Alcina Juliana Soares Barros

Associações entre reações contratransferenciais desencadeadas por agressores sexuais, mecanismos de defesa e trauma vicário em psiquiatras e psicólogos forenses

Tese apresentada como requisito parcial para obtenção do título de Doutor em Psiquiatria, à Universidade Federal do Rio Grande do Sul, Faculdade de Medicina, Programa de Pós-Graduação em Psiquiatria e Ciências do Comportamento.

Orientador: Prof. Dr. Cláudio Laks Eizirik

Co-orientadora: Profa. Dra. Simone Hauck

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A Comissão Examinadora, abaixo assinada, aprova a Tese intitulada Associações entre reações contratransferenciais desencadeadas por agressores sexuais, mecanismos de defesa e trauma vicário em psiquiatras e psicólogos forenses, elaborada por Alcina Juliana Soares Barros, como requisito parcial para obtenção do Grau de Doutor em Psiquiatria.

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Este trabalho é dedicado aos que amo profundamente:

José de Anchieta Barros, pai e Regis Goulart Rosa, marido.

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“He had demonstrated, first, that men of unquestioned bravery could sucumb to overwhelming fear and, second, that the most effective motivation to overcome that fear was something stronger than patriotism, abstract principles, or hatred of the enemy. It was the love of soldiers for one another.”

Judith Lewis Herman

Trauma and Recovery

RESUMO

A avaliação de criminosos sexuais por psiquiatras e psicólogos forenses consiste em atividade específica que envolve desafios intelectuais e emocionais aos peritos. Esses profissionais trabalham diretamente com indivíduos que cometeram atos graves, que violaram o corpo e as emoções de suas vítimas, de modo profundo, estando expostos ao risco de trauma vicário, um subtipo de trauma psicológico indireto. Pouco se sabe, entretanto, sobre as repercussões desse tipo de avaliação na vida pessoal e profissional dos peritos. Assim, a tese aqui apresentada tem o objetivo de examinar as associações entre sentimentos contratransferenciais desencadeados por criminosos sexuais, mecanismos de defesa e manifestações do trauma vicário em psiquiatras e psicólogos forenses. A primeira etapa desse trabalho consistiu na revisão da literatura acerca de contratransferência e sua expressão no setting pericial, mecanismos de defesa e trauma vicário, tendo sido realizado um estudo exploratório com peritos psiquiatras. Ao se verificar que a versão brasileira da escala de avaliação de trauma vicário - a Trauma and Attachment Belief Scale (TABS) – ainda não se encontrava disponível, um estudo foi realizado para sua tradução, adaptação transcultural e validação aparente. Em seguida, o estudo principal, com delineamento transversal e utilizando métodos mistos, foi conduzido com 56 psiquiatras e psicólogos forenses brasileiros, entre outubro de 2016 e maio de 2017. Reações contratransferenciais, mecanismos de defesa e trauma vicário foram avaliados usando a Escala de Avaliação de Contratransferência (ACS), o Defensive Style Questionnaire (DSQ-40) e a TABS, respectivamente. A grounded theory (GT) foi utilizada na análise qualitativa, através de um questionário auto-aplicado, a fim de compreender a influência da avaliação de agressores sexuais na vida profissional e pessoal dos peritos. Correlações positivas foram identificadas entre sentimentos de indiferença e trauma vicário e entre mecanismos de defesa imaturos e trauma vicário. Essas correlações foram muitos fortes no subgrupo de peritos sem história de psicoterapia pessoal. A investigação qualitativa demonstrou que ocorreram mudanças na identidade profissional dos peritos, na visão de mundo e nas crenças relacionadas à segurança e confiança. Concluiu-se que estratégias específicas maladaptativas de enfrentamento, tais como sentimentos de indiferença e defesas imaturas, durante a avaliação de criminosos sexuais, estiveram associadas com manifestações de trauma vicário em psiquiatras e psicólogos forenses.

Palavras-chave: Contratransferência. Criminosos. Mecanismos de defesa. Psicoterapia. Trauma psicológico.

ABSTRACT

The assessment of sex offenders by forensic psychiatrists and psychologists consists in a specific activity that involves intelectual and emotional challenges to experts. These professionals work directly with individuals who have committed serious acts that violated the body and emotions from their victms, in a profound way, being exposed to the risk of vicarious trauma (VT), a subtype of indirect psychological trauma. Little is known, however, about the implications of this type of assessment in personal and professional lives of experts. Thus, the thesis presented here aims to examine the associations between countertransference reactions aroused by sex offenders, defense mechanisms and manifestations of vicarious trauma in forensic psychiatrists and psychologists. The first step of this work consisted in a review of literature about countertransference and it's expression in a forensic setting, defense mechanisms and vicarious trauma, and we have conducted an exploratory study with forensic psychiatrists. Since it was verified that a Brazilian version of the assessment scale of vicarious trauma - the Trauma and Attachment Belief Scale (TABS) - was not yet available, a study was performed for its translation, cross-cultural adaptation, and apparent validation. Then, the main study, using a cross-sectional design and mixed methods, was conducted with 56 Brazilian forensic psychiatrists and psychologists, between October 2016 and May 2017. Countertransference reactions, defense mechanisms and vicarious trauma were assessed using the Assessment of Countertransference Scale (ACS), the Defensive Style Questionnaire (DSQ-40) and the TABS, respectively. The grounded theory (GT) was used in qualitative analysis, by means of a self-report questionnaire, in order to understand the influence of the assessment of sexual aggressors in professional and personal life of experts. Positive correlations were found between feelings of indifference and vicarious trauma and between immature defense mechanisms and vicarious trauma. These correlations were very strong in a subgroup of experts without a history of personal psychotherapy. Qualitative data showed changes in the professionals' identity, worldview and beliefs related to safety and trust. It was concluded that specific maladaptive coping strategies such as feelings of indifference and immature defenses during the assessment of sex offenders were associated with manifestations of vicarious trauma in forensic psychiatrists and psychologists.

Keywords: Countertransference, criminals, defense mechanisms, psychotherapy, psychological trauma

LISTA DE ABREVIATURAS E SIGLAS

ACS	Assessment of Countertransference Scale
BT1	Back-translation 1
BT2	Back-translation 2
DSQ-40	Defensive Style Questionnaire-40
EACT	Escala para Avaliação da Contratransferência
GT	Grounded theory
G1	Group 1
G2	Group 2
ICB	Inventory of Countertransference Behavior
IQR	Interquartile range
MSRS	Mental States Rating System
O	Original scale
PCL-C	Posttraumatic Stress Disorder Checklist-Civilian Version
PC-PTSD	Primary Care PTSD
PF1	Single final version 1
PF2	Single final version 2
PTSD	Posttraumatic stress disorder
P1	Translation 1
P2	Translation 2
SD	Standard deviation
SPAN	Startle, Physiological arousal, Anger, and Numbness
TABS	Trauma and Attachment Belief Scale
TV	Trauma vicário
UFRGS	Universidade Federal do Rio Grande do Sul
VAS	Visual Analog Scale
VT	Vicarious trauma

SUMÁRIO

1 INTRODUÇÃO

Psiquiatras e psicólogos forenses são profissionais desafiados quanto ao intelecto e emoções em seus trabalhos diários. A função primordial desses experts consiste em avaliar e compreender indivíduos, muitas vezes complexos, que cometeram uma variedade de crimes, sendo alguns dos examinados portadores de graves psicopatologias. Um tipo particular de avaliação pericial é o exame de criminosos sexuais.

Os crimes sexuais, por sua vez, vem obtendo cada vez mais atenção pública, particularmente, após os recentes relatos divulgados pelas mídias internacionais, em decorrência das revelações de diversos casos, vitimizando figuras públicas.

A sobrecarga emocional associada ao trabalho com vítimas de estupro e violência já encontra-se descrita na literatura. (1,2,3,4) Esse entendimento, no entanto, não se extende ao trabalho realizado com os perpetradores de violência sexual, por diferentes profissionais. (5) Os psiquiatras e psicólogos forenses são um grupo específico de profissionais que trabalham diretamente com criminosos sexuais, seja tratando-os, durante o cumprimento de medidas de segurança, ou realizando avaliação pericial, com fins de responsabilidade penal ou verificação de cessação de periculosidade.

Crimes como estupro e outros de natureza sexual (homicídio sexual, assédio sexual, tráfico de pessoas para exploração sexual) representam profundas violações nas emoções e no corpo das vítimas, assim como ações relacionadas ao comportamento pedofílico – tais quais: produção e divulgação de pornografia infantil e abuso sexual infantil. (6) Durante o exame desses criminosos, os peritos psiquiatras e psicólogos entram em contato com narrativas e documentação cujo principal conteúdo consiste em violência, abuso e perversão. Poucos estudos existem, entretanto, acerca dos riscos emocionais para tais profissionais da saúde mental e sobre como essa avaliação pode interferir em suas vidas.

O trauma vicário (TV) foi descrito, inicialmente, como um efeito psicológico específico e profundo acometendo psicoterapeutas, resultante do trabalho com vítimas de violência sexual. A exposição às descrições gráficas da crueldade humana poderia afetar aspectos pessoais, profissionais e éticos do terapeuta. (7,8) Ademais, alguns terapeutas que trabalham com criminosos sexuais relataram sintomatologia de TV em variados graus. (9)

Um aspecto que produz mal-entendidos frequentes é considerar o TV como sinônimo de outras entidades, tais quais síndrome de burnout, fadiga de compaixão e estresse pós-traumático secundário. Pearlman, em 1995, já alertou que TV e burnout são diferentes constructos. Enquanto o TV resulta em profundas rupturas no quadro de referências do

terapeuta, sendo uma resposta natural a um trabalho muito especializado, de alta demanda emocional, com material traumático, a síndrome de burnout representa a exaustão emocional resultante do estresse do contato interpessoal e da distância entre expectativas e aspirações, de um lado e as condições reais e desfavoráveis do ambiente de trabalho, do outro. A fadiga de compaixão corresponde a sentimentos de sofrimento profundo ou simpatia, até a exaustão, associados com um desejo de aliviar o sofrimento de outra pessoa. O estresse pós-traumático secundário é uma forma de revitimização e pode ocorrer quando uma pessoa é repetidamente exposta a um tipo de evento traumático. Embora todos eles sejam riscos ocupacionais e alguns possam ocorrer simultaneamente, o foco da presente investigação recairá no TV. (8,10)

Pesquisas prévias indicaram alguns aspectos contratransferenciais de terapeutas, específicos do contato com criminosos sexuais, tais quais: fantasias agressivas e sádicas, polarização do paciente (vítima versus criminoso), sentimentos de estar sendo controlado ou enganado e barreiras para a vinculação empática com o paciente - quando o terapeuta foca no crime ou na negação do crime. (11,12) No que concerne aos peritos, Barros et al. (2014) identificaram a predominância de sentimentos negativos, como nojo, raiva, desconfiança e medo, em uma amostra de 26 psiquiatras forenses brasileiros, durante a avaliação e tratamento de criminosos sexuais. (13) Após esse estudo preliminar, questionamentos emergiram sobre a possibilidade de que a natureza e a intensidade contratransferenciais pudessem estar associadas com a manifestação de TV em peritos.

Pearlman e Saakvitne (1995) sugeriram que os processos envolvidos na interação entre contratransferência e TV em terapeutas são redução do autoconhecimento, aumento das defesas e contestações a identidade e as crenças. (8) Até o presente, a relação entre contratransferência, mecanismos de defesa e trauma vicário ainda não foi examinada em um setting pericial.

2 REVISÃO DA LITERATURA

2.1 CONTRATRANSFERÊNCIA

2.1.1 Desenvolvimento histórico do conceito

Freud introduziu o conceito de contratransferência em 1910, secundariamente ao descobrimento da transferência. Para ele, a contratransferência teria suas fontes inconscientes nos conflitos neuróticos do analista, reativados pelo contato com os conflitos infantis do analisado, consistindo em resistência do analista. Sendo assim, Freud considerou que ela deveria ser eliminada pela autoanálise ou terapia pessoal, a fim de manter-se uma postura fria de observação, como um cirurgião. Esta perspectiva precoce da contratransferência, como um obstáculo ao tratamento, prevaleceu na literatura psicanalítica por várias décadas. (14,15,16)

Historicamente, o conceito evoluiu, identificando-se quatro fases: a) a formulação inicial de Freud; b) os trabalhos de Paula Heimann e Heinrich Racker, que ampliaram o entendimento; c) as décadas de 1970 e 1980, com o emprego intenso do conceito "totalístico"; d) a situação atual de revisão e cautela com a utilização da contratransferência e a proposta de um conceito específico. (17)

A contratransferência adquiriu um sentido amplo ou totalístico, a partir das contribuições de Heimann e Racker, que a consideravam como um fenômeno normal do processo terapêutico e um instrumento imprescindível para a interpretação. Nesta mudança conceitual, ela contém elementos da realidade da relação e pode ter aspectos neuróticos do analista, abrangendo suas reações conscientes e inconscientes. Adicionalmente, transforma-se de interferência à ferramenta principal e o analista passa de observador a integrante do campo de trabalho, reconhecendo-se os aspectos relacionais do seu próprio funcionamento. (15,16,17)

Racker ressaltou que o conjunto de imagens, sentimentos e impulsos do analista para com o paciente, enquanto determinados pelo passado, é chamado de contratransferência. Mostrou como os fenômenos contratransferenciais se expressam em níveis verbais e não verbais da comunicação analítica e se retroalimentam implicitamente, reforçando identificações patológicas. Destacou a necessidade de análise da contratransferência, tanto no tratamento pessoal do analista, como nas supervisões. (15,16,18)

Pacientes especialmente comprometidos tendem a testar, consciente ou inconscientemente, como o analista manejará sentimentos difíceis. O poder de confundir e de invadir a mente do analista, presente nestes indivíduos, pode levar o terapeuta, ao menos por

um tempo, a perder o controle e ficar incapaz de funcionar com o distanciamento necessário para pensar. Além disso, reações emocionais prematuras e intensas do terapeuta, com oscilações rápidas e caóticas, advertem para a presença de grave regressão do paciente. (17,19) Deste modo, na relação analítica, o terapeuta necessita aprender a sentir o terror e ainda assim manter o equilíbrio mental, aceitar ficar perturbado, de acordo com a visão de "continente e contido" do modelo mãe-bebê de Bion. (16)

Willy e Madeleine Baranger incluiram a contratransferência em uma visão mais ampla do processo analítico, este concebido como campo dinâmico constituído pela dupla analítica. Eles acreditavam que a dinâmica inconsciente do campo é determinada por fantasias inconscientes compartilhadas, surgidas após a troca de identificações projetivas do paciente e analista. (15)

Jacobs, em 1986, além de adotar uma visão totalística da contratransferência descreveu vários indicadores de reações contratransferenciais: pontos cegos, atos falhos em relação a honorários, horários, duração das sessões; frequentes pensamentos sobre o paciente, comumente acompanhados de depressão ou outras mudanças de humor; uma necessidade repetitiva de falar sobre as sessões com esse paciente e a presença do mesmo no conteúdo manifesto dos sonhos do analista. (17)

Segundo estudos de Sandler, datados de 1987, a concepção global da contratransferência incluiu os aspectos repetitivos inconscientes do passado infantil do analista, assim como os aspectos de seu funcionamento mental, que foram se desenvolvendo em suas experiências pessoais de análise e formação, em seu diálogo com teorias e colegas e, sobretudo, no contato com os pacientes, integrando fatores conscientes e pré-conscientes do psiquismo do analista e o inconsciente presente. Neste sentido, a experiência contratransferencial oferece ao analista um caminho de crescimento emocional, mental e profissional. As divergências entre os conceitos totalístico e clássico foram diminuindo com o tempo e a visão totalística foi recebendo mais concordância. (15,17)

2.1.2 Contratransferência no setting pericial

O conhecimento sobre a influência da contratransferência em outras áreas de atuação do psicólogo e do psiquiatra, que não a psicoterapia, bem como em outras especialidades médicas permanece pequeno. Dentro da psicologia e da psiquiatria forense, o uso do termo contratransferência tem sido criticado por refletir a base clínica da relação médico-paciente. Embora as interações entre o perito e o examinando sejam diferentes daquelas da prática clínica,

elas também incluem respostas emocionais de ambos os lados. Essas respostas têm o potencial de minar a neutralidade viável e a objetividade dos avaliadores forenses, dos quais, idealmente, se espera superar sentimentos de contratransferência para manter o foco do trabalho na busca pela verdade. (20,21)

O estudo de Barros e cols. (2014) observou que, embora as reações contratransferenciais ocorridas durante uma avaliação psiquiátrica ou psicológica forense se relacionem aos sentimentos despertados no perito em resposta às ações ou comportamentos demonstrados pelo examinado, a análise de outros aspectos vinculados ao caso poderia também afetar os sentimentos e emoções dos profissionais e influenciar a objetividade pericial, no processo de avaliação. Por exemplo, ao se concluir que o examinado sofria de grave transtorno mental durante o crime ou que tinha um quadro de retardo mental, os peritos relataram menos rejeição ao avaliado, como também lhes desencadeava sentimentos de compaixão e desejo de auxiliar o sujeito a receber o tratamento mais apropriado para sua patologia. (13)

2.1.3 Medindo a contratransferência

Os instrumentos para o estudo da contratransferência validados e disponíveis para uso no Brasil são poucos, consistindo no Inventory of Countertransference Behavior (ICB) - nomeado em Português de Inventário do Comportamento Contratransferencial, no Mental States Rating System (MSRS) – Sistema de Avaliação dos Estados Mentais - e na Escala para Avaliação da Contratransferência (EACT), também chamada de Assessment of Countertransference Scale (ACS). Os dois primeiros não dispõem de estudos de validação em nosso meio, além de serem complexos, exigindo treinamentos específicos para pontuação. (22,23,24,25,26,27) A EACT, por sua vez, é um instrumento brasileiro, auto-aplicável, capaz de avaliar a contratransferência através de 23 itens, pontuados em escala Likert (variando de 0=ausente a 3=muito intenso), em três momentos da sessão terapêutica/ou entrevista pericial (no início, durante o atendimento e no final), objetivando apreender como os sentimentos variam durante a sessão/entrevista. Cada sentimento faz parte de uma das três dimensões: aproximação (engloba sentimentos de curiosidade, interesse, simpatia, solidariedade, afeição, desejo de ajudar, alegria, tristeza, pena e atração), afastamento (inclui desconforto, desconfiança, tédio, rejeição, desesperança, reprovação, acusação, irritação, medo e hostilidade) e indiferença (desinteresse, distância, imobilidade). (28)

2.2 MECANISMOS DE DEFESA

Em 1966, Anna Freud definiu os mecanismos de defesa como "os modos e meios através dos quais o ego evita o desprazer e a ansiedade e exerce controle sobre o comportamento impulsivo, afeto e desejos instintivos". Desde então, o conceito de mecanismos de defesa evoluiu e revelou-se útil tanto em contextos clínicos quanto em pesquisa. (29) Os mecanismos de defesa do ego, na teoria psicanalítica tradicional, representam processos inconscientes que distorcem a realidade para proteger o indivíduo de emoções dolorosas, pensamentos inaceitáveis e impulsos. As conceitualizações mais recentes reduziram a ênfase no aspecto protetivo acerca de pensamentos inaceitáveis e focaram no modo como esses mecanismos reduzem afetos negativos e mantém a autoestima. (30) Assim, eles consistem em uma forma de regulação emocional implícita. (31)

Os mecanismos de defesa podem ser agrupados em "estilos" de defesa, baseados na continuidade do desenvolvimento e no grau de adaptação ou distorção da realidade, variando de: imaturos (isto é, manter a distância através da distorção da realidade e/ou das emoções, fechar-se para explorações mais profundas – exemplificado pela negação), neuróticos (como a anulação) e maduros (estabelecer contato com os próprios sentimentos e com os sentimentos dos outros, manter-se aberto para maiores explorações – a sublimação, por exemplo). Indivíduos saudáveis, ao lidarem com conflitos, tendem a utilizar defesas neuróticas, ao invés de imaturas, embora o uso excessivo de defesas neuróticas também esteja associado a uma variedade de transtornos mentais. Defesas maduras, por sua vez, auxiliam na redução de respostas agressivas, contudo verifica-se uma subutilização do estilo de defesa maduro dentro de muitas populações clínicas. (30,31)

Os mecanismos de defesa foram propostos como uma forma de conceitualizar o distanciamento emocional ou a conexão que um médico estabelece com seus pacientes. Estudos prévios demonstraram elevada prevalência de mecanismos de defesa nos médicos, enquanto eles se comunicavam com pacientes reais ou em simulações. Também foi verificada uma relação entre os mecanismos de defesa dos médicos e desfechos de pacientes em tratamentos de câncer, bem como com as habilidades de aprendizado dos médicos. (31) Interessante pontuar que em estudo realizado com oncologistas, quanto maiores eram as dificuldades dos médicos para processarem emoções, seus estilos defensivos se revelaram menos maduros. (31)

Mesmo sendo frequentemente considerados como elementos centrais no trabalho clínico, os mecanismos de defesa tem recebido pouca atenção na literatura forense. (32)

2.2.1 Medindo os mecanismos de defesa

As origens das medidas quantitativas dos mecanismos de defesa datam dos trabalhos de Vaillant (1971, 1976), que utilizou uma hierarquia de defesas e relatou que defesas maduras estavam positivamente correlacionadas, enquanto defesas imaturas estavam negativamente correlacionadas com uma medida objetiva de sucesso na vida. Em 1983, um grupo de pesquisadores composto por Bond, Gardner, Christian e Sigal, considerando o modelo hierárquico de Vaillant, sugeriram um contínuo entre os espectros imaturo-maduro e desenvolveram uma medida auto-aplicada, o Defense Style Questionnaire, com 67 itens (DSQ-67). (29)

A versão original de 67 itens passou por modificações, existindo, atualmente, o Defensive Style Questionnaire-40 (DSQ-40) que, como o próprio nome indica, possui 40 itens, pontuados em escala Likert (variando de 1= discordo fortemente a 9=concordo fortemente) avaliando 20 mecanismos de defesa, os quais foram ordenados dentro de três fatores de segunda orgem ou estilos defensivos: maduro, neurótico e imaturo. O DSQ-40 busca identificar estilos característicos que as pessoas, consciente ou inconscientemente, utilizam para resolver conflitos. Esse questionário mais curto provou ser um instrumento válido e confiável. (29) A versão brasileira do DSQ-40 demonstrou características psicométricas que permitem seu uso em nossa cultura (33,34).

2.3 TRAUMA VICÁRIO

O TV é um importante fenômeno relacionado aos efeitos deletérios da terapia de trauma em terapeutas. Reações psicológicas perturbadoras, dolorosas e prejudiciais podem ocorrer nos terapeutas expostos ao material de pacientes gravemente traumatizados. Esses profissionais passam a se sentir tristes, deprimidos, irritados ou intolerantes, entre outros sentimentos. Trata-se de um trauma psicológico indireto sofrido pelos profissionais, relacionado ao conteúdo traumático do material de trabalho. Deve-se enfatizar que o TV transcende a capacidade empática do terapeuta, afetando também seu rendimento ocupacional, aprendizado e bem-estar. Ademais, ele poderá ser leve e temporário, ou grave e persistente. (35,36,37)

Em 2007, Moulden e Firestone encontraram evidências de que terapeutas de agressores sexuais sofriam sintomas de TV. (9) Previamente, em 1999, Brady havia verificado que terapeutas com altos níveis de exposição a material de abuso sexual relatavam mais sintomas traumáticos. (38) Way, em 2004, descreveu uma maior intensidade de sintomas evitativos e

intrusivos em uma amostra randômica de terapeutas que, ou tratavam pacientes vítimas de abuso sexual, ou os perpetradores deste tipo de violência, com variação das variáveis associadas ao TV, de acordo com a população atendida. (4)

Inicialmente, o TV foi descrito em psicoterapeutas (psicólogos e psiquiatras) que tratavam vítimas de violência sexual e, posteriormente, outros profissionais foram incluídos no grupo de risco, entre os quais os assistentes sociais, advogados e juízes. (39,40,41)

O TV pode se manifestar como um desprendimento por parte do terapeuta, que passa a substituir a empatia pela intelectualização, aparentando uma postura neutra. Em 2009, Harrinson e Westwood, por sua vez, ressaltam a responsabilidade ética compartilhada por profissionais de saúde mental que trabalham com vítimas de trauma. (42)

A literatura, até o presente, não dispõe de estudos sobre a ocorrência de manifestações do TV em psiquiatras e psicólogos forenses, mesmo sabendo-se que eles compõem grupo profissional cujo material de trabalho, comumente, envolve temática traumática de considerável gravidade.

2.3.1 Medindo o trauma vicário

A Trauma and Attachment Belief Scale (TABS) é uma escala fundamentada na teoria construtivista do desenvolvimento, que se propõe a avaliar a relação do estresse produzido por situações traumáticas com os esquemas cognitivos individuais relacionados ao self e aos outros.(43) Ela é composta por 84 itens, que avaliam prejuízos nos esquemas cognitivos nas cinco áreas seguintes: controle, estima, intimidade, segurança e confiança. A TABS utiliza uma pontuação através da escala Likert (1=discordo fortemente a 6=concordo fortemente), produzindo um escore total e 10 subescalas, as quais medem cada área em relação ao próprio self e aos outros: 1) Autossegurança, 2) Segurança dos outros, 3) Autoconfiança, 4) Confiança nos outros, 5) Autoestima, 6) Estima pelos outros, 7) Auto-intimidade, 8) Intimidade com os outros, 9) Autocontrole e 10) Controle sobre os outros. (44-45)

A TABS tem sido utilizada para avaliar os efeitos psicológicos de experiências traumáticas diretas de vida e o trauma vicário. Escores mais altos indicam maiores distúrbios nas crenças. A versão brasileira da TABS demonstrou alta consistência interna, com um alfa de Crombach total de 0.9173 e todos os 84 itens contribuíram favoravelmente para a consistência interna desta escala. (45)

3 JUSTIFICATIVA

A importância desta pesquisa recai na investigação de questões até então pouco exploradas, porém consideradas de extrema relevância para a adequada aplicação da justiça, assim como para o saudável exercício profissional: avaliar a possível interferência da contratransferência, dos mecanismos de defesa e do trauma vicário na realização do trabalho pericial psiquiátrico e psicológico, no contexto de crimes sexuais.

Ademais, o presente estudo disponibiliza informações acerca das repercussões emocionais deste tipo de atividade na vida pessoal e na saúde mental dos peritos.

4 OBJETIVOS

4.1 OBJETIVO GERAL

Este estudo visa investigar aspectos relacionados às respostas emocionais e saúde mental de peritos psiquiatras e psicólogos que realizaram avaliações em criminosos sexuais.

4.2 OBJETIVOS ESPECÍFICOS

1. Examinar as associações entre as reações contratransferenciais desencadeadas por criminosos sexuais, os mecanismos de defesa e o trauma vicário em uma amostra de psiquiatras e psicólogos forenses brasileiros.
2. Desenvolver uma compreensão teórica mais abrangente sobre os efeitos na vida profissional e pessoal de peritos psiquiatras e psicólogos, relacionados à avaliação de criminosos sexuais, através de um método qualitativo.

5. MÉTODOS

5.1 ESTUDO PRELIMINAR OBSERVACIONAL E QUALITATIVO

Após a verificação da ausência de literatura científica versando sobre a contratransferência no setting pericial, especificamente relacionada aos peritos psiquiatras que examinam criminosos sexuais, foi realizado estudo para se investigar, de maneira exploratória, os principais sentimentos desencadeados em psiquiatras forenses brasileiros durante a avaliação e tratamento de criminosos sexuais. Nesse estudo, também foi examinado o modo como os peritos lidam com esses sentimentos. A partir desse trabalho, hipóteses foram geradas para os estudos subsequentes da presente tese.

5.2 ESTUDO DE TRADUÇÃO PARA O PORTUGUÊS BRASILEIRO, ADAPTAÇÃO TRANSCULTURAL E VALIDAÇÃO

Realizou-se a tradução, adaptação transcultural e validação aparente da Trauma and Attachment Belief Scale (TABS). Este estudo envolveu uma revisão de literatura e avaliação da equivalência conceitual e dos itens, empregando grupos de discussão de especialistas. Para a avaliação da equivalência semântica ocorreram duas traduções e respectivas retrotraduções, seguida de avaliação considerando a equivalência referencial e geral entre a TABS original e cada versão. Vinte e oito psiquiatras e psicólogos completaram um pré-teste. A versão final foi testada para confiabilidade através do alfa de Cronbach e para compreensão verbal, através de uma escala verbal-numérica adaptada [variando de 0 (Eu não entendi nada) a 5 (Eu entendi perfeitamente e não tive qualquer dúvida)] em outros 64 profissionais de saúde. A adaptação transcultural demonstrou alta equivalência semântica, tanto para o significado geral (>95,0%) quanto referencial (>90,0%). O alfa de Cronbach total foi de 0,9173. Todos os 84 itens foram mantidos e contribuíram favoravelmente para a consistência interna da escala. Os valores médios da escala verbal-numérica adaptada para a compreensão verbal, obtidos dos profissionais de saúde, variaram de 4,2 a 4,9. A versão brasileira da TABS demonstrou equivalência conceitual, de itens e semântica de alta qualidade com o instrumento original, bem como elevada aceitabilidade, consistência interna e compreensão verbal, tornando-se disponível para uso. (45)

5.3 ESTUDO TRANSVERSAL UTILIZANDO MÉTODOS MISTOS

5.2.1 Desenho e aspectos éticos

Foi realizado um estudo transversal utilizando métodos mistos, com o objetivo de avaliar as associações entre reações contratransferenciais desencadeadas por perícias em criminosos sexuais, mecanismos de defesa e trauma vicário nos psiquiatras e psicólogos forenses. Os dados quantitativos relacionados às informações demográficas dos participantes e as medidas padronizadas foram obtidas para descrever a amostra e fornecer informações sobre a contratransferência, os mecanismos de defesa e o trauma vicário em psiquiatras e psicólogos forenses. Um delineamento qualitativo foi empregado para se obter uma compreensão mais profunda acerca da influência da avaliação de criminosos sexuais nas vidas pessoal e profissional dos peritos. A GT foi identificada como a metodologia mais apropriada para essa investigação, por possibilitar aos pesquisadores o desenvolvimento de conhecimento em áreas nas quais pouco se sabia sobre um fenômeno (46) - precisamente a situação do presente estudo, relativa à contratransferência e TV em um setting forense- através das respostas dos participantes. (47)

O consentimento informado, através da assinatura de um termo, foi obtido de todos os participantes deste estudo. O protocolo de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa da Universidade Federal do Rio Grande do Sul (CAAE: 55151116.4.0000.5347).

5.2.2 Amostra

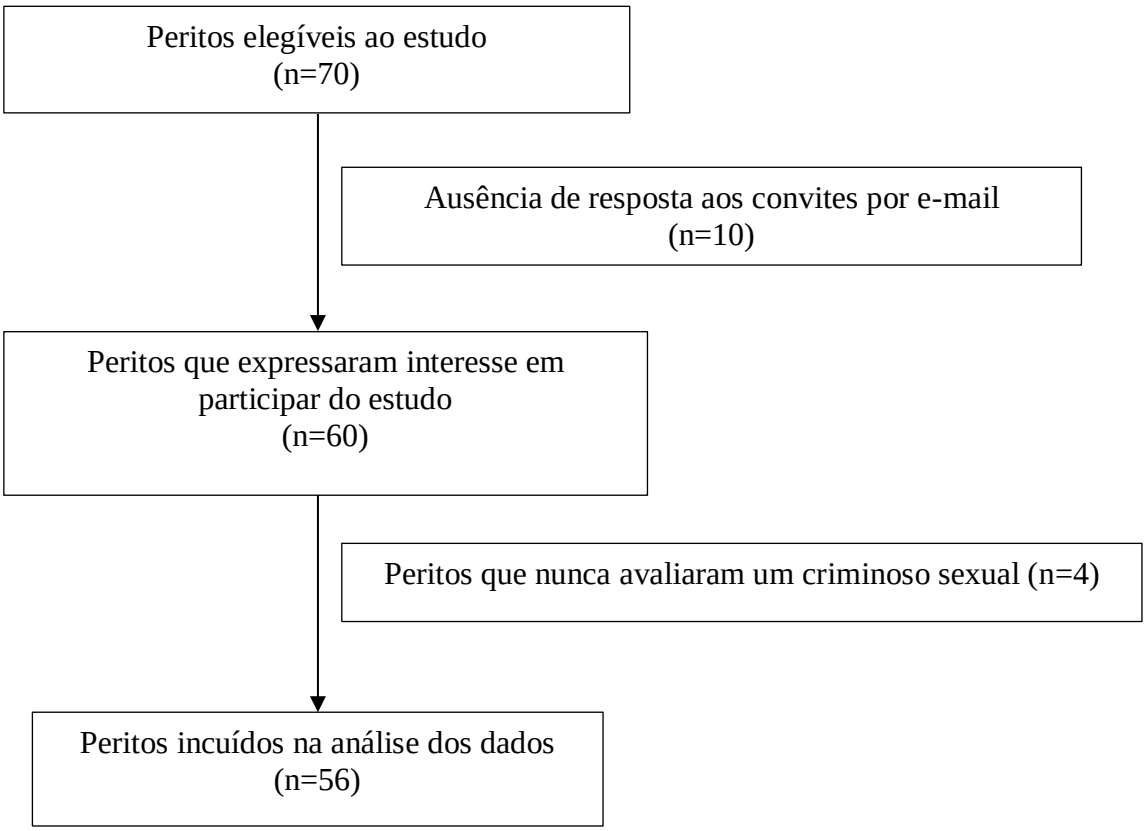
Os critérios de inclusão utilizados foram: 1) ser psiquiatra ou psicólogo forense, e 2) os peritos listados em todos os Conselhos Regionais de Medicina e de Psicologia do Brasil, que pudessem ser contactados (através de números de telefone, endereço profissional ou e-mail disponíveis).

Uma amostra por conveniência foi realizada e o recrutamento dos participantes ocorreu entre os meses de outubro de 2016 e maio de 2017. Todos os participantes receberam um convite por e-mail descrevendo o propósito e conteúdo do estudo, comunicando que a participação seria voluntária e que os dados manteriam-se anônimos. Os peritos tiveram cerca de 4 semanas para considerar a participação. Ao final deste período, se nenhuma resposta fosse

obtida, o perito era excluído do estudo. Peritos sem experiência em avaliações de agressores sexuais também foram excluídos (Figura 1).

A fim de padronizar a coleta de informações relacionadas ao tipo de avaliação forense, as seguintes transgressões legais foram consideradas crimes sexuais: estupro, abuso sexual infantil, pedofilia, produção ou consumo de pornografia pela internet e homicídio sexual.

Figura 1- Fluxograma da seleção dos participantes do estudo



5.2.3 Instrumentos

O método primário utilizado para a coleta de dados para a abordagem através da GT foi um questionário auto-aplicado, não uma entrevista, em razão dos participantes serem provenientes de diversas partes do Brasil, um país de proporções continentais. Esta abordagem também permitiu aos participantes ter privacidade para pensar sobre as especificidades de sua última avaliação com um criminoso sexual, bem como sobre seus sentimentos e reações naquela situação, ajustando-se à especificidades da pesquisa, de acordo com o proposto por Charmaz, em 2014. (48)

O questionário contemplava os seguintes tópicos: gênero, idade, profissão, tempo de experiência forense, história de tratamento psicoterápico pessoal, treinamento em psicoterapia e a data da última avaliação de um criminoso sexual. Baseado em estudos sobre TV, três perguntas abertas foram elaboradas, com o objetivo de encorajar o participante a avaliar suas experiências laborais específicas em crimes sexuais: 1. Como o(a) senhor(a) mantém sua atitude profissional durante a avaliação de um agressor sexual? 2. O(a) senhor(a) continua pensando sobre a avaliação depois de sua realização? 3. Qual é a influência deste tipo de avaliação em sua vida?

A contratransferência foi medida através da EACT. Os mecanismos de defesa foram avaliados utilizando-se a versão brasileira do DSQ-40. O trauma vicário foi avaliado empregando-se a versão brasileira da TABS.

5.2.4 Procedimentos

Tendo o perito aceitado o convite, os materiais foram enviados por e-mail ou carta, pelo sistema postal brasileiro. Os materais consistiam em: um breve guideline, indicando que os peritos deveriam pensar a respeito da útima avaliação pericial de um criminoso sexual, ao completarem os instrumentos; um questionário auto-aplicado, a EACT, o DSQ-40, a TABS e um termo de consentimento informado livre e esclarecido. O questionário e todos os instrumentos padronizados foram completados pelos participantes e devolvidos ao grupo de pesquisa, por e-mail ou carta.

5.2.5 Análise dos dados

Inicialmente, a análise envolveu a coleta dos detalhes demográficos e das informações das medidas padronizadas (EACT, DSQ-40 e TABS). As análises foram conduzidas para os escores totais individuais para cada instrumento, para cada dimensão da contratransferência na EACT, para cada estilo defensivo no DSQ-40 e para cada subescala de TV na TABS. Análises dos coeficientes de correlação de Spearman foram realizadas para avaliar a força e direção das correlações entre a contratransferência e o TV e entre a contratransferência e os mecanismos de defesa. Neste estudo, ajustes para comparações múltiplas não foram feitos e as análises de subgrupo devem ser consideradas como exploratórias. Um nível de significância estatística de 0.05 foi adotado para todas as comparações estatísticas. As análises quantitativas foram conduzidas usando-se o software STATA, versão 12. (49) Os dados qualitativos foram analizados utilizando-se o programa NVivo. (50)

A análise dos dados qualitativos ocorreu em diversos estágios simultâneos, consistentes com a metodologia da GT. (51) O NVivo foi empregado para organizar as informações codificadas, assim que temas importantes eram identificados através do processo manual de open coding, no qual as respostas dos questionários foram quebradas em unidades de significação. Logo após o recebimento dos questionários, os participantes do grupo de pesquisa transcreveram as respostas e redigiram notas. As transcrições foram analizadas utilizando-se de um método comparativo constante e interativo. Quando certos temas tornavam-se frequentemente recorrentes, os pesquisadores discutiam e um investigador escrevia notas, reconhecendo os temas emergentes. O processo de codificação continuava após a identificação de múltiplos componentes-chave, identificando-se como cada linha ajustava-se dentro de um tema, ou reconhecendo-se um novo tema. Quando cessou o surgimento de novos dados, o grupo de pesquisa reunia-se e concordava sobre a saturação teórica. Subsequentemente, outro pesquisador, que não fazia parte das fases anteriores, analizou duas transcrições selecionadas randomicamente, para garantir a confiabilidade entre os códigos. Finalmente, o grupo de pesquisa concordou com a codificação final e todas as transcrições foram re-examinadas para garantir que nenhuma informação relevante fosse esquecida.

6 RESULTADOS

6.1 ARTIGO 1

Countertransference Reactions Aroused by Sex Crimes in a Forensic Psychiatric Environment

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Countertransference Reactions Aroused by SexCrimes in a Forensic Psychiatric Environment

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Abstract

Although countertransference is an established concept within psychoanalysis and psychoanalytic psychotherapy, its influence in other areas of psychology and psychiatric expertise, as well as in other medical specialties, remains low. This study investigated the role

of countertransference in the activities performed by forensic psychiatrists in a Brazilian forensic psychiatric hospital. The study investigated, in an exploratory manner, the main feelings aroused in those doctors during the forensic evaluation and treatment of sex offenders; furthermore, it examined how these professionals addressed such feelings. The present work generates hypotheses for future studies and initiates a discussion of the possible benefits of psychoanalytic psychotherapy or psychoanalysis for candidates for forensic psychiatry and psychology practice.

Keywords: countertransference, forensic psychiatry, sex offenders, vicarious traumatization

Introduction

The concept of countertransference was introduced by Freud in 1910 after his discovery of transference. According to Freud, the sources of countertransference are located in the unconscious neurotic conflicts of the analyst and are reactivated by contact with the infantile conflicts derived from the patient. Freud made only four references to this subject, according to the index of the Standard Edition; he considered countertransference to represent analyst resistance, which should be eliminated through self-examination or personal therapy to maintain a posture of cold observation, similar to a surgeon (1909). This early view of countertransference as an obstacle to treatment prevailed in the psychoanalytic literature for several decades (Bernardi, 2006; Betan, Heim, Conklin, & Westen, 2005; Hinshelwood, 2001).

The issue gained importance during the second half of the twentieth century due to the increasing focus on the analyst in the processes of therapeutic change. This approach recognizes the interactive nature of transference and countertransference. Sandler introduced the concept of roleresponsiveness, in which the therapist acts in accordance with a role that is part of the relational paradigm recreated unconsciously by the patient (Bernardi, 2006; Betan et al., 2005; Hinshelwood, 2001).

Currently, countertransference is an accepted concept of fundamental importance to psychoanalysis and psychoanalytic psychotherapy. Countertransference consists of all the feelings and attitudes of the therapist toward the patient. It contains elements derived from the reality of the relationship and neurotic aspects of the analyst, including conscious and unconscious reactions, and can be used as a valuable tool for understanding and treating patients (Eizirik & Lewkowicz, 2005; Reeder & Schatte, 2011). By allowing the analyst to hear, through

his feelings, not only what the patient says but also, and more importantly, what he does not say because it is ignored by the conscious mind, countertransference is able to provide important information that would otherwise remain inaccessible (Zaslavsky & Santos, 2005). Knowledge about the influence of countertransference in other areas of psychologists' and psychiatrists' expertise, as well as in other medical specialties, remains low. Within forensic psychiatry and psychology, the use of the term "countertransference" has been criticized for reflecting the clinical basis of the physician-patient relationship. Although the interactions between the forensic expert and the examinee differ from clinical practice, they include emotional responses by both parties. These responses have the potential to undermine the neutrality and objectivity of forensic evaluators, who are expected to overcome feelings of countertransference and to maintain the focus of their work on the search for the truth (Sattar, Pinals, & Gutheil, 2004).

Another important aspect to be considered is the vulnerability of forensic mental health professionals to vicarious traumatization (VT), a term that was coined by McCann and Pearlman (1990) to describe the pervasive changes in clinicians that occur over time as a result of working with clients who have experienced sexual trauma. These changes include alterations in the clinician's sense of self, spirituality, worldview, interpersonal relationships and behavior. Typical symptoms of VT include depression, cynicism, boredom, loss of sympathy and empathy and dejection (Pross, 2006; Way et al., 2004). Harrison and Westwood (2009) identified nine protective practices that mitigate the risk of VT among mental health therapists: countering isolation (in professional, personal, and spiritual realms); developing mindful self-awareness; consciously expanding one's perspective to embrace complexity; active optimism; holistic self-care; maintaining clear boundaries; exquisite empathy; professional satisfaction; and creating meaning. The methods used by the investigated psychiatrists to address their countertransference may also reduce the likelihood of vicarious traumatization.

The training of forensic psychiatrists and psychologists in the assessment and treatment of sex offenders is in need of improvement (Gordon & Grubin, 2004), particularly in how to manage the strong countertransference reactions triggered by sex crimes. Despite the existence of an extensive psychoanalytical literature on the theory of perversions and sexual deviation, originally rooted in Freud's centrality of sexuality in human psychopathology, there are few published studies evaluating whether psychodynamic psychotherapy of the psychiatrist can improve forensic evaluations and minimize the risk of emotional burden to the expert.

The present study aimed to examine the role of countertransference in the activities performed by forensic psychiatrists in a Brazilian forensic psychiatric hospital. This study

investigated, in an exploratory manner, the main feelings aroused in these doctors during the forensic evaluation and care of sex offenders, and it examined how these doctors addressed such feelings in an attempt to maintain the conditions necessary for the proper preparation of expert reports.

Methods

Setting, Study Design, and Participants

Brazilian law establishes punishment for sex crimes, such as rape, sexual harassment, pedophilia, and child pornography on the Internet, among others. These crimes result in fines and prison sentences that range from one to 30 years. If the offender claims insanity, he will be evaluated by forensic mental health professionals (psychiatrist and psychologist). If he is deemed mentally unfit (i.e., with impaired capacity of understanding and self-control), he is sentenced to mandatory treatment at a forensic psychiatric hospital (Law No. 7.209 , 1984; Law No. 11.829 , 2008; Law No. 12.015 , 2009).

A unicenter, qualitative, observational study was conducted from August to September 2012. The studied population consisted of forensic psychiatrists who were working during the indicated period at the Instituto Psiquiátrico Forense Maurício Cardoso (IPFMC), a forensic psychiatric institute located in southern Brazil. This hospital is responsible for all forensic psychiatric evaluations and custody treatments of the state for Rio Grande do Sul.

To recruit participants in this study, all the forensic psychiatrists at this facility were approached during working hours and informed about the procedures and purposes of the research. The participants both evaluated cases and treated incompetent patients. According to the Brazilian Code of Medical Ethics, forensic psychiatrists may not treat patients for whom they performed an assessment (Audit and Medical Assessment , 2009). The following inclusion criteria were applied: the participants were required to be psychiatrists who were actively employed by the institution and who provided written informed consent. The exclusion criterion was any psychiatrist who had never evaluated or treated a sex offender.

Variables Investigated

The study variables were the participants' age and sex, length of experience in forensic psychiatry, history of personal psychotherapy, training in any line of psychotherapy,

countertransference feelings aroused during interactions with sex offenders and strategies used to address these countertransference reactions.

Instrument for Data Collection

A standardized questionnaire developed by the researchers was used to collect data. The questionnaire included demographic and professional characteristics of the forensic psychiatrists and the following essay questions: "What were the main feelings you had during the last two interviews with sex offenders?" and "What are the strategies that you use to manage these feelings?" The instrument was self-applied, and it was made available to the participants in the workplace.

Data Analysis

We used a constant comparative analysis as the qualitative analytic strategy. This procedure involves taking one piece of data and comparing it with all others in order to determine connections and develop conceptualizations (Pope, Ziebland, & Mays, 2000; Thorne, 2000). Countertransference experiences and the strategies used to cope with these feelings were analyzed according a thematic framework and the constant comparative method, facilitated by using NVivo software (QSR International Pty Ltd., 2010). The questionnaire responses were transcribed and then analyzed by two independent researchers. Tentative themes were developed through an iterative process of reading and rereading each transcript. Codes were created and categorized, and relationships among categories and themes were identified through this process. The data analysis was iterative and continued until data saturation was achieved. Data saturation occurred when the information became repetitive and contained no new ideas. In addition, throughout the process, memos were written and diagrams were developed to facilitate the visualization of the data for better conceptualization. To enhance the credibility of the study and the quality of the themes, two of the study's researchers worked together on a 'depth perception' exercise (Breuer & Roth, 2003) to facilitate a more critical analysis of the participants' accounts. As a result of this procedure, some minor changes were made to the themes.

Ethical Aspects

This study was approved by the general manager and director of scientific activities of the IPFMC. All of the participants provided written informed consent.

Results

Of the 26 forensic psychiatrists actively employed by the institution, 92.3% (n = 24) agreed to participate. Of the 26 physicians who were approached, one declined and one did not return the instrument. Of the 24 remaining participants, 50% were male, the mean age was 47.16 years and the mean duration of forensics experience was 24.12 years (Table 1).

Table 1

Demographic and professional characteristics of the forensic psychiatrists (n = 24).

Age* (SD)	47.1 (9.9)
Male (%)	12 (50.0)
Length of experience in forensic psychiatry* (SD)	24.1 (10.0)
History of personal psychotherapy (%)	22 (91.6)
Training in some form of psychotherapy (%)	19 (79.1)

Note: * Mean in years; SD = standard deviation.

Most of the evaluated doctors (91.6%, n =22) had a history of personal psychotherapeutic treatment, specifically in psychoanalytic psychotherapy (58.3%, n = 14) and/or psychoanalysis (33.3%, n = 8). Most of them (79.1%, n =19) had completed some training in psychotherapy and five psychiatrists (16.6%) have formal psychoanalytic training. The main countertransference feelings reported by the forensic psychiatrists during their last two interviews with sex offenders were predominantly negative and were characterized by disgust/repulsion and anger (Table 2). Six psychiatrists (20.8%) emphasized that the quality of the feelings aroused during this type of assessment varied based on the existence of mental

health disorders in the sex offenders. When these experts determined that the individual was experiencing mental illness at the time of the action with a causal connection to the crime, their emotional responses were milder and, in certain situations, even positive, such as compassion for the offender.

Table 2

Major countertransference feelings aroused in forensic psychiatrists during the assessment of sex offenders.

Countertransference feelings	Number (%)
Disgust/Repulsion	15 (62.5)
Anger	07 (29.1)
Irritation	07 (29.1)
Distrust	07 (29.1)
Fear	04 (16.6)
Impotence	04 (16.6)
Compassion for the offender	04 (16.6)
Preoccupation	04 (16.6)
Sadness	03 (12.5)
Discomfort	03 (12.5)
Curiosity	03 (12.5)
Affective distancing	02 (8.3)
Desire to practice justice	02 (8.3)
Indifference	01 (4.1)
Avoidance	01 (4.1)

The strategies used by the physicians to manage the feelings aroused during their interactions with sex offenders varied (Table 3). They emphasized maintaining a focus on the task (45.8%, n = 11), followed by self-analysis of countertransference feelings (29.1%, n = 7). Psychotherapeutic treatment was mentioned by 25% (n = 6) of the forensic psychiatrists as an important way to address this situation. They reported that personal psychotherapeutic treatment assisted them in identifying and understanding their own feelings, and it reduced the effect of these feelings on the objectivity necessary for producing reports. Four psychiatrists discussed the case with a supervisor, and three chose to disregard the nature of the offense.

Several representative responses provided by participants concerning the types of reactions experienced and the respective methods used to manage them are presented below.

Table 3

Key strategies of forensic psychiatrists for managing countertransference feelings during the assessment of sex offenders.

Strategies for managing countertransference	Number (%)
Maintaining a focus on the task	11 (45.8)
Self-analysis of countertransference feelings	7 (29.1)
Personal psychotherapy	6 (25.0)
Case discussion with a supervisor	4 (16.6)
Case discussion with other forensic psychiatrists	3 (12.5)
Disregarding the nature of the offense	3 (12.5)
Referring the case to another forensic psychiatrist	2 (8.3)
Preventing influence of countertransference feelings in private life	2 (8.3)
Using standardized assessment tools	2 (8.3)
Reviewing the literature	2 (8.3)

Participant 1

"Disgust, anger, impotence and fear."

"I try to observe my internal responses, analyzing the reasons for their emergence. I stay vigilant to not let myself be dominated by negative feelings and to maintain the impartiality and objectivity of the evaluation. I also discuss the case with a supervisor."

Participant 2

"Distrust and irritation."

"I try to elaborate on these feelings in therapy and during supervision of cases in order to not let my feelings lead me to be biased against the patient's needs."

Participant 3

"Anger and compassion for the offender".

"They are distinct feelings originating in the peculiarities of the situation. When I have contact with a sex offender who has no mental illness and whose main characteristics are psychopathic and perverse aspects, it arouses anger in me. In these cases, I usually keep a clear conscience about my task focus, being objective in my descriptions and conclusions. When the aggressor is a psychotic patient or has mental retardation, the feeling of compassion is predominant, and it relieves me to think I can help better direct the future of the aggressor and, in parallel, decrease the risk of crime recurrence."

Participant 4

"Discomfort, irritation and disgust. I wanted to understand the offender, but, at the same time, when I empathized with the victims, I felt repulsed."

"I try to analyze what I'm feeling, being accustomed to my years of psychotherapy. When the situation seems very difficult to handle, I discuss it with experienced colleagues or take the case to a supervisor."

Participant 5

"I felt uncomfortable and disgusted when I knew the nature of the offense, and I also got irritated when the sexual aggressor denied his crimes".

"I deal with these feelings through analytical treatment, supervision of the case, self-observation and contextualization of the situation since it is part of forensic psychiatric activity."

Participant 6

"I felt disgusted and angry when the aggressor feigned symptoms of bipolar disorder. I was also concerned about the possibility of future new victims."

"I try to keep focused on the task. I research similar cases in the literature and use standardized assessment tools. I also invest in personal psychotherapy because I consider it very important to deal with situations of stress and suffering."

Discussion

The aim of this study was to investigate the main countertransference feelings aroused in forensic psychiatrists during the evaluation of sex offenders. A second objective was to identify the key strategies employed by these experts to handle these emotional reactions. The relationship between countertransference and forensic psychiatry and psychology has rarely been explored in the literature. This essential concept, which has been used in psychoanalysis for over a century and in medical, psychology and psychiatric practice in general, involves a factor that is difficult to study: the physician/psychologist (Eizirik & Lewkowicz, 2005).

Expert activity is complex and involves specific situations, in contrast to general psychiatric and psychological practice. The stories told by examinees may be terrible, placing the expert in contact with the worst aspects of humanity and exposing them to the risk of

vicarious trauma. Because this is a lonely task, the psychiatrist and psychologist are responsible for the proper management of any intense and contradictory feelings that emerge in the course of work (Kapoor, 2008; Simon, 1994).

The evaluation of criminals, especially those who have committed vicious or cruel acts, produces a particular variety of feelings in forensic evaluators. These feelings may hamper the forensic evaluation by influencing the neutrality of the expert opinion. Because sex offenses involve elements of perversity, the evaluation of their agents is even more complex than for other crimes. Thus, it is important for experts to learn to identify and process the feelings that are produced during interactions with these offenders to prevent harmful interference with their forensic reports. Friedrich and Leiper (2006) noted that therapists experience many difficult and negative feelings and tend to feel deceived and controlled during the treatment of incestuous sex offenders, which may influence their ability to create and maintain a therapeutic relationship. Possibly, these same feelings can be experienced by forensic evaluators.

Another situation that can be raised by contact with sex offenders is the vicarious traumatization that can manifest itself as excessive detachment on the part of the therapist, who no longer shows empathy and withdraws into an intellectualizing, apparently neutral posture. Findings obtained by Harrison and Westwood (2009) confirmed and extended previous recommendations for ameliorating VT and underscored the ethical responsibility shared by mental health professionals (Pross, 2006).

All the participants in our study were forensic psychiatrists who performed both the assessment and treatment of sex offenders, although they did not treat the same patients they assessed. It should be noted that the assessment and treatment of sex offenders are very different activities. The forensic evaluator should be as objective and impartial as possible because his main task is to determine, within a limited time interval, whether the aggressor had a mental illness or defect at the time of the crime that compromised his ability to understand and control

his actions. The forensic therapist's function, in turn, is more empathic and long-term. He should provide the best possible psychiatric treatment to the patient, comprising pharmacological and psychotherapeutic aspects while minimizing symptoms and behavioral risks.

The current study used a self-report questionnaire, which is an instrument to collect data on sensitive topics such as perceptions, fears, motivations and attitudes (Portney & Watkins, 2009). The advantages of a self-administered survey are: the potential anonymity of the respondent, which can lead to more truthful responses, elimination of interviewer error and the convenience for the respondent. In turn, the most important disadvantage was the inability to ask follow-up questions or clarify answers. Contrary to the expectation of a low level of cooperation for a self-administered questionnaire, this study received a very high response rate from the forensic psychiatrists who were contacted; only one doctor did not return his questionnaire.

The emotional responses reported by the psychiatrists did not differ significantly in relation to the duration of forensic practice. Negative feelings predominated and were described as disgust, anger, mistrust and fear. Although countertransference during a forensic psychiatric and psychological evaluation refers to the expert feelings evoked in response to the actions or behaviors of the person being evaluated, examining several other aspects of the case may also affect feelings and emotions and may influence the professional's objectivity in the evaluation process. For example, concluding that the patient suffered from severe psychiatric illness or mental retardation generates less rejection by some experts, causing milder and even positive responses, such as compassion and a desire to help the individual receive the most appropriate treatment for his illness (Zaslavsky & Santos, 2005).

Empathic understanding and compassionate responses toward sex offenders are very difficult for forensic mental health professionals to achieve. However, when there is a

psychopathological explanation for the deviant behavior, the offender becomes a patient, someone who, because he may be unable to control his actions, needs and deserves care.

An element that precedes the interview and that is also capable of triggering countertransference responses is the reading of court reports to obtain more information on the case. One expert stated that this activity provided preparation for the situation and a means of avoiding surprises. Another commented that access to this information immediately triggered a feeling of discomfort, which persisted throughout the evaluation. The methods described by these experts to manage the feelings generated during their assessments of sex offenders illustrate the complexity of this activity. The most frequently used strategy involved maintaining a focus on the task, which was explained as a requirement of this type of work. How psychiatrists are able to achieve this goal remains unclear, since they did not provide a detailed description of this strategy.

The self-analysis of countertransference feelings was the second-most frequently reported response by the group. Only by recognizing his/her own feelings and identifying their roots can a forensic psychiatrist hope to achieve the necessary objectivity. Furthermore, psychotherapeutic treatment through psychoanalytic psychotherapy and/or psychoanalysis was noted by the psychiatrists as an important resource for the appropriate conduct of cases and for the maintenance of emotional balance. Treatment allowed these physicians to develop skills for understanding the internal conflicts, fears and anxieties generated by the assessment of sex offenders, and it enabled them to develop deep emotional awareness.

In some cases, the feelings of countertransference were so disturbing that the forensic psychiatrist either referred the case to a colleague or intensely sought a history of a traumatic experience in the life of the aggressor that could justify the grotesque nature of his acts. The psychiatrists who made referrals to colleagues linked this decision to a fear of being unable to

maintain their ethical commitment in the writing of the report due to intolerance to the negative feelings aroused by sex offenders in certain criminal contexts.

The psychoanalytic framework and homogeneity of the providers at the facility where the study was conducted represent limitations, due to the lack of diversity of orientations in the sample. However, the scope of this paper is greater, covering emotional reactions and biases that can be extended to a significant proportion of mental health professionals, as psychologists, social workers and nurses. For evaluators who provide evaluations to the court, therapists who treat sex offenders and judges and juries involved in deciding whether these subjects should be released into the community, it is valuable to have access to one's range of feelings. The current findings generate hypotheses for future studies, opening the discussion of a possible benefit of psychoanalytic psychotherapy or psychoanalysis for candidates for forensic psychiatry and psychology practice. These professionals face challenging tasks and must preserve the spirit of proper investigative neutrality.

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References

Audit and medical assessment. Art 93. Chapter XI. (2009). Brazil: Code of Medical Ethics.

Bernardi, B. L. (2006). Origem e evolução histórica do conceito de contratransferência. In: C. L. Eizirik, R. W. Aguiar, & S. S. Schstarsky (eds.). *Psicoterapia de orientação analítica: fundamentos teóricos e clínicos* (pp. 17-19). Porto Alegre: Artmed.

Betan, E., Heim, A. K., Conklin, C. Z., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *The American Journal of Psychiatry*, 162(5), 890-898.

Breuer, F., & Roth, W.-M. (2003). Subjectivity and reflexivity in the social sciences: epistemic windows and methodical consequences. *Forum: Qualitative Social Research*, 4(2), 25.

Eizirik, C. L., & Lewkowicz, S. (2005). Contratransferência. Psicoterapia de orientação analítica: fundamentos teóricos e clínicos. In: C. L. Eizirik, R. W. Aguiar, & S. S. Schstarsky (eds.). *Psicoterapia de orientação analítica: fundamentos teóricos e clínicos* (pp. 300-309). Porto Alegre: Artmed.

Friedrich, M., & Leiper, R. (2006). Countertransference reactions in therapeutic work with incestuous sexual abusers. *Journal of Child Sexual Abuse*, 15(1), 51-68.

Gordon, H., & Grubin, D. (2004). Psychiatric aspects of the assessment and treatment of sex offenders. *Advances in Psychiatric Treatment*, 10, 73-80.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training*, 46(2), 203-219. doi: 10.1037/a0016081

Hinshelwood, R. D. (2001). *Contratransferência. Livro anual de psicanálise* (15th ed.). São Paulo: Escuta.

Kapoor, R. (2008). A career in forensic psychiatry: the ultimate unconscious resistance? *The Journal of the American Academy of Psychiatry and the Law*, 36, 131-135.

Law No. 7.209 of July 11, 1984. (1984). Brazil: Penal Code.

Law No. 11.829 of November 25, 2008. (2008). Brazil: Child and Adolescent Statute.

Law No. 12.015 of August 7, 2009. (2009). Brazil: Penal Code.

Marques, J. K., Wiederanders, M., Day, D. M., Nelson, C., & Van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: final results from California's sex offender treatment and evaluation project (SOTEP). *Sex Abuse*, 17(1), 79-107.

McCann, L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131-149.

Pope, C., Ziebland, S., & Mays, N. (2000). Analysing qualitative data. *BMJ*, 320(7227), 114-116.

Portney, L. G., & Watkins, M.P. (2009). Surveys and questionnaires. In: Portney, L. G., & Watkins (eds.). *Foundations of clinical research: applications to practice* (pp. 325-353). New Jersey: Pearson Education.

Pross, C. (2006). Burnout, vicarious traumatization and its prevention: What is burnout, what is vicarious traumatization? *Torture*, 16(1), 1-9.

QSR International Pty Ltd. (2010). NVivo qualitative data analysis software. (Version 9). QSR International Pty Ltd.

Reeder, D. J., & Schatte, D. J. (2011). Managing negative reactions in forensic trainees. *The Journal of the American Academy of Psychiatry and the Law*, 39(2), 217-221.

Sattar, S. P., Pinals, D. A., Gutheil, T. G. (2004). Countering countertransference, II: beyond evaluation to cross-examination. *The Journal of the American Academy of Psychiatry and the Law*, 32, 148-154.

Simon, R. I. (1994). Forensic psychiatry and the perturbation of psychiatrists attention and neutrality during psychotherapy. *The Bulletin of the American Academy of Psychiatry and the Law*, 22(2), 269-277.

Way, I., Vandeusen, K. M., Martin, G., Applegate, B., & Jandle, D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence*, 19(1), 49-71.

Zaslavsky, J., & Santos, M. J. P. (2005). Contratransferência em psicoterapia e psiquiatria hoje. *Revista de Psiquiatria do Rio Grande do Sul*, 27(3), 293-301.

6.2 ARTIGO 2

Brazilian Portuguese translation, cross-cultural adaptation, and apparent validation of the Trauma and Attachment Belief Scale

Tradução para o Português brasileiro, adaptação transcultural e validação aparente da Trauma and Attachment Belief Scale

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(Artigo apresentado na versão em inglês, contemplando o resumo em Português, em concordância quanto à formatação da fonte, referências e figuras, em conformidade com as exigências da revista para submissão)

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Abstract

Objective: This article concerns the translation, cross-cultural adaptation, and apparent validation of the Trauma and Attachment Belief Scale (TABS), an instrument used to assess the psychological effects of traumatic life experiences and vicarious trauma.

Methods: This study involved literature review and evaluation of conceptual and item equivalences involving expert discussion groups focused on the existence and pertinence of the underlying theoretical concepts and corresponding items in a Brazilian context. Two translations and respective back-translations were performed during the evaluation of semantic equivalence, as well as an evaluation considering the referential and general equivalences between the original TABS and each version. Twenty-eight psychiatrists and psychologists completed a pretest. The final version was tested for reliability through the Cronbach's alpha and for verbal comprehension through the adapted verbal-numeric scale (ranging from 0 [I didn't understand anything] to 5 [I understood perfectly and I had no doubt]] in another 64 health professionals.

Results: The cross-cultural adaptation demonstrated high semantic equivalence for both the general (>95.0%) and the referential (>90.0%) meaning. The total Cronbach's alpha was 0.9173. All 84 items were maintained, and they favorably contributed to the internal consistency of the scale. The mean values of the adapted verbal-numeric scale for verbal comprehension obtained from health professionals varied from 4.2 to 4.9.

Conclusion: The Brazilian version of the TABS demonstrated high-quality conceptual, item, and semantic equivalence with the original instrument, as well as high acceptability, internal consistency, and verbal comprehension. The scale is now available for use.

Keywords: Interdisciplinary relations, oncology, other specialties, posttraumatic stress disorder, vicarious trauma.

Resumo

Objetivo: Este artigo se refere à tradução, adaptação transcultural e validação aparente da Trauma and Attachment Belief Scale (TABS), instrumento utilizado para avaliar os efeitos psicológicos das experiências de vida traumáticas e do trauma vicário.

Métodos: Este estudo envolveu uma revisão de literatura e avaliação da equivalência conceitual e dos itens, empregando grupos de discussão de especialistas, focando na existência e pertinência dos conceitos teóricos subjacentes e na correspondência dos itens dentro de um contexto brasileiro. Duas traduções e respectivas retrotraduções foram realizadas durante a avaliação da equivalência semântica, bem como foi feita uma avaliação considerando a equivalência referencial e geral entre a TABS original e cada versão. Vinte e oito psiquiatras e psicólogos completaram um pré-teste. A versão final foi testada para confiabilidade através do alfa de Cronbach e para compreensão verbal através de uma escala verbal-numérica adaptada [variando de 0 (Eu não entendi nada) a 5 (Eu entendi perfeitamente e não tive qualquer dúvida)] em outros 64 profissionais de saúde.

Resultados: A adaptação transcultural demonstrou alta equivalência semântica, tanto para o significado geral (>95,0%) quanto referencial (>90,0%). O alfa de Cronbach total foi de 0,9173. Todos os 84 itens foram mantidos e contribuíram favoravelmente para a consistência interna da escala. Os valores médios da escala verbal-numérica adaptada para a compreensão verbal obtidos dos profissionais de saúde variaram de 4,2 a 4,9.

Conclusão: A versão brasileira da TABS demonstrou equivalência conceitual, de itens e semântica de alta qualidade com o instrumento original, bem como elevada aceitabilidade, consistência interna e compreensão verbal. A escala está atualmente disponível para uso.

Descritores: Relações interdisciplinares, oncologia, outras especialidades, transtorno de estresse pós-traumático, trauma vicário.

Introduction

The need for instruments designed to evaluate the psychological impact of traumatic life experiences is increasing. To meet this need, researchers have developed trauma-specific tools, ranging from childhood maltreatment inventories (such as the Childhood Trauma Questionnaire)[1] to posttraumatic stress disorder (PTSD) scales, including the Primary Care PTSD (PC-PTSD),[2] SPAN (Startle, Physiological arousal, Anger, and Numbness),[3] and the Posttraumatic Stress Disorder Checklist-Civilian Version (PCL-C).[4,5]

Another important type of trauma is the one that affects professionals who are repeatedly exposed to traumatic narratives, termed vicarious traumatization. This form of trauma was first described by Pearlman & MacCann in 1990.[6] The authors noted the pervasive effects of performing trauma therapy on the identity, world view, psychological needs, beliefs, and memory system of the therapist. They defined it as "the transformation that occurs within the therapist or another trauma worker as a result of empathic engagement with the client's trauma experiences and their sequelae."[6,7]

The Trauma and Attachment Belief Scale (TABS) is an American self-report, paper-and-pencil psychometric instrument developed to assess the effects of direct traumatization and the impact of indirectly experienced trauma.[8,9] It was designed with items that do not focus on trauma-related symptoms, and it measures beliefs related to five need areas that are sensitive to the effects of trauma: safety, trust, esteem, intimacy, and control. It utilizes separated sets of items within each need area, approaching beliefs about oneself and those about others.[8]

Trauma impacts the lives of people from all cultures, races, ethnicities, gender, ages, communities, and countries. The strengths of the TABS combined with the lack of instruments available for vicarious trauma assessment in Brazil indicates the need for a Brazilian Portuguese scale. Therefore, the present study aimed to describe the translation, cross-cultural adaptation, and apparent validation of the Brazilian Portuguese version of the TABS.[10]

Methods

The Brazilian Portuguese translation, adaptation, and apparent validation of the TABS were authorized by the original author. This study was approved by the research ethics committee of Universidade Federal do Rio Grande do Sul (protocol no. 1.694.773).

Evaluation of conceptual and item equivalences

This evaluation involved a literature review on vicarious traumatization and discussions with a group of specialists comprising seven psychiatrists and four psychologists. The appropriateness of the items presented in the original instrument for assessing psychological trauma in the Brazilian population was also examined.

Evaluation of semantic equivalence

This process was divided into the steps described below.

1) Initial translation into Portuguese

The first translation stage was conducted by two bilingual translator groups (G1 and G2) with expertise in mental health and psychometrics. Each group comprised two psychologists and three psychiatrists. G1 produced translation P1, and G2 produced translation P2. The translators did not interact during the time they were working.

2) Evaluation by three judges

In the second stage, both translations (P1 and P2) were examined by a committee of experts composed of three professors from the Department of Psychiatry and Legal Medicine of Universidade Federal do Rio Grande do Sul (UFRGS). They compared the different translations and evaluated any semantic discrepancies (including any linguistic or conceptual issues). Subsequently, consensus was obtained, and a single final version (PF1) was produced.

3) Back-translation

The final version (PF1) was translated back into English by two native English speakers working independently, producing BT1 and BT2. The first translator was an American psychologist and the second was a British teacher. Neither of the translators was informed of the study objectives.

BT1 and BT2 were assessed to ascertain whether the original meaning of the items (semantic equivalence) of the Visual Analog Scale (VAS) was maintained for referential

equivalence. Referential meaning refers to the ideas or objects of the world to which one or several words refer. If a word has the same referential meaning in both the original and the translated versions, it is assumed that an identical match exists between them.[11] Using VAS, equivalence between pairs of statements was judged in a continuous manner, ranging from 0% (no equivalence) to 100% (full equivalence). Another form was also used to assess general meaning, using a classification involving four levels: unchanged, somewhat changed, much changed, or completely changed. Next, BT1 and BT2 were carefully evaluated for the adequacy of each item and its stability over the translation processes.

4) Synthesized version of the new translations into Portuguese

The same three psychiatrist judges from the previous steps performed all necessary adjustments and produced PF2.

5) Pretest

Participant selection was conducted between August and September 2016. A preliminary test was then performed to investigate whether the items, instructions, and response scale were comprehensible for the target population.

Evaluation of psychometric properties

In the next step, the final version of the Brazilian Portuguese TABS was tested for reliability and verbal comprehension in another sample of health professionals.

1) Reliability

To maintain comparability between the original TABS and this new version, Cronbach's alpha coefficient was used to estimate the reliability of internal consistency of the Brazilian Portuguese TABS.[9]

2) Verbal comprehension

Each participant was requested to assess the clarity and degree of understanding of each

item and the instruction for the use of the instrument using an adapted verbal-numeric scale contained in a questionnaire attached to the final version of the Brazilian Portuguese TABS. They answered the following question: "Did you understand the item?" Answers followed a Likert-type scale, as follows: 0, I did not understand anything; 1, I understood just a little bit; 2, I understood more or less; 3, I understood almost everything, but I had some doubts; 4, I understood almost everything; and 5, I understood perfectly, and I had no doubt. Scores 0, 1, 2, and 3 were considered as insufficient understanding, as suggested by Conti et al.[12,13]

Statistical analysis and ethical procedures

Statistical analysis was performed using STATA version 12.

Written informed consent was obtained from all pretest participants after completely explaining the procedures to them and before including them in the study; anonymity was assured. The participants were given the opportunity to express their comprehension of the scale and suggest any changes that they considered to be necessary.

Results

Conceptual and item equivalences

According to the experts participating in the discussions, 84 items from the original TABS were found to adequately represent the dimensions of vicarious traumatization in the cultural context of Brazil.

Semantic equivalence

Extremely high referential and general equivalences were obtained through the VAS for BT1 and BT2 items vs. the original instrument (Table 1). Referential equivalence was obtained for 76 of 84 (90.5%) items in BT1 and for 77 of 84 (91.7%) items in BT2, with 90-100% equivalence with the original scale. General equivalence was obtained for 81 of 84 (96.4%) items in BT1 and for 82 of 84 (97.6%) in BT2, again with 90-100% equivalence with the original scale. A few changes were made to the scale synthesized version, intended to make the English version more accessible to the target population.

Table 1 - Evaluation of semantic equivalence based on referential and general equivalence between back-translated items and the original TABS

Degree of equivalence between the two back-translations (VAS)	Referential meaning BT1/O, no. items (%)	Referential meaning BT2/O, no. items (%)	Judgment of the evaluators	General meaning BT1/O, no. items (%)	General meaning BT2/O, no. items (%)
90-100%	76 (90.5)	77 (91.7)	Unchanged	81 (96.4)	82 (97.6)
70% ≤ X < 90%	6 (7.1)	7 (8.3)	Little changed	2 (2.4)	1 (1.2)
50% ≤ X < 70%	2 (2.4)	-	Much changed	1 (1.2)	1 (1.2)
< 50%	-	-	Completely changed	-	-
Total	84 (100.0)	84 (100.0)	**Total**	84 (100.0)	84 (100.0)

BT1 = back-translation 1; BT2 = back-translation 2; O = original scale; TABS = Trauma and Attachment Belief Scale; VAS = Visual Analog Scale.

Pretest

A total of 28 volunteer psychologists and psychiatrists participated in the pretest. The mean time needed to respond the instrument was 15 minutes. The participants highlighted several doubts related to scale items and considered the instrument easy to understand. The pretest, which was completed by all participants, demonstrated high acceptability of the instrument.

The suggestions made by pretest participants were evaluated by the experts, and 5 of 84 (5.9%) items were modified for the final scale (Table 2). For example, it was suggested that item (6) be modified from “Eu nunca penso que alguém esteja a salvo do perigo” to “Eu penso que as pessoas nunca estão a salvo do perigo,” moving the negative term “nunca” to the second part of the sentence. This made the phrase more typical of a Brazilian native speaker.

Table 2 - Modifications made during the translation and cross-cultural adaptation procedures

Item from the original TABS	Item from the synthetized version of new translations into Portuguese (P2)	Item after the final adjustments
(6) I never think anyone is safe from danger.	"Eu nunca penso que alguém esteja a salvo do perigo."	"Eu penso que as pessoas nunca estão a salvo do perigo."
(9) When my feelings are hurt, I can make myself feel better.	"Quando meus sentimentos são feridos, eu consigo fazer com que eu me sinta melhor."	"Quando meus sentimentos são feridos, consigo me recuperar."
(21) I feel good about myself most days.	"Eu me sinto bem sobre mim mesmo na maioria dos dias."	"Eu me sinto bem na maioria dos dias."
(56) I have problems with self-control.	"Eu tenho problemas com autocontrole."	"Tenho dificuldades em me autocontrolar."
(76) I don't respect the people I know best.	"Eu não respeito as pessoas que conheço melhor."	"Quando eu conheço melhor uma pessoa, tendo a desrespeitá-la."

TABS = Trauma and Attachment Belief Scale.

Final version in Portuguese

The final version of the Brazilian Portuguese TABS was then sent to and approved by the original author of the instrument.

Psychometric properties

Following translation and cultural adaptation, the psychometric properties of the scale were assessed in a sample of 64 health professionals (psychiatrists, psychologists, social workers, physicians, and speech therapists) between March and April 2017.

Internal consistency

The instrument showed excellent internal consistency (total Cronbach's alpha: 0.9173). All items favorably contributed to the internal consistency of the scale (Table 3).

Table 3 - Evaluation of verbal comprehension and internal consistency of the Brazilian version of the Trauma and Attachment Belief Scale (n = 64)

Question	Verbal comprehension Mean (SD)	Corrected item-total correlation	Cronbach's alpha if item is deleted
1	4.3 (1.0)	0.1404484	0.9181
2	4.6 (0.8)	0.1373516	0.9164
3	4.2 (1.3)	0.1378344	0.9166
4	4.8 (0.5)	0.1359875	0.9151
5	4.7 (0.5)	0.1366883	0.9153
6	4.5 (0.8)	0.1383451	0.9173
7	4.8 (0.4)	0.1380258	0.9166
8	4.6 (0.7)	0.1380305	0.9163
9	4.6 (0.7)	0.1383058	0.9161
10	4.7 (0.5)	0.1393668	0.9169
11	4.7 (0.6)	0.1365181	0.9155
12	4.6 (0.6)	0.1364364	0.9160
13	4.7 (0.6)	0.1356586	0.9152
14	4.8 (0.4)	0.1416595	0.9190
15	4.6 (0.7)	0.1365893	0.9154
16	4.5 (0.8)	0.1387383	0.9174
17	4.7 (0.5)	0.1366356	0.9157
18	4.5 (0.8)	0.1381098	0.9163
19	4.6 (0.7)	0.1383871	0.9164
20	4.8 (0.4)	0.1375594	0.9161
21	4.8 (0.3)	0.1370603	0.9154
22	4.8 (0.3)	0.1375728	0.9160
23	4.7 (0.6)	0.1378577	0.9164
24	4.7 (0.5)	0.1379	0.9171
25	4.7 (0.7)	0.1402682	0.9171
26	4.7 (0.7)	0.1378048	0.9159
27	4.7 (0.5)	0.1375419	0.9186
28	4.7 (0.6)	0.1371623	0.9159
29	4.6 (0.7)	0.1399278	0.9188
30	4.7 (0.7)	0.1393736	0.9167
31	4.7 (0.7)	0.1371953	0.9158
32	4.8 (0.4)	0.1396566	0.9178
33	4.5 (0.8)	0.1372551	0.9156
34	4.7 (0.6)	0.1339433	0.9145
35	4.7 (0.5)	0.1357727	0.9150
36	4.8 (0.4)	0.1365648	0.9152
37	4.5 (0.8)	0.1383941	0.9164
38	4.6 (0.7)	0.1386183	0.9171
39	4.7 (0.6)	0.1377582	0.9160
40	4.6 (0.8)	0.1371618	0.9158
41	4.7 (0.7)	0.1382765	0.9161
42	4.8 (0.3)	0.1400315	0.9174
43	4.7 (0.6)	0.1363441	0.9162
44	4.8 (0.3)	0.139624	0.9168
45	4.6 (0.6)	0.1389352	0.9170

46	4.7 (0.6)	0.1353753	0.9182
47	4.5 (0.8)	0.1387439	0.9157
48	4.6 (0.7)	0.1360627	0.9157
49	4.7 (0.5)	0.1374892	0.9160
50	4.7 (0.8)	0.1392142	0.9172
51	4.9 (0.2)	0.1392444	0.9166
52	4.7 (0.5)	0.1371525	0.9160
53	4.7 (0.5)	0.1394916	0.9180
54	4.7 (0.6)	0.1358045	0.9148
55	4.8 (0.5)	0.1355607	0.9146
56	4.7 (0.7)	0.1384894	0.9165
57	4.6 (0.6)	0.1374299	0.9168
58	4.8 (0.3)	0.1388485	0.9166
59	4.7 (0.6)	0.1362504	0.9155
60	4.7 (0.6)	0.1383016	0.9159
61	4.7 (0.5)	0.1394762	0.9170
62	4.7 (0.6)	0.1412245	0.9199
63	4.7 (0.6)	0.1401219	0.9174
64	4.8 (0.5)	0.1395219	0.9165
65	4.7 (0.5)	0.1380276	0.9171
66	4.7 (0.6)	0.1397331	0.9174
67	4.7 (0.6)	0.134425	0.9143
68	4.7 (0.4)	0.1380349	0.9164
69	4.6 (0.7)	0.1376338	0.9162
70	4.8 (0.4)	0.1376828	0.9161
71	4.6 (0.8)	0.135791	0.9153
72	4.7 (0.7)	0.1387885	0.9162
73	4.7 (0.6)	0.1402497	0.9172
74	4.6 (0.7)	0.1368102	0.9158
75	4.7 (0.8)	0.1386646	0.9161
76	4.7 (0.8)	0.137888	0.9163
77	4.7 (0.6)	0.1395232	0.9175
78	4.7 (0.6)	0.1389156	0.9166
79	4.7 (0.7)	0.1363394	0.9162
80	4.7 (0.6)	0.1400904	0.9179
81	4.8 (0.5)	0.138258	0.9161
82	4.7 (0.6)	0.1371152	0.9153
83	4.8 (0.6)	0.1379393	0.9158
84	4.7 (0.5)	0.1356377	0.9154
Total	-	-	0.9173

SD = standard deviation.

Verbal comprehension

Considering both the instructions for the use of the scale and the 84 items, the mean values obtained in the adapted verbal-numeric scale among the mental health professionals were >4.0. The degree of understanding varied from 4.2 to 4.9 (maximum 5.0), as shown in Table 3.

The whole translation, cross-cultural adaptation, and apparent validation procedure is further illustrated in Figure 1.

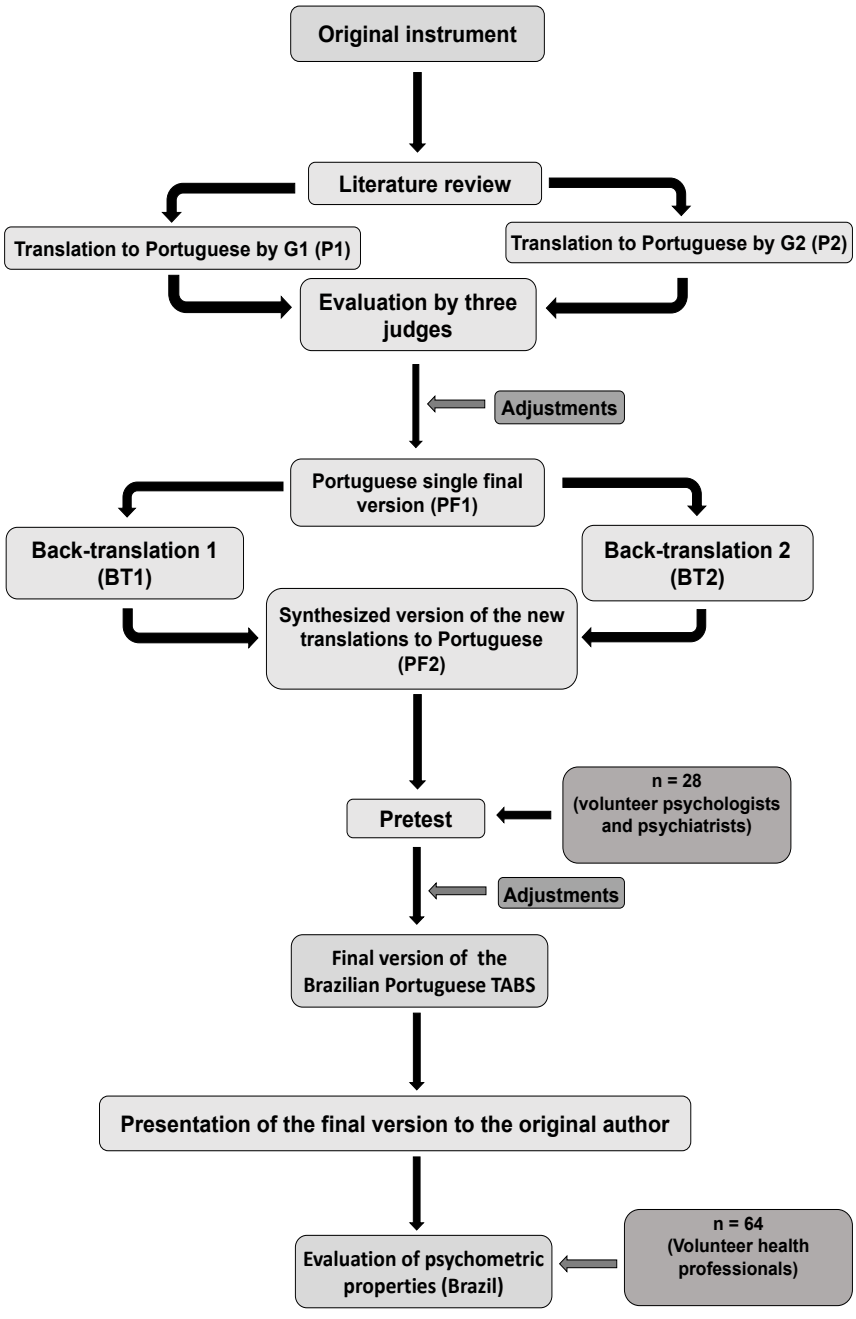

Figure 1 - Steps of the cross-cultural adaptation and apparent validation of the Trauma and Attachment Belief Scale

Discussion

The TABS is a useful instrument for identifying target areas and the best therapeutic intervention for those who have experienced trauma directly or vicariously. In the present study, the cross-cultural adaptation process followed all the recommended steps to develop the official Brazilian Portuguese version of the TABS.

It is interesting to note that the TABS investigates aspects of personality, differently from clinical scales, which focus mainly on symptomatology. Moreover, the TABS measures disruptions in beliefs about personal and interpersonal safety, trust, esteem, intimacy, and control. In turn, these disruptions are related to the harmful effects of traumatic life events.[8]

The adaptation process presented in this article indicated satisfactory equivalence between the original TABS and the Brazilian Portuguese version. This scale can thus help psychologists and psychiatrists in Brazil to assess direct trauma experienced by their patients, such as in cases of PTSD. In addition, it has been established that practitioners working with clients who have experienced trauma are vulnerable to vicarious trauma.[14]Paying attention to the potential impact of clinical work with trauma survivors on the professionals themselves is extremely important for supervision and clinical training.[15] The availability of a tool to monitor the health of those who provide care is important because it considers the existence of humanity on both sides of the situation.

Different professionals (e.g., oncologists and other medical specialties, nurses, social workers, counselors working with clients in substance abuse treatment, firefighters, lawyers, and penitentiary agents) will also be able to use the Brazilian Portuguese version of the TABS, illustrating its potential interdisciplinary relations.[14] Thus, this translated version serves as a novel health promotion instrument, and it can be recommended for application.

We performed the apparent validation of the TABS. Additional studies should assess criterion validity and construct validity.

For the future use of the Brazilian Portuguese version of the TABS, the Western Psychological Services Rights and Permissions department (wpspublish.com) must be contacted and a license must be requested.

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Disclosure

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References

1. Schilling C, Weidner K, Brähler E, Glaesmer H, Häuser W, Pöhlmann K. Patterns of childhood abuse and neglect in a representative German population sample. PLoS One. 2016;11:1-17.
2. Meltzer-Brody S, Churchill E, Davidson JR. Derivation of the SPAN, a brief diagnostic screening test for post-traumatic stress disorder. Psychiatry Res. 1999;88:63-70.
3. Prins A, Ouimette P, Kimerling R, Cameron RP, Hugelshofer DS, Shaw-Hegwer J, et al. The Primary Care PTSD Screen (PC-PTSD): development and operating characteristics. Prim Care Psychiatry. 2003;9:9-14.
4. Gelaye B, Zheng Y, Medina-Mora ME, Rondon MB, Sánchez SE, Williams MA. Validity of the Posttraumatic Stress Disorder (PTSD) Checklist in pregnant women. BMC Psychiatry. 2017;17:179.
5. Gardner PJ, Knittel-Keren D, Gomez M. The Posttraumatic Stress Disorder Checklist as a screening measure for posttraumatic stress disorder in rehabilitation after burn injuries. Arch Phys Med Rehabil. 2012;93:623-8.
6. Pearlman LA, MacIan PS. Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. Prof Psychol Res Pr. 1995;26:558-65.
7. Pearlman LA, Saakvitne KW. Trauma and the therapist: countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: WW Norton; 1995.
8. Raunick CB, Lindell DF, Morris DL, Backman T. Vicarious trauma among sexual assault nurse examiners. J Forensic Nurs. 2015;11:123-8.
9. Pearlman LA. Trauma and Attachment Belief Scale Manual. Los Angeles: Western Psychological Services; 2003.
10. Antai-Otong D. Caring for trauma survivors. Nurs Clin North Am. 2016;51:323-33.
11. Moraes CL, Hasselmann MH, Reichenheim ME. Adaptação transcultural para o português do instrumento "Revised Confluct Tatics Scales (CTS2)" utilizado para identificar violência entre casais. Cad. Saude Publica. 2002;18:163-76.
12. Conti MA, Latorre MRDO, Hearst N, Segurado A. Cross-cultural adaptation, validation and reliability of the Body Area Scale for Brazilian adolescents. Cad Saude Publica.

2009;25:2179-86.

13. Conti MA, Slater B, Latorre MRDO. Validação e reprodutibilidade da Escala de Evaluación da Insatisfación Corporal para Adolescentes. Rev Saude Publica. 2009;43:515-24.
14. Cosden M, Sandford A, Koch LM, Lepore CE. Vicarious trauma and vicarious posttraumatic growth among substance abuse treatment providers. Subst Abus. 2016;36:619-24.
15. Killian K, Hernandez-Wolfe P, Engstrom D, Gangsei D. Development of Vicarious Resilience Scale (VRS): A measure of positive effects of working with trauma survivors. Psychol Trauma. 2016;9:23-31.

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6.3 ARTIGO 3

Associations between countertransference, defense mechanisms and vicarious trauma in forensic psychiatrists and psychologists

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(Artigo apresentado na versão em inglês, em concordância quanto à formatação da fonte, referências e figuras, em conformidade com as exigências da revista para submissão)

Vicarious trauma in forensic experts

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Abstract

Objective: The objective of this study was to examine the associations among countertransference induced by sex offenders, defense mechanisms and manifestations of vicarious trauma in forensic psychiatrists and psychologists.

Methods: A cross-sectional study using a mixed-methods design was performed with 56 Brazilian forensic psychiatrists and psychologists from October 2016 to May 2017. Countertransference reactions, defense mechanisms and vicarious trauma were assessed using the Assessment of Countertransference Scale, Defense Style Questionnaire-40, and Trauma and Attachment Belief Scale, respectively. Qualitative data analysis using grounded theory was also performed to explore the influence of sex offender assessments on the experts' personal and professional lives.

Results: Positive correlations were found between feelings of indifference and vicarious trauma and between immature defense mechanisms and vicarious trauma. In a subgroup of experts without a history of personal psychotherapy, these correlations were very strong. Qualitative data showed changes in the professionals' identity, worldview and beliefs related to safety and trust.

Conclusion: Specific maladaptive coping strategies such as feelings of indifference and immature defenses during the assessment of sex offenders were associated with manifestations of vicarious trauma in forensic psychiatrists and psychologists.

Keywords: criminality, forensic psychiatry, psychotherapy, trauma

Significant Outcomes

- Feelings of indifference and immature defense mechanisms during the assessment of sex offenders were associated with the manifestation of vicarious trauma in forensic experts.
- The strong positive correlations between feelings of indifference and vicarious trauma and between immature defense mechanisms and vicarious trauma found in the subgroup of experts without previous psychotherapy highlight the importance of personal psychotherapeutic treatment for forensic experts.
- Qualitative data reinforces the strong impact that dealing with sex offenders can have on the professional and personal lives of experts, indicating the need for additional studies in this field and for urgent attention to this matter.

Limitations

- This is a cross-sectional study, and thus, temporal relationships between exposures and outcomes cannot be inferred.
- Other risk factors for vicarious trauma that were not investigated during this research may confound the present results.
- Further research is necessary to explore the role of psychotherapeutic treatment in the prevention of vicarious trauma among experts who assess sex offenders.

Introduction

Forensic psychiatrists and psychologists are intellectually and emotionally challenged during their daily work. They must assess and comprehend complex individuals who have committed a variety of crimes, some of them with severe psychopathology. One particular evaluation is the assessment of sex offenders, which is currently gaining increasing attention from the international media due to the disclosure of many cases involving public figures. The emotional hardships associated with working with survivors of rape and violence have previously been described (1-4). Such an understanding, however, does not extend to work with perpetrators of sexual violence by different professionals (5).

Forensic psychiatrists and psychologists are a specific group of professionals who may work directly with sex offenders by evaluating and/or treating them. Rape and sexual violence, as well as pedophilia, represent profound violations (6) of an individual's body and emotions. When assessing these aggressors, experts become familiar with narratives and documentation centered around violence, abuse and perversion. There is nevertheless scarce literature concerning the emotional risks for these mental health professionals and how these specific assessments may affect their lives.

Vicarious trauma (VT) was first described as the profound and unique psychological effect of working with sexual violence survivors on psychotherapists. Being exposed to graphic descriptions of human cruelty can affect the personal, professional and ethical attributes of the therapist (7-8). Additionally, some therapists who work with perpetrators of sexual abuse have reported VT in a moderate to clinical range (9).

One aspect that is often misunderstood is whether VT is a synonym for other phenomena as burnout syndrome, compassion fatigue and secondary traumatic stress. Pearlman (1995) previously explained that VT and burnout are different constructs. While VT results in profound disruptions in the therapist's frame of reference and is a natural response to a very

specialized kind of highly demanding work with trauma material, burnout syndrome represents the emotional exhaustion resulting from the stress of interpersonal contact and the gap between expectations and aspirations on one hand and depleting conditions of the workplace on the other. Compassion fatigue corresponds to deep feelings of suffering, sorrow, or sympathy to the point of exhaustion that are associated with a desire to alleviate the suffering of another person. Secondary traumatic stress is a form of revictimization that can occur when a person is repeatedly exposed to a single traumatic event. Although these are all occupational hazards, and some can occur simultaneously, we will focus our investigation on VT (8,10).

Researchers have previously indicated that some therapist's countertransference issues specific to sex offenders, such as sadistic and aggressive fantasies, polarization of the client (victim versus offender), and barriers to empathic engagement with the client, occur when the therapist focuses on the offense or the offender's denial (11). Concerning forensic experts, Barros et al. (2014) identified a predominance of negative feelings, such as disgust, anger, mistrust and fear, in 26 Brazilian forensic psychiatrists during the evaluation and care of sex offenders (12). After this preliminary study, questions emerged concerning the possibility that the nature and intensity of countertransference could be associated with VT in forensic experts.

Pearlman & Saakvitne (1995) suggested that the processes involved in the interaction between countertransference and VT in therapists are decreased self-awareness, increased defenses, and challenges to identity and beliefs. Until now, the relation between countertransference, defense mechanisms and VT has not been examined in a forensic psychiatry setting.

Study Aims

This study aims first to examine the associations between countertransference reactions induced by sex offenders, defense mechanisms and VT in a sample of Brazilian forensic psychiatrists and psychologists. We then seek to develop a greater theoretical understanding of the professional and personal effects related to sex offender assessments on forensic experts using a qualitative method.

Methods

Study design and ethics

This was a cross-sectional study with a mixed-methods design. Quantitative data regarding participants' demographic information and standardized measures were obtained to describe the sample and provide information on the forensic psychiatrists' and psychologists' countertransference, defense mechanisms and VT. A qualitative design was used to gain a deeper understanding of the influence of sex offenders assessments on assessors' personal and professional lives. Grounded theory (GT) was identified as the most appropriate methodology for this assessment, as it allows researchers to develop knowledge in areas where little is known about a phenomenon and to capture subtleties (13), which was precisely the situation regarding countertransference and VT in a forensic setting in the current study. GT involves the construction of a theory capable of increasing the understanding of a social and/or psychological phenomenon through answers from interviews (14). Informed consent was obtained from all study subjects. The research protocol was approved by the Federal University

of Rio Grande do Sul Institutional Research Ethics Board (CAAE**:** 55151116.4.0000.5347).

Participants

The inclusion criteria were 1) forensic psychiatrists or psychologists and 2) forensic experts listed in all Brazilian Regional Councils of Medicine and Psychology who could be contacted.

Convenience sampling was used, and participant recruitment occurred between October 2016 and May 2017. All participants received an e-mail invitation describing the purpose and content of the study. This e-mail clearly stated that participation was on voluntary basis and that data would be processed anonymously. Experts had approximately 4 weeks to consider their potential participation. At the end of this time period, if no answer had been received, the expert was excluded from the study. Forensic experts without experience assessing sex offenders were also excluded.

To standardize the collection of data in relation to the type of forensic assessment, the following transgressions of the law were considered sex crimes: rape, sexual abuse of children, pedophilia, internet pornography, and sexual homicide; a review of literature has previously shown the impact of these issues on therapists and sex offender researchers (6,9) (Figure 1).

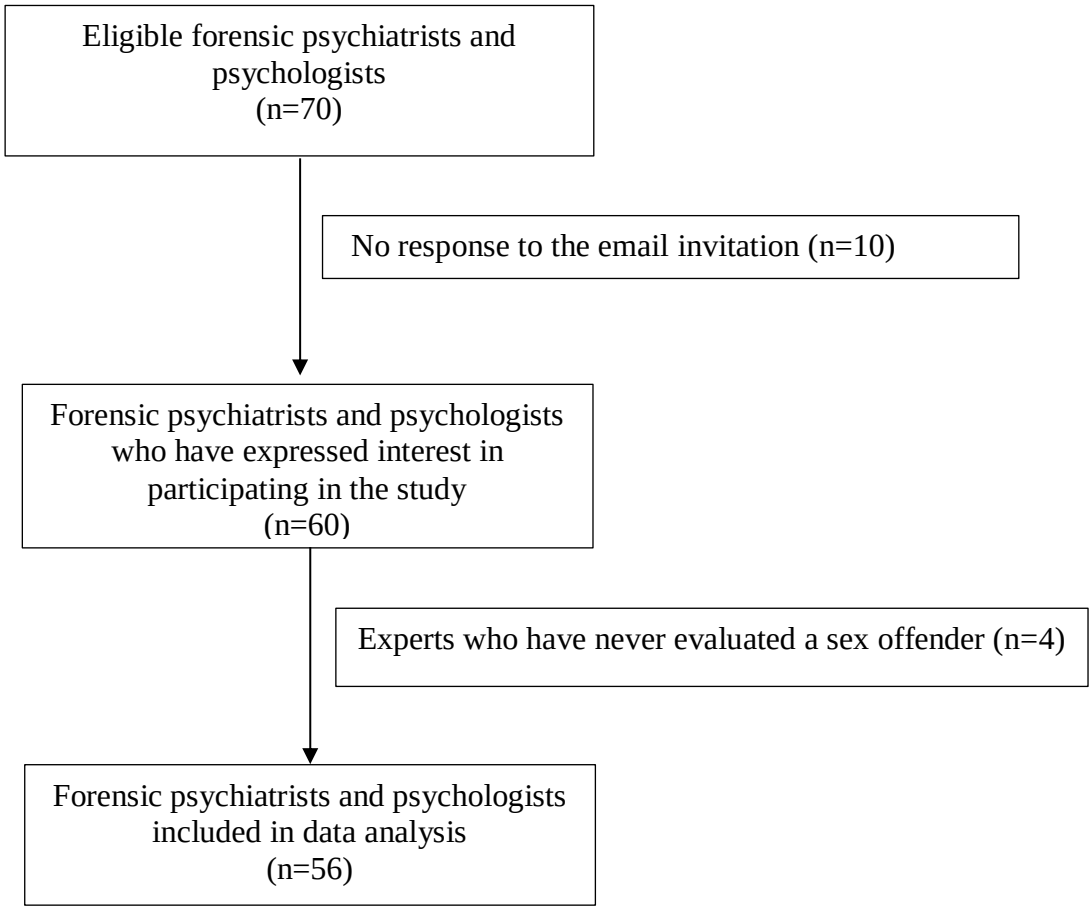

Figure 1: Flow chart for selection of study participants.

Measures

The primary data collection method used for GT assessment was a self-report questionnaire, not an interview, because our participants came from different parts of Brazil, a country of continental proportions; this method also allowed participants the privacy to think about the specifics of their last sex offender's case and their feelings towards and reactions to it. We feel that data collection strategies must fit the particular culture and specific research participants, as stated by Charmaz, 2014 (15). The questionnaire covered the following topics: gender, age, profession (psychologist or psychiatrist), length of forensic expertise, history of

personal psychotherapy treatment, psychotherapeutic training and the date of the last sex offender assessment. Based on VT studies, three comprehensive open-ended questions were developed with the objective of encouraging the interviewee to assess their specific work experiences in sexual crimes: *1. How do you maintain your professional attitude during the assessment of a sex offender? 2. Do you continue thinking about the assessment after it has been performed? 3. What is the influence of this type of assessment on your life?*

Countertransference was evaluated using the *Assessment of Countertransference Scale* (ACS) (16), which is a Brazilian self-report instrument that assesses countertransference through 23 items scored on Likert-type scales (0 = absent to 3 = highly present). The scale was assessed at three times during the session (start, midpoint and end) to determine how feelings varied over the session. Each assessed feeling is part of one of three dimensions: closeness (curiosity, interest, sympathy, solidarity, affection, wishing to help, happiness, sadness, pity, attraction), distance (discomfort, mistrust, boredom, rejection, despair, reproaching, accusation, irritation, fear, hostility) and indifference (disinterest, distance, immobility).

Defense mechanisms were evaluated by the *Defensive Style Questionnaire-40* (DSQ-40) (17-18), a 40-item self-report questionnaire scored on Likert-type scales (1 = *disagree strongly* to 9 = *agree strongly*) that assess 20 defenses. This instrument seeks to identify the characteristic styles that people, consciously or unconsciously, use to address conflicts. The 20 defenses are grouped into three defense styles or factors (immature, mature, and neurotic). The Brazilian-Portuguese version of the DSQ-40 shows psychometric features that allow the use of this instrument in our culture.

VT was evaluated using the *Trauma and Attachment Belief Scale* (TABS) (19-20), an instrument based on constructivism self-development theory. The 84-item TABS assesses disruptions in cognitive schemas in the following five areas: Control, Esteem, Intimacy, Safety, and Trust. The TABS uses Likert-scale scoring (1 = *disagree strongly* to 6 = *agree strongly*) to

produce a total score and ten subscales that measure each area in relation to one's self and others: 1) Self-Safety, 2) Other-Safety, 3) Self-Trust, 4) Other-Trust, 5) Self-Esteem, 6) Other-Esteem, 7) Self-Intimacy, 8) Other-Intimacy, 9) Self-Control, and 10) Other-Control. The TABS has been used by researchers to assess the effects of vicarious traumatization. Higher scores indicate greater belief disturbance. The Brazilian-Portuguese version of the TABS showed excellent internal consistency (total Cronbach's alpha: 0.9173). All items contributed favorably to the internal consistency of the scale (20).

Procedure

If the expert accepted the invitation, then materials were sent by e-mail or letter. The materials comprised a brief guideline indicating that the experts should think about his/her last forensic assessment of a sex offender when completing the instruments, a self-report questionnaire, the ACS, the DSQ-40, the TABS and a consent term. The questionnaire and all standardized measures were completed by the participants and returned by e-mail or postal service to the research team.

Data analysis

Initially, the analysis involved collecting demographic details and data from the standardized measures (ACS, TABS and DSQ-40). Analyses were conducted for individual total scores for each instrument, for each countertransference dimension in the ACS, for each defensive style in the DSQ-40, and for each VT subscale in the TABS. Spearman's correlation analyses were performed to evaluate the strength and direction of correlations between countertransference and VT and between countertransference and defensive style mechanisms.

In this study, no adjustments for multiple comparisons were made, and subgroup analyses should be considered exploratory. A statistical significance level of 0.05 was adopted for all statistical comparisons. The quantitative analyses were conducted using STATA version 12 (21). Qualitative data were analyzed using the NVivo program (22).

The analysis of the qualitative data occurred in several simultaneous stages, consistent with GT methodology (23). NVivo was used to organize coded data once major themes were identified through the process of manual open coding. Immediately after receiving the questionnaires, the researchers transcribed the answers and wrote memos to gain insight into the data. Transcripts were analyzed using a constant and iterative comparative method. Researchers analyzed the initial interviews using line-by-line open coding, assigning a theme to each line of the transcript. When themes frequently reoccurred, researchers had discussions, and one investigator wrote memos recognizing the emerging themes that could be part of a potential theory. The coding process continued after the identification of several key components by identifying how each line fit into a theme or recognizing a new theme that had not yet arisen in the theory. Themes and the understanding of the relationships between them in the larger theory were continuously improved through memo writing and discussions. When no new data appeared to emerge from the answers in the questionnaires, the research team met and agreed that theoretical saturation had been reached. Subsequently, another researcher who was not included in the previous phases analyzed two randomly selected transcripts to ensure inter-coder reliability. A discussion between the researchers revealed agreements on all of the major codes. Lastly, the research team met to agree on the final codes, and all of the transcripts were re-examined to ensure that no relevant data had been missed.

Results

A total of 56 forensic psychiatrists and psychologists (over 70 eligible subjects) were included in the study. The sample characteristics are presented in Table 1. Individuals had an average forensic practice duration of 10.5 years (interquartile range [IQR] 4.0–22.5), and most had an extensive prior history of personal psychotherapy (91%) in different modalities, such as psychoanalysis, dynamic psychotherapy and cognitive behavioral therapy. Moreover, the experts answered the instruments and questionnaires thinking about the last sex offender assessment that occurred a median 4.5 months (IQR] 2.0–24.5) before the data collection.

Table 1. Characteristics of the study population (n=56).

Variable	Statistic
Age, years, median (IQR)	45.5 (33.5-56.0)
Female sex	28 (50.0)
Profession	
Forensic psychiatrist	37 (66.0)
Forensic psychologist	19 (34.0)
Length of forensic expertise, years, median (IQR)	10.5 (4.0-22.5)
Previous psychotherapy	51 (91.0)
Length of psychotherapy, years, median (IQR)	8.0 (4.0-12.0)
Psychotherapy expertise	34 (60.7)
Time between forensic evaluation and study participation, months, median (IQR)	4.5 (2.0-24.5)

Notes: Data showed as n (%), unless otherwise indicated.
Abbreviations: IQR, Interquartile range (P25 – P75).

Results of standardized measures

Investigations on whether countertransference reactions were associated with VT showed that only the indifference dimension was affected (Table 2). Indifference was positively and moderately (rho +0.43, P = 0.002) associated with the Other-Safety TABS subscale. Subgroup correlation analyses (Table 3) indicated that experts with 10.5 years or less of forensic expertise showed a positive and moderate correlation between indifference and VT scores (rho +0.43, P = 0.02). Moreover, experts without previous personal psychotherapy showed a very strong correlation between TABS scores and indifference scores (rho +0.89, P = 0.04).

There was a positive correlation between immature and neurotic factors and TABS total score as well as Other-Safety, Self-Trust, Self-Esteem, Other-Intimacy, Self-Control and Other-Control subscales (Table 4). Immature factors were positively and moderately correlated with TABS total score (rho +0.45, P < 0.001), Other-Intimacy subscale score (rho +0.44, P < 0.001), Self-Control subscale score (rho +0.50, P < 0.001) and Other-Control subscale score (rho +0.55, P < 0.001). Subgroup correlation analyses (Table 5) indicated that experts without previous personal psychotherapy showed a positive and very strong correlation between TABS scores and immature defense mechanisms scores (rho +0.90, P = 0.03) and between TABS scores and neurotic defense mechanisms scores (rho +0.90, P = 0.03).

Table 2. The Spearman correlation coefficient for the association between countertransference and vicarious trauma scores (n=56).

	Closeness	Distance	Indifference
Total TABS Score	-0.06	0.11	0.28*
Self-safety	-0.03	0.23	0.25
Other-safety	-0.11	0.22	0.43**
Self-trust	0.24	-0.02	0.07
Other-trust	-0.17	0.02	0.04
Self-esteem	0.01	-0.05	0.09
Other-esteem	-0.19	0.08	0.16
Self-Intimacy	0.09	0.12	0.21
Other-Intimacy	0.10	-0.10	0.16
Self-control	-0.03	0.07	0.25
Other-control	-0.08	0.05	0.18

Notes: Countertransference was evaluated by the Assessment of Countertransference Scale (ACS) and vicarious trauma was evaluated by the Trauma and Attachment Belief Scale (TABS). The strength of correlation is classified as follows: 0.0-0.19= very weak; 0.20-0.39= weak; 0.40-0.59= moderate; 0.60-0.79= strong; 0.8-1.0= very strong.

* P=0.0008
** P=0.002

Table 3. Subgroup analysis of correlations between indifference and vicarious trauma scores (n=56).

	Spearman coefficient for the correlation between TABS and Indifference scores	***P*-value**
Gender		
Male	0.30	0.11
Female	0.31	0.10
Profession		
Psychiatrist	0.23	0.16
Psychologist	0.29	0.21
Length of forensic expertise		
>10.5 years	0.32	0.08
≤ 10.5 years	0.43	0.02
Previous Psychotherapy		
Yes	0.29	0.03
No	0.89	0.04
Psychotherapy expertise		
Yes	0.21	0.21
No	0.39	0.06
Time between forensic evaluation and study participation		
>4.5 months	0.35	0.06
≤4.5 months	0.14	0.47

Notes: Indifference was evaluated by the Assessment of Countertransference Scale (ACS) and vicarious trauma was evaluated by the Trauma and Attachment Belief Scale (TABS). The strength of correlation is classified as follows: 0.0-0.19= very weak; 0.20-0.39= weak; 0.40-0.59= moderate; 0.60-0.79= strong; 0.8-1.0= very strong.

Table 4. The Spearman correlation coefficient for the association between defense mechanisms and vicarious trauma scores (n=56).

	Mature	Mature without rationalization	Immature	Neurotic
Total TABS Score	-0.11	-0.05	0.45*	0.30**
Self-safety	-0.11	-0.07	0.15	0.15
Other-safety	-0.02	-0.00	0.26***	0.22
Self-trust	-0.29**	-0.23	0.29**	0.17
Other-trust	-0.00	0.06	0.26	0.06
Self-esteem	-0.24	-0.17	0.31****	0.22
Other-esteem	0.03	0.11	0.06	0.06
Self-Intimacy	-0.11	-0.09	0.16	0.10
Other-Intimacy	-0.09	-0.07	0.44*	0.16
Self-control	-0.10	-0.03	0.50*	0.40****
Other-control	0.00	0.05	0.55*	0.26***

Notes: Defense mechanisms were evaluated by the Defensive Style Questionnaire (DSQ) and vicarious trauma was evaluated by the Trauma and Attachment Belief Scale (TABS). The strength of correlation is classified as follows: 0.0-0.19= very weak; 0.20-0.39= weak; 0.40-0.59= moderate; 0.60-0.79= strong; 0.8-1.0= very strong.

* $P<0.001$
** $P=0.02$
*** $P=0.04$
**** $P=0.01$
**** $P=0.002$

Table 5. Subgroup analysis of correlations among immature and neurotic defense mechanisms and vicarious traumatization scores (n=56).

	Spearman coefficient for the correlation between TABS and immature defense mechanism scores	***P*-value**	**Spearman coefficient for the correlation between TABS and neurotic defense mechanism scores**	***P*-value**
Gender				
Male	0.50	0.006	0.20	0.30
Female	0.56	0.001	0.43	0.02
Profession				
Psychiatrist	0.41	0.01	0.09	0.55
Psychologist	0.62	0.004	0.49	0.03
Length of forensic expertise	0.50	0.006	0.22	0.24
>10.5 years	0.38	0.04	0.34	0.06
≤ 10.5 years				
Previous Psychotherapy				
Yes	0.44	0.001	0.27	0.04
No	0.90	0.03	0.90	0.03
Psychotherapy expertise				
Yes	0.49	0.002	0.23	0.18
No	0.30	0.17	0.32	0.14
Time between forensic evaluation and study participation				
>4.5 months	0.36	0.05	0.31	0.09
≤4.5 months	0.34	0.07	0.26	0.17

Notes: Immature and neurotic defense mechanisms were evaluated by the Defensive Style Questionnaire (DSQ) and vicarious trauma was evaluated by the Trauma and Attachment Belief Scale (TABS). The Spearman

correlation coefficient is demonstrated in the table. The strength of correlation is classified as follows: 0.0-0.19= very weak; 0.20-0.39= weak; 0.40-0.59= moderate; 0.60-0.79= strong; 0.8-1.0= very strong.

Results of qualitative data

A total of 56 questionnaires were completely answered. Forty-seven (83%) forensic psychologists and psychiatrists reported that they continued thinking about the case after assessing a sex offender. The analysis of the content of the responses generated a theoretical model about the impact of the sex offender's forensic assessment on the expert. This analysis produced 3 main areas of interest: professional life, personal life and belief and value systems.

Professional life

Most forensic psychiatrists and psychologists endorsed a focus on technical aspects during the assessment of the sex offenders to maintain their emotional stability and neutrality. Another strategy described was to avoid paying too much attention to the specifics of the crime and focus on the person being examined. Participants reported that they focused their attention on the diagnostic procedures of psychopathology and mental disorders, whether the subject's ability to clearly understand his actions and control his behaviors during the crime was affected by any mental disorder, his motivations and the circumstances of the crime. For instance,

> "I focus on the evaluation and on the formalities of the forensic assessment." (Male forensic psychiatrist)

> "I try to focus on the objective data of the case—on the technical evaluation." (Male forensic psychiatrist)

> "I keep my attention on the diagnosis and not on the offense itself." (Male forensic psychiatrist)

> "I try to maintain a neutrality about the sex crime and direct my attention to the diagnosis and if there was any mental disorder when the crime occurred." (Male forensic psychiatrist)

Participants also stressed the importance of work formalities and procedures and trying to collect as much information as possible, either directly from the sex offender or using collateral resources, to maintain their role as a forensic expert and avoid overwhelming negative feelings that may disrupt the assessment:

> "I organize my material and divide the interview by topics that I intend to investigate, leaving the crime as the last issue to evaluate." (Female forensic psychologist)

> "I do a formal contract relating to the forensic assessment, stressing the non-confidentiality in this setting. I try to maintain neutrality without making the issue something personal." (Male forensic psychiatrist)

> "I try to be as neutral as possible but also aware of the inconsistencies and flawed acts of the offender." (Male forensic psychiatrist)

> "In general, my attitude tends to be formal, with few gestures, gazing firmly but without being disapproving, superior or judgmental—just investigative and understanding. I wear understated clothes and avoid accessories that denote personal tastes in my work environment." (Female forensic psychiatrist)

> "I perform the anamnesis, physical and mental examinations, listening with attention to the offender. I try to keep myself neutral, analyzing medical papers, reports and interviewing family members of the offender. I use clarifying questions and try to keep calm, with an appropriate tone of voice, and I emphasize my role as a forensic expert." (Male forensic psychiatrist)

In terms of countertransference, participants emphasized that the assessment of sex offenders awakens strong feelings that are sometimes persistent and cause them to be worried and alarmed:

> "I take as a premise the understanding that our aversion when faced with a crime, whether it is a sexual crime or nor, originates from a personal impulse that is not recognized and that, even if it was transformed into its aesthetics, remains contained by our own imposed psychological structure. We attack the offender as a way to contain certain impulses or thoughts that, even if they will never become an act, arouse the same initial rejection." (Male forensic psychologist)

> "I seek to maintain a medical position, trying to understand the person who is sitting in front of me. At the same time, I work with my countertransference and any feelings that have been awakened." (Female forensic psychiatrist)

> "After a few moments, I seek affective distance from the offender." (Male forensic psychiatrist)

"I am aware of the intensity of the countertransference involved in the assessment of sex offenders, and I seek to exempt myself from moral judgments to understand the subject." (Female forensic psychologist)

"I try to neutralize feelings of hostility." (Male forensic psychiatrist)

"I try to avoid thinking about the victim and focus on the offender, seeking to collect all possible data from his current and past history, with the purpose that maybe knowing him a little better will alleviate my anger." (Female forensic psychiatrist)

"I feel sorry for the victims of sexual violence." (Male forensic psychiatrist)

"I keep my attention on the subject's reports. Although I feel affected by some descriptions and narratives, I try to keep the posture of listening and perform the necessary interventions because I know that, many times, the offender wants to destabilize the expert." (Female forensic psychologist)

"I try to control myself emotionally." (Male forensic psychiatrist)

"The repercussions that I observe in my life after the assessment of a sex offender, in the short term, are of surprise and sometimes of restlessness and regret when the case is shocking or grotesque." (Male forensic psychiatrist)

Participants reported that their experiences with personal treatment combined with their psychotherapeutic training were helpful in performing better assessments of sex offenders

and in feeling confident in their role. Participants also revealed the importance of peer support not only in the technical aspects of the work but in providing a healthier work environment:

> "Personal psychotherapy and discussion of the cases in a team setting help me to minimize the burden of assessing sex offenders." (Female forensic psychologist)

> "In addition to the theoretical and technical resources available to clinical and forensic psychiatrists, relating to neutrality, I use personal resources acquired from my treatment in psychoanalysis and my professional experience as a psychoanalyst." (Male forensic psychiatrist)

> "My years of experience as a psychoanalyst have helped me a lot in assessments of sexual aggressors." (Female forensic psychiatrist)

> "When I assess sex offenders, I trust my own psychoanalytical treatment." (Male forensic psychologist)

> "When I assessed the sex offender, I was able to count on the participation of the entire technical team (a forensic psychiatrist and a social worker), which allowed me to prepare the report with composure and confidence." (Female forensic psychologist)

> "I talk with peers (fellow psychiatrists and psychologists) to try to broaden the understanding of the phenomenon and in some cases I use the assessment as a model for a case study or for a scientific presentation." (Male forensic psychiatrist)

> "I discuss the case with work colleagues." (Female forensic psychiatrist)

Participants disclosed a belief that the assessment of sex offenders makes them more mature human beings in the sense that they lose naivety since they get to know real life stories that other people are blind to.

> "This type of work has shown me a reality that was very different from my life experiences. I can say that it has even helped my personal and professional growth." (Male forensic psychiatrist)

> "These assessments awaken my scientific curiosity, serving as a stimulus for study and research." (Female forensic psychiatrist)

Participants reported that their role in the justice system was sometimes overwhelming. Feelings of responsibility and preoccupation were frequently related to anxiety. Knowing that their assessment has important repercussions in the lives of the victims and the suspects/offenders is a burdensome aspect of their work. Neutrality and a commitment to justice were reported as tools that guide them through the process. Participants also reported concerns in complying with the legal deadlines.

> "I wish that the forensic assessment was conclusive to a good application of justice." (Male forensic psychiatrist)

> "In general, I am anxious and worried about the consequences and possible implications of the report in judgments or decisions about the lives of the people involved, and I am afraid to make a mistake and not be completely fair." (Female forensic psychiatrist)

> "Personal feelings of angst are related to the possibility that the report determines the arrest of someone who is not guilty. In the forensic field, there are many false accusations; therefore, we need to take necessary care not only with the victim—avoiding secondary victimization, not doubting about her/his complaints—but also with the alleged offender, which requires some doubt that he could not have committed the crime." (Female forensic psychologist)

> "The deadlines worry me. After I complete the forensic report, I feel relief." (Female forensic psychiatrist)

Some participants also reported that the feelings induced by the assessment of a sex offender are not different from the ones induced during the assessments of another serious crimes:

> "The evaluation of a sex offender has the same influence on my life as other types of crimes: filicide, murder, etc." (Male forensic psychologist)

> "They do not differ from other assessments of subjects that threaten the lives of others." (Male forensic psychologist)

Personal life

In addition to increase their scientific curiosity and work skills, as mentioned above, participants elaborated on the idea that assessing sexual crimes in particular provided a wider

understanding of human nature and reality, which was considered a form of personal growth. This broader knowledge has the potential to change the way they behave in society.

> "This assessment allows me to bring forms of self-preservation to our experience in society." (Female forensic psychologist)

> "It expands my closeness with human nature." (Male forensic psychiatrist)

> "This assessment allows me to know the human mind and the possibilities of actions that people are capable of due to mental illness." (Female forensic psychologist)

> "These assessments improved my behavior as a human being. Reviewing them, in the face of so many adversities, mental suffering and setbacks throughout life, I noticed that some people have a kind of reaction that is considered unpredictable and aggressive." (Male forensic psychiatrist)

> "It increases my understanding about people and about myself. It increases my curiosity about human behavior." (Male forensic psychiatrist)

The experts reported that assessing sexual crimes leads to repercussions in their feelings of danger/security. These repercussions are expressed in their personal relationships by adopting a more distrustful attitude with strangers and more protective attitude with their families. Participants reported that they feel more aware of the possibility of them or someone important to them (significant other) suffering an act of violence, which makes them more vigilant in avoiding an attack.

> "Certainly, the first aspect affected is personal security: understanding the aesthetics chosen by these subjects to exercise their sexuality, I take a lot of care with the children of my family that, in ordinary situations, I would not." (Male forensic psychologist)

> "I am more careful about my personal safety in any place. I avoid unsafe locations. My trust in others is relative. In my personal circle, I avoid people who are very sick (emotionally), and I do not have contact with drug users. I am more attentive in social situations to signs of simulation and manipulation." (Female forensic psychiatrist)

> "Since I have a daughter, I advise her about the importance of care when dealing with any person because I assume that, until proven otherwise, anyone could be a sex offender."(Female forensic psychiatrist)

> "It makes me more cautious in relation to contact with outsiders, and I take more safety measures with my children." (Female forensic psychiatrist)

> "I am alert about situations that I consider risky for me or for people that I know. I avoid people with characteristics and behaviors that remind me of the sex offender." (Male forensic psychiatrist)

Participants revealed that the assessments of sex offenders eventually invade their personal lives through feelings and negative thoughts that arise even outside the work environment. The sex cases can be quite disruptive and violent, making them difficult to be ignored or forgotten. The feelings reported were discouragement, fatigue, sadness, discomfort and hopelessness.

"For a period of time, I have uncomfortable feelings such as fear." (Male forensic psychiatrist)

"I recognize a gradual detrition over the years. The feeling is that I am always tired." (Male forensic psychiatrist)

"I observe myself thinking about the case outside the work environment since the reports are strong and bring a portrait of significant violence. At many times, I feel powerless." (Female forensic psychologist)

Forensic experts reported that several personal factors affected their disposition when assessing sex offenders:

"It has become more difficult to conduct expert interviews with sex offenders of children after the birth of my son." (Male forensic psychiatrist)

Surprisingly, there were participants who denied any influence in their personal life after assessing sex offenders, and they reported that they were capable of controlling negative thoughts and feelings when they were not at work.

"Little influence. In general, I am able to avoid taking it home." (Female forensic psychiatrist)

"No influence. I have learned that we should separate things and avoid acting on emotions, and instead with professionalism and ethics." (Male forensic psychiatrist)

"In my personal life, it has no influence. As soon as the assessment ends, I no longer remember that it occurred." (Female forensic psychiatrist)

"This type of assessment does not affect my personal life."(Male forensic psychiatrist)

"No influence at all." (Male forensic psychiatrist)

Belief and value systems

Participants felt that these assessments have the power to change the way they see, feel and experience the world, modifying their belief that the world is a good, benign place. They became more pessimist, skeptical and hopeless about human nature than they were before encountering sexual crimes offenders.

"This type of assessment has a numbing effect on me and has changed how I see the world and human behavior. I recognize the changes to my worldview, which now has more negative nuances, and I am deeply saddened. It is as if I am accessing a different world, where tyranny and monstrosities are so trivial and common. It is necessary to maintain a firm conviction that reality and human acts have as many facets of goodness as violence and that life is not restricted to these two poles but that there are many possibilities." (Female forensic psychologist)

"It always causes me to question human nature and malevolence. I have a great desire to understand what leads some people to do things that are appalling." (Female forensic psychiatrist)

"It increases my attention to the perversions of human beings." (Female forensic psychiatrist)

"My focus on the negative aspects of human beings has increased, as has my mistrust in third parties. I am more critical and less tolerant in general." (Female forensic psychiatrist)

"I have become more hopeless about human malice." (Female forensic psychiatrist)

"There was no modifying influence on my actions, but it changed my thoughts and reflections about human behavior." (Male forensic psychiatrist)

Participants reported reflecting on specific aspects of education, such as value systems, ethical aspects, prejudices, and the need for a deep understanding of human nature to properly address ethical concerns:

"This type of assessment produces the concern about how the educational differences between boys and girls generate or could generate deviant male sexual behaviors." (Male forensic psychiatrist)

"It reinforces my belief in the importance of education for a better society, although I know that psychopaths will always exist." (Female forensic psychiatrist)

"This assessment helps me to understand how real life is a result of the control that we can and can't exert on our impulses." (Male forensic psychiatrist)

Discussion

To the best of our knowledge, this study represents the first investigation of the associations between countertransference reactions, defense mechanisms and VT in forensic psychiatrists and psychologists who evaluate sex offenders that combines quantitative and qualitative research methods. A cross-sectional analytic study design combined with GT was chosen to provide a comprehensive analysis of the research problem (24). The collection of both forms of data occurred at same time and involved the same individuals, thus strengthening each other.

Brazil is a large country with a high violent crime rate. However, forensic psychologists and psychiatrists, professionals with many years of education and training, are limited in number in our region. Experts who have evaluated a sex offender are even more rare since most professionals are dedicated to civil cases. Thus, this study presents data from a very particular population.

Even with a theoretical background, specific training and many years of practice, forensic psychiatrists and psychologists are still vulnerable to emotional risks involved in their expert positions. They know how to maintain a professional distance from the examined subject; however, their material related to sex crimes cases is usually disturbing and traumatic. This type of work should not be understood as a mechanical procedure or a sequence of repetitive actions, involving the input of information, analyses and a result. This study reveals that this work can lead to emotional costs for the professionals involved. On the other hand, if the forensic expert completely silences his/her countertransference resources, pursuing perfect neutrality and objectivity, he/she can miss important information, potentially limiting or undermining the conclusions of the forensic report.

Our findings have important clinical and legal implications. The quantitative and qualitative data support existing research on the occurrence of complex countertransference reactions in forensic psychiatrists (12), expand the findings to forensic psychologists and identify additional important elements, such as the occurrence of feelings of indifference. Indifferent countertransference feelings after the assessment of a sex offender were associated with VT in forensic experts, especially in those without a history of personal psychotherapy. It is interesting that feelings of disinterest, distance and immobility were associated with VT and not feelings such as hostility, fear or irritation. When assessing the literature, we found that the emotional distance of professionals who provide treatment services to sex offenders has already been described by Farrenkopf (1992). He commented that professionals who provide treatment services to sex offenders in the adaptation phase appear to find a renewed sense of meaning and motivation for their work by adopting realistic treatment expectations and an attitude of detachment towards their clientele (25).

It is very challenging to the expert to be able to recognize his own state of mind and emotions and to manage these aspects during the assessment of a sex offender or while he is involved with a case since some cases take years to resolve, and the expert can be requested to provide further explanation to the court. This process requires constant self-observation. In this sense, personal psychotherapeutic treatment can provide the opportunity for the expert to face his feelings and find relief, thus enabling the proper continuation of his duty.

Some forensic psychologists and psychiatrists reported that they focus their attention on technical aspects to suppress difficult feelings. Others reported that the assessment of a sex offender has no influence on their personal or professional lives. This last perception signals the complexity involved in the process of the denial of this content in the expert's life, whether personal or professional. Since feeling something is a natural and expected response, the non-recognition of the repercussions of this content may represent a blind spot in his/her forensic

practice and affect the mental health of the professional. Some experts approach sexual crimes in a similar manner as other serious crimes against life, such as homicide, disregarding the peculiarities presented in sex crimes cases.

The qualitative data indicated that experts, even when ignoring the term VT, described the occurrence of VT when reporting their experiences during the assessments of sex offenders. They described detrimental changes in their views of themselves, others, and the world, specifically concerns about the safety of their loved ones, particularly children.

As noted by Coles (2013), the impact of working with child abuse and adult violence offenders on the well-being of medical professionals and their staff is far less frequently discussed in the literature than the traumatic nature of child abuse and adult violence on victim/survivors, with negative effects on emotional, mental, and physical health (26). Since VT can cause decreased motivation, efficacy and empathy of the professional (27), we must debate it in an open and clear way.

We also found associations between immature and neurotic defense mechanisms and VT. It is interesting to note that the length of forensic expertise and a history of personal psychotherapy may influence these associations. Time or experience has already been indicated to play a role in reducing overall distress in trauma workers (28). This finding reinforces the idea that the mental health of the forensic expert should not be neglected.

A lack of personal psychotherapy may represent a risk factor for VT among forensic experts who assess sex offenders. Both quantitative and qualitative results indicate the importance of personal psychotherapeutic treatment by providing awareness about how the experts feel when assessing a sex crime case and how they can properly manage these feelings. The significant impact of these factors on experts who have never been in personal psychotherapeutic treatment emphasizes the importance of treatment, which allows access to the internal thoughts and feelings engendered and the appropriate management of these

emotional states by experts, thus increasing their reflective functioning and defense mechanisms. The factor with the strongest association with VT was feelings of indifference, which signals the consequences of not having adequate tools to address this trauma.

We did not find differences between male and female experts in countertransference, VT or defense mechanisms. Brady (1999), when investigating female psychotherapists who had more sexual abuse clients, stressed the importance of VT prevention and coping in both clinical training and practice (28).

Other factors must be addressed in further studies. Personal qualities, such as optimism, may be able to moderate the negative impact of traumatic work. Additionally, organizational factors (through the provision of institutional support) and personal coping strategies can make a remarkable difference for trauma professionals in managing their distress (29).

Nevertheless, the model developed through this research may function as a tool to help guide the development of programs to investigate the occurrence of VT in forensic psychiatrists and psychologists; this model may also offer effective strategies to help experts, since this topic currently appears to be ignored or minimized. A systematic review performed by Nimmo and Huggard (2013) highlighted that research on the presence of VT, compassion fatigue and secondary traumatic stress in physicians has received little attention, despite these experiences being reported as negative (29). Our findings are consistent with those from other studies on emotional burdens when working with sex offenders. However, this study identified other important elements in this context, such as the expert's increased understanding of the human mind, human nature and psychopathology.

The present research points to the necessity of topics such as countertransference, defensive style mechanisms and VT to be included during the training of new forensic experts. These phenomena need to be systematically recognized as an important part of the work of

forensic psychologists and psychiatrists. By examining these processes more closely and conducting the necessary interventions, we can prevent VT or increase the possibility of vicarious traumatization growth, which includes positive changes following vicarious exposure to trauma, a new appreciation for spirituality, a better awareness of personal good fortune, and a strengthened sense of optimism (30).

Many researchers have suggested that the exposure to traumatic material indirectly from clients consists of an occupational hazard for therapists (31). Considering the recent interest and investigations into VT in forensic experts, if our findings are confirmed in further studies, even with the recognition of the differences between the forensic setting and the clinical environment, VT may be considered an occupational hazard for forensic mental health experts.

Limitations and future considerations

Some limitations of this study should be considered. First, it is difficult to make causal inferences since this is a cross-sectional study with a mixed-methods design. Second, findings should be interpreted with caution, given the limited number of experts. The generalizability of some aspects of the model is limited because of the qualitative nature of the research.

Our results suggest psychotherapeutic treatment, supervision of cases and team work with other professionals, when possible, for forensic psychiatrists and psychologists who assess sex offenders.

Professionals from different countries performing the same job may differ in job burnout, which may also be true for VT (32). Thus, additional research is needed to confirm these findings in other populations of experts, in different cultures and for other types of forensic assessments. Future studies should also investigate the role of additional factors that increase the risk for VT in forensic experts, such as individual vulnerabilities (e.g.,

temperament, identity, character traits, mental disorders), personal trauma history, coping strategies and personal stress.

Shauben (1995) reported that one of the most difficult aspects of working with sexual violence survivors was dealing with injustices in the legal system and the inadequacies of mental health coverage (33). Thus, for appropriate justice and, more broadly, for improved public mental health, the well-being of forensic psychiatrists and psychologists should be a mandatory focus, as these professionals provide technical opinions about cases that may influence the lives of a diverse group of people. Underlying key mechanisms that contribute to VT may be identified, and preventive interventions may be developed and tested. A hypothetical prevention intervention might include both psychoeducational sessions to explain VT and the selection of the best psychotherapeutic methods for each case.

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Declaration of interest

We declare that there are no competing interests to disclose.

References

1. BAIRD S, JENKINS S. Vicarious trauma, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. Violence Vict 2003;**18**:71-86.

2. SLATTERY SM, GOODMAN LA. Secondary traumatic stress among domestic violence advocates: workplace risk and protective factors. Violence Against Women 2009;**15**:1358-1379.
3. VANDEUSEN K, WAY I. Vicarious trauma: an exploratory study of the impact of sexual abuse treatment on clinician's trust and intimacy. J Child Sex Abus 2006;**15:**69-85.
4. WAY I, VANDEUSEN K, MARTIN G, APPLEGATE B, JANDLE D. Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. J Interpers Violence 2004; **19**:49-71.
5. COLES J, DARTNALL E, LIMJERWALA S, ASTBURY J. Briefing paper: researcher trauma, safety and sexual violence research. Pretoria, South Africa: Sexual Violence Research Initiative, 2010.
6. COLES J, ASTBURY J, DARTNALL E, LIMJERWALA S. A qualitative exploration of researcher trauma and researchers' responses to investigating sexual violence. Violence Against Women 2014;**20**:95-117.
7. MCCANN IL, PEARLMAN LA. Vicarious traumatization: a framework for understanding the psychological effects of working with victims. J Trauma Stress 1990; **3**:131-149.
8. PEARLMAN LA, SAAKVITNE KW. Trauma and the therapist: countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: W.W. Norton; 1995.
9. MOULDEN HM, FIRESTONE P. Vicarious traumatization: the impact on therapists who work with sexual offenders. Trauma Violence Abuse 2007;**8**:67-83.
10. TABOR PD. Vicarious traumatization: concept analysis. J Forensic Nurs 2011;7:203-208.

11. MITCHELL JT, MELIKIAN K. (1995). The treatment of male sexual offenders: Countertransference reactions. J Child Sex Abus 1995;**4:**87-93.
12. BARROS AJS, ROSA RG, EIZIRIK CL. Countertransference reactions aroused by sex crimes in a forensic psychiatric environment. Int J Forensic Mental Health 2014;13:363-368.
13. FASSINGER RE. Paradigms, praxis, problems, and promise: grounded theory in counseling psychology research. J Couns Psychol 2005;52:156-166.
14. NAYAR S. Grounded theory: a research methodology for occupational science. J Occup Sci 2012; 19:76-82.
15. CHARMAZ K. Grounded theory in global perspective: reviews by international researchers. Qual Inq 2014;20:1074-1084.
16. SILVEIRA JÚNIOR EM, POLANCZYK GV, EIZIRIK M, HAUCK S, EIZIRIK CL, CEITLIN LHF. Trauma and countertransference: development and validity of the Assessment of Countertransference Scale (ACS). Rev Bras Psiquiatr 2012;34:201-206.
17. ANDREWS G, SINGH M, BOND M. The defense style questionnaire. J Nerv Ment Dis 1993;181:246-256.
18. BLAYA C, DORNELLES M, BLAYA R, KIPPER L, HELDT E, ISOLAN L, et al. Brazilian-Portuguese version of defensive style questionnaire-40 for the assessment of defense mechanisms: construct validity study. Psychother Res 2007;17:261-270.
19. PEARLMAN LA. Trauma and attachment belief scale. Los Angeles: Western Psychological Services; 2003.
20. BARROS AJS, TECHE SP, RODRIGUES A, SEVERO C, SALDANHA R, BASSOLS AM, et al. Brazilian Portuguese translation, cross-cultural adaptation and apparent validation of the trauma and attachment belief scale. Trends Psychiatry Psychother Forthcoming 2018.

21. StataCorp.2015. Stata Statistical Software: Released 14. College Station, TX: StataCorp LP.
22. QSR International Pty LTD (2010). NVivo qualitative data analysis software. Melbourne, QSR International Pty Ltd.
23. CHARMAZ K. Constructing Grounded Theory. 2nd ed. Los Angeles, London, New Delhi, Singapore: Sage; 2014.
24. CRESWELL JW. Research design: qualitative, quantitative, and mixed methods approaches. 4th ed. Los Angeles, London, New Delhi, Singapore: Sage; 2014.
25. FARRENKOPF T. What happens to therapists who work with sex offenders? J Offender Reabil 1992; 18: 217-223.
26. COLES J, DARTNALL E ASTBURY J. "Preventing the pain" when orking with Family and sexual violence in primary care. International Journal of Family Medicine 2013; 1-7.
27. BAIRD K, KRACEN AC. Vicarious traumatization and secondary traumatic stress: a research synthesis. Couns Psychol Q 2006;19:181-188.
28. BRADY JL, GUY JD, POELSTRA PL, BROKAW BF. Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: a national survey of women psychotherapists. Professional Psychology: Research and Practice 1999;30:386-393.
29. NIMMO A, HUGGARD P. A systematic review of the measurement of compassion fatigue, vicarious trauma, and secondary traumatic stress in physicians. Australas J Disaster Trauma Studies 2013;1:37-44.
30. COHEN K, COLLENS P. The impact of trauma work on trauma workers: a metasynthesis on vicarious trauma and vicarious posttraumatic growth. Psychol Trauma 2013;5:570-580.

31. ROBINSON-KEILIG RA. Secondary traumatic stress and disruptions to interpersonal functioning among mental health therapists. J Interpers Violence 2014;29:14771496.
32. CIESLAK R, SHOJI K, DOUGLAS A, MELVILLE E, LUSZCZYNSKA A, BENIGHT CC. A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. Psychol Serv 2014;11:75-86.
33. SCHAUBEN LJ, FRAZIER PA. The effects on female counselors of working with sexual violence survivors. Psychl Women Q 1995;19:49-64.

7 CONCLUSÕES

Este trabalho consistiu na primeira investigação sobre as associações entre contratransferência, mecanismos de defesa e trauma vicário em psiquiatras e psicólogos forenses brasileiros que avaliaram criminosos sexuais, iniciando, deste modo, o preenchimento de lacuna existente na literatura científica. Faltam estudos que abordem as repercussões emocionais de trabalho altamente específico – a perícia psiquiátrica e psicológica - cujo material costuma ter um conteúdo bastante traumático, na saúde mental, capacidade funcional ocupacional e vida dos profissionais envolvidos.

O primeiro estudo, observacional e exploratório, investigou o papel da contratransferência nas atividades desenvolvidas por psiquiatras forenses dentro de um hospital psiquiátrico-forense brasileiro e gerou hipóteses para as investigações subsequentes dessa tese.

A tradução para o Português brasileiro, adaptação transcultural e validação aparente da TABS permitiu o reconhecimento e utilização desse interessante e útil instrumento por diversos psiquiatras e psicólogos participantes do estudo, bem como produziu a disponibilização da ferramenta psicométrica para uso clínico e em pesquisa no Brasil.

O estudo transversal com métodos mistos, principal elemento dessa tese, por sua vez, possibilitou uma compreensão mais abrangente da questão. A abordagem quantitativa permitiu a mensuração dos elementos avaliados (contratransferência, mecanismos de defesa e trauma vicário) e indicou a existência de correlações positivas entre eles. A GT forneceu informações esclarecedoras, as quais não poderiam ser acessadas sem essa análise qualitativa.

Sentimentos contratransferenciais de indiferença (desinteresse, distância, imobilidade) desencadeados após a avaliação de um agressor sexual, bem como mecanismos de defesa imaturos estiveram associados com TV em peritos, especialmente naqueles sem uma história pessoal de tratamento psicoterápico.

Os dados qualitativos revelaram que alguns peritos mantém o foco do trabalho nos aspectos técnicos, a fim de suprimirem sentimentos difíceis. Outros, de modo surpreendente, relataram que a avaliação de um criminoso sexual não exerce qualquer influência em suas vidas profissionais ou pessoais. Adicionalmente, a análise qualitativa indicou que determinados peritos, mesmo ignorando o termo TV, descreveram sua ocorrência, ao informarem as experiências vivenciadas durante esse tipo de exame. Eles descreveram mudanças deletérias no modo de ver a si mesmos, os outros e o mundo, com preocupações relacionadas à segurança dos entes queridos e, dentre eles, especialmente das crianças da família.

Por fim, esta pesquisa pode ser utilizada como ferramenta para quebrar o silêncio sobre o tema, tanto no ambiente acadêmico quanto profissional (hospitais de custódia e tratamento, departamentos médico-legais, foros), guiar o desenvolvimento de programas que incluam a questão no treinamento de novos psiquiatras e psicólogos forenses e investigar a ocorrência de TV no setting forense, oferecendo estratégias efetivas aos peritos em situação de risco - tratamento psicoterápico pessoal, suporte institucional e supervisão/discussão dos casos. Estudos futuros devem ser realizados, investigando-se outros fatores que possam aumentar o risco de TV e desenvolvendo-se estratégias de prevenção e detecção precoce.

REFERÊNCIAS

1. Baird S, Jenkins S. Vicarious trauma, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. Violence Vict 2003 Feb18;18(1):71-86.

2. Slattery SM, Goodman LA. Secondary traumatic stress among domestic violence advocates: workplace risk and protective factors. Violence Against Women 2009; 15(11):1358-79.

3. Vandeusen K, Way I. Vicarious trauma: an exploratory study of the impact of sexual abuse treatment on clinician's trust and intimacy. J Child Sex Abus 2006;15(1):69-85.

4. Way I, Vandeusen K, Martin G, Applegate B, Jandle D. Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. J Interpers Violence 2004 Jan;19(1):49-71.

5. Coles J, Dartnall E, Limjerwala S, Astbury J. Briefing paper: Researcher trauma, safety and sexual violence research. In: Sexual Violence Research Initiative, 2010 May, Pretoria, South Africa.

6. Coles J, Astbury J, Dartnall E, Limjerwala S. A qualitative exploration of researcher trauma and researchers' responses to investigating sexual violence. Violence Against Women 2014;20(1):95-117.

7. McCann IL, Pearlman LA. Vicarious traumatization: a framework for understanding the psychological effects of working with victims. J Trauma Stress 1990 Jan;3(1):131-49.

8. Pearlman LA, Saakvitne KW. Trauma and the therapist: countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: W.W. Norton; 1995.

9. Moulden HM, Firestone P. Vicarious traumatization: the impact on therapists who work with sexual offenders. Trauma Violence Abuse 2007 Jan;8(1):67-83.

10. Tabor PD. Vicarious traumatization: concept analysis. J Forensic Nurs 2011 Nov 28;7(4):203-8.

11. Mitchell JT, Melikian K. (1995). The treatment of male sexual offenders: Countertransference reactions. J Child Sex Abus 1995;4(1):87-94.

12. Friedrich M, Leiper R. Countertransference reactions in therapeutic work with incestuous sexual abusers. J Child Sex Abus 2006;15(1):51-68.

13. Barros AJS, Rosa RG, Eizirik CL. Countertransference reactions aroused by sex crimes in a forensic psychiatric environment. Int J Forensic Mental Health 2014 Oct30;13(4):363-68.

14. Betan E, Heim AK, Conklin CZ, Westen D. Countertransference phenomena and personality pathology in clinical practice: an empirical investigation. Am J Psychiatry 2005 May;162(5): 890-98.

15. Bernardi BL. Origem e evolução histórica do conceito de contratransferência. In: Zaslavsky J, Santos MJP. Contratransferência: teoria e prática clínica. Porto Alegre: Artmed; 2006. p. 17-29.

16. Hinshelwood RD. Contratransferência. In: The Britsh Psycho-Analytical Society – Comitê Editorial da América Latina do International Journal of Psycho-Analysis. Livro Anual de Psicanálise. Tomo XV.São Paulo: Editora Escuta Ltda; 2001.p. 161-82.

17. Eizirik CL, Lewkowicz S. Contratransferência. In: Eizirik CL, Aguiar RW, Schstarsky SS. Psicoterapia de orientação analítica: fundamentos teóricos e clínicos. 2.ed. Porto Alegre: Artmed; 2005. p.300-9.

18. Racker H. Estudo V: A neurose de contratransferência. In: Racker H. Estudos sobre técnica psicanalítica. Porto Alegre: Artes Médicas;1982. p.100-19.

19. Pick IB. Elaboração na contratransferência. In: Spillius EB. Melanie Klein Hoje: desenvolvimento da teoria e técnica. v.2. Rio de Janeiro: Imago;1990. p.47-61.

20. Sattar SP, Pinals DA, Gutheil TG. Countering Countertransference, II: beyond evaluation to cross-examination. J Am Acad Psychiatry Law 2004;32(2):148-54.

21. Taborda JGV, Arboleda-Flórez J. Ética em psiquiatria forense: atividades pericial e clínica e pesquisa com prisioneiros. Rev Bras Psiquiatr 2006;28(Supl II):S86-92.

22. Friedman SM, Gelso CJ. The development of the Inventory of Countertransference Behavior. J Clin Psychol 2000 Sep;56(9):1221-35.

23. Rossberg JI, Hoffart A, Friis S. Psychiatric staff member's emotional reactions toward patients. A psychometric evaluation of an extended version of the Feeling Word Checklist (FWC-58). Nord J Psychiatry 2003;57(1):45-53.

24. Schwartz RC, Wendling HM. Countertransference reactions toward specific client populations: a review of empirical literature. Psychological reports 2003 Apr;92(2):651-54.

25. Goldfeld P, Wiethaeuper D, Terra L, Baumgardt R, Lauerman M, Mardini V, Abuchaim C, et. al. Adaptação transcultural do Inventory of Countertransference Behavior (ICB) para o português brasileiro. Rev Psiquiatr RS 2007 Jan;29(1):56-62.

26. Goldfeld P, Wiethaeuper D, Bouchard MA, Terra L, Baumgardt R, Lauerman M, et. al. Adaptação transcultural do Mental State Rating System para o português brasileiro. Rev Psiquiatr RS. 2008;30(1):59-64.

27. Eikirik CL. Rede social, estado mental e contratransferência: estudo de uma amostra de velhos da região urbana de Porto Alegre. Porto Alegre, RS: UFRGS;1997.

28. Silveira Júnior EM, Polanczyk GV, Eizirik M, Hauck S, Eizirik CL, Ceitlin LH. Trauma and countertransference: development and validity of the Assessment of Countertransference Scale (ACS). Rev Bras Psiquiatr 2012 Jun;34(2):201-6.

29. Giovazolias T, Karagiannopoulou E, Mitsopoulou E. Can the factor structure of Defense Style Questionnaire (DSQ-40) contribute to our understanding of parental acceptance/rejection, bullying, victimization and perceived well-being in Greek early adolescentes? Eur J Psychol 2017 May 31;13(2):269-85.

30. Puhalla AA, McCloskey MS, Brickman LJ, Fauber R, Coccaro EF. Defense styles in intermittent explosive disorder. Psychiatry Res 2016 Feb 13; 238:137-42.

31. De Vries AMM, Gholamrezaee MM, Verdonck-de Leeuw IM, de Roten Y, Despland JN, Stiefel F, Passchier J. Physicians' emotion regulation during communication with advanced cancer patients. Psychooncology 2018 Mar;27(3):929-36. doi:10.1002/pon.4614. Epub 2018 Feb5.

32. Huband N, Duggan C, McCarthy L, Mason L, Rathbone G. Defense styles in a sample of forensic patients with personality disorder. Personal Ment Health 2014 Jul 21;8: 238-49.

33. Andrews G, Singh M, Bond M. The defense style questionnaire. J Nerv Ment Dis 1993 Apr;181(4):246-56.

34. Blaya C, Dornelles M, Blaya R, Kipper L, Heldt E, Isolan L, et al. Brazilian-Portuguese version of defensive style questionnaire-40 for the assessment of defense mechanisms: construct validity study. Psychother Res 2007 May 21;17(3):261-270.

35. Pearlman LA, Mac Ian PS. Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. Professional Psychology: Research and Practice.1995 Dec; 26(6): 558-65.

36. Eizirik M, Schestatsky S, Knijnik L, Terra L, Ceitlin LHF. Contratransferência e trauma psíquico. Rev Psiquiatr RS. 2006; 28(3):314-20.

37. Al-Mateen CS, Linker JA, Damle N, Hupe J, Helfer T, Jessick V. Vicarious Traumatization and Coping in Medical Students: a Pilot Study. Acad Psychiatry. 2015 Feb;39(1):90-3.

38. Brady JL, Guy JD, Poelstra PL, Brokaw BF. Brady JL, Guy JD, Poelstra PL, Brokaw BF. Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. Professional Psychology: Research and Practice. 1999;30(4): 386-93.

39. Palm KM, Polusny MA, Follette VM. Vicarious traumatization: potential hazards and interventions for disaster and trauma workers. Prehosp Disaster Med. 2004 Jan;19(1):73-8.

40. Levin AP, Greisberg S. Vicarious Trauma in Attorneys. Pace L. Rev. 2003; 24(1): 245-52.

41. Jaffe P, Crooks C, Dunford-Jackson BL, Town M. Vicarious Trauma in Judges: The Personal Challenge of Dispensing Justice. Juv. & Fam. Ct. J. 2003; 54:1-9.

42. Harrison RL, Westwood MJ. Preventing vicarious traumatization of mental health therapists: identifying protective practices. Psychotherapy (Chic) 2009 Jun; 46(2): 203-19.

43. Varra EM, Pearlman LA, Brock KJ, Hodgsn ST. Factor analysis of the Trauma and Attachment Belief Scale: a measure of cognitive schema disruption related to traumatic stress. J Psychol Trauma 2008;7(3):185-96.

44. Pearlman LA. Trauma and attachment belief scale. Los Angeles: Western Psychological Services; 2003.

45. Barros AJS, Teche SP, Rodrigues A, Severo C, Saldanha R, Bassols AM, et al. Brazilian Portuguese translation, cross-cultural adaptation and apparent validation of the trauma and attachment belief scale. Trends Psychiatry Psychother Forthcoming 2018.

46. Fassinger RE. Paradigms, praxis, problems, and promise: grounded theory in counseling psychology research. J Couns Psychol 2005;52(2):156-66.

47. Nayar S. Grounded theory: a research methodology for occupational science. J Occup Sci 2012; 19(1):76-82.

48. Charmaz K. Grounded theory in global perspective: reviews by international researchers. Qual Inq 2014 Aug 28;20:1074-84.

49. StataCorp.2015. Stata Statistical Software: Released 14. College Station, TX: StataCorp LP.

50. QSR International Pty LTD (2010). NVivo qualitative data analysis software. Melbourne, QSR International Pty Ltd.

51. Charmaz K. Constructing Grounded Theory. 2nd ed. Los Angeles, London, New Delhi, Singapore: Sage; 2014.

ANEXOS

ANEXO I - Termo de Consentimento Informado, Livre e Esclarecido

Termo de Consentimento Informado, Livre e Esclarecido

Prezado(a) Senhor(a): _____

Código Alfanumérico: ____ ____ ____ ____

Solicitamos sua participação voluntária no projeto de pesquisa intitulado **"ASSOCIAÇÃO ENTRE REAÇÕES CONTRATRANSFERENCIAIS DESENCADEADAS POR AGRESSORES SEXUAIS E TRAUMATIZAÇÃO VICÁRIA EM PSICÓLOGOS E PSIQUIATRAS FORENSES**". Somos um grupo de pesquisadores do programa de Pós-Graduação em Psiquiatria e Ciências do Comportamento da Universidade Federal do Rio Grande do Sul (UFRGS). Esta pesquisa faz parte da tese de doutorado da psiquiatra Alcina Juliana Soares Barros, orientada pelo Prof. Dr. Cláudio Laks Eizirik, pesquisador responsável por este projeto.

O projeto pretende investigar sentimentos contratransferenciais presentes nos psiquiatras e psicólogos, do estado do Rio Grande do Sul, durante as avaliações psiquiátrica-forenses de criminosos sexuais e, simultaneamente, estudar a ocorrência de traumatização vicária nos envolvidos. Os procedimentos adotados serão questionários contemplando perguntas, a serem respondidas por extenso pelos participantes, além da aplicação de 3 escalas, a *Assessment of Countertransference Scal*e, *a Trauma and Attachment Belief Scale* (TABS) e o *Defensive Style Questionaire* (DSQ-40). O tempo estimado para a resposta aos instrumentos descritos é de 90 minutos. Espera-se, com esta pesquisa, que o conhecimento sobre a contratransferência e a traumatização vicária no cenário da psiquiatria e psicologia forense possa ser ampliado. Qualquer informação adicional poderá ser obtida através do telefone (51) 8134-9500, ou do e-mail: alcina.forense@gmail.com, com a Dra. Alcina Juliana Soares Barros.

A pesquisa será realizada em concordância com os princípios de evitar todo e qualquer tipo de dano à dimensão física, psíquica, moral, intelectual, social, cultural ou espiritual dos envolvidos, entretanto poderá haver desconforto pelo tempo despendido na resposta aos questionários e escalas, assim como pelo conteúdo de algumas perguntas (potencial incômodo

emocional por despertar lembranças de eventuais situações difíceis experimentadas pelos participantes da pesquisa).

A qualquer momento, o (a) Senhor (a) poderá solicitar esclarecimentos sobre o trabalho que está sendo realizado e, sem qualquer tipo de cobrança, poderá desistir de sua participação. Os pesquisadores estão aptos a esclarecer estes pontos e, em caso de necessidade, dar indicações para contornar qualquer mal-estar que possa surgir em decorrência da pesquisa ou não. O projeto possui parecer consubstanciado do Comitê de Ética em Pesquisa da UFRGS **sob o número 1.694.773.** Os telefones para contato com os Comitês de Ética em Pesquisa do Hospital de Clínicas de Porto Alegre e da UFRGS são, respectivamente: (51) 3359.7640 e (51) 3308.3738.

Os dados obtidos nesta pesquisa serão utilizados na publicação de artigos científicos, contudo, assumimos a total responsabilidade de não publicar qualquer dado que comprometa o sigilo de sua participação. Nomes, endereços e outras indicações pessoais não serão publicados em hipótese alguma. Os bancos de dados gerados pela pesquisa só serão disponibilizados sem estes dados.

Aceite de Participação Voluntária

Eu, _____declaro que fui informado(a) dos objetivos da pesquisa acima, e concordo em participar voluntariamente da mesma. Sei que a qualquer momento posso revogar este Aceite e desistir de minha participação, sem a necessidade de prestar qualquer informação adicional. Declaro, também, que não recebi ou receberei qualquer tipo de pagamento por esta participação voluntária.

_____ _____

Pesquisador Voluntário

Data: _____/_____/_____

ANEXO II- Questionário da pesquisa

Programa de Pós-Graduação em Psiquiatria e Ciências do Comportamento da Universidade Federal do Rio Grande do Sul

QUESTIONÁRIO DA PESQUISA

Data de preenchimento do questionário ____/____/_____

INFORMAÇÕES GERAIS

Código Alfanumérico: ____ ____ ____ ____

Gênero: ( ) F ( ) M

Idade: _____ anos

Profissão: ( ) Psicólogo ( ) Psiquiatra

Tempo de experiência em Psicologia Forense ou Psiquiatria Forense: _____

BLOCO 1 – ASPECTOS PSICOTERÁPICOS

1. **O (a) senhor(a) já realizou algum tratameno psicoterápico pessoal?**

( ) Não ( ) Sim. Se positivo, qual o tipo de Psicoterapia? E por quanto tempo?

_____

2. **O (a) senhor(a) possui formação em alguma linha de Psicoterapia?**

( ) Não ( ) Sim. Se positivo, qual a linha de Psicoterapia?

_____

BLOCO 2 – ASPECTOS PERICIAIS

1. **Qual foi a data que o senhor realizou a última avaliação de um agressor sexual?**

_____

2. **O que o(a) senhor(a) faz para manter sua postura profissional durante este tipo de avaliação?**

_____

_____

_____

_____

3. **O(a) senhor(a) permanece pensando sobre a perícia após realizá-la?**

( ) Não ( ) Sim

4. **Qual a influência que este tipo de avaliação exerce em sua vida?**

_____

_____

_____

_____

ANEXO III - Escala para Avaliação da Contratransferência

ESCALA PARA AVALIAÇÃO DA CONTRATRANSFERÊNCIA – ASSESSMENT OF COUNTERTRANSFERENCE SCALE (ACS)

Código Alfanumérico: ____ ____ ____ ____

Instruções: Avalie se, durante a realização da entrevista, surgiu, em si, algum(ns) dos sentimentos abaixo descritos, em relação ao(a) entrevistado(a). Faça um círculo ao redor do número que melhor expressa o que sentiu no início, meio e final da sessão.

NADA.....0
POUCO.....1
MODERADAMENTE.....2
MUITO.....3

	No início	Durante	No final
Curiosidade	0 1 2 3	0 1 2 3	0 1 2 3
Interesse	0 1 2 3	0 1 2 3	0 1 2 3
Simpatia	0 1 2 3	0 1 2 3	0 1 2 3
Solidariedade	0 1 2 3	0 1 2 3	0 1 2 3
Afeição	0 1 2 3	0 1 2 3	0 1 2 3
Desejo de ajudar	0 1 2 3	0 1 2 3	0 1 2 3
Alegria	0 1 2 3	0 1 2 3	0 1 2 3
Tristeza	0 1 2 3	0 1 2 3	0 1 2 3
Pena	0 1 2 3	0 1 2 3	0 1 2 3
Atração	0 1 2 3	0 1 2 3	0 1 2 3
Desconforto	0 1 2 3	0 1 2 3	0 1 2 3
Desconfiança	0 1 2 3	0 1 2 3	0 1 2 3
Tédio	0 1 2 3	0 1 2 3	0 1 2 3
Rejeição	0 1 2 3	0 1 2 3	0 1 2 3
Desesperança	0 1 2 3	0 1 2 3	0 1 2 3
Reprovação	0 1 2 3	0 1 2 3	0 1 2 3
Acusação	0 1 2 3	0 1 2 3	0 1 2 3
Irritação	0 1 2 3	0 1 2 3	0 1 2 3
Medo	0 1 2 3	0 1 2 3	0 1 2 3
Hostilidade	0 1 2 3	0 1 2 3	0 1 2 3
Desinteresse	0 1 2 3	0 1 2 3	0 1 2 3
Distância	0 1 2 3	0 1 2 3	0 1 2 3
Imobilidade	0 1 2 3	0 1 2 3	0 1 2 3

ANEXO IV - Defensive Style Questionnaire

Defensive Style Questionnaire: DSQ-40

Código Alfanunérico: ____ ____ ____ ____ Idade: _____ anos

Este questionário consiste de 40 afirmativas relacionadas a como você pensa e funciona em sua vida. Não há questão certa ou errada. Marque o grau em relação ao qual você concorda ou discorda de cada afirmativa e assinale sua resposta, de 1 a 9. Por exemplo, um escore de 5 indicaria que você nem concorda e nem discorda da afirmativa, um escore de 3 indicaria que você discorda moderadamente e um escore de 9 que você concorda fortemente.

1. **Eu fico satisfeito em ajudar os outros e, se eu não puder fazer isso, eu fico deprimido.**
   Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente
2. **Eu consigo não me preocupar com um problema até que eu tenha tempo para lidar com ele.**
   Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente
3. **Eu alivio a minha ansiedade fazendo coisas construtivas e criativas, como pintura e marcenaria.**
   Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente
4. **Eu sou capaz de achar bons motivos para tudo que eu faço.**
   Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente
5. **Eu sou capaz de rir de mim mesmo com bastante facilidade.**
   Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente
6. **As pessoas tendem a me tratar mal.**
   Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente
7. **Se alguém me assalta e rouba o meu dinheiro, eu prefiro que essa pessoa seja ajudada ao invés de punida.**
   Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente
8. **As pessoas dizem que eu costumo ignorar os fatos desagradáveis como se eles não existissem.**
   Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente
9. **Eu costumo ignorar o perigo como se eu fosse o Super-Homem.**
   Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente
10. **Eu me orgulho da minha capacidade de reduzir as pessoas aos seus devidos lugares.**
    Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente
11. **Eu frequentemente ajo impulsivamente quando alguma coisa está me incomodando.**
    Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente
12. **Eu fico fisicamente doente quando as coisas não estão indo bem para mim.**
    Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

13. Eu sou uma pessoa muito inibida.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

14. Eu fico mais satisfeito com minhas fantasias do que com a minha vida real.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

15. Eu tenho qualidades especiais que me permitem levar a vida sem problemas.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

16. Há sempre boas razões quando as coisas não dão certo para mim.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

17. Eu resolvo mais as coisas sonhando acordado do que na vida real.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

18. Eu não tenho medo de nada.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

19. Às vezes, eu acho que sou um anjo e, outras vezes, acho que sou um demônio.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

20. Eu fico francamente agressivo quando sou magoado.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

21. Eu sempre acho que alguém que eu conheço é como um anjo da guarda.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

22. Tanto quanto eu sei, ou as pessoas são boas ou más.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

23. Se o meu chefe me repreendesse, eu poderia cometer um erro ou trabalhar mais devagar só para me vingar dele.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

24. Eu conheço alguém que é capaz de ser justo e imparcial em qualquer coisa que faça.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

25. Eu posso controlar os meus sentimentos se eles interferirem no que eu estiver fazendo.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

26. Eu frequentemente sou capaz de ver o lado engraçado de uma situação apesar de ela ser desagradável.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

27. Eu sinto dor de cabeça quando tenho que fazer algo de que não gosto.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

28. Eu frequentemente me vejo sendo muito simpático com pessoas com quem, pelo certo, eu deveria estar muito irritado.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

29. Eu tenho certeza de que a vida é injusta comigo.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

30. Quando eu sei que vou ter que enfrentar uma situação difícil, eu tento imaginar como isso será e planejo um jeito de lidar com a situação.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

31. Os médicos nunca realmente entendem o que há de errado comigo.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

32. Depois de lutar pelos meus direitos, eu tenho a tendência de me desculpar por ter sido tão firme.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

33. Quando estou deprimido ou ansioso, comer faz com que eu me sinta melhor.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

34. Frequentemente me dizem que eu não mostro os meus sentimentos.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

35. Se eu puder saber com antecedência que vou ficar triste mais adiante, eu poderei lidar melhor com a situação.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

36. Não importa o quanto eu reclame, eu nunca consigo uma resposta satisfatória.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

37. Frequentemente eu me dou conta de que eu não sinto nada em situações que deveriam me despertar fortes emoções.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

38. Manter-me muito ocupado evita que eu me sinta deprimido ou ansioso.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

39. Se eu estivesse passando por uma crise, eu me aproximaria de pessoas que tivessem o mesmo problema.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

40. Se eu tenho um pensamento agressivo, eu sinto a necessidade de fazer algo para compensá-lo.

Discordo completamente 1 2 3 4 5 6 7 8 9 Concordo plenamente

ANEXO V – Trauma and Attachment Belief Scale

Trauma and Attachment Belief Scale – TABS

(Versão Brasileira)

Código Alfanumérico: ____ ____ ____ ____ Idade: ____ anos Data: ___/___/___
CPF: ____.____.____-___ Grau de Escolaridade: _____Gênero: ( ) M ( ) F
Você se considera: ( ) Branco ( ) Pardo ( ) Amarelo ( ) Indígena ( ) Outro: _____
Profissão: _____Localidade (cidade e estado): _____

Instruções: Este questionário é utilizado para se conhecer como os indivíduos enxergam a si mesmos e aos outros. As pessoas diferem entre si de muitas maneiras, não havendo respostas certas ou erradas. Por favor, circule o número próximo a cada item o qual você sinta que mais claramente combina com suas próprias crenças sobre si mesmo e sobre seu mundo. Tente completar cada item. Utilize a seguinte escala de respostas:

1= Discordo totalmente
2= Discordo
3= Discordo um pouco
4 = Concordo um pouco
5 = Concordo
6 = Concordo totalmente

Se você desejar mudar a resposta, marque um X sobre a mesma e circule o número de sua nova resposta.

1= DISCORDO TOTALMENTE 2= DISCORDO 3= DISCORDO UM POUCO 4= CONCORDO UM POUCO 5=CONCORDO 6=

1.	Eu acredito que estou seguro.	1	2	3	4	5	6
2.	Não se pode confiar em qualquer um.	1	2	3	4	5	6
3.	Não sinto que mereço muito.	1	2	3	4	5	6
4.	Mesmo quando estou com amigos e familiares, não me sinto como parte do grupo.	1	2	3	4	5	6
5.	Não consigo ser eu mesmo quando estou com outras pessoas.	1	2	3	4	5	6
6.	Eu penso que as pessoas nunca estão a salvo do perigo.	1	2	3	4	5	6
7.	Posso confiar no meu próprio julgamento.	1	2	3	4	5	6
8.	As pessoas são maravilhosas.	1	2	3	4	5	6
9.	Quando meus sentimentos são feridos, consigo me recuperar.	1	2	3	4	5	6
10.	Fico desconfortável quando outra pessoa é o líder.	1	2	3	4	5	6
11.	Eu sinto como se as pessoas me magoassem o tempo inteiro.	1	2	3	4	5	6
12.	Se eu precisar, as pessoas virão até mim.	1	2	3	4	5	6
13.	Tenho sentimentos ruins sobre mim mesmo.	1	2	3	4	5	6

14. Alguns dos meus momentos mais felizes são com outras pessoas. 1 2 3 4 5 6

15. Sinto como se eu não pudesse me controlar. 1 2 3 4 5 6

16. Eu poderia causar sérios danos a alguém. 1 2 3 4 5 6

17. Quando estou sozinho, eu não me sinto seguro. 1 2 3 4 5 6

18. A maioria das pessoas destrói aquilo com que elas se importam. 1 2 3 4 5 6

19. Não confio nos meus instintos. 1 2 3 4 5 6

20. Eu me sinto próximo de muitas pessoas. 1 2 3 4 5 6

21. Eu me sinto bem na maioria dos dias. 1 2 3 4 5 6

22. Meus amigos não escutam a minha opinião. 1 2 3 4 5 6

23. Eu me sinto vazio por dentro quando estou sozinho. 1 2 3 4 5 6

24. Não consigo parar de me preocupar com a segurança dos outros. 1 2 3 4 5 6

25. Eu gostaria de não ter sentimentos. 1 2 3 4 5 6

26. Não é inteligente confiar nas pessoas. 1 2 3 4 5 6

27. Eu nunca me machucaria. 1 2 3 4 5 6

28. Frequentemente penso o pior sobre os outros. 1 2 3 4 5 6

29. Eu posso controlar se irei machucar os outros. 1 2 3 4 5 6

30. Eu não tenho muito valor. 1 2 3 4 5 6

31. Não acredito no que as pessoas me dizem. 1 2 3 4 5 6

32. O mundo é perigoso. 1 2 3 4 5 6

33. Frequentemente estou em conflito com outras pessoas. 1 2 3 4 5 6

34. Tenho dificuldades para tomar decisões. 1 2 3 4 5 6

35. Eu me sinto excluído pelas pessoas. 1 2 3 4 5 6

36. Sinto inveja das pessoas que estão sempre no comando. 1 2 3 4 5 6

37. As pessoas importantes da minha vida estão em perigo. 1 2 3 4 5 6

38. Eu consigo me manter seguro. 1 2 3 4 5 6

39. As pessoas não prestam. 1 2 3 4 5 6

40. Procuro me ocupar para evitar meus sentimentos. 1 2 3 4 5 6

41. As pessoas não deveriam confiar nos seus próprios amigos. 1 2 3 4 5 6

42. Eu mereço que coisas boas aconteçam comigo. 1 2 3 4 5 6

43. Eu me preocupo com o que as outras pessoas farão comigo. 1 2 3 4 5 6

44. Eu gosto das pessoas. 1 2 3 4 5 6
45. Eu devo estar no controle de mim mesmo. 1 2 3 4 5 6
46. Eu me sinto desamparado entre as pessoas. 1 2 3 4 5 6
47. Mesmo que eu pense em me ferir, não farei isso. 1 2 3 4 5 6
48. Não me sinto muito amado por ninguém. 1 2 3 4 5 6
49. Eu tenho bom julgamento. 1 2 3 4 5 6
50. Pessoas fortes não precisam pedir ajuda. 1 2 3 4 5 6
51. Sou uma boa pessoa. 1 2 3 4 5 6
52. As pessoas não cumprem suas promessas. 1 2 3 4 5 6
53. Odeio ficar sozinho. 1 2 3 4 5 6
54. Eu me sinto ameaçado pelos outros. 1 2 3 4 5 6
55. Quando estou com outras pessoas, me sinto sozinho. 1 2 3 4 5 6
56. Tenho dificuldades em me autocontrolar. 1 2 3 4 5 6
57. O mundo está cheio de pessoas com doenças mentais. 1 2 3 4 5 6
58. Eu posso tomar boas decisões. 1 2 3 4 5 6
59. Frequentemente sinto que as pessoas estão tentando me controlar. 1 2 3 4 5 6
60. Tenho medo do que eu possa fazer a mim mesmo. 1 2 3 4 5 6
61. Pessoas que confiam nos outros são idiotas. 1 2 3 4 5 6
62. Meu melhor amigo sou eu mesmo. 1 2 3 4 5 6
63. Quando as pessoas que eu amo não estão comigo,
eu acredito que elas estejam em perigo. 1 2 3 4 5 6
64. Coisas ruins acontecem comigo porque sou uma má pessoa. 1 2 3 4 5 6
65. Eu me sinto seguro quando estou sozinho. 1 2 3 4 5 6
66. Para me sentir bem, eu preciso estar no comando. 1 2 3 4 5 6
67. Frequentemente duvido de mim mesmo. 1 2 3 4 5 6
68. A maioria das pessoas são boas de coração. 1 2 3 4 5 6
69. Eu me sinto mal comigo mesmo quando preciso de ajuda. 1 2 3 4 5 6
70. Posso contar com meus amigos quando preciso deles. 1 2 3 4 5 6
71. Acredito que alguém irá me machucar. 1 2 3 4 5 6
72. Faço coisas que colocam outras pessoas em perigo. 1 2 3 4 5 6
73. Há uma força maligna dentro de mim. 1 2 3 4 5 6

74. Ninguém me conhece de verdade. 1 2 3 4 5 6
75. Quando estou sozinho, é como se não tivesse ninguém ali, nem mesmo eu. 1 2 3 4 5 6
76. Quando eu conheço melhor uma pessoa, tendo a desrespeitá-la. 1 2 3 4 5 6
77. Eu geralmente consigo descobrir o que está se passando com os outros. 1 2 3 4 5 6
78. Não consigo fazer um bom trabalho, a menos que eu seja o líder. 1 2 3 4 5 6
79. Eu não consigo relaxar. 1 2 3 4 5 6
80. Eu já machuquei outras pessoas fisicamente. 1 2 3 4 5 6
81. Tenho medo de que eu vá ferir a mim mesmo. 1 2 3 4 5 6
82. Eu me sinto deixado de lado em todos os lugares. 1 2 3 4 5 6
83. Se as pessoas me conhecessem de verdade, elas não iriam gostar de mim. 1 2 3 4 5 6
84. Aguardo ansiosamente pelo tempo que passo sozinho 1 2 3 4 5 6