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Impact of a Psychotherapy Protocol on Women with a History of Intimate Partner Violence in Brazil

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Q1

Violence against women is a public health problem, and it causes psychological damage that should be the focus of psychological treatment. Psychological symptoms include anxiety, depression, and trauma-related stress. Scientific, evidence-based practices are recommended for a high-quality outcome. This study aimed to evaluate the impact of a 16-session Cognitive Behavioral Psychotherapy protocol for women with a history of intimate partner violence (IPV). The final sample included 26 women. The participants were evaluated before the intervention and after the end of it. The study results indicate an increase in the level of life satisfaction, as well as a reduction in anxiety, depression, and trauma-related symptoms. Patients with different histories of violence have benefited from the intervention. Despite the limitations of this study, for example, sample size and the absence of a control group, the results provide initial evidence of the effectiveness of the protocol. This study contributes to stimulating evidence-based practices for treatment for this population in Brazil. Future experimental and follow-up studies are necessary to produce evidence of the effectiveness of the protocol.

Keywords: cognitive behavioral therapy; intimate partner violence; evidence-based practice; violence against women; psychotherapy

Q2

Violence against women is a widespread phenomenon in Brazil and worldwide (World Health Organization [WHO], 2014). It is estimated that one out of five women in the world has already been a victim of intimate partner violence (WHO, 2014). In Brazil, the hotline for reporting violence against women received more than 38,000 calls in the first half of 2018 alone (Brazil, 2018). Underreporting of cases is very common, which indicates an even more worrying scenario. Amid significant social movements and international pressure (Angelim &

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Diniz, 2009) in Brazil, specific legislation was enacted for situations of violence against women, which were categorized into five types: physical, sexual, psychological, moral, and equity abuse (Brasil, 2006), all of which are forms of violation of women's rights.

This is not a phenomenon that can be understood exclusively from an individual perspective. Social aspects should be considered as risk factors, since violence is justified by sociocultural beliefs supported by social and relational gender inequalities (Saffioti, 2004). The literature indicates that experiencing mistreatment in childhood is a risk factor for intimate partner violence in adulthood (Li et al., 2019; Till-Tentschert, 2017).

We must consider the normalization of violence, especially psychological abuse, which is sometimes identified in intimate relationships despite not affecting couples' perception of marital satisfaction (Razera et al., 2016). Normalization of violence may be associated with changes in gender relations and meaning (Pick et al., 2017; ICD-11, WHO, 2018). Also, recurrent exposure to traumatic events throughout life is known to potentially lead to difficulties in identifying situations involving exposure to violence and danger and acting appropriately (WHO, 2018). Social gender inequality encourages manifestations of power and domination of males over females in interpersonal relationships. Violence arises in this dynamic as an attempt to perpetuate gender roles and inequality (Pick et al., 2017).

Negative outcomes of IPV include personal consequences for women, which result in significant psychosocial losses (WHO, 2013), for example, low self-esteem, so,cial isolation and feelings of helplessness. Additionally, women with a history of IPV are more likely to have anxiety disorders, depression (Bacchus et al., 2018; WHO, 2014) and post-traumatic stress disorder (PTSD) (Spencer et al., 2019). Suicidal ideation is also strongly associated with the experience of IPV and can increase the risk of suicide attempt or suicide (Ceccon et al., 2014). In addition, regularly experiencing violence in intimate relationships can create emotional regulation difficulties (Tractenberg et al., 2016; Zancan & Habigzang, 2018) and cause a condition with more serious symptoms, such as, disorders of extreme stress not-otherwise specified (DESNOS) (Camargo et al., 2013) or complex PTSD, from the International Statistical Classification of Diseases and Related Health Problems (ICD-11) (WHO, 2018).

A systematic literature review on the evaluation of cognitive behavioral psychotherapy protocols for this population showed that 11 studies were published between 2005 and 2015 (Petersen et al., 2019). Out of these, five evaluated individual psychological interventions — three of which were from the same study — and six analyzed group interventions. The number of sessions ranged from eight to 20. All protocols described the respective psychoeducational strategy in use; nine used the exposure technique; four focused on self-esteem; four employed problem-solving techniques; and three studies addressed prevention skills at the end of treatment. Most studies did not describe the intervention process in detail (Petersen et al., 2019).

A total of 12 studies were found in a new, non-systematic search for articles published in the last five years. Six studies evaluated psychotherapeutic interventions: four in a group format (Johnson et al., 2016; Kelly & Garland, 2016; Santos et al., 2016; Tutty et al., 2016) and two in an individual format (Allard et al., 2018; Patel et al., 2019). One of the intervention protocols focused on mindfulness (Kelly & Garland, 2016), while the others employed cognitive behavioral therapy (Allard et al., 2018; Johnson et al., 2016; Patel et al., 2019; Santos et al., 2016; Tutty et al., 2016). One study was specifically based on Cognitive Trauma Therapy, with the aim of reducing the symptoms of PTSD (Allard et al., 2018). Exposure strategies, cognitive restructuring, emotional regulation, and psychoeducation were used.

In Brazil, a pioneering study conducted with 11 women evaluated evidence of the effectiveness of a 13-session cognitive behavioral psychotherapy protocol. The results indicated a reduction in anxiety, depression, and trauma-related stress, as well as an increase in life-satisfaction levels. However, there were no statistically significant changes in PTSD symptoms (Habigzang et al., 2018). The individual protocol in the current study was adapted from Habigzang et al.

(2018), but it includes three additional sessions — encompassing psychoeducation regarding gender-based violence and cognitive restructuring of dysfunctional beliefs about gender roles, violence, and post-traumatic cognition — in an attempt to improve PTSD symptoms. The latter was applied in tandem with emotional regulation techniques. A qualitative study was conducted by Zamora et al. (2020) and the aim was to evaluate the psychotherapy process. The results indicate that the specific structure of the current protocol leads to therapeutic change and it has a good continuity between sessions. Also, the study unveiled main themes that were potentially related to therapeutic progress: family relationships, gender violence, intimate partner violence, and social support. The results indicate that the protocol structure is fluid and achieves its objectives. Based on these findings, the present study sought to pilot test the adapted 16-session individual cognitive behavioral psychotherapy protocol in an attempt to improve PTSD symptomatology in Brazilian women who experienced IPV.

Given the lack of evidence-based protocols that address the cultural specificities of IPV in Brazil, the objective of this study was to assess the impact of a cognitive behavioral psychotherapy protocol, for women with a history of IPV, on depression, anxiety, trauma-related disorders (PTSD and DESNOS) and PTSD symptoms (negative beliefs about oneself, negative beliefs about the world, feelings of self-blame, reliving past experiences, avoidance, cognition and mood, hyperarousal), and indicators of self-esteem and life satisfaction. The specific objectives were: (a) to describe the participants' history of exposure to violence throughout their lives and symptomatology; (b) to assess whether the severity of a history of mistreatment as a child and IPV has affected the therapeutic benefits of the protocol; and (c) to monitor therapists' adherence to the protocol. It was hypothesized that there would be significant decreases in symptoms (e.g., anxiety, depression, trauma-related disorders — PTSD and DESNOS) and increases in self-esteem and life satisfaction among Brazilian women who experienced IPV who participated in a 16-session cognitive behavioral psychotherapy intervention.

Methodology

Participants

Participants were referred by professionals from a network composed of different local services providing health, public safety, legal, or social assistance. In addition, information on the study was posted on the Internet, especially on social media channels. The inclusion criteria for the sample were: individuals who had experienced intimate partner violence, were not currently experiencing IPV and were over 18 years of age. Exclusion criteria: substance abuse (on an almost daily basis and/or a quantity that impairs consciousness), psychotic symptoms, suicide ideation (even without a plan) or attempted suicide, severe cognitive impairment, other therapeutic demands as a priority, and currently undergoing another type of psychotherapy. These criteria were assessed through an analysis of patients' self-reports during the clinical evaluation in the initial interviews and of data from the sociodemographic questionnaire. Figure 1 shows the flowchart of referrals and completion of psychotherapy by the participants.

In the initial phase, 45 participants were recruited for the intervention. However, there was sample loss — mostly during the pre-test evaluation period — mainly because of the lack of free time or financial resources for weekly attendance, and because the participants did not satisfy the criterion of not currently experiencing IPV. Admittedly, those who experience the cycle of violence have a hard time breaking it, as it is influenced by several factors such as fear, manipulation by the partner, and damage to women's physical and psychological health. In addition, difficulties can be influenced by previous traumatic experiences of violence and by social damage (Lucena et al., 2016).

A total of 26 women concluded the intervention: 18 were white; five were multiracial and three were black. Mean age was 38.4 years (SD = 11.2 years, ranging from 22 to 60 years); among the participants, 27% were 20–30 years old, 27% were 31–40 years old, 35% were 40–50 years old, and 11% were 51–60 years old. Results indicated that 38.5% of the participants had completed high school, while 23.1% had started but not completed higher education and 38.5% had completed higher education. Also, 26.9% had no children; 34.6% had one child, and 38.5% had two or more children. The majority (65.3%) had a paid job. Regarding religious beliefs, 39% declared they were atheists, 27% were Catholic, 19% were Evangelical, 8% followed Afro-Brazilian religions (e.g., umbanda) and 8% were spiritualists. They were all from urban areas, living in or near the state capital.

Instruments

Sociodemographic questionnaire: used for gathering information regarding age, race/ethnicity, marital status, education, employment status, number of children, use of alcohol and other drugs, and religious affiliation, as well as to identify the individual's social support network.

Rosenberg's Self-Esteem Scale: developed by Rosenberg in 1989 and adapted for Brazil by Hutz and Zanon in 2011, it seeks to evaluate a person's view of oneself. It is composed of 10 questions to be answered on the basis of a three-point Likert-type scale. Six questions refer to a positive self-view and four to a self-deprecating view. The Brazilian version had a *Cronbach's alpha* α = .90 (Hutz & Zanon, 2011). In the present sample, the reliability of Rosenberg's Self-Esteem Scale was also adequate (α (95% CI) = .86 (.80–.91)).

Life Satisfaction Scale: developed by Diener, Emmons, Larsen, and Griffin in 1985 and adapted by Gouveia, Milfont, Fonseca and Coelho in 2009. It consists of five items that assess a person's degree of satisfaction with their own life using a seven-point Likert-type scale. The Brazilian version of the instrument had a *Cronbach's alpha* α = .95 (Gouveia et al., 2009). The reliability of the scale was satisfactory for the present sample (α (95% CI) = .84 (.77–.91)).

Beck Anxiety Inventory (BAI): developed by Beck, Epstein, Brown and Sterr in 1988 and adapted and validated for Brazil by Cunha (2001). It aims to investigate the level of anxiety using a 21-item self-administered scale. The scale has a single-factor structure, with a *Cronbach's alpha* α = .92 (Cunha, 2001). In the present sample, the *Cronbach's alpha* of BAI was also satisfactory (α (95% CI) = .88 (.80–.95)).

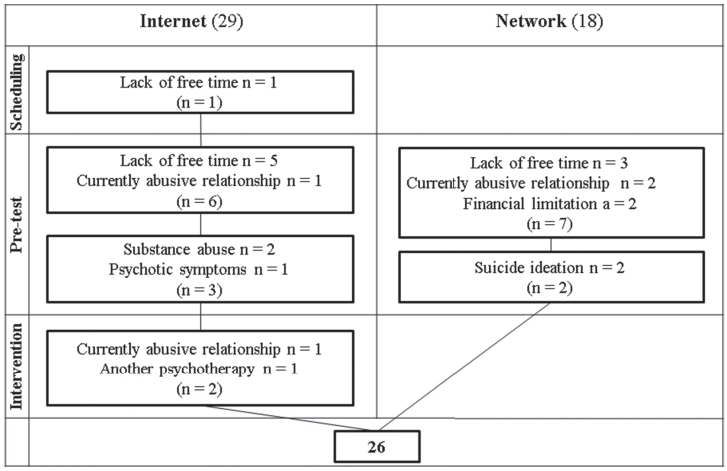

FIGURE 1. Flowchart

Beck Depression Inventory II (BDI-II): developed by Beck, Steer, and Brown in 1996 and adapted and validated for Brazil by Gorenstein et al. (2011). The scale assesses the level of depression using a self-administered scale consisting of 21 items. The original version of the scale has a *Cronbach's alpha* α = .85 (Gorenstein et al., 2011). In the present study, the reliability of BDI was adequate (α (95% CI) = .89 (.84–.95)). Q4

Life Events Checklist for *DSM-V* (LEC-5): developed by Gray, Litz, Hsu, and Lombardo in 2004. It consists of two parts: the first is a list of 17 different types of traumatic events and forms of exposure, aimed at mapping the history of traumatic situations experienced; in the second part, eight objective questions are asked about the characteristics of the worst traumatic event chosen by the participant. In the validation study for Brazil, the questionnaire had a *Cronbach's alpha* between α = .56 and α = .77 (Passos et al., 2012). The value of *Cronbach's alpha* of LEC-5 in the present study was α (95% CI) = .58 (.50–.98).

Post-traumatic Stress Disorder Checklist for *DSM-V* (PCL-5): culturally adapted and validated in Brazil by Osório et al in 2017. This is a list of 20 items with a Likert-type scale from 0 to 4 points. The PCL-5 is self-administered and assesses possible difficulties after someone has experienced a traumatic event that is associated with PTSD symptoms: avoidance, reliving, cognition and mood, and hyperarousal. Agreement was > .9 in 18 of the 20 items (Osório et al., 2017). The reliability of the scale in the present study was adequate for PTSD severity (α (95% CI) = .88 (.81–.95)) and its dimensions (reliving, α (95% CI) = .83 (.75–.91), avoidance, α (95% CI) = .53 (.50–.89), cognition and mood, α (95% CI) = .83 (.74–.92), and hyperarousal, α (95% CI) = .64 (.50–.93)). Q5

Post-traumatic Cognitions Inventory (PTCI): developed by Foa, Ehlers, Clark, Tolin, and Orsillo in 1999, and adapted and validated for Brazil by Sbardelloto, Shaefer, Justo, Lobo, and Kristensen in 2013. The instrument assesses post-traumatic cognitions (associated with PTSD) based on a seven-point Likert scale, organized into three types: negative cognitions about oneself, negative cognitions about the world and self-blame (or self-guilt). In the Brazilian study, *Cronbach's alpha* was α = .96 (Sbardelloto et al., 2013). In the present study, the reliability of PTCI was adequate for all three dimensions evaluated (negative beliefs about oneself, α (95% CI) = .92 (.88–.96), negative beliefs about the world, α (95% CI) = .74 (.55–.93), and beliefs about self-blame, α (95% CI) = .72 (.54–.89)).

Structured Interview for Disorders of Extreme Stress, Revised (SIDES-R): developed by Pelcovitz et al in 1997 and adapted to Brazilian culture by Camargo et al. (2013). The interview assesses behavioral and cognitive changes related to the diagnosis of Unspecified Extreme Stress Disorders (DESNOS), and it detects the symptomatological severity and presence/absence of the diagnosis of DESNOS. This diagnosis is similar to Complex PTSD, for which there is no assessment instrument in Brazil. The Brazilian version includes 38 items classified on a four-point scale according to the severity of symptoms during the previous month. It had a satisfactory kappa coefficient (.85) (Camargo et al., 2013) and the reliability of the scale in the present study was adequate (α (95% CI) = .79 (.72–.86)). Q6

Conflict Tactics Scale (CTS-2): developed by Murray Straus in 1979. It was translated into Portuguese and adapted to Brazilian culture by Schraiber and D Oliveira (2000) in partnership with the World Health Organization (WHO). The scale assesses conflict resolution tactics based on the presence and chronicity of the following dimensions: negotiation, psychological aggression, physical aggression, bodily injury and sexual coercion. In a validation study, *Cronbach's alpha* coefficients were .79 and .80 for the items of perpetration and victimization, respectively (Paiva & Figueiredo, 2006). The reliability for the victim dimensions were adequate (negotiation, α (95% CI) = .79 (.64 – .94), psychological aggression, α (95% CI) = .50 (.45 – .74), physical aggression, α (95% CI) = .64 (.50 – .82), bodily injury, α (95% CI) = .61 (.42 – .72), and sexual coercion, α (95% CI) = .65 (.54 – .87)). Q7

Childhood Trauma Questionnaire (CTQ): developed by Bernstein et al. in 1994, initially with 70 items. Subsequently, a short version with 28 items was validated (Bernstein et al., 2003). In Brazil, Grassi-Oliveira et al. (2006) translated and adapted the content of the short version, called the Childhood Trauma Questionnaire (CTQ). This questionnaire evaluates five dimensions of mistreatment: physical abuse, emotional abuse, physical neglect, emotional neglect and sexual abuse, with five items for each dimension. Three items of the scale are aimed at identifying minimization/negation. In the Brazilian study, *Cronbach's alpha* was α = .64 (Grassi-Oliveira et al., 2006). In the present study, the reliability was adequate for overall mistreatment as a child (α (95% CI) = .56 (.50 – .82)) and its dimensions (physical abuse, α (95% CI) = .77 (.64 – .91), emotional abuse, α (95% CI) = .54 (.50 – .83), sexual abuse, α (95% CI) = .77 (.62 – .91), physical neglect, α (95% CI) = .56 (.52 – .85) ,and emotional neglect, α (95% CI) = .91 (.84 – .97)). The questionnaire was included to measure participants' chronic exposure to violence throughout their lives.

Form for evaluation of adherence to the protocol: created for this study to evaluate if the psychotherapists achieved the objectives of each session. An external evaluator assigns scores — 0 (not achieved), 1 (partially achieved), or 2 (satisfactorily achieved) — for each item after listening to the recording of the session. The number of items ranges from 6 to 11, according to the number of objectives to be achieved in the session. For example: the purpose of the session and the tasks were clearly explained for the sake of patient engagement (all sessions); the main concepts, such as gender, role and gender violence, were clearly addressed by the therapist (session two); the therapist assisted in the development of achievable goals (session 15).

Ethical Procedures and Data Collection

The project was approved by the Research Ethics Committee (protocol number 1.000.590). Ethical procedures are in accordance with resolution 466/12 of Brazil's National Health Council (Brasil, 2012). The Informed Consent Form, evaluated by the University's Ethics Committee, was read out loud and explained to the participants. All of them agreed and signed it. Note that, when participants met some exclusion criteria, they were referred to other mental health care services that could provide treatment according to their specific needs.

The research team was composed of eight members in charge of carrying out clinical pre- and post-test assessments and conducting psychotherapy. Only one member of the team was male. Data collection training took place during four meetings lasting approximately three hours each. The objective of each psychotherapy session was discussed theoretically and methodologically. All cases attended to were supervised weekly by the researcher proposing the psychotherapy protocol. To avoid bias in the evaluation, the pre- and post-test evaluators were professionals other than the therapist for each participant. In addition, within this same team, judges were randomly and confidentially selected to assess the therapists' adherence to the protocol. Data collection was carried out at the University's Psychology Clinic. The evaluation and protocol sessions were all carried out on a weekly basis for each individual and lasted approximately 1 hour each.

The pre-test assessment took place during three weekly meetings. One week after the pre-test assessment, the participants returned for the first session of psychotherapy. The first phase of psychotherapy proposed psychoeducation on relevant topics: ABC Model (relating "Activating event", "Belief" and "Consequences"), types of violence, gender roles, gender stereotypes.

In this phase, it was possible to better know the patient and identify the presence of cognitions related (mainly) to violence. The discussion of the cognitive model and other relevant content enabled the next step. The second phase aimed at cognitive restructuring of post-traumatic cognitions (identified in the previous phase) and emotional regulation; the third focuses on problem-solving, which mainly involves discussing a situation arising from previous violence; and the

TABLE 1. Intervention Protocol Description

Phases	Session	Description
Psychoeducation-on violence against women and gender relations and cognitive restructuring	1	Therapeutic agreement, Evaluation of participant's expectations, Establishment of therapeutic objectives. Creation of a card with the vision of oneself and a belief card about the role of women in different contexts.
	2	Psychoeducation about the different types of violence, Assessment of the current risk and, if necessary, preparation of a security plan to develop and train protection skills.
	3	Reflections on gender relations. Psychoeducation on gender violence.
	4	Psychoeducation regarding the ABC Model (Event — Interpretation — Consequences: emotions, behaviors, physical reactions).
	5	Psychoeducation about the consequences of violence.
Cognitive restructuring of post-traumatic cognitions and emotional regulation	6	Creation of a timeline for mapping the history of violence.
	7	Resumption of the timeline, development of narratives about traumatic events. Emotional regulation (functions of emotions). Relaxation.
	8	Strategies for handling emotions relative to traumatic events. Relaxation.
	9	Strategies for handling emotions relative to traumatic events. Cognitive and behavioral coping strategies — Emergency button. Relaxation.
	10	Strategies for managing emotions, cognitions, and behaviors relative to traumatic events. Relaxation.
Problem-solving	11	Problem-solving training.
	12	Problem-solving training.
Strengthening protection strategies and developing future projects	13	Prevention of exposure to violence, Development of protection strategies, Protection Network Operation.
	14	Protection skills training.
	15	Development of a project for the future in the timeline.
	16	Self-assessment — Resumption of the card with a view of oneself and the belief card on the role of women in different contexts.

goal of the final phase is prevention. Protection skills are addressed throughout the protocol, but mostly in the first and final phases. Table 1 contains a description of each session of the individual protocol intervention.

The psychotherapy sessions were recorded with the participants' permission, and the recording was used for later evaluation of the therapists' adherence to the objectives of the protocol. Finally, one week after the protocol had been concluded, the post-test assessment took place

during one or two meetings; the instruments were reapplied, with the exception of those dealing with the individual's history of violence. All data collection was completed before the start of the COVID-19 pandemic in Brazil.

Data Analysis Procedures

Initially, descriptive analyses were carried out. The normality tests (Kolmogorov–Smirnov and Shapiro–Wilk) showed that the variables did not have a normal distribution. Therefore, non-parametric tests were used, and exact probability tests (Monte Carlo) were applied to increase the accuracy of the analyses.

In order to assess the impact of the intervention, the scores of the participants were compared before and after the intervention for the symptoms of depression, anxiety, trauma-related symptoms (negative beliefs about oneself, negative beliefs about the world, and beliefs about self-blame, DESNOS severity, reliving, avoidance, cognition and mood, hyperarousal and severity of PTSD), and indicators of life satisfaction and self-esteem. The analysis of mean differences was

TABLE 2. Analysis of the Impact of Intervention on the Dimensions Evaluated as an Outcome

	Application of Instruments		Wilcoxon Signed-Rank	
Dimensions	Pre-test (*M*(*SD*))	Post-test (*M*(*SD*))	*Z*	*r*
Life Satisfaction	17.8 (7.4)	22.8 (5.7)	6.3*	.63
Self-esteem	27.7 (4.5)	32.9 (5.0)	6.3*	.78
Anxiety	16.5 (9.8)	11.2 (8.7)	−5.4*	.44
Depression	22.9 (9.6)	9.9 (9.0)	−4.2*	.77
Negative Beliefs about Oneself	70.9 (23.4)	45.6 (18.3)	4.4*	.82
Negative Beliefs about the World	30.2 (6.6)	23.5 (6.5)	6.2*	.74
Beliefs about Self-blame	17.8 (7.3)	11.5 (6.9)	4.4*	.73
DESNOS Severity	30.3 (14.1)	14.5 (12.1)	−5.8*	.86
Reliving	8.6 (4.4)	4.4 (3.6)	−1.3*	.70
Avoidance	5.0 (2.0)	3.1 (2.2)	−2.5*	.64
Cognition and Mood	12.0 (6.9)	6.3 (4.3)	−1.2*	.66
Hyperarousal	9.0 (4.0)	5.0 (4.2)	−2.0*	.74
Severity of PTSD	34.6 (13.2)	18.8 (11.1)	−1.1*	.75
			McNemar	
	Presence (%)	Absence (%)	Presence (%)	Absence (%)	McNemar	*V*
DESNOS Diagnosis	38.5	61.5	11.5	88.5	5.7*	.46
PTSD Diagnosis	50	50	3.8	96.2	1.0*	.20

Note. M = Media; SD = Standard Deviation

*$p < .05$.

TABLE 3. Analysis Jacobson and Truax (JT) Method to Assess Changes in Life Satisfaction Dimensions, Self-Esteem, Anxiety, Depression, DESNOS Severity, and PTSD Severity

	LS				SE				Anx				Dep				DS				PS			
ID	*M 1*	*M 2*	RCI		*M 1*	*M 2*	RCI		*M 1*	*M 2*	RCI		*M 1*	*M 2*	RCI		*M 1*	*M 2*	RCI		*M 1*	*M 2*	RCI	
1	9	29	−1.0		25	40	7.9	+	6	31	0.9		15	16	−0.5		63	43	**−3.0**	+	33	45	0.9	
2	12	25	**3.3**	+	27	36	4.7	+	20	1	0		36	7	0.8		31	13	−0.5		56	12	−0.7	
3	22	32	−0.5		30	37	3.7	+	25	9	**−7.1**	+	20	2	**−3.2**	+	43	11	**−2.6**	+	30	10	**−5.2**	+
4	29	28	1.0		32	32	0.0		34	2	−1.1		12	1	-0.5		18	2	0.5		34	5	**−3.2**	+
5	12	24	0.5		24	31	**3.7**	+	14	0	**−6.7**	+	27	5	**−2.3**	+	33	18	−1.0		31	6	**−4.5**	+
6	13	26	**2.4**	+	21	34	**6.8**	+	13	9	**−4.5**	+	32	0	**−6.1**	+	40	1	**−2.2**	+	58	19	−0.5	
7	19	27	**−4.8**	−	27	31	**2.1**	+	23	16	1.5		31	32	1.5		51	41	−1.5		39	19	1.3	
8	22	24	**4.8**	+	25	21	**−2.1**	−	9	8	**−3.6**	+	23	20	**−5.2**	+	15	10	**−5.3**	+	42	30	**−3.6**	+
9	27	28	1.0		32	34	1.0		37	7	−0.2		11	3	−0.9		10	4	−0.8		41	16	−2.2	
10	12	19	**3.8**	+	26	27	0.5		34	20	−1.6		36	16	0.2		45	14	−1.6		46	30	**−3.6**	+
11	29	22	0.0		36	33	−1.6		15	15	−1.6		8	11	0.0		13	10	−0.6		14	10	−1.6	
12	25	15	0.5		31	28	−1.6		6	13	1.3		19	24	**−3.5**	+	19	10	**−4.0**	+	25	32	0.7	
13	10	24	0.5		22	36	**7.3**	+	2	4	−1.4		34	0	**−4.6**	+	43	6	**−2.5**	+	43	5	−1.6	
14	9	18	**2.9**	+	22	30	**4.2**	+	5	0	−1.1		15	0	**−3.5**	+	17	7	**−2.8**	+	24	1	**−2.2**	+

(*continued*)

LS					SE				Anx				Dep				DS				PS			
15	18	19	1.4		26	30	**2.1**	+	26	32	−0.7		31	19	**−6.7**	+	45	21	**−5.1**	+	22	26	**−4.9**	+
16	17	18	1.9		26	33	**3.7**	+	21	15	0.5		26	10	−1.2		39	24	−1.5		40	31	**−3.6**	+
17	12	20	**6.2**	+	31	37	**3.1**	+	16	6	−0.9		19	4	**−9.2**	+	14	2	**−6.5**	+	19	6	**−7.0**	+
18	14	18	**5.7**	+	23	30	**3.7**	+	11	13	**−3.2**	+	16	12	**−6.4**	+	20	11	**−2.5**	+	41	21	**−4.5**	+
19	9	20	**3.3**	+	21	35	**7.3**	+	5	4	**−3.2**	+	33	4	**−5.8**	+	29	10	**−5.1**	+	53	26	**−2.9**	+
20	14	17	0.4		25	27	1.0		13	10	−0.5		27	4	−0.9		45	14	−0.3		46	19	−0.8	
21	16	22	**3.8**	+	32	40	**4.2**	+	10	5	**−2.2**	+	16	4	**−4.3**	+	27	10	−1.9		28	16	**−2.3**	+
22	9	9	**6.7**	+	24	24	0.0		9	26	0.4		44	25	**−9.8**	+	44	44	**−6.1**	+	41	36	**−6.8**	+
23	27	29	0.0		32	34	1.0		18	13	**3.8**	−	12	10	**−5.5**	+	19	22	0.0		41	23	−0.9	
24	19	19	**5.2**	+	32	36	**2.1**	+	24	17	−0.2		20	20	**−8.4**	+	22	18	**−3.1**	+	34	25	**−4.9**	+
25	26	31	**4.3**	+	32	40	**4.2**	+	25	5	−1.2		21	0	**−4.3**	+	21	8	−1.6		14	11	**−4.1**	+
26	33	31	**9.5**	+	35	40	**2.6**	+	7	11	**5.6**	−	11	9	0.3		21	3	**−3.3**	+	5	10	**2.2**	+

Note . $^{+}$**= Clinically Positive and Significant Change;** $^{-}$**= Clinically Negative and Significant Change;** Anx = Anxiety; Dep = Depression; DS = DESNOS Severity; LS= Life Satisfaction; M1 = Media of participants in the Pre-Test; M2 = Media of participants in the Post-Test; SE = Self-esteem; PS = PTSD Severity.

TABLE 4. Intimate Partner Violence, Mistreatment as a Child and Traumatic Events Associated With the Benefits of the Intervention

	Categories		M-W		Categories		M-W		Categories		M-W		Categories		M-W		Categories		M-W	
	Low LTE	High LTE	*Z*	*r*	Low PAP	High PAP	*Z*	*r*	Low BIP	High BIP	*Z*	*r*	Low SCP	High SCP	*Z*	*r*	Low MC	High MC	*Z*	*r*
LS	6.3 (6.9)	2.6 (6.3)	4.4*	.01	4.7 (7.5)	5.9 (4.8)	4.4*	.03	4.1 (4.2)	5.9 (8.8)	4.4*	.32	4.3 (6.6)	8.8 (8.3)	−4.4*	.01	2.2 (6.6)	7.8 (6.0)	4.4*	.03
SE	6.3 (5.5)	3.3 (4.3)	4.5*	.09	5.4 (5.9)	4.9 (3.3)	4.4*	.27	5.0 (4.5)	5.5 (6.1)	4.4*	.01	4.9 (5.3)	6.5 (6.1)	−4.4*	.02	3.4 (5.0)	7.2 (5.0)	−1.2*	.01
Anx	−7.2 (14.6)	−1.4 (6.9)	−4.2*	.12	−5.7 (13.0)	−3.9 (12.4)	−4.2*	.08	−8.5 (9.9)	−1.9 (14.5)	−4.1*	.06	-5.6 (11.7)	0.2 (17.5)	−3.9*	.10	−7.5 (13.0)	−3.0 (12.3)	−2.9*	.01
Dep	−16.8 (11.2)	−5.7 (8.2)	−4.4*	.43	−11.8 (12.1)	−16.0 (9.6)	3.4*	.05	−11.8 (9.1)	−14.2 (13.7)	−4.2*	.09	−13.0 (11.8)	−10.5 (11.8)	−3.8*	.08	−9.5 (10.8)	−16.4 (11.5)	−2.2*	.01
NBO	−27.8 (24.6)	−20.7 (18.0)	3.2*	.04	−22.8 (23.1)	−32.3 (20.4)	4.4*	.20	−20.5 (20.4)	−30.2 (24.0)	3.0*	.10	−24.6 (21.8)	−32.0 (30.5)	−3.8*	.09	−20.2 (22.5)	−30.5 (22.0)	2.8*	.16
NBW	−8.0 (7.7)	−4.4 (5.6)	4.4*	.11	−5.6 (6.6)	−9.9 (8.1)	3.0*	.08	−6.8 (6.5)	−6.8 (7.9)	4.4*	.10	−6.4 (6.9)	−8.2 (9.9)	−4.2*	.07	−3.5 (5.4)	−10.0 (7.3)	4.4*	.10
BSB	−6.4 (7.7)	−6.3 (5.3)	2.8*	.30	−6.7 (7.5)	−5.6 (5.3)	2.8*	.30	−6.8 (5.9)	−6.0 (7.9)	2.9*	.04	−6.3 (6.7)	−4.5 (7.9)	3.5*	.06	−6.5 (5.9)	−6.3 (8.0)	2.6*	.19
DS	−18.0 (12.2)	−11.6 (8.0)	−4.4*	.17	−14.6 (11.2)	−18.9 (11.4)	−4.4*	.32	−14.5 (9.9)	−17.1 (12.6)	−4.3*	.35	−15.1 (10.6)	−20.0 (16.3)	−4.3*	.01	−12.8 (10.6)	−18.8 (11.4)	−4.4*	.43
Rel	−18.8 (14.9)	−10.1 (12.3)	−2.4*	.10	−15.1 (14.4)	−17.7 (15.6)	1.0*	.04	−14.1 (9.3)	−17.5 (18.5)	−2.5*	.11	−16.9 (14.3)	−13.2 (17.3)	−1.8*	.03	−13.2 (14.4)	−18.3 (14.6)	−4.2*	.08
Avo	−4.3 (4.7)	−3.9 (5.2)	.8*	.08	−4.2 (5.5)	−4.0 (2.4)	−2.4*	.02	−4.5 (4.4)	−3.8 (5.3)	.9	.02	−4.6 (4.7)	−2.0 (5.8)	1.5*	.02	−5.2 (5.7)	−3.1 (3.6)	−3.3*	.19
CM	−2.5 (2.6)	−0.8 (3.0)	−2.9*	.20	−2.0 (2.6)	−1.7 (3.4)	−2.3*	.03	−1.9 (1.7)	−1.9 (3.6)	−2.5*	.03	−1.9 (2.9)	−2.5 (2.5)	−1.7*	.03	−1.2 (2.9)	−2.6 (2.6)	1.0	.25
Hy	−7.3 (7.0)	−2.8 (6.1)	−3.0*	.20	−5.5 (6.8)	−6.4 (7.8)	−3.0*	.08	−4.8 (5.8)	−6.6 (8.1)	−2.9*	.17	−6.1 (7.4)	−5.0 (4.8)	−1.9*	.01	−3.2 (6.5)	−8.2 (6.7)	−3.3*	.15
PS	−4.6 (4.9)	−2.7 (2.4)	−2.5*	.14	−3.4 (3.7)	−5.6 (5.4)	−2.3*	.02	−2.8 (2.7)	−5.2 (5.3)	−2.5*	.18	−4.2 (4.0)	−3.8 (5.9)	−1.4*	.03	−3.5 (3.4)	−4.4 (5.1)	−3.3*	.18

Note.; Anx = Anxiety; Avo = Avoidance; BIP = Bodily Injury by the Perpetrator; BSB = Beliefs about Self-blame; CM = Cognition and Mood; Dep = Depression; DS = DESNOS Severity; Hy = Hyperarousal; LS= Life Satisfaction; LTE = List of Traumatic Events; M = Medium; MC = Mistreatment as a Child; NBO = Negative Beliefs about Oneself; NBW = Negative Beliefs about the World; PAP = Psychological Aggression by the Perpetrator; PS = PTSD Severity; Rel = Reliving; SCP = Sexual Coercion by the Perpetrator; SD = Standard Deviation; SE = Self-esteem; .

*$p < .05$

performed using the Wilcoxon Signed-Rank test. In addition, a comparison was made of the presence/absence of a diagnosis of DESNOS and PTSD using the McNemar Test. Additionally, the effect size of each test was calculated.

The impact of the intervention was also investigated using the Jacobson and Truax Method (JT Method) to assess the reliability of the individual changes of the participants who completed the intervention. To this end, the JT Method uses clinical significance (CS) and the reliability change index (RCI). CS assesses how much the intervention produced relevant changes by comparing the participants with themselves (external validity). The RCI shows whether the changes that occurred between the pre- and post-intervention assessments are due to the procedures being used or whether they result from the evaluation process. It investigated the differences in the scores of the participants before and after the intervention for the symptoms of depression, anxiety, PTSD severity and DESNOS severity, and indicators of life satisfaction and self-esteem.

In addition, the benefits of the intervention were investigated by calculating the difference in scores in the post- and pre-intervention assessments for the dimensions assessed at each time. We assessed whether IPV severity, mistreatment as a child and traumatic events were associated with the benefits of the intervention. For this purpose, the participants were categorized into groups of high and low severity compared to the medians for each dimension of the history of violence, and comparison of the groups was performed using the Wilcoxon test and the effect size of each test was calculated.

Finally, to investigate the adherence of the five therapists to the protocol, one patient from each therapist's group was randomly selected, and six randomly selected sessions of the therapeutic process were analyzed, covering the four stages of the protocol. Adherence was assessed according to the fulfillment of the objectives previously defined for each session. For each objective achieved satisfactorily, the value 1 was assigned (100%), and for each objective partially achieved, the value 0.5 was assigned. The values were added and divided by the maximum number of points in each session (ranging according to the number of items/objectives). The rate of adherence for each session was calculated, and the total adherence rate for each therapist was subsequently determined.

Results

In this purposive sampling of women, who declared to have experienced IPV in their previous relationships, all participants reported psychological violence, 96% reported physical violence, with or without bodily injury, and 80% experienced sexual coercion in their relationship. The relationships lasted between five months and thirty-one years. In turn, the history of overall mistreatment as a child was reported to be at a moderate to extreme level by 53% of the participants. In other words, more than half of the participants reported suffering more than one type of abuse. Specifically, the following were found to occur at a moderate to extreme level: psychological abuse for 75% of participants (extreme for 25% of them), physical abuse for 49% (extreme for 33%), emotional neglect for 46% (extreme in 13% of the cases), physical neglect for 33% (extreme for 8%), emotional neglect for 50% (extreme for 13%), and sexual abuse for 42% of participants (extreme for 13% of them).

In the total sample, before the intervention, 38% of the participants were diagnosed with DESNOS. As regards anxiety symptoms before the intervention, 35% showed minimal levels, 27% had mild levels, 27% had moderate levels, and 12% presented severe anxiety symptoms. Also, it was found that 19% showed minimal levels of symptoms of depression, 31% had mild levels, 27% moderate levels, and 31% severe symptoms of depression. The evaluation of PTSD before the intervention showed that 50% of participants had this diagnosis, with 46% having high scores for avoidance, 12% for reliving, 15% for cognition and mood, and 4% for hyperarousal.

The results of the analysis of the impact of the intervention demonstrated statistically significant differences with a strong effect size for increased life satisfaction and self-esteem levels, and reduction of symptoms of depression, negative beliefs about oneself, negative beliefs about the world, beliefs about self-blame, DESNOS severity, reliving, avoidance, cognition and mood, hyperarousal and severity of PTSD. There was also a significant decrease in anxiety averages, and the effect size was moderate. Regarding the presence of PTSD (3.8% post-intervention) and DESNOS diagnosis (11.5% post-intervention), there was a statistically significant reduction in the diagnosis of PTSD, but with a low effect size. For the diagnosis of DESNOS, there was also a statistically significant decrease, with a moderate effect size (Table 2).

The impact analysis using the JT Method demonstrated that 23 participants showed clinically significant and positive changes after the intervention in at least one of the six indicators (Table 3). Nine participants showed differences in five or six indicators; six of them exhibited differences in three or four indicators, and eight participants displayed differences in one or two indicators. The participants demonstrated increased self-esteem (n = 17) and life satisfaction (n = 13), as well as reduced anxiety (n = 7), depression (n = 16), PTSD severity (n = 16), and DESNOS severity (n = 14). Four participants showed a clinically significant, but negative, change in one dimension each, i.e., there was a decrease in the levels of life satisfaction (n = 1) and self-esteem (n = 1) and an increase in anxiety levels (n = 2) (Table 3).

Finally, Table 4 shows the variables that were associated with the greatest benefits of the intervention. The results showed that the history of traumatic events, history of mistreatment as a child, psychological aggression and bodily injury caused by the perpetrator showed differences with medium effect size on the levels of life satisfaction, depression, beliefs about self-blame and DESNOS severity (Table 4). Moreover, the participants with higher levels of bodily injury caused by the perpetrator showed higher levels of life satisfaction after the intervention. The presence of higher levels of history of traumatic events was associated with lower levels of depression after the intervention. Also, the participants with lower levels of traumatic events and those with higher levels of psychological aggression had lower levels of beliefs about self-blame after the intervention. Furthermore, the participants with lower levels of history of mistreatment as a child, psychological aggression by the perpetrator and those with lower levels of bodily injury showed a lower level of DESNOS severity after the intervention (Table 4). Regarding the adherence of therapists to the protocol, it was found that all of them reached at least 65% of the objectives of the sessions evaluated, and adherence ranged from 65.3% to 93.5%.

Discussion

The aim of the study was to evaluate the impact of a 16-session Cognitive Behavioral Psychotherapy protocol for women with a history of IPV. The results indicated significant differences in all indicators evaluated, with an increase in the levels of life satisfaction and self-esteem, a reduction in depression and anxiety symptoms, and a reduction in trauma-related indicators.

The reduction in the levels of anxiety and depression had already been reported in the study of the first version of the protocol (Habigzang et al., 2018). Other international studies of individual psychotherapy have also found reduced anxiety (Matud et al., 2014) and depression (Patel et al., 2019). Such proposals used psychoeducation techniques and problem-solving training, which are potentially beneficial for these symptoms. As far as life satisfaction is concerned, it is known that there is a negative correlation with symptoms of anxiety and depression (Habigzang et al., 2018). Therefore, the reduction in the levels of these symptoms may explain an improvement in their feeling of well-being and in their life satisfaction levels.

In turn, a desirable self-esteem involves the perception of value and personal qualities, a sense of ability, as well as satisfaction, respect and a positive self-attitude (Hutz & Zanon, 2011). The development of an individual's self-esteem is influenced by significant people, cultural aspects and life experiences (Assis & Avanci, 2004). Self-esteem is not fixed and can be positively or negatively impacted by different events and psychosocial aspects throughout life (Papalia & Feldman, 2013). Evidence shows that exposure to mistreatment during childhood has a negative impact on self-esteem development (Karakuş, 2012; Xiang et al., 2018). Furthermore, experiencing IPV in adulthood may impair the victim's self-esteem (e.g., causing self-guilt, shame) (Bacchus et al., 2018; WHO, 2014).

Evidence-based interventions have demonstrated that IPV victims' levels of self-esteem may be increased through psychoeducation techniques, since they stimulate the development of a positive self-concept, increase self-value, promote self-protection (e.g., affirmation of women's rights), and improve self-care strategies. Additionally, they promote rewarding activities, exposure to traumatic memories, relaxation techniques, and assertiveness training (Matud et al., 2014; Ortiz et al., 2011). Thus, it is clear that different interventions may contribute to increase individuals' self-esteem. In this study, improvement in the levels of self-esteem can be understood as being procedural and cumulative, as long as the objectives of each phase of the protocol have been achieved, potentially leading to flexibility in beliefs regarding devaluation and the improvement of personal emotional regulation, self-protection and guarantee of women's rights, as well as problem solving. In turn, the improvement in self-esteem can buffer anxiety and symptoms of depression to a moderate degree (Costa & Gomes, 2018).

In this study, all PTSD indicators decreased at the end of the intervention, indicating that the reformulations made with respect to the initial protocol were positive. Emotional regulation techniques associated with the flexibilization of dysfunctional beliefs about violence proved to be important psychotherapeutic components in reducing PTSD symptoms.

A history of mistreatment as a child was found in more than half of the participants. Having experienced different situations of violence throughout life can contribute to the presence of the DESNOS diagnosis. After this intervention, there was a 27% reduction in the initial number of women diagnosed with DESNOS, which is preliminary evidence of the effectiveness of this protocol for reduction of DESNOS' symptoms. For women with a history of IPV, there are no other protocols with a focus on DESNOS. However, a recent Brazilian study found that 31% of the sample of women with a history of IPV had met criteria for DESNOS' diagnosis (Zancan et al., 2019). In the present study, 37.5% of the participants had a diagnosis of DESNOS in the pre-test evaluation. Thus, it is an important factor to be evaluated and a focus of intervention in the population with violence history.

Regarding the history of intimate partner violence, most participants identified having suffered more than one type of IPV. These results highlight the importance of the victims' gender, since IPV is not perpetrated by women against men to a significant extent (Razera et al., 2016), and also underscore the association between different types of violence in abusive relationships.

Also, 15 participants exhibited a positive, clinically significant change in at least half of the indicators. It is known that exposure to violence can trigger different changes and symptoms whose severity may vary. In this study, different symptoms and severity were observed in the pre-test results. For this reason, protocols for victims of IPV need to take into account different target symptoms for the purpose of intervention design (Cohen et al., 2013; Cort et al., 2014; Resick et al., 2008). Four participants showed significant clinical worsening in one of the indicators. However, three of them showed significant clinical improvement in other indicators. Only one participant showed a reduction in life satisfaction levels and did not obtain other significant results; this finding may be explained by the fact (self-reported by the patient) that she would like to change another aspect of her life.

Finally, the results showed that the benefits of the intervention were impacted by exposure to mistreatment as a child, past traumatic events, IPV victimization via psychological aggression and bodily injury by the perpetrator. In another protocol study, it was found that the frequency of IPV was related to a greater severity of PTSD and also to a greater decrease in the symptoms of PTSD after treatment. The significant reduction in PTSD symptoms may be due to the initial exacerbated severity of PTSD. In addition, improvements in the symptoms of PTSD and depression were significantly greater for women who had experienced IPV (Iverson et al., 2011).

In turn, the participants who most improved in terms of DESNOS severity were those who had the lower levels of history of both IPV and mistreatment as a child. These findings highlight the relationship between chronic exposure to violence and DESNOS. The results also indicate the importance of understanding the complexity of the clinical conditions of women with exposure to mistreatment as a child and IPV, underscoring the importance of taking its many facets into account when planning a therapeutic intervention for a population with a history of both IPV and child abuse. Lastly, those participants who had suffered higher levels of psychological violence experienced a larger decrease in self-blame. The improvement of participants in terms of the reduction in levels of (trauma-related) self-blame is evidence of the importance of implementing a non-judgemental approach, in addition to techniques to promote flexibilization of dysfunctional beliefs. Furthermore, we observed that addressing trauma-related guilt contributes to improvements in PTSD symptoms (Allard et al., 2018).

Future studies should be carried out, including treatment strategies for women who are still in an abusive relationship, and for those who represent a suicide risk or are abusing substances. It is understood that strategies for handling these cases require structured and multidisciplinary services to guarantee the women's rights and lives.

This study had methodological limitations. The first was the final sample size. The second limitation was the absence of a control group, which could not be organized with a waiting list owing to the significant vulnerability of the recruited women. In addition, there were no other services that provide psychotherapy for women with IPV using a different approach, which would otherwise have allowed a comparison. There is an important gap in specialized mental health services for victims of IPV in Brazil. There need to be further studies with experimental and follow-up designs to monitor the maintenance of therapeutic gains after the end of psychotherapy in order to consolidate the effectiveness of the protocol. In addition, qualitative studies about drop-out cases are important to aid in the development of adjustments that could enhance adherence to psychotherapy.

Despite its limitations, the present study showed initial evidence of a positive impact of the intervention on indicators of self-esteem, life satisfaction, anxiety, depression and trauma-related symptomatology. In Brazil, to date, there are no published research papers evaluating other psychotherapy protocols for women with a history of IPV. Evidence-based practices are still hardly ever incorporated into mental health services in the country. Therefore, this study is an important contribution toward promoting the use of evidence-based interventions. Finally, we would like to emphasize the importance of including psychotherapy as a strategy to face violence, associated with other measures indicated by the healthcare network. Without integration with healthcare policies and current legislation, psychotherapy may pose the risk of revictimization. On the other hand, when psychotherapy is integrated with other protection measures and services, it can contribute to breaking the cycle of violence and minimizing the damage caused by such experiences.

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