AVALIAÇÃO E INTERVENÇÃO EM SITUAÇÕES COMPLEXAS DE LUTO E TRAUMA

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Dissertação de Mestrado em Psicologia da Saúde e Neuropsicologia

Orientação: Professor Doutor José Carlos Rocha

Gandra, Dezembro de 2016

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Resumo

A experiência do luto e do trauma está, indubitavelmente, presente no nosso percurso enquanto seres humanos. É uma experiência dolorosa, intensa e potencialmente devastadora, merecendo especial relevância em termos de investigação e na prática clínica. Neste sentido, torna-se pertinente a investigação nesta área, focada na construção de instrumentos avaliativos, que posteriormente possibilitem uma intervenção mais direcionada para situações específicas de luto e trauma particularmente complexas.

O interesse neste âmbito surgiu no contexto de estágio curricular realizado no Centro Hospitalar do Tâmega e Sousa, E.P.E. Foi-me proporcionada a observação da intervenção realizada com pacientes em luto complicado, tanto a nível individual como a nível grupal.

A primeira parte desta dissertação consiste num manuscrito já submetido com o seguinte título: *Psychometric properties of the ICD-11 Trauma Questionnaire, Portuguese Version*, com o objetivo de traduzir e validar o questionário de avaliação do trauma complexo e para o qual foi utilizada uma amostra de 268 participantes, portugueses e angolanos, com exposição de, pelo menos uma vez, a um acontecimento traumático. Já a segunda parte consiste num artigo em submissão com o título: *Randomized Controlled Trial of a Cognitive Narrative Intervention for Complicated Grief in Psychiatric Outpatients*, tendo como objetivo avaliar a eficácia da terapia cognitiva-narrativa na redução de sintomas de luto complicado em pacientes psiquiátricos e para o qual foi utilizada uma amostra de 51 participantes, divididos em dois grupos, sendo o grupo de intervenção submetido a uma intervenção cognitiva narrativa.

Os resultados permitiram a obtenção de um instrumento com boas características psicométricas para avaliar sintomas mais complexos de exposição traumática, por outro lado, verificamos a boa eficácia da intervenção cognitivo-narrativa no luto complicado.

Palavras-chave: Intervenção cognitiva narrativa; Luto Complicado; Trauma; Trauma Complexo.

Abstract

The experience of grief and trauma is undoubtedly present in our journey as human beings. It is a painful, intense and devastating experience, deserving, therefore, special relevance in terms of research in clinical practice. In this sense, it becomes pertinent a continuity of research in this area, focused on the construction of evaluative instruments, which later enable a more targeted intervention for specific complex situations of grief and trauma.

The interest in this scope arose in the context of a curricular internship at the Tâmega e Sousa Hospital Center, E.P.E. I was able to observe the intervention performed with complicated grief patients, both individually and at group level. In addition to the previous interest in this area, this experience and the collaboration of the institution's professionals led to a more in-depth research on this subject.

The first part of this dissertation consists in the accomplishment of an article for submission with the following title: Psychometric properties of the ICD-11 Trauma Questionnaire, Portuguese Version, with the main purpose of translating and validating the complex trauma evaluation questionnaire, with a sample of 268 Portuguese and Angolan participants with at least one traumatic event exposure. The second part is an article in the process of submission with the title: Randomized Controlled Trial of a Cognitive Narrative Intervention for Complicated Grief in Psychiatric Outpatients, with a sample of 51 participants in complicated grief, allocated in two groups. The intervention group had a cognitive narrative intervention aiming to evaluate the effectiveness of cognitive-narrative therapy in reducing symptoms of complicated grief in psychiatric patients.

The results enabled the obtention of an instrument with good psychometric characteristics for assessment of most complex symptoms of traumatic exposure, also, we verified the good efficacy of cognitive-narrative intervention in complicated grief.

Keywords: Cognitive narrative intervention; Complicated Grief; Trauma; Complex Trauma.

PARTE I - Artigo submetido em revista: *Psychometric properties of the ICD-11 Trauma Questionnaire, Portuguese Version*.

Psychometric properties of the ICD-11 Trauma Questionnaire Portuguese Version

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Abstract

Objective: The ICD-11 Trauma Questionnaire (ITQ) is an instrument recently developed to evaluate Posttraumatic Stress (PTSD) and Complex Posttraumatic Stress (C-PTSD) symptoms based on the ICD-11 proposal. This is a multi-center international collaborative work, which aims to translate and back translate simultaneously this instrument in different languages considering the specific contexts related to complex traumatization. We focus in the Portuguese translation and validation of the ITQ in order to develop an instrument able to evaluate symptoms that transcend the existing literature and to verify its psychometric characteristics,

Method: Two instruments were applied: ICD-11 Trauma Questionnaire, that evaluates symptoms resulting from a traumatic life event; and Life Events Checklist (LEC), which evaluates stressful life events, in a sample of 268 Portuguese and Angolan participants.

The general features of the scales are described, reliability analysis and validity are performed. Results: Cronbach's alpha values varied between .84 and .88 and the exploratory factorial analysis results are consistent with C-PTSD construct with five components explaining 61.58% of scale variance.

Conclusion: Results suggest good psychometric characteristics for the Portuguese version of ITQ, which may be included in protocols that are intended for evaluation of complex traumatic symptoms.

Keywords: Traumatic Events; ICD- 11; PTSD; C- PTSD.

Introduction

The World Health Organization and the American Psychiatric Association generally define traumatic event as a personal experience from an episode that involves death, or threat of death or serious injury; through direct exposure, through witnessing, or through learning that occurred to close family member or friend, or through repeated extreme exposure to aversive details of events[1, 2]. Associated to those traumatic events, the individual may develop Posttraumatic Stress Disorder (PTSD). Therefore, in accordance with the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)[1] and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)[2]the diagnosis of PTSD necessarily involve exposure to a traumatic event with three or four groups of symptoms, respectively: re-experiencing the traumatic event (intrusive thoughts and images; recurrent dreams; psychological distress during situations resembling the event; feel or act as if the traumatic stressor were happening again- including delusions, hallucinations, dissociative flashback); avoidance, or emotional numbing, of stimulus associated with the traumatic event (avoid thoughts, feelings and situations associated with the stressor; psychogenic amnesia, significant decreased interest in activities; feeling of remoteness and strangeness towards others; restricted affection/emotional dullness; shortened vision of the future); and changes in neurovegetative reactivity (sleep disturbance, irritability or outbursts of anger, impaired concentration, hypervigilance, exaggerated startle response, physical reactions to stimulations reminiscent of the traumatic event); and only in DSM-5 there is the group of symptoms related to negative cognitive and mood alterations triggered by the traumatic exposure (inability to remember an important aspect of the traumatic event; persistent negative beliefs or expectations about oneself, other or the world; persistent negative emotional state).

However, several clinical reports and observations had difficulty on the classification of symptoms after accumulated or repeated traumatic exposures, considering a differ set of symptoms. Herman[3] argues that repeated exposure, or multiple traumatic events, may provide conditions for developing more complex symptoms, this is, not just PTSD symptoms but also symptoms that reflect affective and interpersonal disorders[3]. For Herman, Complex Posttraumatic Stress Disorder (C-PTSD) results from prolonged exposure to a social and / or interpersonal traumatic event in the context of any captive or trap, abandonment and depersonalization of self[3]. Certain risk factors for the development of C-PTSD include long-term traumatic exposure (months or years) to chronic victimization, and full loss of control for the other, as domestic violence and physical and sexual abuse of children[4, 5]. Thus, C-PTSD involves complex and reciprocal interactions between multiple biopsychosocial systems. Individuals with C-PTSD have increased risk for personality disorders with a significant risk of revictimization[5].

There are many tools available (and adapted to Portuguese) for assessment of PTSD symptoms, however there are no instruments to assess more complex symptoms. The fact that C-PTSD is a diagnosis not totally disseminated in clinical practice, the symptoms may be confused with symptoms of severe PTSD or not connected with previous traumatic history or confused with other conditions. Therefore, attempting to achieve a differential diagnosis, is necessary in the development of tools to differentiate the two concepts.

It is crucial to define the concept C-PTSD, in order to facilitate diagnosis and allow a proper treatment. DSM-IV reflections on disorders of extreme stress not otherwise specified was one of the first attempts to define the group of symptoms related to complex trauma[4, 6]. Cloitre et al.[7] looked for clusters of symptoms associated with

Complex PTSD and found three categories: Affect dysregulation, Negative self-concept and Interpersonal problems. Maercker et al.[8] formulation to ICD-11 clarifies the inclusion of difficulties in emotion regulation, diminished beliefs about oneself, defeated or worthless, and difficulties managing relationships.

Based on such assumptions, an international collaborative work enabled the simultaneous construction of several linguistic versions of the first instrument built to assess C-PTSD symptoms. The aim is to study the psychometric characteristics of the Portuguese version of ICD-11 Trauma Questionnaire (ICD-TQ)[9], as the general characteristics of the scales, reliability and dimensionality analysis. Moreover external validity could be provided based on primary hypothesis that cumulative traumatic exposure is positively correlated with C-PTSD symptoms.

Method

Study design

This research was based cross-sectional study, aiming to study the psychometric characteristics of the Portuguese version of ICD-11 Trauma Questionnaire, as the general characteristics of the scales, reliability and dimensionality analysis.

Procedures

After an informed consent procedure, the convenience sample was recruited both in Portugal and Angola, and included individuals with an history of exposure to at least one traumatic event.

Measures

For this purpose we used Life Events Checklist (LEC)[10], which evaluates exposure to stressful life events. LEC is the translation of a checklist of potentially traumatic events, being part CAPS interview, Portuguese version, for PTSD diagnose.

We used ICD-11 Trauma Questionnaire (ITQ), translated, back translated and adapted to the Portuguese from 1.0 and 1.2 English versions, after consensus work. This instrument aims to assess Posttraumatic Stress Disorder (PTSD) and Complex Posttraumatic Stress Disorder (C-PTSD) symptoms.

Participants

Two convenience samples, one with 110 Portuguese and another with 158 Angolans participants are described separately. The Portuguese sample is mostly made up of women, with 67 (60.9 %) women and 43 (39.1%) men, aged 16 to 69 years (M=30.25, SD=12.54). With regard to the education level of the Portuguese sample, 4.5% has completed elementary school, 20% basic school, 40 % has high school level of education and 35.5% higher education. In the Angolan sample we found 106 men (67.1 %) and 52 women (32.9%), aged between 18 and 70 years (M=36.85, SD=11.7). Concerning the education level, in the Angolan sample 31.6 % has basic school, 23.7 % has high school, and 44.7 % has higher education (Table 1).

Statistical analyses

Statistical procedures were performed in order to analyze: sample characteristics; the general characteristics of the scales; reliability and dimensionality by exploratory factor analysis and the external validity studies. To provide additional evidences of external

validity, it was performed a Pearson Correlation between the symptoms and the cumulative values of traumatic exposure.

Results

General characteristics of the scales

The ITQ is an instrument composed by two subscales (PTSD and C-PTSD). The PTSD symptoms are evaluated by 7 items and the C-PTSD evaluated by 17. Through the analysis of the general characteristics of the scales, we find that the Angolan sample (*M*=9.56; *SD*=4.87) presents higher results in PTSD subscale compared with the Portuguese sample (*M*=7.61; *SD*=4.87; Table 2).

Reliability Study

By analyzing the values of the level of internal consistency, Cronbach's alpha, we observe values of .882 for the C-PTSD scale and .839 for PTSD that, according to Pestana and Gajeiro[11], are considered good results of reliability (Table 3).

Analysis of dimensionality

Before being carried out the exploratory factor analysis, we calculated the Kaiser-Meyer-Olkin values (KMO=.88, which is considered a good value and adequate to perform factor analyses).

In the results of the varimax rotation (Table 4.), the F1 component items have semantic correspondence with the negative self-concept and interpersonal problems. Items from F2 component corresponds to symptoms of PTSD. The items of the F3 component correspond to symptoms of emotional numbing. The items of F4 component describe the affective dysregulation. Finally, the items of the component F5 correspond to control of impulsivity. This factorial solution explains 61.58% of the scale variance.

Evidence of external validity

An evidence of external validity with LEC is observed with the positive correlations between trauma, the sum of traumatic exposures history, and both PTSD and C-PTSD specific symptoms, respectively, $r=.284$ and $r=.266$ ($p<.01$).

Discussion

This study has the main purpose to validate the Portuguese version of ICD-11 Trauma Questionnaire, analyzing their subscales: C-PTSD and PTSD. Additionally, the aim was to analyze variables (such as gender, age, education and the number of traumatic exposures) which may contribute to the development of disorders associated with C-PTSD.

In the examination of the varimax rotation, we found that the items are grouped into five components. They are: negative self-concept (F1); PTSD symptoms (F2); emotional numbing (F3); affective dysregulation (F4); and control of impulsivity (F5).

The results are consistent with existing literature, which states that the PTSD and the C-PTSD are characterized by exposure to a traumatic event and three groups of symptoms, including: personal experience of an event that involves death, or the threat of death or serious injury, or threat to physical integrity; affective numbing / avoidance of stimuli associated with the trauma; restricted affection / emotional numbing; long-term trauma exposure (months or years) of chronic victimization, and full control each other as domestic violence and physical and children sexual abuse [4]. Most relevant is the clear separation of PTSD from the other groups of C-PTSD specific symptoms. Additionally, correlating C-PTSD symptoms with the number of exposures to potentially traumatic events, it is clear that the higher levels of exposures represent higher values on C-PTSD.

There is need for additional research providing a higher level of clarification for diagnostic criteria, maybe using a new golden standard interview for C-PTSD diagnosis and providing cut-off values. Another limitation, the variability of used samples can be considered both a positive and a negative aspect. Positive considering the high level of generalization on different cultural backgrounds; negative, because the diversity of

exposure and other social characteristics limit here the conceptual discussions about C-PTSD. Nevertheless, the focus is mainly related with the usability and psychometric appropriateness of the scale in different cultural settings. Future developments using specific samples should provide additional data of the concepts and processes underlying complex traumatization.

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Table 1

Sample Characteristics

	Portuguese (n=110)				Angolan (n=158)			
	n	%	*M*	*SD*	*n*	%	*M*	*SD*
Sex:							-	-
-Female	67	60.9%	-	-	52	32.9%		
-Male	43	39.1%	-	-	106	67.1%	-	-
Habilitations:								
-Elementary School	5	4.5%	-	-	0	0.0%	-	-
-Basic School	22	20%	-	-	12	31.6%	-	-
-High School	44	40.0%	-	-	9	23.7%	-	-
-Higher Education	39	35.5%	-	-	17	44.7%	-	-
Age	-	-	30.25	12.54	-	-	36.85	11.70
Number of traumatic exposures	-	-	1.37	1.03	-	-	3.85	3.05

Table 2

Descriptive values of the General characteristics of scales in both samples

		Portuguese		Angolan			
	Items	*M*	*SD*	*M*	*SD*	*t*	*p*
ICD-11 PTSD	7	7.61	6.72	9.56	4.87	2.71	.007
ICD-11 C-PTSD	17	16.60	11.75	16.01	9.15	.44	.664

Table 3

Cronbach's alpha values of internal consistency

	Cronbach's Alpha
PTSD	.839
C-PTSD	.882

Table 4

Values of the total saturation for each item on the varimax rotation, including on same level PTSD and C-PTSD items.

	PTSD and C-PTSD				
Item	F1	F2	F3	F4	F5
PTSD 1		.594			
PTSD 2		.536			
PTSD 3		.705			
PTSD 4		.741			
PTSD 5		.774			
PTSD 6		.632			
PTSD 7		.636			
C-PTSD 1				.624	
C-PTSD 2				.751	
C-PTSD 3				.569	
C-PTSD 4					.769
C-PTSD 5					.821
C-PTSD 6			.463		
C-PTSD 7			.594		
C-PTSD 8			.581		
C-PTSD 9			.722		
C-PTSD 10	.460				
C-PTSD 11	.751				
C-PTSD 12	.789				
C-PTSD 13	.790				
C-PTSD 14	.638				
C-PTSD 15	.704				
C-PTSD 16	.752				
C-PTSD 17	.712				

PARTE II - Ensaio clinico randomizado controlado (RCT), em formato de artigo para submissão em revista: *Randomized Controlled Trial of a Cognitive Narrative Intervention for Complicated Grief in Psychiatric Outpatients.*

Short title: Complicated Grief Intervention in Psychiatric Outpatients

Randomized Controlled Trial of a Cognitive Narrative Intervention for Complicated Grief in Psychiatric Outpatients

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Abstract

Objective: The use of narrative interventions has positive results in bereavement. However, the complex overlapping grief reactions in psychiatric outpatients challenges the overall efficacy of this intervention. The aim is to evaluate the effectiveness of cognitive-narrative intervention in reducing symptoms of Complicated Grief (CG).

Method: Longitudinal randomized controlled clinical trial with 51 participants allocated in two groups: control group and intervention group in two assessments (baseline before intervention and a follow-up three months after). Both with Socio-Demographic Questionnaire, Inventory of Complicated Grief, Center for Epidemiologic Studies Depression Scale, ICD-11 PTSD Questionnaire. The intervention group has the four session cognitive narrative manualized intervention.

Results: There are no baseline differences between groups for the main and secondary outcome measures. However, analyzing baseline-follow-up evolutions between groups, there are positive effects sizes for CG, Traumatic stress and Depression, between 0.94 and 0.40.

Conclusions: This intervention for the psychiatric out-patients with complicated grief is effective.

Keywords: complicated grief, depression, trauma, psychiatric outpatients, cognitive narrative intervention.

Introduction

Death is part of the human development process and is inevitably present in our daily lives. Live implies the establishment of attachments and possible disruptions of meaningful relationships, which results in loss experience. There are numerous possibilities to lose something or someone that has importance to us humans. The death of a loved one, divorce, dismissal, loss of a limb and the prospect of death itself are examples of experiences of loss to which we respond with reactions that characterize the grieving process.

When the loss suffered is full accepted, and people keep the ability to continue life regularly, we are talking about "normal grief" (Bonanno, 2001; Parkes, 2006). For the realization of the this process is important carry out certain tasks, including the recognition of loss and exploitation of its meaning, expressing the feelings of loss, as well as report the changes this causes in the world of the bereaved (Carvalho, 2006).

However, when this process is not experienced this way, we talk about of a complicated grief situation, "*if there is exacerbation of the grieving process with a long, along the obsessiveness characteristics, it creates a complicated grieving process*" (Flach, Lobo, Potter, & Lima, 2012, p. 88).

There is a strong evidence that individuals who are in a chronic or severe bereavement above share a common profile, in so far have an ambivalent relationship with the person who died, because are unable to accept loss and progressing with their lives (Silva, 2004). Thus, the term Complicated Grief (CG) designates a prolonged and intense pain associated with significant impairment of health syndrome, work and social individual functioning (Zisook & Shear, 2009). It may also be defined as the combination of separation anxiety with cognitive, emotional and behavioral symptoms

developed after the loss (Wittouck, Van Autreve, De Jaegere, Portzky & Van Heeringen, 2011).

According to Boelen, Bout and Hout. (2003), despite the loss of a loved one generally be regarded as one of the most stressful life events that a person may experience, the majority of individuals recover from loss without professional assistance. However, some people do not recover, experiencing constant changes in mental health. The most common comorbidities include depression, symptoms of post-traumatic stress disorder (PTSD) and other anxiety disorders, anger and guilt (Bonanno & Kaltman *cit. in* Boelen, Bout & Hout, 2003).

There are many investigations that are dedicated to the clarification of co-morbidity between the CG and other psychiatric disorders (Major Depression Disorder, PTSD and anxiety disorders) (Horowitz, 1986; Zuckoff et al., 2006), to try to clarify what factors permit the distinction of CG as psychiatric disorder (Golden & Dalgleish, 2010; Prigerson et al., 2009; Simon et al., 2007).

In order to clarify the relationship between CG and psychopathology, have been made so far two relevant scientific studies which clarify the presence of complicated grief in psychiatric patients. Piper et al. (2001) conducted a study to explore the prevalence of significant losses and CG in psychiatric patients. They found that in a sample of 235 psychiatric patients, there was 60% prevalence of Complicated Grief.

Kersting et al. (2009) evaluated 73 psychiatric patients diagnosed with depression. This study found that 96% of the sample had significant history of loss and that among patients with complicated grief, the most common kinship degree was related to the loss of a close relative (parent, sibling or spouse). In addition, patients with depression and complicated grief showed higher levels of depressive and post-

traumatic stress symptomatology related with loss, and higher levels of psychopathological symptoms than depressed patients without complicated grief.

The use of narratives have shown positive results in intervention with individuals grieving (Parkes, 2006; Currier, Neimeyer & Berman, 2008) and the expression of emotions (Stroebe, Schut & Stroebe, 2005) and thoughts have positive therapeutic effects (Pennebaker et al., 1988). The use of creative metaphors promotes the reconstruction of meanings (Gonçalves, 1994; Gonçalves 2002a), taking into account a care use of sensory memories because of the risk of PTSD (Rocha, 2004), it is possible building an appropriate grieving narrative.

Cognitive narrative perspective emphasizes the power of the word and sees the individual as a builder of their experiences through storytelling (Gonçalves, 2002b). The complexity, multiplicity and narrative power, lead to a better psychological well-being and overall health (Pennebaker, 1997; *cit. in* Rocha, 2004).

During the complicated grief process, people can experience many symptoms (Kristjanson, Lobb, Aoun, & Monterosso, 2006): sadness, loss of interest, intrusive thoughts, and we can be in the presence of similar criteria to those of other disorders such as Major Depressive Disorder (Zisook, Shuchter, Sledge, Paulus, & Judd 1994), Post-Traumatic Stress Disorder (Schut, de Keijser, Van Den Bout, & Dijkhuis, 1991) or other anxiety disorders (Jacobs et al., 1990). Thus, CG patients may experience higher levels of depression, anxiety and post-traumatic stress disorder associated with loss compared to patients without CG (Piper et al., 2001; Kersting et al., 2009).

Simon et al. (2007), found that in addition to CG, 55% of the sample of their study showed PDM and 49% met criteria for PTSD (Silva, 2010). It found that 70.9% of psychiatric patients have CG and PDM, 73.6% have CG and PTSD, and there is a triple comorbidity between CG, PDM and PTSD of 69%.

In this study, the main objective is to evaluate the effectiveness of a cognitive narrative intervention, made in 4 sessions, to verify if this therapy is capable of reduce complicated grief, depression and psychotraumatic symptoms in psychiatric outpatients, examining differences between IG and CG.

Method

Trial Design

Is a longitudinal randomized controlled clinical trial and the aim of this study was to evaluate the effectiveness of cognitive-narrative intervention in reducing symptoms of grief, depression and trauma. The main outcome variable is complicated grief, and the secondary are depression and psychotraumatic symptoms. Repeated measures, including ICG, CES and ITQ, were used.

After received the authorization from the ethics committee of the hospital, fifty-one bereaved persons were contacted and sequentially randomized allocated in two groups: control group and intervention group in two assessments (baseline before intervention and a Follow-up three months after). This randomization consisted of the following phases: (1) participants were recruited by psychiatric medical staff identifying patients with signs of complicated grief; (2) a preliminary assessment with ICG, identified the patients above the cut-off value for CG (3) informed consent procedure for eligible patients; (4) participants were randomly sequentially allocated to the control (waiting list) and to intervention group; (5) both groups were subjected to a semi-structured interview (SQD) and three instruments -ICG, CES and ITQ- at baseline, before intervention; (6) finally, at follow-up, three months after, the evaluation was repeated in the same conditions on both groups. Meanwhile, the experimental group also had the four weekly sessions of the cognitive narrative manualized intervention.

Intervention: Manualized cognitive narrative program for complicated grief

This manual is based on the Gonçalves, Machado, and Rosas (1997) and Barbosa, Sá & Rocha (2013).

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. The four sessions involved: 1) recall, whose objective is the loss of the significance of understanding the patient's life and the promotion of the memory of a specific episode for loss; 2) a session which will be due to speak of the emotional and cognitive subjectivity, giving space to the exploration of the emotional aspects and the multiplicity and diversity of cognitive experiences of loss; 3) metaphorization, where the goal is the exploration of different meanings for the episode of grief and the choice of a metaphor through which the redundancies of narrative expression configure a variety of meanings, and 4) a projection session, where the therapist directs the patient to a continuous process of metaphors productions, be aware of the importance of his narrative capacity and uniqueness of their this consciousness to the grief experience.

Therapists

The therapists are independent from the main research team and were subjected to training on the manualized intervention. The intervention was monitored and supervised, in order to guarantee the consistency and adherence to the manual.

Sample size

The selected sample is composed of 51 participants with ages between 18 and 64 years (*M*=46.41; *DP*=10.25) with complicated grief. The participants were blindly, randomly sequentially allocated to two groups: control group (n=20) and intervention group (n=31) (Figure 1). Both groups experienced bereavement and had social-demographic and clinical similarities (Table 1). Those who fulfilled the following

inclusion criteria were eligible: (1) have results in ICG > 30 points (cut off), (2) have more than 18 years, (3) bereavement more than six months ago.

Outcome measures

Complicated grief symptoms: It was used the *Inventory of Complicated Grief* (ICG), that consists of a list of symptoms associated with CG, helps to distinguish between CG (cutoff total ICG > 30) and not complicated grief when applied 6 months or more after the death of loved one (Zuckoff et al., 2006). Consists of 19 items in a Likert scale [0-4] (0 = never, 1 = rarely, 2 = sometimes, 3 = often 4 = always) (Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka, & Miller, 1995). The ICG has good psychometric characteristics in terms of fidelity: Cronbach's alpha = 0.91 (Frade et al, 2010; Silva, 2010) and shows a multidimensional structure with five factors: the first presents traumatic difficulties, the second refers to separation difficulties, the third dimension corresponds to the denial, the room is related to psychotic dimension and the fifth factor suggests depressive dimension (Frade, Sousa, Pacheco and Rocha, 2010).

Depressive symptoms: The instrument used to assess depression was the *Center for Epidemiologic Studies Depression Scale* (CES-D), with a little structure, applied to brief and appropriate interviews to different subgroups of the population, assess depressive symptoms at different ages (Radloff, 1977; Filho & Teixeira, 2011). Scores range from 0 to 60, with high scores indicating greater depressive symptoms. The CES-D also provides cutoff scores (e.g., 16 or greater) that aid in identifying individuals at

risk for clinical depression, with good sensitivity and specificity and high internal consistency (Lewinsohn, Seeley, Roberts, & Allen, 1997).

Psychotraumatic symptoms: The ICD-11 Trauma Questionnaire (ITQ) is designed to evaluate the post-traumatic stress disorder (PTSD), Complex Post-Traumatic Stress (C-PTSD) and symptoms of Borderline Personality (BPD). It has good psychometric characteristics and can be included in protocols that are intended to be used in cases of traumatic high exposure to clarify the most complex consequences (Soares, 2015). This instrument was translated and validated to Portuguese with Cronbach's alpha of .882 for the C-PTSD scale and .839 for PTSD and 68.71% of the variance was explain with a five factors structure (Rocha, Azevedo, Rodrigues, Machado, Soares & Cloitre, 2016).

Statistical method

To assess the differences between the groups at complicated grief, depression and the traumatic stress symptoms, we performed independents samples *t*-test and effect sizes. We also calculated delta values (Follow-up – Baseline) to clarify the changes in outcome measures over the longitudinal profile (Table 2). To calculate the effect size (ES), we use the Cohen’s d value, considered to be the most suitable.

Results

An analysis and comparison of results between the two groups (CG and IG), at baseline assessment and at follow-up (3 months) was performed.

To assess the differences between the groups, was used *t-test* for independent samples and it was found that on baseline there are no statistically significant differences between the two groups for CG (p=.958), depression (p=.379) and traumatic stress (p=.838) values.

Regarding the follow-up assessment, there are statistically significant differences between groups for CG (p=.005) and depression (p=.037). For the variable traumatic stress, there are no statistically significant differences between the two groups in the evaluation of follow-up, however, there are differences in the averages, and the intervention group experienced values much lower than the control group (IG, *M*=9.58, *SD*=6.33; CG, *M* = 13.60, *SD*=8.23;).

Analyzing the results of follow-up, there was a large effect between the GI and the CG with respect to CG (*d*=0.835), and a moderate effect with respect to the depression (*d*=0.603) and traumatic stress (*d*=0.547). As for the initial evaluation, the *d* Cohen showed us that there is little or no effect related to allocation. Nevertheless, the delta values (difference between follow-up and baseline) are a more appropriate way to compare effects on the longitudinal profile intercepting between groups. Comparing the delta values for CG, between groups, we find and an effect size of .002 for CG, for Depression .176, and .076 for Traumatic stress.

Conclusions

For many bereaved people, their grief experiences are lived in silence, either by social and family imposition or ignorance of its disastrous long-term consequences, which leads to much of the affected population does not receive the care suitable health (Parkes, 1998, 2006; Stroebe et al, 2005, 2006).

According with some studies, to solve the CG symptoms, a psychotherapeutic intervention is necessary (Prigerson et al, 1995; .Wittouck et al, 2011.). Thus, most of the participants can improve the symptoms of your experience when subjected to a cognitive narrative therapy (Gonçalves, 1998, 2000, Niemeyer, 2000: Pennebaker et al, 1988; Boelen, Keijser, Hout & Bout, 2007; Greenberg, 2002).

This brief randomized controlled trial evaluated the effectiveness of four-session cognitive narrative intervention, reducing complicated grief, depressive and traumatic symptoms in bereaved participants and examines differences between the two groups at baseline and follow-up three months after therapy.

The results of this study reinforce the idea that participants can improve the symptoms of your experience when subjected to cognitive-narrative therapy (Gonçalves, 1998, 2000, Niemeyer, 2000; Pennebaker et al, 1988; Boelen, Keijser, Hout & Bout, 2007; Greenberg, 2002).

The study of Peri, Hasson-Ohayon, Garber, Tuval-Mashiach, and Boelen (2016) also meet our results, saying that evaluations conducted before and after treatment, and at a 3-month follow-up, demonstrated the effectiveness of narrative reconstruction in reducing symptoms of complicated grief and depression.

Our results are consistent with the meta-analyses of Wittouck *et. al* (2011). The results of this meta-analysis conclude that there is a difference between effects of preventive and treatment strategies for CG, favoring treatment strategies. Recent

treatment interventions for CG were designed more appropriately and have proved to be efficacious.

Nevertheless, there is some limitations to consider. The major limitation of this research is related to the impossibility of making a safe generalization to psychiatric patients in general, due to issues related to the sample size and to the fact that sample is mostly composed by women. The predominant representation of females in the studies may limit the generalization of results to men (Wittouck *et al*., 2011).

However, taking into account the prevalence of devastating consequences of CG, this type of study should be continued with the use of larger samples and long-term follow-up periods.

Furthermore, it would be interesting to continue this investigation and perform a more specific approach to the development of Complicated Grief in different groups of psychiatric disorders to complement all the results.

This research design in a collaborative environment with hospitals revealed very positive. However, there are ethical limitations for a control group when the public services are beginning to offer new support services. Treatment as usual (or waiting list) control group was limited in the number of patients, this aspect can be circumvented in future research using alternative interventions as control groups. Nevertheless, we explored the maximum results considering this limitation.

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Table 1

Sociodemographic and clinical characteristics of CG (n=20) and IG (n=31)

	Control Group				Intervention Group			
Characteristics	*n*	%	*M*	*DP*	*n*	%	*M*	*DP*
Gender								
Female	19	95.0			28	90.3		
Male	1	5.0			3	9.7		
Profissional Situation								
Employee	4	21.1			10	34.5		
Attest	6	31.6			7	24.1		
Unemployed	9	27.1			9	31.1		
Retired	0				2	6.9		
Marital Status								
Not Married	2	10.0			7	23.3		
Married	12	60.0			18	60.0		
Widow(er)	0	0.0			1	3.3		
Divorced	6	30.0			4	13.3		
Education level (in years)								
Between 4 and 6 years	17	85.0			13	41.0		
Between 9 and 12 years	3	15.0			14	45.2		
More than 12 years	0	0.0			4	12.9		
Loss suffered								
Spouse	5	25.0			3	10.0		
Son	5	25.0			5	16.7		
Father	5	25.0			9	30.0		
Mother	3	15.0			11	36.7		
Psychiatricmonitoring								
Yes	6	30.0			10	34.5		
No	14	70.0			19	65.6		
Death type								
Sudden death	3	15.0			7	22.6		
Chronic disease	11	55.0			17	54.8		
Accident	3	15.0			3	9.7		
Suicide	2	10.0			4	12.9		
Funeral								
Yes	15	75.0			26	83.9		
No	5	25.0			5	16.1		
Age of lost person			52.2	23.34			56.8	20.54
Time from loss (mounths)			53.2	99.08			44.8	43.68

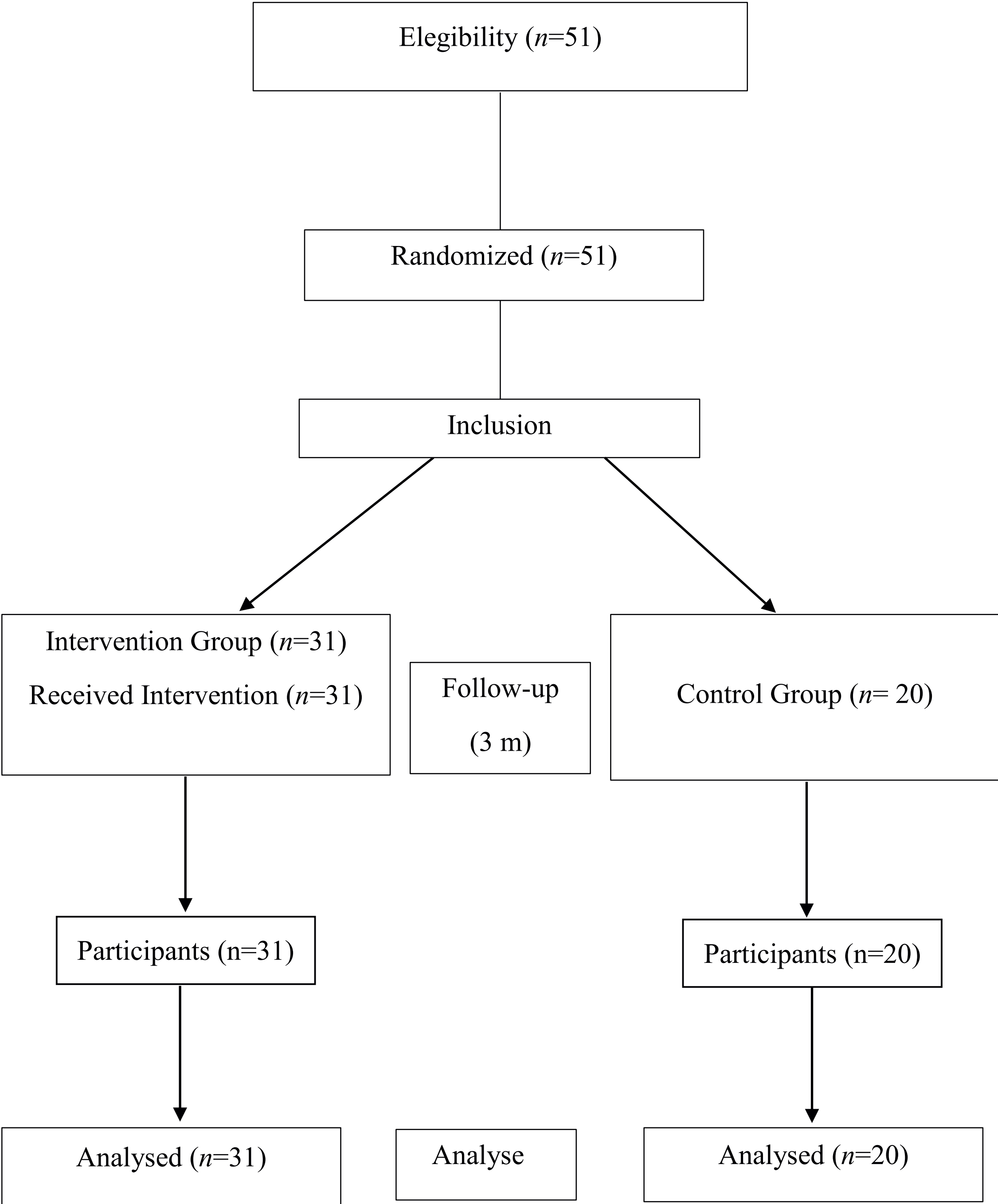
Table 2

Complicated grief (ICG), Depression (CES-D) and Trauma (ITQ). Comparing between CG and IG baseline and follow up

	Control Group		Intervention Group				
	M	*SD*	*M*	*SD*	*t*	p	*Cohen's d*
ICG baseline	45.35	9.49	45.52	11.63	0.05	.958	0.009
ICG follow up	41.05	15.48	28.39	14.91	2.92	.005*	0.835
CES baseline	30.80	9.97	27.97	11.80	0.89	.379	0.266
CES follow up	30.89	14.14	23.39	10.49	2.15	.037*	0.603
ICD baseline	15.89	6.15	15.53	5.86	0.21	.838	0.066
ICD follow up	13.60	8.23	9.58	6.33	1.97	.055	0.547
Δ Grief	4.30	10.80	17.13	14.94	3.32	.002*	0.984
Δ Depression	.26	10.85	4.58	10.74	1.37	.176	0.400
Δ Trauma	2.00	6.77	5.87	7.56	1.82	.076	0.539

* $p < 0.05$

Figure 1. *Flow diagram of participants in each phase of investigation*



ANEXOS

Anexo I – Normas para submissão na Revista Brasileira de Psiquiatria

RBP
Revista Brasileira de Psiquiatria
Official Journal of the Brazilian Psychiatric Association

ISSN 1516-4446 *printed version*
ISSN 1809-452X *online version*

INSTRUCTIONS TO AUTHORS

- Aim and editorial policy
- Manuscript preparation
- Manuscript submission

Aim and editorial policy

Revista Brasileira de Psiquiatria is a quarterly publication that aims to publish original manuscripts in all areas of psychiatry, including public health, clinical epidemiology, basic science, and mental health problems. The journal is fully open access, and there are no publication fees. Articles should be written in English.

These instructions were written based on the Uniform Requirements for Manuscripts Submitted to Biomedical Journals: Writing and Editing for Biomedical Publications, edited by the International Committee of Medical Journal Editors (ICMJE). The original document is available at http://www.icmje.org/.

Revista Brasileira de Psiquiatria supports the clinical trial registration policies of the World Health Organization (WHO) and the ICMJE, recognizing the importance of such initiatives for the registration and disclosure of trial results to the international community through open access. According to this recommendation and to the BIREME/OPAS/OMS guidelines for journals indexed in the LILACS and SciELO databases, ***Revista Brasileira de Psiquiatria*** will only accept for publication clinical trials that have been registered in Clinical Trials Registries that meet the WHO and ICMJE requirements (URLs available athttp://www.icmje.org/faq_clinical.html; a Brazilian registry is also available at http://www.ensaiosclinicos.gov.br/). The clinical trial registration number should be informed at the end of the abstract.

Peer review process

The selection of manuscripts for publication is based on their originality, relevance of the topic, methodological quality, and compliance with these instructions. All manuscripts considered for publication are peer-reviewed by anonymous external referees. Whenever possible, an editorial decision (acceptance, revisions required, or rejection) will be made within one month after submission.

Manuscript preparation

Revista Brasileira de Psiquiatria publishes original articles, brief communications, review articles, update articles, editorials, and letters to the Editor. Consult a current issue of the Journal for style and format. The text should be double-spaced with broad margins.

Original articles, review articles, update articles, and brief communications all follow the format described below.

Title page: Full title, authors' names, their departments and institutions, including the city and country of origin. Please also include a running title with a maximum of 50 characters (letters and spaces). The full name, telephone number, fax number, e-mail address and full postal address of the corresponding author should be stated.

Page 2: A structured abstract not exceeding 200 words with the following sections: Objective, Methods, Results, and Conclusion. Please indicate three to five keywords in strict accordance with Medical Subject Headings.

Main text: The Introduction should be one to three pages long (do not extensively review the literature), concluded by a clear statement of the aims of the study. A thorough Methods section should include study design, setting, participants, main outcome measures, statistical analyses, trial registration, ethics committee approval, and informed consent procedures (avoid referring to design, method and material described in previously published articles). Results should be clear; repetition of data in the text and in tables/figures is not allowed. Discussion: Do not include a conclusion section; concluding remarks should be presented in the final paragraph of the text.

Acknowledgements: Should include grants, sponsorships and other types of support provided to the study. Some authors may wish to thank collaborators who contributed significantly to the manuscript but do not fulfill authorship criteria. It is the responsibility of the author to obtain permission from the persons mentioned.

Disclosure: Each author should disclose potential conflicts of interest in general, not only related to the present study. Examples include but are not limited to previous or current jobs/positions, research grants, speaker's honoraria, ownership interest, and work as a consultant or advisory board for organizations. Studies that in any way involve pharmaceutical companies or other private or public enterprises should clearly disclose the role of these organizations in the study. Moreover, if the study in any way investigates pharmaceutical compounds, the Disclosure should contain information about by whom and which institutions the statistical analyses were performed and an e-mail address where to obtain the protocol.

Reference list: References should be kept to the pertinent minimum and should be numbered consecutively in the order in which they appear in the text, in accordance with the Vancouver system. We recommend the use of a tool such as Reference Manager or Endnote for reference management and formatting. Identify references in text, tables, and legends using superscript Arabic

numerals. References cited only in tables or figure legends should be numbered in accordance with their first citation in the text.

Please observe the style of the examples below. To include manuscripts accepted, but not published, inform the abbreviated title of the journal followed by (in press). Papers published electronically, but not yet in print, should be identified by their DOI number. Information from manuscripts not yet accepted should be cited only in the text as personal communication. Reference accuracy is the responsibility of the authors. Journal titles should be abbreviated in accordance with Index Medicus.

Examples:

Standard journal article: List all authors when six or fewer. When there are seven or more, list only the first six authors and add "et al.". Coelho FM, Pinheiro RT, Silva RA, Quevedo LA, Souza LD, Castelli RD, et al. Major depressive disorder during teenage pregnancy: socio-demographic, obstetric and psychosocial correlates. Rev Bras Psiquiatr. 2013;35:51-6.

Book: Gabbard GO. Gabbard's treatment of psychiatric disorders. 4th ed. Arlington: American Psychiatric Publishing; 2007.

Book chapter: Kennedy SH, Rizvi SJ, Giacobbe P. The nature and treatment of therapy-resistant depression. In: Cryan JF, Leonard BE, editors. Depression: from psychopathology to pharmacotherapy. Basel: Karger; 2010. p. 243-53.

Theses and dissertations: Trigeiro A. Central nervous system corticotropin releasing factor (CRF) systems contribute to increased anxiety-like behavior during opioid withdrawal: an analysis of neuroanatomical substrates [dissertation]. San Diego: University of California; 2011.

Tables and figures: All figures/tables should clarify/complement rather than repeat the text; their number should be kept to a minimum. All illustrations should be submitted on separate pages, following the order in which they appear in the text and numbered consecutively using Arabic numerals. All tables and figures should include descriptive legends, and abbreviations should be defined. Any tables or figures extracted from previously published works should be accompanied by written permission for reproduction from the current copyright holder at the time of submission.

Abbreviations and symbols: All terms or abbreviations should be spelled out at first mention and also in table/figure legends. All units should be metric. Avoid Roman numerals.

Supplementary material online

Revista Brasileira de Psiquiatria does not publish supplementary or supporting material online.

Manuscript categories

Original articles: These should describe fully, but as concisely as possible, the results of original research, containing all the relevant information for

those who wish to reproduce the research or assess the results and conclusions. Original manuscripts should not exceed 5,000 words, excluding tables, figures, and references. No more than six tables or figures, and a maximum of 40 references, will be accepted. The text should be organized in the following sections: Introduction, Methods, Results, and Discussion. Clinical implications and limitations of the study should be stated. Randomized clinical trials should be registered in online clinical databases (the clinical trial registration number should be informed at the end of the abstract).

Brief communications: Original but shorter manuscripts addressing topics of interest in the field of psychiatry, with preliminary results or results of immediate relevance. These papers should be limited to 1,500 words, one table or figure, and 15 references.

Review articles: These articles are preferably solicited (by the Editors) from experts in the field. They are systematic, critical assessments of

literature and data sources, aimed at critically reviewing and evaluating existing knowledge on a designated topic, in addition to commenting on studies by other authors. The search strategy and selection process (including inclusion/exclusion criteria) should be described in detail. Review articles are limited to 6,000 words, excluding tables, figures and references. The total number of tables and figures may not exceed six.

Update articles: Update articles address current information relevant to clinical practice and are less comprehensive than review articles. Update articles should be no longer than 2,000 words and 30 references.

Editorials: Critical and in-depth commentary invited by the Editors or written by a person with known expertise in the topic. Editorials should not exceed 900 words and five references. A title page should be included as described above.

Letters to the Editor (maximum of four authors): Letters can contain reports of unusual cases, comments on relevant scientific topics, critiques of editorial policy, or opinions on the contents of the journal. Letters should include a maximum of 500 words, one table, one figure, and five references.

Author Statement

Authors of accepted manuscripts should complete the Author Statement below and send it to editorial@abpbrasil.org.br. To avoid any delays in publication, a signed form should be sent to the production office as soon as the manuscript is *accepted* for publication (not required upon submission). Production will not commence until the signed form is received.

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I, the undersigned author, certify that I and all other co-authors of the manuscript no. __________________, entitled ____, submitted for publication in ***Revista Brasileira de Psiquiatria***, have participated sufficiently in the intellectual content, data analysis, and writing of

the manuscript, and take public responsibility for it. Also, I and each of the co-authors have reviewed the final version of the manuscript, believe it represents valid work, and approve it for publication. On behalf of all coauthors, I certify that the manuscript has not been previously published or accepted for publication, nor is it currently under consideration for publication elsewhere, either in whole or in part.

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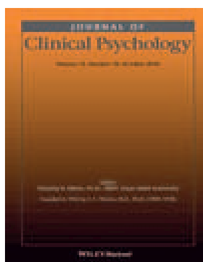
Anexo II – Normas para submissão na revista *Journal of Clinical Psychology*

Journal of Clinical Psychology



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Jackie Beggins
E-mail: jbeggins@wiley.com

ANEXO III - Resumo submetido, aceite e apresentado em comunicação oral no Congresso da Ordem dos Psicólogos Portugueses

Proposta de Avaliação e Reabilitação Neuropsicológica na Obesidade

FILIPA MENANO DE ALMEIDA, ENRIQUE VÁZQUEZ-JUSTO

Diagnóstico precoce de demência de Alzheimer: Contributo de baterias breves de avaliação do funcionamento executivo

HELENA MOREIRA, CÉSAR LIMA

Competências de Linguagem Oral em Crianças com Epilepsia Benigna de Infância com Pontas Centro-Temporais: Revisão Teórica

JOANA MARTA TEIXEIRA, MARIA EMÍLIA SANTOS

MESA 54

17:00 - 19:00 | SALA S. JOÃO

SIMPÓSIO

Psicopatologia na Contemporaneidade: Compreensão, Diagnóstico e Intervenção

JORGE GRAVANITA

COMUNICAÇÕES

Novas fronteiras do mal-estar na contemporaneidade

JORGE GRAVANITA

A metodologia clínica projectiva face aos novos desafios da

Ponto de Corte e Características Psicométricas do Inventário de Luto Complicado

VIRGIANA SOUSA, JOSÉ CARLOS ROCHA

Avaliação do Stress Traumático Complexo

VERÓNICA RODRIGUES, INÊS AZEVEDO, CÉLIA SOARES

Enquadramento geral da avaliação do Trauma e do Luto

JOSÉ CARLOS ROCHA

Título: **Avaliação do Stress Traumático Complexo**

Resumo: O ICD-11 Complex Trauma Questionnaire (ICTQ) é um instrumento desenvolvido originalmente por Cloitre, para avaliar os conceitos de Stress Pós Traumático (PTSD) e Stress Pós Traumático Complexo (C-PTSD). Esta investigação surge na sequência de um trabalho colaborativo internacional multicêntrico, que visa a tradução e retroversão deste instrumento em diferentes línguas. O objetivo desta investigação centra-se, assim, na tradução e validação do ICTQ, de forma a verificar as suas caraterísticas psicométricas, desenvolvendo um instrumento que avalie sintomas que transcendam a literatura já existente. Para o efeito foi selecionada uma amostra de conveniência com um total de 268 participantes. Foram aplicados dois instrumentos: ICD-11 Trauma Questionnaire, que avalia sintomatologia resultante de um acontecimento de vida traumático; e o Life Events Checklist (LEC), que avalia a exposição a acontecimentos de vida potencialmente traumáticos. São descritas as caraterísticas gerais das escalas, realizada uma análise de fidelidade e validade e, finalmente, apurados os resultados para cada fator da escala. Os resultados encontrados indicam boas caraterísticas psicométricas para a versão Portuguesa do ITQ, podendo este ser incluído em protocolos que se destinam à avaliação de sintomatologia traumática.