

Contextual Adaptation of the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders in Victims of the Armed Conflict in Colombia: A Case Study

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The delivery of a contextually adapted version of the Unified Protocol for transdiagnostic treatment of emotional disorders is illustrated through a case study of an internally displaced female victim of armed conflict in Colombia. A detailed account of how her history of continuous traumatic events and her forced displacement resulted in multiple emotional disorders and behaviors which hindered her ability to react to daily stressors illustrates the particular conditions of individuals exposed to extreme violence. Emphasis is placed on how her culture and context required adaptations of evidence-based interventions. The contextually adapted UP (CXA-UP) is described in “slow-motion,” through a session-by-session account of the procedure along with the specific changes in each module. Outcome measures showed four positive diagnoses at pretreatment, but none at posttreatment, 3-month, or 2-year follow-up. Implications for global applications with individuals in similar contexts and for widening access to such interventions are discussed.

ARMED conflict around the world represents one of the major threats to mental health and quality of life (Murthy & Lakshminarayana, 2006; World Health Organization [WHO], 2003). Many emotional and behavioral problems, including PTSD, panic disorder, generalized anxiety disorder, depression, and substance abuse, occur in individuals previously or currently exposed to recurrent violence, torture, and multiple and continuous traumatic events in conflict zones (de Waal, Hazlett, Davenport, & Kennedy, 2014; Higson-Smith, 2013; Searing, Rios-Avila & Lecy, 2013; Silove et al., 2014; Suarez, 2013; Weaver & Roberts, 2010). Exposure to continuous stressors gives rise to particular emotional problems such as complicated PTSD (Kaminer, Plessis, Hardy, & Benjamin, 2013) and continuous traumatic stress (Campo-Arias, Sanabria, Ospino, Guerra, & Caamaño, 2017; Diamond, Lipsitz, Fajerman, & Rozenblat, 2010; Eagle & Kaminer, 2013). Several decades of armed confrontation between government forces and armed groups in Colombia have left over 8 million registered victims,¹ many of whom

suffer from severe emotional disorders (Gómez-Restrepo et al., 2016).

While most evidence-based interventions for emotional problems are disorder-specific, the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (Allen, McHugh, & Barlow, 2008; Barlow et al., 2013; Barlow et al., 2018) is a single protocol aimed at changing maintenance processes common to different emotional disorders. The UP is particularly appropriate for victims of armed conflict, who are often reluctant to be labeled with psychiatric diagnoses and present multiple comorbid disorders and a wide array of emotional behaviors that are not always covered by diagnostic categories. However, its implementation in the context of armed conflict, which differs from the context where the UP was originally developed, requires a careful process of adaptation to the contextual, cultural, social, and individual characteristics of this population.

A detailed description of the UP's contextual adaptation (CXA-UP) is presented in a companion article in this issue (Castro-Camacho et al., *this issue*), as part of an ongoing randomized clinical trial (RCT) to evaluate its effects. Although all psychological interventions require adaptations to the particular context of individuals in any setting (Castro-Camacho et al.), the present paper describes in detail the delivery of the CXA-UP to an internally displaced woman who lived in the context of armed conflict and completed treatment as part of the ongoing RCT. Detailed description is given of her context (e.g., continuous exposure to violent events, displacement, and hardship living conditions) and cultural characteristics

¹ Even though the term “victim” is subject to controversy for its subjective and helplessness connotations, it will be utilized throughout this and the companion paper, as the term is widely used and clearly defined in the local context due to legal implications of the Law of Victims (Congress of the Republic of Colombia, Law 1448, 2011).

Keywords: case studies; unified protocol; armed conflicts; cultural adaptation; global mental health

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(e.g., values, family, educational and social background, and customs). Diagnostic information is provided but more emphasis is placed on *specific emotional experiences and behaviors* and their impact on daily functioning in a challenging context. As the effects of changing the content and order of the original protocol's modules has not been established empirically, we attempted to balance fidelity with the original protocol and adaptation to contextual needs by retaining the original module order and key principles but changing content as necessary. Progress reports at the beginning of each session allow full appreciation of the relationship between particular modules and therapeutic changes, thus offering a "slow motion" description of the way in which the CXA-UP evolves over time.

Background

Gloria G.² is a 50-year-old Afro-Colombian woman from a small village in a rural area, which used to be a conflict zone between guerrillas and paramilitaries. She has a son, 30, and a daughter, 29, with two small children. She completed only 3 years of elementary education, having to work from a young age. She lived most of her youth in this area, taking care of animals and harvesting fruits and vegetables. Nature has been a fundamental part of her life, and her customs are linked to rural activities, such as walking long distances, horse riding freely, and having close relationships with neighbors of nearby farms, helping each other in everyday activities such as childcare. Family is one of the most important cultural values for her. Relatives play important roles like teaching their children social customs and traditional knowledge of food preparation, nature conservation, and animal care. Gloria had a close relationship with her mother, who helped her raise her children, and with her siblings, with whom she shared social and recreational activities. Like many people in this context, Gloria seldom visited nearby cities, as most necessities were readily available. As a result, Gloria did not have much contact with medical health providers, since villagers privileged the use of traditional medicine for health problems, and she had no knowledge of mental health services.

Context of violence

Gloria has experienced periods of violence most of her life. When she was 12, she was sexually abused by a neighbor farmer for whom she was working. Eventually, her neighbor moved, and Gloria continued working in

nearby farms for several years until she married at 23 and had two children. She reports that this was a pleasant and happy period in her life when she and her husband were taking care of a farm close to a small village and had daily contact with her mother, siblings, and friends.

When she was 27 she experienced a highly traumatic event. One day before sunset, when she was home with her husband and children, she heard noises of motorcycles and horses and saw men with weapons heading to the nearby village. She heard sounds of shots and explosions and people yelling and crying. She was terrified and hid with the children under the beds. Right before dawn, she walked towards the nearby village and was horrified to see dead bodies, including children and her niece's boyfriend. She later found out there had been a massacre where 27 villagers had been killed by paramilitaries. Soon afterwards, her family started receiving death threats, warning them to leave the area. Consequently, Gloria and her family went to work on another farm close to a nearby city. Since then, she started experiencing severe sleep difficulties due to nightmares several nights a week, she became hypervigilant and extremely protective of her two children, reported high levels of distress and "nervousness" when she heard loud noises, motorcycles or horses, avoided leaving her home, and became withdrawn and irritable. Two years later, her husband left them, and she had to do extra work to support her two children who were attending school. Although Gloria had fewer nightmares, she still experienced constant anxiety, startle reactions, and low mood. She missed her mother, siblings, and friends. On two occasions she attempted to visit them but became overwhelmed by distress while approaching the village and had to return to the city, feeling frustrated.

At the age of 14, her daughter was raped by a guerrilla group while walking from school and became pregnant. This event was devastating for Gloria, and she started feeling guilty for "being unable to take care of her daughter." Her nightmares increased in frequency, and she started experiencing chest pains and other somatic symptoms. She then moved to a nearby city with her children where she worked as a housemaid. She had a close and loving relationship with her two children and grandchild but was still experiencing intense anxiety and distress. When her son finished high school, he started working at a local business to help his mother sustain her family.

One year later, her son was intercepted and kidnapped by two armed men while running errands. Gloria reports she felt she would "go crazy" and started looking for him fruitlessly for several weeks. Soon after, she received anonymous threatening notes saying that if she kept looking for him, she and her daughter would be killed. She has not heard from him since. Consequently, for safety reasons, Gloria sent her daughter and granddaughter to live with her mother in her village, while she moved

²Names and nonessential details have been modified to protect anonymity. Informed consent to write the present case study was obtained from the participant. Although language and educational barriers prevented her from reviewing the original manuscript, its content was thoroughly described and approved by her.

to Bogotá. She was in great pain due to the disappearance of her son and separation from her daughter and granddaughter.

In Bogotá, she registered as a victim in a government agency to obtain shelter and food, and she got a job as a housemaid. One day Gloria overslept after a night with multiple nightmares and, because she was late for her job, took a taxi. Suddenly, she noticed the driver took a different route and was heading out of the city. She tried to step out of the car, but the driver hit her and left her unconscious. When she recovered consciousness, she was in a paddock and he was trying to abuse her sexually. She tried to resist, but with a strong blow, he broke her knee. As she was screaming, some people passing near came to assist her while the driver, scared, fled the scene—leaving her wounded. She never fully recovered from her broken knee and has had difficulties walking ever since.

Gloria's adjustment to Bogotá continued to be extremely difficult as her living conditions changed drastically and her emotional problems did not allow her to face daily stressors. She missed living in a rural area with natural surroundings and described her new experience as "living in a cement jungle." Even though her basic needs were satisfied, she initially lived in a small room in the outskirts of the city, in an unsafe neighborhood with many more internally displaced families. Due to her walking difficulties and lack of money for transportation, she did not have permanent employment, only sporadic shifts as a housemaid. She and a group of friends created handicrafts and manufactured toiletries.

Presenting Problems

For 20 years, Gloria experienced emotional and physical problems that worsened during the year prior to initiating treatment. She constantly displayed intense feelings of fear and anxiety that interfered with most areas of her life. She was startled by loud noises, cars, and especially motorcycles, experiencing frequent flashbacks of her trauma. She experienced frequent panic attacks, keeping her housebound, sometimes for several days, and hindering her possibility to maintain regular jobs and to earn money to meet basic needs. She always felt unsafe and kept her door locked and the curtains closed. She felt constantly frightened by strangers, especially men, which led to her self-isolation. Gloria avoided attending parties and listening to music, which reminded her of her son. Gloria had difficulties sleeping due to frequent nightmares about the massacre and her lost son, which led to nocturnal panic attacks and deep sadness. She complained of frequent headaches and joint and chest pains that prevented her from doing manual tasks and made her visit the hospital at least three times a week. She was diagnosed with arthritis and prescribed with sleep aids and pain medication. Finally, she reported she was not enjoying anything and cried almost every day, missing her

previous lifestyle in the countryside while thinking about her family and her lost son and feeling guilty for not spending more time looking for him. She did not have any pleasurable activities.

Gloria had been having suicidal thoughts for several months until she finally took an overdose of medication because she felt hopeless and could not tolerate her painful memories and current way of life. After her suicide attempt, Gloria was hospitalized. She experienced critical reactions from healthcare staff about her suicide attempt, making her feel guilty. She was referred to our program by a psychologist at the hospital she attended. In the screening, Gloria was told that she was eligible to attend a free program aimed at helping individuals who were suffering from consequences of the armed conflict to better deal with past experiences and current daily living difficulties and to evaluate its efficacy. She consented to participate in this study and to attend an initial assessment session and 12 sessions (twice a week for 6 weeks).

Measures

As part of the standard study assessment, Gloria was initially screened with a diagnostic interview, the MINI-International Neuropsychiatric Scale (MINI; Lecrubier et al., 1997), where she met diagnostic criteria for major depressive disorder (MDD), posttraumatic stress disorder (PTSD), generalized anxiety disorder (GAD), and panic disorder (PD). Given her educational background, all self-report questionnaires were read and thoroughly explained to her. The Patient Health Questionnaire (PHQ; Spitzer, Kroenke & Williams, 1999), PTSD Checklist for DSM-5 (PCL-5; Blevins, Weathers, Davis, Witte, & Domino, 2015) and Quality of Life and Enjoyment and Satisfaction Questionnaire (Q-LES-Q; Endicott, Nee, Harrison, & Blumenthal, 1993) were administered pre- and post-treatment and at 3-month and 2-year follow-ups. At pretreatment, the PHQ showed positive diagnoses for MDD, somatoform disorder (SD), PD, and other anxiety disorders, while the PCL-5 yielded a positive score for PTSD. To monitor session-by-session change, at the beginning of each session Gloria completed two short 5-item questionnaires assessing frequency, intensity, avoidance, and interference of anxiety and sadness with activities and social life: The Overall Anxiety Severity and Impairment Scale (OASIS; Norman, Cissell, Means-Christensen & Stein, 2006), and the Overall Depression Severity and Impairment Scale (ODSIS; Bentley, Gallagher, Carl & Barlow, 2014). These were complemented with the CURE (Uniandes Pictorial Questionnaire for Emotional Reactions), a pictorial 12-item self-report scale designed for this study to ensure validity across all educational levels. Participants rated from 1–5 the frequency and intensity of specific emotional reactions: avoiding intense emotions, feeling nervous, difficulties sleeping, nightmares, anger,

Table 1
Pretreatment, Posttreatment, and Follow-up Outcome Scores

	Pre	Post	3-month FU	2-year FU
OASIS	11	0	2	0
ODSIS	12	0	0	0
PCL-5	76	0	6	1
Q-LES-Q	56	60	44	70

Note. The Overall Anxiety Severity and Impairment Scale (OASIS) is from Norman et al. (2006); the Overall Depression Severity and Impairment Scale (ODSIS) is from Bentley et al. (2014); the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) is from Blevins et al. (2015) and the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) is from Endicott et al., 1993.

emotional outbursts, pain, worries, sadness, and physical symptoms (Castro-Camacho et al., this issue). PCL-5, ODSIS, and OASIS pretreatment scores are presented in Table 1. Also, after presenting a list of 15 current stressors to Gloria, she identified the following as current sources of stress: being under current threat, medical conditions, lack of formal employment, difficulties obtaining food, and unstable housing conditions. Her current coping strategies were mostly attending religious services and praying.

Description of the CXA-UP Intervention

Sessions took place in a university clinical setting and were conducted by the principal investigator (LCC), a clinical psychologist with training and experience in cognitive-behavior therapy (CBT), with the assistance of an advanced graduate clinical student (JDM) who performed the initial assessment and observed all sessions.

Session 0

One major adaptation of the UP to this context was the introduction of this additional session. As described in Castro-Camacho et al. (this issue), this enables establishment of a trusting, validating, and respectful relationship and time to explain the program's nature, as shown in other cultural adaptation studies (Acosta, Yamamoto, Evans, & Skilbeck, 1983). These factors are often important in low- and middle-income countries, given the frequency of negative help-seeking experiences or lack of familiarity with psychological treatments. Additionally, this provides an opportunity to talk more extensively about experiences. In Gloria's case, beginning with Session 1 would not have allowed her to tell her difficult story freely, which may have been important for her to feel understood and validated.

The therapist set the stage for a collaborative relationship by establishing an informal dialogue about common experiences like the setting, traffic, and weather. Then he introduced himself and the co-therapist as clinical psychologists willing to work along with her to help

her overcome her suffering and difficulties. As recommended in the literature (Hays, 2009), to reduce the power imbalance between therapist and client that can arise (especially with differences in education), Gloria was encouraged to address him by his first name and to provide feedback about her experiences with the treatment. Even though emphasis on the establishment of a collaborative relationship in a safe, validating space is a common practice in regular CBT interventions in clinical settings, they are not explicit in the original protocol. Therefore, this additional session was deemed necessary to achieve this, given the contextual characteristics of the present population.

Other key goals of the session were to allow the therapist to detect particular cultural and contextual characteristics of Gloria (e.g., coming from a rural environment), collective values and religious beliefs, establish her emotional state and cognitive functioning, and evaluate how the CXA-UP could be tailored to her particular needs. The therapist asked her to talk about her current situation and past experiences with armed conflict. Gloria talked without apparent difficulties. She was outgoing and smiled frequently. She first talked about her current living conditions, her financial and health difficulties, and her suffering due to past experiences and being away from her family. The therapist validated her concerns through open questions and reflections on her difficult circumstances and clarified that although this program would not solve immediate economic difficulties, it could provide her with concrete tools to manage them effectively. While talking about her past traumas she cried, making frequent pauses for the rest of the session. She stated that the disappearance of her son was the event that most troubled her, as she had been looking for him for years. The therapist recognized her effort of talking about painful experiences and connected her current and past experiences with her present feelings and attempts to cope. Finally, when asked how she had felt during the session, Gloria said she felt understood and comfortable.

Session 1: Areas of Distress and Impact on Functioning

Another key modification to the original UP to fit Gloria's cultural and contextual characteristics, both in sessions and in the workbook, involved replacing the descriptions of disorders in Session 1 with identification of emotional difficulties and their impact on daily functioning (see accompanying article, Castro-Camacho et al., this issue). Instead of focusing on diagnoses, like in the original protocol, current reactions that interfere with daily functioning and well-being were described and reframed as "normal" reactions to "abnormal" events. This was a core modification to the original protocol, framing symptoms as responses to contextual demands

rather than inner pathologies. Besides, since Gloria met criteria for four diagnoses, as it is common with extreme contextual conditions and multiple traumas, it would have been overwhelming and unnecessary to discuss diagnoses with her. An illustrated worksheet with icons representing family, work, relationships, recreation, and health was used to identify specific emotional reactions in each area.

Gloria was introduced to the ODSIS and OASIS, adapted to include a rating scale graphically depicted in shades of light-to-dark grey. The therapist then explained the CURE and helped her fill it out. Gloria identified that her sleep difficulties were causing tiredness, irritability, and poor concentration, and could attribute these to current worries and past traumas. As explained in the companion article (Castro-Camacho et al., *this issue*), this illustrates how she learned that her difficulties were caused by inaccurate information of current contextual elements (e.g., noise of motorcycles as dangerous) based on past experiences. She realized that her hypervigilance, reactions to physical sensations, and tendency to stay home hampered her functioning in her current context (e.g., seeking jobs) and worsened her financial situation. Avoiding her family's village maintained her loneliness and yearning to see her mother and siblings. Finally, she could pinpoint that her isolation and rumination were negatively impacting her mood, preventing her from enjoying everyday activities.

In consideration of Gloria's difficulty with abstract concepts (common in individuals with lower educational levels), the therapist regularly used an inductive method to explain concepts using examples *from her own experience*. These inductive explanations were a major adaptation of the UP for this context (Castro-Camacho et al., *this issue*). For example, rather than explain theoretically the role of interpretations in maintaining distress, he identified an example where Gloria had blamed herself excessively after breaking her room key. He explained that emotional distress and certain ways of thinking often amplify daily difficulties and that learning to deal with them would result in decreasing suffering. She said she felt better "to know I could do something about it." Unlike the original UP, which encourages reading the workbook before sessions, all key explanations were provided in session while referring to the adapted workbook to illustrate concepts through pictorial material, since Gloria and others in her context are not accustomed to, nor do they have the need to, read extensive written material. The therapist explained to Gloria that the workbook was for her to keep, and to be used to review sessions, to guide her practice of homework, to record assignments, and keep track of progress. Given her cultural socially oriented values, she was encouraged to share the workbook with family and friends. He emphasized the importance of practice between sessions.

When asked about willingness to participate, Gloria described being hesitant before the initial session, but felt more confident after hearing that she would learn new tools instead of "just talking." The therapist explained the homework task of recording situations producing distress, degree of intensity, areas of life affected, and coping strategies.

Module 1: Motivation Enhancement

Session 2

Gloria completed her homework and said that after the previous session, she felt hopeful about the possibility of change, reflected in a decrease in her ODSIS-OASIS scores for Session 2 (Figure 3). After completing the progress measures, the main goals of the session were briefly introduced through examples from Gloria's own experiences, again illustrating the contextual adaptation of using inductive explanations (Castro-Camacho et al., *this issue*). She was asked to describe a time she had decided to change something in her life, the reason why, and actions required to achieve this. Gloria mentioned learning to do handicrafts to earn money, which required teaching from a friend and many hours of practice. From this example, the therapist explained that changing can help us achieve our desires but requires effort. To illustrate, the therapist used the concept of weather—that is, stormy weather represents remaining the same, and sunny weather represents change (see Figure 1). A decision-balance exercise in the workbook was presented to help her identify the advantages and disadvantages of changing or staying the same, again illustrated with sun and clouds. Gloria found the pictures appealing, repeatedly reflecting that changing would lead her to sunny days, while not changing would keep her in the stormy weather she was experiencing. As Castro-Camacho et al. (*this issue*) state, incorporating graphic material throughout the workbook was a key adaptation made for participants' previous experiences and lower formal education level. While she found it difficult to identify the benefits of staying the same, as she said her life was miserable as it was, the therapist pointed out that staying the same would not require any additional effort. She easily identified the disadvantages: namely, if she did not change, her condition would worsen. The main advantages of changing were better sleep, less anxiety, seeing her family, enjoying life more, and a better job. When identifying disadvantages of changing, the therapist helped her realize that change required more effort on her part, like attending sessions, doing homework, and facing painful experiences. She stated she felt ready to attempt change.

Gloria was helped to set manageable goals through an illustrated worksheet. Figure 2 demonstrates her completed exercise. She was asked to repeat the exercise with different goals for homework. Finally, she was helped to complete a form identifying the main obstacles to

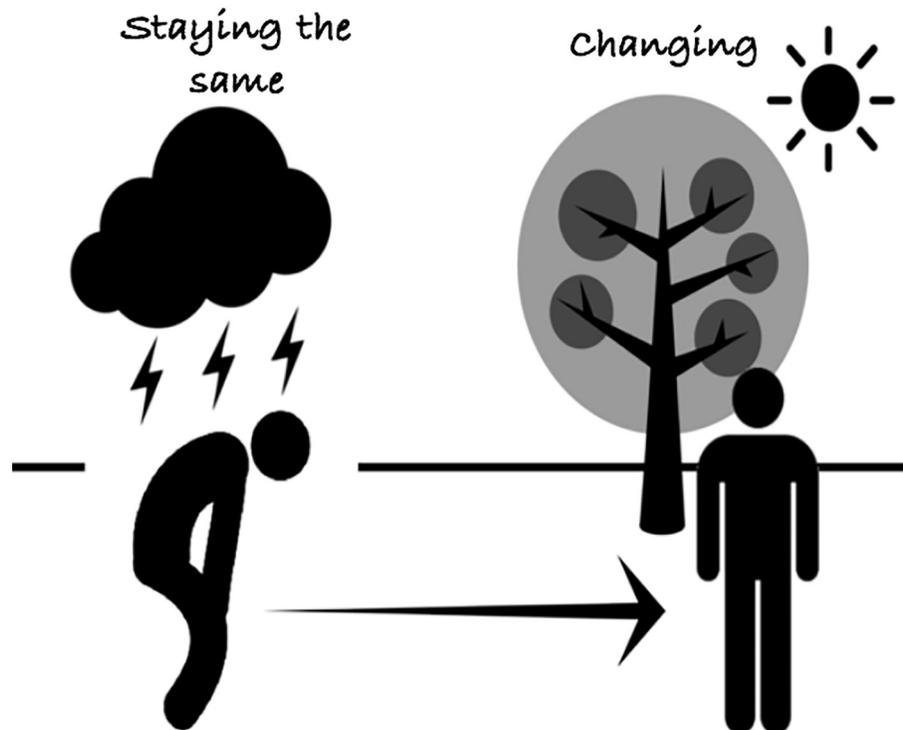


Figure 1. Graphic illustration of “Staying the same” vs. changing from the CXA-UP workbook.

completing the program and anticipating possible solutions. One obstacle identified was paying for transport to the sessions. Gloria was relieved to know that the program would cover participants’ bus tickets.

Module 2: Psychoeducation and Tracking Emotional Experiences

Session 3

The adaptive function of emotions was introduced by eliciting specific examples of her experience when she witnessed the massacre, and how her emotions, such as fear, helped provide useful information to protect her children and herself. Use of inductive explanations here is another adaptation from the original protocol (Castro-Camacho et al., *this issue*). Different emotions and their components were explained using examples of her current context. She identified her most frequent emotions as fear, nervousness, anger, guilt, and sadness. An illustrated example was used to demonstrate the three components of emotions (for fear: thought bubble, heart pounding, running away) and the importance of perceiving them as an external observer. She identified physical sensations like rapid heartbeat and sweating, thoughts about being attacked, and action tendencies like running home when she heard a loud noise or a motorcycle. This example was used to illustrate how, while in some circumstances emotions might be helpful, in others they may hinder appropriate reactions, like going out for work or socializing. For homework, Gloria

was encouraged to identify the three components of her other common emotions using the workbook.

Session 4

This session aimed to strengthen Gloria’s skills at identifying the components of her emotional episodes. Given her educational level, this session involved repeated practice and use of concrete examples from recent personal experience. Gloria reported feeling angry a few days previously when a neighbor did not pay her money he owed. She thought he was taking advantage of her, felt increased tension, joint and chest pain, and she started arguing with him. Afterwards, she was in a bad mood for several days with increased physical symptoms, as shown in an elevated OASIS score for Session 3 (see Figure 1). She became aware of how her emotions might have an impact in her physical sensations (Figure 4), pain (Figure 5), and sleep (Figure 6), all measured with the CURE, and how those, in turn, amplify her negative mood (Figure 3). To build on this learning, she was then asked to complete an illustrated worksheet, “When Emotions Show Up,” where she had to record situations and triggers, both external and internal, physical sensations, thoughts and actions, and immediate and delayed consequences of her reactions. This was a simplification of the original protocol’s worksheet, “Antecedent-Response-Consequence, ARC, of Emotions.” She learned that an external event, such as a motorcycle sound, would trigger her physical reaction of

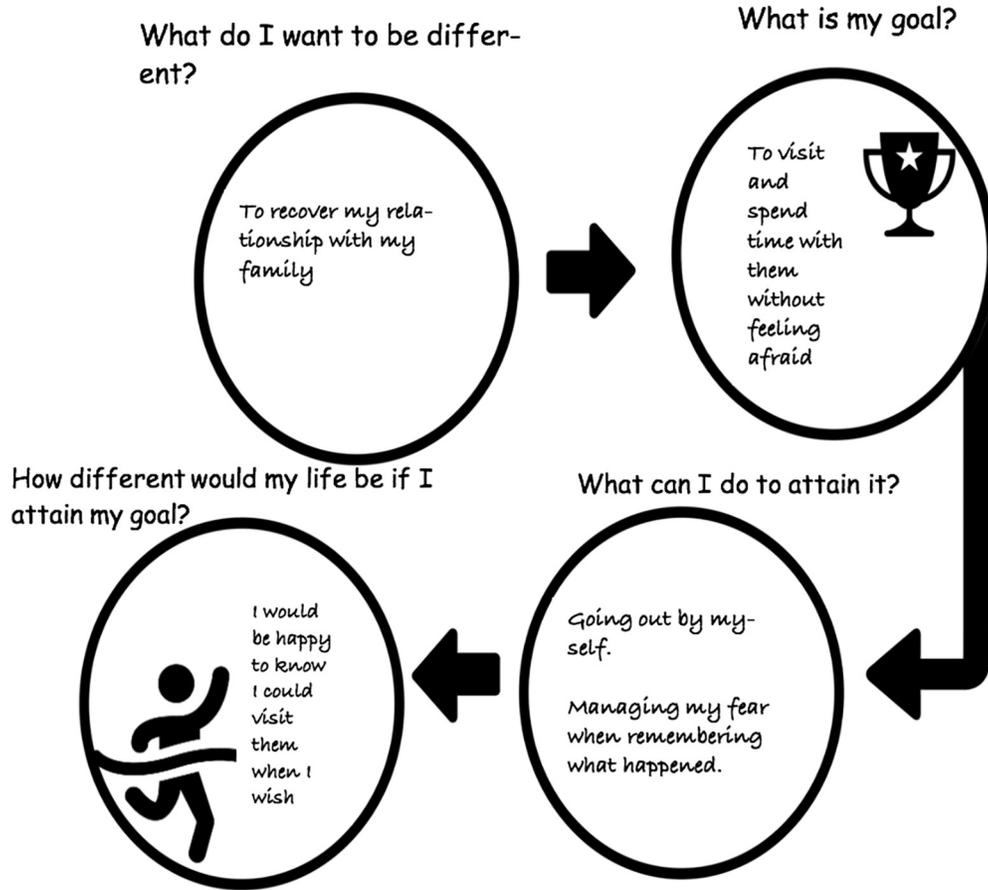


Figure 2. Gloria's completed form of the CXA-UP workbook exercise on Manageable Goals.

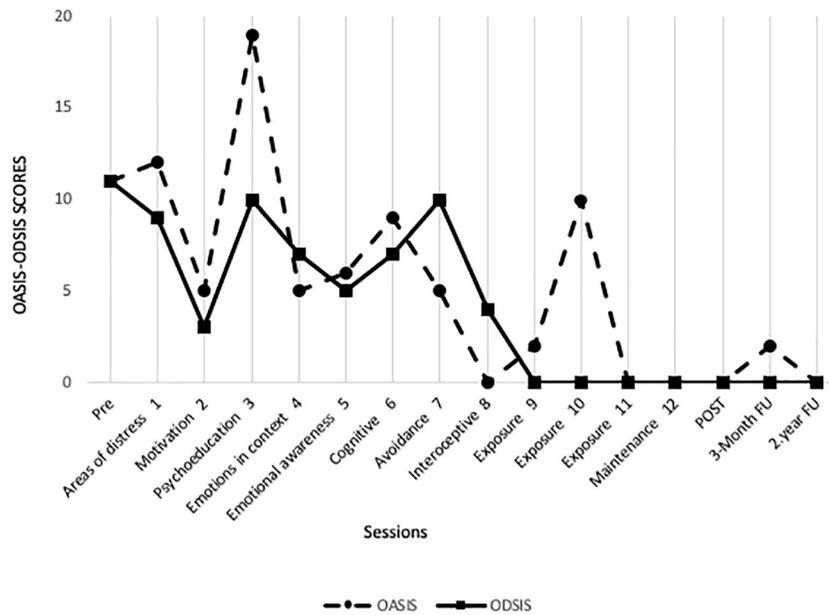


Figure 3. ODSIS and OASIS scores at pretreatment, each session, posttreatment, 3-month follow-up, and 2-year follow-up.

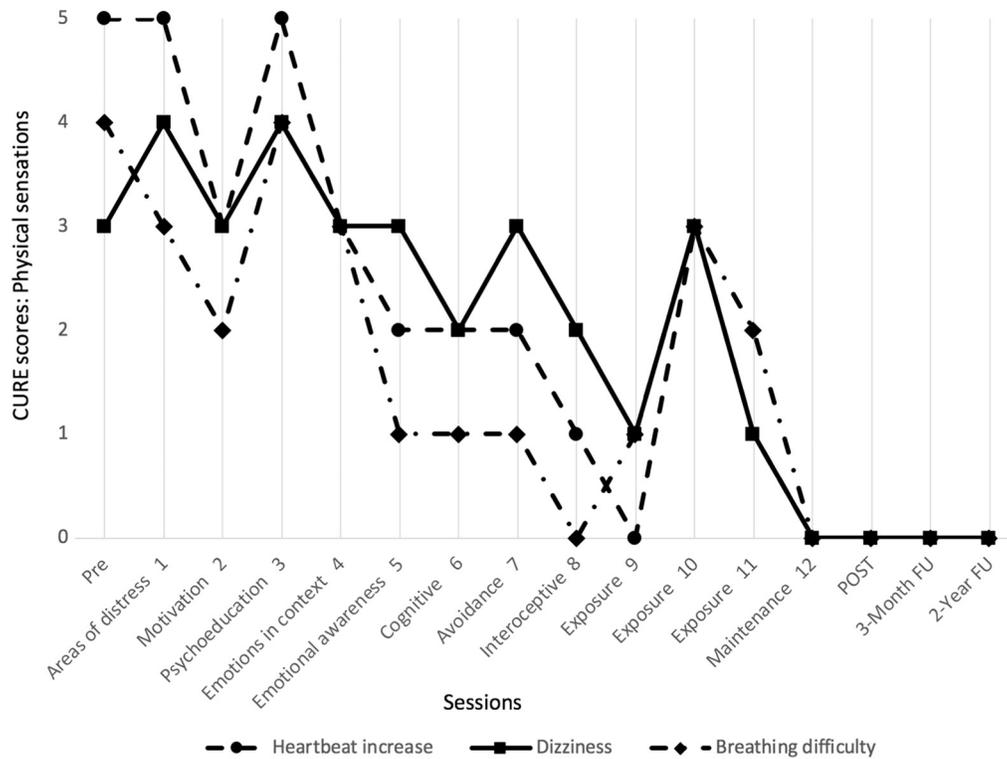


Figure 4. CURE self-report of intensity of physical sensations at pretreatment, each session, posttreatment, 3-month follow-up, and 2-year follow-up.

rapid heartbeat and muscle tension, her thoughts about being attacked, and her immediate reaction of going back to her room and locking her door. Gloria realized that even though she felt an immediate relief, in the long run this reaction would hinder the possibilities of securing a job and enjoying daily activities. The therapist explained that the rest of the program would provide her tools to become more aware of her emotional reactions and to deal more effectively with each component. Homework was to continue practicing the same exercise.

Module 3: Emotional Awareness Training

Session 5

Gloria completed the homework and showed understanding of the task. She reported a decrease in OASIS and ODSIS scores (Figure 3), physical sensations and pain (Figures 4, 5), and improved sleep (Figure 6). She attributed these changes to not reacting automatically and testing out new behaviors when feeling distressed. This session focused on learning to adopt a nonjudgmental, present-focused stance of how emotions unfold. Considering her lack of familiarity with the concept of focused attention, a detailed rationale for the exercise was provided, emphasizing the need to “update” new information when her emotional reactions were stuck in past painful events and not in the present. Due to painful past

experiences, Gloria tended to be hypervigilant and was reluctant to close her eyes during guided exercises. In order to adapt the original UP to her contextual characteristics (Castro-Camacho et al., this issue), the two exercises from the UP of mindfulness and anchoring in the present moment were integrated into one. The therapist first asked her to attend carefully to the appearance of three objects in the room, observing every detail, and then to the feel of the texture of the chair or the desk and to listen to any sounds she could hear. She said she was feeling calm and relaxed. Then, Gloria was asked to shift her attention to internal experiences and close her eyes and concentrate on her breathing, physical sensations, and to observe her thoughts and feelings as if she were watching a movie, without trying to change them. Even though she felt “trapped” by some thoughts, she learned to gently return to the present moment and observe her experience.

The session also involved an affective induction exercise. Given her love of the countryside, music was replaced by nature sounds, during which she was asked to close her eyes and observe her feelings. She felt nostalgic and cried while remembering the time when she lived at her farm but was able to tolerate those feelings while connecting to the present moment. To reinforce previous learning, Gloria was helped to identify the three components of her sadness and its trigger. For homework,

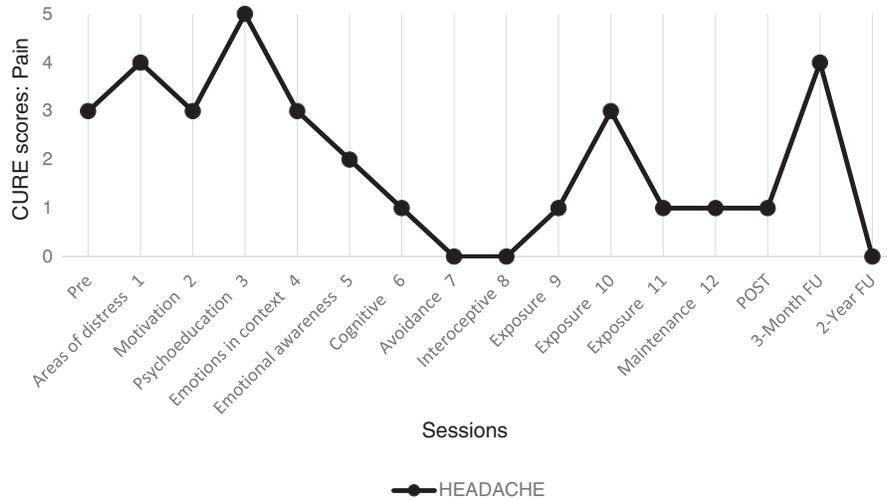


Figure 5. CURE self-report scores of pain at pretreatment, each session, posttreatment, 3-month follow-up, and 2-year follow-up.

Gloria was given a device with an audio-recording of both exercises and asked to practice at least daily. This exercise was given in accordance with her context: an inability to concentrate because of ambient noises.

Module 4: Cognitive Appraisal and Reappraisal

Session 6

At the beginning of the session, Gloria said she had been practicing every night and enjoyed the exercises so much that she had shared the workbook and recordings with some friends, as suggested earlier. Since the previous session, she reported an improvement in physical sensations (Figure 4), pain (Figure 5), and ODSIS scores

(Figure 3). She could better focus her attention on daily activities, such as cooking with friends. In periods of low activity, she thought about her son and felt sad, but tried affective induction using a song that her son had dedicated to her on the last Mother’s Day before his disappearance. She had been unable to listen to it and avoided going to parties or places where it could be played. Gloria had played the complete song once and cried while listening to it. She had found it difficult to observe her emotions, as her distress was extremely intense. However, she took the initiative to listen to the full song again and observe her distress. Gradually, she started recalling pleasant memories about him. She also

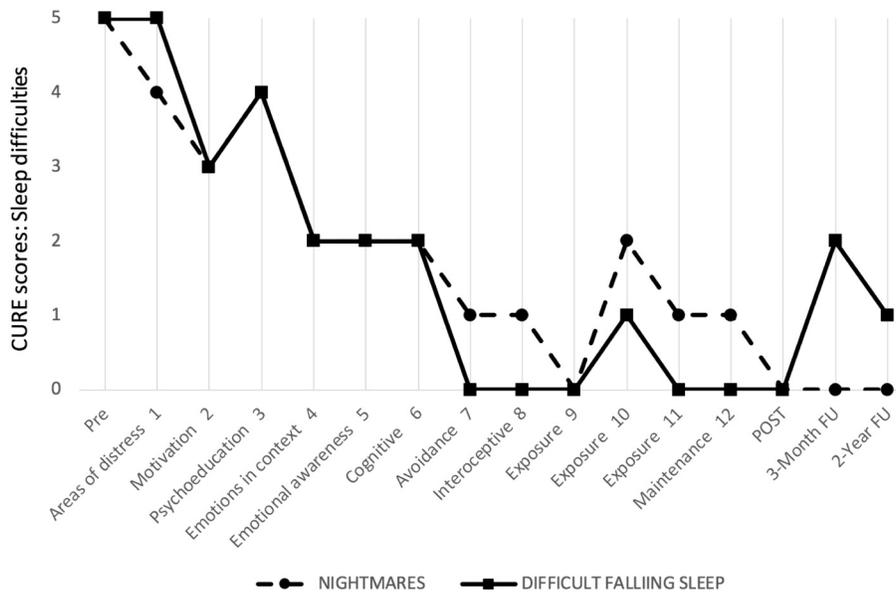


Figure 6. CURE Self-report of difficulties falling asleep and nightmares at pretreatment, each session, posttreatment, 3-month follow-up, and 2-year follow-up.

was able to look at his picture for the first time after his disappearance. Although she felt sad, she kept his picture in her wallet and proudly showed it in session. She said that through the anchoring in the present, she realized that past memories were often the trigger for her distress.

The focus of this session was on the first component of the emotional experience: the role of thoughts and appraisals. Instead of first introducing the concept of selective attention and the role of interpretations according to past experiences as in the original UP, the session initiated with an exercise where Gloria was asked to interpret what was happening in an ambiguous image³ depicting a woman lying in bed and a man standing by her side with his arm covering his eyes. When asked to describe what was happening in the scene, she said that he had just raped her. When asked about what feelings she was having, she said she was feeling scared and angry. When the therapist asked to provide other explanations, she said he had just murdered her and was thinking how to get away, and she felt anger. Another possibility was that she was ill and had just died and he was mourning, which made her feel sad. When prompted to provide a positive interpretation, she said they had just had sex and he was preparing to go to work and did not have any particular negative feeling. This now provided an opportunity to give her the explanation suggested in the original workbook as to how previous traumas might influence her current interpretations, how different interpretations affect our emotional states and mood, and how emotions in turn impact thoughts. The therapist then reviewed some of the more frequent emotions Gloria reported, and they identified interpretations that triggered these emotions.

Subsequently, the concept of thinking traps (jumping to conclusions and thinking the worst) was introduced through examples from her own experience. Guided by the workbook, Gloria identified her most frequent interpretations when feeling afraid and provided other possible explanations. She realized that her catastrophic thoughts about having a stroke when experiencing chest pains amplified the physical sensations and caused her frequent hospital visits, even though she had no heart condition. The concept of automatic, inflexible interpretations was explained through examples from her experience. She found this tool to be helpful to deal with her guilt about not doing enough to find her son and thoughts that moving on with her life meant she did not love him. She reframed this by acknowledging that some events were not under her control. As described in the companion article (Castro-Camacho et al., *this issue*), in order to adapt the original UP to the particular context of extreme traumatic events she had to endure, as well as to the current difficult conditions she has to face, the

³ Image 13B from the Thematic Apperception Test (Murray, 1943).

exercise of downward arrow in the original workbook was omitted since repeatedly asking about the meaning of such painful events could be unnecessary and invalidating. Homework was to practice identifying interpretations and seek alternatives.

Module 5: Emotional Avoidance and Emotional Behaviors *Session 7*

Gloria completed the assigned homework and practiced the skills learned in the previous session on several occasions. She reported improved sleep, no more nightmares, and was no longer taking sleeping pills (Figure 6).

The second component of emotions, actions, was introduced by identifying Gloria's most frequent avoidance strategies and emotional behaviors. Gloria readily realized that she used avoidance heavily to prevent triggering anxiety or sadness. She avoided visiting her village, reading or watching news, taking cabs, being in noisy places, going out by herself, attending social events, and thinking or talking about her son. When memories of the massacre arose, she distracted herself by reading the Bible or watching TV. After explaining the concept of subtle avoidance and safety behaviors, Gloria identified that she closed her eyes and tried to think of other things when others talked about their families, since this reminded her of being far from her family. When she had to go out, she always invited a friend or wore a medal to feel protected. The main emotional behavior Gloria identified was shouting or having emotional explosions when angry.

These examples were used to explain the adverse effects of avoidance and emotional behaviors. Although they temporally decreased her distress, they maintained and amplified her feelings of anxiety, sadness, and hopelessness in the long term, hindering her actions to improve her living conditions and leading to interpersonal conflicts and social isolation. When completing a workbook exercise on avoidance and emotional behaviors, Gloria realized she was reacting to memories and not to current situations with avoidance and emotional behaviors. The concept of opposite action was introduced to help her test out her negative predictions and develop more useful emotion-regulation strategies. The homework was identifying avoidant and emotional behaviors and opposite actions.

Module 6: Awareness and Tolerance of Physical Sensations *Session 8*

At this point, as shown in her OASIS score (Figure 3), Gloria was feeling less anxiety. She felt satisfied with being able to look at her son's picture, to listen to his song and to talk freely about him, although still felt sad when thinking about him, as shown in her higher score on ODSIS (Figure 3). Nevertheless, she reported fewer

physical sensations (Figure 4) and pain (Figure 5), and seldom visited the hospital.

The therapist presented the rationale for inducing physical sensations by reviewing her previous experience with physical symptoms like chest pain, which triggered thoughts (e.g., imminence of a heart attack) and escape or avoidance tendencies (e.g., running to the hospital). By learning to tolerate physical sensations, her body would learn that those were not signals of imminent danger, but merely reactions to past events or flawed interpretations. The therapist modeled each exercise in advance and practiced with her.

Gloria was exposed to three types of physical sensations. First, she was asked to take rapid deep breaths and hyperventilate for 1 minute. She reported intense dizziness, numb fingers, and a sense of unreality, which resembled her sensations during panic attacks or when she feared a heart attack. Second, she had to breathe through a straw, which produced lack of air and drowning sensations, which brought memories of her sexual abuse. Finally, she spun in a chair, which produced dizziness and lack of balance. She observed that although those sensations were intense and evoked high distress, they disappeared quickly without her making any effort, and that her catastrophic prediction of a heart attack never happened. She was asked to keep doing daily practices at home, noticing her emotional experiences as an external observer. The CXA-UP workbook included a guide with simple pictures indicating ways to induce physical sensations.

Module 7: Interoceptive and Situation-Based Emotional Exposures

Session 9: Emotional Exposure and Hierarchy Construction

At the beginning of the session, Gloria reported she had been practicing daily hyperventilation and breathing through a straw without much difficulty. She found the dizziness sensation initially distressing, but after repeated practices, this was less intense and took longer to appear. She felt satisfied with her progress. At the beginning of this session, all her measures had dropped to minimum levels (Figures 3–6).

When presenting the goal of this session, Gloria was somewhat apprehensive about facing her most intense fears. The therapist acknowledged her fears as normal reactions to past experiences but highlighted that she actually had already been practicing exposure, even though this had not been formally assigned. He pointed out her initiative to listen attentively to her son's song and regularly look at his picture. He asked her to describe how her emotions had evolved throughout this practice and to anticipate how they would unfold with new exposures. The therapist emphasized that she already had learned powerful tools, and this was the opportunity for her to

put them into practice and become aware of how much progress she had made. She was reminded that emotional awareness, cognitive reappraisal, and tolerance to physical sensations could continue supporting approach behavior and opposite actions. She agreed to do emotional exposures in-session and situational exposures for homework, and start facing her traumatic memories, as she realized they produced the highest interference with her life.

For the first in-session emotional exposure, Gloria was asked to narrate, as vividly as possible, her experience before, during, and after witnessing the massacre, including the events that happened and her feelings, thoughts, and action tendencies at the time. She was encouraged to use all the tools she had learned, mostly observing her emotions and anchoring to the present. In describing the events before the massacre, Gloria became upset and started crying, her breathing agitated, making frequent pauses before reinitiating her recount. Since this exercise aimed to expose her both to her detailed memories and to her emotional experience, when there were "hot spots" of intense emotional reaction, she was asked to use her emotional awareness skills to observe her emotions, while keeping focused in the story details. After the first exposure, she reported that in recounting the story previously, she had missed many details—either because the details were distressing or because she did not recall the details—but was now able to remember. During two subsequent in-session exposures, she reported less distress at the beginning of her description and could recall more details. At the end of the session, she built a hierarchy of exposures to practice as homework. Detailed instructions about how to use the tools she had learned were provided. She agreed to write a narrative of her traumatic experiences and to complete a record of emotional exposure: going out by herself and riding a cab before the next session.

Session 10: Emotional and Situational Exposure

Although Gloria had difficulties writing her narrative, she decided to tell her story to one of her friends. She said that even though she was somewhat nervous at the beginning, eventually she could tell her detailed story and describe her emotions. She observed that her distress when recounting her past had reduced. She mentioned she had been sleeping soundly and was no longer experiencing nightmares (Figure 6).

Gloria reported that while doing the taxi exposure, she was distressed by the memories of her previous attack and experienced urges to stop and get out of the cab. However, she focused on her current experience and completed the cab ride. She felt much calmer and satisfied with her achievement. Likewise, when she walked at night in her neighborhood to help a friend cook, she

felt hypervigilant at first but realized that there was no real danger and felt satisfied with being “autonomous” and capable of doing things without relying on others. She mentioned she felt ready to keep practicing from then on. In Session 9, Gloria showed reductions on all measures and felt proud of her achievements (see Figures 3–6).

For the second in-session exposure, she repeated the narrative of the massacre once more and stated that even though remembering was painful, she was feeling less distress and realized that she had been reacting to events in the past. Subsequently, she was asked to talk about her son’s disappearance while listening to his song and viewing a picture of him. Although she had already exposed herself to the song and his picture, doing the three activities simultaneously was particularly distressing. She became very agitated and started crying again. She was particularly troubled by her thought of not making more of an effort to find him, and said she felt as if “I had abandoned him.” The therapist asked her to focus on the details of when she learned about his disappearance, and her efforts to look for him. She recounted every effort she had made to find him for several years: calling the police, asking people living nearby, calling radio stations, and so forth. She was encouraged to use cognitive reappraisal, which helped her realize that some things were beyond her control. Subsequently, she reported feeling calmer while looking at her son’s picture. For the next session, she was asked to keep doing exposures of going out alone, riding cabs, listening to the song, and writing memories about her son.

Session 11: Emotional and Situational Exposure

As expected, as Gloria was facing most of her fears, she felt more emotionally activated, as shown in her elevated scores in most of her measures, except ODSIS (Figure 3–6). She reported more confidence after completing several exposures. She could now ride cabs and go out by herself while enduring some anxiety. She said it was becoming “normal” for her. Then, she said she felt ready to visit her family for Christmas and New Year’s Eve to achieve what she had been dreaming for years. The therapist encouraged her to make the trip and, based on her positive experiences in previous exposure sessions, to believe that now she had new tools to face the distress of revisiting the place associated with her most painful memories. Since this was a highly complex exposure, this session was devoted to imaginal exposure to different situations involved in her trip. First, she identified the most difficult situations she anticipated. Second, reviewing the “toolbox” she had acquired in the program, she realized she could use mindfulness to keep focused on her present experience, and reappraise catastrophic thoughts about the possibility of further attacks, having examined newspapers and finding no evidence of recent

violence. Reevaluating the forthcoming experience as an opportunity to consolidate progress, rather than a threat, would make her maintain higher motivation to practice, despite the potential for distress. She was asked to imagine her positive emotion on reencountering her mother, siblings, and other relatives, and the positive impact this would have on her life. As she was afraid of her physical sensations being triggered, she was reminded of her tools for enhancing emotional awareness and tolerating physical sensations without avoiding or escaping. At the end of the session, Gloria expressed she felt ready for her practice.

Module 8: Maintaining Progress

Session 12

The first part of the last session was devoted to a detailed review of her trip to visit her family and her use of the program’s skills. Gloria came to this session very excited to have successfully achieved her most valued goal. At this point, she had achieved minimum scores in ODSIS and OASIS and in most of her measures (Figures 3–6).

Gloria stated that reappraising her upcoming trip as an opportunity rather than as a threat helped her cope with anticipatory anxiety. She reported feeling mixed emotions upon arriving at the village: On the one hand, she felt intense distress, fear, and anxiety, including increased heart rate, sweating, muscle tension, and dizziness, accompanied by intrusive memories of the massacre and strong urges to escape and take the bus back. On the other hand, she was excited to see her mother and family. She was able to observe these intense emotions while focusing her attention on greeting her family and friends. After a while, her fear had decreased. She was crying out of happiness rather than sadness. In the afternoon, just before sunset, Gloria, her mother, and two of her brothers visited the place where the massacre had taken place. She left flowers and lighted candles in some of the places where she had seen dead bodies. She said she felt she was “doing something” and felt great relief. The following days, she visited friends and former neighbors, “catching up” on 20 years. Unexpectedly, on New Year’s Eve, while she was at a party at the village, she noticed some guerrilla members were attending. Initially, she felt nervous and wanted to escape, but remembered the session on opposite action and decided to stay. She was able to focus and enjoyed dancing. She even accepted a dance with one of them and said that even though she could feel his weapon in his belt, she enjoyed her dance. She spent 2 weeks with her family in her village, enjoyed everyday activities, and reported “going back to normal life.” As Gloria recounted her experience, the therapist, to enhance her perception of control, asked her about (a) her emotions, components, and triggers; (b) the specific tools of the program she had used; and (c) the specific outcomes and consequences. She stated that,

after that trip, she felt ready to face any situation. She was encouraged to keep practicing exposures.

According to the CXA-UP protocol, the final session focuses on reviewing progress and relapse prevention. In reviewing her scores during treatment, Gloria stated she felt a definite change, not only in how she felt but in her level of functioning. Gloria emphasized that the exposure had been particularly helpful to develop confidence in facing situations she tended to avoid. When appraising how she was using each of the learned tools, she stated they had become a habit for her. Furthermore, she was reviewing each session's exercises with her handcrafting friends and felt happy sharing her positive experiences and being able to help them. She reported she was going out by herself, had a group of new friends, and had stopped visiting the hospital.

The final part of the session was devoted to making specific plans and goals to maintain progress. She set goals to get a permanent job and visit her family regularly. She made a weekly plan including daily emotional awareness anchoring in the present practices, observing her physical sensations, reappraising thoughts, and doing opposite action.

Results

Gloria's response to the CXA-UP was positive. After 6 weeks of treatment, she no longer met criteria for any of the four diagnostic disorders she presented at pretreatment evaluation, her PTSD scores in PCL-5 had reached a subclinical level, and she had reached minimum scores in ODSIS and OASIS (see Table 1). Furthermore, these results were maintained at 3-month and 2-year follow-up. Most important, her level of functioning and ability to face stressors improved considerably: She could now sleep soundly, go out alone, maintain a social network, and visit her family. At 3-month follow-up she had a critical health condition with her knee, which is reflected in her elevated pain scores and decreases on the Q-LES-Q. At 2-year follow-up, she reported, "I feel proud of what I have achieved and feel happy." She had permanent employment, was visiting her family, and had become active in victims' organizations. These have contributed to improved quality of life as shown by Q-LES-Q score increases from 56 (pretreatment) to 70 (2-year follow-up).

Figures 1–4 portray scores on the ODSIS, OASIS, and self-report of physical sensations, pain, and sleep at pretreatment, each session, posttreatment, 3-month, and 2-year follow-up.

Conclusion

The case of Gloria illustrates how the UP was adapted to help her learn to relate differently to a context of extreme violence and adversity, which provided her with inaccurate information about current context, and

eventually to alter her living conditions (e.g., having employment, social, and family relations). There are two ways of influencing the relationship between context and individuals: direct modifications of contextual variables affecting individuals or influencing individuals' behavior to modify their context. Unlike *contextual interventions*, which are aimed at changing the environment (Castro-Camacho, 1980), *contextual adaptations* are aimed at modifying evidence-based interventions to fit the relationship between individuals and their particular context (Castro-Camacho et al., this issue). The latter may be more appropriate when contexts are not amenable to change, at least not in the short term (e.g., economic conditions, safety). Improvement of economic, educational, and health contextual variables typically requires long-term multilevel interventions combining governmental and political action and environmental, community, and psychosocial interventions. Finally, contextual adaptations of EBIs are aimed at empowering individuals both to relate more adaptively to current contexts and to modify them in the long term. Both approaches are necessary and complement each other to provide integral care for individuals living in violent and hardship contexts.

In our view, the most important contribution of the CXA-UP to improve Gloria's emotional reactions, functioning, and quality of life was targeting common processes in different emotional reactions and focusing on the function of her reactions to contextual demands, rather than specific disorders. The most significant adaptations of the original protocol to Gloria's context were the addition of Session 0 to expose her to a validating, safe context and offer information about the program's nature, focusing in Session 1 on areas of distress in context rather than specific disorders, and using inductive methodology and examples from her own experience to illustrate concepts.

Gloria's progress involved several key elements. First, linking her initial emotional reactions with contextual adverse events, past and present, and the demands of daily life in a challenging context normalized her present condition and prevented her from attributing this to personal deficits. Second, this improved understanding of her emotions increased her perception of control. Third, learning that tools exist for reacting differently to emotions increased her motivation for change. Finally, learning to identify emotional components and change these empowered her to face her fears. Repeated applications of specific measures relevant to her particular needs allowed for a fine-grained analysis of change throughout the treatment, and of the specific effects of each module. While the session descriptions outline some changes, other changes are also interesting to note. First, except for occasional increases in some measures

associated with temporary events (like her anger episode described in Session 4, and health problems at 3-month follow-up), all measures show a gradual trend of improvement. Consistent with research on exposure (Craske, Treanor, Conway, & Zbozinek, 2014), more pronounced changes were related to exposure modules: All measures increased at the start of the exposure module (Session 10) and, as expected, tended to decrease with further exposure sessions until reaching minimum levels at post-treatment and follow-up. Although ODSIS and OASIS scores tend to be related along sessions, the exposure module is associated with elevated scores in OASIS, physical sensations, pain and sleep difficulties, but not on the ODSIS. Based on exposure research, it may be that exposure was associated with an increased perception of control, which maintained the ODSIS scores at a minimum level (Aderka, Gillihan, McLean, & Foa, 2013). These results point to the need for process studies to evaluate the effects of individual modules and their order of presentation according to individual needs, to develop targeted, more precise interventions. Modular and stepped-care approaches would make evidence-based interventions available to wider segments of population.

In summary, the case of Gloria shows that individuals who have experienced extreme traumatic conditions can overcome distress, function effectively, and achieve their goals, even with brief interventions. This suggests that when evidence-based interventions are adapted to the contextual and cultural characteristics of individuals who have undergone extreme adverse conditions, it is possible to impact not only symptom reduction but, most important, level of functioning and quality of life. The impact of recovering family relationships for Gloria's quality of life underlines the importance of considering cultural values in selecting treatment goals. The present case study suggests that the CXA-UP could support individuals who are victims of armed conflict and refugees around the world.

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