Introduction Risk and protective factors for PTSD can be grouped into pretraumatic, peritraumatic, and posttraumatic. Reported childhood abuse has predictive risk effects for PTSD than most other pretraumatic risk factors.
Objective To examine childhood physical abuse history in war veterans.
Aims To determine whether childhood physical abuse is risk factor for PTSD in war veterans.
Methods Cross-sectional study of 205 war veterans tested by Harvard Trauma Questionnaire and sociobiographic Questionnaire (with data of childhood physical punishment).
Results A significant difference in reported childhood physical punishment between war veterans with and without PTSD was found. Veterans with PTSD were identified as recipients of childhood physical punishment.
Conclusions Childhood physical punishment has positive correlation with development of PTSD in war veterans.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV905

Metamorphosing histories: The narrative as a tool for psychological trauma's recovery

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Considering psychological traumatism as a subject in constant discussion, this study approaches the recovery of the patients that suffered violent events. Based on studies about the reflection of disasters and wars, we present trauma as a consequence of the unexpected event from where is originated intense fear. Trauma is a violation, an abruption, which disorganizes and incapacitates the victim. When a violence situation is experienced, the physical and verbal abuses are not alone as the elements that interfere in the trauma's establishment, but also their representations. Thereby, the event that produces trauma is imposed, although its meaning depends of the history and beliefs of the subject. Understanding that the accident's representation is the cause of the trauma's establishment, we introduce the narrative as tool for psychological trauma's recovery, because it allows the victims relive their past and reframe their feelings. Regarding it, we highlight the relevance of the sociocultural context – before, during and after the trauma –, once it has direct influence over the way the person deals with adversities, as it can stimulate or stop a resilience process. This study takes in consideration that resilience is not something static, a faculty that the subject has or not, but a process that can be developed, improved or reduced. Thus, the narrative is presented as essential to initiate a resilience process, empowering the victims to confront the trauma and to rewrite their history and their return to life.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV906

Prevalence of post-traumatic stress disorder and associated events in adults victim of displacement in the Colombian Caribbean

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The forced displacement in Montería, a region from the Colombian Caribbean could become a risk factor for the existence of Post-Traumatic Stress Disorder (PTSD), nevertheless, there isn't data of the prevalence of this disorder.
Aim To identify the prevalence of the PTSD and associated events in adults victims of the displacement in the city of Montería.
Method Transversal and explorative study, 117 adults (M: 40,41; SD: 13,14). The PTSD was verified with the checklist for PTSD (Weathers, Litz, herman, Huska & Keane, 1993) and according to criteria of DSM-5 (APA, 2014). The 3 factors associated with the disorder were analyzed according to age groups. To evaluate the events associated to the disorder was used the checklist of events (Blake, Weathers & Nagy, 1990). Occurred and witnessed by the subject events were analyzed. Descriptive were used to determinate the existence of the PTSD and an ANOVA to contrast the symptomatology of the PTSD by age groups.
Results The 26,49% ($n = 31$) of the sample had the clinic criteria of PTSD. An ANOVA of a factor evidenced that the activation was present in a biggest proportion in the range of 53-59 years old (M = 18.73); intrusion and avoidance was shown mostly in the range of 60-71 years old (intrusion M = 14.00; avoidance M = 14.85). In relation to the associated events occurred to the subjects, there was found that the highest incidence were: natural disasters (42.7%) and unexpected death (35.9%); the witnessed events with higher percentage where: unexpected death (19.70%) and traffic accidents (15.4%).
References not available.
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EV907

Posttraumatic stress disorder, violence and war

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Introduction In a globalized world, violence, present in all forms and in all places, is a public health problem with serious early or late consequences for the mental health of those who are direct or indirect victims. Violence is avoidable and preventable and is not evenly distributed by population groups or regions being among the top 20 causes worldwide of years lost due to disability and with a projected increase by 2030 according to the World Health Organization (Mathers, Fat & Boerma, 2008).
Methodology The search was made on ScienceDirect database, using the following keywords: posttraumatic stress disorder; violence and war. It was included documents in English published between 2004 and 2015; as well as textbooks and documents officers.
Discussion Violence is a risk factor for the disorder of post-traumatic stress disorder (PTSD) which, in turn, is also a risk factor for perpetrating violence. The PTSD can occur when a person faces or faces an unexpected traumatic stressor, such as war, violent personal assault, have been held hostage or kidnapped confinement as a prisoner of war, torture, terrorist attack, or serious car accidents (Javidi & Yadollahie, 2012). The costs of violence are high and its routinization for a living have important effects on mental health.

Considerations Studies in relation to PTSD and violence are necessary for us to have a better understanding of the phenomenon and its consequences for public health, as well as to promote the mental health of all.
References not available.
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EV908

Cognitive behavioral therapy in a group of militaries with posttraumatic stress disorder

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Introduction Posttraumatic stress disorder (PTSD) has a high prevalence and severe impact in military populations. Cognitive behavioral therapy (CBT) is indicated in this condition but it is a structured therapy that requires patients' motivation and doctors' availability.
Objectives and aims Assess feasibility and effectiveness of CBT in a military group with PTSD.
Methods A group of six militaries that witnessed the same traumatic event (an armed attack) and were diagnosed with PTSD were involved in a structured individual session CBT with one therapist. An assessment using the PTSD checklist for DSM (PCL) was performed initially and in halfway therapy. The therapy included an education about PTSD, a cognitive restructuring, a behavioral approach via home tasks and relaxation techniques.
Results The initial PCL scores varied from 25 to 55. All patients were initially on sick leave. Five patients had adjunctive antidepressant medications and one patient was only on therapy. Three patients showed no motivation and were excluded after 3 sessions. Two patients have had 7 weekly sessions and were able to return to work in the same place. One patient with severe PTSD had 2 sessions monthly, he had slight clinical improvement and could not come back to military work. The three patients who are still in therapy have improved PCL scores.
Conclusions CBT can be effective in PTSD. The outcome depends on initial severity of PTSD and assiduity.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV909

Challenging MCMI-III results with in-depth psychometric assessment and Lacter & Lehmann (2008) complex trauma guidelines

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Introduction Complex trauma resulting from neglect and abuse in early childhood is frequently misdiagnosed.
Objective This presentation shares emerging "best assessment practices" that help to differentiate complex trauma from Schizophrenia.
Aims The case study demonstrates that a wide-ranging psychometric assessment and the application of Lacter & Lehmann (2008) guidelines provide accurate results while MCMI-III results can be spurious.
Method "Unbelievable" disclosures of an adult survivor prompted a search for scientific references, experiences in the survivor scene and historical examples. Work-related personality questionnaires, in-depth ability tests and Lacter & Lehmann (2008) guidelines were deployed to differentiate complex trauma from an erroneous diagnosis based largely on MCMI-III results.
Results The research identified measurement issues with the MCMI-III clinical personality questionnaire that generated spurious elevations on Narcissistic, Delusional and Paranoid scales. Work-related personality questionnaires provided much more useful information showing no "personality disorder" risks at all. WAIS results confirmed an earlier "Twice Exceptional" ability pattern with very high verbal IQ (95%ile) and extraordinarily poor auditory working memory (2nd%ile) i.e. a "Dyslexia" performance pattern. Lacter & Lehmann (2008) guidelines showed that none of the 42 schizophrenia indicators applied and only 1/3 of the complex trauma indicators.
Conclusion Mental health professionals must remain cognizant to the chilling notion that extreme abusers may "frame" victims in order to make them "appear" schizophrenic. As MCMI-III was developed originally for those seeking therapy, its use in forensic settings with the general population should be avoided. Tests do not diagnose people – people do!
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EV910

PTSD and quality of life among firefighters and municipal police forces

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Research has shown that PTSD is prevalent among firefighters and police forces and that Quality of Life (QoL) is seriously compromised in individuals suffering from PTSD. However, QoL studies with these professionals are scarce. This study results from a screening program held by the Portuguese Red Cross (PRC) aiming to analyze predictors of QoL. Participants were 95 firefighters and municipal police officers. They answered the Posttraumatic Stress Disorder Checklist (PCL-5) in order to evaluate the prevalence of PTSD symptoms, as well as measures of social support (3-Item Oslo Social Support Scale) and QoL (EUROHIS-QOL-8). From the results, there were no group differences regarding total PTSD, social support or QoL and 10% of participants reported enough symptoms to PTSD diagnostic. Social Support and PTSD explained 25% of QoL variance, PTSD symptoms explaining 10% (negative beta) and, in the second step, social support explained 15%. The results suggest that it would be important to include QoL as an outcome measure in clinical and research work in these populations, with special attention to PTSD and social support.
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