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Themes and Techniques in Cycles of Change in the Psychotherapy Treatment of Women Who Experienced Violence: An Exploratory Study

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ABSTRACT

The aim of this study was to identify and analyze cycles of change present in the psychotherapeutic treatment of women with a history of intimate partner violence. The sessions were audio-recorded and transcribed with the aid of the software TCM. Then, Theme Analysis was used for analysis of the transcribed cycles of change. There was a total of 78 cycles of change, and all therapy sessions that were analyzed produced at least one cycle of change. The main techniques were Socratic questioning, downward arrow, psychoeducation on violence and emotions, and protection skills training. The themes that were frequently reported by the participants were family relationships, gender violence, intimate partner violence, and social support. There was evidence that the protocol leads to therapeutic change, with good continuity between sessions.

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Cycles of Change; Violence against women; Intimate Partner Violence; Psychotherapy

Violence against women is considered as a violation of human rights and a serious public health problem (World Health Organization [WHO], 2013). Under Brazilian law, domestic and family violence against women is any action or omission, based on gender inequalities, which causes death, injury, suffering, or harm to women (Brazil Federal Law no. 11.340, 2006). Partners and former partners are the most frequent abusers, and violence often takes place in the household (Waiselfisz, 2015; World Health Organization [WHO], 2014).

Violence has serious effects on women's mental health. Therefore, it is imperative that psychotherapeutic interventions be based on scientific evidence of efficacy and effectiveness (Conselho Federal de Psicologia, 2012), and that they can be evaluated through research in psychotherapy. In psychotherapy, process-outcome research plays an important and complementary role in enhancing the quality of interventions. Process studies seek to assess which elements affect intervention outcomes, they are focused on variables that, despite being considered as unspecific in psychotherapy, have an effect on such outcomes (Peuker et al., 2009). The concept of change can be more

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clearly understood when it is broken down into two elements: moment and episode. A moment of change refers to the main aspect or theme that is addressed by the therapist and the patient, and it is reported by the patient. In turn, an episode of change covers an entire unit of time or session segment that precedes a moment of change and allows change to take place.

Process researchers have sought to improve their methods of investigation by using tools that enable a more comprehensive evaluation of the interpersonal experiences that are present in psychotherapy, for example, change in psychotherapy (Bucci, 2007). One of such tools is the *Therapeutic Cycles Model (TCM)*, developed in Germany by Erhard Mergenthaler (1996a), and adapted for use in Brazil by Elisa Yoshida (2008) and adopted by other Brazilian researchers (Cassel, Sanchez, Campezatto et al., 2015a). The aim of this tool is to identify cycles of change that occur in psychotherapy, also known as key moments, which refer to "one or more sessions of a treatment or to segments of a session that are seen as clinically important" (Mergenthaler, 1996a, p. 1306). The tool is associated with therapeutic progress (Mergenthaler, 2008) and is indicative of the effectiveness of psychotherapy. This tool has been used in several studies, such as those by Vizziello et al. (2011), Lo Verde et al. (2012), and Sassaroli et al. (2014), Cassel, Sanchez, Campezatto and Nunes (2015b), and Von Mengden Campezatto et al. (2017). Although the tool has been applied in different populations, no studies to date have focused on cycles of change with women in situations of intimate partner violence (IPV).

With regard to protocol studies with this population in the cognitive-behavioral approach, Petersen, Zamora, Fermann et al. (2019) did not find any Brazilian studies with this format. Moreover, of the 11 protocols that they had identified, none was focused on psychotherapy treatments, which makes it impossible for researchers and practicing psychologists to replicate the interventions. To investigate the elements associated with therapeutic improvement, the therapeutic process needs to be addressed.

The general objective of this study was to identify and analyze cycles of change present in the psychotherapeutic treatment of women with a history of IPV. Specific objectives were: 1) to identify which stages of the psychotherapy protocol produced the greatest number of cycles of change through the *TCM*; 2) to check which techniques used in the protocol are associated with cycles of change; and 3) to identify key moments in each session of the psychotherapy protocol through the TCM and to analyze the central theme present in these moments.

Method

Participants

The sample consisted of three women aged 18 and over who experienced IPV. To be included in the study, the participants had to be living away from their

abusers, by means of separation or a restraining order, because the impact of an intervention on the target symptoms can only be measured after the abusive relationship has been broken off. Women with symptoms of psychosis, signs of mild to severe intellectual disability, continuous practice of substance abuse, or under another psychotherapy treatment, were not included in the study. These exclusion criteria were assessed in clinical interviews. None of the participants had been taking psychiatric medication during the intervention period. The participants were selected by convenience sampling through referral by partner institutions.

Before the start of the intervention, they underwent a clinical psychological assessment that was held by Psychology students over a period of three meetings, on average. The aim of this pretest was to assess symptoms of anxiety, depression, PTSD and Disorders of Extreme Stress, as well as presence of a history of mistreatment in childhood and adolescence and types of violence experienced and perpetrated in intimate relationships. The results of this assessment were used to provide further insights into the psychotherapy treatment, which is the objective of this study.

Patient 1, Simone*, was 41 years old at the time of the intervention; She had a college degree and a regular job. She had been separated from her abusing partner for 4 years. They had a daughter. Because of the ongoing legal proceedings, Simone only communicated with her former husband through her lawyer, which was a matter of concern to her. Their relationship had lasted 3 years, and they separated at the end of her pregnancy because she wanted her daughter to grow up in a healthier environment. She had a restraining order against her ex-partner. Throughout psychotherapy, the therapist detected some aspects indicative of unstable bonds in the patient's relationships, as well as problems relative to emotional regulation. Simone's assessment showed that she had a minimum level of anxiety and mild depression, and met some of the criteria for PTSD. She had a history of minimal emotional abuse in childhood, and she experienced physical and psychological violence during intimate relationships.

Patient 2, Carolina*, was 41 years old. She had some elementary school education, and she had a regular job. She had been separated from her abusing partner for a year. They have two children. She had been granted a restraining order against him, and she had filed a claim for marital property division. Their relationship lasted for 20 years, and she got divorced when she discovered that her ex-husband had extramarital affairs. Because she had been repeatedly exposed to violence during her growth and development, Carolina had difficulty in trusting people and was extremely concerned about the judgment of others. She reported feeling strong fear and anxiety when recalling experiences with her ex-husband. Carolina had moderate levels of anxiety and depression. She had a history of minimal physical abuse in childhood, and she experienced all forms of violence during intimate relationships in adulthood.

Patient 3, Anita*, turned 47 during the psychotherapy treatment. She had a high school diploma, and she was unemployed. She had two grown-up children who were not father by her abuser. Her abusive relationship lasted for 4 years, with episodes of psychological, moral and patrimonial violence. One aggravating circumstance was the fact that they lived very close to each other, and he repeatedly violated the restraining order. Anita had filed several police reports for these events, and she was waiting for a legal decision. The patient had mild levels of anxiety and depression at the beginning of the intervention. She had a history of moderate emotional neglect and emotional abuse in childhood.

Instruments

(1) Sociodemographic Questionnaire: seeks to investigate characteristics about the profile of the participants and whether they have a history of violence in their family.

(2) Therapeutic Cycles Model (TCM): this is a computer-assisted text analysis tool based on the CM software, which uses 'dictionaries' with previously developed narrative styles (Mergenthaler, 1996a). The Brazilian version was produced from transcripts of psychotherapy sessions, diagnostic interviews and papers published by Brazilian researchers. The text is broken up into 150-word blocks for identification of communication patterns, namely (A) Relaxation; (B) Reflection; (C) Experience, and (D) Connection. The cycle of change occurs when there is at least one word block with the Connection pattern and its initial and final limit is the occurrence of a Relaxation pattern (Mergenthaler, 1996b).

Data collection procedures

The protocol is based on the cognitive-behavioral approach, and it consists of 16 sessions divided into four stages, according to the objectives and techniques used in the treatment (Table 1). The protocol sessions were conducted by two previously trained psychologists at a university psychology clinic. The therapy sessions were audio-recorded and then transcribed. For this research, nine sessions were analyzed for each patient (sessions 1, 2, 3, 6, 8, 12, 13, 15, and 16). The sessions for analysis were defined by convenience, seeking to satisfy two criteria: (1) to include at least 50% of the protocol sessions and (2) to cover all stages of the protocol. To avoid possible conflicts of interest, the two therapists that applied the protocol did not apply the pre- and posttests.

Data analysis procedures

First, computer-aided transcriptions of the sessions were performed using the software TCM. These analyses generated graphs indicating

Table 1. Psychotherapy protocol.

Stage	Session	Description
Stage 1 \Psychoeducation on violence against women and gender relations Cognitive restructuring	1	Therapeutic contract and definition of therapeutic objectives. Design of a "Vision-of-Oneself Card" and assessment of the patient's beliefs about the role of women in different contexts.
	2	Psychoeducation on different types of violence; Assessment of current risk and, if required, design of a security plan (bringing forward the protection skills training).
	3	Psychoeducation on gender violence.
	4	Psychoeducation on the ABC Model.
	5	Psychoeducation on consequences of violence.
Stage 2 \Gradual exposure to traumatic memories and emotional regulation.	6	Design of a timeline for mapping one's 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 management of emotions, cognitions and behaviors relative to traumatic events. Relaxation.
Stage 3 \Problem-solving.	11	Problem-solving Training.
	12	Problem-solving Training.
Stage 4 \Consolidation of protection strategies and design of future projects	13	Prevention of exposure to violence, protection strategies and operation of Protection Networks.
	14	Protection skills training.
	15	Design of a project for the future and resumption of the timeline.
	16	Self-assessment – Resumption of the Vision-of-Oneself Card and beliefs about the role of women in different contexts.

therapeutic cycles. Subsequently, transcriptions of the session segments that contained cycles of change were analyzed qualitatively by two independent judges, based on the Thematic Analysis proposed by Braun and Clarke (2006). Inductive logic was used, and the themes were the participants' needs.

Results and discussion

The results and discussion are organized into three axes, according to the specific objectives of this study. The first axis presents quantitative results on the cycles of change identified at each stage of the process. The second axis presents the techniques used in this research that were related to the cycles of change. The third and final axis refers to the theme analysis of cycles of change.

Cycles of change

In all the sessions, at least one cycle was produced (Table 2). The greatest number of cycles of change was found in the first stage of psychoeducation on violence against women and gender relations and cognitive restructuring, followed by the fourth stage, i.e., consolidation of protection strategies and design of future projects. The participants Simone and Carolina presented more cycles of change (4 and 6, respectively) in session six – mapping one's history of violence. This session allows the recognition of different types of violence experienced during one's growth and development. It was particularly relevant for these patients, as both of them reported minimal maltreatment during childhood. By creating their timeline, they may have recognized signs of violence that they were exposed to. Participant Anita, in turn, presented more cycles of change in the second session of the protocol, which involves psychoeducation on the different types of violence with assessment of current risks and design of a security plan, if required.

The data indicate the importance of the first stage of psychotherapy for therapeutic progress. This stage focuses on and reinforces basic aspects that need to be addressed with women with a history of IPV, for example, psychoeducation on types of violence, reflections on gender violence and its stereotypes and mapping past and current situations of violence (Conselho Federal de Psicologia, 2012). The first stage of the protocol is the one that most closely resembles the classic cognitive therapy proposed by Beck; it assesses the participants' goals and offers psychoeducation on the phenomenon that motivated them to seek treatment (Beck, 1997). Moreover, if the therapist and the patient realized that the latter was at risk, they developed a security plan, as recommended by the Brazilian Board of Psychology (Conselho Federal de Psicologia, 2012). This practice should be a priority when it comes to reinforcing the protection of women.

Session two – psychoeducation on dynamics and types of violence – was the one that generated the greatest number of cycles of change for Anita, since this participant often minimized the seriousness of the violence she had experienced because it had not been physical. Still, this session proved to be especially important because Anita lives close to her abuser, which was perceived as a risk. Based on this fact, security strategies were developed for the participant. The stage of emotional regulation was also important for Anita, as she had characteristics of emotional inhibition. These findings may be related to the fact that she has experienced abuse and emotional neglect in childhood.

Table 2. Number of cycles of change per patient and stage of the protocol.

Participant	Stage 1	Stage 2	Stage 3	Stage 4	Total number of cycles per participant
Simone	7	7	2	7	23
Carolina	7	8	4	8	27
Anita	12	3	4	9	28
Total number of cycles per stage	26	18	10	24	-

For the participants Simone and Carolina, the highest number of cycles of change occurred in session six – design of a timeline and beginning of the emotional regulation stage. In this session, a timeline is designed with a view to mapping one's history of violence, because previous research has reported associations between a history of abuse in childhood and adolescence and violence in intimate relationships (Bass et al., 2014; Miller et al., 2014; Oliveira & Benetti, 2015). Simone and Carolina have reported experiences of emotional abuse, and several experiences of physical abuse, respectively. These situations usually generate learned helplessness, and the timeline technique allows the detection of cycles of violence and the different manifestations of violence; also, it helps the participants realize the consequences of these situations. This procedure enables the recognition of behavioral and emotional patterns that are repeated and result in vulnerability. Figure 1 shows the graphs of the sessions with the highest number of patients' cycles of change.

Importantly, cycles of change are moments in the session that promotes therapeutic progress, but it cannot be claimed that a certain stage of the psychotherapy protocol is necessarily responsible for the changes, since therapeutic progress occurs cumulatively over sessions. This finding can be discussed on the basis of the considerable number of cycles of change present in the last stage of the protocol; however, these changes may also have been driven by previous moments in psychotherapy. For example, an effective Emotional Regulation Therapy, when associated with past situations of violence, requires a clear understanding of the dynamics of violent relationships, as well as their maintenance factors.

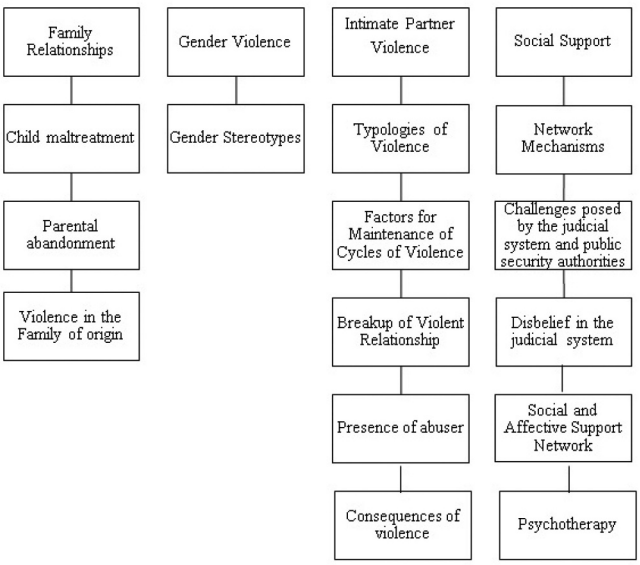

Figure 1. Graphs of the sessions with the highest number of cycles of change for Simone, Carolina and Anita.

It was found that the number of key moments per stage was similar with different participants and therapists, which indicates that the protocol is standardized. The use of the TCM shows initial evidence that the protocol promotes therapeutic changes. These data corroborate the results of the post-intervention psychological assessment, which also showed improvements in symptoms. At the end of the intervention, the participant Simone no longer met the criteria for PTSD and started to present minimal symptoms for depression; however, she had a subclinical increase in anxiety. Carolina, in turn, showed a decrease in levels of anxiety and depression from moderate to minimum. Anita also improved her symptoms of anxiety and depression, going from mild to minimal levels.

The results of the TCM were, therefore, aligned with the clinical indicators of the assessment instruments. This is clear in the case of Simone; she was the patient who showed the least clinical improvement using the assessment tools, and also the participant with the smallest number of cycles of change throughout the therapeutic treatment.

Techniques relative to cycles of change

The main techniques relative to the changes were: Socratic questioning, downward arrow, psychoeducation on violence and emotions, emotional validation and protection skills training. The data found in the present study corroborate previous findings in the literature regarding the techniques perceived as effective for the treatment of women who have experienced IPV. Petersen, Zamora, Fermann et al. (2019) found that psychoeducation is one of the main techniques in the protocols used with women with a history of violence. This technique can be used to help patients understand the types of violence and the violent cycle, take ownership of their rights and understand their thinking and response patterns when attempting to cope with situations.

Studies that used the *Cognitive Processing Therapy* (CPT) (Iverson, Gradus, et al., 2011a, Iverson, Resick, et al., 2011; Resick et al., 2008) proved to be effective for the treatment of this population. They focused on cognitive restructuring using techniques such as Socratic questioning, which was also used in this study. Self-protection skills training sessions were also addressed as important elements in international studies (Cort et al., 2014; Matud, Fortes & Medina, 2014) as a way of working on the prevention of revictimization.

The techniques detected are in line with the main components of CBT, e.g., problem-oriented focus, homework assignment, structured sessions, techniques for development of flexible thinking patterns, and increase in the behavioral repertoire (Beck, 1997). When analyzing the present protocol, Petersen, Zamora, Ligório et al. (2019) also found that it matches the framework of cognitive-behavioral therapy.

Theme analysis of cycles of change

An analysis was made of the themes relative to therapeutic changes, and some of them were common among all patients, for example: Family relationships; Gender Violence; Intimate Partner Violence and Social Support (Figure 2).

All participants had key moments in their sessions when focusing on situations they had experienced in their family of origin. The contents were particularly related to situations of violence, in which the participants were victims or witnessed their parents' violent relationship. Anita explained, "I've grown up watching my parents fight. I slept in the next room, and I covered my head. They used to argue a lot." Carolina reports a situation of sexual abuse:

> These men tried to open the flies of our pants, and then I put my little sister behind me and stayed in front of her, because I was taller. Then you start to defend yourself. If I'd complained, I think my mother would have hit me. She would've said that I was flirting with them.

Their reports corroborate data from the literature that have identified the presence of childhood abuse as a risk for violent relationships in adulthood (Martins-Borges et al., 2017). Therefore, therapy treatment can focus on cognitive restructuring of patients' perception of guilt for the violence they experience, as well as the image they have of themselves, which is repeatedly self-deprecating, as a result of the continued violence that they have experienced.

The family context can promote the subjectivation of individuals through shared experiences and values that tend to be passed on to future generations of the family, e.g., the definition of roles or the method for conflict resolution (Falcke & Féres-Carneiro, 2011). Thus, gender issues must be taken into account because they can provide further insights into transgenerational intimate partner violence, since the values culturally established by society also permeate the family system, shaping the dynamics of the relationships among family members, for example, the roles attributed to women and men (Falcke et al., 2012).

Although previously experienced violence may increase the risk of revictimization in adulthood, there are protective factors that can help to break down the transgenerational nature of violence. This can take place by means of

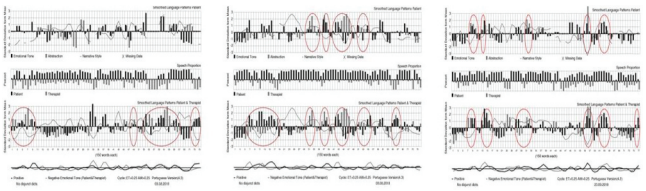

Figure 2. Flowchart of the themes and subthemes present in the cycles of change.

people's separation and individuation from their family of origin, positive relationship models, strong social support and the use of psychotherapy as a resource for change (Rosa & Falcke, 2011).

The design of the timeline for narration of traumatic events led to the realization that, prior to the beginning of psychotherapy, during the period of psychological assessment, patients possibly minimized the situations of violence they had experienced in their family of origin. In this way, the protocol may have been one of the first moments when they were able to effectively recognize the violence that they had experienced and its consequences.

Subthemes relative to the patients' children were identified throughout psychotherapy. The participants addressed issues about their children in different ways. Simone explained, "If I didn't have a daughter, this guy would never see me again. I would vanish without a trace. But I have a daughter with him."

Not infrequently, many women still associate the maintenance of marriage and the presence of a partner as an important factor for her children's development and to ensure their basic living conditions, despite the violent relationship between the couple. Therefore, marriage is sometimes maintained because women believe they have to be committed to and take care of their children (Dutra et al., 2013). Simone recounted, "She came back home acting very aggressively [after coming back from her father's home]." She also explained, "He hit her when she was three, he gave her medication that was seven months past its expiry date, dangled her out of the window on the 7th floor of a building, in front of me. That's when I told him he wouldn't get any closer to her because the judge had decided that." Carolina explained, "He just left home, and he acts as if his son had died, as if he'd never existed. He started telling everyone that all his children were buried in graves. The kids heard that, and they felt hurt."

The women assisted were concerned about the way that their ex-partners have been bringing up their children when they are not around. Parental abandonment, on the other hand, has also caused women to be concerned, not only because they need to raise and financially support their children on their own, but also because they fear that their children may be negatively affected by their father's rejection.

The participants' reports showed that, although there is an increased number of women working in regular jobs outside their homes and a higher number of fathers looking after their children, parental responsibilities are not perceived as equally shared between women and men. As found by Beccheri-Cortez and Souza (2013), during or after the end of the marital relationship, women ultimately provide the greatest amount of care to their children. They are actually expected to do that, while men seem to play a more flexible role as fathers to avoid responsibilities that could otherwise prevent them from having other professional or social activities.

Sometimes, men's violent behavior was not restricted to their partner, but was also extended to their children. Therefore, some women were concerned about their ex-partners visits to their children. In addition, these men often seek to undermine women's full experience of motherhood by disqualifying them as mothers or blaming them for the breakup of the family (Sani, 2008).

For these reasons, the presence of children in the relationship is perceived as a risk factor for the maintenance of the violent relationship (Silva et al., 2015). Conversely, some women point out that their children played a key role in their decision to leave the relationship when they realized what losses they were suffering and what risks they were running (Sani, 2008). The psychotherapist is expected to assess the risk situations involving the children and, if there is any suspicion or confirmation of risk, help the patient devise appropriate strategies to protect the children, as well as notify the responsible authorities.

There were serious reflections on Gender Violence and its different manifestations throughout the psychotherapy protocol, which highlights the need for the therapist and the patient to address the social constructions of gender in order to shed light on the dominant notions of relationship and family. Carolina explained, "I was always raised like that – a woman who has no husband, is a slut." Anita recounted, "Things are a lot easier for men. When they separate from their wives, they think that they can separate from their children and get rid of expenses, of their responsibilities." Simone explained, "When a woman takes a stance, she is seen as arrogant, crazy and such, but when a man expresses his opinion in the same way, he is right."

The literature has also underscored the social norms of gender as a factor that makes women stay in violent relationships. It is essential that the therapist can draw on appropriate theoretical constructs about basic aspects of gender violence, because this theme needs to be addressed on several occasions, via cognitive restructuring, with women who have experienced violence. This procedure can also assist the therapist in the emotional regulation of patients. An appropriate intervention is supposed to include elements that go beyond the rescue and appreciation of women's individual aspects; the issue of violence against women needs to be addressed not only at the individual level, but also from the perspective of the relevant social structures involved. To tackle this phenomenon, clinical psychologists need to revise their interventions for this population with a view to making clinical treatment more comprehensive, covering social processes and multidisciplinary practices, as well as adopting psychosocial treatments concomitantly with symptom-focused treatments (Conselho Federal de Psicologia, 2012).

In the theme of Intimate Partner Violence, the following sub-themes were identified: types of violence; factors that maintain the violent cycle; breaking off the violent relationship; minimization of violence; consequences of violence and presence of the abuser. Carolina recounted, "Whatever I asked him

for, he asked 'will you have [sex] with me?' It was always like that, a bargaining chip." Blackmail appeared as a way to maintain the relationship, according to Anita's report, "What took me longer to make a decision was this emotional game he played. He made a series of threats, I was terrified." Carolina also explained:

> Because if I didn't lie, he would hit me. If he broke something,, I had to say I was the one who did that. He cursed me, punched me, humiliated me and I had to pretend that everything was fine. I didn't let anyone know, because I was ashamed.

All types of violence described in the Law were addressed during the therapeutic treatments, but the ones most often reported by the participants were, respectively, psychological, physical and sexual. This result differs from the one found in other studies (Ribeiro & Coutinho, 2011; Waiselfisz, 2015), which identified a higher prevalence of physical violence. This difference can be explained by the fact that the psychotherapy environment was more appropriate to identify the consequences of psychological violence.

The moments of becoming aware of violence and leaving the relationship also appeared in key moments of the psychotherapy sessions. They are seen as stages of empowerment, as opportunities for women to break paradigms and do away with severe standards, as well as change their lives. The moment when women recognize their potentialities and express them through behaviors and decision-making is crucial for them to start getting rid of the cycle of violence (Morais & Rodrigues, 2016).

Women tend to remain in violent relationships when they keep expecting their partner to change and attribute their violent behavior to pathologies or substance abuse, and when they feel afraid of their partner's threats and ashamed about reporting the violent situation (Dutra et al., 2013). They ultimately assume the responsibility of solving their partner's problems as a result of cultural and family constructions in which they are expected to take on the role of caregivers who need to be tolerant of their partners' attitudes. The trivialization of intimate partner violence seems to be interwoven with the violent cycle on the basis of the minimization of violence on the part of both women and security agents. The latter tend to prioritize cases with imminent risk (Romagnoli, 2015) and disregard the progression of violence in intimate relationships. Addressing the physical, emotional, and relational consequences of violence is essential for the treatment of this population. As Carolina explained, "I was just drinking and taking medicines." Anita reported, "I don't know who I am. I think I've lost a little bit of my identity."

The data collected from the participants are in line with previous findings in the literature that point to the fact that women resort to substance abuse (drugs and alcohol) to deal with violent situations – a behavior that commonly becomes a risk factor (Rodrigues et al., 2016). The therapist and the patients also dealt with their feelings of loss of identity, fear, guilt, and shame. Typical

symptoms of trauma, such as hypervigilance and revival, also surfaced throughout the protocol. They were the target of intervention at the emotional regulation stage. Despite the adverse consequences, the patients seemed to demonstrate greater knowledge of indicators of violent relationships, thereby enhancing their risk assessment skills.

In view of the different consequences arising from intimate partner violence, it is essential that psychotherapeutic care be underpinned by the unique demands of each woman and take into account their life context, their symptoms, and their assessment of risk situations (Zamora et al., 2019). CBT emerges as a resource that can reduce negative cognitive, behavioral, and emotional impacts.

The presence of the perpetrator of the aggression was also important content to be worked on. Such presence could be perceived symbolically, in the form of ongoing legal proceedings or consequences of violent behavior, or materially, for example, attempts to approach their (ex-) partners and failure to comply with restraining orders. Carolina explained, "He walked to the door! I already had the restraining order! He would knock on the car doors to frighten me, to make me see that he was damaging the car!" Similarly, Simone stated, "I feel very helpless, you know? I can't make my own decisions. For example, taking my daughter out of school, or firing a maid. He threatens me, based on our custody agreement."

Simone felt more disturbed when her ex-partner contacted her to talk about their daughter. Admittedly, any marital separation can be a difficult process, and it may be even harder when the partners have had children, as issues relative to custody and alimony can become new stressors after the separation. In an ideal parenting perspective, parents should be able to peacefully interact with each other, but this is not usually feasible when a relationship has a history of violence because revictimization may occur (Kappaun, 2018).

When it comes to legal mechanisms, e.g., legal proceedings and restraining orders, there is always a great demand for assistance from the institutions that compose the security network, which results in lengthy procedural delays regarding proceedings and sanctions against noncompliance with restraining orders. Women only leave a violent relationship when they feel protected against their abuser; therefore, the State needs to ensure full enforcement of the Law in order to offer them adequate protection (Meneghel et al., 2013). Their fear and feeling of powerlessness are congruent with the threats they have been receiving for years. The participants' reports make it clear that getting out of their violent relationship is a process that goes beyond the physical marital separation. For this reason, they may feel as if they are still tied to their abuser.

Social Support was a significant theme for all participants, and it was divided into five sub-themes: challenges posed by the judicial system and public security authorities, disbelief in the system, resources of the coping

network, social and affective support, and psychotherapy. Simone explained, "The judge always looks down on me at the hearing, he ignores what I say. And when he does listen to me, he's not very interested." Anita recounted, "I have to hide somewhere else, at another address, so he won't get close to me, because justice can't keep him away. In some police reports that I've filed, I was subtly asked if I didn't cause that."

When struggling to overcome violence, women still face challenges that are also present in specialized services, such as courts and police stations. For example, the number of Women's Police Stations is still insufficient to meet the current high demand for assistance. Some professionals working in these services lack proper training and skills, i.e., they sometimes disregard or ignore gender markers or aspects inherent in the cycle of violence. Such an attitude is evident in their judgments of the women seeking assistance. These professionals need to be educated on gender issues (Meneghel et al., 2013). Not infrequently, public security agents also disregard psychosocial elements of the cases that they are dealing with and eventually provide assistance that lacks in empathy and goodwill. As a consequence, women may be revictimized within the network itself.

In the judicial system, there are challenges that make it difficult for women to leave an abusive relationship, e.g., a high turnover of defenders, short hearings, etc. Law enforcement officers may sometimes coerce women into making decisions that do not offer them enough protection (Meneghel et al., 2013). Being that some cases remain unpunished, some women still feel insecure about the effectiveness of protection services. This is evidence that law enforcement officers should receive continuing education and the State needs to make investments to continue developing and improving public policies for the benefit of women. Disbelief in protection mechanisms also discourages women from following the route of confrontation. Such disbelief is usually the result of negative experiences of their own or of others (Romagnoli, 2015).

Although the participants have reported gaps in the coping network, it is clear that all of them were minimally aware of their rights, and they sought to stand up for them by filing police reports and requesting renewal of restraining orders. These findings are in line with opinion polls conducted all over Brazil, which show that Brazilians have grasped the basic concepts of the *Maria da Penha* Law (which targets gender violence in Brazil) because they have been widely disseminated in the media. Even faced with doubt and restrictions, women have been resorting to the mechanisms of this law. Resources to combat violence need to be constantly assessed with a view to improving current public policies (Meneghel et al., 2013).

With regard to the social and affective support, the participants Simone and Carolina were more fragile, while the participant Anita had the strongest support. Carolina endured greater financial hardship, and she felt particularly unsupported by social services, while Simone felt discriminated against by people around her.

> Most people were on his side. Around five people, if that many, were on my side, you know. And they were clueless, they just sided with him because he is more persuasive, because he manipulated his daughter so he could say that I was doing things against him.

Having strong social support has an important role in helping women leave violent relationships (Dutra et al., 2013). Several studies in the literature have reported that family and friends can serve both as a protective factor and as a risk factor, because people often have ambivalent attitudes that are intertwined with conservative conceptions of gender and of an 'ideal' family.

In the case of Simone and Carolina, people in their affective networks were not understanding – or it took them a long time to be understanding – of the situations of violence these participants had been experiencing; therefore, these women postponed the decision to leave their relationships. Carolina's account of feeling unsupported by social workers points out an important fact; of the three participants, she was the one with the lowest socioeconomic status. This suggests that social markers need to be considered on an individual case basis to determine the social support that is required for breakup of an abusive relationship. These data are in line with the results reported by Carmo and Moura (2010), who found that women need institutional support to be able to break away from violence. The therapist should investigate the structure of the patient's social and affective support network, seeking to encourage her to access the network when it proves to be protective.

Finally, addressing psychotherapy itself in the sessions proved to trigger cycles of change. Anita explained,

> I am very happy about the work we've done. I have to thank you for everything we've built together and for the results. I had the chance to assess and understand my reactions, and each and every one of my feelings. And it took me a while to understand that it wasn't my fault. You gave me this task, you were trustworthy and also serious, and you made me feel very comfortable.

The psychotherapy protocol seemed to represent an important step in the process of overcoming the violent relationship; thus, the cycles of change also surfaced when the therapist and the patient verbally acknowledged the therapeutic progress that had been achieved. The outcomes of psychotherapy that were found using the TCM were reinforced by Theme Analysis when it was found that Simone was the participant who had presented the smallest number of cycles of change throughout the protocol and at the final stage. Notably, she verbalized the therapeutic progress less often than the others, and she was the most reluctant participant at the end of psychotherapy.

Limitations and future direction

One limitation was that the participants were similar in age, which may have influenced the themes that were reported in the sessions. Future studies with

younger adult women could offer relevant findings. It is emphasized that the results must be interpreted considering the number of cases studied. This protocol also requires impact research with a view to gathering further data that can corroborate the results found in the present study.

The discourses of the participants clearly show the strong bond that they had developed with the therapists. These results corroborate the data of Petersen, Zamora, Ligório et al. (2019), who used the Working Alliance Inventory (WAI-O) and the Psychotherapy Process Q-Set (PQS) to find evidence of patients' commitment to psychotherapy and the good therapeutic alliance established in this protocol. A safe bond and a good alliance are predictors of positive clinical outcomes in psychotherapy (Byrd et al., 2010; Oliveira & Benetti, 2015). This perspective is also in line with the idea of collaborative empiricism in CBT.

In this population, the role of psychotherapy is to help women restore their self-esteem and autonomy and develop strategies that can increase their quality of life, thereby enhancing the possibilities of healthy relationships in their life context. To this end, psychotherapy needs to open room for reflection on the elements that make up women's identity so that they can be agents of their own experiences (Aguiar & Roso, 2016).

Conclusion

Based on the analysis of the cycles of change, the present study pointed out initial evidence that the protocol can result in significant therapeutic changes. The protocol proved to be effective for the treatment of women from different socioeconomic statuses, levels of education and age groups, and with different experiences of intimate partner violence, as long as they were already living away from their abusers. Also, the protocol also showed good continuity between sessions and unveiled topics that were potentially related to therapeutic progress, as well as relevant techniques for treatment of this population.

Process and outcome studies, as is the case of the present research, shed a great deal of light on relevant techniques and themes that need to be addressed with women who experienced violence. It is essential that psychotherapies for this population be based on scientific evidence and that clinical practice be focused on the social processes of subjectivation of women and men that help maintain and break off violent relationships.

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Disclosure statement

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Ethical Standards and Informed Consent

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (Pontifical Catholic University of Rio Grande do Sul, under the number 1.000.590 and with resolution 466/12 of the Brazilian Ministry of Health) and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.

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