hasn't changed this. For some, the only impact has been that charity organisations are closed and not accepting goods. For others, the lockdowns have reinforced their beliefs that they need to save to always be prepared. And yet for others, they are using the pandemic to directly challenge their beliefs that they need possessions to manage loneliness and are now discarding more possessions.

COMMUNICATING WITH DIFFICULT PATIENTS

Dmitrii Kovpak



Dmitrii Kovpak is a Professor of Psychology at North-Western State Medical University Mechnikov in St. Petersburg. President of the Association for Cognitive and Behavioral Psychotherapy.

**Tell us about the role of psychologists in your country – what is the current situation regarding clinical psychology in Russia? Are clinical psychologists fully integrated in the Russian health system? What's the relationship with other mental health professionals? Could you tell us about the main tasks they carry out within the health system?*

In Russia, there is a clear trend of growth in the number of psychologists, primarily clinical psychologists. This is the result of an interest among specialists in the field of psychology in clinical phenomena that help in actively studying the specific mechanisms of the human psyche. On the other hand, the demand among our country's population for qualified non-pharmacological care and nonbiological therapies in the field of mental health is very high.

Clinical psychology in our country has a long history of development and is based on the fundamental national scientific school of psychology and its traditions. At the same time, due to its active integration into the global scientific environment and practical psychological assistance, the modern model for clinical psychology is becoming more functional, flexible and multifaceted.

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Unfortunately, the integration of clinical psychologists into the treatment process in the mental health field, despite their broad representation in public health, is much more active in private forms of psychological assistance to the population. The number of private practitioners in the field of clinical psychology exceeds those who work for public organizations, both in terms of the absolute number and in terms of the volume of assistance provided to the population.

In public clinics and outpatient clinics, the integration of clinical psychologists is often declarative and formalized. It is reduced to the implementation of routine narrow-profile tasks, without the full implementation of a wide arsenal of the capabilities that a modern, competent specialist in the field of clinical psychology can provide. Private organizations involving clinical psychologists who assist the population in mental health are often more flexible and innovative, more fully and adequately meeting patients' demands.

Clinical psychology in Russia has been like "Cinderella", existing in the shadows of general psychiatry. The attitude of colleagues among psychiatrists has sometimes been somewhat defensive. The successes of modern psychotherapy have helped clinical psychologists to become equal partners, providing assistance to the population and supporting the development of modern psychiatry through the second and third words in the title of the biopsychosocial model on an equal footing. This allows psychiatry to become a more modern, innovative, socially integrated and holistic discipline.

The Ministry of Health of the Russian Federation has officially declared adopted a "team" approach in the provision of assistance in the field of mental health. In this approach, both in public and private institutions, psychiatrists, clinical psychologists, speech therapists, social workers, physical therapists, and even specialists in internal medicine can be brought together to create functional teams. The teams can vary in composition and size depending on their profile and the challenges they face. For example, in the case of neurorehabilitation for stroke patients, they are treated by a large team, including a neurologist, a psychiatrist, a psychotherapist, a physiotherapist, a clinical psychologist, a speech therapist, a specialist in social work and an instructor for the development of motor skills. In the case of patients with psychosomatic disorders, psychiatrists, psychotherapists and clinical psychologists form a similar multi-professional team. That also includes neurologists (pain neuralgic syndrome, hypertonicity of the muscular system, pseudo-paralysis and pseudoparesis, etc.), gastroenterologists (for example, in the case of Irritable Bowels Syndrome (IBS), functional biliary dyskinesia, functional enteritis and colitis, etc.), cardiologists (anxiety disorders with dysfunction in the cardiovascular system), dermatologists (dermatitis, psoriasis, neurodermatitis), pulmonologists (functional disorders of the respiratory system) and other specialists (physical therapy instructors, kinesiologists, massage therapists, physiotherapists, yoga

instructors, specialists in meditation and mindfulness practices, stretching trainers, Tai Chi (T'ai chi ch'üan) and Wushu instructors.

Clinical psychologists perform a wide range of tasks, such as psychological diagnostics and testing, individual and group psychotherapy, psychoeducation and psychological support and prevention.

> *As the president of the Association for Cognitive and Behavioral Psychotherapy, could you specify what the distinctive role of cognitive-behavioral psychologists is compared to the clinical psychologists that are part of the Russian professional network?*

The distinctive features of clinical psychologists specializing in cognitive behavioral therapy in Russia include a highly developed structure in their work, methodological transparency, a clarity in the model for therapy for both professionals and their patients and a high degree of compliance and quality in the therapeutic relationships. All this allows patients to be actively motivated and involved in therapy, with a number of techniques and technologies for independent use consistently being delegated them, alongside the formation of an active involvement in the therapeutic process and a responsibility for its results.

> *Given the high levels of psychosomatic disorders, depression and anxiety-related problems detected in primary care, as well as the difficulty in accessing psychological treatments at this level in Spain, we are currently working on the integration and recognition of clinical psychologists in all the different levels of the health system and specifically in primary care. Does your healthcare system face the same challenges and what is being provided to patients with these kinds of problems? Are there plans for the future? Do you think that patients are being offered the appropriate and optimum help in terms of resources, access to psychological treatment, and so on?*

We face exactly the same problems as our Spanish colleagues. These include the same leading disorders in a large part of the population, such as anxiety, depression and psychosomatic disorders. What is more, we encounter similar difficulties in the optimization and integration of resources to provide affordable, competent and high-quality psychological assistance. Today, the improvement of such assistance is mainly a result of the flexibility and innovation of the non-state forms of its provision. In addition to face-to-face reception of patients in the form of individual consultations, family therapy, group psychotherapy, skills training, coaching and other modern models, new technologies of remote assistance via the Internet (in good cases, through specialized secure software and communication channels, but we often encounter assistance via Skype, ZOOM

and other programs) in the form of individual reception, group psychotherapy, online workshops and webinars for clients, even including such unusual options as "marathons" with a series of varied surveys and assignments - all these options are being used with increasing frequency and scope. Specialists seek to expand their audiences and that includes their work with younger sections of the population, through the use of the specific communication channels that they prefer. Mental health specialists try to attract the attention of potential clients not only through popular articles published in specialized psychological web resources, but also through illustrated posts and videos distributed on social networks. This form of reporting has a dual purpose: both the dissemination of elements of psychoeducation and the promotion of clinical psychology, as well as the advertising of their private services and the formation of personal brands for each specialist.

> *As we mentioned previously, psychosomatic disorders are one of the most prevalent issues encountered in primary care. You have organized various conferences related to psychosomatic disorders. What are the demands and needs of Russian psychologists (and any given psychologist) in approaching these problems? In your opinion, what is the role of psychology in this specific field?*

For the past twenty years, I have been organizing various conferences in the field of mental health, including those dedicated to psychosomatics. I am convinced that psychotherapy and clinical psychology have a leading role in this field. Psychotherapists and clinical psychologists consider a person not as a set of tissues and organs, but systemically and holistically. Many reports and theses over the years have been devoted to the role of psychology in understanding the mechanisms of the central genesis of psychosomatic disorders. Higher neurological activity in the context of Ivan Pavlov's works is considered to be the integrator of all organs and systems of one organism. Both internal and external conflicts of the person, his mental overstrain and distress are of key importance for understanding the etiology and pathogenesis of these difficult disorders. We have numerous randomized controlled trials that confirm the clinical efficacy of psychotherapy in general and cognitive behavioral therapy in particular in addressing this type of disorder and the issues that it presents to the general population.

> *You also organize periodic conferences oriented around the modern practice of Psychiatry. In this regard, what practices/tendencies in mental health are currently focused on Russian professionals and researchers?*

As a general trend in recent years in Russia, we are seeing the increasing role of clinical psychology in the field of mental health and the potential of the psychological and social component in the biopsychosocial model in contemporary psychiatry and psychotherapy. In Russia, the ideas of modern brain sciences (neuroscience) and the methods of the cognitive behavioral approach are becoming more and more popular.

> *From a global point of view, we are witnessing a crisis in mental disorders classification/diagnosis systems as well as a downturn in the biological models applied to mental health. How is this crisis or debate impacting psychology in your country?*

A revision of the classification and diagnostic models is unavoidable. We cannot effectively operate only with a mechanical sum of clinical phenomena turning them into lifeless labels of formal diagnoses that emasculate the complex mechanisms involved in the genesis and maintenance of the dysfunction and pathology of the mind and body. The current DSM and ICD models have been widely criticized by specialists. This is largely justified. Modern classifications are more convenient for healthcare providers and insurance companies than they are for clinicians and practitioners. They are convenient for reporting, but they tend to create the illusion of understanding disorders rather than revealing their basic mechanisms for the treatment of the causes rather than the consequences, which is to say that they eliminate pathogenesis rather than symptoms. The value of a transdiagnostic approach is widely recognized as it is more likely to reflect the everyday life experiences of individuals with mental health problems, at the same time increasing the likelihood that inquiry and treatment are in line with underlying mechanisms, neurobiology, social environment, personal resources and optimally effective interventions.

Yes, we still face a number of mysteries about what consciousness is, how the leading mental processes actually function (take, for example, human memory alone, the models for which are obviously not yet exhaustive). Therefore, in Russia, there is a long-lasting tradition of expression which states that we treat the human and the individual, not the diagnosis and disease. A human is an open, complex, dynamic system. It's a lot harder than just applying labels. We have no way of telling how broad the person's interconnections are within the widest neural network with 86 billion neurons and the trillions of connections between them. These internal relationships result from learning not only simple conditioned reflexes, but also thinking and language, a symbolic system or Ivan Pavlov's second signal system and external social relations from the microsocial system titled the family to the macro-social level of state, ethno-cultural, gender, professional, religious, political or other value systems. Ignoring these factors and connections critically reduces medical and psychological care to the level of

professionals who "specialize in left little fingers," as we call it here, professionals who might consider a person, regardless of the universe, within the framework of a model of a "spherical horse in vacuum" (as something ideal, but existing only in theory and impossible to apply in practice; in theory, however, it "lives and works" perfectly). In psychotherapy, we try to talk not about a complex client, but about a complex client case. Meaning that it is the case that is difficult for us, rather than the person himself being difficult or simple.

Regarding the conference you will be presenting during the XI Congreso Internacional de Psicología Clínica in Granada on communicating with difficult people, could you give a more detailed description of what a difficult person is? Why is it so important that clinical psychologists are aware of these difficulties and what are the core competencies they should develop in order to approach these situations?

A difficult person for us is someone whom we don't understand, whose motives are not clear to us, and whose behavior does not fit into our patterns of perception and information processing. These are the people with whom communication is most difficult or ineffective. A difficult person is not a problem, but he or she is a challenge not only for professionals but also for the general population. After all, a new experience lies beyond the borders of our patterns of thinking and behavior. By going beyond these limiting beliefs, we can gain not only greater knowledge about others, but also about ourselves.

After all, in the philosophical tradition, the Other with a capital letter is a mirror of our soul, communication with whom is an important step in our development. The skills and competencies of psychologists in building effective communication go far beyond the clinical model. They also relate to interpersonal relationships, working with families, groups and organizations.

One of the aspects you will be focusing on in your conference is interpsychic and intrapsychic conflicts in communication. How do these conflicts manifest in a psychotherapeutic context and how can they affect the patient-psychotherapist relationship?

Intra-psychic and inter-psychic conflicts are not just closely related. They are an integral continuum. The whole person is a holistic phenomenon as well. Being mere observers, we notice only parts of it, but as researchers, we split it into components. After dissecting it into parts, we can look inside this "machine", but we cannot see the spirit connecting its elements – the psyche. Conflicts expose this spirit at the peak of contradiction, demonstrating how it works in life. Experiments on dissected mice may provide unsatisfactory models and obviously incomplete analogies. The map is not a territory.

In cognitive behavioral therapy, diagnosis has been transdiagnostic since the early works of A. Ellis, A.T. Beck and then their followers. This was perfectly helped by the conceptualization proposed by A. T. Beck, and then modified by J. S. Beck. Examples of overcoming the problems of modern classification in cognitive behavioral therapy are the current model of holistic conceptualization, where the problem-oriented conceptualization of J. S. Beck is complemented by a resource-oriented conceptualization – a strength-based cognitive conceptualization diagram. Other modern examples of the transdiagnostic approach of CBT include David Barlow's UP-transdiagnostic protocols and Process-Based Therapy (PBT, previously titled Process-Based CBT) by Steven C. Hayes and Stefan G. Hofmann, as well as cognitive behavioral therapy based on needs (NBT, Need-based therapy or NBCBT, need-based cognitive behavioral therapy), which my colleagues and I from the Russian Association for Cognitive and Behavioral Psychotherapy have been developing for many years and continue to develop.

In most types of psychotherapy, therapeutic relationships are regarded today as one of the leading factors in its effectiveness. It's neither just compliance and cooperation, nor mere adherence to therapy. It's a really specific (and not non-specific, as earlier believed) factor of therapy. Therapeutic relationships can help a client (and sometimes a therapist as well) to form new experiences and new patterns of thinking and behavior. Professional development of high-quality complementary relationships enables the fullest use of therapeutic relationships in many aspects of therapy. Conflicts often lead to difficulties in therapy for both participants and even raises the likelihood of patients' withdrawal from therapy.

> *Your abstract appears to contend that you regard cognitive-behavioral therapy as an adequate technique when approaching these communication problems. Could you elaborate on this idea? What are the main tools that cognitive-behavioral therapy can offer to solve these communication problems?*

Cognitive behavioral therapy provides a wide arsenal of techniques and a well-developed and scientifically based methodology for solving problems caused by interpersonal conflicts and miscommunication as individuals, as well as groups and organizations. I'm not afraid to say that global conflicts between countries and political blocs could be solved much more effectively by relying on clinical psychology and psychotherapy, overcoming the cognitive distortions, biased thinking and intrapersonal problems of politicians and decision-makers, which affect their uncritical preferences and choices. There is much more that unites us than divides us. Russians and Spaniards, Asians and Europeans, residents of Granada and Madrid, or even residents of Barcelona and

Bilbao. What separates us is often the result of cognitive distortion rather than irreconcilable contradictions. The leading diagnostic tool of CBT is the analysis that allows to identify both external manifestations and internal processes that contribute to the formation and development of miscommunication and conflicts. CBT is based on the theory of learning and clarifies the models built by a person on the basis of their experience.

From the point of view of CBT, a person learns the patterns for the processing of incoming information and its interpretation, which then forms the basis for further requirements. Some of these models become dysfunctional for several different reasons. These reasons include, for example, specific parent-child relationships. A child may receive insufficient attention, lack emotional support, love and care. Any child is largely trained by reinforcements from significant adults. An "emotionally cold mother" (for example, a depressed one or one suffering from a personality disorder) or her absence can lead to deficiencies in the formation of effective communication skills, self-regulation and social competencies. A person's belief system may include various dysfunctional schemas, beliefs of different levels that have arisen as a result of traumatic experiences or lack of satisfaction of significant needs.

This significantly affects a child's perception, thinking and behavior. The realization of his or her own needs, from basic to social ones, will be difficult for such a person. Deep beliefs of non-acceptance or helplessness will force them to build a system of rules, walls of defenses and compensatory strategies designed to protect them from new pain, disappointments and failures.

But this entire arsenal turns into a suffocating cocoon. Instead of protecting, it leads to a person being distanced from others and the world, reliably preventing the realization of his or her need for contact. As Somerset Maugham wrote,

> "Each one of us is alone in the world… We seek pitifully to convey to others the treasures of our heart, but they have not the power to accept them, and so we go lonely, side by side but not together, unable to know our fellows and unknown by them. We are like people living in a country whose language they know so little that, with all manner of beautiful and profound things to say, they are condemned to the banalities of the conversation manual. Their brain is seething with ideas, and they can only tell you that the umbrella of the gardener's aunt is in the house."

Awareness of such limitations and dysfunctions is possible both through cognitive analysis and conceptualization with the introduction of alternatives through therapeutic disputing and through the influence of new behaviors.

We don't you to reveal the entire content of your conference or to provide spoilers, but could you tell us about some of the best and essential practices in efficiently communicating with difficult people?

Naturally, there is no magic sleight of hand, no waving of a wand or manipulative tricks which can simultaneously resolve all the accumulated human communication problems and help us manage people the way it's done in movies. However, mindfulness and acceptance practices and skills trainings will help us establish the necessary tasks and form useful competencies. Psychological flexibility, based on the elaboration of our cognitive distortions, the formation of useful skills (e.g. concentration, active listening, self-regulation, assertive behavior, etc.) can significantly expand the range of communication and the possibility of constructive contact with a wider range of people.

Overgeneralizing and labeling, emotional reasoning and mental filtering, magnifying negatives and minimizing positives, personalizing and catastrophizing, polarization splitting (all-or-nothing thinking, black-or-white thinking, dichotomous reasoning), making "must" or "should" statements and frustration intolerance are examples of cognitive distortions and dysfunctional rules of thinking formed on their basis. These are limiting beliefs.

They significantly influence the possibilities of communication, narrowing the range of choice and subordinating narrow and rigid dysfunctional patterns of thinking and behavior. Not everyone can fit in this hard Procrustean bed. And then it will inevitably become difficult for us. Accepting ourselves (self-acceptance) and accepting others as they are is not only an encouraging slogan, it's also a systemic practice that contributes to a significant change in the system of relations between ourselves and others.

CBT clarifies the algorithms of these practices, making them understandable and implementable for both clients and patients. Overcoming the learned helplessness and development of the competencies described above also significantly expands the behavioral repertoire of choice and communicative flexibility. As a specific exercise, I can give an example of working with acceptance. Try to observe what you don't like about other people. Write down ten of the most annoying or frightening things that you can recall. See how you feel about such things with regard to yourself, if you identify them in your own personality.

Do you condemn them, are you afraid to show them, do you try not to notice them? Over the next week, try to set yourself a challenge for a complete, non-judgmental acceptance of these qualities in yourself and other people. Watch how it affects your communication.

We hope you enjoy your participation in the Congress that will be held in Granada. Is there anything you would like to add before we conclude our interview?

I would like to thank the organizers of the Congress for the invitation. It is a great honor for me. I am very grateful for the opportunity to speak to an international audience of colleagues. I would also like to thank the entire, large team for their great and very important work in preparing for the Congress.

CULTURAL ADAPTATION OF PSYCHOTHERAPIES

Shin-ichi Ishikawa

Shin-ichi Ishikawa is a Professor of Psychology at Doshisha University, Kyoto. Member of the Executive Board of the Asian Cognitive Behavioral Therapy Association.

**The subject of your presentation at the upcoming 13th International and 18th National Congress of Clinical Psychology is the cultural adaptation of cognitive behavioral therapy for anxiety in children. To set the scene regarding this subject, what is understood by the approach of cultural adaptations of psychological therapies? When and why did the first proposals arise in this field and what is the current situation in this line of research?*

The effectiveness of cognitive-behavioral therapies (CBTs) as psychosocial treatments have been established in outcome studies. However, the research has focused exclusively on populations from Western cultures; consequently, studies considering cultural influences related to ethnicity, religion, sexual orientation, disability, or social class are scarce (Iwamasa & Hays, 2019). Cultural adaptation is the systematic modification of an evidence-based treatment or intervention protocol considering the language, culture, and context of the client (Bernal et al., 2009). It is unavoidable when implementing evidence-based psychosocial treatments.

The concept of cultural adaptation first appeared in the healthcare literature in the 1990s (Saha et al., 2008); however, cultural mismatches in delivering

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mental health services have already been reported. For example, Sue (1998) articulated in American Psychologists that cultural competency, which consists of a triad of ethnicity, services, and cognitive matches, is essential in psychotherapy. Forehand and Kotchick (1996) advised behavioral therapists to be more sensitive to cultural contexts when providing parent training. Since then, several theoretical models have been proposed for cultural adaptation. Considering the globalization in today's society, cultural adaptation is practically required for all clinicians, especially when they provide a CBT to their clients from diverse cultures.

> *With regard to the fact that the studies, the psychological treatment protocols and the recipients of these interventions are centered on a specific culture, what risks are involved in applying them to other groups outside the cultural context for which they were designed?*

Regardless of cultural diversity, functional communication is fundamental to cognitive-behavioral approaches. Culture-adapted treatments focus not only on improving therapeutic outcomes but also on increasing client engagement, knowledge and buy-in of treatment processes and methods, and consumer satisfaction, improving therapeutic relationships, and reducing premature dropout (Hwang, 2016). As CBTs have been developed in the Western cultural background, they inherently include flavors from these cultures. Here, I would like to give two examples of cultural adaptation for Asian population. First, Asian clients tend to somatize their emotional symptoms more than those from Western cultural backgrounds, emphasizing talking about problems and verbally expressing themselves (Chun et al., 1996). Second, the stigma of mental health and treatment is prevalent in Asian countries. Therefore, Asian clients typically take more time to verbally communicate their emotional difficulties. These examples show the risks of difference in cultural context in conducting therapies for children and adolescents from Asian cultural backgrounds.

> *Taking into account the different studies that have adapted these psychological treatments to minority groups or cultures other than the Anglo-Saxon one, what results have they found? Is it better to apply culturally adapted therapies in these groups or the original, non-adapted therapy?*

Several meta-analyses supported the efficacy of culturally-adapted psychosocial treatments. Griner and Smith (2006) conducted the first meta-analysis of 76 studies on culturally-adapted mental-health interventions and found a medium average effect size ($d = 0.45$). In particular, interventions provided to same-race participant groups ($d = 0.49$) were more effective than

those provided to mixed-race ones (d = 0.12). A subsequent meta-analysis focused on refining the criteria also found a moderate effect size (d = 0.46; Smith et al., 2011). Moreover, a meta-analysis directly comparing adapted and unadapted treatments showed that culturally-adapted psychotherapies were superior to unadapted bona fide ones (d = 0.32; Benish et al., 2011). Finally, Hall et al. (2016) integrated 11 meta-analyses involving 78 studies and 13,998 participants. The overall effect size supported higher efficacy of culturally-adapted interventions than other conditions (g = 0.67) and unadapted versions of equivalent interventions (g = 0.52). Overall, the evidence demonstrates the efficacy and effectiveness of culturally-adapted treatments.

> *One of the aspects that have received the most attention regarding the cultural adaptation of cognitive-behavioral therapy to Asian contexts in adults has to do with the interdependence of Asian cultures versus the focus on social contexts of cognitive-behavioral therapy. Could you explain this problem to us? What other peculiarities are there for psychological intervention in Asian contexts that are not usually considered from an Anglo-Saxon or European perspective?*

Asian societies are generally considered interdependent. However, an effortful discussion is needed on how the context might affect the implementation of CBTs. Our study suggests that the correlation between independent and interdependent self-construal is much stronger in adolescents in Japan than in those in the UK, while the linear effects of self-construal and social support on psychopathological symptoms do not differ between populations in the two countries (Essau et al., 2013). Considering that the concepts of independence and/or interdependence can be evaluated based on cultural norms, the mechanism of the effects is complicated. For example, according to the guidelines of treatment trials for child and adolescent anxiety disorders (Creswell et al., 2020), independent diagnostic interviews for the child and parent is recommended; however, joint parent and child interviews might be more acceptable in Japan, considering the social norms of consultation with health professionals (Ishikawa et al., 2019).

Moreover, somatization and stigma, which I have discussed previously, should be considered when introducing psychosocial interventions. Clinicians in Western cultures may misunderstand clients from Asian backgrounds as less-motivated or less-engaged if they are reluctant to talk about their symptoms. However, a passive attitude toward authorities might imply respect for Asian individuals (Hwang, 2016). Given their cultural norms, it takes more time to accept such conversations and clinicians should appreciate the communication attentively, especially in the first few sessions.

According to your line of investigation, the analysis of the scientific evidence on cognitive behavioral therapy for anxiety in the child-youth population, what are the peculiarities in terms of cultural biases? What role does the cultural context play in these results and what implications does it have?

Although a meta-analysis by Hall et al. (2016) supported the efficacy of culturally-adapted psychotherapies, evidence for children and adolescents of Asian culture is scarce. Of the 27 studies that focused on youths, only three included Asian populations. In addition to systematic reviews, scientific evidence of psychosocial interventions for ethnic minority youths in the USA is available in Journal of Clinical Child & Adolescent Psychology (Huey & Polo, 2008; Pina et al., 2019). Again, while the efficacy of CBT for Hispanic/Latino individuals with anxiety disorders was supported, no studies were found on Asian populations.

To fill this gap, we developed the Japanese Anxiety Children/Adolescents Cognitive Behavior Therapy (JACA-CBT) program and conducted the first randomized controlled trial with Japanese children. We found a significant difference between the treatment and waitlist groups post-treatment; specifically, 50% of participants in the treatment condition were free from their primary diagnoses compared to 12% in the waitlist condition (Ishikawa et al., 2019). Therefore, CBTs can be universally effective for anxiety disorders in children and adolescents. However, it is premature to detect mediators or moderators owing to a lack of clinical trials. Specifically, we could not reach consensus regarding the mechanism of a culturally-adapted treatment for youths with anxiety and the target for whom a modified intervention is required in each cultural context.

Although the need to carry out these cultural adaptations to improve the efficacy of interventions has been recognized in the scientific literature, do we have evidence-based protocols to carry out this process with guarantees? Currently, what is the most recommended methodology that ensures that the essential elements of the original protocol are preserved? What phases does it involve?

Higa-McMillan et al. (2016) reviewed research spanning over half a century on the treatment of children and adolescents with anxiety disorders. According to the review, 145 of 165 studies (87.9%) included exposure as an active therapeutic element. Moreover, the within-effect size of exposure was large (1.05), even when the component was extracted from the integrated treatment approach as CBT (1.19). Considering that the main components of integrated cognitive behavioral programs are exposure-based techniques, exposure is

an essential component for children and adolescents with anxiety disorders. Our program, the JACA-CBT, also emphasizes that therapists should set the maximum possible homework opportunities to engage participants in gradual in vivo exposure in sessions. In addition, in terms of components, our program is comparable to previous evidence-based programs developed in the Western culture. Therefore, the main issues are not related to compliance with the components, but to expression of the components for a specific population.

> *Specifically, in your line of research, in which you have adapted cognitive behavioral therapy for anxiety in Japanese children, what elements or details of the original protocol have been considered essential for the adaptation to this context? To what extent have these modifications resulted in an improvement in the efficacy of the intervention in the case of your study?*

Please let me clarify whether the components of our program are comparable to those of existing programs in Western countries. JACA-CBT has eight sessions, including psychoeducation, cognitive restructuring, anxiety hierarchies, relaxation, and exposure (Ishikawa et al., 2019) and has been adapted for Japanese children and families.

Two major avenues exist for cultural adaptation. The first is a top-down approach, in which an existing intervention for one group is modified for application to another group, and the second is a bottom-up approach that develops an original protocol in a particular cultural context to address culturally-specific concerns (Hall et al., 2016; Hwang, 2016). Although a bottom-up approach is important and indispensable for cultural adaptation, developing domestic psychosocial interventions ignoring existing evidence-based interventions is not sensible. Thus, an approach that capitalizes on existing evidence-based practices may be more practical. Therefore, we applied an innovative bidirectional approach, including both top-down and bottom-up approaches, and aimed to develop a novel treatment based on previous studies, not just translating them (Ishikawa et al., 2019).

Thus, the treatment has considered both contextual and content-related cultural adaptations over the past decade. First, it addresses six contextual adaptations: population, personnel, setting, format, dosage, and procedures. For example, parents are in the same room as their child, receiving explanations and discussing each topic; whereas, parents and children are typically seen separately in Western countries. In addition, the treatment length is shorter (eight sessions) compared with 16 sessions for Coping Cat (e.g., Kendall, 1994). Second, regarding the content, the JACA-CBT tailored materials as well as adjusted elements and time management. For example, culturally-specific

illustrations and acronyms were prepared and the habituation model of anxiety was compiled to encourage the exposure session. Vignettes were associated with socially-relevant situations, given that most clients referred to the clinic had social anxiety disorder, and relaxation was included as a compulsory topic, considering that Asian individuals tend to show their anxiety as physical symptoms.

In your opinion, is it possible to create evaluation tools and intervention protocols for cross-cultural use? What steps should be taken in this field to avoid cultural biases in the research?

We have started a new research project in collaboration with *Macquarie University*, Sydney, Australia (Ishikawa et al., 2023). We developed an observational coding system named the Cross-Cultural Behavioral Observation System (C-BOS) to examine the behaviors exhibited by children, parents, and therapists during CBT sessions. The behavioral system focuses on the topographical aspects of objective behavior that can be observed during CBT to enhance coding consistency between the two countries. In addition, we prepared independent evaluators for each country to confirm interrater reliability.

The results of this study suggest that Japanese children are less ready during the first CBT session and less likely to respond to therapists' questions about their anxiety than Australian children. A higher percentage of Australian children, parents, and therapists talked during the CBT sessions than their Japanese counterparts. This finding aligns with previously mentioned cultural norms. Moreover, although Australian therapists talked less during the final session of the therapy, Japanese therapists maintained a similar proportion of talking throughout the sessions. This finding suggests that Japanese therapists may need to reduce initiative-taking over time so as to avoid monopolizing discussions and better facilitate the transfer of control.

To finish, would you like to add any other comments regarding this subject?

Research on the cultural adaptation of CBTs is scarce, and no study has focused on actual interactions during CBT sessions. Finally, the last study which I mentioned provides practical suggestions that may be useful in the context of culturally-adapted CBT programs delivered in both Eastern and Western countries. Further studies are needed to elucidate the clinical implications of cultural adaptations worldwide.

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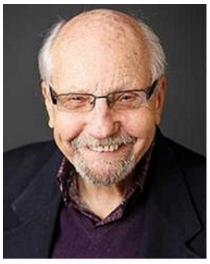
HOW TO SELECT THE MOST APPROPRIATE TREATMENT FOR EACH PATIENT

Larry E. Beutler and Gualberto Buela-Casal



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** During the editing of this book, we received the sad news of the death of Dr. Larry E. Beutler. This posthumous publication serves as a tribute to his brilliant academic career, which will undoubtedly occupy a relevant place in the History of Clinical Psychology.*

Gualberto Buela-Casal is a Professor of Clinical Psychology at the University of Granada (Spain). Founder of the Professorship of Sleep Research at the University of Granada. President of the Asociación Española de Psicología Conductual (AEPC). He is one of the most influential scientists in the world according to the Stanford University Ranking.

**I would like to begin with a more personal introduction, one that allows me to take advantage of the friendship and mutual knowledge we have developed since we worked together on research during my sabbatical at the University of California. Very few people know that you were a professional cowboy before you became a psychologist and that you later*

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decided to train as a psychologist. Tell us why you changed careers and how your previous experience has helped you in your work as a psychologist.

I'm sure many would see these two parts of my life as inconsistent. And certainly what I did as a ranch cowboy and occasional rodeo rider during my adolescence and young adulthood was quite inconsistent with my role as a psychologist. At that point in my life, horses were just something to ride and a way to exercise my physical and mental abilities in an unusual way. Then in 1993, long after I had left the cowboy life and completed my education, I decided to give up my biggest hobby at the time -flying airplanes- because of both the cost and the growing awareness that I was not a good enough pilot to ensure my safety. That was the beginning of the integration of my two passions: psychotherapy and horseback riding. I picked up the passion of my youth and bought an Arabian horse, a used saddle, an old truck and trailer, and began to ride the trails. But I soon discovered that my horse needed training: he had never been out of a pasture in his six years of life, was always nervous and unsteady, panicking if confronted with a wind-blown tree or walking through water. Drawing on my childhood experiences, I decided to train him myself. After all, I had ridden wild colts, roped trained horses, and owned half a dozen Arabians and half-Arabian horses before I left that life at the age of 19. Then, over the next few years, I discovered that training horses was a different experience than it had been in my youth. For the next seven or eight years, I became a student and then a professional horse trainer in a discipline called "Natural Horsemanship". This was in my spare time, because at that time, as you know, I was a full-time professor at the University of California, Santa Barbara. It was during this time that you and I first met. It was also during this time that I came to understand many things about psychotherapy and healing relationships through my work with horses. I learned that people, like horses, don't care how much you know until they know how much you care. I discovered that collaboration is a more effective agent of change than control. I also learned that it is the consequences of an action that teach a new one, that you often have to allow animals/humans to make mistakes in order to change them, and that punishment doesn't always work as well as reward. Of course, I "knew" all these things: I had studied these ideas in college, practiced them as a psychotherapist, and taught them to other students. But there was something about the honesty and immediacy of seeing them in action as I trained horses, worked with riders, and applied the "horse sense" I had observed and developed to negotiating difficult human relationships that really brought these principles to life. Today, in retirement, in addition to consulting on psychotherapy research, supervising my Ph.D. students, directing research programs, and lecturing, I have more firmly established the distance between my role as a "horseman" and my role as a "science-based

practitioner. My wife and I run an equine assisted therapy program, using this focus for both research and teaching my Ph.D. students. We work with women who have been subjected to domestic violence and are learning a great deal about how the identification they develop with a horse - who is, after all, a prey and perpetual victim - can bring healing and empowerment. Here's the short answer to your question.

> *I know you don't like to brag, but I think it's interesting for a personal presentation to report that you're in the top 100 bareback horse riders in the United States of America. Can you explain to our readers what bareback horse riding is and how someone who devotes so many hours to research in psychotherapy has time to be in this ranking?*

I think the more important question is how and by whom such rankings are made. For my part, I refuse to make such a concession and consider myself a perennial student of the horse, just as I am a perennial student of the person (none of us is expert enough). There are many, many who are better than I am both as a psychotherapist and in working with a horse in "freedom," as we may call it. But aside from the question of the validity of the label you have kindly given me, your question is an important one in understanding my interest in reconciling my interests in the horse and in psychotherapy. The test of whether one has a relationship with one's horse is to see what one can do when the horse is free to choose its own behavior. This is when the horse has no restraints. No saddle, no halter, no bridle, just you and the horse. It is said, "When the bridle is removed, all that remains is honesty. What the horse does, it does because you are a couple; it chooses to do it without intimidation, threat, pain, or coercion. My wife and I met at a horse boarding ranch in Santa Barbara. She sought me out, she tells me, when she saw me the first day she got there and saw me riding my white horse, Taj (you met him when you were in Santa Barbara), with nothing on his head or back, just me. Taj and I galloped over the remote hills and trails, his mane flying and my bald head glistening in the sun. I imagine she was impressed. I still ride, often without a bridle, asking my young horses to follow my directions as we jump, practice sliding stops, turn in fast circles, and chase cows. These days, however, post-kidney transplant and at age 74, my balance is not as good as it once was, so I usually ride with a saddle. But working at liberty also takes place when the cowboy is standing on the ground. I stand in my arena, without a rope or other props to tie me to the horse, and ask him to stand on a stand, do the figure eight around two barrels, zigzag through the obstacles, go over the jumps, and sit on my lap. He does everything but sit on my lap, all in the name of relationship. I often think that if we psychotherapists could learn to develop this kind of cooperative trust with our patients, we might actually improve our psychotherapeutic outcomes. Are we too preoccupied

with their resistance, our performance, and establishing control to allow for such intense collaboration? I wonder. What I know most about horses that applies to psychotherapy is that "resistance is not the patient's problem, but the therapist's failure to provide a safe enough environment. There are few horses or patients whose resistance is a trait they carry with them. Resistance does not occur in a vacuum, it occurs because the therapist or trainer does not know how to provide a safe enough environment.

> *I once heard you give a great talk on how animals differ in their defense and self-protection behaviors, using the example of predators such as lions (carnivores) and predators such as horses (herbivores). These differentiated patterns of behavior were the origin of your model of differential selection of psychological treatment for each patient, briefly explain how these animal behavior patterns gave rise to his treatment model.*

Let me qualify your assumptions: these differences among animals that I (and others) have described did not lead me to develop my ideas about differential treatment selection, but rather provided a metaphor that helped me describe how the principles I use in psychotherapy work. I have come to believe that many of the same principles that work with animal thinking also characterize people. My wife, a devoted animal advocate, taught me that animals have feelings, that they are not simply stimulus-response machines. And when I give them problems to solve, I can see it in them cognitively. In the animal world, the difference between predator and prey is very important. Humans are predators by nature and, as such, are the potential enemies of most animals and are prone to be destructive to each other as well. Our predatory behaviors are as natural to us as they are to lions, tigers, and other carnivores. But most animals are biologically assigned to their roles as predator or prey and cannot deviate from them completely. We humans, however, can overcome our assigned roles through knowledge and will. Many people fail to make this choice and continue to live as predators. They remain enemies of animals, humans, and even the environment. The prey of these predatory people can become trapped in "victimhood", and the predatory people themselves can become addicted to power, money, and control, which are the badges of their predatory nature. But, as we have learned with our groups of victimized women in our Equine Therapy Program, victims can become "survivors". They do so when they are empowered and can resist the compulsion that often causes them to recoil from victimizing their husbands/partners. They can take a stand, file complaints against harassing bosses and restraining orders against partners. They can empower themselves with education and knowledge. Even predators can, though they rarely do, abandon their lust for power and control and find

pleasure in equality. This parallels what you are saying. Predators and victims require different approaches, seek different ends, have different reinforcers, and respond to different styles of therapy. This is just one part of the *Systematic Treatment Selection* (STS) treatment model that I have proposed. I developed it primarily as a non-theoretical but scientifically based response to the Tower of Babel that our craving for theories of change has given us.

You will be presenting your model at the congress. Briefly tell us what it consists of and what advantages it has over other psychological treatment selection strategies.

STS is a means of applying the scientific knowledge that has been accumulated in the process of change to the practicality of tailoring treatments to each individual patient. Its major advantages are that it is transdisciplinary, minimizes the role of unsupported theory, and is practical. We have looked at the styles and sub-styles, even accumulating psychotherapies for different conditions, and found that these lists are largely at odds with the now overwhelming evidence that "all [styles] have won and should be rewarded". We differ from most scientifically oriented researchers/practitioners in that we believe what good research tells us. Let's say that (1) among the more than 1. 000 styles of psychotherapy, there are few (if any) treatments whose effects are specific to a particular diagnosis; (2) most evidence-based psychotherapies produce similar and nearly equivalent results; (3) there are numerous therapist and patient factors (independent of diagnosis) that contribute more to change than either the style of psychotherapy being practiced or the diagnosis of the patient receiving it; (4) relational and contextual factors are probably more important than "treatment" in effecting change; and (5) the research methods currently dominant among evidence-based researchers are designed to minimize or ignore the importance of these therapist, patient, relational, and contextual factors in change. They rely only on "interventions" (among the least important of the many contributors to change). STS is a means of creating an individualized, transdisciplinary, empirically driven treatment for each patient, rather than for those tied to one type of diagnosis. This individualized treatment plan can be applied systematically or prescriptively by therapists of many different viewpoints who can be easily trained to integrate STS principles into their theory-based approaches.

When we teach undergraduate and graduate students, we usually tell them that there are different strategies for selecting a treatment: the most effective technique, the most effective technique, the most efficient technique, functional analysis, differential treatment selection, the key behavior technique, etc. Let's focus on the latter. It is said that if we

change a" key" behavior that is highly related to the problem behavior, the problem is eliminated. Does this really happen in reality?

Let me expand and integrate this perspective, if I may. No, I don't think the problem is like blocks stacked on a playground. Don't pull the bottom one out to find that all the others have fallen apart. But I do believe that the effort to identify a "key" problem behavior in order to affect a chain of problems is logically the same as the effort to define a "central conflict theme" that then guides the focus of treatment.

Under various names, from psychodynamic to cognitive, these approaches share the hope that conflicts or related behaviors tend to generalize. It is a persuasive idea, and no doubt the interconnectedness of symptomatic behaviors, the fact that there are few symptomatically "pure" disorders, predisposes that a change in one symptom cluster will have an effect on other clusters and related symptoms. For example, changing one patient's substance abuse will change another's depression, family functioning, and so on. Similarly, a change in a core theme of emotional dependence or a key symptom cluster may be followed by changes in assertiveness, marital satisfaction (at least for one spouse), and self-esteem. I recall a 27-year-old severely anorexic patient I worked with for three years who was "cured" of anorexia one week after her "codependent" husband left her. My understanding of this research, which may not be entirely current, leads me to urge some flexibility and to avoid assuming that the observed patterns operate the same for all patients. In the STS system, our evidence demonstrates that patients who adopt an internally focused interpersonal coping style benefit quite a bit from a therapy orientation that identifies key issues and focuses the therapeutic goal on resolving negative interpersonal issues and related symptom clusters. However, patients who tend to be more externalizing in their typical ways of dealing with conflict and change often misuse this type of therapy and respond better to one that matches their own orientation and readiness for action. Narrowing the goals of change to clusters of symptoms rather than issues and linking those symptoms to the direction of change with overt consequences, is a more compatible treatment option. So, yes, I am hopeful about these strategies that rely on generalizing change from some behaviors to many, but I am also skeptical that all patients will be equally prepared to respond to this approach. We need to identify and develop measures that allow us to use different therapeutic stances and perspectives to facilitate individual patterns of change.

In recent decades, the selection of therapies based on empirical validity has become increasingly important, which is undoubtedly positive, but the proliferation of agencies and institutions that evaluate the empirical validity of treatments (NICE, APA, national agencies,...) is increasing,

and this is a problem for professional clinicians, because depending on which catalog they consult, they will find different treatments listed and also that some treatments have empirical support in one list and not in another. What do you think about this and what could be the solution?

There are currently more than 200 empirically supported therapies, each of which is on at least one of many "lists". Why do you think there is such a proliferation of "scientific" models and lists? Their number is certainly beyond the capacity of any therapist to learn. Any one of these therapies will require a therapist to learn and practice for several years, and a significant proportion of experienced therapists will not be able to become sufficiently amenable to be used in a clinical trial. Would there be so many failures and so much difficulty in maintaining adherence if the therapist was producing markedly better results? I think not. I think we need to face the fact that we have failed to find the promised improvement in efficacy and effectiveness and accept the reality that another clinical trial is not going to solve the problem. If we were able to see meaningful effects at the clinical level, wouldn't we expect to see a relatively small number of specific treatments for specific emerging diagnostic conditions? I believe that the process of identifying empirically valid treatments is out of control because this movement has narrowed the focus of what is defined as "psychotherapy" to the point where the important variables are ignored. And at the same time, they have expanded the number of "disorders" to which treatments are targeted. The result is chaos. In the search for a "pure" treatment for an equally "pure" group of patients, two counterproductive things have happened: (1) therapist factors, not patient diagnostic characteristics, and treatment context variables have been ignored or controlled as sources of "error" rather than accepted as important parts of the therapeutic process; and (2) a "methodological idolatry" has developed around the use of randomized clinical trials, which now relegates those who dare to use other methods to the category of "non-scientists" or "pseudoscientists. Placing arbitrary and a priori restrictions on what can be studied within the domain of psychological science, and then making another a priori decision that only one type of research design will meet the "standard of excellence" that serves as the starting point for peer acceptance, would be dangerous for any science. Not least for us. I think we would benefit from redefining what we mean by "psychotherapy" to take more (not less) account of context, participant factors, and meaningful relationships. Psychotherapy, in my view, should not just be a set of interventions and a manual to guide their application, but should include guidance to lead the therapist to find creative ways out of the office mentality to modify pathogenic environments, to direct change to non-random contributors, and to include a variety of quality relationships (also non-randomized) that allow the patient to learn to

"ride without a bridle" if you will, and to extend our reach to environmental and socio-political barriers that threaten to limit our power for good. But to do this, we must use multiple research methods to address multiple variables (many of which cannot be randomly assigned), and we must become more like astrophysicists than chemists. There is no advantage to being "real scientists" if we ignore the factors that enhance the patient's ability to change.

> *I would like to know your opinion about the training method of some new therapies that have appeared in the last decades. For example, in the case of EDMR, ACT, Mindfulness, Coaching, ... The training is done in schools of each technique, where the most experienced train those who are starting out, giving certificates attesting to their training and in most cases outside the formal training at universities. In a way, it is similar to the way psychoanalysts are trained. What do you think about this kind of training?*

A few years ago, a student and I wrote an article entitled "The Germ Theory of Education". In that article, we lamented that undergraduate and graduate education, especially specialized training, seemed to adhere to the view that if you are exposed to a particular skill for a limited period of time, you will "catch" it like a cold. It is easy to design a curriculum and require students to attend so many sessions, quarters, semesters, or years, sitting at the feet of a guru, after which they will receive a certificate that allows them to charge more for their services and makes them feel proud of themselves, but produces no change in effectiveness. Such guilds, however, have some fatal flaws, not the least of which is that they do not require one to make people better after such exposure. It is not only important to demonstrate that your students have received the advanced or specialized exposure to your view of things to be a member of your guild, or that they revere the teacher, but you have the responsibility to show that the students have become more useful and effective in their therapeutic work as a result. As I will describe in my presentation at the congress, we are currently analyzing whether psychotherapy supervisors who are trained and monitored to ensure that they are teaching the application of STS principles that anticipate patient behavior will be more effective than supervisors who review behaviors moment-by-moment after they occur and provide post-hoc guidance. We have obtained promising initial results confirming that patients assigned to graduate students who have been or are being specifically trained in the use of STS principles actually improve more than those whose student therapists receive usual and customary supervision. I am old-fashioned when I reiterate my belief, derived from earlier behavior therapists, that competency-based education should be the usual, not the unusual, nature of undergraduate

training. And that includes requiring students to be able to actually produce a positive outcome in patients.

> *More and more clinical psychologists are looking to neuroscience as a scientific guarantee for psychological therapies, and at the same time there is a proliferation of critics of the need for neuroscientific support for therapy. What do you think, is it a fad, or is the neuroscientific guarantee really a guarantee?*

As much as we have rejected the medical model throughout our history as a helping profession, most of us secretly wish we could believe that we are treating "real diseases" with "real treatments." The term "real," in this context, is usually defined as medically credible. Hence the acceptance as our gold standard in research of a methodology that originated in biochemistry, the RCT design. By using this ill-fitting design for psychotherapy, many hope that we will finally find the spoiled gene and the magic therapeutic pill. Adding to this vestige of the long battles with psychiatry and medicine are the fascinating developments coming out of neuroscience and cognitive science. These findings are fascinating, but in my opinion are often a distraction, at least at this stage of our knowledge. Most of the neurochemical actions and reactions that are so fascinating prove only that something is at work, that something is more often a correlation than a proven cause of behavior. We can help people without assuming biological causation. To say that even seems radical to me, in this age when all things are being linked to factors that are viewed or inferred through an electron microscope. Paradoxically, at the same time, I recognize that it is useful to discover that certain types of empathic words trigger action in brain centers associated with positive feelings and motivation. We can use that knowledge directly in psychotherapy, and it would even be useful to have a direct link to activate the affected neurological region. But just as importantly, it is good to know that even with crude measures of empathy, we cannot induce macro changes in the patient's feelings, decisions, and symptoms. Not everyone needs to have all the knowledge, and it is prudent to evaluate information and new technologies carefully to avoid the trap of developing or adhering to another methodological idolatry.

> *Speaking of fashions, at the moment we have psychological coaching, which is growing in a surprising way in some countries, creating associations, congresses, ... Do you really think that there is something new in this movement, or is it just a fashionable name for what has always been psychological counseling and advice?*

The best estimates I have been able to glean from the available research is that about 70% of patients seeking treatment will be helped by a caring relationship with an interesting person. Only about 30% of people really need the specialized techniques that we have developed. I think there is room for caring caregivers who are interesting people. The problem, as I see it, is that such people almost inevitably want to be more than that. They want to specialize and be experts. That's how we became teachers, therapists, etc. There is a parallel here in the health care system in the United States of America. You know, I'm sure, we finally, in 2010, managed to develop a national health care program, but we have found it to be inefficient because we have too many specialists and too few general practitioners than we need. Similarly, in psychotherapy, most of our patients probably don't need the degree of expertise that we have at our fingertips. We need to learn to recognize when a relationship is sufficient and when more expertise is needed. And we need to make sure that this information is made public and is specifically communicated to patients so that they can make their own decisions. So I don't think the problem is that coaches are ineffective, I think the problem is that we don't have a way of distinguishing patients who need no more than what coaches provide and no less than what we can provide. This requires some regulation of psychotherapy, which rarely occurs today. In the absence of such regulation, we need to do a better job of monitoring ourselves and educating the public.

Animal-assisted therapy is another treatment strategy that is growing in recent years. It is practiced with dolphins, dogs, birds, cats, horses, etc. What is your opinion on this?

Like the term "psychotherapy" itself, the term "animal-assisted psychotherapy" is not simple or uniform. There are four main models in equine-assisted therapy alone. In various ways, some work aims to promote cognition, other approaches aim to develop coping skills, and still others aim to stimulate the use of damaged muscles and retrain neurological pathways. Regardless of type, research is very poor on all types of animal-assisted treatment. Most of the "research" consists of unsystematic case studies and reports from previous clients. Quasi-experimental and actual experimental studies have been conducted on only a few of the applications currently offered. The research is best on therapeutic dogs and on the use of equine therapy with children who have developmental disabilities. Kazdin has concluded that pet-assisted therapies of these types are qualified to be termed "empirically supported." But, I believe that the real question is not simply whether one or more of these therapies produce noticeable changes. I believe there is an additional question that should apply here. Specifically, is this form of animal-assisted therapy gradually valid as a treatment? In other words, does it produce a large enough change to justify its

use in place of a less expensive treatment? Therapeutic animals such as birds, cats, and even dogs are readily available, inexpensive to maintain, and practical, so perhaps the question of whether it helps more than a control condition or no treatment is sufficient in these cases. However, when exotic animals, including horses, are used as therapeutic assistants, the economic issue must be carefully considered. We need to maintain at least five trained horses for our own program. The horses require constant feeding and training to be valuable to the program. There are also vet bills, shoeing, nutritional supplements, all of which must be provided, whether the program puts them into action once a year or twice a day. There are several things that have impressed us in our own experience with equine therapy. It is clear that: (1) people are helped by equine-assisted therapy, but not uniformly; (2) patients' subjective impressions of their improvements in this therapy are much higher than estimates based on standardized outcome measures; (3) the magnitude of objective change is not appreciably greater than that obtained with good conventional psychotherapy; and (4) in the usual group delivery method, there is very little room for tailoring the intervention to each patient, as we would ideally like to do in applying an individual STS intervention. We have had people label their work with us as "life-changing" and they have persisted in making many gains after therapy, but these changes are not captured by the *STS/innerlife* assessment system that monitors change or by the OQ-45 that we also use to assess change. We conclude that (1) equine therapy is not for everyone who wants it; (2) if we use it we need to develop and use measures that incorporate the patient's subjective experience as well as symptom change; (3) we must also find ways to reduce the cost of maintaining animals for this use; and (4) unless there are specific cases of intransigent individuals whose care is supported by unproven methods, it is risky to "sell" these therapies to patients without full disclosure. In all honesty, I could not justify my use of equine-assisted therapy were it not for the fact that it is a research grant, rather than individual patients, who bear the cost.

> *At the beginning of the interview, I asked you how being a cowboy influenced your psychology. Now I ask you the other way around. I know that you use a very unconventional method to tame horses. I have personally seen you apply systematic desensitization to tame horses that are difficult because of their age and resistant to classical dressage, with spectacular results in very few sessions. How did you come up with the idea of using this technique and what are its advantages over traditional dressage?*

The originality of my approach, as you recognize it, is that it uses basic principles of behavioral psychology, expressed in more interesting terminology, to change the horse's behavior. In conventional horse training, including

traditional dressage, which focuses on control and intimidation, the horse is subdued and overpowered, and unwanted behavior is punished until the horse gives up and submits. The good news is that my form of training (what is called "natural horsemanship"), is no longer "unusual". It is becoming widespread in most horse training communities, even in dressage. Thus, much more so today than ten or twenty years ago, the focus of training is shifting to simple behavioral strategies such as conformation, avoidance, training, positive reinforcement and satiation. Although, as is well known, these terms are not used, being replaced by more compatible and understandable terms. Thus, we hear exhortations such as "reward the minimum effort" (conformation), "release the pressure" (avoidance training), "horses follow the carrot" (use of positive reinforcement), "lead the horse until it seeks a change" (satiety training) to describe these various techniques. The advantages of the natural approach over any traditional horse training program are that (1) natural approaches reduce the horse's resistance through positive relational cues that are familiar to the horse, (2) natural approaches reduce resistance and fighting by reducing the predatory actions of the trainer, (3) natural approaches reduce training time by taking advantage of the horse's natural curiosity and desire to be a leader, and (4) natural approaches focus on establishing the trainer as a source of safety and comfort to increase their reinforcing power. So, in short, all the benefits are embodied in the goal of reducing conflict and applying systematic reinforcement (both positive and negative) in the absence of punishment to the task of developing a relationship through which to teach skills. This is all basic psychology.

> *As you know, there is currently a strong criticism of the DSM-5 by thousands of psychologists and psychiatrists. I suppose that over time you will feel recognized, since you were a pioneer in criticizing the DSM system and its application in clinical psychology several decades ago. What is your current position on this?*

I see little in DSM-5 that provides a "cure" for the problems that have been attributed to previous DSMs. The exceptions to this conclusion are (1) the introduction of a spectrum of disorders, derived in part from the need for categorical labels for things that exist as a continuum; and (2) the effort to clarify some of the over-inclusion of Axis II disorders. I'm sure there are other positive changes, but overall, DSM-5 continues the march toward the medicalization of all behaviors as "real" illnesses, which I find counterproductive, misguided, and misleading. As you know, the American Psychological Association (APA) has taken a step toward ICD-11 as it appears, based in large part on its functional perspective and contributions made by many psychologists. I think this is a good step, but I maintain the illusion that the diagnostic groupings were designed to have more relevance to treatment decisions.

A few years ago, you wrote the book "Am I Crazy, or Is It My Shrink?", which was a great success in Anglo-Saxon countries. Tell us, what message did you intend to convey with this book?

In short, my coauthors and I sought to underscore the need for an empirical, rather than simply rational, grounding of practice. I considered then, and only minimally less than I do now, that clinicians' tendencies to over pathologize patient behavior, to value timeless psychotherapy, and to rely on authority rather than evidence as the basis of treatment, was self-serving, dangerous, and demeaning to patients and to clinicians themselves.

Changing the subject, you are not only a famous researcher in the field of psychotherapy, but you also have a lot of experience in scientific publications, in fact you were the editor of the most important journal in clinical psychology, the Journal of Consulting and Clinical Psychology, so you know the publishing world very well. As we know, researchers are under increasing pressure to publish, hence the classic phrase "publish or perish". This has led to an increasing number of researchers manipulating or falsifying data to facilitate the publication of articles. In fact, there are already initiatives by some journals, such as Perspectives on Psychological Science, to encourage replication of research. What do you think about this and how could this tendency to publish more "whatever it takes" be changed?

All of the trends you describe - to which I would add the proliferation of "for-profit" journals that publish articles of any quality for a price - are increasing because we as a group of scientists have been willing to both define quality and value it in decisions about tenure, promotion, and career advancement. I support the need for replication and applaud any editor who devotes space in the journal to this type of research. But I also advocate doing replications in a way that adds to the body of knowledge. Specifically, I mean that a replication of a study need not simply be a perfect copy of an earlier one, but can introduce some selective methodological changes and additions that not only promise to cross-validate earlier findings, but also to steer our quest for knowledge on the topic in promising directions. For example, one need not simply demonstrate once again that a collaborative relationship brings about change, but may include structured observation on the precipitating conditions that enhance the relationship in a way that sheds light on how such a relationship develops. As a field, we need to establish hierarchies of what constitutes good research, including placing value on convergent programmatic research designs and encouraging further expansion of statistical methods such as model building. We can encourage actions that support these goals by mainstream organizations, both within various countries

and internationally. We in the United States of America would do well to initiate a discussion within APA governance to change the current trend of expanding our APA journal pool, even to the point of maintaining a smaller number of higher quality journals. It must be recognized, however, that such suggestions must confront the disparity between these quality-oriented goals and the financial rewards that cater to quantity over quality in publishing. Hence, we need to strengthen the argument for standards by pressing academic institutions to establish and articulate inclusive standards of research within core disciplines, by which promotion, tenure, and hiring will be governed.

> *Finally, you have come to Spain several times and have collaborated with people and institutions, such as in a Congreso del Colegio Oficial de Psicólogos, so you are quite familiar with our situation and that is why I would like to know your opinion about clinical psychology in our country.*

You must remember, as I try to answer this interesting question, that due to health problems, my retirement in 2002 and again in 2013, not to mention a heavy ongoing workload, I have not visited Spain for several years. My impressions may be outdated or obsolete. However, I have always been impressed by Spanish researchers for two basic reasons: (1) they frequently draw insights from their research efforts around the world including the United States of America, and (2) they have learned not to blindly accept research findings; they still have the power of critical thinking. As a result, and in large part due to the proximity of many different cultures in Europe, Spanish researchers (and I believe others in the Mediterranean) have been ecumenical not defensive. They share knowledge, collaborate with peers, and develop communities of scholars that extend beyond the walls of universities and clinics. Collaborative research programs and academic exchange programs are prevalent and encourage the exchange of ideas. The longevity of some of these relevant and collaborative research programs seems to far exceed those in the United States of America, which seem to represent more transient interests, sometimes bordering on brainstorming. I admire their work and their interest in cognitive/behavioral therapy, for which they have always remained open to the input and influence of people like me whose ideas are not always congruent with traditional views. I believe that the diversity of opinions represented by the speakers at this congress is a good example that supports my thesis of non-defensive sharing of ideas and views.

EVIDENCE-BASED PSYCHOLOGICAL TREATMENTS

Michael Kyrios

Michael Kyrios was director of the Research School of Psychology at the Australian National University, Vice-President at Flinders University (Australia) and is now an Emeritus Professor. He was President of the Australian Psychological Society.

**Could you tell us your opinion about the situation of research in Psychology in your country? Do you think it is a discipline sufficiently promoted and supported by government and related organizations?*

Despite being a small country in terms of population, psychological research in Australia has impact that is perhaps greater than its direct investment by government. The 2023 QS World University Rankings by Subject ranked 4 Australian universities within the top 30 Departments of Psychology in the world and 14 amongst the top 200. In a similar vein, the 2024 Times Higher Education World University Rankings found 14 Australian universities amongst the top 200 in Psychology. In 2018, the last national exercise in identifying Excellence in Research, rated 11 of 36 Australian universities assessed as demonstrating Psychological and Cognitive Sciences research "Well above world standards and another 11 as "Above world standard", while a further 9 were "At world standard." Australian psychological research has many strengths, it also has areas of research that require further growth. According to a 2013 report published by the Australian Chief Scientist, some fields of Australian Psychology have citation rates below the European average, such as Neurosciences, Experimental Psychology and Cognitive Psychology.

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* This interview was conducted by the Infocop staff and originally published in *Infocop* Online.

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However, Applied Psychology, Clinical Psychology, Educational Psychology and Developmental Psychology were above the European average. Australia's most recent reported gross expenditure on Research and Development (R&D) as a proportion of Gross Domestic Product (GDP) was 1.79% for 2019–20, which is lower than the OECD and European averages of 2.6% and 2.1%, respectively. Australia's relative under-investment in research, along with its associated weaker research quality, higher student-staff ratios and lower international student and co-authorship scores, is further reflected in recent lower reputation ratings and a decline in university rankings for its higher ranked universities. Nonetheless, research productivity across the country has remained very positive and industry engagement metrics are improving.

With respect to government research funding, at a national level, the two main sources of funding are the Australian Research Council and the National Health and Medical Research Council. The Australian Government's R&D expenditure in 2022–23 was forecast to be 0.49% of GDP, which is below the long-term average of 0.6% and the lowest since the beginning of the data collection in 1978–79. Presently, the government is in the process of developing an updated national science policy framework, which will impact on funding. With specific reference to psychological research, a 2022 report from data collected in 2018, higher education research expenditure for psychological and cognitive science research was $AUD366 million, accounting for only 3% of all research expenditure. However, this may be an underestimate of all expenditure on psychological research as it may not account for investment in Medical and Health Sciences where mental health research led by psychologists is often concealed. In attempts to increase amounts and sources of funding, universities are turning to philanthropy, corporations and other sources. Unlike the United States of America, Australia has not had a tradition of philanthropic funding or collaboration with industry. The great strength of psychological research in Australia is found not only in our academic staff and collaborators, but also in our graduates, Master's students and PhD students, who carry out the bulk of the research under the supervision of academic staff and whose research is supported by the University and the Psychology training system. However, our tertiary education system is currently underfunded and universities have become more dependent on fee-paying international students and are increasingly turning to industry to support training and research.

Both government and industry are increasingly investing in mental health research as a reflection of interest in the provision of mental health services. In fact, government spending alone on mental health services increased on average by 3% per year from 2016/17 to 2020/21. Overall, government spending on

mental health-related services increased from $9.3 billion in 2016-17 to $11.6 billion in 2020-21.

> *Part of your research has focused on the search for new effective treatments for Obsessive-Compulsive Disorder (OCD), in order to improve recovery rates. Could you tell us, in general terms, what your research has consisted of?*

From the beginning, our research goals focused on understanding the cognitive factors that influence the development and maintenance of OCD and its symptoms, with the ultimate goal of developing interventions targeting those cognitive factors. While behavioural treatments such as exposure with response prevention (ERP) have demonstrated excellent results, we observed the immense difficulties of some clients in carrying out ERP, the high proportion of treatment dropouts, the lack of response of some people, especially those with mainly obsessional presentations, and the excessive number of relapses. We were also aware that there are "better" and "worse" ways to motivate people to engage in ERP or help them change the way they manage their obsessions. Most of the successful strategies included significant cognitive and interpersonal components. Thus, we set out to understand those cognitive and interpersonal components, and to incorporate them into our theoretical models and treatments. We also set out to find efficient and effective ways to disseminate our treatments among the OCD population, who are known to be resistant to treatment seeking and presentation due to issues of stigma and shame. We wanted to facilitate access to these treatments them across our large continent, where there are few specialized psychologists working in rural and remote areas. In our work with the international consortium called the Obsessive Compulsive Cognitions Working Group (OCCWG), we identified a group of beliefs associated with OCD. Furthermore, greatly influenced by the work of Guidano and Liotti, our group carried out empirical research about the "self" in OCD. We found significant associations between OCD symptom severity and ambivalence about one's self-esteem, perceptions about the importance of the moral domain in establishing one's self-esteem, and the dissonance between implicit and explicit self-esteem. These investigations helped to understand the development of possible prequalae and sequelae of OCD and to understand its impact on the self, which is manifested in cognitions and responses to intrusive thoughts relevant to OCD. Based on our findings about the relevance of these self-based factors, we have developed not only a conceptual model of OCD that incorporates self- and cognitive interpretations, but also pointing to therapeutic and intervention strategies focused on the self in the treatment of OCD. Through our work with neuropsychiatrists, we have also been able to examine neuropsychological deficits, functional brain patterns,

and metamemory in OCD, which are important in understanding how people with OCD process information during treatment and that can help us predict treatment outcomes. In recent years, our research has prioritised self-based factors that influence symptoms and treatment of OCD and related disorders such as Body Dysmorphic Disorder, Hoarding Disorder and compulsive buying, as well as the dissemination of evidence-based treatments via the Internet which can facilitate broader access to such treatments across our large continent.

Based on your experience, what future prospects are expected for the treatment of OCD? What is still missing to investigate?

Efficacious biological and psychological treatments for OCD currently exist, such as seritonergic medications (e.g., SSRIs) and Exposure with Response Prevention (ERP). However, systematic reviews support unacceptably high drop out and relapse rates, as well as large proportions of less-than-optimal outcomes and treatment-resistance. Furthermore, not only is access to evidence-based treatments by well-trained practitioners limited, but stigma and shame preclude many consumers to seek out treatment. Fortunately, there are different biological, psychological and social/community perspectives regarding the future of OCD treatment.

Brain imaging studies have supported abnormalities in the cortico-striato-thalamo-cortical (CSTC) loop. As a consequence, invasive and noninvasive neuromodulation experimental interventions, such as deep brain stimulation and transcranial magnetic stimulation, are emerging biological approaches. New medications and use of biological agents to augment psychological treatments are also being researched. To date, however, research support has been limited and/or disappointing, although multiple trials are underway.

Advances are also being made in psychological approaches to treatment. Cognitive and metacognitive theories have led to a broader array of strategies aimed at correcting dysfunctional cognitive processes in OCD. In particular, Cognitive Therapy has been shown to be efficacious on its own or in conjunction with ERP (i.e., cognitive-behaviour therapy [CBT]). The use of cognitive rehabilitation strategies to address idiosyncratic neuropsychological deficits and attention and metamemory processes could also be added to future treatments. In addition, there is broader interest amongst anxiety researchers comparing graduated exposure treatments versus non-graded exposures. Recent notions related to demonstrated deficits amongst anxious individuals in inhibitory regulation and extinction learning processes have supported the use of more optimal exposure strategies. Traditionally, ERP for OCD has focused on systematic graded exposure, whereas researchers could further investigate protocols that vary within-exposure fear randomly so as to maximise

generalisation and maintenance. There are also benefits in developing specific treatments for certain types of obsessions and compulsions (e.g., Danger Ideation Reduction Therapy for contamination presentations). Broadening the use of idiosyncratic protocols across the range of OCD presentations may well lead to improved outcomes. These more idiosyncratic approaches to treatment are consistent with "personalised medicine" frameworks and could also accommodate the combination of biological and psychological approaches for specific OCD presentations (e.g., obsessional presentations with comorbid major depression).

The Third Wave of therapies (inclusive of Acceptance and Commitment Therapy, Schema Therapy, Narrative Therapy and Mindfulness) have also been embraced. Emerging interest in "self" cognitions in OCD have led to suggestions that the Third Wave of therapies can be further advanced and that correcting dysfunctional self processing can improved efficacy, much like it has in the treatment of social phobia. To date, "self" approaches to OCD have focussed on perceptions about one's moral and feared self and self-ambivalence, but controlled trials have yet to be conducted.

Families and parents of affected individuals can also be helped systematically, something especially useful in cases of OCD where those close to the client engage in accomodation in misguided attempts to help. Such contextual approaches can also be useful more broadly in educating the public and OCD consumers so as to facilitate help seeking.

Finally, the use of digital technologies can help disseminate evidence-based treatments and improve access to specialists, especially through different communication modalities. As ERP and CBT are still generally found to have greatest efficacy, e-therapy approaches have focussed on the dissemination of such strategies, with or without therapist support. Therapist-supported programs have been found to have greater efficacy than those that are self-guided but both approaches have a range of uses, e.g., as preparation for face-to-face treatment, as sole treatment for mild and moderate presentations, as relapse prevention, etc. Future developments in Artificial Intelligence and the use of avatar "therapists" will inevitably advance the use of e-therapies in providing support and facilitating ongoing monitoring of symptoms in those affected by OCD.

> *In recent years, new technologies have invaded all areas of our lives. How has your work group incorporated digital technologies in online assisted therapy and in the dissemination of treatments?*

As I have indicated above, the dissemination of Cognitive-Behavioral Therapy (CBT) is hampered by a series of drawbacks such as the lack of trained specialists,

the geographical remoteness of trained personnel, especially in a large country like Australia, and consumer reluctance to seek treatment. In response, like other researchers, we have sought to develop new modalities for CBT dissemination through the use of digital technologies. The Australian Government has been instrumental in evolving funding for the online dissemination of evidence-based treatments and many industries are incorporating the use of digital resources into workplace settings. These frameworks aim to utilize trained professionals efficiently, while at the same time offering additional options for those with highly prevalent disorders, which may be more easily accessible remotely, privately, and as part of treatment, early intervention or maintenance strategies. Our group has focused on programs using computers or tablets, although smartphones and virtual reality applications are increasingly being used. In addition, online treatments are increasingly individualized, transdiagnostic programs have evolved, programs have been adapted to incorporate idiosyncratic factors such as age, gender and culture/race. Furthermore, the use of multiple communication modalities, the use of biofeeback , and the use of avatars and virtual reality environments is increasing. Moreover, the advent of Artificial Intelligence platforms have led to further advances so as to help make online treatments more attractive and better adapted to each individual's profile and communication preferences. Despite the advantages of using digital technologies, there are many issues to take into account when developing good practice guides, including ethical issues and concerns about client safety when carrying out such treatments online. The Australian Psychological Society has taken a leading role in preparing, supporting and training psychologists in these new and exciting innovations in psychological practice.

> *Next November you will participate in the VIII International Congress of Clinical Psychology with a conference on advances in the treatment of Obsessive-Compulsive Disorder. Could you tell us what topics you will address in your presentation?*

My talk will be about the research we were carrying out at that time, which I have talked about in previous questions in this interview. It will focus on the benefits and limitations of CBT for OCD, so one can reflect on options for moving forward. The results of our group's OCD treatment evaluations will be presented, including a face-to-face CBT manual and an online therapy program. As a result of our evaluations and experimental research, we have developed a conceptual model of OCD incorporating cognitive and individual factors, from which recommendations can be made regarding the future evolution of OCD treatment.

In published reports on the happiest countries, Australia always appears at the top. Do you think that mental health policies and actions to improve the quality of life in your country are driving these data?

In 1964, the famous author Donald Horne described Australia as "the lucky country," arguing that Australia's rise in wealth and influence is due almost entirely to the luck of having so many natural resources, rather than being due to the political system, companies, the use of technological advances or other innovations. Much of our "happiness" is due to a series of cultural attitudes regarding informality and friendship, anti-authoritarianism and the relative ability for all socioeconomic classes to interact, love of nature and our abundant natural resources, as well as the opportunities that a resilient economy offers, giving rise to a relatively high quality of life. However, this is not always the case. For example, just to mention a few areas of challenge, our Indigenous population experiences a growing "gap" in life expectancy and well-being in relation to the rest of the population, our young people struggle with the pressures and lack of personal opportunities , some ethnic communities struggle with issues of identity and social integration and suicide rates among older men continue to rise. In addition, recent economic developments have seen a rise in middle income distress, as interest rates and housing prices have risen dramatically, along with cost-of-living expenses. Nonetheless, such issues and Horne's comment aside, Australia has been at the forefront of the evolution of public health and public mental health. With our universal healthcare system, access to reimbursement for psychological services, our youth mental health services, our innovations in online therapy and the concerted public mental health outreach strategy, Australians have enjoyed many benefits thanks to to publicly funded evidence-based psychological treatments. Although these measures have had less impact than expected in some sectors of our society, they have undoubtedly had an impact on the lives of a large part of the community. Certainly, the implementation of access to reimbursement of the costs of psychological services has been widely accepted, resulting in a decrease in drug prescriptions and greater contact of affected people with health professionals. and mental health. The Australian Psychological Society fights, on behalf of the community and the profession, to ensure that the impact of these policies on the health and well-being of the population is not forgotten, and that governments facing budget cuts do not forget the financial benefits and the moral obligation to have a healthy and happy population.

According to what you tell us, is Australia a country that facilitates its inhabitants' access to psychological treatments and invests in evidence-based treatments?

As I have mentioned, our government funds a universal health system that facilitates the reimbursement of psychological services, through the referral of Primary Care physicians, psychiatrists and pediatricians, and importantly to registered generalist and clinical psychologists. Although social workers and occupational therapists also participate in this program, the vast majority of services are performed by psychologists. Although the number of allowable funded sessions doubled during the COVID pandemic after a drop, they have now dropped again to only ten sessions per year. The COVID pandemic also saw allowances for remote phone consultations. Unfortunately, the current low number of allowable sessions for evidence-based psychological treatment does not facilitate adequate care for more serious or complex mental health needs (e.g., psychosis, OCD, PTSD). Nonetheless, the government has provided additional funding for a number of specific initiatives, such as additional sessions for eating disorders, services for autism spectrum disorder, online therapy and virtual clinics, youth mental health drop-in centers, early intervention programs for psychosis, suicide prevention programs, educational programs through schools, public mental health literacy programs, workplace mental health programs, a national disability service, chronic illness services, etc. We are lucky to enjoy these types of publicly funded services, from which Australians have reaped many benefits. However, as I have mentioned, and as is evident across the world, we live in financially and politically difficult times, and mental health needs are on the increase. All governments are under pressure to cut budgets and these types of initiatives are always at risk of being cut. The Australian Psychological Society hopes that its advocacy role on behalf of the public will help maintain these important services nationally. I also believe that our experiences to date, and the experiences of other psychological societies around the world, could be shared to help us all understand how best to promote and advocate for our profession and the communities for which we work. To this end, we have tried to develop agreements and collaborations with other national psychological societies, and it would be great to also collaborate with other countries such as Spain.

WRITING THERAPIES FOR POST-TRAUMATIC STRESS DISORDER

Arnold Van Emmerik

Arnold van Emmerik is an Assistant Professor at the University of Amsterdam (the Netherlands). He is a Board Member of the European Association for Cognitive and Behavioural Therapies and past President of the Dutch Association for Behavioural and Cognitive Therapies.

**Your participation in the XII International and XVII National Congress of Clinical Psychology is entitled "Writing therapies for PTSD". To orient us in this interesting field of intervention, could you explain what writing therapies consist of and, specifically, what is meant by the term "structured writing therapy"? What approach underlies the application of these therapies?*

Structured writing therapy is basically a procedural variant of trauma-focused cognitive behavioural therapy (TFCBT). There is a large overlap in intervention techniques, for example imaginal exposure, cognitive restructuring, and ways of coping with the trauma and its consequences. The main difference is in their procedures: in writing therapy these techniques are done through writing, in traditional TFCBT they are done verbally or in other exercises. The term 'structured' simply refers to the fact that it is not some form of free, expressive, or creative writing, but that specific instructions for writing are followed.

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* This interview was conducted by the Infocop staff and originally published in *Infocop* Online.

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Since the 1980s, the structured writing therapy has been applied to student samples and clinical samples (patients with chronic pain, asthma, PTSD, etc.), and its efficacy has been evaluated in numerous indicators of mental and physical health, including immunological variables. What are the main demonstrated benefits of applying this technique?

I think this question refers to the writing paradigm of James Pennebaker, that indeed has been shown to have positive impact on a wide range of outcomes. Interestingly, although participants write about traumatic or stressful experiences, it has not been designed as a PTSD treatment and PTSD symptoms are not an outcome on which it is particularly effective. Writing therapy or Structured Writing Therapy as presented in this keynote is specifically designed and tested as a treatment for PTSD. A growing number of controlled trials demonstrate its efficacy in adults and children, but specifically for PTSD.

With regard to the treatment of post-traumatic symptomatology, the written narrative of the traumatic event is part of various protocols for the intervention in PTSD, such as cognitive processing therapy or cognitive behavioral therapy focused on trauma for children and adolescents. However, structured writing therapy has also been used successfully in isolation. According to the research carried out, what is the current state of the scientific evidence about its efficacy?

Writing therapy is supported by several controlled trials in adults, compared to waitlist. We conducted one randomized clinical trial in which it's efficacy does not differ from traditional TFCBT, and another group in the Netherlands recently compared writing therapy to EMDR in children, again demontrating no differences in efficacy between both treatments. I would say that writing therapy has become a second-choice treatment, immediately after TFCBT and EMDR.

One of the most controversial aspects of the expressive writing therapy has to do with the underlying mechanisms that explain the success of the intervention. In this regard, various theoretical models have been proposed to explain the effects of structured writing, such as cognitive processing, exposure, and social support theory, among others. Today, which of these theories has the most scientific support? Which processes (habituation, emotional reprocessing, cognitive assimilation, etc.) have been shown to have a determining role?

Oeps, that's a tricky one. The effects of writing therapy can indeed be explained by learning or conditioning theory, cognitive theory, etcetera. But

I think the issue is far more complicated than we sometimes tend to think. A couple of years ago I did a study that tried to identify a mechanism that might be specific for writing, but the study failed to reveal this.

> *Several studies have attempted to identify the variables that influence the efficacy of the application of the technique when used in isolation. Could you tell us some of these findings? What are the key variables (duration of sessions, type of instructions, etc.) that affect the efficacy of the results and that, therefore, must be considered when designing the intervention?*

Most research studies have shown significant and large effects for writing therapy after five weekly feedback sessions, with participants completing three 45-minute writing sessions in between the sessions at home. I would recommend this as a rough minimum. But in clinical practice you can of course be more flexible, and prolong treatment for as long as your patient benefits from it.

> *According to your extensive knowledge, what benefits does the application of the structured writing therapy have compared to other interventions for the management of post-traumatic symptomatology? What can this technique contribute to the treatment of PTSD?*

I think that TFCBT and EMDR will continue to be the first-choice treatments of PTSD for quite some time, and that is fine because they are great treatments. Writing therapy may be useful for patients who refuse or don't respond to these treatments. And the main advantage of writing therapy is of course, that it can be conducted online. This is great for patients who have to travel far or on inconvenient times to physically meet with a therapist.

> *Is any patient that has been diagnosed with PTSD a candidate for this type of therapy? Its application could be contextualized in two profiles of victims that have great social impact through the media in Spain: (1) victims of sexual assault or gender violence and (2) victims of traffic accidents. In the first case, the traumatic event is associated with a criminal act, in the second case, not necessarily. Would both profiles be equal candidates for this therapy? Would there be slight distinctions between the two?*

Yes, we have no indications that writing therapy would be differentially effective for victims of specific types of trauma. We know of course that the risk of PTSD is higher after interpersonal trauma (such as sexual assault or gender

violence) compared to accidental trauma, but predicting PTSD is not the same as predicting PTSD treatment outcome.

> *Finally, once this psychotherapeutic technique and its benefits have been described, we would like to know the degree of diffusion it has among clinical psychologists. Do you have data about the knowledge and application of this technique by professionals (in your country and other countries)? To what extent is it being used?*

There's no hard data available on this. But from the many requests and questions that I receive, I suspect that quite a number of therapists use writing therapy in their treatments. Perhaps not as a stand alone treatment, but integrated with other PTSD techniques and perhaps only parts of the writing treatment. To promote the dissemination however, we are currently developing a self-help format of the writing therapy, and we are available for workshops of various lengths.

PSYCHOLOGICAL TREATMENTS FOR CHILDREN AND ADOLESCENTS BASED ON EMPIRICAL EVIDENCE

Carmem Beatriz Neufeld and Juan Carlos Sierra

Carmem Beatriz Neufeld is a Full Professor at the University of São Paulo (USP), Brazil. She is the Coordinator of the Laboratory of Cognitive-Behavioral Research and Interven-tion (LaPICC) at USP and President of the Latin American Association of Cognitive and Behavioral Psychotherapies (ALAPCCO).

Juan Carlos Sierra is a Professor of Psychological Assessment and Human Sexuality at the University of Granada (Spain). Director of the Human Sexuality Laboratory at the Mind, Brain, and Behavior Research Center in Granada. Editor of the International Journal of Clinical and Health Psychology since its foundation until 2021.

**Dr. Neufeld, you are the Coordinator of the Cognitive-Behavioral Research and Intervention Laboratory (LaPICC) at the University of São Paulo, one of the most prestigious universities in Latin America. Can you describe the work carried out in this laboratory? What role does it play in a country like Brazil, where Clinical Psychology has a big psychodynamic tradition?*

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The foundation of LaPICC has been a great step forward, since there was no laboratory with these characteristics at the University of São Paulo until now. At LaPICC, research and clinical practice are inseparably combined, so that all our interventions in Cognitive-Behavioral Therapy (CBT) are supported by research, and vice versa. Our lines of research focus on different cognitive-behavioral interventions, both individual and, above all, in groups. We carry out, for example, group interventions in anxiety disorders, depression, obesity, parental guidance and health promotion in the school environment. In the context of individual therapies, we have tested different interventions, both in adults and children. LaPICC has become a reference for research groups in CBT, as well as in CBT education and training, in addition to being a reference in the study of needs in the field of health prevention and promotion in young people. Although CBT has experienced a great development in Brazil, laboratories such as LaPICC play a key role in its dissemination among undergraduate and graduate students, as well as in the expansion of evidence-based mental health interventions among the general population.

In addition to your teaching and research work at the University of São Paulo, you have been the president of the Brazilian Federation of Cognitive Therapies (FBTC) and are the current president of the Latin American Association of Cognitive and Behavioral Psychotherapies (ALAPCCO). Can you tell us about the current situation of these types of psychotherapies? How have they evolved since their beginnings?

Cognitive-behavioral therapies have achieved enormous development in Latin America in general and in Brazil in particular. However, if we take into account the magnitude of the number of psychologists being trained each year, their diffusion should be much greater. For example, during the four years that I was at the head of the FBTC, the number of members increased from 900 to 2,500. It might seem like a big increase based on the numbers, but if we think in terms of the potential of the geographical area that Brazil represents, there is no doubt that a greater investment in the dissemination of this type of psychological therapies is needed. On the other hand, the South American continent already had the deference of organizing the World Congress in this field in 2013, in Peru, which clearly reflects this growth. CBT has been gaining ground in the different countries of Latin America. The number of therapists is growing significantly, as is the patient demand for this type of therapy. However, in terms of knowledge production, we are still suffering the consequences of the "youth" and scarce history of this type of psychotherapy in our countries. In most of the countries in our area, the arrival of cognitive therapy took place in the 1990s, which is a very short period of time for a scientific trend. In other

words, we are 30 years behind in comparison with other continents. However, we are supported by the growing demand for these therapies in our region.

In relation to the above, can you tell us a little more about the situation of cognitive psychotherapies in the specific context of Latin America? What is the degree of diffusion and implementation of this psychotherapeutic orientation in the different Latin American countries?

As I have mentioned, the diffusion is increasing. In countries such as Panama, cognitive therapies are widely studied from the undergraduate level. In other countries, where Psychology has a much longer history and tradition, such as Brazil or Argentina, cognitive therapies are experiencing a great growth since the beginning of the 21st century. This fact is reflected, for example, in the fact that courses and subjects on these therapies in Psychology Degrees are gaining ground, at the expense of other psychodynamic therapies.

Let us now focus more specifically on the contents of your interventions at the IX International Congress of Clinical Psychology. Both in your pre-congress workshop and in your lecture, you are going to cover cognitive-behavioral group therapies. Can you tell us about this type of therapy, and describe the differential characteristics and advantages that this psychotherapeutic modality has over individual interventions?

Group interventions seem to be excellent solutions to the old problems of health systems that limit the number of sessions and often reduce the possibility of appropriate interventions for a large number of problems. The advantages lie in the therapeutic factors that are established in a group setting and that end up contributing to the treatments. Examples of these therapeutic factors are group cohesion, the establishment of hope and the possibility that one is not alone in suffering from a certain symptomatology or mental disorder. The normalizing vision and the establishment of this hope are aspects to be promoted in individual therapy, while in group therapy they arise almost automatically. Another characteristic of this modality of intervention is that it has good results as an additional treatment to specific demands of people who are in individual treatment. In the case of chronic patients, or in the acute phase of certain disorders, group intervention may not be sufficient due to the fact that it is focused on a specific demand. In these cases, group treatments can be an additional complement to the individual intervention. Data support that the presence of these additional group treatments positively influences the results of the individual intervention.

Is any patient, regardless of the disorder, a potential candidate for this type of therapy or, on the contrary, is it specific to some particular cases?

This is precisely the disadvantage of group intervention, as it is aimed at specific demands. As such, its use is not possible for patients with particular characteristics, such as personality disorders, multiple comorbidities or severe suicidal ideation. In these cases, group interventions are not recommended. Group interventions in the field of cognitive-behavioral therapy have programs focused on specific objectives. Patients with multiple comorbidities or personality disorders usually need more individualized interventions adapted to their symptoms and problems. In a group setting, it would not be possible to work on all the individual and distinct demands of ten participants in one session. Therefore, the process of patient selection for a therapeutic group in cognitive-behavioral therapy is fundamental. The demands and characteristics of the participants must present a certain homogeneity to ensure the success of the psychotherapy.

A meta-analysis has just been published in the Journal of Anxiety Disorders on the efficacy of group psychotherapy for social anxiety disorders in adults, concluding that group cognitive behavioral therapy is equally effective as individual therapy (see Barkowski et al., 2016). From your experience in this type of therapy, would these results be generalizable to other disorders? Is there evidence of it in other psychological disorders?

In addition to social anxiety disorders, group interventions have been shown to be more effective for obsessive-compulsive disorder, obesity, social skills training and interpersonal relationships. Studies such as those of Heimberg's group, for example, comparing group interventions with individual interventions for social anxiety, showed that patients decreased their anxiety indexes in social situations to a greater extent after group treatment. Cordioli obtained similar results in patients with obsessive-compulsive disorder without other comorbidities. When patients underwent group intervention, in addition to obtaining better results, they had fewer relapses than patients with similar characteristics who underwent individual treatment.

In one of your interventions at the Congress, you will talk about group treatments for children and adolescents. For which problems typical of this age group would you recommend these group treatments? How widespread is this treatment modality in clinical practice with children and adolescents? Does the application of this psychotherapeutic modality present different nuances in children/adolescents than in adults?

The literature supports group interventions with children and adolescents, mainly in cases of anxiety disorders, depression, attention deficit/hyperactivity disorder, as well as in the development of specific skills, social skills, empathy and assertiveness. Another field of action of group interventions for this age group supported by the literature is the promotion of health in childhood. One of the most prominent programs cited in the literature is the FRIENDS program developed by Barret. In the 1990s, the World Health Organization already pointed out that health promotion in childhood requires the development of life skills in groups and, preferably, in the school setting. Apart from the adaptations of the therapeutic programs themselves for these ages, there are particular issues for the management of groups in these age groups. For example, with young people who are not accustomed to dialogue-based interventions, it is necessary for psychotherapists to employ more playful strategies. Specific issues to consider in these age groups are the duration of the sessions, the form of the patient-therapist relationship, patience for the control and management of the group, and empathic training with the children during the intervention. In general, the challenges facing the group therapist with children and adolescents are currently a focus of debate. There are several such challenges, but perhaps the most important is the lack of preparation of therapists to manage this population in groups, since, for example, we cannot expect children to sit in silence for long periods of time. Some challenges that need to be overcome by those who want to do group therapy with children and adolescents are the school-like nature many therapists imbue therapeutic sessions with and the lack of knowledge about how children and adolescents behave at each age.

> *For some years now, much has been published and discussed about psychological treatments based on empirical evidence. Can you tell us about the current situation of this issue in the field of psychological treatments for child and adolescent disorders? Can you tell us what you will present about the effectiveness of group therapies in children and adolescents at the Congress?*

As I have already indicated, there is empirical evidence for group treatments of mood and anxiety disorders in childhood. Research in this direction has been published in the Journal of Clinical Child and Adolescence Psychology. However, the literature comparing individual treatments with group interventions is scarce. What we do have to date are well-established programs such as COPING CAT, whose evidence of improvement in children is irrefutable, being associated, for instance, with a significant decrease in the levels of anxiety and depression. However, I would say the comparison with individual interventions is rather scarce. Something similar occurs with group interventions focused on health promotion and prevention of mental disorders. In this context, the program

I mentioned earlier, FRIENDS, has demonstrated its effectiveness in the prevention of anxiety and depression in childhood and adolescence, being one of the few programs listed by the World Health Organization as effective in this area. My lecture will focus on group interventions with evidence and, especially, on the group process and the training of therapists in the management of groups with children and adolescents. I will discuss group interventions that have shown empirical evidence and the benefits of these interventions for the target population, not as a perspective that replaces individual treatments, but as viable treatments for specific symptoms in specific populations. In addition, we will discuss group therapeutic factors in childhood/adolescence and how these can help therapists conduct and manage groups, which is one of the challenges in this type of psychotherapy, as I noted earlier.

> *Along the lines of the previous question, many meta-analyses on evidence-based treatments for children and adolescents have focused on specific psychotherapies (e.g., Cognitive-Behavioral Therapy) for generic disorders (e.g., anxiety disorders). Could you expand this question to other treatments and other disorders? What types of interventions are most effective in the treatment of the most common clinical disorders at these ages?*

In addition to the various anxiety disorders that become relevant at this age, such as separation anxiety, phobias and worries, cognitive-behavioral therapies have proven to be effective in mood disorders, obsessions and compulsions, attention deficit/hyperactivity disorder, learning disorders or excretion disorders. An excellent review on the treatment of anxiety disorders, recently published in the *Journal of Clinical Child and Adolescent Psychology*, shows robust effects of different modalities of cognitive-behavioral therapy in childhood anxiety disorders, with cognitive-behavioral therapy, exposure, modeling, cognitive-behavioral therapy with parents, psychoeducation and cognitive-behavioral therapy combined with pharmacological treatment forming part of level 1 evidence. In 2014, a review referring to attention-deficit/hyperactivity disorder was also published, with behavioral-based interventions being those identified in level 1 evidence: parental behavioral training, classroom behavioral management, peer behavioral intervention, combined behavioral management interventions, and organizational training. One of the greatest challenges of studies focused on evidence for psychological treatments in childhood has to do with a distinctive characteristic of this population: the absence of a diagnosis per se. Children who come to therapy often present symptoms of different diagnoses, and their treatments need to be personalized to consider this combination of symptoms. For researchers working with randomized clinical trials, this poses an additional challenge when developing studies on the efficacy of treatments.

This is not to say that evidence-based child psychotherapy is not possible, but we may need to look for new ways to ensure that interventions consider the specific characteristics of this population.

> *Let's look at this issue a little more closely. A recent article published in the Journal of the American Academy of Child & Adolescent Psychiatry questions the dissemination and implementation of evidence-based practices for child and adolescent mental health. As you know, there is not always an optimal match between the conclusions reached by research on the efficacy of treatments and what clinicians do in their daily practice. As a good expert on the Latin American reality, what do you think of this problem in our geographical context within the field of Clinical Child Psychology?*

This is precisely where I think we need to evolve. We need intervention programs that work and that offer treatment modules that can be applied, so that the particularities of the child population are addressed and professionals feel more supported by empirical evidence-based practice. I perceive different challenges in this regard. On the one hand, methodology and research should reflect the reality of professional practice; on the other hand, professionals should focus more on the study of scientific evidence. In our reality, we see a lack of correspondence between the production of knowledge and its application. This is a great challenge that we must face. In our laboratory, we have opted for very realistic objectives in this regard, developing studies that prioritize internal validity, but never forgetting external validity. This is a challenge, at least in our reality.

> *Good. Lastly, you visit our country regularly and are familiar with the reality of Psychology in Latin America. From this perspective, how does Latin America in general and Brazil in particular see the current situation of Psychology in Spain?*

From our perspective, Psychology in Spain has achieved a good level of development and is gradually accumulating data about its cultural specificities. I confess that as a researcher and therapist, I would like to find more cross-cultural studies to help us identify our similarities and differences, and at the same time learn from your achievements.

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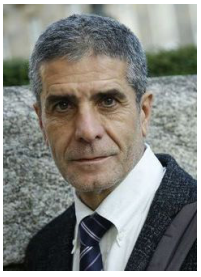
PARENT-CHILD INTERACTION THERAPY FOR CHILDREN WITH EMOTIONAL AND BEHAVIORAL PROBLEMS

Amanda Clinton and Wenceslao Peñate

Amanda Clinton is head of the Office of International Affairs of the American Psychological Association (APA).



Wenceslao Peñate is Professor of Clinical Psychology at the University of La Laguna. He is a member of the Instituto Universitario de Neurociencia.

**I would like to start this interview with your lecture on Parent-Child Interaction Therapy (PCIT). Apparently, PCIT follows the tradition of models related to the systematic use of basic learning processes (remarkably operant conditioning). According to your opinion, what would be the distinctive elements of the PCIT?*

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PCIT is a therapeutic intervention for young children with serious conduct problems that is grounded in social learning theory and attachment theory and incorporates a mix of play therapy and behavioral therapy techniques. Attachment theory is utilized in the Child-Directed Interaction stage of PCIT where parents are taught to build warm and responsive relationships with their children. Social learning theory supports the Parent-Directed Interaction (PDI) stage of PCIT where parents are taught to consistently apply consequences to their child's unwanted behavior. A unique feature of PCIT that makes it particularly effective is the use of direct coaching of parent-child interactions. That is, specific skills are taught to parents, coaching is provided, and opportunities for practice, feedback and improvement provided at home and in therapeutic sessions.

> *The therapy then has two formal parts. One directed towards the boy and another towards his parents. What functions does this double direction try to achieve?*

PCIT consists of two critical parts: one that is parent-driven and one that is child-driven. Attachment theory is utilized in the Child-Directed Interaction stage of PCIT where parents are taught to build warm and responsive relationships with their children. Social learning theory supports the Parent-Directed Interaction (PDI) stage of PCIT where parents are taught to consistently apply consequences to their child's unwanted behaviors. This bidirectional approach is important in helping support parental skill development and deepening a strong attachment between child and parent.

> *Without wanting to "reveal" the contents of your conference, I would like to know some aspects of the therapy. What is the PRIDE process?*

PRIDE skills are an important component of PCIT that are utilized to help parents and children connect with one another during daily interactions, such as play, in order to build a healthy relationship. PRIDE stands for Praise, Reflect, Imitate, Describe, Enthusiasm. Questions, commands, and criticism are forbidden when PRIDE-oriented "special play time" is being practiced and the child is allowed to take the lead in the activity.

> *Initially, this therapy was basically linked to children with behavioral problems. Subsequently, it has been observed the therapy can also be useful with emotional disorders. How do you observe this expansion? What is your opinion of the use of PCIT for emotional disorders in childhood, especially in relation to traditional psychological treatments?*

PCIT is an evidence-based intervention that was initially developed for families of children with behavior disorders ranging in age from 2- to 7-years-old. Within recent years, PCIT implementation expanded to a broader age range and the evidence suggests that, with minimal changes to the therapeutic protocol, PCIT is effective for older children and adolescents as a method for reducing impulsive and aggressive behaviors. In regard to use of PCIT for very young children, my experience with this therapeutic technique and preschool-aged/early elementary school aged children and their families is that PCIT is a particularly effective approach because it is so family oriented. For most children, incorporating parents into the treatment process is critical if we hope to achieve significant change. In the case of children as young as 2 to 6 years old, parents are absolutely fundamental to the process. In fact, progress will be very limited if parents are not involved because of the enormous influence they have over their child's behavioral and emotional development. Even where behaviors have a biological underpinning – such as Autism or AD/HD – they may be intensified by the parental reaction to the child. Parents form the center of a small child's world. As such, those parents need to be involved in resolving behavioral and emotional issues and PCIT successfully achieves this.

Another of your interests has to do with socio-emotional skills in children, which the congress participants will also be able to learn with your applied session. I would now like to conduct the interview on this topic of your expertise. Is social skills training more than to teach a technique itself? Is it a cross resource that plays a protective role in facing psychological problems (mainly emotional problems)?

Yes, absolutely. There is a significant body of psychological research that has demonstrated that children with good social-emotional skills experience much greater success in school and, as adults, in the workplace. More specifically, children who demonstrate poor social-emotional knowledge demonstrate higher rates of school failure, lower levels of academic performance, increased use of illicit substances, and elevated rates psychiatric disorders (especially depression and anxiety).

Isn't it surprising that, with the excellent biological equipment we have, we have not been biologically "programmed" to successfully deal with interpersonal relationships?

Human beings are inherently social beings, and the human brain is the driving force behind our desire and need for interaction with others. Generally, all human beings learn how to manage interpersonal relationships with success when they are in the right kind of learning environment, in the same way the

majority of individuals acquire literacy and numbers of skills without significant challenges when taught how to do so. It's a common misconception that social-emotional abilities are absorbed in a completely automatic manner, however. Human beings learn how to manage their emotions, define their feelings, express their needs, empathize with others and solve social problems from others through opportunities for observation, engaging with models and direct instruction. This is true whether the topic is reading, math or social-emotional interaction. Keep in mind that social-emotional interaction is a very high-level skill that relies upon many neurological processes: language comprehension, verbal expression, emotion control, interpretation of another's expressions and words, identifying possible solutions, and so on, and typically occur quickly and in a variety of contexts. For this reason, our "biological social program" improves when children are provided social-emotional learning instruction.

> *With your experience in language and transcultural studies, can substantive differences be established in interpersonal skills based on culture? Or are social skills cross-cultural? What role does language play in those skills?*

Research on cultural context and social-emotional development suggests the presence of both similarities and differences. As a child grows and their brains mature, cultural norms and values guide the interpretation and evaluation of social experiences and the way in which meaning is attached to behavior. As a result, distinct patterns of socio-emotional functioning may be observed across cultures in areas such as internalized control and self-regulation, social engagement, quality of social interactions and even social attitudes and practices.

> *Finally, because of your management of the international relations of the American Psychological Association (APA), we would like to know your qualified opinion on some aspects of our profession as a global profession. How do you assess the level of collaboration between the different psychology associations in different countries and regions? How are we facing cultural differences?*

In my experience, collaboration between national psychological associations is excellent and offers one of the best avenues for psychology to move forward on the global health stage and even more broadly to the human experience worldwide. The colleagues with whom I have interacted in leadership at national psychological associations are talented scientists, practitioners and diplomats who offer creative ideas and endless energy to help psychology address critical issues on an international scale. My sense is that we all, as

leaders of national psychological associations, work hard to identify ways to work together to achieve shared goals regarding contributions of psychology to assisting children, women and men to achieve their highest potential.

> *According to your expertise, how far away are we from a global agreement on the professional and ethical commitments of psychology, especially professional psychology?*

This is an excellent question that many practicing psychologists and leaders of national and international psychological associations are asking. The International Project on Competence in Psychology (IPCP), which establishes a set of internationally recognized competencies, was adopted by the International Association of Applied Psychology (IAAP) and the International Union of Psychological Science (IUPsyS) in 2016. The IPCP provides a meaningful framework for the advancement of global quality assurance standards. In terms of a practical model of competencies, the EUROPSY credential represents a significant advance in the field. Due to the mobile nature of professionals in 2018 and decades to come, my sense is that further work will continue to be done to address international competencies in psychology and significant progress will be made within the next 10 years.

ONE-SESSION TREATMENT OF PHOBIAS: REFLECTIONS IN CLINICAL CHILD PSYCHOLOGY

Thomas H. Ollendick and Juan Preciado

Thomas H. Ollendick is a University Distinguished Professor Emeritus of Psychology and the Director of its Child Study Center (United States of America). He was a founder of the Clinical Child and Family Psychology Review. He is one of the most influential scientists in the world according to the Stanford University Ranking.

Juan Preciado is Professor of Health Education at Hostos Community College of the City University of New York (United States of America).

**As was previously noted, you have one of the most impressive research oriented and highly cited publication records. I noticed that you also published an encyclopedia, what made you decide to create an encyclopedia in the field?*

First off, allow me to thank you and the Organizing Committee for inviting me to attend this prestigious meeting. I have had the pleasure of attending once before and visiting Granada earlier for a behavior conference. It is one of my favorite cities in Spain and in Europe. I am honored to be with you in October.

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Now then, to your first question. The Encyclopedia was published in 2003 and co-edited with my long-time friend and colleague, Dr. Carolyn Schroeder. Dr. Schroeder is viewed by me and many, many others as one of the co-founders of the field of Pediatric Psychology. At that time, I was president of the Society of Clinical Child Psychology. Jointly we decided to co-edit The Encyclopedia of Clinical Child and Pediatric Psychology – a venture that took us 2 and ½ years to complete. It has over 1,000 entries. Importantly, it allowed us to combine in one volume the work of psychologists in both pediatric and clinical settings. We wanted my clinical colleagues to be aware of pediatric complications and she wanted her colleagues to be aware of more traditional clinical problems. It worked – we were able to pull together the best of both disciplines in the service of children, adolescents, and their families. However, it is now 15 years old, and much has changed – it needs to be updated!

As a leading expert in childhood and adolescent anxieties and phobias, you are often asked by news outlets to comment on various public concerns. Are psychologists and researchers doing enough to communicate with the lay media about the implications of their research?

This is a very good question and I do not have a very good answer! I think some in our profession do so, but so many do not. On the one hand, doing so requires time and energy and a style that is not always compatible with our scientific ways of thinking or writing. We like to talk in lengthy discourse; the media want "bullet points." We are more guarded in what we say, they want us to speculate and give them a "bottom line." Most of our articles and talks end with "it depends" and "more research is needed." Right? They want a clear message not an ambiguous, qualified set of statements. We know a lot and have discovered much over the years – yet here is so much pseudo-science and voodoo out there – we know what works – let's inform the world!

One of your most influential works (cited over 1,000 times) is the chapter entitled, Empirically Supported Psychological Interventions: Controversies and Evidence, which was co-authored by Dianne Chambless, and published in the Annual Review of Psychology. Although this classic, and most comprehensive work, was published in 2001, its content remains as relevant as it was 17 years ago. Do you think that empirically validated treatments are extensively used by practitioners today? What can we do to ensure that the most effective treatments are employed in everyday clinical practice?

Again, you pose good questions! I am very committed to what are now collectively referred to as evidenced-based practices – both assessment and

treatment. One of the problems is that our early work and that of others was too "tied" to disorders and the typical clinician might see multiple "disorders" in her or his weekly practice. Recently, one clinician offered to me that she saw 17 different disorders in one week. How – she mused – could she possibly learn and deliver that many protocols. It was a good question and we mused on this dilemma together – no simple answers but when we started to see if we could look at "transdiagnostic issues" we seemed to move forward. Yes, it is difficult for clinicians in applied settings setting to master and use evidence-based approaches – yet, we must simply solve this problem and move forward. We cannot rest on our laurels, nor can we rest on things that do not work. No other pro¬fession does so – why should we? Let's get together and solve this problem. By the way, it would be so good to involve our families and patients in such dialogue. Now, don't ask me any more difficult questions.

Now, let's move on to the area that you are going to talk at the upcoming 11th International Congress in Granada. You and other colleagues successfully developed a CBT One Session Treatment (OST) for specific phobias. How was the OST approach conceived? Has this approach been tested across geographical contexts? Could you comment on its effectiveness for different phobias subtypes? Who are best candidates for this approach?

First off, I give full credit to the seminal work of Lars-Goran Ost from Stockholm University for the development of this approach. He and I have now examined its use and effectiveness with children and adolescents in several studies. Subsequently, colleagues in Japan and Australia have also come aboard and are using this treatment. Why One-Session Treatment? Three major reasons: 1) both of us had seen many children (and adults) who had been in treatment – sometimes for years and they had not gotten better. That was unacceptable to us. We surely could do more. 2) Then we looked at the standard treatment of phobias and anxieties and that too was taking too long in our opinion. Surely, we could treat these problems in a more intense and briefer period of time. 3) We used the good work of several learning theorists including recent ones like Michel Craske who have taught us that learning principles are most effective when learning opportunities are consolidated and delivered in a more succinct and concentrated manner. Voila! One Session Treatment was born and lives on! The approach works best for a variety of individuals – some of which will be discussed in my presentation – I cannot reveal everything today!!

An issue of concern in clinical settings is how to address the needs of individuals resistant to treatment. I realized that you will likely address this topic in our Granada Congress, and I do not want to get ahead of

your talk, but could you perhaps give us a preview of how to address non-responders in phobic and anxiety disorders?

Now here is another difficult question. I am ready for it! In my opinion, this happens more often than we like to admit. Most of the time, it is our own fault. We cannot blame the patients – let's put the blame where it usually belongs, on ourselves. In my clinic we try not to use the word "resistance." We reframe to "what can we do differently." The chances of what you refer to as resistance can be reduced by a good evidence-based assessment that is then followed up by a good functional analysis. We need to look at predisposing, precipitating and perpetuating factors – the triple P's. Then, it might also be helpful to not forget protective factors – the fourth P. In most cases this thorough assessment for treatment planning is effective, and our patients are not "resistant."

Let's us now talk about prevention as we do not want our readers to wonder why we have not discussed early interventions aimed at larger cohorts of children and adolescents. Are researchers generally focusing more on treatment than on prevention of phobic and anxiety disorders?

Well, much has been done in the area of prevention in terms of school-based program, effective parenting programs, and resilience efforts with children. We have noted that phobias are "gateway" disorders meaning they lead to other disorders if left untreated. Still, events occur – whether accidents, school shooting, terrorism, and yes even war. These are tragic events and even our best – yes even evidence-based treatment programs may not be effective. Quite clearly, in our modern society, we must do more to create a safe and secure environment for our children and adolescents and yes even our adults! How can we become more resilient in a society that is characterized by unpredictability? No easy answers, right?

Now let's talk about cultural factors since the upcoming XI International Congress in Granada has attracted numerous participants from around the globe who are eager to hear about new developments in the field, particularly from the United States. Our readers might be interested in hearing your take on cultural factors, as you have done research across geographical boundaries and frequently worked overseas. Can therapeutic techniques developed in one cultural context (e.g., the United States) be readily applied to another non-western country (e.g., China) without regard to culture? Are researchers paying enough attention to cultural factors in phobic and anxiety disorders?

Culture is a most important factor that has not been sufficiently addressed in studies, including our own – most unfortunately. We and others are trying to address this need but we are not there yet. We do work now in six continents and some things seem to translate well and others do not. In 1983, for example, I published a fear survey schedule that has been translated into 19 languages – the basic fear structure seems to hold relatively well but youth differ across nationalities in extent and type of their fears. Also, CBT, with modifications, seems to work within Eastern philosophies – yet important aspects need to be changed. Some of the new wave therapies are addressing these changes. I think it would be great if we develop research and clinical teams that would transcend boundaries. Then and only then, in my opinion, can we advance our knowledge base and extend our clinical reach. Who will fund us?

> *I now would like to briefly turn to the classification of anxiety disorders. De¬spite the research evidence for a more dimensional or trans-diagnostic approach to said disorders, the DSM V and the soon to be released ICD 11 retained categorical approaches to the classification of anxiety disorders. The DSM V actually increased the number of anxiety disorders from 10 in DSM IV to 23. Although the upcoming ICD 11 recognized some commonality, it opted to keep the categories to maintain parity with other systems of classification of diseases. Should we continue the "splitting "process? After all, it seems that most clinical interventions and manuals on anxiety disorders are developed for specific conditions. What would be your advice to clinicians when dealing with classification and assessment of anxiety disorders in their daily practices?*

Well this is a very important question. In my first book, *Clinical Behavior Therapy with Children*, I recommended not diagnosing our children and adolescents. Yes, they had problems but diagnoses were more a figment of our imagination. Well, times have changed and I now do arrive at diagnoses. It is true, as you state, that most manuals are disorder specific but not all, Some are transdiagnostic and others are more 'mechanism" oriented. With the various anxiety disorders (which by the way are highly comorbid it one another), the underlying mechanism – from a psychosocial perspective – are likely related to faulty cognitions (catastrophic thoughts), behavioral avoidance, and skill deficiencies. If we can become more "principle" oriented and address these areas in our treatments, and do good evidence-based assessments, we will go a long way to advancing our science and practice. The force is with us, let's embrace it!

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ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD) IN CHILDREN

Joanne Hands and Juan Carlos Sierra

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**You are the current president of the Middle East Psychological Association (MEPA), one of the collaborating societies of the XI International Congress of Clinical Psychology. Can you briefly talk to us about it?*

Yes, I have been the president of MEPA during the 2015-2017 term and was reelected for the 2017-2019 term. The association is relatively young. It was established in 2010 with the purpose of providing resources and professional guidelines to mental health professionals working in the Middle East. This association has three specific goals or purposes:

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(1) To characterize the discipline of Psychology in this part of the world, as it is still seen as a taboo and something exclusive to Western countries.

(2) To provide resources not only for professionals in this field but also for the general community.

(3) To establish relationships and collaborations with other organizations and entities from around the world, with the aim of incorporating the most recent and up-to-date information and techniques into our Middle Eastern countries, as well as exchanging information with experts from other countries.

Unfortunately, in the Middle East, Psychology is not viewed with the respect it deserves. It is a relatively new profession that is associated with many stigmas and even shame, which prevents many from fully accepting it. One of my personal goals is to give this beautiful and important profession the recognition it deserves and to have it acknowledged, accepted, and treated like any other profession such as Medicine, Engineering, or Architecture. I am confident that with the support of everyone, we will soon be able to reach this level. The signing of a memorandum of agreement with the American Psychological Association (APA) in 2018 is indeed a significant step for MEPA. This partnership will bring numerous benefits, such as the exchange of knowledge, experts, and general information. It will undoubtedly contribute to the growth of our countries and enable us to provide better services to the community. Collaborating with the APA will open up opportunities for learning, sharing best practices, and staying updated with the latest advancements in the field of psychology. This collaboration is a testament to MEPA's commitment to enhancing the profession and improving mental health services in the Middle East.

Let's talk a little more about this issue. In Spain, the situation and reality of Psychology in the Middle East are hardly known. Could you provide us with information about it? What kind of training do future professionals receive? What is the level of research in the field of Psychology in those countries? What can you tell us about professional practice? What role do psychologists play in society? As you can see, there are many questions, but we would like to know more about this reality.

Yes, I understand that there are many questions, but I realize that there is very little knowledge about psychological practices here in the Middle East. As I mentioned before, Psychology is a relatively new profession that deals with many sensitive issues, which many people do not want to discuss. In our Arab society, there is a lot of stigma surrounding anything related to mental health. I know many cases where families prefer not to acknowledge that a family member is experiencing a psychological problem out of fear of societal reaction

and how it could affect other family members in general. Due to this reason, families prefer to hide the problem by isolating the affected family member and do not seek professional help. Many focus on natural remedies or spiritual resources without realizing that professional help could often address the issue. This societal perception leads to another problem, which is the lack of resources and educational support, as very few universities offer Psychology studies due to the low number of prospective students. I know of schools that do not include the discipline of Psychology because it is not considered important. However, I must mention that in the thirteen years I have lived in Kuwait, I have witnessed a significant change in this regard. Nowadays, more and more universities are opening their doors to this profession, and we now have many training schools and events that offer courses and degrees in this professional field. In many parts of the Middle East, Bachelor's, Master's, and even PhD degrees in Psychology are offered. However, in many other places, like Kuwait, only a Bachelor's degree in Psychology is available. Regarding research, there is a limitation in that many studies and research papers are published in English, making it challenging for Arabic schools to utilize them unless they are translated into the local language. This delays the currency and relevance of the information. In my personal opinion, this region requires significant support and intellectual/educational exchange to provide our young people and professionals interested in this profession with the necessary resources to evolve.

> *Well. Let's now focus on your intervention at the XI International Congress of Clinical Psychology, where you will address Attention Deficit/Hyperactivity Disorder (ADHD) in children. You are aware that in recent years, there have been movements calling for the abolition of diagnostic systems, with a particular focus on this disorder (see Timimi and Pérez-Alvarez in this same book). What do you think about this issue? Are diagnostic classifications really necessary?*

I think it is a controversial issue. I don't believe that we are at a point where we should completely eliminate diagnostic classifications. However, I do think that there have been abuses, and in many cases, therapists focus solely on seeking a diagnosis rather than addressing the problem itself. Personally, I first concentrate on listening to the patient and understanding the issues they bring. I try to work with various methods that I believe could benefit them, and as we progress, we assess if a psychometric evaluation and a specific diagnosis are necessary. I believe that knowing the diagnosis of the individuals we work with brings many benefits, as it allows us to provide appropriate treatment without wasting excessive time. However, as I mentioned, I believe that in many cases, there has been abuse, and this is not beneficial for the patient.

> *In the specific case of ADHD, there are authors like Dr. Timimi who consider it an example of the "pathologization of normal problems that adults often have with children and adolescents," lacking clinical validity. I would like to know your opinion on this matter based on your professional experience with these types of cases.*

Certainly, we do see cases where the child does not have any clinical pathology; rather, there is a mismatch in family dynamics, parenting styles, and dietary habits. However, I have witnessed many cases where the child truly suffers from attention deficit that significantly affects their academic abilities, and medication is recommended. In my professional experience, I have encountered many cases of ADHD, and, in general, my recommendation to parents is to pay attention to the child's behavior from an early age, as the earlier the behavior is addressed, the better the outcomes. A structured multidisciplinary program (involving parents and teachers) is recommended, where the child can have clear expectations that facilitate their behavior. I have seen many cases where pharmacological treatment was not necessarily due to effective educational, psychological, and behavioral interventions. So, regarding your question, I share the opinion of Dr. Timimi or Dr. Pérez, but at the same time, I believe that we cannot exclude those cases where there is a genuine deficit in attention and hyperactivity, as indicated in the DSM-5.

> *A question I would like to address, considering your multicultural background and experience, is the role that cultural factors can play in the disorder of ADHD. For example, Spain is one of the countries where the highest number of ADHD diagnoses are made, with a significant difference compared to other neighboring countries. What could be the reasons behind these cultural differences? What is the reality of this phenomenon in Middle Eastern countries compared to Western countries?*

Well, the truth is that I didn't know ADHD was so common in Spain, but it doesn't surprise me, as it is increasingly being seen worldwide. In my opinion, cultural factors may contribute based on dietary and behavioral traditions. It has been found that children who engage in frequent social activities (parties, family celebrations, etc.) are more exposed to foods with high levels of sugar and other ingredients that could contribute to decreased attention and increased hyperactivity. In the Middle East, we are seeing more and more cases of ADHD every day, and I believe there is a strong relationship with lifestyle factors.

When comparing Middle Eastern countries to Western countries on this issue, I think that Western countries have more advanced medical expertise, which leads to more studies and preventive programs than in our Middle

Eastern countries. It is also important to consider that the diagnosis of ADHD in the Middle East is relatively new, so now we often see more children being diagnosed with this disorder. During my postgraduate research in this area, I found that in the last 15 years, there have been more diagnoses of this disorder than in previous years, which may indicate a tendency to automatically label cases with this diagnosis. One could say it has become a trendy diagnosis, with a greater tendency to provide a diagnosis or parents perhaps exaggerating when referring to their children's behavior. There are many factors that could play a role in why this disorder is more prevalent in certain countries than in others.

One of the key points of controversy surrounding ADHD lies in its psychopharmacological treatment, as we have witnessed a significant increase in the prescription of psychotropic medications in recent years. However, in your presentation at the XI International Congress of Clinical Psychology, you propose a psychoeducational program for these children. What is your stance on medical treatment? Is it actually necessary to medicate these children?

Look, I am not a strong advocate for the pharmacological approach to this disorder, at least as an initial treatment. Undoubtedly, there are many cases that require psychopharmacological treatment due to their greater severity, where both the child and the parents and educators are affected. However, I believe that great care must be taken when working with this population, as I have seen many cases where therapists do not even attempt to treat the condition without medication, but immediately resort to the use of drugs for treatment. In a study that I have led, it was found that the psychoeducational component is very important and, in some cases, the only intervention required. I have worked with many patients who have been able to achieve their educational goals with just psychoeducational treatment. Of course, every case is unique, and there is no specific plan that works for all children with this disorder. That is why cultural information plays an important role in these cases.

The alternative is psychological treatments. Could you give us a preview of the psychoeducational program for children with ADHD that you will focus on in your presentation? What are its main characteristics?

Yes, of course. In my presentation, I focus more on the psychoeducational aspect, which involves working not only with the child but also with the parents and educators. It is important to help them understand which activities are beneficial and which are not. At the same time, it is crucial to work with the personal expectations of each parent and educator, as well as the levels of stress that these expectations may bring. It is important to remember that, in many

cases, it is the goals and attitudes with which the child is treated that actually contribute to improvement.

> *In this program, you emphasize the important role of parents and educators. What role do these key figures play in the understanding and management of ADHD? In the case of educators, in Spain, the Education Law includes children with ADHD in the Special Educational Needs Group. Do you consider this measure appropriate?*

Yes, absolutely agree. We need to understand that in order for the child to succeed, we need to provide them with the best help we can, and one of the most beneficial conditions is an educational classroom with a reduced number of students per class, where they can receive more individual attention and fewer distractions.

> *Finally, you are licensed as a Couples and Family Therapist in the state of Louisiana (United States of America), and among the psychotherapeutic services you offer are marital and couples' relationships. Currently, we are witnessing a worldwide social movement advocating for women's rights, which is becoming increasingly significant. How is this reality being reflected in couples' relationships and the demand for solutions to relationship problems? How are these issues being experienced in Middle Eastern culture?*

Currently, my work primarily focuses on couples. I work with many cases of couples, and undoubtedly, we see how the global movement for women's rights is reflected in marital issues. What used to be the cause of marital problems in the past may not necessarily be what brings couples to therapy nowadays. At the same time, we observe that couples therapy is becoming more common and less taboo. People today have higher levels of education, and there is greater equality in rights. There are more working women, and more households where both parents are economic providers. These changes bring about consequences that are not only positive but sometimes negative as well. This field is one that attracts me the most because, as we know, the relationship between couples impacts children, other family members, friends, and society as a whole. Therefore, when we learn to communicate in a healthier way and better understand our partners, the atmosphere at home is reflected, and this eventually influences society.

CYBERBULLYING IN ADOLESCENTS

Carlos P. Zalaquett and Juan Carlos Sierra

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**You are a past president of the Interamerican Society of Psychology (SIP), one of the Societies collaborating with the XIII International Congress of Clinical Psychology. It is a scientific and professional society founded more than 70 years ago with the intent of promoting exchanges between psychologists from all the American countries. Could you briefly describe to us to what extent the SIP has and continue to contribute to the development of psychology in the American continent?*

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Of course, we are more than 70 years old, and am delighted to share that since its beginning in 1951 SIP has established communication and collaboration networks involving psychologists from North, Central, South America, and the Caribbean. By doing so, SIP has increased the academic, professional, and research exchanges between the nations of the Americas and the world. Furthermore, SIP has and continues to lead the advancement of the profession, the improvements of international understanding, and engagement in the process of understanding the cultural differences across the region.

SIP promotes progress in all areas of our discipline through its inter-American congresses, regional congresses, and, more recently, the first international virtual conference and virtual congress of Psychology. In addition, the organization honors and rewards the work of our professionals via awards such as the student research awards in psychology, the Ignacio Martín Baró Award, given to undergraduate and postgraduate students, and the Inter-American Psychology Awards, for scientists and professionals that has made outstanding contributions to psychology as a science or as a profession, and the José Miguel Salazar Award, given by the Inter-American Journal of Psychology (RIP) for the best-published article. The fruit of all this work is reflected in the quality of the RIP publications (https://journal.sipsych.org/index.php/IJP). We also publish the SIP Bulletin (https://sipsych.org/publications/sip-bulletin/) to contribute to the development of our profession. As you can see, we have remained true to our goals. Furthermore, we continue to expand them by incorporating new virtual technologies to support the activities and collaborations among psychologists of the Americas and the Caribbean.

> *As you know, for a few years now, the SIP has been one of the international scientific institutions collaborating with the International Clinical Psychology Congress, which is annually celebrated in Spain. What Is the role of SIP in the field of psychology in the world? What connections with professional institutions and associations does it have (for example, Spain)?*

SIP plays an essential role in global Psychology. We participate in many international initiatives. Indeed, SIP is the most well-known and active inter-american psychological society in Latin America and represents psychology as a science and profession in North, Central, South America and the Caribbean. Furthermore, it is the oldest society that brings together Spanish- English, and Portuguese-speaking psychologists. SIP has contributed enormously to the growth of Inter-American psychology, promoting a significant increase in publications in the main languages of Latin America (that is, Spanish and Portuguese), increasing the number of international meetings and cooperation projects for research, training of professionals, and the establishment of new

psychology associations in recent decades. All of these has facilitated the interrelationships between professionals and groups around shared interests.

Furthermore, SIP has actively contributed to international psychology by collaborating with regional and international psychological societies. In fact, SIP is a member of the International Union of Psychological Sciences (IUPsyS) and has collaborative relationships with other societies, such as the American Psychological Association (APA), and several of its division, such as 52-International Psychology, the International Association of Applied Psychology (IAAP), the International Association for Cross-Cultural Psychology (IACCP), the Consejo General de la Psicología de España (COP-ES) and, of course, the XIII International Congress of Clinical Psychology that you represent. I have participated in your excellent conference and keynoted for the COP=ES conference, where I was made an honorary member, a truly wonderful honor. Due to these types of collaborations, we have enjoyed a strong representation of professionals from Spain and Portugal at our last conferences, which makes me extremely happy.

> *Following your response to the first question, and before addressing the topic that will cover your participation in the XIII International Congress of Clinical Psychology, I would like to discuss the current situation experienced worldwide. We know that SIP is playing a very active role in providing a response from Psychology to the pandemic caused by COVID-19. Could you tell us what type of actions you are carrying out? In your opinion, what response should psychology give to this suffering worldwide?*

SIP had a very active role in the development and socialization of a response to the challenges brought up by the COVID-19 pandemic. We were the first psychological society to summarize for our professionals the initial information available about this epidemic, offer guidelines and suggestions for the prevention and containment of the virus and for the treatment of the psychosocial consequences of the pandemic. This was followed by a special issue of the SIP Bulletin reporting on topics essential to work with the COVID-19, consequences, such as psychological assistance for health personnel, raising awareness about the danger of self-medication, suggestions to managing working from home, and how to reduce domestic violence during the confinement period. Everything was complemented with other offers, such as online courses and seminars sent through our communication channels (email and Facebook) and different collaborations with other psychological organizations from the U.S, Spain, Peru, Brazil, and Portugal, for example. During this time, we have placed particular emphasis on preparing our professionals to offer telepsychology or telemental health, and we have supported all initiatives carried out by members of the SIP. Furthermore, Zoom has become our second name! As the SIP president and

as a professional in Psychology, I participated in many groups and initiatives, and I also volunteered to provide services to patients via telepsychology. In all these activities I continued to discover and admire both the magnitude of what we do and the enormity of our needs. To facilitate Interamerican cooperation, we collaborated with the Office of International Affairs of the American Psychological Association (APA), the International Union of Psychological Science (IUPsyS), the Colombian College of Psychologists (COLPSIC) and the Coordinator of Psychologists of Uruguay (CPU) to published a list of the websites of psychological groups dedicated to respond to the COVID-19 epidemic in the Americas, the Caribbean and Ibero-America (https://drive.google.com/file/d/1WN-3LjH-jfWnFZPJYVXWZ1MNqWBvXblf/view?usp=sharing). This was a large-scale effort to facilitate our professionals' access to the information presented by many of these organizations and ensure that these associations shared resources with each other. We have also socialized resources in several languages since we have much diversity in our countries, and have adapted all efforts to reach the entire population, including minorities and most alienated groups in our area and beyond. Many of my professional efforts were aimed at reducing inequalities, facilitating access, and adapting resources so that they increase their reach and do so while respecting the worldviews and values of the people, groups, and countries with which we interact. Especially important here is to prevent racism and discrimination against groups that are blamed without clear evidence for causing or stimulating the pandemic, such as people of Chinese origin, immigrants, and low-income people. These critical aspects were shared with leaders of psychological organizations from many parts of the world. Personally, I interviewed and shared many of the experiences and actions of colleagues from all over the Americas and the Caribbean and more than 60 psychology groups worldwide through the Global Psychology Alliance (GPA). Many of those interviews have included Spanish-speaking colleagues. The interview with a colleague fighting COVID-19 requires a special mention, as it opens a window for us to directly learn about the effects of this virus. Our first international conference, titled "Psychology's Responses to the Challenges of COVID-19: A Special Response for a Special Time," in collaboration with Carlos Albizu University and the Office of International Affairs of the American Psychological Association, represents another great example of our contributions. This conference socialized for a global audience the innovative and effective response to the COVID-19 implemented by 29 psychologists from countries ranging from China to Spain. We believe this has been the first example of psychological interventions that have worked in the world and a clear demonstration of what we were able to do at the time.

As you can see, COVID-19 affected us all, but it did not stop us. We continued to work virtually, and we had virtual conferences socializing the contributions of our psychological science to confronting the challenges produced by the

COVID-19 epidemic. These experiences clearly demonstrated the essential role our profession has in our world then, now, and in the future.

> *This pandemic is having and will have effects on the mental health of many people; it has caused drastic changes in the way we behave, we interact with other people, and definitely in our way of living. Do you think psychology is facing a historical moment that is essential to face a situation like this?*

That is an excellent question. The answer is yes. Let's reflect for a moment… at the onset of the COVID-19 pandemic there were no vaccines with the capacity to prevent the coronavirus disease nor medications to treat the viral infection. It became clear that the best thing we could do was to prevent the disease from spreading, and the way to do that was to reduce exposure to the virus. All those measures required behavioral changes, and all those behavioral changes involved psychological factors. Behavioral changes included avoiding contact with people with the COVID-19 infection, maintaining an approximate distance of two meters from others, covering your mouth and nose with a mask when in public, frequently washing your hands, and cleaning touched surfaces. Educating and engaging people to follow these guidelines required psychological conceptualization and psychoeducation. For example, we would not have used terms like social distance to prevent contagion; we would have used physical distance. We promoted the rapprochement and the incrementing of social relationships using existing virtual means, such as the telephone and the virtual platforms offered by WhatsApp, Skype or Zoom, to reduce the negative consequences of isolation and lockdowns.

The pandemic highlighted the great demand for attention to the psychological needs of those affected, including the needs of COVID-19 patients, their families, the health personnel who treated them, and their communities, as well as those affected by other diseases who were frightened by the possibilities of contagion. Also included were all the people confined to their homes and their families who were immobilized and could not carry out their professional, educational, social, and other activities. We were all affected but we all responded with different degrees of anguish, fear, depression, or other psychological reactions, and part of our role was to normalize these reactions, which in extreme cases like this were expected. Psychology professionals became aware of these circumstances and reactions and contributed to all the aspects mentioned so far, including reducing the stigma associated with the need for psychological assistance, and supporting families and healthcare personnel. We were making an essential contribution to all aspects of treatment, recovery, and rehabilitation of patients affected by COVID-19. A colleague told me about her work in the physical therapy ward of her hospital, where she assisted coronavirus patients who needed to learn to breathe and

speak, again after weeks of intubation. Another described working with families who had just lost a loved family but had no chance to visit or see their beloved one due to restrictions imposed by the epidemic. Equipped with the science and art our profession has developed over time, psychologists rose to the challenges brought up by the COVID-19 pandemic and addressed the psychological needs of people, groups, and communities affected by the pandemic. Our discipline offered many of the first answers to these challenges. Our professionals were integrated into teams within emergency rooms, health professionals support groups, psychoeducational programs, and online treatments via telepsychology, jus to name some of the areas in which we participated.

As you suggested, the pandemic caused by COVID-19 changed our world. The epidemic produced countless physical and mental consequences, financial concerns, and personal and social insecurity. Nobody has seen anything like this in the recent past and we were appalled by the many challenges and in need for answers. Our professionals were at the forefront of offering innovative and creative responses. Our virtual conferences demonstrated much of what was done and the lessons learned. We hope that all of this experiences, learnings, and actions will serve to continue advancing effective guidelines and solutions for needs of people, communities, and societies. We know this pandemic will not be the last, reason why I believe it is essential to show the world the importance of what we do and the many ways in which psychology contributes to individual, public, and population health.

> *You are a Professor at The Pennsylvania State University, where you are part of the "Counselor Education Program," and the author of several internationally renowned books on Counseling. Would we like to know how Counseling can contribute to people successfully coping with situations such as this new way of life (in Spain, they speak of the "new normal") associated with the pandemic caused by COVID-19?*

Yes, I am a professor in the Department of Educational Psychology, Counseling, and Special Education at The Pennsylvania State University (affectionately known as Penn State), where I co-coordinate the Clinical Mental Health in Schools and Communities program. I am also a Guest Professor at several Universities around the world. One of the most outstanding contributions my colleagues and I have made is the description, teaching and training of the microskills that are fundamental to establishing relationships and achieving therapeutic effectiveness in counseling and psychotherapy. These skills, which allow active listening and building new possibilities working collaborative with others, are fundamental for the construction of the new normality you mentioned and will allow us to reestablish our social relationships so seriously affected by the restrictions and challenges imposed by the pandemic. In fact, the

therapeutic microskills have been used by many of our professionals in their responses to the COVID-19 challenges and will continue to do so. For example, the guides developed by our colleagues at the Complutense University of Madrid to provide remote (non-face-to-face) counseling to those experiencing psychological consequences from the COVID-19 epidemic clearly indicate that "in the online and telephone environment, it is essential to maintain and adapt basic therapeutic communication skills to enable the development and maintenance of the therapeutic alliance." Active listening, empathy, the reflection of emotions, summarizing, and reframing, just to name a few, will also facilitate social communication. The international conference on Intentional Responses to the COVID and Racism Pandemics and the Role of the Listening Skills showed how these skills have been fundamental to many programs designed to respond to the challenges of the pandemic and racism, for example. Recently, we have implemented "Moments of Excellence," a training program to help our professionals learn and use evidence-based relationship skills with the power of improving the quality and strength of the therapeutic relationship. Used ethically, intentionally, and with respect for the culture of our interlocutors, we will be able to establish relationships that respect the diversity and values of people and help us reinvent ourselves in a more integrated and fair society.

> *Let us now focus on his intervention at the XIII International Congress of Clinical Psychology, which is one of his current areas of work: cyberbullying. In the last decade, nearly two thousand scientific articles have been published on this topic, which shows its enormous relevance today. I was hoping you could tell us about this problem's importance and magnitude worldwide.*

Yes, research in cyberbullying, also known as online or virtual bullying, has surged in the last decade, which is understandable given the magnitude of this negative phenomenon. Cyberbullying is recognized as a serious societal issue of great concern, affecting the psychological development of adolescents around the globe. Cyberbullying can have a devastating effect on adolescents, producing negative emotions such as anger, embarrassment, fear, and sadness (Borka Balas et al., 2023); poor academic performance, work performance, and interpersonal relations; and psychological disorders such as anger, depression, substance use, and suicide (Vismara et al., 2022). These effects can be more pronounced on marginalized populations and individuals with disabilities, and can continue into adulthood (Aboujaoude & Savage, 2023).

On average, 30.50% of adolescents between 12 and 17 years old suffer this type of harassment, according to the study by Biswas and collaborators published in EclinicalMedicine (see Biswas et al., 2020). This elevated cyberbullying as a critical factor affecting physical and mental health during adolescence. Of course, there

is a significant variation in the prevalence of this type of harassment worldwide. However, studies like the one mentioned above demonstrate that a large number of adolescents suffer from this type of violence in all countries. Furthermore, it affects adolescents of all social and economic levels (Craig et al., 2020). Given the magnitude and severity of this critical problem and the increments in virtual platforms available to users, we can only expect an increase in its prevalence and consequences. We can also expect increased research, intervention programs, and studies on the results of our proposed interventions. The latter is essential to establish evidence-based solutions.

> *To clarify this question, is it a phenomenon that shares the properties of other types of traditional harassment, or are we facing a unique problem with its differential characteristics that must be addressed differently from other types of harassment?*

That is an excellent question. It reminded me of a lecture on cyberbullying I gave a few years ago, in a very low-income country. During the intermission, journalists questioned my presentation arguing that there were not enough computers available in their country's schools for students to harass others virtually. There were still about 400 teachers in the auditorium, representing public and private schools from all economic segments. Using the microphone, I asked them if any of their students had been bullied using cell phones. The majority responded affirmatively and added that the attacks had included aggressive or slanderous messages or denigrating or compromising photos. I explained to these journalists that cyberbullying does not require computers, most students from all socioeconomic levels in their country have cell phones and they used their cell phones to bully other! This example shows that cyberbullying can occur in every country, from the less developed to the most, and across all social segments. Current research confirms this and indicates that it occurs more frequently in less developed countries. Given the ubiquity of means available to cyberbully, any adolescent with minimal knowledge or technological skills can attack others. Cyberbullies can be poor or rich, or weak or strong, or they may believe they have immunity and privacy in their actions. The important point is that they can do much damage. This creates a reality that must be addressed differently from other forms of harassment.

> *Specifically, your intervention at the XIII International Congress of Clinical Psychology will focus on cyberbullying in adolescents, a population at risk. Given that it is a complex problem involving at least two actors (perpetrator and victim), could you briefly describe a profile of both? What risk or causal factors cause a teenager to become an aggressor or a victim? What effects does cyberbullying have on adolescent victims?*

You are absolutely right; it is a very complex phenomenon that has been studied using a variety of methodologies, groups, and evaluation instruments. In addition, the provision of means to harass cybernetically and the minimum knowledge needed to use them means that any young person can turn into a cyberbully or instigate group cyberbullying, with the consequent damage to the target of such action. Furthermore, participants can be categorized into more than two groups and include cyberbully, cyber-victim, cyberbully/cyber-victim, and bystanders. The latter group who may remain indifferent, reinforce the cyberbullying by supporting the bully or participating in the bullying, or they can defend the target of cyberbullying. Bullied targets suffer less anxiety and depression when viewers defend them. All of this serves to underline how difficult it is to achieve a specific and global profile of the participants in the world of cyberbullying. Some researchers suggest that there is no single profile of young people involved in cyberbullying. They can have good social relationships or be marginalized from them, and they can be harassed by others and become bullies, or vice versa. Young people who bully others and are harassed are at highest risk for behavioral, mental health, and academic problems. Using a bioecological vision of human development, such as that proposed by Bronfenbrenner (Bronfenbrenner and Morris, 2006), we can understand that the perpetrators' behaviors are shaped by the multiple ecological systems in which they are immersed. Therefore, the study of these influences must include intrapsychic competencies (for example, family and peers) and extra-personal variables (for example, social and cultural and extra-personal variables (for example, social and cultural) to understand the behavior of these actors, which implies that the national and cultural characteristics of different countries and groups will influence how young people use the Internet and participate in these different roles. Recent research suggests that a bioecological perspective will allow us to deepen our understanding of cyberbullying among adolescents and improve preventive and intervention programs in schools. While we move in this direction, we can highlight some general guidelines to guide the implementation of prevention programs in different countries. Cyberbullying affects cyberbullies, cyber-victims, and bystanders, although with different profiles. For example, studies such as those by Ansary (2020), Cañas et al. (2019) or Livanzonvic and Ham (2019) show that cyberbullies and cyber-victims tend to show greater stress, symptoms of depression, anxiety, loneliness, hostility, interpersonal sensitivity, paranoia, and suicidal behaviors, and they tend to use drugs and experience a lower self-concept than young people who do not participate in cyberbullying. In general, these actors report low satisfaction with their family, social, and academic lives. Boys tend to bully more than girls. They all tend to use cell phones, computers, and tablets and spend much more time connected virtually than other youngsters. Factors such as family, school, and relationships with peers protect against cyberbullying. We know little about

cyberbullying based on prejudice. However, we have evidence that different groups, such as ethnic minorities, the LGTBQI community, and people with disabilities, are more at risk of being victims of cyberbullying, and we should study the role of cultural prejudices on cyberbullying. With Dr. Seria Chatters, we were the first to realize that most forms of bullying and cyberbullying began in early school years and continues in college and beyond.

During your conference, you will present the results of a comprehensive training program in cyberbullying. Could you describe to us in general terms what this program consists of? Can you tell us any significant results?

Let me begin by mentioning that our work with Dr. Chatters changed drastically after 2014 when we concluded that cyberbullying continued from school to university (see Zalaquett and Chatters, 2014). We quickly realized that multicultural factors played a prominent role in bullying. Our studies revealed that most cyberbullying was based on some form of bias, prejudice, or racist ideation. We incorporated these factors in what we called bias-based bullying or prejudicial bullying. Since then, we have integrated strategies into our work to prevent both cyberbullying and cultural prejudices, and we apply them at all levels, from students to teachers and educators. One of our first significant results came from bullying trainings in which we integrated bullying prevention and bias reduction. The participants reduced their prejudices and increased their knowledge about bullying, a result observed at the end of the program and at a two-month follow-up. The control group did not show any of these changes. Since then, we have observed similar changes at all levels of program implementation, demonstrating a positive and sustained impact of the bias-based integrated program.

In this context of intervention, a recent meta-analysis of cyberbullying prevention and intervention programs in schoolchildren (see Gaffney et al., 2019), published in the journal Aggression and Violent Behavior, concludes that the reviewed programs are effective since they reduce cyberbullying perpetration by 20% and cyberbullying victimization by 15% What do you think of these results? How could the effectiveness of these programs be improved?

The work of Hannah Gaffney and collaborators reports that bullying prevention programs reduce bullying perpetration by 19-20% and victimization by 15-16%. Their results confirm that prevention programs are effective. However, they also demonstrate that these effects vary greatly from program to program and even within the same program when applied to different

schools. Most researchers mention the heterogeneity of programs, definitions, and measurements to explain these differences. We believe that these research results show the promise of existing programs in reducing bullying and cyberbullying. Nonetheless, they also indicate that the results are inconsistent, and we hypothesize that these differences are due to the lack of integration of biases, discrimination, and prejudice reduction within the bullying and cyberbullying prevention programs (see Chatters and Zalaquett, 2018).

> *Let us focus a little more on the exciting field of prevention. A fundamental line of work in cyberbullying should be prevention, where we will encounter multiple actors (parents, teachers, peer groups, etc.). In what contexts should we influence? What elements should a good cyberbullying prevention program necessarily include?*

Prevention research clearly demonstrates the need to use comprehensive, stratified programs that include multiple levels of care and focus on students, teachers, other staff, other adults (e.g., family members), the school, and the community. In a first level, these programs may include the virtual space in the school (Web pages) to communicate and promote prosocial and positive behaviors; a system for evaluating and monitoring harassing behaviors and the virtual spaces where cyberbullying occurs; a program to develop prosocial behaviors and academic skills; communication of expectations and rules of conduct in class and online; and consequences associated with cyberbullying. A second layer may include actions to ensure a safe and supportive classroom environment when students at risk of getting involved in cyberbullying are detected. Educational lessons and time can be offered to discuss school cyberbullying and effective communication, as well as strategies for responding to cyberbullying. The third layer may include programs to respond to cases of cyberbullying and work with cyberbullies, cyber-victims, bystanders, and their families. We add the integration of biases and discrimination prevention and prejudice reduction programs to these stratified interventions, given the strong relationship between biases and harassment. Of course, as professionals, we must also advocate for each country's Departments of Education and the Ministries of Education to establish legislation that promotes and supports the application, study, and updating of bullying and cyberbullying prevention programs.

> *Finally, we would like your opinion about the recent line of work related to the brain and cyberbullying. An article has just been published in the journal Aggression and Violent Behavior (McLoughlin, Shan, Broadhouse, Lagopoulos et al., 2020), which describes a functional magnetic resonance imaging protocol to elucidate the neurobiological*

foundations of cyberbullying through the exploration of brain responses. What do you think about this line of research that is yet to be explored? What advances can this path mean in understanding and addressing cyberbullying?

As I have mentioned in presentations and publications, neuroscience confirms the effectiveness of our practices and their effect on the brain. Our interventions not only change the mind but also the brain! The other side of this discovery is that intense or recurring negative experiences damage the brain and reduce people's mental health. Intense and repeated cyberbullying cannot be an exception, so the work carried out by Larisa McLoughlin and collaborators is vital to elucidate which parts of the brain are involved in this behavior and to give us new tools to understand and reduce its occurrence. In fact, this team of researchers published a pilot study identifying parts of the brain of bystanders, such as the left and right middle temporal gyrus, cerebellum, and vermis and putamen that responded to harassing photos but did not respond to neutral photos (see McLoughlin, Shan, Broadhouse, Winks et al., 2020). The integration of Social Sciences and Neuroscience can give us essential keys to understanding the impact of bullying and cyberbullying on the brains of adolescents. It can guide us in developing innovative interventions and help us understand the short-term and long-term of both forms of harassment. The work in our Brain-Based Laboratory supports progress in this direction and offers yet another reason to support this type of study. We know that self-reports do not always reveal people's actual responses. A person can say that he follows all the precepts and behaviors his religion requires but does not participate in any of its required rites. We have studied the expression of preferences in the brain using our decision-making model (see Collura et al., 2014), and we have confirmed in the laboratory that the brain tends to respond asymmetrically to certain stimuli, demonstrating approach or rejection, and that these brain responses differ from the responses reported by participants. We are in the process of publishing our studies on ethical decision-making and evaluating preferences for different racial groups. We believe that evaluating brain responses can give us another way to evaluate people's spontaneous preferences. So, I see that this line of research can offer us new ways to study the responses of the different groups involved in bullying and cyberbullying.

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INCLUSIVE PSYCHOLOGY FOR ALL

Cynthia de las Fuentes and Saúl Neves de Jesus

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**The American Psychological Association (APA) is the largest professional psychology association worldwide, both in terms of the number of members, and the importance it has had in the history of Psychology. The role of APA President is very demanding and involves great responsibility. Why did you decide to be President of APA? And what has changed in your life since you have been President?*

The decision to run as a candidate for president was made in collaboration with my colleagues and family. My colleagues encouraged me to run because they saw and appreciated my involvement in various state and national psychological associations. Of course, I had to speak with my family and receive their support

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(they have always been so supportive of my career!) because of the time commitments away from my home that this professional service would require should I win. One of my colleagues once called me a "reluctant leader" in that while I value the opportunities to serve on boards of organizations, my service has typically been in the role of "secretary" of a group. I sincerely enjoy taking minutes of meetings because of the opportunity that role provides me with a birds-eye view of the landscape of the organization. As secretary of a board, I can influence decisions and policy - without having the pressure of being the chair or president of the group, or organization. With a few exceptions, I managed to avoid being at the head of the table. What has changed most is probably control of my time. Since 2007 when I left academia, I have been in private practice delivering psychological services to clients, conducting forensic evaluations, and consulting with groups. I was able to schedule my own time and choose who I wanted to work with. The addition of this role means I double my work hours and am meeting with all kinds of people representing a variety of groups. Of course, this experience has been incredibly rewarding, although the task-switching between my practice and my role in the APA took some acclimation.

> *APA has had moments when the presidency was held by psychologists with a more professional orientation, and others when the presidency was held by psychologists with a more investigative profile. In Cynthia's case, although you also has experience as a university professor, seems to be more intervention-oriented, particularly in the context of social inclusion and the protection of immigrants. In fact, your conference at the "17th International Congress of Clinical Psychology", to be held in November 2024, will be on the topic of forensic evaluations of immigrants. The problem of immigration is very current in Europe, in particular due to immigrants from Africa trying to reach Europe. Only in 2023, there were more than 2000 people missing in the Mediterranean Sea, leading the International Organization for Migration to consider this the most dangerous route in the world. Currently, with the war in Ukraine, the problem of displaced people and immigrants has increased in Europe. The problem of immigration seems to be very interconnected with the problem of war. We can see what is happening in the Gaza, for example. This war between Israel and Hamas was fueled by the Hamas terrorist attack on October 7, 2023. This century has been marked by this phenomenon of terrorist attacks, since September 11, 2001, in New York (USA), and March 11, 2004, in Madrid (Spain). So, I ask you, how important are Psychologists in promoting peace in the world and, in particular, in the context of migratory crises arising from war situations?*

Psychologists play a crucial role in promoting peace in the world, especially in contexts affected by war and migratory crises. Our peace psychology colleagues study the mental processes and behaviors related to violence prevention and facilitation of peaceful resolutions to conflict. Their activities inform policies and interventions while they advocate for peacebuilding efforts at local, national, and international levels. At local levels, they additionally teach individuals and communities about conflict resolution, empathy, and understanding. As you note, war situations often lead to forced migration, displacing millions of people around the world. Psychologists play a critical role in supporting refugees, asylum seekers and migrants via the delivery of evaluation and trauma-informed care to those who have experienced violence, loss, and displacement. Many of us also advocate for policies that protect migrants' rights and reducing barriers to access to a safe community and integration in the receiving countries. In the United States, to qualify as a refugee or asylee, one must demonstrate fear of persecution in their native country because of race, religion, nationality, political opinion, or membership in a particular social group. The U.S. has historically led the world in numbers of refugees resettled annually, but there were major dips following the 9/11 terrorist attacks and after Trump became president in 2017, a drop that has continued. In 2021, for example, the United States admitted the fewest refugees since the modern resettlement framework was created in 1980. Recent filings of asylum cases, largely by Central Americans (primarily from countries of the "northern triangle") and Venezuela, have reached heights not seen in at least three decades. Furthermore, my colleagues at the border are seeing more and more Haitians since the murder of its president Jovenel Moïse last July; and Russians, especially Russian men attempting to avoid conscription into military service, since the start of its war with Ukraine.

> *Psychology has increasingly focused on current topics, such as climate change or artificial intelligence. In general, what is the role of psychologists in achieving the Sustainable Development Goals (SDGs), established by the United Nations (UN) in 2015, with a view to a global agenda for the construction and implementation of public policies until 2030?*

At APA, we are increasing our focus on population health to enact our mission of "promoting the advancement, communication, and application of psychological science and knowledge to benefit society and improve lives." Toward this end, our population health goals are in alignment with the goals of the UN in that we work to advocate for the alleviation of poverty by addressing health and mental health disparities and access to quality healthcare. We work toward enhancing educational experiences and opportunities by investigating effective teaching methods and learning environments and we advocate for inclusive and equitable educational access for all, especially for women, girls,

and people with disabilities. Our science around work and economic growth builds upon those goals by also focusing on addressing workplace well-being, proper work conditions, productivity, and job satisfaction all of which help create inclusive, safe, and resilient cities and societies. In general, we advocate for policies that reduce disparities related to income, education, and access to resources by applying our expertise by improving mental health, promoting well-being, and addressing societal challenges, aligning with the SDGs' vision for a better world by 2030.

> *Another topic I would like to discuss with you concerns the relationships between research and intervention, between the academic world and the professional world of psychologists. In Portugal, in order to promote greater rapprochement between universities and the Order of Portuguese Psychologists (OPP), the equivalent of the APA, we created the National Psychology Forum, that integrate OPP and the 31 Higher Education Institutions (HEIs), public and private, that provide training in Psychology. In this Forum we have taken positions and made recommendations on topics relating to training and research in Psychology, with implications for the professional practice of Psychologists. What do you think about the relationship between research, training and intervention in Psychology? How does APA work in connection/collaboration with universities?*

As a clinician in private practice, my work is informed by evidence-based and empirically validated interventions. As an evaluator, the instruments I use and the interpretations I make also have strong validity for the populations with whom I work. Furthermore, as a meeting facilitator and group leader, I have been especially compelled by the contributions of our applied colleagues on what makes meetings effective, how to understand organizational change processes, and different leadership styles for different contexts. My point here is that science, training, and practice are inextricably connected. To support the work of our academic, scientific, and applied research colleagues, we need to help funders and the public see the value and application of psychological science to their lives and communities. Our psychological science can provide both theories and approaches on best practices in education and training, addressing the real-world concerns such as climate changes' contribution to migration patterns and community spread of disease, as well as behavioral changes to reduce symptoms of individual and family disfunction. We must continue our work to expand our own and the public's views of who a psychologist is and what a psychologist does. To strengthen our position in support of the future of our profession psychological scientists, educators, and practitioners, we must encourage and facilitate interdisciplinary and international collaborations that take advantage of research-training-practice opportunities that can inform and

impact real world and global problems. Housed within universities and other institutions of higher education, the APA accredits graduate programs to assure the public that those programs have clearly defined education and training goals and experiences that meet scientific and professional standards that support the successful ethical and professional conduct of psychological science and delivery of psychological services. The APA Commission on Accreditation (APA-CoA) is the premier accreditor in the U.S. for psychology. In addition to graduate programs in clinical, counseling, and school psychology, the Commission also accredits doctoral internships as well as postdoctoral residencies those areas as well as in specialty areas of health service psychology. There are currently more than 422 accredited doctoral programs, approximately 672 accredited internship programs, and more than 178 accredited postdoctoral residency programs. Furthermore, APA-CoA is currently embarking on accrediting master's programs in the above areas as well. The work we do with our education and training is informed by our standards and guidelines (https://www.apa.org/research-practice/standards-guidelines), which are mandates from our legislative body, the Council of Representatives.

> *In 2020, with the COVID-19 pandemic, the training of future psychologists took place online for some time. Currently, classes at universities are back to being in person, but some universities have started to offer training courses in Psychology carried out remotely. Taking into account the learning and skills necessary to practice Psychology, as well as the importance of universities for the integral development and mental health of young people, what is your position on the initial training of psychologists being carried out online?*

At APA, we have historically allowed doctoral programs to provide some (but not all) education through distance education and that is currently still the case. Our focus is on how the distance education program can show us they meet our accreditation standards by demonstrating compliance with all the Standards of Accreditation in their distance education components. As such, additional, unique information may be required from the program in their application for accreditation. For example, if the program is authorized to provide distance education, how does the program verify the identity of students and how does this process protect students' privacy, details about the how the program provides regular and substantive interactions with students, faculty qualifications for distance education, and how the program discloses to students' relevant information about its use of distance education. Doctoral programs must require one year of full-time (or the equivalent) in residence.

From 2020 onwards there was also an increase in Psychology consultations carried out online. What do you think about psychological intervention carried out remotely?

Although I saw some clients online prior, since the beginning of the pandemic in March 2020, my psychotherapy practice has been carried out exclusively online. The reason I am comfortable doing so is because research indicates that teletherapy can be as effective as traditional in-person therapy for treating conditions such as anxiety, depression, PTSD, and adjustment disorders. Furthermore, in my community, bilingual psychologists are not common, so teletherapy makes mental health services more accessible, especially for individuals who need services delivered in another language or who live in remote or underserved areas. My clients report high levels of satisfaction with teletherapy, appreciating the convenience and comfort of receiving therapy from their homes or offices without the time spent commuting to and from a psychotherapy office. Overall, teletherapy is a valuable tool that offers effective and flexible options for those seeking psychological support.

Based on their priorities and themes of research and intervention, some APA presidents defined the priorities of Psychology at a global level, from the moment they exercised these functions. For example, Guilford increased research in the field of creativity from the 1950s onwards, Spielberger achieved this for studies on stress and anxiety, in the 1980s, and Seligman allowed a change in the focus of Psychology at the beginning of this century, enhancing the research on Positive Psychology variables. In Cynthia's case, I would like to highlight a phrase that you presents on your account on the social network X: "I am honored to be elected President of the American Psychological Association. Let's continue to work together to use psychology to benefit society and improve lives while working toward an inclusive psychology for all." Can we say that your main "mark" in the history of Psychology will be this focus on Inclusive Psychology? In 20 years, how would you like to be remembered as President of APA?

For me, "Inclusive psychology for all" is an approach that emphasizes ensuring everyone, regardless of their identities, abilities, or circumstances, feels valued, respected, and understood within psychological practice, science, education and training. This theme emphasizes creating a more equitable and supportive environment for everyone, enhancing our overall well-being and sense of belonging not only within our discipline, but in society. In addition, inclusive psychology encompasses the career emphasis of the professionals as psychologists. Most people think that psychologists are health service providers,

and indeed many of us are, but we have psychologists who are scientists, who work in business and industry, who are administrators of public agencies, who work for fashion houses and for NASA, and in so many other capacities. I want all psychologists to be seen and to feel that APA is their professional home. In 20 years, I hope I am remembered as an effective leader who helped the American Psychological Association achieve its impact via our strategic plan in fulfilment of our mission of "promoting psychological science and knowledge to benefit society and improve lives."

I gave the example of Spielberger and remember that he was the founder of STAR (currently "Stress, Trauma, Anxiety and Resilience Society"), in the 80s of the last century. This society currently has representatives from more than 40 countries, holding an annual congress (the last one, in 2023, was organized at the University of Algarve, Portugal, and the next one will be in the USA), and allowing research to be carried out in different countries on current topics related to stress and anxiety. In turn, APA has divisions of various specialties in Psychology. What is the point of specific scientific societies, such as STAR, if the APA integrates psychologists from the various specialties of Psychology, organizing itself by divisions?

While the American Psychological Association (APA) does integrate psychologists from various specialties and organizes itself by specialty "divisions," specific scientific societies still play a crucial role in the field of psychology in that they: (a) offer focused expertise within subfields (such as in applied psychology or psychoanalysis), (b) provide a sense of community and opportunities for networking, (c) deliver tailored professional development, and (d) can advocate for the interests and needs of their specific subfields more effectively. In essence, while the APA provides a "big tent" for the field of psychology, specific scientific societies offer the depth and focus needed to advance particular areas of science, practice, training, and advocacy.

What is the relationship between the APA and the associations of psychologists in European countries, namely Spain and Portugal? Do you think this relationship should deepen in the future? In what sense? What common projects can be implemented?

APA signed Memoranda of Understanding (MOU) with the "Ordem dos Psicólogos Portugueses" OPP) in July of 2013 and with the "Consejo General de la Psicología" (COP) in Spain in August of 2012, in addition to other MOUs with EU countries. Additionally, the OPP and COP contribute to the Global Psychology Alliance (GPA) of which APA is also a member. The working relationship between

the APA and both the OPP and COP focuses on advancing psychological science, practice, education and advocacy for increased impact within each of our nations and between associations. In recent years, representatives from each organization have been actively involved in professional academic exchanges, shared conference presentations, joint global initiatives, and resource sharing on key issues ranging from regulation to artificial intelligence. APA, OPP and COP are strong partners who share the mission of bringing psychology to the world to improve lives and are actively collaborative as we achieve this aim.

Finally, would you like to add some final message that seems very relevant to Psychologists in Europe, in USA and in the world in general?

The more I interact with psychologist colleagues at organizational and individual levels across the world, the more I realize that we have shared challenges. These range from advancing recognition of psychological science and practice to research funding to questions about mobility, technology and human well-being. The pandemic made all of us – no matter where we are from – aware of the significant mental health challenges children, youth and adults face across the globe. It also taught us a lot about the importance of contributions from behavioral science in addressing climate change, digitalization, and consequences of isolation. The best way to overcome big obstacles is by learning from and working with one another. We know that psychology worldwide is needed now more than ever. Let's join to support key roles for psychologists in addressing the issues that touch humanity. The moment is here, it's up to global psychology to make the most of it.

THE EDUCATIONAL CONTEXT OF MENTAL HEALTH INTERVENTIONS WITH CHILDREN AND ADOLESCENTS

Frank C. Worrell and Cristián Oyanadel

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**You grew up in Trinidad and Tobago, and then you were an international student. And in a brilliant career you became the 2022 President of the APA. Who do you think has influenced your professional career and the development of your talent?*

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Thank you for the question. I think there are several things that matter. I mean I think I was very lucky to have parents who even though they didn't go to college made it very clear that when you were doing a job you should do it to the best of your ability. I didn't always listen to them when I was in elementary and secondary school, but I actually did practice that from the time I started in college, and you know, trying to do a job to the best of my ability, I think that paid off; it paid off as an undergraduate student where I graduated at the top of my class. Although I wasn't working for that, but it happened. When I was here at UC Berkeley for my PhD, my dissertation got the outstanding dissertation award, and again, I was not working towards that, so I think that is again my parents insisting that I do the best that I could.

I also think that having good mentors matters and I had a lot of really good mentors. From people who believed in me and who supported me along the way. When I got into UC Berkeley for my PhD. I, you know, didn't have the money for the first year, and my music teacher from secondary school lent me the money to pay for the first year. Yeah, I paid her back, but she believed in me and lent me the money from her husband's life insurance.

I also had a really wonderful advisor for my undergraduate and master's degrees in Canada, and then again here at Berkeley for my PhD. I actually had more than one mentor here at Berkeley and then, when I became a junior faculty member, again I had supportive colleagues. So, it's a combination of parents and support, and the third piece I would say is being open to feedback, because I think sometimes, we think we know it all. Sometimes, the people who are supporting us or mentoring us give us advice that we don't want to hear, but I think it's really important to be open to feedback; somebody else may have a point of view that is useful. So those three things: support from my family and the messages they gave me, the mentors over time, and then you know being open to feedback. I think all of those things contributed to me being where I am today.

And I guess I would add one other thing, actually, and that is getting along well with people, being sociable. I think there are some people who do not get along well with others—they are always quarreling and upset. I have been involved in APA and other professional associations where a lot of the work that we do is by committee; you've got to be able to work well with people, to get along well with them, and so just being open to feedback and open to their ideas, but being willing to share your ideas politely and respectfully. Being able to work well with others is another piece of this.

APA is the most influential Psychology organization in the world. Looking back at your work in APA, now as Past President, how do you see the evolution of this organization in the last two decades?

Yeah, that's an interesting question. You know, I actually began working with the APA about 20 years ago, and I think that there are several things that have happened and that we continue to work on as an association. The first is a commitment to the members, so always being committed to the members. I mean APA has, I think, over 140,000 members, about 148,000 members, and we have clinicians, we have scientists, we have, basic scientists, applied scientists, and so forth. We have student members, and paying attention to all of the groups is important, and we are still working on doing that. For instance, the 2023 president did a survey of members and found out that the student members care more about belonging and having a sense of belonging than some of the older members; that members from ethnic minority groups care more about a sense of belonging than White members, so paying attention to what the various groups want, we've been trying to do that. We are also paying attention to our budget, because there's stuff we need to do for the members, and we try not to have the costs of membership be too high, and that requires a good budget.

Much of APA's revenue comes from the journals; we have something like 89 journals, so making sure that those journals are of high quality, which means having good review processes, good editors. And I would say particularly in the last five to six years, APA has spent a lot of time paying attention to our mission, and our mission is not just to serve the members, but the broader mission of APA is to serve the greater good, to serve society. So how can psychology give back to society? And that means then paying attention to what is going on in society. So, when COVID was raging, looking at issues like how do we get people to take vaccines, vaccine hesitancy? As you know, there is now a lot of political fighting in the United States. One of the things that is being worked on is disinformation. How can APA combat disinformation online, how do we appropriately engage with artificial intelligence? And how do we deal with climate change. APA has a climate change task force and last year we had a climate summit—it was our second climate summit. How can psychologists work with communities to take climate change seriously so that they will then do the necessary things to help mitigate climate change?

And just earlier this year, for example, one of the big things that's been going on for young people in particular is social media, so APA issued in 2023 for the first time a health advisory on social media and youth. Normally, APA would just put out a press release, but we termed this an advisory, specifically to give it more weight: the literature is saying that engaging with social media can have some very negative impacts on youth, can lead to depression and anxiety and sometimes even substance use, so we need to be paying attention to how these platforms are working. APA has gotten more and more focused

on that mission of serving society over the last two decades and I think that's a good thing.

> *Many of these topics are related to interventions with children and adolescents in the school context. What problems do you see for school climate and mental health in a postcovid era?*

I think COVID-19 has changed how we think about ourselves, and I think in some sense it has had a more profound impact on children and adolescents, because I think we are now back to an era where young people are worried not just about what the future will be—that's still a concern—but will there be a good future at all. We know that back in the 1970s and 1980s, when the Cold War was raging between the US and the communist world, children were very afraid. Children and adolescents were very afraid of nuclear war—it was one of their top fears—because they were concerned that these the countries were not talking to each other and there'd be a nuclear war which would be a disaster for the world. And then, the Cold War ended, the Berlin Wall came down, and that fear went away. But in the last decade, climate change has accelerated. We've been talking about climate change for a while, but the impacts of climate change are becoming more and more evident. And we are seeing them every year: we are seeing it in floods during the rainy season, and in fires during the dry season; we are seeing tremendous impacts, people losing their homes. The hurricanes have gotten much stronger, the hurricane season is lasting longer. So children have been seeing these events, and in the midst of all of these, we get COVID-19 and the world shuts down in a way that it has never really done before.

I think that all of these events have had profound impacts on children in many ways. When we think about school climate, the idea is that you're feeling a sense of belonging, you're feeling connected to your peers, and therefore you know, you're willing to get along because we're all together. But if I do not know that I have a future, I am less willing to get along; I might as well do anything I want to do. My behavior is going to be more out of control, why engage in self-regulation? These events have had a profound negative impact on school climate. We are certainly seeing it in the United States. We had thought that elementary school students would need to be re-socialized to school, but we are finding that it's not just elementary school students, but also middle school students, high school students, college students need to be re-socialized and even adults in the workplace need to be re-socialized. All of this is an impact of the COVID-19 shutdown, and then we still had the impacts of climate change through the shutdown.

One of the things that the shutdown did is it amplified other concerns like climate change, because people were at home. They were not out partying as

usual, so when fires happened, they saw them, they paid more attention, they were looking at the news. And then climate change is happening everywhere: it's happening in Australia and it's happening in Pakistan, it's happening in America, and it's happening in central America and it's happening in Canada and the ice is melting at the poles; it's in Greece and it's in China. You hear about the impacts of climate change everywhere, so it relates to a topic that you and I study, time perspective. Can we have an optimistic future? Is there going to be the possibility for a positive future? That's one of the things we as adults and as psychologists are going to need to work on with kids: to build trust that human ingenuity will come through and that we will come up with solutions; we will actually get greenhouse gases under control, so that they have a future that they can live in, a world that they can live in. But I think it's a hard sell, because we have a lot of work to do.

> *In that sense, what are your reflections on policies for the prevention of suicide attempts, violence, abuse, eating disorders in schools, from an intersection between health and education?*

So that's a long list of concerns. From an education point of view, a lot of people forget that education in and of itself is a preventive factor. If schooling is doing what it's supposed to do well, children and adolescents get a sense of not just academic competence, but they get a sense of behavioral competence, they get a sense of social competence, they get emotional competence. School at its best is making students better at doing reading, writing, and arithmetic, but also better at getting along with peers, better at socializing, better at making friends, better at controlling emotions when one gets angry. So I think education has becomes much more important: the role of the teacher, the role of the school and schooling more generally.

The other thing I think we need to think about alongside competence is this sense of "Who am I." Everybody needs to have a sense that they matter, so a fundamental question is an identity question. We know that identity comes to a head in adolescence but younger children are working on developing their identities. So, who am I in this world? Am I a person that matters? Am I a person whose group matters, the group that I belong to? Do I have the capacity to make a difference, to make a positive contribution? So competence is tied to identity. I have learned these skills and I can use these skills in service of my community, in service of my society. And I think all of these things help with the list of concerns that you mentioned. I think if we feel competent, if we feel a strong sense of identity and, if we feel a sense of hope in the future, then things like abuse and violence go down.

But we know that for some people that's not going to be enough. So we are still going to need people who are trained as therapists to be able to do interventions and to help people who need to learn to think differently. To prevent things like suicidal ideation, stop people believing that the fact that you failed this test doesn't mean that you are absolutely worthless as a human being.

I think there's also a role that goes much beyond those of us who are psychologists, and that is the role of people in important places and positions in society. The politicians, the leaders at the national and local levels, teachers, policemen. How are they responding when there are problems? Children and youth are watching us. And if when we get angry, we lash out, we call our enemies names, or we pull out a gun and shoot someone. Children are seeing that; we need to model a different way.

We need to model treating each other with respect, agreeing to disagree. We need to learn that we may not agree on X and Y, but we can both agree on Z, so where can we find the common ground. I think there's a larger role for the adults in society to be role models for all our children and youth. And that is becoming even more crucial today, because when we have politicians here in the United States, and I'm not going to call names, but who act like children and scream and shout and call people names, that's not just seen in the United states; you see it in Chile and you see it all over the world, and not only do you see it once, it gets taped and so you can see it again and again and again. So, that's what we are faced with countering. We've got to think prevention, but we also have got to keep the tools for intervention in place as well.

OVERCOMING FEAR AND TRAUMA AND THE 'DECOLONIZATION' OF PSYCHOLOGY

Thema S. Bryant and Carlos Del Río

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Carlos Del Río (PhD, University of Iowa USA) is a neuroscientist and senior medical writer. Prior to working full time as a scien-tific/medical writer in the pharmaceutical industry, Carlos held sev-eral teaching and research positions in international settings, in-cluding the University of Iowa (USA, supported by the Fulbright Program), the University Hospital of Bern (Switzerland), the Univer-sity of Reykjavik (Iceland), and the University of Granada (Spain).

**First, I would like to thank you for accepting the invitation to conduct this interview and for giving a keynote presentation at the 16th International Congress of Clinical Psychology (ICCP). Indeed, the APA and the ICCP have had a robust institutional relationship for many years. I would also like to congratulate you on being elected president of the American Psychological Association (APA). Can you tell us about your journey to becoming APA's 2023 president? What motivated you to pursue a leadership role in the organization?*

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Thank you for inviting me to participate. As someone raised by parents who were community leaders, I grew up with a sense of responsibility and a desire to be a part of creating solutions wherever I am. Their example was the motivation for me assuming multiple leadership roles over the years locally and globally. I was elected a member of my neighborhood council in Los Angeles where I currently live and I was appointed one of APA's first six representatives to the United Nations over 20 years ago. As it relates to the presidency specifically, mentorship and the support of colleagues in the association led me to pursue the role. Dr. Jessica Henderson Daniel, the first Black woman to be president of APA, was my mentor. She and many other colleagues asked me to consider running for the position after my successful tenure as president of APA's Division 35, the Society for the Psychology of Women. Additionally I am a trauma psychologist, who focuses on multiple forms of trauma including the trauma of oppression. The year I ran, the nation was being bombarded by the stress and trauma of the pandemic and racial injustice. I was motivated to run at this time as I felt my experience and areas of expertise would be beneficial to the association's aim of enhancing people's lives.

The APA plays a crucial role in advocating for the mental health needs of various communities. This is particularly relevant considering that psychological support is still not affordable or accessible for many citizens around the globe. What initiatives or policies is the APA promoting under your leadership to democratize mental health, especially in underserved populations?

The APA has a strong advocacy office which mobilized our over 130,000 members to advocate on the state level, as well as nationally and globally for access to quality mental health services, especially or underserved communities. We provide training in advocacy in person and virtually to empower psychologists and psychology students to actively engage in the transformation of policy around mental health equity.

Your own research and clinical work focus on interpersonal trauma and the societal trauma of oppression. In a deeply inspiring TED talk in Nashville earlier this year entitled 'Why we need to decolonize psychology', you claim that a while a colonized psychology sees the individual as a 'series of cognitions for us to diagnose, pathologize, control, transform, change, detect, research', a decolonized psychology 'recognizes that your social, political, economic environment, and systems affect your mental health (…) and recognizes that 'justice is therapeutic, justice is healing'. The implications of the concept of decolonized psychology deeply shake every aspect of both clinical practice and research. Can you further

explain to our readers what justice needs to be achieved and how far are we from truly decolonizing psychology? What advise do you have for practicing psychologists and researchers addressing trauma, grief, and oppression in individuals from diverse cultural and social backgrounds?

To decolonize psychology is to contextualize our psychology and to work to combat oppression in all forms while helping individuals and communities to work toward psychological health and liberation. A decolonial framework attends to indigenous wisdom, as well as the impact and counter-action for the stress and trauma of oppression. Practitioners, consultants, and researchers should acknowledge oppression, its effects, and the potential healing pathways to both eradicate oppression and heal its wounds. I recommend practitioners ask about experiences of oppression, discrimination, stereotype, and stigma during the intake process and to then incorporate it in the treatment plan for interventions that are more inclusive and ethical. Additional to decolonize our curriculum is to ensure that we are learning and teaching the richness of the field of psychology which has contributors of diverse identities. Psychology researchers need to consider ecological frameworks so we can determine the ways various systems interact with our internal functioning. Finally, it is important for psychologists consider ways to apply our psychological science to enhance people's lives through advocacy and dissemination of knowledge beyond the academy.

In recent years, there has been a growing institutional emphasis on promoting representation, equity, and inclusion in both clinical and academic settings. In these settings, creating more inclusive and diverse environments is an ongoing challenge. Indeed, in the abovementioned talk, you share that only 4% of psychologists in the US are Black, 4-5% Asian, 5% Latinx, and 0.3% Native American. Why do you think this is worrying, particularly in the field of Psychology? What strategies do you believe are essential for overcoming the existing challenges and achieving representation and diversity at the undergraduate, graduate, and faculty levels?

The diversity of the population in the United States is growing and people are deserving of engaging with psychologists who reflect their various identities. A lack of cultural representation in our programs and clinics can lead to greater misunderstanding, bias, and harm to underserved communities. Marginalized community members are at increased risk for various stressors and sources of traumatic stress. They deserve culturally informed care which is enhanced by a diverse psychological workforce. To increase diverse representation in the field, we need early exposure to psychology in primary education, increased scholarships, institutions that are intentionally inclusive for recruitment and

retention, direct efforts to address hostile, unwelcoming behaviors in our programs, and mentors who will advocate for underrepresented students.

> *On the topic of (collective) trauma, the COVID-19 pandemic, together with the growing political polarization, increase in hate crimes, accelerated climate change, and resurgence of armed conflicts worldwide is having a profound impact on individual mental health. Indeed, some have warned that the long-term effects these stressful and traumatic global events are difficult to predict and will undoubtedly have a severe impact in individuals and communities for years to come. Do you think that collectively we have done enough to address this collective trauma and learn from it? In this context, what is your advice to the readers to promote resilience and coping in the context of the current social and political climate?*

We need to do more to address the various collective traumas we are facing. We need to provide more psychoeducation on stress and traumatic stress, as well as healthy coping strategies. We need more community-based programming and virtual programming to create space for the grief people are experiencing based on recognizing and unrecognized losses. We need to conduct and disseminate more research on changing behaviors from climate to discrimination. All of these efforts need to be implemented across the lifespan to attend to children and older adults. Finally, we need to learn from decolonial scholars and population health scholars to determine ways to address structural inequities.

> *You have recently published the book 'Homecoming: Overcome Fear and Trauma to Reclaim Your Whole Authentic Self'. This book, inspired by your own personal journey, provides tools to reconnect with the neglected parts of ourselves and lead a more expansive life and healthier relationships in the context of a larger community. For you, what is the meaning of the title word 'Homecoming'? Can you tell us more about the process of writing this book and who can benefit from reading it?*

Stress and trauma can cause us to disconnect from ourselves. We may abandon and neglect ourselves in attempts to find safety, whether psychological or physical. As we recover and heal, we can reclaim ourselves by being more self-aware and by defining ourselves more holistically instead of simply seeing ourselves through the eyes of those who harmed us. I wrote the book during the pandemic as most psychologists had a wait list and so many people were feeling overwhelmed by the stress and trauma. I wanted to create a resource that would be relevant and accessible. Each chapter has a homework assignment which people can complete alone or with their therapist. I'm grateful that I

was also able to record an audio version of the book for people who prefer that format. The workbook for Homecoming entitled Reclaim Yourself, will come out next year.

Following up on this topic, in everyday conversations and particularly among young social media users, I believe the word 'trauma' is often thrown around and overused. In this context, it is common to see teenagers claim in front of the camera that they are being 'traumatized' because Starbucks messed up their order, or that studying for a difficult exam 'gives them trauma'. Is this hypothetical banalization and overuse of the term downplaying the suffering of victims of severe trauma such as sexual assault, domestic violence, sexism, or racism? In your opinion, does it make sense to differentiate 'levels' of trauma or stick to a clinical definition or do you think that to some extent everyone has dealt with traumatic or shameful experiences that prevent them from being their authentic selves?

Misunderstanding of the concept of trauma and other words such as narcissism, bipolar disorder, and even depression, is an important reason for psychologists to engage with the public to share our expertise. While it is beneficial that the public is more interested and engaged around mental health, there can also be a lot of misunderstanding when we are disengaged from the public discourse. As it relates to trauma in particular, the area of trauma that has been most overlooked by trauma psychologists ourselves is the trauma of oppression, also referred to as societal trauma, intergenerational trauma, racial trauma, ancestral wounds, and historical trauma. It is important that trauma psychologists not dismiss these collective traumas which have short and long term consequences.

You are the host of Homecoming, an acclaimed podcast with more than 180 episodes aimed at 'facilitating our journey home to ourselves by providing weekly inspiration and health tips'. Throughout the years, the podcast has had exceptional guests and covered such diverse and important topics as exposing oppression, self-sabotage, sexual health, coping with depression and anxiety, or grief. Could you please tell us more about this experience, what motivated it and what have you learned from it so far? Do you believe that alternative communications channels like podcasts bring psychological science to people and ultimately promote well-being and mental health?

A component of liberation psychology and African-centered psychology is an emphasis on dissemination of knowledge as a way of removing barriers

to access to underserved communities. There are still financial and cultural barriers to accessing quality, culturally informed care. I engage on social media, starting my podcast, and have published a popular book as a way of sharing psychological knowledge. The APA also has a very successful podcast which covers a range of topics based on the latest psychological science. I have been heartened by the response to the podcast not only nationally but globally. A large component of my audience is outside of the United States and many are in nations with a small number of psychologists. I'm grateful for this medium to be able to share and learn with a global community.

> *Social media, popular science books, podcasts… these are indeed effective channels to reach the general public. However, another crucial goal of practicing psychologists, researchers, and associations such as the APA is to have a broader impact in society by bridging the gap between psychology and public policy. From your recent experience and also as former APA representative to the United Nations, what can be done to improve the influence of psychology on policymakers and promote evidence-based policy decisions worldwide?*

I encourage psychology researchers to include policy implication in their discussion of the their findings when relevant. Psychological associations can then utilize those fndings and implications to inform policy makers and to advocate for policies that will enhance people's lives. The biggest points of wisdom I gained from psychology advocacy locally, nationally, and globally are that (1) do not assume the general public is aware of our scientific findings as often they are not and (2) we can get more accomplished by collaborating with other organizations than we can achieve alone.

> *On a more personal level, I am aware that you are an ordained minister. How do your faith and personal values shape your teaching, leadership, and therapeutic approach? Many scientists (including psychologists) find that science and religion/spiritual practices mutually exclusive. Do you think Western, contemporary psychology is lacking or can benefit from a spiritual, more holistic component?*

My faith and values cause me to center compassion, liberation, wholeness, and collaboration as an educator, leader, practitioner, and researcher. Traditionally many leaders in the field of psychology were people who endorsed a faith belief. Later in our field's history people began to pathologize or simply ignore faith, spirituality, and religion. Given that the majority of the nation and global community endorse spirituality and/or religion, it is important for psychologists to adopt a more holistic approach which acknowledges that for

some faith communities have been a source of harm and for others it has been a source of resilience. It's important for us to explore the meaning and impact of faith on people's lives as a growing number of researchers and practitioners are doing. I'm the second minister in APA's history to become president and we have a very active division, Society for the Psychology of Religion and Spirituality, which continues to make strong contributions in this area of study.

You have also identified yourself as a 'sacred artist'. What role does art play in your clinical practice? Do we have scientific evidence that art can help suffering and recovering individuals with specific pathologies heal and thrive?

The expressive arts are especially helpful with trauma survivors and any person who has experiences that are difficult to name due to shame or neurodiversity. Researchers have found expressive arts an effective tool for child trauma survivors to share their trauma narratives in trauma-focused cognitive behavioral therapy. Additionally various art mediums from music to dance have been found effective in affect recognition, self-expression, improving mood, and enhancing communication and relationships.

Finally, what advice do you have for aspiring psychologists and students who are looking to contribute to the field and potentially assume leadership positions in the future?

I would tell aspiring psychologists that the field is in need of your presence and contribution. You have something to offer and this is an exciting time to become a part of the field as we are seeing innovation in every area of psychology. While there is great suffering all around us, there is also a growing recognition in society that psychologists are a part of the solution. As you enter the field, I encourage three things. The first is a care ethic, not only for those you may serve but also for yourself. The second point of advice is to embrace the richness of your culture as an important aspect of your identity. You do not need to erase your identity to be professional. There is a wealth of knowledge from your culture that you can utilize to enrich your teaching, practice, research, and consultation. Finally I would encourage you to become active with a psychology organization. There are great mentors, projects, and initiatives that can nourish you professionally and give you a greater sense of fulfillment and purpose as we can make more impact when we work together.

APPENDIX A.
CONGRESSES AND TRAINING ACTIVITIES ORGANIZED BY THE ASOCIACIÓN ESPAÑOLA DE PSICOLOGÍA CONDUCTUAL (1990-2025)

1. I Symposium de Psicología Clínica Aplicada. Jaén (Spain), 1989.
2. II Symposium de Psicología Clínica Aplicada. Jaén (Spain), April 2-6, 1990.
3. I Symposium Nacional de Psicología Conductual. Jaén (Spain), April 1-5, 1991.
4. I Syposium Iberoamericano de Psicología Conductual. San José (Costa Rica), July 15-16, 1991.
5. Symposium Iberoamericano sobre Sueño e Hipnosis. Granada (Spain), April 27-30, 1992.
6. II Congreso Nacional de Psicología Conductual. Palma de Mallorca (Spain), April 5-7, 1993.
7. Symposium sobre el Sueño y sus Trastornos. Malaga (Spain), April 28-30, 1993.
8. I Encontro Internacional de Terapia Cognitivo-Comportamental. Rio de Janeiro (Brazil), June 12-13, 1993.
9. Actualidad Clínica en Psicología Conductual. Córdoba (Argentina), June 30, 1993.
10. I Edición del Máster Internacional en Psicología Clínica. Granada, 1993-1995.
11. Symposium sobre Sexualidad Humana. Granada (Spain), April 14-16, 1994.
12. II Symposium Iberoamericano sobre el Sueño y la Hipnosis. Granada (Spain), May 4-6, 1994.
13. I Congreso Internacional de Psicología Conductual. A Coruña (Spain), July 12-15, 1994.
14. 1st Ibero-American Conference on Health & Behavior. New York (United States of America), November 9, 1994.
15. II Edición del Máster Internacional en Psicología Clínica. Málaga, 1994-1996.

16. II Congreso Internacional y III Congreso Nacional de Psicología Conductual. Granada (Spain), April 24-28, 1995.
17. III Edición del Máster Internacional en Psicología Clínica. Granada, 1995-1997.
18. II Congreso Iberoamericano de Salud y Conducta. Granada (Spain), March 19-22, 1996.
19. Simposium sobre Avances en la Evaluación y Tratamiento de los Problemas de Relación de Pareja y Sexuales. Granada (Spain), January 15-17, 1997.
20. III Congreso Internacional y IV Nacional de Psicología Conductual. Granada (Spain), March 3-7, 1997.
21. V Congreso Nacional de Psicología Conductual. Vitoria (Spain), March 5-8, 1998.
22. Symposium sobre Análisis Funcional y la Planificación del Tratamiento Psicológico. Granada (Spain), March 20-21, 1998.
23. Symposium sobre Psicofarmacología Aplicada. Granada (Spain), April 24-25, 1998
24. III Congreso Iberoamericano de Psicología de la Salud. Torremolinos (Spain), May 15-17, 1998.
25. Curso Internacional sobre VIH/SIDA: Entrenamiento para Profesionales de la Salud. Torremolinos (Spain), May 18-22, 1998.
26. Symposium sobre Problemas de Conducta en el Aula. Granada (Spain), May 30-31, 1998.
27. I Symposium Internacional sobre Trastornos de Ansiedad. Granada (Spain), November 20-21, 1998.
28. I Symposium sobre Psicología Jurídica. Granada (Spain), November 27-28, 1998.
29. IV Congreso Ibérico de Terapia Cognitivo/Comportamental. Salamanca (Spain), December 1-4, 1998
30. IV Edición del Máster Internacional en Psicología Clínica. Granada, 1998-2000.
31. VI Congreso Nacional de Psicología Cognitivo/Conductual. Madrid (Spain), March 4-7, 1999.
32. Curso Aplicado sobre Terapia de Parejas. Granada (Spain), March 26-27, 1999.

33. Curso Internacional sobre Hipnosis Clínica. Granada (Spain), April 16-17, 1999.
34. IV Congreso Iberoamericano de Psicología de la Salud. Granada (Spain), April 22-24, 1999.
35. II Symposium Internacional sobre la Planificación del Tratamiento Psicológico. Santa Cruz de Tenerife (Spain), May 14-15, 1999.
36. Symposium Internacional sobre Avances en Terapias Cognitivas. Aguadulce (Spain), May 21-22, 1999.
37. I Symposium Internacional de Conducta Criminal. Bogotá, Colombia, August 27-28, 1999.
38. Symposium sobre Avances Psicológicos y Psiquiátricos en Trastornos de la Personalidad. Granada (Spain), November 4-6, 1999.
39. Symposium Internacional sobre Depresión. Granada, November 18-20, 1999.
40. Curso-Taller sobre Entrenamiento en Habilidades Sociales para Profesionales de la Salud. Valencia (Spain), November 21-December 1, 1999.
41. IV Congreso Internacional de Psicología Cognitivo/Conductual. Valencia (Spain), December 1-4, 1999.
42. V Edición del Máster Internacional en Psicología Clínica. Granada, 1999-2001.
43. Symposium Internacional sobre Inteligencia y Rendimiento Académico. Granada, March 2-4, 2000.
44. Symposium Internacional sobre Hipnosis y Psicología Clínica: Fuentes, Usos y Abusos de la Hipnosis en Psicología Clínica. Almería (Spain), March 10-11, 2000.
45. VII Congreso Nacional de Psicología Cognitivo/Conductual. Santiago de Compostela, March 23-25, 2000.
46. V Congreso Iberoamericano de Psicología de la Salud. Cartagena de Indias (Colombia), March 29-April 1, 2000.
47. Symposium Nacional sobre Trastornos de la Conducta Alimentaria. Granada (Spain), April 6-8, 2000.
48. I Symposium Nacional sobre Casos Clínicos de Trastornos Psicopatológicos. Granada (Spain), May 18-20, 2000.

49. XXX Congress of the European Association for Behavioural & Cognitive Therapies. Granada (Spain), September 26-28, 2000.
50. I Symposium Internacional sobre Casos de Peritajes Psicológicos y Psiquiátricos en el Ámbito Forense. Granada (Spain), November 2-4, 2000.
51. I Symposium Internacional sobre Psico-Oncología. Granada (Spain), November 9-11, 2000.
52. I Symposium Internacional sobre Intervención en Violencia Familiar y Social. Granada (Spain), November 16-18, 2000.
53. II Symposium Nacional sobre Avances Psicológicos y Psiquiátricos en la Evaluación y el Tratamiento de la la Esquizofrenia. Granada (Spain), November 23-25, 2000.
54. Symposium Internacional sobre Psico-Oncología. Valencia (Spain), November 30, 2000.
55. VI Edición del Máster Internacional en Psicología Clínica. Granada, 2000-2002.
56. Curso sobre Afrontamiento a la Muerte: Enfoque Práctico. Tenerife (Spain), February 16, 2001.
57. Curso Internacional sobre Estrés, Salud y Enfermedad. Granada (Spain), February 21-23, 2001.
58. Curso Internacional sobre Psico-Oncología. Santiago de Compostela (Spain), February 26-28, 2001.
59. Curso Internacional sobre Aplicaciones Clínicas de la Hipnosis. Granada (Spain), March 1-3, 2001.
60. Curso Aplicado sobre Psicología Clínica Infantil. Granada (Spain), March 105-17, 2001.
61. Curso sobre Evaluación y Tratamiento de la Hiperactividad y de la Impulsividad. Granada (Spain), March 22-24, 2001.
62. II Symposium Nacional sobre Casos Clínicos de Trastornos Psicopatológicos. Granada (Spain), April 26-28, 2001.
63. Curso Aplicado sobre Psicología del Consumidor. Granada (Spain), May 14-16, 2001.
64. VII Congreso Latine Dies. Granada (Spain), May 17-19, 2001.
65. Symposium sobre Psicópatas, Asesinos en Serie y Conducta Antisocial. Granada (Spain), May 29-31, 2001.

66. VI Congreso Iberoamericano de Psicología de la Salud. Buenos Aires (Argentina), September 30-October 3, 2001.
67. IV Symposium sobre el Sueño y sus Trastornos. Granada (Spain), October 25-27, 2001.
68. Symposium sobre Drogodependencias y Nuevas Adicciones. Granada (Spain), November 8-10, 2001.
69. Curso Aplicado sobre Intervención en Violencia Infantil y Adolescente: Manejo de Conductas Agresivas. Granada (Spain), November 15-17, 2001.
70. VIII Congreso Nacional de Psicología Cognitivo Conductual. Palma de Mallorca (Spain), November 22-24, 2001.
71. VII Edición del Máster Internacional en Psicología Clínica. Granada, 2001-2003.
72. I Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2001-2003.
73. Curso sobre Implicaciones Psico-Socio-Legales en Condenas de Larga Duración, Cadena Perpetua y Pena de Muerte. Granada (Spain), March 6-8, 2002.
74. Curso Práctico sobre la Intervención y Manejo de la Conducta Adolescente: Adoles. Granada (Spain), March 2002.
75. II Simposium Nacional sobre Psicópatas, Asesinos en Serie y Conducta Antisocial. Granada (Spain), April 4-6, 2002.
76. II Symposium Nacional sobre Psicología Jurídica. Granada (Spain), April 10-12, 2002.
77. Curso Aplicado sobre Intervención Psicológica en Catástrofes y Crisis. Valencia (Spain), April 17-18, 2002.
78. Curso sobre Amor, Pareja y Relaciones Interpersonales. Granada (Spain), April 25-27, 2002.
79. Cómo Dirigir Eficazmente los Recursos Humanos dentro de la Organización. Granada (Spain), May 8-10, 2002.
80. Curso Práctico sobre Escuela de Padres: Ayudar a los Padres, Ayudar a los Hijos. Granada (Spain), November 13-15, 2002.
81. II Symposium Nacional sobre Casos Clínicos de Trastornos Psicopatológicos. Granada (Spain), May 16-18, 2002.
82. Symposium Nacional de Depresión: Avances en la Evaluación y Tratamiento. Granada (Spain), November 27-29, 2002.

83. VIII Edición del Máster Internacional en Psicología Clínica. Granada, 2002-2004.
84. II Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2002-2004.
85. Curso Aplicado sobre Trastornos de la Conducta Alimentaria: Evaluación, Tratamiento y Prevención. Enfoque Multidisciplinar. Granada (Spain), March 19-21, 2003.
86. Curso Aplicado sobre Psicología Forense. Almería (Spain), March 20-22, 2003.
87. Symposium Aplicado sobre Técnicas de Intervención Clínica en Psicología Infantil y Adolescente. Granada (Spain), April 3-5, 2003.
88. Curso de Actualización en Neuropsicología Clínica. Granada (Spain), April 24-26, 2003.
89. Symposium sobre Intervención en Secuestro y Terrorismo. Granada (Spain), May 8-10, 2003.
90. Curso Aplicado sobre Intervención Psicológica en Suicidio. Alicante (Spain), May 15-16, 2003.
91. IV Symposium Nacional sobre Casos Clínicos de Trastornos Psicopatológicos. Granada (Spain), May 15-17, 2003..
92. Curso sobre la Terapia de Aceptación y Compromiso (ACT). Granada (Spain), June 6-7, 2003.
93. Curso Aplicado sobre Psicología en el Ámbito de Menores. Granada (Spain), November 13-15, 2003.
94. Curso Práctico sobre Intervención y Manejo de la Conducta Adolescente: Adolescencia Difícil. Almería (Spain), November 19-21, 2003.
95. IX Edición del Máster Internacional en Psicología Clínica. Granada, 2003-2005.
96. III Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2003-2005.
97. Curso Aplicado sobre Entrenamiento en Habilidades Sociales. Granada (Spain), March 17-19, 2004.
98. Symposium Internacional sobre Maltrato Psicológico. Granada (Spain), April 14-16, 2004.
99. II Symposium Nacional de Depresión: Avances en la Evaluación y Tratamiento. La Laguna (Spain), May 6-8, 200.

100. Curso Práctico sobre Intervención de la Conducta Adolescente: Adolescencia Difícil. Jaén (Spain), May 13-15, 2004.
101. III Symposium Nacional de Esquizofrenia: Avances en la Evaluación y Tratamiento. Granada (Spain), November 10-12, 2004.
102. Curso Aplicado sobre Intervención en Catástrofes y Crisis. Seville (Spain), November 18-20, 2004.
103. V Symposium Nacional sobre Casos Clínicos de Trastornos Psicopatológicos. Valencia (Spain), December 1-3, 2004.
104. X Edición del Máster Internacional en Psicología Clínica. Granada, 2004-2006.
105. IV Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2004-2006.
106. Curso sobre la Agresividad Infantil: Maltrato, Abuso y Bullying. Granada (Spain), April 21-23, 2005.
107. Curso Aplicado sobre Intervención Psicológica con Mujeres Víctimas de la Violencia Doméstica. Madrid (Spain), May 5-6, 2005.
108. VI Symposium Nacional sobre Casos Clínicos de Trastornos Psicopatológicos. Granada (Spain), November 16-18, 2005.
109. II Curso Aplicado sobre Psicología Forense, Jaén (Spain), December 1-3, 2005.
110. XI Edición del Máster Internacional en Psicología Clínica. Granada, 2005-2007.
111. V Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2005-2007.
112. Curso Aplicado sobre Intervención en Trastornos Clínicos en la Adolescencia. Granada (Spain), April 5-7, 2006.
113. Curso Aplicado sobre Intervención en Catástrofes y Crisis. Tenerife (Spain), April 20-22, 2006.
114. III Symposium Nacional sobre Psicópatas, Asesinos en Serie y Conducta Antisocial. Seville (Spain), October 25-27, 2006.
115. Curso Aplicado sobre la Detección de la Simulación y la Mentira en Evaluación Psicológica. Granada (Spain), November 8-10, 2006.
116. XII Edición del Máster Internacional en Psicología Clínica. Granada, 2006-2008.

117. VI Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2006-2008.
118. Curso Aplicado sobre Intervención Psicosocial en Centros de Menores. Granada (Spain), November 28-30, 2007.
119. VII Symposium Nacional sobre Casos Clínicos de Trastornos Psicopatológicos. Granada (Spain), April 25-27, 2007.
120. XIII Edición del Máster Internacional en Psicología Clínica. Granada, 2007-2009.
121. VII Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2007-2009.
122. IV Congreso de Psicología Jurídica y Forense. Murcia (Spain), May 8-10, 2008.
123. VIII Symposium Nacional sobre Casos Clínicos de Trastornos Psicopatológicos. Granada (Spain), April 23-25, 2008.
124. XIV Edición del Máster Internacional en Psicología Clínica. Granada, 2008-2010.
125. VIII Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2008-2010.
126. V Congreso Nacional de Psicología Jurídica y Forense. Granada (Spain), November 19-21, 2009.
127. XV Edición del Máster Internacional en Psicología Clínica. Granada, 2009-2011.
128. IX Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2009-2011.
129. Congreso Internacional sobre Avances en Tratamientos Psicológicos. Granada (Spain), April 14-17, 2010.
130. Curso Aplicado sobre Intervención Psicoeducativa en Centros de Menores. Santiago de Compostela (Spain), November 4-6, 2010.
131. Curso Aplicado sobre Intervención Psicológica en Violencia de Género. Granada (Spain), November 11-12, 2010.
132. IX Symposium Nacional sobre Casos Clínicos de Trastornos Psicopatológicos. Seville (Spain), November 18-19, 2010.
133. XVI Edición del Máster Internacional en Psicología Clínica. Granada, 2010-2012.

134. X Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2010-2012.
135. IX Congreso Nacional de Psicología Clínica. San Sebastian (Spain), July 7-9, 2011.
136. Symposium Nacional sobre Avances en Tratamientos Psicológicos de Trastornos Infanto-Juveniles. Granada (Spain), November 25-26, 2011.
137. XVII Edición del Máster Internacional en Psicología Clínica. Granada, 2011-2013.
138. XI Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2011-2013.
139. V Congreso Internacional y X Nacional de Psicología Clínica. Santander (Spain), April 26-28, 2012.
140. XVIII Edición del Máster Internacional en Psicología Clínica. Granada, 2012-2014.
141. XII Edición del Máster en Psicología Infantil: Aspectos Clínicos, Evolutivos y Educativos. Granada, 2012-2014.
142. VI Congreso Internacional y XI Nacional de Psicología Clínica. Santiago de Compostela (Spain), June 6-8, 2013.
143. VII Congreso Internacional y XII Nacional de Psicología Clínica. Seville (Spain), November 14-16, 2014.
144. III Congreso Iberoamericano de Psicología de la Salud. Seville (Spain), November 14-16, 2014.
145. VIII Congreso Internacional y XIII Nacional de Psicología Clínica. Granada (Spain), November 19-22, 2015.
146. IX Congreso Internacional y XIV Nacional de Psicología Clínica. Santander (Spain), November 17-20, 2016.
147. X Congreso Internacional y XV Nacional de Psicología Clínica. Santiago de Compostela, November 16-19, 2017.
148. XI Congreso Internacional y XVI Nacional de Psicología Clínica. Granada (Spain), October 25-28, 2019.
149. XII Congreso Internacional y XVII Nacional de Psicología Clínica. Santander (Spain), November 13-16, 2019.
150. XIII Congreso Internacional y XVIII Nacional de Psicología Clínica. Virtual Congress, November 11-14, 2020.

151. XIV Congreso Internacional y XIX Nacional de Psicología Clínica. Virtual Congress, November 10-13, 2021.

152. XV Congreso Internacional y XX Nacional de Psicología Clínica. Virtual Congress, November 16-18, 2022.

153. XVI Congreso Internacional y XXI Nacional de Psicología Clínica. Congreso Virtual, November 15-17, 2023.

154. XVII Congreso Internacional y XXII Nacional de Psicología Clínica. Congreso Virtual, November 13-15, 2024.

155. XVIII Congreso Internacional y XXIII Nacional de Psicología Clínica. Congreso Virtual, November 12-14, 2025.