ASSESSMENT OF A PSYCOThERAPY PROTOCOL FOR WOMEN WITH A HISTORY OF INTIMATE PARTNER VIOLENCE: STUDY OF CLINICAL CASES

EVALUACIÓN DE UN PROTOCOLO DE PSICOTERAPIA PARA MUJERES CON HISTORIA DE VIOLENCIA DE PAREJA: ESTUDIO DE CASOS CLÍNICOS

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Abstract

Violence against women is a complex phenomenon that negatively impacts mental health (WHO, 2016). This study aimed to assess the process of a psychotherapy protocol for women with a history of intimate partner violence. A clinical case study design was used and the sample consisted of three participants. The process was analyzed using the Working Alliance Inventory (WAI-O) and Psychotherapy Process Q-Set (PQS), which assess therapeutic alliance and the most and least characteristic items of psychotherapy, respectively. The findings demonstrated good therapeutic alliance and good connection between the sessions, indicating that the protocol is correlated with the expected prototype for cognitive-behavioral therapy. Additionally, symptoms declined in all the women treated. The results provide initial evidence of the effectiveness of the intervention.

Key words: Violence against women; Evidence-based psychotherapy; Cognitive-behavioral therapy.

Resumen

La violencia contra las mujeres es un fenómeno complejo que afecta negativamente a la salud mental (OMS, 2016). Este estudio tuvo como objetivo evaluar el proceso de un protocolo de psicoterapia para mujeres con historial de violencia de pareja. Se utilizó un diseño de estudio de caso clínico y la muestra constó de tres participantes. El proceso se analizó utilizando el Inventario de Alianza de Trabajo (WAI-O) y el Proceso de Psicoterapia Q-Set (PQS), que evalúan la alianza terapéutica y los elementos más y menos característicos de la psicoterapia, respectivamente. Los resultados demostraron una buena alianza terapéutica y una buena conexión entre las sesiones, lo que indica que el protocolo está correlacionado con el prototipo esperado para la terapia cognitivo-conductual. Además, los síntomas disminuyeron en todas las mujeres tratadas. Los resultados proporcionan evidencia inicial de la efectividad de la intervención.

Palabras clave: Violencia contra la mujer; Psicoterapia basada en la evidencia; Terapia cognitiva conductual.

INTRODUCTION

Violence against women is any act of gender-based violence. It is a serious global problem based on gender inequality, independent of social class, race, religion, culture and education level (Carneiro et al., 2017; Correia et al., 2014; WHO, 2013). Violence or abuse that occurs in a domestic setting is known as domestic violence, whereas violence between partners or former partners falls under intimate partner violence (Carneiro et al., 2017; Deewe, Boing, Oliveira, & Coelho, 2009). Being the victim of any form of violence can result in negative psychological and physical consequences for women, affecting their family life, careers, academic performance and community/social relationships (Netto, Moura, Queiroz, Tyrrell & Bravo, 2014; WHO, 2016). The literature indicates that exposure to violence is associated with the onset and exacerbation of psychological disorders, the most
frequent being anxiety, mood and stress-related disorders, as well as substance abuse and obsessive-compulsive disorders (Adeodato, Carvalho, Siqueira & Souza, 2005; Jonas et al., 2014; Netto et al., 2014).

Of these, posttraumatic stress disorder (PTSD) is highly prevalent (Bermann & Graff, 2015; Ortiz, Encinas, Mantilla & Ortiz, 2011). Also in relation to the psychological impact, research shows that women who have experienced violence are up to five times more likely to commit suicide and more prone to mental disorders than those who have not (Ceccon, Meneghel, & Hirakata, 2014; Treviñlon, Oram, Feder & Howard, 2012). The physical consequences associated with violence include pain, injuries, gastrointestinal disorders, unwanted pregnancy and sexually transmitted diseases (Côrtes, 2012; Netto et al., 2014).

From a clinical psychology perspective, research shows that psychotherapy can be effective at improving patients’ symptoms and preventing revictimization (Matud, Fortes & Medina, 2014; Ortiz et al., 2011). Among the theoretical approaches, there is evidence that cognitive-behavioral therapy (CBT) is effective at treating this population because it is objective, brief and focuses on the symptoms and the present (Beck, 2007; Crespo & Arinero, 2010; Echeburúa, Sarasúa & Zubizarreta, 2013). Moreover, CBT has been recommended for the treatment of specific symptoms common to situations of violence, such as anxiety, stress and depression (Bermann & Graff, 2015; Miller et al., 2014; Ortiz et al., 2011).

A systematic literature review on CBT protocols for women with a history of violence identified key elements in the treatment of this population (Petersen et al., in press). Psychoeducation was used in all the protocols. It is vital for patients to recognize the cycle of violence, understand how it operates and know their rights within the protection networks in place in each country (Gomes, 2012; Ortiz et al., 2011). Techniques for treating PTSD have targeted emotional regulation and trauma narratives (Iverson et al., 2011). Addressing aspects related to preventing revictimization and developing self-protection skills are also essential in these protocols (Basso, Pauli & Bressan, 2014; Miller et al., 2014). Other techniques identified are relaxation training, problem solving, behavioral activation and cognitive restructuring (Iverson et al., 2011; Ortiz et al., 2011). Finally, some studies have suggested developing positive aspects in patients, such as self-esteem and life satisfaction (Matud et al., 2014; Ortiz et al., 2011).

Evidence-based practices allow clinical psychologists to apply effective interventions. There is an urgent need for researchers to assess the processes and results of psychotherapy protocols (Monteleone & Witter, 2017). Process studies aim to evaluate how changes occur in psychotherapy, including the study of patient-therapist interaction and their communication in the therapeutic setting (Brum et al., 2012).

These studies are important because they link psychological treatment with its effects and identify effective strategies and mechanisms of action that favor psychotherapy.

Nonspecific (common) factors that explain the outcomes of psychological treatment are the focus of analysis and therapeutic alliance is the main factor studied and related to the outcome and evolution of psychotherapy (Oliveira & Benetti, 2015; Serralta, Nunes & Eizirik, 2007). This means that a good alliance tends to predict a positive result, whereas a weak alliance could explain treatment interruption, failure to identify an improvement in symptoms or a change in the patient’s overall function (Byrd, Patterson & Turchik, 2010; Oliveira & Benetti, 2015). The concept of therapeutic alliance is not theoretical and can be understood as a set of aspects that promote patient-therapist collaboration. These may be related to agreement on treatment objectives or tasks proposed during sessions, or development of the relationship between the two parties (Bordin, 1979; Zetzel, 1956).

The study of psychotherapy processes also aims to measure how much a given intervention resembles the standard model for its theoretical framework. The Psychotherapy Process Q-Set (PQS) prototype method assesses the level of agreement between psychotherapies for real cases and the theoretical approach they are based on. It is important to conduct this assessment when a new intervention is formulated and its results can validate the theoretical framework for a psychotherapy protocol (Serralta & Ablon, 2016). As such, it is vital for research to incorporate elements related to process, analyzing both therapeutic alliance and the most and least characteristic items of each session (Oliveira & Benetti, 2015; Byrd et al., 2010; Ackerman & Hilsenroth, 2003), which contribute to understanding treatment interruption in patients with a history of child abuse and borderline personality disorder (Campezatto, Serralta, & Habigzang, 2017). The main limitation of the study was the lack of pre- and post-test measures for outcome assessment and possible comparison with process measures.

Based on the preliminary results of the protocol developed by Habigzang et al. (2018), the protocol was reformulated for reevaluation. The general objective of this study is to assess the psychotherapy process based on application of the reformulated protocol to women with a history of intimate partner violence, in order to understand the clinical outcomes. The specific objectives are to analyze intrapersonal aspects of the patient and therapist, as well as interpersonal patient-therapist elements; determine whether the prototype complies with the ideal model for cognitive-behavioral therapy (CBT); evaluate the level of therapeutic alliance between the patient and therapist; and compare clinical symptoms before and after treatment.
METHOD

Participants
The three participants were selected by convenience based on the following inclusion criteria: age between 18 and 60 years, with a history of intimate partner violence and a restraining order against a former partner due to violence. Exclusion criteria were: presence of psychotic symptoms, severe cognitive deficits and substance abuse disorders. Additionally, the participants could not be undergoing any other form of psychotherapy during the intervention. The exclusion criteria were applied via a clinical interview. The participants were referred by the Legal Psychology Assistance Center (NAPSIUR – PUCRS), Trauma and Stress Research Center (NEPTE – PUCRS) and Specialist Court for Domestic and Family Violence against Women.

Patient 1 is Laura*. She was 41 years old at the time of the psychotherapy treatment and had been separated from the perpetrator for four years. She has a college degree and was working in a company. She has a five-year-old daughter with her former partner and is in contact with him through his attorney. She was involved in legal proceedings in family court for a review of the visitation and child maintenance arrangements, which caused significant stress and anxiety. Her relationship with her daughter’s father lasted three years, during which Laura suffered physical and psychological abuse. They separated at the end of Laura’s pregnancy and she moved in with her parents. She reported the violence and took out a restraining order on her former partner. The psychotherapy process identified emotional dysregulation in her personal relationships and problems controlling her emotions when interacting with others.

Patient 2 is Paola*. She was 41 years old at the time of the psychotherapy treatment and had been separated from her abuser for a year. She has an incomplete elementary school education, worked as a career for the elderly, and had a teenage son and adult daughter with her ex-husband. During treatment, the couple were involved in a court case to divide their assets and Paola had a restraining order on her husband. Their relationship lasted for 20 years, during which Paola was subjected to sexual, physical, economic and psychological abuse. Also, Paola suffered moral violence, which refers to moral exposure to other people, like insults and defamations. Paola filed for divorce when she found out that her husband was having an affair with a neighbor. The violence she experienced during their relationship made Paola insecure about her relationships with others and concerned about what people thought of her. When remembering her experiences with her ex-husband she immediately felt anxious and afraid. These symptoms of emotional dysregulation caused the patient significant discomfort.

Patient 3 is Arlete*. She turned 47 during the treatment process, had a high school education and had worked in the corporate environment, but was unemployed at the time. She had two adult children from a previous marriage. She sought psychotherapy treatment after a violent relationship that lasted four years. In the relationship she suffered psychological, moral, heritage and sexual violence. Although she had separated from her partner and had a restraining order against him, he had violated it several months before and was attempting to contact her. The aggravating factor in her situation was that her former partner lived nearby and was constantly watching her through a window, using the intercom to contact her at home and circulating around the neighborhood. During the psychotherapy process, he systematically attempted to make contact with her to convince her to resume their relationship. Arlete had reported his behavior and violation of the restraining order several times and was waiting for a court decision on the matter.

Clinical Assessment Instruments
(1) Personal and Sociodemographic Data Form: the aim of this instrument is to obtain personal and sociodemographic characteristics (Lima, 2010).
(2) Beck Anxiety Inventory (BAI): Developed by Beck, Epstein, Brown and Steer in 1998, and adapted and validated for Brazil by Cunha (2001), it is a 21-item self-report inventory that investigates anxiety. The original scale included only two components, with a satisfactory Cronbach’s alpha (α = .92).
(3) Beck Depression Inventory – BDI-II: Designed by Beck, Steer and Brown in 1996, adapted and validated for Brazil by Gorenstein, Pang, Argimon and Werlang (2011), it assesses symptoms of depression using a 21-item self-report scale. The original scale had a Cronbach’s alpha of α = .85.
(4) Childhood Trauma Questionnaire (CTQ): In Brazil, Grassi-Oliveira, Stein and Pezzi (2006) translated and adapted the 28-item CTQ for application in adolescents and adults. The questionnaire five dimensions of childhood trauma (emotional, physical and sexual abuse, and emotional and physical neglect). The scale has a Cronbach’s alpha of α = .64 (Grassi-Oliveira et al., 2006).
(5) Conflict Tactics Scale (CTS): developed by sociologist Murray Straus in 1979, the instrument was translated and adapted to Brazilian culture by Schraiber and D’Oliveira (2000) in partnership with the World Health Organization (WHO), and assesses how couples resolve conflicts, through negotiation or abusive strategies: (a) physical abuse without injury, (b) psychological aggression, (c) physical assault (d) sexual coercion. The Cronbach’s alpha for perpetration is α = .79 and α = .80 for victimization.
(6) The Posttraumatic Symptoms Checklist (PCL-5)(Weathers, Marx, Friedman & Schnurr, 2014) is a 20-item self-report scale that measures the severity
of symptoms to provide a diagnosis of PTSD. In a study aimed at contributing to validating the instrument in Brazil, acceptable internal consistency values were found, with Cronbach’s alpha varying from $\alpha = .56$ to $\alpha = .77$ (Passos, Figueira, Mendelowicz, Moraes, & Coutinho, 2012).

**Instruments for Assessing the Psychotherapy Process**

(1) Working Alliance Inventory (WAI; Horvath & Greenberg, 1989): designed to evaluate therapeutic alliance for different therapeutic approaches. There are three versions: observer, therapist and patient, denominated WAI-O, WAI-T and WAI-P, respectively. The instrument contains 36 questions, with responses scored on a 7-point scale (always-never) divided into three subscales: goals (negotiation and mutual agreement between the therapist and patient and regarding the goals of therapy); tasks (specific activities carried out by the therapist and patient to promote change); and bond (interpersonal relationship between the therapist and patient). Reliability of the instrument, based on homogeneity (Cronbach’s alpha) between the items, varies from .84 to .93. The subscales are intercorrelated, with reliability between 0.68 and 0.92 (Horvath, 1994). The Brazilian Portuguese version was developed by Serralta and Benetti and authorized by the author (Adam Horvath).

(2) Psychotherapy Process Q-Set (PQS): used to quantitatively describe the process of different psychotherapies in clinically significant terms. The instrument consists of 100 items presented in a table, with a manual containing descriptions and operating examples of the items. These can be classified into three groups: 1) patient’s attitudes, behaviors or experiences; 2) therapist’s actions and attitudes; 3) patient-therapist interaction or therapeutic climate (Serralta et al., 2007). It was translated into Portuguese by Serralta, Nunes and Eizirik (2007). After examining the material from the therapy sessions and initial formulation of the data, the raters (judges) distribute the items into nine lists, varying from least (category 1) to most characteristic (category 9). The number of items on each list is distributed according to the normal curve, varying from five items in the extreme categories and 18 items in the middle categories. This distribution means that raters have to find the best arrangement to describe the phenomena, considering the frequency, intensity and importance of an item in relation to the others (Serralta et al., 2007). The instrument also allows the use of the prototype method, which measures the extent to which psychotherapies for real cases are related to their proposed therapeutic approach. This makes it possible to validate the theoretical framework of a psychotherapy protocol (Serralta & Ablon, 2016). For this study, the instrument was used with the objectives of quantitative and reliable description of the psychotherapeutic process, and to verify the adherence of the protocol of psychotherapy to the cognitive-behavioral model, based on the prototypes method.

**Ethical and Data Collection Procedures**

The data were collected at the PUCRS Center for Psychology Research and Care (SAPP). The research team consisted of two psychologists trained in CBT and previously trained in the protocol studied, as well as five undergraduate students with clinical experience, who were carefully trained in the clinical assessment instruments and psychotherapy process.

The women referred for treatment were invited to participate in the study and given a detailed description of the relevance of the study, its benefits and the possible risks involved. After agreeing to take part, they signed informed consent forms and application of the clinical assessment instruments began. This process was performed by an undergraduate psychology student over three 50-minute sessions. The instruments used were distributed across the three sessions to avoid tiring the participants. Next, the women were referred for psychotherapy by one of the psychologists on the team.

The psychotherapy protocol consisted of 16 sessions in four stages: (1) Psychoeducation on violence against women and gender relations; cognitive, restructurizing; (2) Gradual exposure to traumatic memories and emotional regulation; (3) Training in problem solving and (4) Strengthening protection strategies and building future projects. Table 1 presents a detailed description of the protocol and the structure of each session. All the sessions were recorded and 50% were analyzed by at least two independent raters (judges). The sessions analyzed were selected by draw to obtain at least one session for each stage of the protocol. In order to avoid possible bias, the case therapist did not serve as a judge.

Following application of the protocol, the participants were clinically reassessed to determine their levels of anxiety, depression, life satisfaction, and self-esteem, as well as complex trauma and PTSD diagnoses. Reassessment was performed by the same team member that conducted the pretest evaluation. Verbal feedback was given on the final report.

**Data Analysis Procedures**

The clinical assessment instruments were qualitatively assessed to determine the impact of the intervention. The sessions selected were listened to by the judges and, based on the coding obtained in the PQS and WAI-O, Pearson’s correlation coefficient was calculated to establish interrater agreement, accepting agreement ≥ 0.50. Assuming good agreement, the mean for each item on the WAI-O and PQS
RESULTS

Results of the Clinical Assessment Before and After Intervention

With respect to the pre and post-intervention results, a clinical improvement was observed in the patient’s symptoms. After the intervention, Laura’s depression and PTSD symptoms improved, with an increase in a subclinical category of the anxiety scale. Paola and Arlete showed a decline in depression and anxiety levels and neither met the criteria for PTSD before or after intervention. Table 3 shows the results of the clinical assessment of the patients before and after treatment.

Experiences of conjugal and childhood violence were assessed in all three participants. The results indicated that Laura had suffered from physical and psychological abuse at the hands of her ex-husband. By contrast, she had also subjected him to psychological abuse, but had never physically assaulted him. She reported that her ex-husband only ever tried to resolve conflicts violently. Laura was found to have experienced emotional abuse (low levels) as a child. Paola was subjected to all forms of abuse by her former partner and had physically assaulted him on a few occasions. She did not report any childhood abuse. Arlete experienced psychological, sexual, moral and economic abuse by her partner and she psychologically abused him on some occasions, but primarily attempted to resolve conflicts in a nonviolent manner. She also reported suffering emotional abuse and neglect (moderate levels) as a child.

Psychotherapy Process Results

Therapeutic Alliance

Therapeutic alliance was assessed by independent judges using the observational version of the Working Alliance Inventory (WAI-O). A score of 4 is considered average or “neutral” alliance. The results demonstrated that, in all three cases, therapeutic alliance was above average throughout the psychotherapy process (Table 4). The level of agreement between the reviewers of the patient analyzes was 84% in the case Of Laura, 80.4% in the case of Paola and 86% in the case of Arlete.

Characteristic and non-characteristic items of the process

The Psychotherapy Process Q-Set provides a description of the most clinically significant terms in the therapy process of the patients. Table 5 presents the most significant items identified and Table shows the least significant items.

A comparison of the characteristic items for all three cases indicated that items 6, 45, 46, 73, 86 and 88 were common to all the processes. Additionally, the non-characteristic items 5, 9, 14, 15, 25, 44 and 77 were also observed for all three patients. This demonstrates that, in general, the therapists communicated clearly and coherently with the patients, were sensitive, empathetic and self-confident, and provided support and comfort. They were tactful, responsive and involved in patient improvement. All three patients were committed to therapy and brought significant issues and material to the discussions, initiated subjects spontaneously, and felt secure and confident during the process. They also felt that the therapists understood them and their experiences easily.

Some items were common to the processes of two patients. Item 69 emerged in Laura and Paola’s psychotherapy, indicating that both needed to address their current or recent life in the sessions. Laura and Paola directly accepted the comments and observations of the therapist. Item 54 emerged as characteristic in Laura and Arlete’s therapy, suggesting that both patients expressed themselves in a clear and organized manner. Item 95 was identified as significant for Paola and Arlete and item 93 as non-characteristic, indicating that both felt that the therapist was helping them and represented a neutral figure.

Although most of the items were observed in all or at least two of the processes, some emerged as case-specific descriptors. In Laura’s psychotherapy, the dialogue had a specific focus and the therapist’s comments were aimed at making it easier for her to talk. The therapist was not condescending with the patient and a competitive tone was not identified in the relationship. In Paola’s psychotherapy, the treatment goals were discussed on several occasions, the therapist conveyed non-critical acceptance and the patient expressed approval of the therapist. Finally, the specific items for Arlete’s process indicate that the therapist provided explicit advice and guidance and the patient understood the nature of the treatment and what was expected. She felt comfortable and secure and did not resist examining her thoughts, reactions or motivations related to her problems. Regarding the level of agreement reached between the evaluators, the following results were obtained: 63.4% agreement with the patient Laura, 60% with the patient Paola and 63% with the patient Arlete.

Prototypes

The correlation between the CBT prototype generated by the PQS and the cases analyzed demonstrated that the process was compatible with the cognitive-behavioral model in all three psychotherapy treatments. In Laura’s psychotherapy, correlation was 64% (r=0.64; SD=2.66); 61%
cry. "My lawyer says I need to learn to control thoughts. I still feel really angry. I dream that I’m even read and my heart starts racing and I could stop remembering this” (Paola). “just knowing that he started this court case makes me desperate. It's very difficult to live with”. “What can I do to cope with this guilt? I need to try and use this emotion to help me be a better person and not punish myself for staying in the relationship too long” (Arlete). Gradual exposure to their traumatic memories enabled a sense of greater control over the resulting physiological and emotional reactions. The emotional regulation techniques contributed to helping the women recognize the adaptive function of their emotions and develop strategies to identify and cope with the emotional responses.

The third stage focused on training in problem solving. In these sessions, the therapists helped patients to define their current problems, list alternative solutions and analyze their advantages and disadvantages to solve problems. The following statements illustrate this phase: “How do I handle running into my abuser at my daughter’s school?” (Laura). “What can I do to move away from where I live now?” (Paola). “How do I cope with this attempt to get close to me, despite the restraining order?” (Arlete). After learning how to cope with these situations step by step, the patients identified the technique that reduced their impulsiveness and helped them act more appropriately to solve their problems.

The final stage of the protocol was strengthening protection strategies and building future projects. The patients were trained in protection skills and helped to create a project for the future, with a view to preventing relapse. The following statements illustrate this phase of treatment: “Today I can see things happening, my life getting back on track. I don’t blame myself anymore. I’ve learned I can ask for help and there’s nothing wrong with that” (Arlete). “I had to lie. Otherwise he would hit me, humiliate me. I had to tell people that everything was fine. But therapy has taught me that I can ask for help. I can say that everything’s not alright. And if I know who to turn to, I’ll get help”... “You (therapist) have really made me look at all the bad things that happened to me. Therapy has taught me that I can live well now, instead of just waiting for tomorrow. I was surrounded by people who weren’t interested in my well-being. You’ve helped me to get away from that. Therapy has taught me to choose people carefully, and that not everyone will hurt me. I’ve learned that I can be whoever I want, that I’m just as human as everyone else. Therapy has brought me back to life. Now I know that I can learn too. I can also be happy. I’ll always carry that with me” (Paola). “Therapy has taught me to take a look at myself. To look after myself. To limit the space that he occupies in my life and my thoughts. I’ve learned to protect myself the right way” (Laura). The patients set short, medium and long-term achievable goals that involved resuming their studies, enjoying leisure time, engaging in volunteer work, moving home, resuming relations-

(r=0.61; SD=2.68) for Paola, and 63% (r=0.63; SD=2.82) for Arlete.

Stages of the Process
The first stage of psychotherapy focused on two techniques: Psychoeducation on violence against women and gender relations, and cognitive restructuring, consisting of five sessions. This phase was vital in establishing the therapeutic relationship and sharing the goals of the intervention. Thoughts associated with gender stereotypes and the trivialization of violent behavior by former partners were identified, such as: “I know I took too long to get out of the situation. I didn’t even realize that some of his behavior was abusive. I thought I deserved to be sworn at. I spent 20 years like that, being humiliated, forced to have sex if I wanted to eat. But it’s no easy to get out of it. I’m a woman, he’s a man. Because he was the man, I thought he could ruin my life. I was very afraid” (Paola); “People tend to sympathize more with the man. The women are always seen as the crazy ones in the relationship.” “The first time he hit me it was actually a push. I remember thinking it was normal. Today I realize that I was physically abused from that moment on” (Laura); “It’s a mother’s responsibility to make sure her children grow up healthy and don’t get involved in things like drugs, for example. The role of educating and nourishing is entirely the mother’s” (Arlete). The psychoeducational approach allowed the patients to identify violent situations they experienced as a violation of their rights. The cognitive restructuring techniques promoted reflection and a relaxation of the gender stereotypes that contributed to their remaining in violent relationships.

The second stage of psychotherapy involved exposure to traumatic memories and training in emotional regulation. In this phase the patients constructed a timeline of their traumatic memories and the therapists helped them create new strategies to cope with the resulting negative emotions. The patients reported the following experiences; “It’s very difficult to remember. But I need to learn to cope with it all. I’m going to tell you about it now because you’ve told me it’s important, but after that I don’t want to remember anymore, OK” “The physical marks, the injuries, the scars….those were the least of it. The problem is what it does to your mind. Even though we’re separated, he still occupies my thoughts. I still feel really angry. I dream that I’m punching him. Why do I still feel this way? I wish I could stop remembering this” (Paola). “Just knowing that he started this court case makes me desperate. I can’t even read and my heart starts racing and I cry.” “My lawyer says I need to learn to control myself, otherwise it could hurt my chances in the court case. It’s true, when I get angry I realize that nobody listens to me” (Laura). “I feel guilty for staying in the relationship. How could I do that to myself? I get angry when I remember all the insults, the injustices. It’s very difficult to live with”.

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The third stage focused on training in problem solving. In these sessions, the therapists helped patients to define their current problems, list alternative solutions and analyze their advantages and disadvantages to solve problems. The following statements illustrate this phase: “How do I handle running into my abuser at my daughter’s school?” (Laura). “What can I do to move away from where I live now?” (Paola). “How do I cope with his attempts to get close to me, despite the restraining order?” (Arlete). After learning how to cope with these situations step by step, the patients identified the technique that reduced their impulsiveness and helped them act more appropriately to solve their problems. The final stage of the protocol was strengthening protection strategies and building future projects. The patients were trained in protection skills and helped to create a project for the future, with a view to preventing relapse. The following statements illustrate this phase of treatment: “Today I can see things happening, my life getting back on track. I don’t blame myself anymore. I’ve learned I can ask for help and there’s nothing wrong with that” (Arlete). “I had to lie. Otherwise he would hit me, humiliate me. I had to tell people that everything was fine. But therapy has taught me that I can ask for help. I can say that everything’s not alright. And if I know who to turn to, I’ll get help”... “You (therapist) have really made me look at all the bad things that happened to me. Therapy has taught me that I can live well now, instead of just waiting for tomorrow. I was surrounded by people who weren’t interested in my well-being. You’ve helped me to get away from that. Therapy has taught me to choose people carefully, and that not everyone will hurt me. I’ve learned that I can be whoever I want, that I’m just as human as everyone else. Therapy has brought me back to life. Now I know that I can learn too. I can also be happy. I’ll always carry that with me” (Paola). “Therapy has taught me to take a look at myself. To look after myself. To limit the space that he occupies in my life and my thoughts. I’ve learned to protect myself the right way” (Laura). The patients set short, medium and long-term achievable goals that involved resuming their studies, enjoying leisure time, engaging in volunteer work, moving home, resuming relations-
DISCUSSION

The results of the CBT protocol made it possible to understand the positive clinical outcomes of psychotherapy for all three participants. All the patients exhibited symptoms as a result of exposure to violence at the start of treatment. Previous studies corroborate the presence of stress, anxiety and depression on women with a history of domestic abuse (Bermann & Graff, 2015; Jonas et al., 2014; Netto et al., 2014). The patients also reported negative effects on almost all the areas of their lives. They felt anxious and afraid and had difficulty trusting people. The conflict tactics scale demonstrated that all three women experienced more than one type of violence in their conjugal relationship, but also adopted violent behavior in their relationships. The literature describes some cases in which the cycle of intimate partner violence goes in both directions, meaning that the women may respond to violence aggressively, perpetuating the cycle (Falcke, Oliveira, Rosa & Bentancur, 2009; Garcia, Duarte, Freitas & Silva, 2016).

Another relevant result is the presence of a history of child abuse in Laura and Arlete. Evidence in the literature shows that experiencing childhood abuse increases the likelihood of being victimized as an adult in conjugal relationships (Basso et al., 2014; Miller et al., 2014; Oliveira, Costa & Sousa, 2015; Silva, Neto & Filho, 2009). All the patients reported that they did not recognize their former partners’ behavior as violent, which can be explained by the abuse in their childhood that desensitized them to violence. Other damage included a low degree of autonomy, which directly affected their ability to solve everyday problems. The literature indicates that the low autonomy of women and the controlling, authoritative role of men in the domestic setting are risk factors that perpetuate violence in intimate relationships (Narvaz & Koller, 2006; Oliveira et al., 2015). By contrast, all three women had a support network of social and affective relationships, had sought psychological treatment as a result of the violence and taken out restraining orders. These protective factors are described in the literature (Colossi, Razera, Haack & Falcke, 2015) and may also be related to the positive outcome of the psychotherapy process.

Although the study sample consisted of only three women, they had different schooling levels. Paola had completed basic education, while Laura had a graduate degree and Arlete was high school educated. These data corroborate the literature which reports a high rate of violence committed by romantic partners in all social classes, regardless of schooling level or socioeconomic class (Correia et al., 2014; Fonseca, Ribeiro & Leal, 2012; Garcia et al., 2016; WHO, 2013). The patients’ positive response to the protocol suggests initial evidence of effectiveness, irrespective of schooling level.

From the beginning of treatment, items related the patients’ commitment to their improvement were identified, corroborating the fact that the therapeutic alliance was above average from the first session. Moreover, the data suggest that the initial objectives of the protocol were achieved, namely establishing a connection, setting realistic goals and making the women responsible for their own progress. The literature demonstrates that establishing a good alliance from the first session predicts a positive outcome for the psychotherapy process (Byrd et al., 2010; Oliveira & Benetti, 2015). All the patients exhibited difficulty trusting people and believing they could be helped. Experiencing any form of abuse can trigger consequences that affect all areas of a woman’s life, including difficulty establishing health relationships and differentiating between abusive and non-abusive relationships (Lettieri et al., 2012, Netto et al., 2014). As such, in specific cases of violence, it is essential for the therapist to establish a stable and secure bond with the patient from the outset (Bermann & Graff, 2015). In other words, it is vital to focus on forging a secure connection with the patient from the first session. A good overall therapeutic alliance was identified and, across all the subscales, symptoms improved or disappeared completely at the end of treatment. Additionally, the characteristic and non-characteristic items of the sessions described treatments that worked. Combining analysis of the important elements of each session with therapeutic alliance allowed the researchers to identify effective mechanisms of action for psychotherapy (Campezatto et al., 2017; Bucci, 2007; Serralta et al., 2007).

The characteristic and non-characteristic items of each process, coded by the PQS, demonstrated that the therapists were generally positive and empathetic and were viewed as supportive by the patients. In response, the patients felt they were being helped and contributed to the sessions with important material. Previous research shows that an empathic approach is vital to create a safe, friendly environment for women who have been assaulted (Crespo & Ariñero, 2010; Ortiz et al., 2011).

For most of the sessions, Laura and Paola’s needs centered on their children and the ongoing court cases for custody and child maintenance, which negatively affected their lives. Studies show that the presence of children in the relationship contributes to ongoing symptoms of anxiety after separation (Deeke et al., 2009; Falcke et al., 2009). The results of the PQS identified the need to address aspects related to their current lives as a common item to both cases. In addition to being a specific need for
these patients, focusing on the present and training in problem solving are goals of CBT (Cort et al., 2014; Gomes, 2012; Ortiz et al., 2011).

With respect to the peculiarities of each process, the following proposals were highlighted. Laura had recurring problems with her assailant even after her divorce as a result of the ongoing court cases for visitation and child maintenance. She also experienced conflicts with the people around her, including her parents and colleagues. These issues are characteristic of women who have been subjected to violence in conjugal relationships (Ceccon et al., 2014; Deeke et al., 2009), which may have prompted the therapist not to be protective or condescending with the patient, as identified in item 51 of the PQS. The lack of a competitive tone between them and the fact that the therapist treated Laura empathically are likely to have contributed to her acceptance of the therapist’s observations and the establishment of a bond of trust. Objectivity and an empathic approach are typical of CBT (Bermann & Graff, 2015; Crespo & Arinero, 2010; Echeburúa et al., 2013). From the 15th session, the patient began to express anxiety about the end of the treatment process, which was addressed in the final two sessions. This may have influenced the post-treatment result on the anxiety scale, which assesses patient symptoms in the previous week. Although recorded in a subclinical category, Laura’s anxiety increased at the end of psychotherapy.

The treatment goals had to be discussed with Paula frequently because she recognized the significant impact of her emotional dysregulation on her everyday life and wanted to learn how to cope with her emotions. Since CBT requires defining well-defined goals (Beck, 2007; Matud et al., 2014), this was not problematic during the psychotherapy process. Paula had spent the longest period of time in a violent relationship and reported the most physical symptoms of anxiety resulting from traumatic memories. These symptoms are common in people who have experienced stressful situations over a number of years (Jonas et al., 2014; Netto et al., 2014) Although reviewing the treatment goals was a repetitive theme in the sessions, the PQS results indicated that the therapist was tactful, empathic and effectively engaged, which likely made Paula feel safe and comforted. This case required the therapist to be neutral in several instances, since Paola required direct and explicit support to rebuild her self-image. Directness and explicit support on the part of the therapist are characteristics identified in CBT protocols (Bermann & Graff, 2015; Crespo & Arinero, 2010; Echeburúa et al., 2013). This may have been successful, given that the patient showed higher levels of self-esteem and life satisfaction at the end of treatment. She also underwent an abdominoplasty that she had planned for some time as a result of previous bariatric surgery. Her motivation for the surgery may have been her improved self-esteem.

Arlethe expressed a number of beliefs regarding the role of women as solely responsible for the psychological well-being of the family and raising the children, which is consistent with reports in the literature that cultural beliefs and values reinforce gender stereotypes (Falcke et al., 2009; Oliveira et al., 2015) As such, an interesting element of her treatment process was the focus on cognitive restructuring. This can be observed in the PQS results, which identify as characteristic the patient’s exploration of her thoughts and reactions related to her problems. Additionally, in some instances the therapist offered specific guidance and advice, which is also a typical feature of CBT treatment aimed at establishing protective strategies and preventing revictimization (Bermann & Graff, 2015; Crespo & Arinero, 2010; Echeburúa et al., 2013). This was important because the patient was still at risk, since her abuser lived nearby and she was being threatened throughout the psychotherapy process, despite the restraining order. The therapist was tactful and conveyed confidence, which probably helped the patient to follow her advice and invest in a self-protection plan. In CBT for women with a history of violence, it is essential for therapists to assess the current risk and help patients create a safety plan to strengthen their self-protection strategies and prevent possible revictimization (Bermann & Graff, 2015; Miller et al., 2014).

One of the main characteristics of cognitive therapy is its focus on the symptoms and establishing specific goals that can be achieved through treatment (Beck, 2007; Crespo & Arinero, 2010; Echeburúa et al., 2013). The target symptoms were addressed during the process and the protocol showed a good connection between sessions. Furthermore, the intervention exhibited a strong correlation with the cognitive-behavioral psychotherapy prototype, which is fundamental in validating the theoretical framework of the protocol (Serralta & Ablom, 2016). Aspects inherent to the profile of cognitive therapists were identified as characteristic and non-characteristic items of the process. For example, the fact that therapists were supportive, their observations were aimed at making it easier for the patients to talk, and they were neutral are features of cognitive therapy (Gomes, 2012; Miller et al., 2014; Ortiz et al., 2011). With respect to patient-therapist interaction, focused dialogue and emphasizing the patient’s current life situation in the session are also typical attributes of a CBT process (Iverson et al., 2011; Miller et al., 2014).

In general, each stage of the protocol led strategically into the next in a natural and fluid manner. The first phase, involving psychoeducation on violence against women and gender relations, was vital to cognitive restructuring and relaxing beliefs related to gender stereotypes. Previous research con-
firms the importance of addressing these aspects in patients that have experienced domestic abuse (Gomes, 2012; Oliveira et al., 2015; Ortiz et al., 2011). Laura heavily criticized gender-based roles, but Paola and Arlete stated they had never realized the extent to which the abuse they suffered was related to gender inequality. During exposure to traumatic memories and emotional regulation training, Paola showed resistance by stating that she knew it was important to relive her memories, but it would be the last time she would do so. Laura and Arlete readily accepted the exercises. Reliving traumatic experiences is essential to accepting and reshaping negative experiences and triggering dysfunctional emotions for subsequent training in emotional regulation (Iversen et al., 2011; Ortiz et al., 2011). The problem-solving stage was successful for all three patients, who put forward pertinent problems and managed to replicate the technique in their homework assignments. Finally, the strengthening protection strategies and building future projects stage was instrumental in preventing revictimization on completing the psychotherapy. The women stated they felt they had been helped. These statements are also important because they validate the clinical results as well as the alliance and process outcomes. It is important to develop psychotherapy protocols that incorporate techniques aimed at preventing revictimization and compiling life projects for women with a history of violence (Basso et al., 2014; Miller et al., 2014).

FINIAL CONSIDERATIONS

This study sought to combine aspects related to therapeutic alliance, describing therapeutic processes and technical CBT factors when analyzing the treatment process of three women with a history of intimate partner violence. The findings demonstrate that the proposed intervention enabled a good connection between sessions and showed potential for treating typical symptoms resulting from exposure to domestic violence. Additionally, it was concluded that the three cases exhibited above average therapeutic alliance, which explains the positive treatment outcome when comparing clinical symptoms before and after therapy. Finally, the intervention displayed good correlation with the prototype for cognitive-behavioral therapy.

Limitations of this study include the fact that the sessions were only recorded and not filmed, which interfered in the non-verbal elements of the processes. Moreover, therapeutic alliance was analyzed by judges using the observational version of the WAIs; analyses by the therapist and patients were not included. Future studies should include therapist and patient measurements to triangulate the results.

Initial evidence of the effectiveness of the protocol studied could be extended to future clinical trials. This would allow the impact of the intervention to be assessed by comparing pre- and post-treatment measurements. Clinical studies aimed at developing and evaluating evidence of the effectiveness of psychotherapy for women with a history of violence are needed in Brazil. Adequate treatment for these women is an important strategy in addressing the problem. Psychotherapy can be a device for change to break the cycle of violence; however, it should be combined with other protective and care-related strategies and interventions. In conclusion, it is important for the practices of psychologists working in clinics and care networks to be scientifically supported by protocols with evidence of effectiveness.

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Table 1. Psychotherapy Protocol

| Stages | Session | Description |
|--------|---------|-------------|
| Stage 1 Psychoeducation on violence against women and gender relations Cognitive restructuring | 1 | Establishing the therapeutic contract; assessing the participant’s expectations; setting therapeutic goals. Compiling a poster depicting self-image (collage of pictures and/or words that describe personal characteristics) and evaluating beliefs about the role of women in different contexts. |
| | 2 | Psychoeducation about different types of violence; Evaluating the current risk and, when necessary, compiling a safety plan (in anticipation of training for protection skills). |
| | 3 | Reflections on gender relations. Psychoeducation on gender violence. |
| | 4 | Psychoeducation on the ABC Model (Activating Event – Beliefs – Consequences: emotions, behavior, physical reactions). |
| | 5 | Psychoeducation on the consequences of violence. |
| Stage 2 Gradual exposure to traumatic memories and emotional regulation | 6 | Compiling a timeline to map the history of violence. |
| | 7 | Reviewing the timeline; Compiling narratives about traumatic events. Emotional regulation (functions of emotions). Relaxation. |
| | 8 | Strategies for coping with emotions related to traumatic events. Relaxation. |
| | 9 | Strategies for coping with emotions related to traumatic events. Cognitive and behavioral coping strategies – Panic button. Relaxation. |
| | 10 | Strategies for coping with emotions, cognition and behaviors related to traumatic events. Relaxation. |
| Stage 3 Problem solving | 11 | Training in Problem Solving. |
| | 12 | Training in Problem Solving. |
| Stage 4 Strengthening protection strategies and building future projects. | 13 | Preventing exposure to violence /protection strategies /Functioning of Protection Networks. |
| | 14 | Training in protective abilities |
| | 15 | Compiling a project for the future and revisiting the timeline. |
| | 16 | Self-assessment – Reviewing the self-image poster and beliefs about the role of women in different contexts. |

Table 2. Instrument Application

| Instrument | Pre-test | During Psychotherapy | Post-test |
|------------|----------|----------------------|-----------|
| Personal and Sociodemographic Data Form | X | | |
| BAI | X | | |
| BDI | X | | |
| Childhood Trauma Questionnaire - CTQ | X | | |
| Conflict Tactics Scale | X | | |
| PCL 5 | X | X | |
| WAIO | | X | |
| PQS | | X | |
### Table 3. Pre- and Post-Test Clinical Assessment

| Symptoms | Time       | Laura    | Paola  | Arlete  |
|----------|------------|----------|--------|---------|
| Anxiety  | Pre-test   | Minimal  | Moderate| Minimal |
|          | Post-test  | Mild     | Minimal| Minimal |
| Depression | Pre-test   | Mild     | Moderate| Mild    |
|          | Post-test  | Minimal  | Minimal| Minimal |
| PTSD     | Pre-test   | Yes      | No     | No      |
|          | Post-test  | No       | No     | No      |

### Table 4. Therapeutic Alliance

| Patient | Overall Alliance | SD  | Bond | Tasks | Goals |
|---------|------------------|-----|------|------|-------|
| Laura   | 5.28             | 0.43| 5.90 | 5.78 | 5.15  |
| Paola   | 5.45             | 0.42| 5.57 | 5.45 | 5.35  |
| Arlete  | 5.55             | 0.21| 5.63 | 5.81 | 5.32  |

### Table 5. Most Characteristic Items of the Process

| Laura  | M   | Paola | M   | Arlete | M   |
|--------|-----|-------|-----|--------|-----|
| Item 46: The therapist communicates with the patient clearly and coherently. | 7.73 | Item 45: The therapist adopts a supportive stance. | 7.71 | Item 54: The patient expresses herself clearly and in an organized manner. | 7.92 |
| Item 6: The therapist is sensitive to the patient’s feelings and in tune with her; empathic. | 7.66 | Item 6: The therapist is sensitive to the patient’s feelings and in tune with her; empathic. | 7.47 | Item 46: The therapist communicates with the patient clearly and coherently. | 7.61 |
| Item 23: Dialogue has a specific focus. | 7.46 | Item 69: The patient’s current or recent life situation is emphasized in the discussion. | 7.41 | Item 86: The therapist is secure and self-confident (versus insecure or defensive). | 7.53 |
| Item 45: The therapist adopts a supportive stance. | 7.46 | Item 86: The therapist is secure and self-confident (versus insecure or defensive). | 7.41 | Item 88: The patient contributes with significant themes and material. | 7.53 |
| Item 69: The patient’s current or recent life situation is emphasized in the discussion. | 7.46 | Item 18: The therapists conveys non-critical acceptance (Note: scoring on the non-characteristic end indicates disapproval, lack of acceptance). | 7.23 | Item 95: The patient feels she is being helped. | 7.53 |
| Item 3: The therapist’s observations are aimed at making it easier for the patient to talk. | 7.23 | Item 73: The patient is committed to therapy. | 7.18 | Item 45: The therapist adopts a supportive stance. | 7.43 |
| Item 88: The patient contributes with significant themes and material. | 7.2  | Item 4: The patient’s treatment goals are discussed. | 7.12 | Item 6: The therapist is sensitive to the patient’s feelings and in tune with her; empathic. | 7.3  |
| Item 54: The patient expresses herself clearly and in an organized manner. | 7.0  | Item 88: The patient contributes with significant themes and material. | 7.12 | Item 27: The therapist provides explicit guidance and advice (versus delaying, even when pressured to do so). | 7.23 |
| Item 66: The therapist is secure and self-confident (versus insecure or defensive). | 6.68 | Item 46: The therapist communicates with the patient clearly and coherently. | 7.05 | Item 72: The patient understands the nature of the therapy and what is expected. | 7.23 |
| Item 73: The patient is committed to therapy. | 6.8  | Item 95: The patient feels she is being helped. | 7.0  | Item 73: The patient is committed to therapy. | 7.15 |
Table 6. Least Characteristic Items of the Process

| Laura | M | Paola | M | Arlete | M |
|-------|---|-------|---|--------|---|
| Item 77: The therapist is tactless. | 1.53 | Item 9: The therapist is distant, indifferent (versus responsive and effectively engaged). | 1.11 | Item 25: The patient has difficulty starting the session. | 1.53 |
| Item 5: The patient has difficulty understanding the therapist’s comments. | 1.66 | Item 77: The therapist is tactless. | 1.47 | Item 15: The patient does not start discussions; passive. | 1.69 |
| Item 9: The therapist is distant, indifferent (versus responsive and effectively engaged). | 1.8 | Item 15: The patient does not start discussions; passive. | 1.82 | Item 5: The patient has difficulty understanding the therapist’s comments. | 1.76 |
| Item 15: The patient does not start discussions; passive. | 2.0 | Item 1: The patient expresses negative feelings (such as criticism, hostility) toward the therapist (versus comments showing approval or admiration). | 1.94 | Item 93: The therapist is neutral. | 2.07 |
| Item 51: The therapist is condescending or protective toward the patient. | 2.13 | Item 14: The patient does not feel understood by the therapist. | 2.0 | Item 58: The patient resists examining her thoughts, reactions or motives related to problems | 2.15 |
| Item 14: The patient does not feel understood by the therapist. | 2.26 | Item 5: The patient has difficulty understanding the therapist’s comments. | 2.05 | Item 14: The patient does not feel understood by the therapist. | 2.38 |
| Item 44: The patient is cautious or suspicious (versus confident and secure). | 2.46 | Item 25: The patient has difficulty starting the session. | 2.17 | Item 9: The therapist is distant, indifferent (versus responsive and effectively engaged). | 2.46 |
| Item 42: The patient rejects (versus accepts) the therapist’s comments and observations. | 2.6 | Item 42: The patient rejects (versus accepts) the therapist’s comments and observations. | 2.17 | Item 61: The patient feels shy or embarrassed (versus at ease and secure). | 2.46 |
| Item 25: The patient has difficulty starting the session. | 2.66 | Item 93: The therapist is neutral. | 2.35 | Item 77: The therapist is tactless. | 2.48 |
| Item 39: There is a competitive tone in the relationship. | 2.73 | Item 44: The patient is cautious or suspicious (versus confident and secure). | 2.41 | Item 44: The patient is cautious or suspicious (versus confident and secure). | 2.53 |