



Evidence of Effectiveness of a Psychotherapy Protocol for Women with a History of Intimate Partner Violence: Follow-up Study

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Abstract

This study aims to evaluate the therapeutic effects of the cognitive behavioral psychotherapy protocol for women with a history of intimate partner violence 6 months after the end of the intervention. The study employed a mixed method with pre-experimental design. Fifteen women ($M=36.67$ years; $SD=11.89$; 22 to 60 years) who had completed the intervention participated in the study. The majority of the participants were white, divorced, with complete higher education, and employed. Data collection was carried out from May 2019 to September 2020 in person at Psychology Practice and Research Service (*Serviço de Atendimento e Pesquisa em Psicologia—SAPP*) of the university with 7 participants, and online with 8 participants. Instruments applied aim to assess levels of self-esteem, life satisfaction, anxiety, depression, post-traumatic stress disorder, post-traumatic beliefs, and complex trauma. The instruments were applied at pretest, post-test, and follow-up. A structured interview was applied only at the follow-up. Descriptive analyses of frequencies were carried out, Friedman's test to verify differences between the evaluation times, analyses with JT method to evaluate individual differences, and clinical significance. Content analysis was also carried out from the structured interviews. The intervention reduced symptoms of depression (Cohen's $d=0.45$), post-traumatic stress disorder (Cohen's $d=0.33$), and complex trauma (Cohen's $d=0.57$), which were maintained at follow-up. Participants showed higher levels of self-esteem and life satisfaction after the intervention, when comparing pretest and follow-up evaluations ($p<0.005$). In the interviews, participants indicated that the psychotherapy process contributed to better quality of life. The study results indicate the potential of the intervention for the replication in mental health services for women with a history of intimate partner violence. Cognitive-behavioral therapy is an effective approach and it can be a tool to reduce negative mental health outcomes in long-term process.

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Keywords Intimate partner violence · Psychotherapy · Cognitive behavioral therapy · Follow-up study · Treatment outcome

Introduction

Intimate partner violence (IPV) is one of the most frequent expressions of violence against women (World Health Organization [WHO], 2019), and it is estimated that 1 in 3 women has experienced physical and/or sexual violence in the intimate relationship (WHO, 2017). A study that analyzed notifications of violence against women between 2011 and 2017 in Brazil identified 454,984 cases of IPV (62.4% of all notifications), with physical violence (86.6%) and psychological violence (53.1%) as the most prevalent (Mascarenhas et al., 2020).

The Maria da Penha Law (Lei Federal nº 11.340, 2006) represents a milestone in legislative terms in guaranteeing the rights of women victims of violence. The forms of violence described in the law are as follows: (1) physical violence, any action that offends the physical integrity and bodily health; (2) psychological violence, any conduct that causes emotional damage, decreases self-esteem, or impairs development; (3) sexual violence, any conduct that forces the victim to witness, maintain, or participate in unwanted sexual intercourse, through threat, intimidation, or use of force. Actions that prevent any contraceptive method or that force marriage, pregnancy, abortion, or prostitution, through coercion, blackmail, bribery, or manipulation; (4) property violence, any conduct that configures retention, subtraction, partial or total destruction of objects, work instruments, personal documents and economic resources; (5) moral violence, any conduct that constitutes slander, defamation, or injury (Lei Federal nº 11.340, 2006). The law creates mechanisms to curb, prevent, and punish any act of violence based on gender that causes physical, psychological, sexual, moral, and property damage or the death of the woman. In addition, the law determines the multidisciplinary care network, creating specialized courts and protective measures (Lei Federal nº 11.340, 2006).

Experiencing violence can generate a series of negative consequences for women's physical, mental, and reproductive health (WHO, 2019). Studies highlight the worsening of psychological disorders, such as mood changes, anxiety, difficulties in emotional regulation, substance use, suicide ideation or attempts (Bacchus et al., 2018; Zancan & Habigzang, 2018); sexually transmitted infections, and sleep and eating disorders (Netto et al., 2014). Furthermore, chronic exposure to violence is related to the emergence of a set of symptoms called complex PTSD (Baird et al., 2019; Zancan et al., 2019). Exposure to IPV also triggers negative beliefs associated with guilt, low self-efficacy and self-esteem, and feelings of insecurity and worthlessness (Papadakaki et al., 2009).

Considering this, the development of interventions, which can act in the prevention, identification, or treatment/clinical care of women who have experienced IPV, becomes essential (Trabold et al., 2020). A meta-analysis study evaluated brief interventions for women with a history of IPV, finding that the 21 protocols included were effective in reducing the target symptoms, particularly depression and PTSD. It also indicated that the most effective protocols were based on cognitive

behavior therapy (Arroyo et al., 2017). In Brazil, there are few studies related to psychotherapy protocols for women victims of IPV (Foschiera et al., 2021). However, there are studies on the protocol developed by Habigzang et al. (2018), anchored in cognitive-behavioral therapy and consisting of 16 sessions divided into four steps: step 1 — psychoeducation on violence against women and gender relations, cognitive restructuring; step 2 — gradual exposure to traumatic memories and emotional regulation; step 3 — troubleshooting; and step 4 — consolidation of protective strategies and plans for the future (Zamora et al., 2020). The first version of the intervention conducted with 11 women showed a significant reduction in levels of anxiety ($r=0.55$) and depression ($r=0.60$), as well as an increase in levels of satisfaction with life ($r=0.49$), which indicated evidence for the effectiveness of the treatment for some clinical indicators. However, this first version was not effective in reducing PTSD symptoms (Habigzang et al., 2018). Therefore, the protocol was reformulated, including cognitive restructuring techniques for stereotyped beliefs about gender roles and that legitimize violence, as well as emotional regulation techniques associated with exposure to intrusive memories.

After reformulations in the protocol, two studies were carried out with the aim of evaluating the therapeutic process. The results indicated good levels of therapeutic alliance and items characteristic of CBTs (Petersen et al., 2019), with at least one cycle of change identified in all sessions (Zamora et al., 2020). After the evaluation of the process, an impact evaluation study was carried out, in which 26 women participated. Pre- and post-test comparisons indicated a significant reduction in symptoms of depression, anxiety, PTSD, and complex PTSD, lower rates of post-traumatic cognitions, and increased levels of satisfaction with life and self-esteem (Curia et al., 2021).

Considering that follow-up assessments allow the effectiveness of the proposed interventions to be verified, this study sought to assess the therapeutic effects of the protocol 6 months after the end of the intervention proposed by Habigzang et al. (2018) and the factors associated with the impact of this intervention through the perceptions of the participants. In order to investigate the effects of the intervention 6 months after the end of the psychotherapy, the symptoms of depression, anxiety, PTSD, complex PTSD, post-traumatic cognitions, and levels of satisfaction with life and self-esteem of the participants were re-evaluated. The hypotheses evaluated were as follows: (H1) — there would be a reduction in the levels of depression, anxiety, PTSD, complex PTSD, and post-traumatic cognition indices in the post-test and follow-up compared to the participants' scores prior to the intervention; (H2) the levels of self-esteem and satisfaction with life in the post-test and follow-up would be higher than the participants' scores prior to the intervention; and (H3) the participants would present a reliable change index (RCI) at post-test and follow-up for depression, anxiety, PTSD, complex PTSD, post-traumatic cognition indices, satisfaction with life, and self-esteem. In order to understand in-depth the factors associated with the effects of the intervention on the participants' experiences, their perceptions about the impact of the psychotherapy protocol on their lives and on the events that occurred after the end of the intervention were investigated.

Ensuring the effectiveness of psychological interventions for women with a history of IPV favors the improvement of techniques and methods in psychotherapy, in

addition to promoting a clinical practice based and committed to scientific evidence. In Brazil, there are few studies with this proposal. Therefore, this research pioneers the development a psychotherapy protocol for this population. In addition, it enables the instrumentation of professionals in the protection network to face violence against women.

Method

Design

This is a mixed character study with a pre-experimental design. Qualitative and quantitative methods were employed for data analysis. A pre-experimental design with pre- and post-test comparisons was used without random selection and a control group.

Participants

The first stage of this research started in 2018 with a psychotherapy protocol study completed by 26 women. Fifteen women from this sample attended a 6-month follow-up evaluation after intervention. The follow-up evaluations were carried out from April 2019 to September 2020. The sample selection flowchart is presented in Fig. 1. Sampling was performed by convenience, through online dissemination (e.g., Instagram and Facebook) ($N=11$) and service network referral ($N=4$).

To be included in the study, participants had to be over 18 years of age and have left the offender, either through protective measures or termination of the relationship. Exclusion criteria were as follows: having a substance use disorder; having psychotic symptoms, suicidal ideation, severe cognitive deficit, or already being in psychotherapy. Symptoms were assessed through a clinical interview by the authors. All participants ($N=15$) experienced psychological aggression. Most experienced physical aggression ($N=14$), with the presence of bodily harm ($N=12$) and sexual coercion ($N=12$). The sociodemographic characteristics of the participants are described in Table 1.

Instruments

- (1) Sociodemographic Questionnaire: applied in the pre-test. It investigated characteristics such as age, race/ethnicity, marital status, education, employment status, presence of children, and the use of alcohol and other substances. Protective factors were also investigated (e.g., support network, spirituality).
- (2) Rosenberg Self-Esteem Scale (Hutz & Zazon, 2011; Rosenberg, 1989): applied in the pre- and post-test, and at follow-up. It assessed the individual's view of herself, consisting of ten items on a three-point Likert-type scale. The Brazilian adaptation has a Cronbach's alpha of 0.90 (Hutz, & Zanon, 2011). In the present study, the reliability indices were adequate (α (95% CI) = .86 (0.80–0.91)).

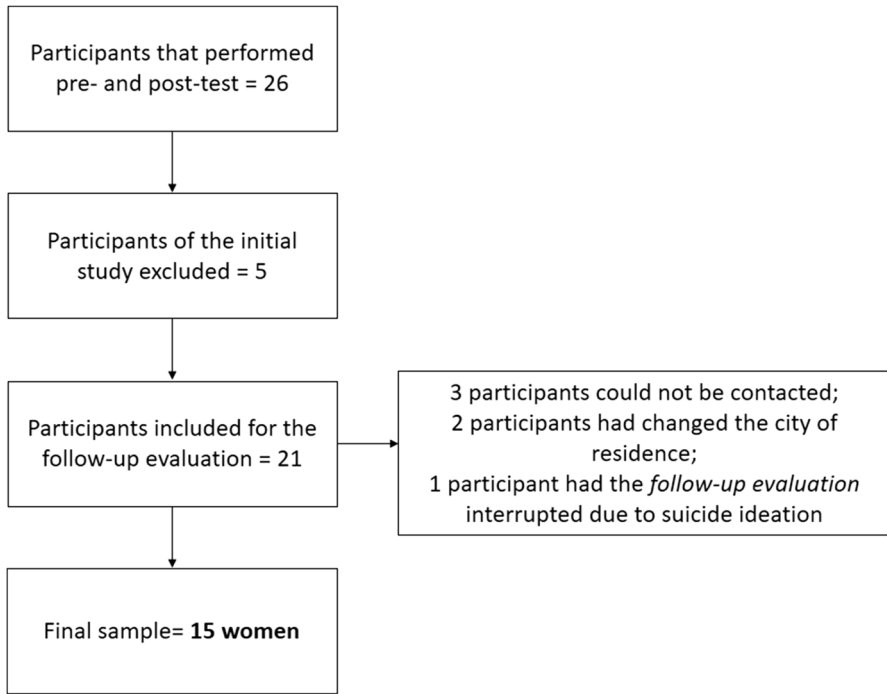


Fig. 1 Sample selection flowchart

- (3) Satisfaction With Life Scale (Diener et al., 1985; Gouveia et al., 2009): applied in the pre- and post-test, and at follow-up. The scale consists of five items that assess satisfaction with life rates using a seven-point Likert-type scale. The adapted version has a Cronbach's alpha of 0.95 (Gouveia et al., 2009). The internal consistency of the scale was adequate in this sample (α (95% CI) = 0.84 (0.77–0.91)).
- (4) Beck Anxiety Inventory (BAI) (Beck et al., 1988; Cunha, 2001): applied in the pre- and post-test, and at follow-up. The scale investigates the level of anxiety through 21 items. The scale has a satisfactory Cronbach's alpha, $\alpha = 0.92$ (Cunha, 2001). In the present sample, the Cronbach's alpha values of the BAI were satisfactory (α (95% CI) = 0.88 (0.80–0.95)).
- (5) Beck Depression Inventory II (BDI-II) (Beck et al., 1996; Gorenstein et al., 2011): applied in the pre- and post-test, and at follow-up. It seeks to investigate depression levels through a scale consisting of 21 items. The scale has a Cronbach's alpha of 0.85 (Gorenstein et al., 2011). The BDI reliability indices were adequate in the present sample (α (95% CI) = 0.89 (0.84–0.95)).
- (6) Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) (Osório et al., 2017): applied in the pre- and post-test, and in the follow-up. The scale has 20 items, which are answered using a Likert-type scale of 0 to 4 points. The reliability indices of the scale to assess the severity of PTSD ((95% CI) = 0.88 (0.81–0.95)) and its dimensions: reexperiencing, (α (95% CI) = . 83 (0.75–0.91)),

Table 1 Sociodemographic characteristics of the sample ($N = 15$)

Participants	Age	Number of children	Skin color	Schooling	Payed employment	Marital status
1	31	5	White	Complete high school	No	Stable union/married
2	40	4	White	Complete high school	Yes	Divorced/separated
3	31	1	Brown	Complete high school	No	Divorced/separated
4	24	0	White	Incomplete higher education	Yes	Single
5	42	2	White	Incomplete higher education	Yes	Divorced/separated
6	60	2	White	Complete higher education	No	Divorced/separated
7	24	0	White	Complete higher education	Yes	Single
8	22	0	White	Incomplete higher education	Yes	Single
9	49	3	White	Incomplete elementary school	Yes	Divorced/separated
10	41	2	White	Complete higher education	Yes	Divorced/separated
11	37	1	White	Complete higher education	Yes	Divorced/separated
12	27	1	Black	Incomplete high school	No	Single
13	28	0	Brown	Complete higher education	Yes	Stable union/married
14	36	0	White	Complete higher education	Yes	Single
15	58	1	White	Complete higher education	No	Divorced/separated

Frequencies, means e standard deviation $M = 36.67$; $SD = 11.89$ $M = 1.44$; $SD = 1.55$, White ($N = 12$), Complete Higher Education ($N = 7$), With employment ($N = 10$), Divorced/separated ($N = 8$)

- avoidance, (α (95% *CI*)=0.53 (0.50–0.89)), cognition and mood, (α (95% *CI*)= .83 (0.74–.92)), and arousal, (α (95% *CI*)=0.64 (0.50–0.93)) were adequate.
- (7) Posttraumatic Cognitions Inventory (PTCI) (Foa et al., 1999; Sbardelloto et al., 2013): applied in the pre- and post-test, and at follow-up. It investigates the presence of post-traumatic cognitions, arranged in three different types: 20 negative cognitions about self, negative cognitions about the world and self-blame, through a 7-point Likert-type scale. The Brazilian version has a Cronbach's alpha of 0.96. In the present sample, the reliability indices were adequate in the three dimensions assessed by the PTCI: negative cognitions about self, (α (95% *CI*)= .92 (0.88–0.96)), about the world, (α (95% *CI*)= .74 (0.55–0.93)), and self-blame, (α (95% *CI*)= .72 (0.54–0.89)).
 - (8) Structured Interview for Disorders of Extreme Stress Revised (SIDES-R) (Camargo et al., 2013; Pelcovitz et al., 1997): applied in the pre- and post-test, and at follow-up. The Brazilian version contains 38 items, each classified as yes or no, and scored from 0 to 4 according to the severity of symptoms in the previous month. The scale has a kappa coefficient of 0.853 (Camargo et al., 2013), and the scale's reliability indices in the present study were adequate (α (95% *CI*)= .79 (0.72–0.86)).
 - (9) Structured Interview for Follow-up: This was carried out with the women that completed the psychotherapy. It aimed to investigate the moment of life at the time, to comprehend the experience in relation to the psychotherapy protocol and process, and to evaluate the short and medium-term goals established in the final stage of the treatment.

Data Collection Procedures

Participant evaluation was performed in three phases: pre-test, post-test, and follow-up. After the initial contact from the patient, an in-person evaluation was scheduled. In this evaluation, a brief anamnesis and clinical interview was conducted in order to filter the potential participants according to the inclusion criteria. Pre-test evaluation was performed following participant inclusion and agreement. Post-test evaluation was performed after 16 psychotherapy sessions. The pre-test and post-test were also carried out in-person, lasting approximately 90 min. For the pre-test, post-test, and follow-up assessments, participants were contacted by telephone by a member of the research team who did not act as a psychotherapist.

Follow-up assessments were carried out 6 months after intervention end through an in-person evaluation. However, due to the context of the COVID-19 pandemic, it was necessary to change the data collection to an online format. Accordingly, the participants were contacted to carry out the assessment online. The in-person evaluations took place at the Psychology Practice and Research Service (*Serviço de Atendimento e Pesquisa em Psicologia*—SAPP) of the university, lasting approximately 90 min. The online assessment was carried out by video call through the Google Meet platform and the instruments were made available on the Qualtrics platform. The entire team of evaluators received training in the assessment and application of risk protocols, revictimization, and suicide ideation or attempt

protocols, in both evaluation formats. The interviews, both online and in person, were audio-recorded and later transcribed.

Ethical Procedures

This study was approved by the Research Ethics Committee of the Pontifical Catholic University of Rio Grande do Sul (PUCRS) under authorization number 4.141.234. To be included, the participants had to read and sign the consent form. In both evaluation formats, the recommendations of the risk protocols were followed. Consequently, in cases where a new situation of violence was confirmed by the ex-partner, a safety plan was established with the participant. If a risk of suicide was identified, an emergency referral was made to a mental health service. During the follow-up assessment, two participants were under suicide risk. Participant 16 could not finish the evaluation and was excluded from the study. Differently, participant 4 presented suicide risk after finished the follow-up evaluation. In both cases, the participant's family was contacted by the evaluator and referred to an emergency psychiatric care.

Analysis Procedures

Initially, the scores of the participants were analyzed using descriptive statistics. The participants' anxiety and depression scores were analyzed according to the categories proposed in the standardization studies of the Brazilian versions of the scales (Cunha, 2001; Gorenstein et al., 2011). The analysis of the scores of variables that do not present standardization studies in Brazil (PTSD's gravity and its dimensions avoidance, reexperiencing, cognition and mood, arousal, negative beliefs about self, self-blame, negative beliefs about the world, complex PTSD's gravity, satisfaction with life and self-esteem) was carried out by categorizing the participants as low when they had scores below the 30th percentile, moderate when they presented scores between the 30th and 90th percentile, and high when they obtained higher scores at the 90th percentile.

In order to investigate the maintenance of the benefits of the intervention 6 months after the end of the intervention, the three data collection moments (pre-test, post-test, and follow-up) were compared using the Friedman Test. Levels of depression, anxiety, post-traumatic stress disorder, self-esteem, and satisfaction with life were established as outcome variables for each repeated measures test performed. Effect sizes (Cohen's *d*) were also calculated.

The maintenance of the benefits of the intervention was also evaluated using the JT Method (Jacobson & Truax, 1991), based on the reliable change indices (RCIs) of the participants from pre-test to post-test and from pretest to follow-up. The RCI identifies whether the changes that occurred during the assessments are due to the procedures used in the intervention. The change is considered clinically relevant if the difference between assessments is at least two standard deviations above the pre-test mean for positive outcomes, the difference should be superior to 1.96, at least

two standard deviations below the pretest mean for negative outcomes, and the difference should be inferior to -1.96 (Jacobson & Truax, 1991).

In addition to investigating the maintenance of the benefits of the intervention, we sought to understand the factors associated with the positive/negative effects of the intervention based on the experience of the participants. Therefore, content analysis (Bardin, 2009) was performed by two independent judges. In addition, relevant data from the interviews were triangulated with the instruments in order to identify significant factors or events in recent months that could explain clinical differences between the evaluation times.

Results

When analyzing the participants' responses before starting the intervention, in relation to anxiety, 5 participants presented minimal symptoms, 4 mild symptoms and 2 severe symptoms. Regarding depression, 6 participants presented severe symptoms and four had moderate symptoms. It was evidenced that 10 participants fulfilled the diagnostic criteria for PTSD, with high scores in the avoidance, reexperiencing, and arousal dimensions. Negative beliefs about self, self-blame, and negative beliefs about the world presented medium scores at the beginning of the intervention. The results showed that 6 participants fulfilled the diagnostic criteria for complex PTSD in the pre-test. Furthermore, the participants presented medium levels of satisfaction with life and self-esteem.

In the post-test and at follow-up, the anxiety scores remained minimal in most of the women ($N=8$). The post-test and follow-up scores for depression were low. In the post-test, none of the participants presented a diagnosis for PTSD and levels in these dimensions reduced considerably, followed by a decrease at follow-up. It was observed that only one participant (participant 3) fulfilled diagnostic criteria for PTSD at follow-up. In the post-test and at follow-up, negative beliefs about self, self-blame, and negative beliefs about the world were low. Regarding complex PTSD, in the post-test and at follow-up, 2 participants (participant 4 and 12) presented the diagnosis.

In order to investigate the effects of the protocol over time, the participants' scores at the three collection moments were compared. The results showed that there was a significant reduction in depression scores at the different moments of assessment, with differences over time having a moderate effect size. The PTSD severity and the PTSD arousal dimension also decreased over time, with a moderate effect size for PTSD severity and a small size for the decrease in arousal levels. The levels of the PTSD dimensions reexperiencing, avoidance, and cognition, and mood showed a significant decrease when comparing the pre-test and the post-test, with the effect size of these comparisons being small (Table 2).

The complex PTSD severity scores and negative beliefs about self-scores significantly decreased throughout the assessments, both of which had a large effect size. Reductions in negative beliefs about the world and self-blame were also observed when comparing the pre-test and post-test evaluations, with the effect size of these being, respectively, small and moderate. In addition, a significant increase in satisfaction with

Table 2 Means, standard-deviation, effect size and *p* value of pre-test, post-test and follow-up assessment (*N* = 15)

Variables	Pre-test		Post-test		Follow-up		Effect Size (Cohen's <i>d</i>)	<i>p</i> value T1 T2	<i>p</i> value T1 T3	<i>p</i> value T2 T3
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
Satisfaction with life	18.30	6.50	22.70	5.40	22.90	5.90	0.31	.071	.016*	.124
Self-esteem	26.80	4.50	31.70	4.30	32.70	4.40	0.55	.008**	.003**	.109
Anxiety	16.70	7.60	10.90	5.10	12.90	8.40	0.08	.160	.945	.394
Depression	25.40	8.20	11.20	8.10	13.20	7.90	0.45	.007**	.021*	.197
PTSD	38.30	10.50	20.50	8.60	21.30	9.80	0.33	.006**	.025*	.574
Reexperiencing	9.70	4.30	4.80	2.60	6.10	3.40	0.22	.021*	.275	.794
Avoidance	5.10	1.80	3.40	1.80	3.90	1.90	0.17	.030*	.246	.613
Cognition and Mood	13.80	6.10	6.90	3.90	6.70	4.50	0.26	.015*	.071	.284
Arousal	9.80	3.00	5.40	3.20	4.70	3.80	0.31	.008**	.029*	.432
Neg. beliefs self	73.50	19.20	45.50	14.40	45.50	17.70	0.57	.002**	.003**	.197
Self-blame	17.50	5.80	11.30	5.50	10.80	5.60	0.42	.01**	.060	.312
Neg. beliefs world	29.70	5.80	23.10	5.00	23.90	8.60	0.24	.016*	.086	.743
Complex PTSD (DESNOS)	31.50	11.50	14.70	9.60	17.20	10.30	0.57	.004**	.005**	.594

life and self-esteem scores was observed over time, both of which had a large effect size. No significant changes in the anxiety scores were observed (Table 2).

The analysis of the JT method was performed to investigate the maintenance of the benefits of the intervention for the participants, in order to quantify the clinical improvement over time for each individual participant. The clinical outcomes with the highest positive reliable clinical change indices (RCI) over time were depression ($N=10$) and PTSD ($N=11$). Negative beliefs about the world were the indicator with the lowest RCI ($N=4$). The results for each participant are presented in Fig. 2.

Finally, to understand in-depth the impact of the psychotherapeutic process for the participants, content analysis was carried out to identify categories and sub-categories of the content of the structured interviews conducted only in the follow-up. Four content categories were identified: (1) self-care; (2) interpersonal relationships; (3) legal requirements; and (4) effects of the psychotherapy (Table 3).

The first category is associated with the development of self-knowledge, self-efficacy, and strengthening of individual aspects. The category interpersonal relationships concerns the presence of the support network, such as family, friends, and institutions, as well as the difficulty of reapproaching them, particularly due to feelings of shame and guilt. Relating romantically with another person and identifying possible situations of risk of violence was also highlighted as a challenge by the participants. The third category refers to legal requirements and processes for custody, child support, and visitation rights. The women reported the lack of help from the institution, as well as little credibility and low quality of the service received from legal professionals. The last category describes the women's perception of the long-term effects of the psychotherapy, as well as the use of techniques that were more relevant and that they used in their daily lives. Aspects such as the reduction of symptoms through breathing, awareness of gender violence as a macro-structural

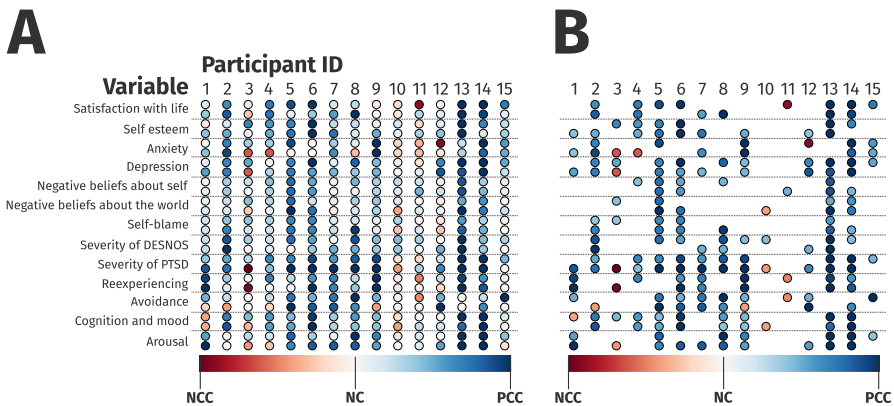


Fig. 2 JT Analysis to evaluate the reliable change index (RCI) in the variables: satisfaction with life, self-esteem, anxiety, depression, negative beliefs about self, negative beliefs about the world, self-blame, severity of DESNOS, severity of PTSD, reexperiencing, avoidance, cognition and mood, and arousal. The color scale represents the significance of the clinical change. **A** all results displayed. **B** significant results displayed. PCC, positive clinical change; NCC, negative clinical change; NC, no change

Table 3 Categories, subcategories and representative unites of the qualitative interviews

Category	Subcategory	Representative unit
Self-care	Individual empowerment	"Early on, I was afraid of how it would be going forward (after psychotherapy), but I kept trying to make my limits stronger, more expressed, to keep myself strong." (P.11)
	Self-knowledge	"I learned to understand myself a little better, to have peace with myself... Now, I've learned to have time for myself, to be more positive and to take care of myself more too." (P.1)
Interpersonal relationships	Support network	"Now I belong to a church and I have made a network of friends. Even in the police. Today I call the police and I say, it's immediate, a police car goes straight to my house. I'm no longer a lonely person like I was when I was married." (P.5)
	Social isolation	"But I even isolate myself from my brothers, because I feel like a burden. The others, I don't know, they do it a bit, of course, but for the most part it is me who distances myself from people, because I don't feel good enough for anyone." (P.3)
Legal requirements	New affective relationships	"I ended up having a relationship with a person too, but it didn't last long. I started to identify one more process, of being a possessive person, of questioning me, of following me, where are you going?, what are you doing?... This whole situation bothered me a lot." (P.14)
	Not believing in the system	"In my legal process, a protective measure was never mentioned, that's why it never happened... I went 900 days without any measure. My ex-husband still doesn't pay child support and nothing happens. He has not paid child support for 18 months." (P.3)
	Legal processes related to child custody, visitation rights and support	"I went to court and asked for child support and then this thing about visits came up and I told them straight away that I wouldn't want them to see their father... because of everything they went through, so much violence... But the law, you know how it is. Especially in Brazil, where I don't think it's very good, so it's complicated."(P.2)

Table 3 (continued)

Category	Subcategory	Representative unit
Effects of the psychotherapy	Use of therapeutic techniques	“The breathing technique helps me a lot and this exercise helps me assess my thoughts... It’s a medicine, it really is.” (P.15)
		“Breathing exercises help me when I’m more stressed, to not let my emotions control me.” (P.7)
	Validation	“One thing that helped me was that I learned to stop and breathe before acting. I kept things in a lot and just reacted aggressively. Today I try to understand more what I’m feeling, I allow myself more. I still use this a lot.” (P.12)
		“I liked having my experience validated, what I went through was validated. Not being seen as madness or disqualified in that regard. This was very important for me.” (P.11)
Awareness of gender violence	“Women in this situation of violence, in this situation of overcoming difficulties, it’s very difficult, because women are always excluded and put down. So, it has to be a valorization, because women have an important role in society. (Violence) It starts before the relationships, the woman is always on the sidelines.” (P.2)	

concept, and therapeutic validation were reported by the participants as the most important factors of the intervention.

Discussion

The present study sought to assess the therapeutic effects of the psychotherapy protocol for women with a history of intimate partner violence 6 months after the end of the intervention. Analyses were performed through clinical indicators and the participants' experiential narrative during the follow-up assessments 6 months after the end of the psychotherapy. The results showed that, in general, the intervention was effective in reducing depressive and post-traumatic symptoms, with moderate effect sizes in the post-test and in the follow-up evaluation, confirming the study's hypotheses that the benefits of the psychotherapy would be maintained over time. These results corroborate international studies, which also identified a reduction in depression and PTSD through CBT protocols for women victims of IPV (Crespo & Arinero, 2010; Johnson & Zlotnick, 2011; Matud et al., 2014).

These results may be associated with the changes that were made to the protocol. Emotional regulation techniques were included in this version of the protocol with the aim of developing more effective strategies to manage uncomfortable and potentially painful emotional symptoms arising from memories of the abusive experience. Techniques associated with restructuring stereotyped gender beliefs were also included. Both can be associated with the positive result regarding the PTSD symptoms, complex PTSD and in the arousal dimension, since physiological symptoms impact the emotional response. Violence experiences can negatively impact the development of emotional regulation skills, contributing to an increase in anxiety and post-traumatic symptoms (Zamir & Lavee, 2014). In addition, symptoms of depression are strongly related to beliefs that legitimize violence (Habigzang et al., 2019), considering that the aggressor can blame the woman for the violence or justify his behavior.

The qualitative results of the study showed that the use of cognitive and behavioral strategies, including breathing techniques, emotional validation, and cognitive restructuring, was effective and that learning was maintained by the participants. These techniques significantly contribute to the maintenance of therapeutic gains, as they help in the modulation and intensity of emotions (Leahy et al., 2013), reduce beliefs associated with self-blame and devaluation, and strengthen the recognition of signs of violence, preventing revictimization (Zamir & Lavee, 2014).

Another indicator with a statistically significant effect size was self-esteem. It was found that the participants already presented medium levels of self-esteem before starting the psychotherapy, which increased in the post-test and at follow-up, indicating positive effects of the intervention on this clinical outcome. Similar to the results of this study, Matud et al. (2014) also showed important improvements in self-esteem immediately after the intervention, which were maintained in the follow-up assessment. It is understood that the increase in self-esteem may be associated with other indicators that were also worked on during the intervention, such as the modification of negative beliefs about oneself and self-blame. It is possible to

identify this association in the qualitative results of the study when the participants reported greater individual empowerment and self-care strategies 6 months after the psychotherapy. Furthermore, interventions that elicit behaviors related to self-compassion reduce levels of depression and anxiety (Raes, 2011; Souza & Hutz, 2016).

In the individual assessments of the participants, carried out using the JT test, it was possible to identify that all the women presented positive clinical change (PCC) in at least one of the indicators. This result is associated with levels of symptom severity prior to the intervention, as described in the results. The indicators with the highest levels of severity before the intervention were depression, PTSD (avoidance, reexperiencing and arousal dimensions), complex PTSD, negative beliefs about self, and self-blame, which showed significant reductions in the subsequent evaluations. However, some indicators were not clinically significant in the pre-test (anxiety, satisfaction with life, self-esteem, negative beliefs about the world, and cognition and mood), which could progress to clinical improvements or no significant changes during the psychotherapy (Curia et al., 2021).

The results identified that one participant (3) had a diagnosis of PTSD, and two (4 and 12) had diagnoses of complex PTSD in the follow-up assessment. Regarding PTSD, studies indicate the need for interventions to adhere to the principles of the trauma-focused model (Trabold et al., 2020; Warshaw et al., 2013). Concerning the diagnosis of complex PTSD, studies indicate important associations with consecutive experiences of violence throughout life (Poletto et al., 2015; Zancan & Habigzang, 2018), with a history of maltreatment identified in all participants of this study. Accordingly, both factors may require longer interventions that focus on the reduction of the associated symptom. It should be noted that participants 3 and 12 faced legal challenges and disputes over the custody of their children with their ex-partners. Participant 4 had significant emotional dysregulation due to depressed mood, reporting suicidal ideation and planning on the day of the follow-up assessment. These results suggest that the symptomatological reduction of the disorder may be more difficult for some participants, as it may be mediated by external factors that may be associated with the ex-partner or not. The results also highlight the confirmation of our third hypothesis, in which the clinical maintenance would also depend on the experience of adverse experiences after the intervention. In this sense, it is essential to comprehend for whom and under what conditions interventions focused on IPV work, in order to make viable adaptations (Bair-Merritt et al., 2014).

Similarly, it is important to discuss the homogeneity of the sample of this study. Most participants had a high level of education, were in employment, and were white. Therefore, it cannot be considered a representative sample of the general population. Improvement rates may be associated with schooling, as this can influence the use of psychotherapy. Education provides greater comprehension of cognitive and behavioral techniques, as well as facilitating task adherence and problem solving outside the psychotherapeutic environment (Beber et al., 2014).

Another important result to be discussed is associated with the scores of negative beliefs about the world, which remained medium at all evaluation times. Traumatic experiences contribute to the development of more rigid negative beliefs about oneself and about the world (Schaefer et al., 2012). The diagnostic presence of PTSD is related to a constant perception of threat, which directly influences the negative

interpretation of thoughts (Ehlers & Clark, 2000). Negative beliefs about the world may also be associated with carrying out the follow-up assessment during the COVID-19 pandemic. The participants reported the main repercussions and difficulties encountered, such as financial problems, adaptation of the work routine at home with their children, fear of traveling to the workplace by public transport, and even enforced social distancing. Natural, environmental, or traumatic disasters are accompanied by a significant increase in the levels of illnesses that affect mental health, such as anxiety, stress, and depression (Cullen et al., 2020; Galea et al., 2020).

Therefore, it appears that the protection and social support networks are essential to help to interrupt the cycle of violence, as well as in situations after the separation. Psychological interventions can act as a coping mechanism in breaking off violent relationships. However, most studies develop brief psychotherapies, with few longitudinal evaluations (Trabold et al., 2020). Therefore, it can be questioned how these interventions can help even after the end of the psychotherapeutic process. In this sense, follow-up evaluations can constitute a resource. The qualitative assessments carried out in this study can be highlighted, due to making it possible to comprehend more sensitive aspects of the women's lives that were not identified by the psychometric instruments. From a socio-ecological perspective, factors such as spirituality, relational quality, and community cohesion can increase resilience and enable more assertive responses to adverse situations (Howell et al., 2018). Even after psychotherapy, it is important for the therapist to be able to recognize what each woman's coping resources are, in order to reinforce potential protective community bonds (e.g., religion, work) that provide more meaning to life.

Psychotherapy is an important tool that can alleviate mental health consequences arising from violent experiences in the intimate relationship (Hameed et al., 2020). It can help women to recognize their identity and autonomy, as they develop behaviors for their well-being and safety (Feder et al., 2006). Furthermore, the psychotherapeutic environment can be seen as a non-judgmental and validating place of listening. The qualitative results of this study indicate that the intervention was also effective in promoting the participant's trust in the therapist, considering that the reports were received in an empathetic way. Therefore, psychotherapy can be constituted as a support network for women, enabling the construction of a safe and non-violent relationship (Feder et al., 2006). It should be noted that interventions should also be based on socially relevant aspects that directly affect women's rights (Zamora et al., 2020).

Limitations

Regarding the limitations of the study, the absence of a control group creates limitations regarding the level of evidence of the effectiveness of the intervention. Experimental designs with a control group allow a more robust and reliable level of effectiveness to be established. However, as this is a population in a context of vulnerability with limited access to mental health services, placing women with a history of violence on a waiting list group is ethically delicate. An alternative would be to compare women assisted through this protocol with some other type of

intervention, so that future studies could look for new evidence of the effectiveness of this intervention.

Another limitation was the sample size. Even in a pandemic context and with online follow-up, only one of the contacted participants did not return to participate in the assessment. It is possible to verify the possibility of follow-up evaluations being made feasible and offered through other models in addition to the in-person form. The small sample size implies limited possibilities for statistical analysis. However, the JT method allowed the clinical impact of the intervention to be individually analyzed, confirming that the statistically significant differences represented effective therapeutic gains for most of the participants. The expansion of the sample and inclusion of participants with more diverse sociodemographic characteristics (lower education; black and brown) would allow an assessment of whether the protocol has positive effects for different women, considering intersectionalities of race and class.

Future Research Directions

Despite the limitations, the results indicate that the intervention significantly reduced the levels of depression and PTSD and increased levels of self-esteem between the pre- and post-test, which were maintained 6 months after the end of the psychotherapy. Complex PTSD levels also reduced considerably between the pre-test and follow-up. Negative beliefs about self and self-blame had moderate effect sizes, also indicating the intervention's effectiveness in reducing these clinical outcomes.

The results also indicated evidence of effectiveness and an advance in relation to the qualitative methodology used in the follow-up assessments, which provide results beyond the reapplication of scales. The protocol was qualitatively well evaluated by the participants, who indicated that the psychotherapy process contributed to better quality of life. These results indicate the potential of this intervention for replication in mental health services that serve women with a history of intimate partner violence. Training new therapists to use protocols with evidence of effectiveness is a promising proposal to qualify mental health care networks and promote women's rights in Brazil.

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Declarations

Ethics Approval and Consent to Participate This study was approved by the Research Ethics Committee of the Pontifical Catholic University of Rio Grande do Sul (PUCRS) under authorization number 4.141.234. All the participants were included by signing the informed consent statement. The study was performed in accordance with the ethical standards of resolution 466/2012 and 510/2016 of the Conselho Nacional de Saúde (Brazil).

Competing Interests The author declare no competing interests.

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