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ENSAIOS CLÍNICOS SOBRE A EFICÁCIA DA INTERVENÇÃO COGNITIVA-NARRATIVA NO LUTO: PREVENÇÃO E TRATAMENTO

Dissertação de Mestrado em Psicologia Clinica

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ENSAIOS CLÍNICOS SOBRE A EFICÁCIA DA INTERVENÇÃO COGNITIVA-NARRATIVA NO LUTO: PREVENÇÃO E TRATAMENTO

Dissertação apresentada no Instituto Universitário de Ciências da Saúde,

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Prof. Doutor José Carlos Rocha

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INTRODUÇÃO

A presente dissertação para obtenção do grau de Mestre em psicologia clínica, insere-se no âmbito da unidade curricular do Instituto de Investigação e Formação Avançada em Ciências e Tecnologias da Saúde – IINFACTS, do 2º ano de Mestrado, em Psicologia Clínica do Instituto Universitário de Ciências da Saúde, realizado sob orientação do Prof. Doutor José Carlos Rocha.

A primeira parte consiste em um artigo para submissão com o tema: A eficácia da intervenção clinica cognitiva- narrativa no tratamento do luto complicado, com base nas normas solicitado pela revista Psicologia, Saúde & Doenças.

A segunda parte consiste em um artigo em submissão com o tema: *Randomized controlled trial of a cognitive narrative crisis Intervention for bereavement in primary healthcare*, com base nas normas solicitadas pelo jornal – *Journal of Psychology & Psychotherapy (JPPT).*

Por último, comporta um resumo de comunicação livre realizada no *XIV Confrence of European Society for Traumatic Stress Studies Trauma in Changing Societies: Social Contexto and Clinical Pratice 10-13 june 2025 – Vilnius, Lithuania.*

PARTE I

Ensaio clínico randomizado controlado (RCT), em formato para submissão em revista.
A eficácia da intervenção clinica cognitiva-narrativa no tratamento do luto complicado.

Efeitos de um programa de intervenção cognitivo-narrativa no luto

Titulo: A eficácia da intervenção clínica cognitiva- narrativa no tratamento do luto complicado.

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RESUMO

Objetivos: Os indivíduos enlutados apresentam maiores riscos de perturbações a nível físico e mental. As intervenções no luto complicado têm sido cada vez mais solicitadas, embora a sua eficácia tenha vindo a ser contestada. Neste sentido, o objetivo deste estudo é determinar a avaliação da eficácia da aplicação de um programa manualizado de intervenção cognitiva-narrativa, no luto complicado, de forma a reduzir a depressão e os sintomas pós-traumáticos decorrentes daquele fenómeno.

Métodos: Este estudo consistiu num ensaio clínico randomizado controlado longitudinal no qual foi aplicado um manual cognitivo-narrativo. Foram estabelecidos dois grupos: grupo de intervenção (GI) (n=18), e grupo de controlo (GC) (n=20). Os grupos foram avaliados antes e após três meses da intervenção. Como instrumentos foram utilizados: CES-D: *Center for Epidemiologic Studies Depression Scale*, *Inventário de Luto Complicado* (ICG) e *Questionário de Trauma* (ICD-11). O GI foi sujeito a um programa de intervenção constituído por quatro sessões de 60 minutos.

Resultados: Através da análise das médias obtidas nos instrumentos e comparadas as diferenças através de um teste t para amostra independentes, verificou-se que na avaliação inicial não existiram diferenças estatisticamente significativas entre grupos. No entanto, na avaliação de *follow-up* constatou-se que o GI experimentava valores muito inferiores no ICG, quando comparado com o GC ($p < .05$).

Conclusão: Neste estudo, foi avaliada a eficácia de uma intervenção cognitiva-narrativa no luto, na redução da sintomatologia depressiva, traumática e de luto complicado. Através da análise dos instrumentos utilizados, verificou-se uma elevada aceitabilidade e satisfação com o programa, sendo que este não provocou efeitos negativos nos participantes ao nível da sintomatologia depressiva e traumática, verificando-se ainda diferenças estatisticamente significativas entre os grupos na área do luto complicado.

Palavras-chave: Intervenção cognitiva narrativa, luto complicado, depressão, trauma.

ABSTRACT

Objectives: The grieving individuals present a bigger risk of the disturbance at a physical and mental level. The implementation of interventions on complicated grieving have been more requested, although their efficiency has been contested. The objective of this study is to determinate the effectiveness of the implementation of a manualized program of cognitive narrative intervention, in complicated grieve, in order to reduce the depression and the post-traumatic symptoms.

Method: This consists in a randomized clinical trial longitudinal in which was implemented a cognitive narrative manual. There were established two groups: an intervention group (GI) (n=18), and a control group (GC) (n=20). All groups were assessed before and three months after the intervention. The use instruments were: CES-D: Center for Epidemiologic Studies Depression Scale, ICG: Inventory of Complicated Grief and ICD-11 trauma questionnaire. The GI was subjected to an intervention program comprising four sessions of 60 minutes.

Results: By analyzing the mean values of the instruments and compared the differences using a T-test for independent samples, we found that the baseline there was no statistical significant between the groups. However in the follow-up evaluation, we found that the GI was experiencing much lower values in the ICG, when compared with GC ($p<.05$).

Conclusion: In this study, was evaluated the efficacy of a grief cognitive narrative intervention, the reduction of the depressive, traumatic and complicated grieve symptoms. By analyzing the instruments, it was verified a high acceptance and satisfaction with the program, not causing adverse effects on the participants at the level of depressive and traumatic symptomatology, and was still verified the statistically significant differences between the groups in the complicated grief area.

Keywords: Cognitive narrative intervention, complicated grieve, depression, trauma.

INTRODUÇÃO

O luto, causado pela perda de ente querido (por morte, separação conjugal, emigração e encarceramento), pela perda de fantasia de afeto (por interrupção de gravidez ou nascimento de filho deficiente), pelo dano ao amor-próprio (por mastectomia, amputação ou paraplegias) ou pela desqualificação social (por desvalorização da imagem pública, desemprego e não reconhecimento de competências), tem sido considerado um processo de reação à perda, com um significado pessoal profundo (SPEIL, 2016). No seio destas causas, a morte suspende a expetativa do ciclo de vida e dá início a uma crise que conduz à reconstrução da identidade do enlutado, quer ao nível das suas funções, quer à gestão compartilhada de emoções intensas (Andrade, Afonso, Pacheco & Rocha, 2008, p. 269). Sendo uma reação à privação e à perda, o luto por morte dificilmente será considerado com superficialidade, pelo que será normal que as pessoas enlutadas procurem ajuda dos técnicos de saúde, desde que este fenómeno não seja tratado como uma doença, uma vez que o funcionamento do sistema imunológico é afetado pelo *stress* que dele decorre (Parkes, 1998, pp.15-19). O que poderá sancionar ou colocar termo ao luto será um indício de que o sujeito sobreviverá ao próprio sofrimento e não sucumbirá a ele, um sinal de que se restaurará um lugar em si e para o próprio devir, que não será o trauma o efeito de uma experiência de perda (Endo, 2013, pp. 46-47).

Embora o pesar do luto possa ser forte ou fraco, breve ou prolongado, imediato ou adiado (Parkes, 1998, p. 145), as pessoas enlutadas que sofrem um tipo de colapso ou se “desmontam”, após a perda, apresentam características de luto patológico (Parkes, 1998, p. 133), isto é, após a morte de um ente querido, um pequeno grupo de pessoas enlutadas desenvolvem um estilo de luto anormal, denominado luto complicado ou prolongado (Rosner, Pfoh e Kotocova, 2011, p.1). O luto pode ser considerado o fator universal causador do *stress,* mas para uma minoria substancial, a dor, que lhe está associada, pode tornar-se uma sentença de prisão perpétua (Neimeyer, 2010, p. 82).

O termo Luto Complicado (LC) ou perturbação de luto complicado persistente (PLCP), tal como utilizado pela 5ª edição do Manual de Diagnóstico e Estatística das Perturbações Mentais (DSM-V), é diagnosticado apenas quando níveis de resposta de luto graves persistem, decorridos pelo menos 12 meses (ou 6 meses nas crianças), após a morte de um ente querido, causando incapacidade de o indivíduo funcionar. O termo LC é a designação atual de uma síndrome de dor prolongada e intensa que está associada ao comprometimento substancial do trabalho, saúde e funcionamento social (Zisook &

Shear, 2009, p. 67), sendo definido como a combinação da angústia da separação com os sintomas cognitivos, emocionais e comportamentais desenvolvidos após a morte de um ente querido (Wittouck, Van Autreve, De Jaegere, Portzky, Van Heeringen, 2010 p. 70).

Vários estudos e análises quantitativas têm descrito sintomas psicológicos que surgem associadas às reações problemáticas do luto. No seio deles, foram detetadas: expressões extremas de culpa ou autoacusação, com tendência para prolongar o período de pesar, ou com tendência para adiar a reação ao luto (Parkes, 1998, p. 134), sintomas de identificação e adiamento do início do luto (Parkes, 1998, p. 143). As ideias de culpa, autoacusação ou auto reprovação, comportam eventuais atitudes hostis perante os ex cuidadores do ente perdido, sentimentos de responsabilidade face à morte e raiva, ainda que com menor intensidade (Parkes, 1998, p. 139). No luto "crónico", onde o luto é prolongado e intenso desde o início (Parkes, 1998, p. 134; Parkes, 2009, p. 40), destacam-se casos de momentos de agitação e agressividade, relatos de ideação suicida, solidão e isolamento social, redução da capacidade para o trabalho, raiva, fobias, reações depressivas crónicas, incredulidade relativamente à perda, ataques de pânico e angústia da separação, revelação de sintomas de identificação, isto é, idênticos aos sentidos pela pessoa falecida, podendo estes serem classificados, uns de histéricos, outros de hipocondríacos (Parkes, 1998, pp. 134-141). Contrariamente ao luto "crónico", o luto considerado "conflituoso" demora mais tempo a se instalar, é um adiamento do luto que tem como complicadores a raiva e a culpa (Parkes, 2009, p. 40). Neste luto adiado, a reação à perda do ente querido, surge, aproximadamente, após duas ou mais semanas, é caracterizado pela evitação, descrença e angústia de separação intensa e forte, podendo originar sintomas de depressão, pensamentos suicidas, ansiedade e ataques de pânico (Parkes, 1998, p. 136-138). Além desta sintomatologia, o DSM-5 (pp. 939-941), destaca, ainda: saudades persistentes, mágoa intensa e choro frequente, preocupação com o ente perdido, amargura, evitamento excessivo de lembranças da perda, avaliações desadaptativas relativamente à pessoa falecida ou à morte, desejo de morrer e voltar a estar com a pessoa perdida, perda de interesse pela vida, dificuldade em planear o futuro, queixas somáticas (dor, fadiga) e alucinações visuais ou auditivas (perceção da presença física do ente perdido).

O LC é um marcador independente da psicopatologia relacionada com o luto (Bonanno, Neria, Mancini, Coifman, Insel & Litz, 2007, p. 342), ou seja, é diferente da depressão e da perturbação de *stress* pós-traumático (PTSD), mas muitas vezes comórbido com outros

transtornos psicológicos (Rosner et al., 2011, p.1). Na sequência dele podem desenvolver-se: doenças físicas (doenças cardíacas, hipertensão, cancro, deficiência imunológica e qualidade de vida reduzida); a perturbação depressiva major (PDM); a perturbação de stress pós-traumático (PTSD) e as perturbações de uso de substâncias (DSM-5, pp. 941-942). Daqui se depreender que o luto complicado é um fator de risco quer para as doenças físicas, quer para a depressão. Num estudo sobre o aborto, Beutel, Deckardt, Rad e Weiner (1995, p. 517) distinguiram os termos Luto e Depressão, concluindo que as consequências físicas e psicológicas prejudiciais ocorrem apenas quando um aborto não é chorado, resultando numa reação depressiva, mas não numa reação de luto.

Apesar dos sintomas comuns entre as duas entidades clínicas, existem pontos-chave que distinguem o luto (normal ou complicado) e a depressão (DSM-5, p. 190-197):

a. No luto, a perda é reconhecida, sendo normalmente negada, no caso da depressão;
b. No luto, a inquietação e agitação estão mais presentes, ao passo que a falta de energia é uma característica do quadro depressivo;
c. Embora os episódios depressivos majores (EDM) partilhem, com o LC, o humor deprimido, neste último caso o foco está centrado na perda (DSM-V, p. 941). Os EDM revelam infelicidade penetrante, não vinculada a pensamentos ou preocupações específicas, enquanto o humor deprimido do LC está associado aos pensamentos e recordações relativas ao falecido;
d. Nos EDM a autocrítica, o miserabilismo, os sentimentos de inutilidade ou avaliações negativas irrealistas do seu próprio valor podem resultar da afetividade negativa ou neuroticismo, de experiências adversas vividas na infância, dos acontecimentos de vida geradores de *stress* ou de doenças como a diabetes ou a obesidade mórbida; contrariamente, a ideação auto depreciativa, no luto, está associada a falhas sentidas em relação ao falecido;
e. No LC os desejos de morrer justificam-se pela necessidade "patológica" de voltar a estar junto do ente perdido, enquanto nos EDM os pensamentos suicidas estão associados aos sentimentos de inutilidade, desmerecimento da vida, ou com a incapacidade de lidar com a dor da depressão.

Assim, se o luto não for vivenciado de uma forma natural, se não for não resolvido e se as suas respostas graves persistem de forma intensa, então a PDM é uma das suas mais comuns comórbidas, isto é, o LC pode precipitar um EDM. Nos indivíduos com vulnerabilidades preexistentes, a dor intensa e o sofrimento pode continuar

interminavelmente e a perda pode provocar depressão major (Zisook & Shear, 2009, p. 67). Assim, e contrariamente ao luto sem complicações, extremamente doloroso, mas geralmente tolerável e sem necessidade de um tratamento formal, o Luto Complicado (LC) e a dor da Perturbação Depressiva Major (PDM) podem ser persistentes, incapacitantes, interferir na função e qualidade de vida, podendo tornar-se fatal, no caso da inexistência de intervenção clínica (Zisook & Shear, 2009, p. 67).

Quando a morte ocorre em circunstâncias traumáticas ou violentas, a Perturbação Pós-Stress Traumático (PTSD) é a mais frequente comórbida com a perturbação do luto complicado persistente (DSM-5, p. 942). Contudo, relacionar o luto com uma doença mental pode levar à estigmação da pessoa enlutada como um doente mental pelo que o risco de percecionar o enlutado como "doente" poderá induzir, no sujeito, comportamentos conducentes e justificativos do novo "pseudo-estatuto" (Andrade et al., 2008, p. 274).

As psicoterapias de intervenção podem reduzir os sintomas do LC (Wittouck et al., 2010 p. 77), pelo que as teorias psicológicas aplicadas à experiência do luto têm sido objeto de evolução e revolução considerável, onde as séries de estágios de adaptação, que conduzem à recuperação, têm sido postas em causa pelo *new look* das novas pesquisas que exploram a reconstrução, os laços contínuos ou evolutivos e os processos sociais na adaptação ao luto (Neimeyer, 2006, p.181). Independentemente da teoria de intervenção ou do alvo, não há dúvida de que a psicoterapia fornece meios eficazes de ajuda para a maioria das pessoas em perigo (Currier, 2008, p. 4) pelo que este estudo pretende testar a eficácia da perspetiva cognitiva-narrativa.

Na psicoterapia, o processo terapêutico conversacional tem sido um fator comum; neste sentido, para a psicoterapia cognitiva-narrativa, o uso dos jogos de linguagem permite a expansão e flexibilização das significações dos pacientes; estes jogos, manipulados pelo psicoterapeuta, não têm como intenção a resolução do "problema" insolúvel da vida do paciente mas a de proporcionar as condições de adaptação proactiva, do paciente à sua situação (Gonçalves, 2000, p. 113). Nesta perspetiva o ato narrativo não é apenas um instrumento e objeto de cura, nem o "depósito" e reestruturação, para maior flexibilização e congruência, das narrativas; ele proporciona o desenvolvimento, a potenciação e a libertação (Gonçalves, 2000, p. 106). A intervenção cognitiva-narrativa descende das terapias comportamentais e cognitivas, mas situa-se, epistemologicamente, nos modelos construtivistas (Gonçalves, 2000, p. 107), para os quais, o luto é um processo de

reconstrução de um mundo de significados que foi contestado pela perda (Neimeyer, 2010, p. 73). As terapias que integram a perda, na vida narrativa dos enlutados, estabelecem um fio de coerência e significância no meio de uma transição turbulenta, nomeadamente uma maior consciência da coerência das ações e das intenções relativamente à dor da perda (Neimeyer, 2010, p. 82).

As dificuldades de adaptação dos indivíduos, à sua nova realidade, podem ser causadas pela visão e atitude simplista, única e absolutista face a si próprio e à realidade que o envolve; no entanto, a perspetiva cognitiva-narrativa potencia a construção criativa de múltiplas versões da realidade, por contraposição à realidade singular e objetiva (Gonçalves, 2000, p. 108). Nesta perspetiva, mais criativa e menos resolutiva, o psicoterapeuta transforma a linguagem saturada de sintomatologias, num discurso criativo onde o paciente é conduzido para um processo de contínua e crescente mudança (Gonçalves, 2000, p. 107). No caso do LC, os psicoterapeutas têm à sua disposição estratégias que ajudam o paciente a estabelecer uma auto narrativa coerente que integre a perda e permitam que a sua história de vida avance noutros moldes (Neimeyer, 2010, p. 73). A auto narrativa é desafiada quando os indivíduos experimentam a morte de um ente querido, porque agora este indivíduo é "removido" da sua história de vida (Bocchino, 2008, p. 27). Desta forma, a narrativa é um processo construtivo de um ato criativo e é dessa construção que se alimenta o sucesso terapêutico (Gonçalves, 2000, p. 106); é através da co construção narrativa das experiências partilhadas com os outros que se organiza o conhecimento e se dá um sentido de coerência temporal e pessoal ao self e ao mundo (Simões, 2007, p. 76); nesse processo construtivo a pessoa enlutada desenvolve novas estratégias para lidar com a situação, estabelecendo, deste modo, uma ligação entre o passado, o presente e o futuro (Stroebe, 2002). A reconstrução, como tarefa de lidar com a perda, vê os seres humanos como tomadores de significados enraizados, tecelões de narrativas que são significado temático às estruturas de enredo das suas vidas (Neimeyer, 2006, p. 184). Da promoção dessa reconstrução e renovação, advém, como resultado, a compreensão mais adequadas de como as pessoas organizam as suas histórias de vida, na sequência de uma perda profunda, e encontram significado e propósito nos capítulos ainda a serem escritos (Neimeyer, 2006, p. 187).

De acordo com Gonçalves (2000, p. 114; 1998, p. 62), o processo terapêutico, de um programa cognitivo-narrativo, desenvolve-se numa sequência de fases e subfases:

1) Recordação, como um ato narrativo criativo e não apenas evocativo, onde o paciente identifica, através da regressão temporal e do exercício da imaginação guiada, episódios da sua vida, como se os tivesse a viver no presente;

2) Adjetivação, que inclui as subfases: objetivação, subjetivação emocional e cognitiva e metaforização. Nesta fase, o paciente consegue dar vida à sua experiência, através da simbolização narrativa, da introdução de diversas sensações, emoções, pensamentos e significados, deixando de subsistir e estar preso a determinadas sensações e emoções e à repetição inútil de pensamentos e significados (Gonçalves, 2000, p. 129). No processo da adjetivação, enquanto na subfase objetivação, o terapeuta convida o paciente a desmultiplicar a sua experiência numa multiplicidade de componentes sensoriais (visuais, auditivos, olfativos, gustativos e táteis/cenestésicos), constatando que já não está presos a uma única construção sensorial da experiência, na fase da subjetivação emocional e cognitiva, aquela desmultiplicação dá-se ao nível das emoções e da cognição (Gonçalves, 2000, pp. 130-143), isto é, solicita-se que o paciente tenha perceção das suas experiências internas. Na subfase terapêutica da metaforização, o paciente cria metáforas que condensam o significado da sua narrativa e dá significado às significações que a subjetivação lhe tinha proporcionado (Gonçalves, 2000, p. 149).

3) Projeção, onde o paciente projeta, na imaginação, os aspetos de objetivação, subjetivação emocional e subjetivação cognitiva da sua experiência, isto é, onde toma consciência que o único significado que se mantém constante é o da mudança (Gonçalves, 2000, p. 156).

Baseado no processo terapêutico desenvolvido por Gonçalves (2000, pp. 113-163; 1998, pp. 62-73) e no estudo de Barbosa, Sá e Rocha (2014), foi desenhado, no presente estudo, um programa de intervenção breve com quatro sessões de 60 minutos. De acordo com Barbosa et al. (2014) a importância de intervenções breves, que combinam um número reduzido de sessões com custos mais baixos, são reforçadas dado que refletem um aumento da adesão ao programa, juntamente com alta eficácia: no estudo destes autores houve uma redução estatisticamente significativa do LC, sintomas depressivos e traumáticas em comparação com os controles; por sua vez, foi refletida a eficácia da intervenção ao longo do perfil longitudinal adotado. As sessões envolveram: 1) narrativas de evocação, cujo objetivo é o entendimento do significado da perda na vida do paciente e a promoção da memória de um episódio específico relativamente à perda; 2) uma sessão onde dever-se-á falar da subjetivação emocional e cognitiva, dando espaço à exploração

dos aspetos emocionais e à multiplicidade e diversidade das experiências cognitivas da perda; 3) a metaforização, onde o objetivo é a exploração de diferentes significados para o episódio do luto e a escolha de uma metáfora através da qual as redundâncias da expressão narrativa configure uma diversidade de significados e 4) uma sessão de projeção, onde o terapeuta direciona o paciente para um processo contínuo de produções de metáforas, onde este se consciencializará da importância da sua capacidade narrativa e da singularidade da sua experiência, aplicando essa consciência à experiência do luto.

MÉTODO

Neste capítulo esclarece-se a caracterização da amostra, os instrumentos utilizados e os seus processos. Foi realizado um estudo clínico controlado randomizado (RCT), aplicado ao Grupo Controlo (GC) e ao Grupo de Intervenção (GI).

Com um protocolo de avaliação e intervenção e o consentimento do IUCS – Instituto Universitário de Ciências da Saúde, do Centro Hospitalar Tâmega e Sousa e de pacientes enlutados foi recolhida e selecionada uma amostra através de entrevistas semiestruturadas e individualizadas, do Questionário Sociodemográfico (QSD) e do Inventário do Luto Complicado (ICG). Analisados os questionários foram selecionados os pacientes que preencheram os critérios de inclusão: pacientes com resultados no ICG $\geq$ 30 pontos (ponto de corte), de ambos os sexos, que voluntariamente colaborassem no preenchimento dos questionários e que tivessem como referência uma situação de luto com significado pessoal acima dos seis meses. Estes elementos foram divididos aleatoriamente em GI e GC, sendo que estes responderam posteriormente aos CES-D e ICD-11.

Amostra

Para a amostra foram elegíveis 38 participantes (n=38), com idades compreendidas entre os 18 e 66 anos (M=48; DP =10,36), não havendo desistência até ao final do estudo. Estabeleceram-se dois grupos: grupo de controlo (GC) (n=20) e grupo de intervenção (GI) (n=18) que foi sujeito à Intervenção Cognitiva Narrativa no Luto (Figura 1). A todos os grupos foram aplicadas entrevistas semiestruturadas e os instrumentos de avaliação, em dois momentos: avaliação inicial e *follow-up* (após 3 meses). Terminada a recolha procedeu-se à construção da base estatística, a anonimização dos dados e sua inserção no *IBM SPSS Statistical* (versão 23) do *Windows.* A Tabela 1 descreve as caraterísticas dos

participantes dos dois grupos: o Grupo de Controlo (GC) e o Grupo Intervenção (GI) (sujeito a terapia cognitiva-narrativa). Os participantes do GI e GC são homogéneos, isto é, apresentam semelhanças quanto às caraterísticas sociodemográficas. Constata-se que não existem diferenças estatísticas significativas entre os grupos o que propõe que a randomização foi bem-sucedida (Tabela 1).

Instrumentos e Procedimentos

As variáveis dependentes foram instrumentalizadas através de três instrumentos de medida: *Inventory of Complicated Grief* (ICG), *Center for Epidemiologic Studies Depression Scale* (CES-D), e Questionário de Trauma (ICD-11). Para se obterem alguns dados sobre os participantes, aplicou-se um breve Questionário Socio Demográfico (QSD).

O *Inventory of Complicated Grief* (ICG), uma lista de sintomas associados ao LC, ajuda na distinção entre LC (ponto de corte de ICG total ≥ 30) e luto não complicado, quando aplicado 6 meses ou mais após a morte do ente querido (Zuckoff et al., 2006) e é constituído por 19 itens, numa escala tipo *Likert* [0-4] (0=*nunca*; 1=*raramente*; 2= *às vezes*; 3=*muitas vezes*; 4=*sempre*) (Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka, & Miller, 1995).O ICG possui boas caraterísticas psicométricas ao nível da fidelidade: Alfa de *Cronbach* = 0.91 (Frade et al., 2010; Silva, 2011) e evidencia uma estrutura multidimensional, com cinco fatores: o primeiro apresenta dificuldades traumáticas, o segundo refere-se às dificuldades de separação, o terceiro corresponde à dimensão negação, o quarto é referente à dimensão psicótica e o quinto fator sugere dimensão depressiva (Frade, Sousa, Pacheco e Rocha, 2010).

A escala *Center for Epidemiologic Studies* (CES-D), uma estrutura pouco extensa, aplicada a entrevistas breves e adequada a diferentes subgrupos da população, avalia a sintomatologia depressiva em diversas faixas etárias e revela uma estrutura de quatro fatores oblíquos: afetos positivos, depressão, aspetos somáticos/atividade reduzida e problemas interpessoais (Radloff, 1977; Filho & Teixeira, 2011).

O ICD-11 *Trauma Questionnaire* (ITQ) destina-se à avaliação do Pós-stress Traumático (PTSD), do Pós-stress Traumático Complexo (C-PTSD) e dos sintomas de Personalidade Borderline (BPD); tem boas caraterísticas psicométricas e pode ser incluído em protocolos que visam ser usados em casos de elevada exposição traumática a fim de esclarecer as consequências mais complexas (Soares, 2015).

O QSD, deste estudo, compreendeu dados pessoais (e.g. idade, sexo, habilitações, situação profissional, estado civil), situação clínica (sofre de alguma doença; problemas psiquiátricos/psicológicos), história familiar (acontecimentos de vida, problemas graves de saúde), apoio sociofamiliar (apoio após a perda; tipo de apoio…), dados da pessoa que morreu e acerca das circunstâncias da morte (sexo, data da morte, tipo de morte). Os dados permitiram salvaguardar os critérios de elegibilidade, verificar a homogeneidade entre GI e GC e foram úteis para revelar a perda na primeira sessão da intervenção. Estas informações não foram utilizadas para a análise dos resultados.

RESULTADOS

Da análise e comparação dos resultados, obtidos entre o GC e o GI, no momento inicial e no momento de follow-up (3 meses), através do teste *t* para amostras independentes (Tabela 2), verificou-se que na avaliação inicial não existiram diferenças estatisticamente significativas entre grupos relativamente aos valores de Depressão ($p=0.896$), LC ($p=0.935$) e Trauma ($p=0.278$) e que na avaliação de *follow-up* o GI experimentava valores muito inferiores relativamente ao LC, quando comparado com o GC ($p=0.001$). Não foram encontradas diferenças, estatisticamente significativas, entre grupos, quanto às variáveis Depressão ($p=0.120$) e Trauma ($p=0.066$); apesar de não existir uma significância estatística, existem diferenças nas médias obtidas, e o grupo sujeito a intervenção cognitiva-narrativa experimentava valores inferiores ao do GC nas restantes variáveis avaliadas neste estudo: trauma (GI M=9,33; GC M=13,83) e depressão (GI M=24,88; GC M=31,87). Foi calculado o tamanho do efeito, *effect size* (ES); utilizou-se o valor de *d* de Cohen, por ser o mais adequado para o tamanho da amostra. A importância do ES, estatisticamente, traduz o tamanho, dimensão ou magnitude do efeito e pode ser definido como grau em que o fenómeno está presente na população (Cohen, 1988), isto é, diferença efetiva na população, permitindo estabelecer a diferença real entre grupos (2 no caso do teste t). O ES é representado pela letra *d* no caso do teste *t*. Assim, quanto maior for o ES, maior será a demostração do fenómeno na população estudada. De acordo com Cohen (1988), os valores de *d* são estimados pequenos se ($.20 \leq d < .50$); médios se ($.50 \leq d < .80$) e grande se ($d \geq .80$). Assim, ao analisarmos os resultados obtidos em *follow-up* verificou-se um grande efeito entre o GI e o GC no que respeita ao LC ($d=1.326$) e Trauma ($d=0.8414$), e um médio efeito no que concerne à Depressão ($d=0.560$). Quanto à avaliação inicial, o *d* de Cohen diz-nos que existem um efeito pequeno ou nulo.

Na avaliação da eficácia da intervenção cognitiva-narrativa em quatro sessões, verificando-se uma grande diminuição dos sintomas, nomeadamente, no LC, ao longo do perfil longitudinal; há um efeito esperado de tempo e uma relação significativa (tempo x grupos) e no *follow-up*, houve diferenças significativas entre grupos para ($p < 0.05$), com o GI indicando menores valores nas médias, no ICG, no ICD e no CES em comparação com o grupo de controlo; não se verificaram efeitos negativos nos participantes ao nível da sintomatologia do luto, depressiva e traumática, sendo que todos eles relevaram diminuição nestas dimensões após a avaliação final, comparativamente à inicial.

DISCUSSÃO

Embora a intervenção psicológica nesta área tenha obtido resultados controversos, os resultados do presente estudo reforçam a ideia de que a maioria dos participantes podem melhorar os sintomas, da sua experiência, quando sujeitos a uma terapia cognitiva-narrativa (Gonçalves, 1998, 2000; Niemeyer, 2000: Pennebaker et, al., 1988; Boelen, Keijser, Hout & Bout, 2007; Greenberg, 2002); os sintomas característicos do LC não se resolvem naturalmente, sendo necessária uma intervenção psicoterapêutica (Prigerson et al., 1995; Wittouck et al., 2011); outros estudos demonstram que existem evidências empíricas de que uma intervenção com avaliação longitudinal ajuda a estabilizar as reações à experiência de luto (Bonanno, Wortman & Nesse 2004) e aumenta a capacidade de resiliência do indivíduo (Bonanno & Lillienfeld, 2008).

O nosso estudo foi ao encontro da APA (2002) que refere que para a eficácia de uma intervenção, no momento inicial, não devem existir diferenças estatisticamente significativas entre os grupos e, após três meses, é presumível que haja diferenças significativas entre estes; desta forma, no nosso caso, não existiam diferenças estatisticamente significativas na avaliação inicial entre o GI e o GC no que se refere à Depressão, Luto Complicado e Trauma. Foi utilizado um manual de intervenção, previamente utilizado em outros contextos, havendo evidências da sua eficácia, eficiência e com menos efeitos secundários que as demais alternativas conhecidas no LC.

Apesar de um número reduzido de sessões, o presente trabalho abre caminho para futuras investigações, nomeadamente, em outras áreas de intervenção. Considera-se a pertinência de futuras investigações, que analisem a utilização de desenhos longitudinais, com follow-up, de um ano após a perda, no sentido de contrariar a ideia de que aquando uma

intervenção, os indivíduos geralmente diminuem os seus níveis de depressão apenas nos primeiros meses após a perda, com inserção do GI. Entre as limitações à generalização dos resultados deste estudo encontra-se a reduzida amostra, não representativa da população, e a grande percentagem de participantes do sexo feminino. Face a estas limitações entende-se que este estudo poderá ser replicado neste ou noutros contextos de forma a obter resultados mais generalizados.

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ANEXOS

Termo de consentimento

Eu,____, após ser devidamente informado (a) sobre os objetivos e sobre o protocolo de investigação, declaro que aceitei participar de livre vontade no estudo que está a ser realizado sobre o processo de Luto, pelo Centro Hospitalar do Tâmega e Sousa em colaboração com IINFACTS, CESPU.
Declaro, ainda, que tenho conhecimento acerca do meu direito de desistir de participar no estudo, se assim o desejar. Neste estudo procura-se obter diversos dados da população para recolher indicadores que permitam compreender melhor o Luto e todos os circunstancialismos que lhe estão inerentes, bem como ajudar a validar um programa de intervenção psicológica.

______________________, ____ de _______________ de _________

Assinatura: ____

Obrigado pela sua colaboração

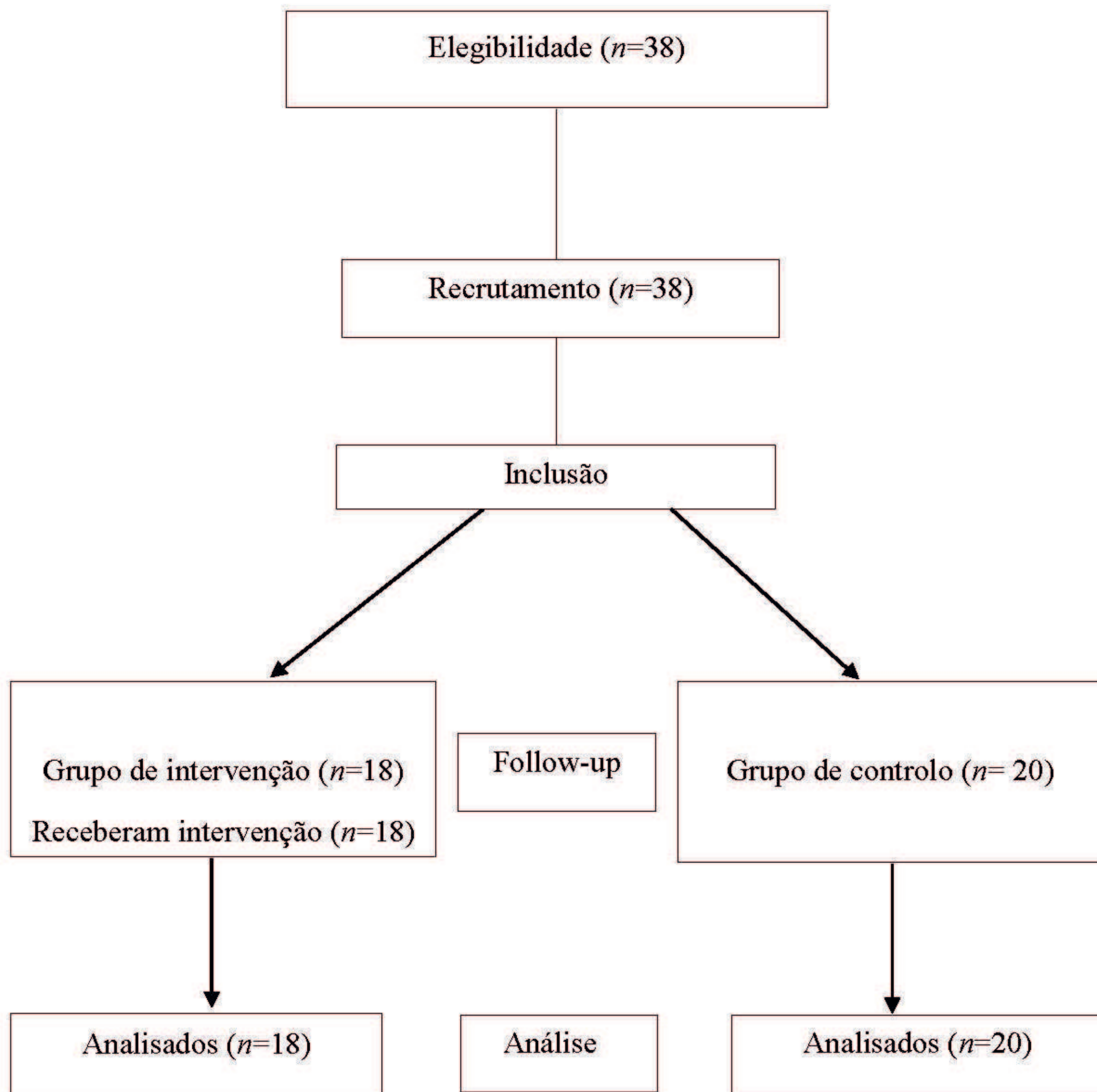

Figura 1. Fluxograma de participantes em cada fase da investigação

Tabela 1

Caraterísticas sociodemográficas e clínicas GC (n=20) e do GI (n=18) e valores de significância de teste t entre grupos

	Grupo Controlo				Grupo Intervenção					
Caraterísticas	*n*	%	*M*	*DP*	*n*	%	*M*	*DP*	*t*	*p*
Sexo										
Feminino	19	95.0			17	94.4				
Masculino	1	5.0			1	5.6				
Situação Profissional										
Empregado	4	20.0			4	22.2				
Atestado	6	30.0			5	27.8				
Desempregado	9	45.0			6	33.4				
Reformado	0	0			2	11.1				
Estado civil										
Solteiro	2	10.0			4	22.2				
Casado	12	60.0			10	55.6				
Viúvo	6	30.0			2	11.1				
Divorciado	0	0.0			1	5.6				
Habilitações										
4º Ano	12	60.0			0	0.0				
6º Ano	5	25.0			7	38.9				
9º Ano	2	10.0			3	16.7				
12º Ano	1	5.0			4	22.2				
Ensino superior	0	0			4	22.2				
Perda sofrida										
Cônjuge	5	25.0			2	11.1				
Filho	6	30.0			4	22.2				
Pai/Mãe	8	40.0			9	50.0				
Sobrinho	1	5.0			0	0.0				
Irmão	0	0.0			2	11.1				
Acompanhamento Psiquiátrico										
Sim	6	30.0			6	33.3				
Não	14	70.0			10	55.6				
Idade			45.3	11.3			49.9	9.7	1.35	n.s.
Tempo após perda (meses)			57.1	22.6			52.3	23.4	0.62	n.s.

* $p < 0.05$

Tabela 2

Luto complicado (ICG), sintomatologia depressiva (CES) e sintomatologia traumática (ICD): Comparação entre GI e GC inicial e três meses.

	Intervenção		Controlo					
	M	*DP*	*M*	*DP*	*gl*	*t*	*p*	*d de Cohen*
CES inicial	33.00	10.64	32,52	9,52	30	,132	.896**	.046
CES 3 meses	24,88	9,66	31,86	14,77	30	-1,601	.120**	.560
PTSD inicial	17,83	4,32	15,89	6,15	35	1,102	.278	.0077
PTSD 3 meses	9,33	5,41	13,83	8,48	34	-1,901	.066	.8414
ICG inicial	47,26	12,31	46,93	9,65	28	,083	.935	.031
ICG 3 meses	26,64	14,82	44, 87	12,57	31	-3,797	.001*	1.326

* $p < 0.05$

PARTE II

Artigo submetido ao *Journal of Psychology & Psychotherapy*

Randomized controlled trial of a cognitive narrative crisis intervention for bereavement in primary healthcare.

Running Head: Cognitive narrative intervention for bereavement

Randomized controlled trial of a cognitive narrative crisis intervention for bereavement in primary healthcare

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Randomized controlled trial of a cognitive narrative crisis intervention for bereavement in primary healthcare

Abstract

Background: Grief may take many expressions and can have consequences on physical and mental health, and clinicians generally accept that psychological intervention may help to reduce the intensity of the grief promoting resilience in the process of adjustment. However, there are known risks of re-traumatization through bereavement crisis interventions. We tailored a new intervention lowering the degree of direct emotional activation one month after loss, achieving an episodic narrative with diversity of content, multiple coherences and meaning.

Objectives: The research main goals were the prevention of the depression and traumatic stress symptoms, six months after loss, and also the achievement of high levels of acceptance and participation.

Method: It is a sequential, pragmatic and randomized controlled trial with two groups, control group (n=18) and experimental group (n=11) in two assessments (one and six months after loss), both included a semi-structured interview (Socio-Demographic Questionnaire, Beck Depression Inventory and the Impact of Events Scale-Revised). The experimental group had a cognitive-narrative program with four sessions: recalling, cognitive and emotional subjectivization, metaphorization and projecting sessions.

Results: Participants in the experimental and control groups have lower levels of depression and traumatic stress six months after a loss. Statistically significant results in emotional numbing IES-R sub-scale are observed.

Conclusion: After the study, we have evidence available that there is a brief narrative in cost-effective crisis intervention with positive outcomes controlling the traumatic stress and time after a loss.

Keywords: prevention; primary health care; randomized trial; cognitive narrative; crisis

Key messages:

-Bereavement crisis interventions may have negative effects due to high emotional activation.

-A new very short narrative approach was manualized and a RCT was implemented with grievers one month after loss.

-This intervention has a high effect size for prevention of depression and null or even preventive for traumatic stress.

Introduction

It has been demonstrated that experiences of loss can take multiple forms of expressions, and generally have consequences on physical and psychological health (Stroebe, Schut & Stroebe, 2007; Currier, Berman & Neimeyer, 2008). Additionally, some individuals tend to develop psychological reactions to loss, characterized by negative emotions such as depressions, anxiety, disbelief, anger, social isolation, self-blame, despair (Stroebe, Schut & Stroebe, 2007) and complicated grief (Boelen, Bout & Hout, 2009). Complicated grief is a phenomenon that can be treated, but can't be prevented, which doesn't mean that interventions with the goal to prevent this type of grief do not have value (Wittouck, Autreve, Jaegere, Portzky & Heeringen, 2010). Therefore, considering known risks related to traumatic stress on crisis narrative interventions (Barbosa, Sá & Rocha, 2013) and the time after loss variable, there is need for evidences to support effective crisis interventions aiming to prevent emotional problems related to bereavement. A meta-analysis on complicated grief has shown that there is a difference among the short-term and long-term effects of preventive and treatment strategies, in favor of the latter (Wittouck, Autreve, Jaegere, Portzky & Heeringen, 2011). In parallel, we also know that there is a positive correlation between depressive symptoms and absenteeism, which is reflected at the levels of national productivity (Gusmão, Xavier, Hector, Pope & Almeida, 2005). The possibility of other medical conditions, such as substance abuse and dependence with sexual risk behaviors may also be associated (Le et al., 2003). Psychological intervention in grief has been a controversial issue. However, it has been generally accepted by researchers that psychological interventions help to reduce the intensity of the mourning, promote greater resilience in the process of adjustment after the loss (Kato & Mann, 1999; Wittouck, Autreve, Jaegere, Portzky & van Heeringen, 2011) and intervene in complicated bereavement is more effective than not doing so (Currier, Berman & Neimeyer, 2008). It is extremely important to understand that each person grieves in a unique way, so, the treatments protocols applied in a certain case need to be adaptable to the individual needs (Wittouck, Autreve, Jaegere, Portzky & Heeringen, 2011). Grief work is a concept essential at some point of our lives; it is crucial to pay attention to the significance of changing of thoughts and emotions, to clearly see all the benefits of seeking help, as well as to recognise that mourning doesn't pass with the "cure of time" (Barbosa, Sá & Rocha, 2013). Studies have shown that there is empirical evidence that a longitudinal intervention

helps to stabilize the reaction to bereavement (Bonanno, Wortman & Nesse, 2004), during an intervention, people usually show resilience, i.e., reduce their levels of depression in early after the loss (Bonanno et al., 2002; Bonanno, Wortman & Nesse, 2004). Based on the negative results of the debriefing (Mayou, Ehlers & Hobbs, 2000),the positive results that cognitive-narrative therapy has shown in intervention with bereaved individuals (Currier, Neimeyer & Berman, 2008) and after a review of empirical studies that have followed its protocol in health setting, which results proved to be effective at the level of psychotraumatic (Gonçalves, Machado & Rosas, 1997), depressive and anxious (Rocha, 2004) symptoms, the question formulated was if psychologists at primary health care center can help to prevent bereavement problems through a brief narrative intervention?

In order to answer this question we develop a randomized controlled trial of an intervention manual with following main goals: a) to prevent psychotraumatic and depression symptoms on bereaved, b) to promote the participation in the program in order to help the persons in need, and c) to implement a brief intervention that can be adjusted to the primary healthcare with the consideration of costs-benefits for the patients and the healthcare facilities.

Method

Trial Design

This study is a longitudinal randomized controlled clinical trial and respects CONSORT guidelines. Repeated measures, including BDI and IES-R, were used. The outcomes variables considered are (a) depressive and traumatic symptoms. The study had the objective of diminish of the symptoms with the main goal as the prevention of the depression and psychotraumatic symptoms and consisted on the following sequential phases: (1) participants were recruited by medical staff of a Primary Health Care Unit; (2) data was selected and treated; (3) Clients were contacted by phone to book the first session; (4) participants sign informed consent; (5) eligible participants were randomly allocated in the control and experimental groups; (6) both groups were subjected to a semi-structured interview (SDQ) and to two instruments – BDI and IES-R – one month after the loss, baseline assessment at the first time it was given (referred as T1) ; (7) Finally, six months after the loss, the evaluation was repeated in the same conditions as the first one, follow-up assessment at the second time the study was given (T2). The experimental group had additionally a cognitive narrative manualized intervention.

Participants

Participants were recruited by the medical staff of a Primary Health Care Unit located in the cities of Paredes and Rebordosa (Porto, Portugal). Those who fulfilled the following three inclusion criteria were eligible: individuals with a significant loss within last month, older than 18 years old and with the at least fourth grade of primary school completed. A total of 52 eligible participants have been contacted, however only 29 participated to this study (Figure 1.). The study objectives and the description were disclosed in detail and informed consent was requested.

Intervention

Manualised cognitive narrative programme for complicated grief

To achieve the main goals, it is crucial to consider the robustness of the treatment based on an intervention manual, which should be descriptive (Jané-Llopis & Barry, 2005; Nezu & Nezu, 2008). Thus, this manual is based on the Gonçalves, Machado, and Rosas (1997) and Barbosa, Sá & Rocha (2013).

The manual was structurally separated in characteristics of the client, of the psychologist, of the process, objectives and methods for each session. The process was designed in four weekly sessions of 60 minutes and the objectives and therapeutic techniques used during the sessions were the recall, the cognitive and emotional subjectification, the metaphorizing and the projection. Each session began with a summary of the previous and ended up with a review of it. The first session involved recalling narratives; the main objective of the first session is to understand the meaning of the deceased in the life of the client and to promote the memory of a specific episode (something to do with the loss). Initially, the participant describes the importance of the deceased in his/hers life and the type of their relationship. Subsequently the client describes an episode so that he/she structure his/her experience with a sense of authorship and consistency. The second session addresses emotional and cognitive subjectivization; the main objectives of this session is to provide a greater awareness of emotional and cognitive dimensions of the experience; to promote the exploration of other aspects of emotional and cognitive experience, not previously appreciated; and to explore the multiplicity and diversity of cognitive and emotional experiences of the episode. The therapist summarizes the activated and evoked emotions from the narrative construction and later suggests the client to explore the cognitive component of the episode and to make successive associations to the thoughts and emotions evoked. The third session involves methaphorization; in which the objective is to explore the different possible meanings for the episode and to choose a metaphor that has more tension and condensation of meaning. Initially, it is important to summarize and retrace the route already described focusing particularly the emotional subjectification and the cognitive experience. The use of paraphrases, silence, reflection of meaning and summarization are important interview skills. Subsequently, the client is prompted to generate metaphors establishing analogies between different frameworks, fostering tension between different levels of meaning and suggesting answers (Gonçalves, 2000). The therapist should encourage metaphors from the others perspective including more references and asks the client to create a unifying metaphor that condense the meaning of the episode. Finally, on the fourth session, projecting took place; in this session we want to promote the construction and the experience of other possible organizations of the episode. Reflecting on the metaphor, a client is requested to present an episode that ran in an alternative way to the root metaphor, followed by metaphorization of this episode. The therapist encourages the client to imagine the episode with the alternative metaphor and clarifies the different emotions and

thoughts in the two narratives. In the end, it is discussed how the new metaphor might be an alternative way more suitable to operate. The experimental group completed a checklist in order to evaluate the acceptability of the program.

Therapists and treatment reliability

The therapist was subjected to training on the manualized intervention, in order to have a direct experience of the characteristics and requirements of the task. The therapist was monitored to maintain the structure of the program and to solve the difficulties arising from the process and had to make her own assessment at the end of each session. The therapist had to be able to present the techniques and objectives in a clear and simple language. Despite the demanding levels of structure and directivity of the process, the therapist had to be able to establish very high levels of empathy, positive acceptance, neutrality and authenticity.

Outcome measures: Depressive symptoms

The instrument used to assess depression was the BDI adapted for the Portuguese population by Serra and Abreu (1973), with the main goal of distinguishing the non-depressed and the depressed persons, with the cut-point value of 12, in this study, we used the value of g Hedges since I was the most suitable for the size sample.

Psychotraumatic symptoms

The IES-R is the most frequently used instrument for assessing bereavement traumatic reactions (Stroebe & Schut, 2006). We used the cut-off point > 35, a value that has been used in other studies, with a diagnostic sensitivity of 0.91 and diagnostic specificity of 0.82 (Creamer, Bell & Failla, 2003; Matthiesen and Einarsen, 2004). The IES-R included 22 items, which were distributed among the three scales, namely the subscale avoidance (8 items), the subscale intrusion (8 items, having been added new item) and subscale hypervigilance (with 6 items). In addition, a fourth factor became known as sub-scale emotional blunting (Sundin & Horowitz, 2002).

Sample Size

52 recently bereaved (less than one month) persons were initially contacted and sequentially randomized 15 for the intervention group and 37 for the control group. In the experimental group, four participants failed intervention enrolment reporting that they did not consider relevant to participate. On the control group, 19 were lost declining the

second assessment referring as transportation difficulties, low-level symptoms considering not relevant to follow-up assessment.

Randomization

The selected sample is composed by 29 participants. These participants were randomly sequentially allocated into two groups: a control group and an experimental group. Table 1 describes participant characteristics for each group. Both control group (n=18) and experimental group (n=11) experienced bereavement and have social-demographic and clinical similarities.

Analysis of attrition rates in sample

The values of attrition rates for IG considered were the following: (a) number of contacted individuals (n = 15); (b) number of participants in the intervention (n = 11); (c) number of participants who completed the interventions (n = 11); and (d) number of participants who completed the last evaluation (n = 11). During the 4 sessions of the program, a participation of the clients was 100%, i.e., 0% of attrition. This result might be additionally explained by the flexibility given to the clients by a therapist in terms of booked dates and timetables.

However, the high attrition verified on enrolment is mainly due to the high inclusiveness of eligibility, considering both participants with low and high symptoms, on a preventative perspective of the design. Also, baseline results at T1 do not evidence significant differences on the outcome measures, suggesting low-bias risk.

Statistical methods

To assess the differences between the groups, during both periods of analysis, Tl and, T2, at the level of the depression and the psychotraumatic symptoms we performed a t-test, chi-square and side-effects. In order to obtain a more complex analysis that allowed evaluating the time variable, as a mediator of possible bias, we performed repeated-measures, which is an extension of the t-test for impaired samples (Field, 2009). We used the analysis of tables / data , with the objective of making more visible the evolution of the mean from the first to the second assessment in the control and experimental groups at the level of BDI, IES-R and the sub-scale, IES-R Emotional numbing. At the end of the 2nd evaluation, the experimental group completed a checklist in order to evaluate the

Comparative analysis of depression symptomatology in group applicability and success of the program. Considering the small sample, there is the main focus on describing and analysing effect size values. A published meta-analysis (Jané-Llopis, Hosman, Jenkins & Anderson, 2003) for the different types of programs for the prevention of depression found a weighted mean effect size of 0.22 (95% CI 0.14–0.30). In this study, it is used the value of Hedges (g), since this is more conservative and the most suitable for the size of the sample.

Results

Analysis for depressive symptoms

Comparisons between the control group and experimental group

The BDI values obtained for both groups, in baseline and Follow-up (FU), do not have a statistically significant difference ($p>0.05$). However, considering effect-sizes analysis on the second evaluation, there is a medium to a high value on lowering depressive symptoms ($g = 0.65$), comparing control and intervention groups.

There are high prevalence of above cut-off value of depressive symptoms in the experimental group (90.9%) and in the control group (83.3%) at baseline. In FU assessments those values decrease, respectively, to 54.5% and 55.6%. In spite of a higher decrease on intervention group at FU, there are no significant differences between groups, as shown in table 3.

Traumatic stress symptoms

Comparisons between the control group and experimental group

Through a descriptive analysis of the indicators of psychotraumatic symptoms (Table 2) that the mean decreased proportionally in both groups with the exception of IES-R Intrusion, which maintain values. A significant positive difference in Emotional Numbing for the experimental group is also observed, comparing both groups and showing a clear effect in the experimental group. Effect-size values range between 0.01 and 0.8, with 0.80 for Emotional Numbing (confidence interval 95% between 0.02 and 1.58), as shown in table 2.

Comparative analysis of the prevalence of traumatic stress

We calculate the values prevalence of psychotraumatic symptoms, considering the cut-off point above 35 on IES-R, we find in the control group a rise and fall effect, i.e., 6 participants decreased traumatic symptoms, but other 6 increased (50%). Analyzing the experimental group we observe that 4 participants with psychotraumatic symptoms evolve positively for values below cut-off and no other participant had increased values, which is a consistent low risk of re-traumatization of this crisis intervention. However, after examining chi-square those differences are not statistically different between groups.

Analysis of the positive and negative evolutions

In order to understand the positive and negative evolutions between the experimental and control groups we subtracted FU and baseline results and flagged participants with a decrease of symptoms as “Positive Evolutions”. There are strictly positive evolutions in the experimental group (100%) between the first and second evaluation (Table 3).

In the control group, 4 participants did not show improvement over time in their depression and traumatic symptoms and only 77.8% of the 18 clients showed positive evolution. This observation is consolidated by the chi-square results which show significant differences between groups over time (X^2, $p<.05$).

Intervention group acceptability of the cognitive narrative protocol

Intervention group participants responded to questions regarding the acceptability of the intervention program. The response options ranged from 0 to 10. Table 4 shows that we obtained very satisfactory answers, with an average variation (approximated) of 8 to 10, indicating that the program was important for the participants. We emphasise that the participants consider this intervention as an opportunity to support and to clarify their thoughts and emotions. The IG felt that they received more support and that it is important to receive such help when solving problems, leading to a better and more adaptive life.

Discussion

This randomized controlled trial evaluated the effectiveness of four-session cognitive narrative intervention reducing depressive and traumatic symptoms in recently bereaved participants and examines differences between the two groups at baseline and six months after the loss. The manual included recalling, cognitive and emotional subjectivization, metaphorization and projecting sessions focused on providing a space for narrative production, to coherently externalize emotions with the adequate level of activation and to generate new meaningful narratives.

Indicators of depression and trauma were compared in the experimental group at six months. Most relevant results for psychotraumatic symptoms, due to known negative results on short crisis interventions, we found no negative evolutions and very positive improvements on emotional numbing. Evidences of efficacy of preventive bereavement interventions are scarce or even negative (Wittouck et al., 2011).

The effect sizes results allow us to compare this intervention with other already published, for instance, considering specifically for complicated grief preventive interventions, the Wittouck et al. (2011) meta-analysis showed a negative evolution mean effect size of 0.13 (for treatment interventions, there are positive evolutions with mean effect size of 1.38). This important synthesized evidence generated a negative appraisal for preventive crisis interventions, which sustains our effort to develop new interventions targeting and controlling psychotraumatic symptoms. Also, Jané-Llopis (2003) extensive meta-analysis of depression prevention programs found a mean side-effect of 0.22. Our effect-sizes reveal positive evolutions for depression value of 0.65 and for the traumatic stress of 0.19.

It is also noted a very positive effect IES-R sub-scale for emotional numbing, a Hegde's g effect size of 0.80 (IC 95%, between 0.02 and 1.58). Nevertheless, there are no conclusive results regarding the structure of the IES-R and its subscales, in particular at level of emotional numbing (Asmundson, Frombach, McQuaid, Pedrell, Lenox & Stein, 2000; Duhamel et al., 2004).

Tracking the evolution of all participants, we found in the experimental group that 100% had positive evolutions, five months after the intervention, that is, all participants show a decrease on the symptoms (depressive and psychotraumatic). On the other hand, 22.2% of the control group participants had an increase on symptoms.

This condition might have biased the values of depression and trauma in the control group and reduced the statistical effect of the intervention. Attrition analysis can check this possible bias and the use of non-parametric analysis should be provided for main results, as a full description of effect-sizes. However, the experimental group has considerable less education, a higher prevalence of sick leave (45.5%) and a higher frequency of widows(ers). All these aspects suggest that experimental group may have more theoretical difficulties than the control group.

Conclusion

These positive results on such a small scale study may be explained by the careful manualization considering emotional activation, specifically the not inclusion of sensorial (objectivation) work of episodic memories, which have positive implications on future bereavement or crisis interventions concerning the management of the optimal level of activation. These results confirms the importance metaphor construction by patients as part of a coherent episodic narrative providing a functional structure to work with emotions and thoughts, and can be used to understand the changes in relation to the perception of bereavement (Maercker et al., 2008; Neimeyer, 200) and to provide new perspectives for life and new meaningful memories. This intervention seems to accelerate this process; however, the process itself does not occur in sessions. It opens a way for contextual narrative production with very high level of creativity and coherence.

However, the limitation of the sample used is a very relevant aspect concerning generalization and possible bias from attrition or from randomization. Analyzing possible bias on differences at baseline and of risk factors between groups, show that (1) there are not relevant differences at baseline; (2) the attrition rates on control group was considerable, however, comparing the included participants characteristics at baseline in both groups, the differences are minimal and the theoretical trends indicate a negative bias for experimental group (i.e, less education and less social support perception). Nevertheless the pilot nature of this randomized trial, in future research this sample should be expanded to provide more robust evidence of efficacy.

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Table 1

Sociodemographic characteristics of IG (n=11) and controls (n=18)

Social demographic measures	Control Group				Experimental Group			
	n	%	*M*	*SD*	*n*	%	*M*	*SD*
Age			44.28	13.57			42.18	11.47
≤ 30 anos	5	28			2	18.2		
> 35 anos	9	72.7			9	81.9		
Education level (in years)								
Between 4 and 6 years	10	55.6			8	72,7		
Between 7 and 12 years	6	33.3			3	27.3		
More than 12 years	2	11.1			0	0		
Marital Status								
Single	2	11.1			3	27.3		
Married	12	66.7			5	45.5		
Widow(er)	4	22.2			3	27.3		
Previous histories of grief								
No	5	27.8			2	18.2		
Yes	13	72.2			9	81.8		
Perception of + social support								
No	4	22.2			5	32.7		
Yes	14	77.8			6	67.3		
Sick leave								
No	12	66.7			6	54.5		
Yes	6	27.8			5	45.5		

Table 2

Depressive symptoms (BDI) and traumatic symptoms (IES-R): comparison between the IG and controls at T1 and T2

Outcome variable	Intervention		Control					
	M	*SD*	*M*	*SD*	*Df*	*t*	*p*	*Hedges's g*
BDI T1	20.09	10.75	21.61	10.34	20.62	-0.37	*.71*	
BDI T2	9.73	6.45	15.89	10.49	26.98	-1.99	.06	0.65
IES-R T1	44,55	13.25	48.17	14.66	23.11	-0.69	.50	
IES-R T2	32.18	15.82	35.22	16.03	21.50	-0.50	.62	0.19
IES-R Intrusion T1	2.27	0.68	2.45	0.70	21.79	-0.68	.50	
IES-R Intrusion T2	1.73	0.78	1.73	0.79	21.68	-0.04	.99	0.01
IES-R Hypervigilance T1	2.47	0.80	2.18	0.84	22.03	0.91	.37	
IES-R Hypervigilance T2	1.67	0.76	1.65	0.85	23.27	0.06	.95	0.02
IES-R Emotional numbing T1	1.36	0.92	1.80	1.27	26.04	-1.08	.29	
IES-R Emotional numbing T2	0.64	0.64	1.39	1.04	26.99	-2.42	.02*	0.80
IES-R Avoidance T1	1.31	0.83	1.90	0.81	20.95	-1.90	0.71	
IES-R Avoidance T2	1.07	0.89	1.40	0.70	17.42	-1.04	0.31	0.04

* $p < 0.05$

Table 3

Frequence, prevalence and positive evolutions between both groups in IES-R and BDI at T1 and T2

	Intervention		Control		*p for* $\chi^2(1)$
	n	%	*n*	%	
Traumatic stress					
Above IES-R cut-off T1	9	81.8	15	83.3	
Above IES-R cut-off T2	5	45.5	9	50	*n.s.*
Depression					
Above BDI cut-off T1	10	34.5	15	51.7	
Above BDI cut-off T2	6	20.7	10	34.75	.19
Positive evolution T2-T1 on Depression and Traumatic Stress	11	100.0	14	77.8	.04

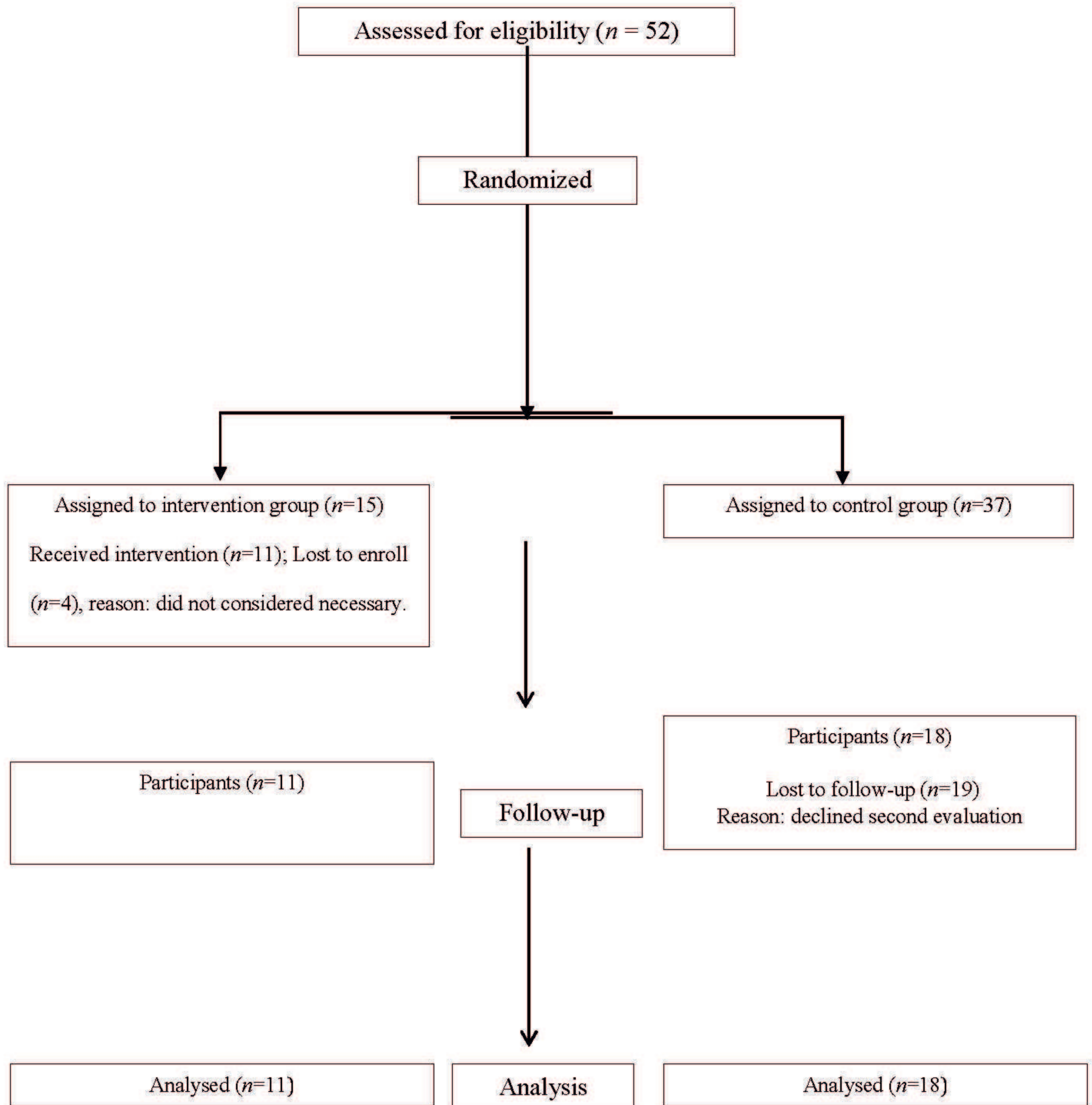
Note. T1 = 1st evaluation; T2 = 2nd evaluation

Table 4

Program acceptability by participants (n=11)

	M	*SD*
Helped me to clarify my feelings	9.36	0.50
Supported me in what I felt	9.27	0.45
Helped me to organize my feelings	9.00	0.89
Helped me to organize better my thoughts and doubts	9.00	0.63
Helped me to communicate better with significant persons	8.91	0.70
Helped me to live better my own life	8.91	0.94
Helped me to be less afraid of eventually new relationship	8.00	1.09
Helped me to be aware of my personal meanings	9.00	0.63
Helped me giving information about this process	9.00	0.63

Figure 1. Flow of participants through each stage of an experiment



PARTE III

Resumo de comunicação livre

XIV *Conference of European Society for Traumatic Stress Studies Trauma in Changing Societies*

Randomized controlled trial of a cognitive narrative crisis intervention for bereavement in primary healthcare

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Abstract

There are known risks of re-traumatization through bereavement crisis interventions, therefore we defined a new intervention lowering the degree of direct emotional activation. However, we need evidences on the effects on depression and psychotraumatic symptoms between one and six months after loss.
It is a randomised controlled trial with two groups, control group (n=18) and experimental group (n=11) in two assessments (one and six months after loss), both included a semi-structured interview (Socio-Demographic Questionnaire, Beck Depression Inventory and the Impact of Events Scale-Revised. Experimental group had a program with four sessions of approximately 60 minutes: recalling, cognitive and emotional subjectivation, metaphorization and projecting sessions.
Participants in the experimental and control groups have lower levels of depression and traumatic stress six months after loss. Statistically significant results in emotional numbing IES-R sub-scale are observed.
Brief narrative based and cost-effective crisis interventions have increased positive outcomes, controlling traumatic stress and time after loss.

Introduction

At some point of our lives, we face Grief work as part of our lives: meaning changes and new thoughts and emotions arise, and we can be aware of the benefits of seeking for help, as well as we recognise that mourning doesn't pass with a passive "cure of time"[1]. Considering known risks related to traumatic stress on crisis narrative interventions and effects of the time after loss, there is need for evidences to support effective crisis interventions aiming to prevent long-term emotional problems related to bereavement. A meta-analysis on complicated grief has shown that there is a difference among the short-term and long-term effects of preventive and treatment strategies [2]. In parallel, we also know that there are positive correlations between grief symptoms, absenteeism, productivity, health in general, quality of live, risk behaviors and other negative effects frequently underestimated [3]. It has been generally accepted by researchers that psychological interventions help to reduce the intensity of most grief symptoms, promote greater resilience in the process of adjustment after the loss [4] and intervening in complicated bereavement is more effective than not doing so [5]. However, Psychological crisis interventions has been a controversial issue considering the possible negative traumatic effects. Mainly based on the negative evidences of the debriefing strategies [7] but, in another hand, with the very positive results that cognitive-narrative treatment of complicated grief[5], the question about new preventive methods arises.

Objectives

Can psychologists at primary healthcare centre help to prevent bereavement problems through a very short narrative intervention? In order to answer this question we develop a randomized controlled trial of an intervention manual with following main goals: a) to prevent psychotraumatic and depression symptoms on recently bereaved, b) to promote high levels of participation in the program and c) to implement a brief intervention that considers the costs-benefits and adjusted to primary healthcare context.

Discussion

Most relevant results are related to psychotraumatic symptoms, due to known negative results on short crisis interventions, we found no negative evolutions and very positive improvements on emotional numbing. Evidences of efficacy of preventive bereavement interventions are scarce or even negative. It is also noted a very positive effect on IES-R sub-scale for emotional numbing. Positive results on such a small scale study may be explained by the careful manualization of the degree of emotional activation, specifically the not-inclusion of sensorial work of episodic memories. These results confirms the importance metaphor construction by patients as part of a coherent episodic narrative providing a functional structure to work with emotions and to provide new perspectives for life and new meaningful memories. This intervention seams to accelerate this process; however, the process itself does not occur in sessions. It opens a way for contextual narrative production with very high level of creativity and coherence.

Methods

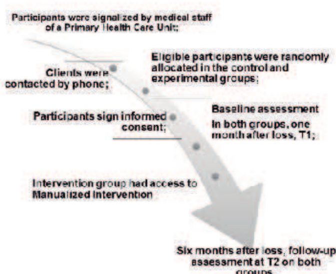
TRIAL DESIGN

This study is a longitudinal randomised controlled clinical trial and respects CONSORT guidelines. Repeated measures, including BDI and IES-R, were used.

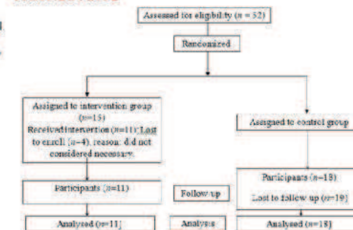
OUTCOME VARIABLES:

Depressive and traumatic symptoms, baseline and follow-up.

SEQUENTIAL PHASES OF THE DESIGN



PARTICIPANTS



INTERVENTION

Results

Analysis of intervention effects

Outcome variable	Intervention M	Intervention SD	Control M	Control SD	Df	t	p	Hedges's g
BDI T1	20.09	10.75	21.51	10.34	20.62	-0.37	.71	
BDI T2	9.73	6.45	15.89	10.49	25.58	-1.95	.06	0.65
IES-R T1	44.55	13.25	48.17	14.66	23.11	-0.69	.50	
IES-R T2	32.18	15.82	35.22	16.03	21.50	-0.50	.62	0.19
IES-R Intrusion T1	2.27	0.68	2.45	0.70	21.79	-0.68	.50	
IES-R Intrusion T2	1.73	0.78	1.73	0.79	21.68	-0.04	.90	0.01
IES-R Hypervigilance T1	2.47	0.80	2.18	0.84	[illegible]	0.9[illegible]	.37	
IES-R Hypervigilance T2	1.67	0.76	1.65	0.85	23.27	0.06	.95	0.02
IES-R Emotional numbing T1	1.36	0.92	1.80	1.27	25.04	-1.08	.29	
IES-R Emotional numbing T2	0.64	0.64	1.39	1.04	25.59	-2.42	.02*	0.80
IES-R Avoidance T1	1.31	0.85	1.90	0.81	20.55	-1.90	0.71	
IES-R Avoidance T2	1.07	0.89	1.10	0.70	17.42	-1.04	0.31	0.01

Effects considering cut-off values

	Intervention n	Intervention %	Control n	Control %	p for $\chi^2(1)$
Traumatic stress					
Above IES-R cut-off T1	9	81.8	15	83.3	
Above IES-R cut-off T2	5	45.5	9	50	n.s.
Depression					
Above BDI cut-off T1	10	34.5	15	51.7	
Above BDI cut-off T2	6	20.7	10	34.75	.19
Positive evolution T2-T1 on Depression and Traumatic Stress	11	100.0	14	77.8	.04

Intervention group satisfaction

	M	SD
Helped me to clarify my feelings	9.36	0.50
Supported me in what I felt	9.27	0.45
Helped me to organize my feelings	9.00	0.89
Helped me to organize better my thoughts and doubts	9.00	0.63
Helped me to communicate better with significant persons	8.91	0.70
Helped me to live better my own life	8.91	0.94
Helped me to be less afraid of eventually new relationship	8.00	1.09
Helped me to be aware of my personal meanings	9.00	0.63
Helped me giving information about this process	9.00	0.63

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ANEXOS

ANEXO I

Normas para submissão de artigos portugueses

ANEXO II

Normas para publicação e submissão de artigos internacionais

Journal of Psychology & Psychotherapy
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3. Doroshenko V, Airich L, Vitushkina M, Kolokolova A, Livshits V, et al. (2007) YddG from Escherichia coli promotes export of aromatic amino acids. FEMS Microbiol Lett 275: 312-318.

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2. Zhang Z (2006) Bioinformatics tools for differential analysis of proteomic expression profiling data from clinical samples. Taylor & Francis CRC Press.

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1. Hofmann T (1999) The Cluster-Abstraction Model: unsupervised learning of topic hierarchies from text data. Proceedings of the International Joint Conference on Artificial Intelligence.

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