UNIVERSIDADE FEDERAL DO RIO GRANDE DO SUL

Faculdade de Medicina

Programa de Pós-Graduação em Psiquiatria e Ciências do Comportamento

FUNCIONAMENTO PSICODINÂMICO DE MULHERES VÍTIMAS DE VIOLÊNCIA POR PARCEIRO ÍNTIMO SOB A PERSPECTIVA DO DIAGNÓSTICO PSICODINÂMICO OPERACIONALIZADO (OPD-2)

Luciane Maria Both

Tese de Doutorado

Porto Alegre
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Tese apresentada ao Programa de Pós-Graduação em Psiquiatria e Ciências do Comportamento, da Universidade Federal do Rio Grande do Sul, como requisito parcial para obtenção do título de Doutor em Psiquiatria.

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Porto Alegre
2021

"A ciência moderna ainda não produziu um medicamento tranquilizador tão eficaz como o são umas poucas palavras boas" (FREUD, 1930/1996).

À minha amada família e amigos, que sempre me apoiaram, incentivaram e acreditaram em mim, em especial à minha mãe Marlise, à minha dinda Marinês e ao Heitor.

Aos meus professores e colegas, particularmente à minha orientadora Lúcia Helena, que dividiu comigo seu conhecimento e oportunizou meu crescimento teórico, profissional e pessoal.

Ao grupo de pesquisa, que sempre me apoiou muito em cada etapa da pesquisa, principalmente as colegas Taís e Cleo.

À equipe do DML que concedeu a oportunidade de coleta de dados, principalmente à Angelita Rios.

Ao Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq) pela concessão de bolsa de doutorado que financiou meus estudos nesse período.

Minha eterna gratidão.

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RESUMO

FUNCIONAMENTO PSICODINÂMICO DE MULHERES VÍTIMAS DE VIOLÊNCIA POR PARCEIRO ÍNTIMO SOB A PERSPECTIVA DO DIAGNÓSTICO PSICODINÂMICO OPERACIONALIZADO (OPD-2)

Autora: Luciane Maria Both
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Introdução: A violência por parceiro íntimo refere-se a qualquer comportamento de um parceiro íntimo ou ex-parceiro que cause abuso físico, sexual ou emocional, em que um parceiro exerce poder e controle sobre o outro. É uma das formas mais comuns de violência e é considerada um problema de saúde pública e causa danos físicos e psicológicos às vítimas – traumas. O trauma psicológico recorrente modifica o funcionamento psicológico do sujeito e certamente piora a qualidade de vida dos envolvidos. Assim, é imprescindível a avaliação psicológica multiaxial dessa população, de maneira que haja a integração da dimensão psicodinâmica à sintomatologia descritiva, como proposto no *Diagnóstico Psicodinâmico Operacionalizado (OPD-2).*
Objetivo: Investigar as características do funcionamento psicodinâmico de mulheres vítimas de violência por parceiro íntimo, sob uma perspectiva dimensional operacionalizada. Para atingir esse objetivo, o projeto foi composto por sete estudos.
Método: *Estudo 1:* revisão sistemática; *Estudo 2:* qualitativo e transversal; *Estudo 3:* Adaptação Transcultural e Validação do Eixo I; *Estudo 4:* quantitativo e transversal; *Estudo 5:* Classificação de texto com uma técnica de análise de nuvem de palavras; *Estudo 6:* quantitativo e transversal; *Estudo 7:* estudo de caso. Os estudos empíricos basearam-se na amostra de 56 mulheres vítimas de violência por parceiro íntimo com idade média de 30,07 anos (SD=9,65). Foram incluídas mulheres de 18 a 65 anos vítimas de violência por parceiro íntimo autorreferida que procuraram o serviço de exame de corpo de delito, durante o plantão do pesquisador. Utilizou-se a Entrevista Clínica do Diagnóstico Psicodinâmico Operacionalizado, gravadas e transcritas. Essas entrevistas foram codificadas e analisadas por dois juízes independentes treinados no OPD-2, com desenho de confiabilidade entre juízes. E para o Estudo 6 também foi utilizado o *Defensive Style Questionnaire (DSQ-40).*
Resultados: *Estudo 1:* foram incluídos 14 artigos, categorizados conforme o tema central, local de pesquisa e ano de publicação; *Estudo 2:* foi compreendida as fases do ciclo da violência; *Estudo 3:* houve validade de conteúdo e propriedades psicométricas satisfatórias da adaptação do Eixo I; *Estudo 4:* a gravidade da violência estava associada à intensidade do sofrimento subjetivo das mulheres. No padrão relacional, as vítimas permanecem no relacionamento, deixando-se vulneráveis; percebiam o parceiro como controlador, agressivo, ofensivo e possuíam medo do abandono. A vítima antecipou o desejo do agressor, como um mecanismo defensivo de desconforto e sofrimento relacionais, tornando-se, portanto, submissa. O principal conflito psíquico foi a "necessidade de cuidado *versus* autossuficiência" (78,6%). O nível de estrutura predominante foi mediano, no qual elas têm objetos internos inseguros, apresentando dificuldades na regulação emocional e percebendo a realidade de maneira distorcida. Portanto, elas não reconhecem suas limitações e necessidades. Constatou-se que 78,6% dos casos apresentavam algum distúrbio psiquiátrico: TDM e TEPT; *Estudo 5:* o discurso das mulheres nas entrevistas concentrou-se em entender o que realmente havia acontecido em seu relacionamento, relatando suas situações abusivas; *Estudo 6:* predominou o uso de defesas maduras, principalmente da antecipação; *Estudo 7:* o desenvolvimento das

capacidades de autopercepção e percepção do objeto foi o foco principal desenvolvido do processo terapêutico.
Conclusão: Esta tese fornece evidências empíricas sobre o funcionamento psicológico das vítimas e as questões que compõem a manutenção da violência perpetrada por parceiro íntimo contra as mulheres, tais como: constituição dos impasses e obstáculos do contexto violento, disfuncionalidades em função de um estresse *versus* estrutura de personalidade vulnerável, recursos intrapsíquicos desses sujeitos.
A compreensão de padrões internalizados, funções estruturais e tensões motivacionais são fundamentais para a prevenção da revitimização, a construção de mecanismos de enfrentamento mais adaptativos e a promoção de maior adesão ao tratamento. A identificação dimensional psicodinâmica é uma ferramenta útil para o planejamento e o foco terapêutico com o intuito de superar obstáculos e impasses na interrupção do ciclo de violência.
Palavras-chave: Violência por Parceiro Íntimo, Violência Doméstica, Violência Contra a Mulher, Psicologia Clínica, Psicoterapia Psicodinâmica, Diagnóstico, Saúde pública.

ABSTRACT

PSYCHODYNAMIC OPERATION OF WOMEN VICTIMS OF VIOLENCE BY AN INTIMATE PARTNER FROM THE PERSPECTIVE OF THE OPERATIONALIZED PSYCHODYNAMIC DIAGNOSIS (OPD-2)

Author: Luciane Maria Both
Advisor: Lúcia Helena Freitas, PhD

Introduction: Intimate partner violence refers to any behavior by an intimate partner or ex-partner that causes physical, sexual or emotional abuse, in which one partner exercises power and control over the other. It is one of the most common forms of violence and is considered a public health problem and causes physical and psychological damage to victims - trauma. Recurrent psychological trauma modifies the subject's psychological functioning and certainly worsens the quality of life of those involved. Thus, the multiaxial psychological assessment of this population is essential, so that there is the integration of the psychodynamic dimension with the descriptive symptoms, as proposed in the *Operationalized Psychodynamic Diagnosis (OPD-2).*
Objective: To investigate the characteristics of the psychodynamic functioning of women victims of intimate partner violence, from an operationalized dimensional perspective. To achieve this goal, the project consisted of seven studies.
Method: *Study 1:* systematic review; *Study 2:* qualitative and transversal; *Study 3:* Transcultural Adaptation and Validation of Axis I; *Study 4:* quantitative and transversal; *Study 5:* Text classification with a word cloud analysis technique; *Study 6:* quantitative and transversal; *Study 7:* case study. The empirical studies were based on the sample of 56 women victims of intimate partner violence, with an average age of 30.07 years (SD = 9.65). Women from 18 to 65 years of age who were victims of intimate partner violence by self-reported who sought the body of crime examination service during the researcher's duty were included. The Operationalized Psychodynamic Diagnosis Clinical Interview was used, recorded and transcribed. These interviews were coded and analyzed by two independent judges trained in OPD-2, with a design of reliability between judges. And for Study 6, the *Defensive Style Questionnaire (DSQ-40)* was also used.
Results: *Study 1:* 14 articles were included, categorized according to the central theme, place of research and year of publication; *Study 2:* the phases of the violence cycle were understood; *Study 3:* there was content validity and satisfactory psychometric properties of the adaptation of Axis I; *Study 4:* the severity of the violence was associated with the intensity of the women's subjective suffering. In the relational pattern, the victims remain in the relationship, leaving themselves vulnerable; they perceived their partner as controlling, aggressive, offensive and were afraid of abandonment. The victim anticipated the aggressor's desire, as a defensive mechanism of relational discomfort and suffering, thus becoming submissive. The main psychic conflict was the "need for care versus self-reliance" (78.6%). The predominant level of structure was average, in which they have insecure internal objects, presenting difficulties in emotional regulation and perceiving reality in a distorted way. Therefore, they do not recognize their limitations and needs. It was found that 78.6% of the cases had some psychiatric disorder: TDM and PTSD; *Study 5:* the women's speech in the interviews focused on understanding what had really happened in their relationship, reporting their abusive situations; *Study 6:* the use of mature defenses predominated, especially anticipation; *Study 7:* the development of the self-perception and perception of the object was the main focus developed in the therapeutic process.

Conclusion: This thesis provides empirical evidence on the psychological functioning of the victims and the issues that make up the maintenance of violence perpetrated by an intimate partner against women, such as: constitution of impasses and obstacles in the violent context, dysfunctionalities due to stress versus vulnerable personality structure, intrapsychic resources of these subjects. The understanding of internalized patterns, structural functions and motivational tensions are fundamental for the prevention of revictimization, the construction of more adaptive coping mechanisms and the promotion of greater adherence to treatment. Psychodynamic dimensional identification is a useful tool for planning and therapeutic focus in order to overcome obstacles and impasses in interrupting the cycle of violence.
Keywords: Intimate Partner Violence, Domestic Violence, Violence Against Women, Clinical Psychology, Psychodynamic Psychotherapy, Diagnosis, Public Health.

LISTA DE ABREVIATURAS

BDI - Inventário de Depressão de Beck

BWS - Síndrome da Mulher Espancada *(Battered Woman Syndrome)*

CID - Classificação Internacional de Doenças

CNS - Conselho Nacional de Saúde

COREQ - Consolidated criteria for reporting qualitative research

DML - Departamento Médico-Legal - IGP-RS

DSM - Diagnostic and Statistical Manual of Mental Disorders

DSQ-40 - *Defensive Style Questionnaire*

IPV - Violência por parceiro íntimo (*Intimate partner violence*)

ONU - Organização das Nações Unidas

OPD-2 - Diagnóstico Psicodinâmico Operacionalizado (*Operationalized Psychodynamic Diagnosis)*

PRISMA - *Preferred Reporting Items for Systematic Reviews*

SCL-90 - *Symptom Check-List-90-Revised*

SD - Desvio Padrão *(Standard Deviation)*

SPSS - *Statistical Package for the Social Science*

TCLE - Termo de Consentimento Livre e Esclarecido

TDM - Transtorno Depressivo Maior

TEA – Transtorno de Estresse Agudo

TEPT - Transtorno de Estresse Pós-Traumático

WHOQOL-BREF - *The World Health Organization Quality of Life – brief version*

1 APRESENTAÇÃO

"As marcas pelo corpo desapareceram em poucas semanas, mas ficaram para sempre na lembrança" (Lariane Cagnini).

Esta tese apresenta os resultados do projeto de doutorado intitulado "FUNCIONAMENTO PSICODINÂMICO DE MULHERES VÍTIMAS DE VIOLÊNCIA DOMÉSTICA SOB UMA PERSPECTIVA DO DIAGNÓSTICO OPERACIONALIZADO PSICODINÂMICO (OPD-2)". Insere-se na linha de pesquisa do Trauma. Foi registrado na Universidade Federal do Rio Grande do Sul (CAAE 68271917.7.0000.5347). É um projeto guarda-chuva, ampliado para pacientes que sofreram diversos tipos de trauma – violência urbana ou doméstica. De tal maneira, este projeto de pesquisa trabalhou com o enfoque psicodinâmico da violência, na perspectiva traumática, com mulheres vítimas de violência por parceiro íntimo.

O trabalho é apresentado no formato de artigos, estruturado da seguinte forma: Introdução, Fundamentação Teórica, Justificativa, Objetivos, Método, Artigos, Discussão e Considerações Finais. Ademais, os apêndices complementam o trabalho com resumos das produções em coautoria e demais materiais pertinentes à compreensão dos estudos.

2 INTRODUÇÃO

2.1 VIOLÊNCIA POR PARCEIRO ÍNTIMO

A violência é definida pelo uso intencional do poder ou da força, real ou ameaça, contra si ou contra os demais que resulte algum dano, privação ou sofrimento (OMS, 2005). A violência por parceiro íntimo (*Intimate partner violence - IPV*) refere-se a qualquer comportamento de um parceiro íntimo ou ex-parceiro que cause abuso físico, sexual ou emocional, incluindo agressão física, coerção sexual, abuso psicológico e comportamentos de controle, em que um parceiro exerce poder e controle sobre o outro. Ocorre em diferentes contextos socioeconômicos, religiosos e culturais. Mais comuns em mulheres, elas carregam o enorme fardo global da IPV (OMS, 2017).

A IPV é considerada uma subcategoria da violência de gênero, mas também são terminologias utilizadas como sinônimas na literatura (LOURENÇO *et al.,* 2013). Além disso, a violência por parceiro íntimo, geralmente chamada de violência doméstica, é uma das formas mais comuns de violência.

Segundo Crempien (2009, 2012), a violência doméstica possui variáveis culturais, familiares, relacionais, bem como características individuais de vítimas e agressores que são fundamentais na etiologia e manutenção da violência. Há um esforço concentrado na compreensão da violência e sua repercussão sobre vítimas e agressores. Mais especificamente, a violência doméstica contra a mulher é uma violência de gênero que situa a mulher como vítima e o homem como o agressor; nesse sentido interacional, fala-se da violência conjugal (FALCKE; FÉRES-CARNEIRO, 2011). Apresenta-se como uma tentativa de prejudicar ou controlar seus atuais ou antigos parceiros românticos contra sua vontade. Também, é referido como a combinação paradoxal de afeto e agressão (CHESTER, DEWALL, 2018).

As causas associadas à violência por parceiro íntimo são multifatorial: a) fatores comunitários: pobreza, desemprego, isolamento familiar, redes de prevenção e proteção deficitárias; b) fatores da sociedade: naturalização da violência para resolução de conflitos, dominação masculina, papéis de gênero estereotipados; c) fatores do agressor: uso de substância, transgeracionalidade da violência (BINS, TELLES, PANICHI, 2015) e suspeita de traição (AMARAL *et al.,* 2016), desemprego do companheiro (SANZ-BARBERO *et al.,* 2016); d) fatores da vítima: baixa autoestima, baixa escolaridade, histórico de violência familiar na infância e no decorrer do desenvolvimento, existência de doença mental (AMARAL *et al.,* 2016; ANACLETO *et al.,* 2009), ser mulheres

imigrantes; e) fatores envolvendo a relação: ausência de união legal, presença de filhos de relacionamentos prévios, violência anterior na relação, violência durante a gestação, ciúmes e diferença de idade entre os parceiros (SANZ-BARBERO *et al.,* 2016).

Trata-se de uma violência com consequências significativas para a saúde (GARCIA-MORENO *et al.,* 2013), como problemas de saúde mental, problemas sexuais reprodutivos e condições crônicas - e representam uma carga de saúde significativa para as mulheres. Tais situações de violência são provocadoras de traumas que afetam consideravelmente o funcionamento do sujeito (ZIMERMAN, 2001). A maioria das queixas dos indivíduos na clínica psicoterápica colocadas por esses pacientes que vivenciaram algum evento traumático são carregadas de emoções dolorosas e referem-se a queixas que influenciam o momento de vida atual, alterando o equilíbrio do sujeito e causando desajustes significativos no cotidiano (PERES, 2009).

Representa a principal causa de morte por homicídio de mulheres e é tipicamente vivenciada pelo sexo feminino, independentemente da idade (MAZZA *et al*., 2020). Em todo o mundo, 35% das mulheres que estão em um relacionamento sofreram violência física e / ou sexual por seu parceiro íntimo. Com base nos dados da Organização Mundial da Saúde, a exposição ao longo da vida das mulheres à violência por parceiro íntimo está associada a inúmeras consequências de saúde, dentre elas: resultados fatais, lesões, depressão, estresse pós-traumático, transtornos de ansiedade, dificuldades para dormir, distúrbios alimentares e tentativas de suicídio (OMS, 2017).

Conforme a presidenta da Assembleia Geral das Nações Unidas, Maria Fernanda Espinosa, em 2018, apontou que 38% dos homicídios de mulheres foram realizados pelo parceiro íntimo da vítima (ONU, 2018). Já, em abril de 2020, com a pandemia em curso, ocasionada pelo SARS-CoV-2, agente causador da síndrome respiratória aguda grave COVID-19, o chefe da Organização das Nações Unidas, António Guterres, pediu medidas para combater o "horrível aumento global da violência doméstica" dirigida às mulheres e meninas em meio a quarentena (ONU, 2020a). Percebe-se, assim, que a violência por parceiro íntimo se mostra ainda mais alarmante frente as medidas de isolamento social adotadas mundialmente. Em fevereiro de 2020, as linhas de ajuda às vítimas da violência por parceiro íntimo registraram um aumento de 91% na Colômbia, 60% no México, 40% na Austrália, 30% em Chipre e 20% nos Estados Unidos (RUIZ-PÉREZ, PASTOR-MORENO, 2020). Em Ontário, os departamentos de polícia regional de Nova York e Durham relataram cerca de 22% de crescimento em incidentes domésticos e relatos de agressão sexual (BRADLEY *et al.,* 2020).

No Brasil, o Ministério da Saúde registra que a cada quatro minutos uma mulher é agredida por um homem e sobrevive; na maioria das vezes o agressor é o ex ou atual companheiro (CUBAS, ZARAMBA, AMÂNCIO, 2019). Conforme o Atlas da Violência de 2019 realizado pelo Instituto de Pesquisa Econômica e Aplicada, o indicador de feminicídio é 31,6 casos a cada 100 mil habitantes. Do total de homicídios contra mulheres no Brasil, 28,5% ocorrem dentro da residência, casos decorrentes da IPV (ATLAS DA VIOLÊNCIA, 2019). Segundo a Organização Mundial da Saúde, os casos de feminicídio durante a pandemia cresceram 22,2% entre março e abril do ano de 2020, em 12 estados do país, comparativamente ao ano de 2019 (OMS, 2020). Ainda mais alarmante, segundo relatório da ONU (2020b), menos de 40% das mulheres vítimas de violência buscavam qualquer tipo de ajuda ou denunciavam o crime e menos de 10% das mulheres que procuravam ajuda, iam à polícia.

Nesse sentido, é um problema de saúde pública devido às altas incidências estatísticas e enfrenta diversas barreiras no contexto brasileiro, onde há uma permissividade social em relação à agressão com banalização do comportamento violento contra a mulher (BINS, TELLES, PANICHI, 2015; FALCKE, FÉRES-CARNEIRO, 2011; LAMOGLIA, MINAYO, 2009; SCHRAIBER *et al.,* 2007). Ou seja, está naturalizada na sociedade (CORTEZ *et al.,* 2010; LEÔNCIO *et al.*, 2008). Entretanto, é considerada uma violação dos direitos humanos (OMS, 2005).

Dessa maneira, foi criada a Lei 11.340/06, conhecida como Maria da Penha, que integra princípios referentes à violência contra mulher ou à violência de gênero. Ela cria mecanismos jurídicos para coibir e punir a violência doméstica contra a mulher; ou seja, a violência doméstica deixa de ser um crime de menor potencial ofensivo para ocupar o patamar de violação dos direitos humanos. Essa Lei considera como violência doméstica e familiar contra a mulher qualquer ação baseada no gênero que provoque sofrimento físico, sexual ou psicológico, dano moral, patrimonial ou físico. A Lei está dividida em três eixos principais quanto às medidas de intervenção: a) criminal; b) de proteção dos direitos e da integridade física da mulher; c) de prevenção e educação (BRASIL, 2006).

Diante dessas questões, é inegável a necessidade de compreender esse contexto de violência diante da alta prevalência de casos e suas consequências sociais. Frente ao exposto, a presente tese procurou aprofundar e ampliar o conhecimento atual sobre as questões apontadas, a fim de responder a principal questão de pesquisa: quais as características do funcionamento psicodinâmico de mulheres vítimas de violência por parceiro íntimo, sob uma perspectiva dimensional operacionalizada?

2.2 DIAGNÓSTICO PSICODINÂMICO OPERACIONALIZADO

As pesquisas em psicoterapia constituem um campo fértil para investigação, já que aprimoram o trabalho clínico (PEUKER *et al.*, 2009). Em psicanálise, há um esforço na produção de pesquisas relacionadas ao processo e resultado (SERRALTA *et al.,* 2010), há estudos comparativos entre psicanálise e demais modalidades psicoterapêuticas (HUBER *et al.,* 2012) e pesquisas direcionadas às questões diagnósticas. Tais pesquisas diagnósticas destacaram-se devido às deficiências na operacionalização de um diagnóstico psicodinâmico compreensivo em detrimento ao diagnóstico descritivo (CIERPKA *et al.,* 2010).

Nesse sentido, criou-se em 1990 um instrumento chamado Diagnóstico Psicodinâmico Operacionalizado (*Operationalisierte Psychodynamische Diagnostik*, OPD), que integra a dimensão psicodinâmica à sintomatologia descritiva comum dos manuais diagnósticos (TASK FORCE, 2016). Atualmente, encontra-se na 2ª versão do manual operacionalizado, com validação nas línguas: espanhol, inglês, português (Portugal e Brasil; VICENTE *et al.,* 2012; KRIEGER, 2013).

O *Diagnóstico Psicodinâmico Operacionalizado (OPD-2)* é um sistema de diagnóstico multiaxial e compreende cinco eixos, o qual quatro deles são psicodinâmicos e o último é descritivo: (I) vivência da doença e pré-requisitos para o tratamento; (II) relações interpessoais; (III) conflito psíquico; (IV) estrutura psíquica; (V) diagnóstico nosológico tradicional, tais como *Manual Diagnóstico e Estatístico de Transtornos Mentais (DSM)* e *Classificação Internacional de Doenças e Problemas Relacionados à Saúde (CID*; TASK FORCE, 2016). O instrumento objetiva a formulação, identificação, foco e planejamento do tratamento (SCHNEIDER, *et al.,* 2008). O manual tem como base os pressupostos da teoria do apego e das relações objetais (TASK FORCE, 2016).

O OPD-2 pode ser utilizado em diversos contextos clínicos e perturbações psíquicas (TASK FORCE, 2016; PAULO; PIRES, 2013). Nesse sentido, é pertinente questionar se o instrumento OPD-2 pode avaliar ou constituir-se como uma ferramenta útil no diagnóstico e planeamento terapêutico para mulheres vítimas de violência por parceiro íntimo.

3 FUNDAMENTAÇÃO TEÓRICA

3.1 TRAUMA PSICOLÓGICO

O trauma psicológico é considerado o resultado de uma situação experenciada pelo sujeito em que houve ameaça da integridade física e/ou psicológica a si mesmo ou aos demais, tais como: assaltos, acidentes, perdas e violência de maneira geral (EIZIRIK *et al,* 2006; PERES, 2009). Ou seja, são causados por um agente externo de maneira que sobrecarregaram a capacidade do ego em processar a angústia e a dor psíquica provocadas (ZIMERMAN, 2001).

Conforme Garland (2015), Freud apontou o trauma como eventos violentos ou inesperados que rompem com as defesas do psiquismo, tornando-o incapaz de funcionar normalmente. Entretanto, é determinante a maneira como as pessoas processam a situação estressora após sua ocorrência para o estabelecimento do trauma em si ou recuperação satisfatória do evento. Destaca-se que os eventos traumáticos do presente podem associar-se inconscientemente às situações traumáticas do passado vivenciadas durante o desenvolvimento. Aponta-se que após a ocorrência estressante, o sujeito reage de forma a ocorrer a configuração de hiperestimulação ao aparelho psíquico, cuja ansiedade é prevalente, ou pode configurar-se como dissociação, em que o indivíduo parece "anestesiado", mas esconde grande sofrimento interior.

Evidências científicas apontam associação entre violência doméstica e problemas de saúde mental, tais como depressão, ansiedade, tentativas de suicídio, sintomas de estresse pós-traumático (LUDERMIR *et al.*, 2008). As características diagnósticas de pessoas que sofreram violência referem-se ao Transtorno de Estresse Pós-Traumático (TEPT). Os sintomas predominantes desse diagnóstico descritivo são: lembranças intrusivas, recorrentes e involuntárias; sonhos angustiantes; reações dissociativas de revivência do evento traumático; sofrimento psicológico e reações fisiológicas intensas; evitação de estímulos associados ao trauma; cognições distorcidas; reações comportamentais, entre outros (APA, 2014). Na concepção inicial do DSM-III, o evento traumático foi definido como um estressor catastrófico fora do escopo de experiências esperadas para a vida de alguém (APA, 1980).

Para Kane e colaboradores (2016), as vítimas de trauma em função da violência por parceiro íntimo que tinham maior contato social, apresentaram menor prejuízo na execução das atividades cotidianas como cozinhar, no cuidado com os familiares e no trabalho. Martins (2011) destaca que os aspectos que interferem na relação entre

traumatização e adoecimento também se referem à: apoio social, rede de proteção social, tipo de vitimização, idade, sexo, autoeficácia percebida, entre outros.

Sobre os recursos individuais, há características que auxiliam na elaboração do evento traumático, tais como: a constituição da capacidade de resiliência, a fase da vida que o evento traumático ocorreu e história pregressa. A internalização das representações de bons relacionamentos na infância, auxiliam na estruturação de sujeitos mais seguros e estáveis (GARLAND, 2015). Destaca-se que as representações são construídas desde as relações primárias com os cuidadores e resultam em esquemas mentais representativos do *self* e objeto que se desenvolvem ao longo do ciclo vital pelo próprio processo de amadurecimento, sendo que a experiências internalizadas são as bases para a construção de estruturas representacionais complexas (PRIEL *et al.*, 2007). Tais representações internalizadas são determinantes na regulação emocional e comportamental e funcionam como modelo representacional de si mesmo e dos demais e das relações interpessoais (BLATT, AUERBACH, LEVY, 1997; FONAGY, 1999; ZANATTA, BENETTI, 2012). Nesse sentido, há associação entre trauma vivenciado na infância e ocorrência de violência por parceiro íntimo (SAHIN *et al.,* 2010), já que esses sujeitos estabelecem um vínculo de dependência com o outro, em que as demais pessoas abusam dela até tornar-se desconfortável e degradante (MONTERO, 2001).

Pesquisadores apontam que o trauma, devido a constante violência, provoca mudanças no funcionamento estrutural psicológico e do conflito intrapsíquico (TASK FORCE, 2016). Em situações traumáticas como violência, no geral, pode haver o estabelecimento de estruturas psíquicas desorganizadas. Este funcionamento psicológico caracteriza-se pela cisão das representações de objeto, instabilidade nas relações, dificuldade na organização de um sentido de identidade e falhas na capacidade de mentalização / função reflexiva (KERNBERG, WEINER, BARDENSTEIN, 2003). Assim, há alteração das capacidades de *self* para manejar a experiência interna e a interação com os demais, tornam-se envolvido por vergonha e estigma, ocorre o surgimento de humor negativo e dificuldades em regular suas emoções no relacionamento com os demais (LANG *et al.,* 2008).

Demais autores apontam que há problemas no desenvolvimento da mentalização quando há traumas, cuja ruptura prejudica a capacidade de pensar e refletir sobre os estados mentais ou de relatar relacionamentos passados (BATEMAN, FONAGY, 2006, 2010; 2013; FONAGY, TARGET, 1997; WEINBERG, 2004). Em processo psicoterapêutico, há a reencenação traumática com a estimulação da capacidade de refletir

e mentalizar sobre o acontecido. E, pode-se proporcionar uma nova compreensão da violência vivenciada, produzindo novas representações (GABBARD, 2006).

Os mecanismos de defesa específicos podem estar relacionados à manifestação de sintomas psiquiátricos. Em situações de estresse ou trauma, há uma predisposição de estilos de defesa não adaptativos (BOND, PERRY, 2004; YONG JUN, 2015). As defesas são as mediadoras entre o mundo interno (desejos, pulsões e ansiedades) e o mundo externo do indivíduo, assim, determinando o tipo de relação do mesmo com o ambiente (LAPLANCHE, PONTALIS, 1991). Os mecanismos de defesa podem ser adaptativos e protetores aos conflitos do ego (BOND, GARDNER, CHRISTIAN, SIGAL, 1983). As defesas maduras são consideradas bem-sucedidas por conseguirem melhor adaptação entre mundo interno e externo. As neuróticas permitem que alguns componentes dos conteúdos mentais indesejáveis cheguem à consciência de forma encoberta e/ou distorcida através das formações de compromisso do conflito psíquico. Os mecanismos de defesa imaturos ou ineficazes são aqueles que acabam por constituir um ciclo de repetições, o que é característico nas neuroses e outras patologias (ANDREWS; SINGH; BOND,1993; BOND, PERRY, 2004).

De acordo com o modelo de trauma, a cisão é o mecanismo de defesa mais comum diante da IPV, cuja ansiedade e a experiência do perigo resultante do trauma podem levar a desregulação emocional. A cisão tem o potencial de alterar a autopercepção do indivíduo de uma maneira que a vítima se considera inútil ou responsável pela violência. E tais distorções cognitivas, por sua vez, podem levar a estados de humor negativos e comportamentos disfuncionais (SIGIEL, FORERO, 2012).

3.2 DINÂMICA DA VIOLÊNCIA POR PARCEIRO ÍNTIMO

A dinâmica da violência por parceiro íntimo implica em um padrão comportamental repetitivo nas relações. Conforme Slootmaeckers e Migerode (2019), a violência conjugal possui padrões de relacionamento mal adaptativos com ciclos de interação negativos. A perspectiva masculina caracteriza-se por condutas abusivas e coercitivas físicas ou não-físicas, havendo reconhecível desigualdade de poderes e jogo de forças. Já em relação ao comportamento feminino, há presença de temor com resposta de evitação, adaptação e submissão. A dinâmica estabelecida entre o casal é cíclica: acúmulo de tensões, crise e fase de reconciliação (CORTEZ *et al.,* 2010; CREMPIEN, 2009; KATZ, 2019; WALKER, 2016). Geralmente apresenta-se com um início lento e

silencioso sem apresentar agressão física; aos poucos progride para ações com maior intensidade e humilhação, até mesmo manifestação pública (LEÔNCIO *et al.,* 2008). E ainda, pode agravar-se devido a vergonha da mulher em denunciar, falta de meios educacionais e de acesso à informação jurídica e falta de assistência e proteção (SIGNORI, MADUREIRA, 2007). Nesse sentido, o conceito referente ao processo do fenômeno de violência doméstica chama-se "traumatização" (CREMPIEN, 2012). Na compreensão da IPV torna-se importante diferenciar o padrão do fenômeno da violência, já que esse pode manifestar-se com episódios de raiva e frustração que irrompem em ocasionalmente em forma de agressão ou também, pode demonstrar um padrão mais grave e crônico, apresentando-se diretamente através de violência psicológica ou física (SCHRAIBER *et al.,* 2007).

Segundo Falcke e Féres-Carneiro (2011), as mulheres que sofrem violência doméstica não são fáceis de serem identificadas, já que escondem as marcas devido a vergonha, mas possuem um caráter intenso que parecem modificar sua personalidade. Essa violência revela um aprisionamento em si mesmas, pois perdem o interesse pela convivência social na preferência da convivência no espaço do lar e chegam a naturalizar os comportamentos violentos.

Socialmente pode-se levantar que há a presença maciça da ideologia patriarcal no mundo, cuja violência associa-se a masculinidade. Os autores discutem sobre a dinâmica da violência entre o casal apresentar-se desde a escolha do parceiro, como uma reprodução dos padrões comportamentais violentos vivenciados na infância, e ainda, sobre a incapacidade das mulheres em refletir suas escolhas relacionais como consequência da dinâmica traumática e da falta de experiências emocionais significativas (COIMBRA, LEVY, 2015). Entretanto, percebe-se a necessidade de mais dados visando identificar com maior precisão as características estruturais do indivíduo, tais como relacionamento parental, conflito intrapsíquico prevalente, tipo e severidade da violência sofrida (CREMPIEN, 2012).

3.3 AVALIAÇÃO DAS VÍTIMAS DE VIOLÊNCIA DOMÉSTICA POR PARCEIRO ÍNTIMO A PARTIR DO OPD-2

Em contexto clínico, as vítimas de violência são consideradas pacientes difíceis, pois geram sentimentos contratransferencias de frustração (CREMPIEN, 2009); assim como, o tratamento de pacientes traumatizados é considerado provocador de sofrimento

psíquico para o terapeuta em função da carga emocional intensa e significativa (EIZIRIK *et al,* 2006). Diante disso, é necessária a avaliação específica desse contexto violento do paciente, procurando identificar os recursos e obstáculos do paciente, qual a explicação pessoal em relação a vitimização, o ganho secundário possível, ou seja, investigar as características e o funcionamento psicodinâmico auxiliam na avaliação e compreensão clínica desses pacientes; tal levantamento pode ser realizado conforme os Eixos dimensionais do OPD-2.

Dessa forma, houve uma adaptação específica do OPD-2 em relação ao Eixo I para avaliar mulheres que sofreram violência doméstica desenvolvido pela professora chilena Dra. Carla Crempien; apoiadora do projeto de pesquisa em questão. O Eixo I original do OPD-2 é chamado "v*ivência da doença e pré-requisitos para o tratamento",* focado na perspectiva saúde-doença. A partir dessa adaptação do Eixo I foi possível focar no contexto da violência doméstica: avaliar a gravidade da violência, o tipo (emocional, física, sexual), duração do problema de violência doméstica, intensidade do padecimento subjetivo, explicação pessoal do problema de violência doméstica, conceito de mudança e recursos e obstáculos para a mudança. A autora construiu critérios específicos para avaliar cada aspecto (CREMPIEN, 2009).

O Eixo II do OPD-2 é o eixo relacional (Relações interpessoais) que analisa os padrões desadaptativos ou disfuncionais relacionais do paciente. Avalia sob a perspectiva do paciente, no sentido de como ele descreve suas experiências relacionais e o seu próprio comportamento; e sob a perspectiva dos demais, que considera como os outros, inclusive o terapeuta, experenciam e percebem o relacionamento com o paciente. O objetivo do eixo é formular a dinâmica relacional do paciente, cuja percepção está relacionada à origem de conflitos intrapsíquicos e de relacionamento (TASK FORCE, 2016; KRIEGER, 2013). Essas percepções têm como base a internalização de representações das figuras primárias de apego que serviram como modelo para a configuração relacional futura (FONAGY *et al.,* 2002). É importante destacar que não é válido a informação de terceiros para a integração dos dados, pois o que realmente interessa é como o paciente vivencia o seu ciclo repetitivo interacional, seja ele adaptativo ou mal adaptativo. Coleta-se os dados a partir dos relatos dos episódios relacionais do sujeito e na dinâmica com o entrevistador (TASK FORCE, 2016).

O conflito – Eixo III – é considerado o aspecto central no entendimento psicodinâmico do paciente. Esse fenômeno refere-se ao tensionamento de motivações ou desejos opostos, internos ou externos, conscientes ou inconsciente, que culminam no

aparecimento de conflitos (TASK FORCE, 2016). Segundo Caligor, Kernberg e Clarkin (2008), os conflitos – motivações conflitantes ou impulsos – são padrões internalizados de relacionamento mantidos fora da consciência por mecanismos defensivos, protegendo o indivíduo de aspectos ameaçadores e dolorosos.

O OPD-2 avalia tanto o momento atual do paciente, como o biográfico, pois são configurações continuadas, repetitivas e inconscientes na vida do sujeito, dessa forma se diferencia do estresse atual pela avaliação longitudinal. Os conflitos, também identificados pelo afeto guia, comportam-se de modo passivo ou ativo a partir das perspectivas: família de origem, laboral, social, relacionamento conjugal e em relação à enfermidade.

Há sete conflitos que integram o OPD-2: individuação *versus* dependência; submissão *versus* controle; necessidade de ser cuidado *versus* autossuficiência; conflito de autoestima; conflito de culpa; conflito edípico; conflito de identidade (TASK FORCE, 2016; KRIEGER, 2013). Em estruturas muito desintegradas pode ocorrer diversos conflitos atuando concomitantemente, não havendo um padrão prevalente; dessa forma, não é possível avaliar esse eixo. Assim como invalida-se o eixo, quando as defesas do ego estão encobrindo o real funcionamento do sujeito, havendo insegurança diagnóstica (TASK FORCE, 2016).

O eixo estrutural – Eixo IV –, avalia o nível de integração das capacidades ou limitações do paciente na regulação das funções mentais capazes de estabelecer a homeostasia interna, nos últimos dois anos. Comporta oito funções: autopercepção; percepção do objeto; autorregulação; regulação do objeto; comunicação interna; comunicação com o mundo externo; capacidade de vinculação dos objetos internos; capacidade de vinculação dos objetos externos. Tais funções integram as capacidades do *self* na regulação da sua experiência interna e no manejo da sobrecarga e estresse, permitindo a elaboração e a adaptação. É resultado de um processo de maturação e do desenvolvimento de representações internas do mundo (TASK FORCE, 2016). O seu entendimento compõe os padrões de apego precoces a partir da internalização de representações mentais (KRIEGER, 2013).

Observa-se que em situação de trauma, como foi comentado, há déficits na capacidade de mentalização, que são avaliados nesse eixo. É importante diferenciar o déficit estrutural e a vulnerabilidade da estrutura. Os déficits caracterizam-se por representações internas inseguras que não permitem a regulação de si mesmo, apresentando variados obstáculos internos. Já a vulnerabilidade é uma instabilidade

devido a estímulos estressores que tendem a desorganizar os recursos do sujeito, estabelece-se um estado regressivo no sujeito que culminam em desregulação afetiva e da autoestima. E por fim, tem-se no Eixo V a compreensão do diagnóstico conforme o DSM ou CID (TASK FORCE, 2016).

Os dados dos respectivos eixos são identificados através da entrevista clínica, pelo discurso e conduta do paciente, e também pela observação do terapeuta, seja pela contratransferência ou inferência de questões (TASK FORCE, 2016). São dados que compõem um sistema diagnóstico e investigativo pertinentes no âmbito clínico-psicoterapêutico (CIERPKA *et al.,* 2010), que auxilia no planejamento das intervenções e também, pode ser usado no treinamento de futuros psicoterapeutas (VICENTE *et al.,* 2012). Cada um desses eixos foi operacionalizado em um inventário diagnóstico, formulado por meio de abstração para avaliar os processos observáveis e descritos (PÉREZ *et al.,* 2009).

Dessa forma, a indicação, o foco e o planejamento terapêuticos se dão pela integração dos respectivos eixos: o Eixo I compreende a indicação e motivação terapêuticas; Eixo II – Relacional, cujo padrão de relacionamento é avaliado; Eixo III – Conflito, em que há a expressão dos conflitos ou vulnerabilidades das representações interpessoais; e Eixo IV – Vulnerabilidades e capacidades estruturais, o qual avalia-se tais capacidade e habilidades do paciente. Diante desse diagnóstico dimensional seleciona-se o foco: conflito, estrutura ou ambos; mas sempre elegendo o foco estrutural (Eixo IV) primeiro caso haja desintegração, pois é um pré-requisito para o desenvolvimento do conflito (Eixo III) e consequentemente do padrão relacional disfuncional (Eixo II).

Localizou-se apenas um único estudo referente a aplicabilidade do OPD-2 no contexto da violência; trata-se de um estudo chileno com 28 mulheres oriundas de um centro atendimento de violência doméstica em Santiago. As mulheres que demonstraram maior gravidade da violência foram aquelas que relataram maior presença de sintomas depressivos, TEPT e baixa escolaridade. Complementar, prevaleceu o conflito principal: necessidade de ser cuidado *versus* autossuficiência (39%), seguido pelo secundário: submissão *versus* controle (50%) que podem estar relacionados a revitimização (CREMPIEN, 2012).

Assim como, o funcionamento global das mulheres vítimas de violência sexual apresentou-se pior que as demais vítimas, já que sofrem concomitante a violência psicológica e física; em que se sugere um acúmulo de múltiplos traumas. A autora ainda

estima que com a interrupção da violência e o processo de recuperação da paciente é possível que a respectiva mulher seja capaz de recobrar seus recursos internos, já que a estrutura psíquica é uma organização dinâmica. Dessa forma, a estrutura vulnerável devido ao trauma sofrido é considerada um obstáculo para a vítima manejar suas emoções e o estresse. Pela compreensão dimensional foi possível identificar recursos e obstáculos a serem trabalhados em psicoterapia, cuja relação terapêutica pode ser uma oportunidade de uma configuração relacional que oferece o desenvolvimento de representações internas de vínculo seguro. Assim, o tratamento também é uma forma de prevenir a revitimização e construir mecanismos de enfrentamento mais adaptativos (CREMPIEN, 2012).

Os resultados do OPD-2 integram informação clínica que auxiliam na indicação e planificação da terapia, oportunizando uma compreensão do funcionamento psicodinâmico do paciente de forma mais clara que pode facilitar a compreensão do contexto clínico de vítimas de violência. Dessa forma, destaca-se a importância de investigação das características de vítimas brasileiras com a aplicabilidade do OPD-2 em tal contexto; como realizado nesse projeto de pesquisa.

4 JUSTIFICATIVA

A violência contra mulher perpetrada por parceiro íntimo é um fenômeno extremamente complexo que possui raízes nas relações de poder entre gênero – homem e mulher – e apresenta-se como um conjunto de comportamentos deliberados, autoritário e progressivo a partir de ameaças e agressões (LEÔNCIO *et al.,* 2008). E ainda, tem se destacado entre os pesquisadores no cenário internacional como um dos principais problemas da sociedade, pois é um fenômeno que impacta gravemente a qualidade de vida e a saúde das vítimas e das pessoas próximas (LOURENÇO; BAPTISTA, 2013).

A clínica com pacientes vítimas de violência por parceiro íntimo é considerada um desafio tanto à aderência das mulheres como para o terapeuta suportar toda a demanda emocional (CREMPIEN, 2009). Dessa forma, torna-se indispensável um conhecimento consistente e claro baseado em evidências empíricas sobre o funcionamento dinâmico, sob uma perspectiva traumática, para que se possa focar em questões pertinentes e específicas dessa população: constituição dos impasses e obstáculos do contexto violento, disfuncionalidades em função de um estresse *versus* estrutura de personalidade vulnerável, recursos intrapsíquicos desses sujeitos.

Nesse sentido, um diagnóstico dimensional em complemento ao descritivo é uma necessidade clínica que facilita a compreensão do sujeito e o planejamento clínico, oferecendo uma estimativa da dinâmica interna e sobre o significado da sintomatologia apresentada. Diante disso, o OPD-2 é um instrumento que integra constructos psicodinâmicos de uma forma operacionalizada em formulários de avaliação multiaxial. A operacionalização oportuniza um conhecimento e prática a respeito da psicodinâmica do paciente, havendo mais clareza no planejamento e foco terapêutico do sujeito, assim como facilita a comunicação entre a comunidade científica (BERNARDI, 2010; TASK FORCE, 2016).

É escasso os instrumentos que operacionalizem os constructos psicodinâmicos, tanto a nível internacional como nacional (KRIEGER, 2013) e principalmente no contexto de violência por parceiro íntimo contra a mulher, cujas variáveis que integram a violência são peculiares. Assim, destaca-se a necessidade de pesquisa com a aplicação do instrumento OPD-2 no contexto de violência doméstica, já que os resultados podem servir de instrumental da investigação diagnóstica, contribuindo para o aprimoramento da psicoterapia e compreensão do funcionamento dinâmico dessas mulheres.

Complementar a essas questões, localizou-se apenas um estudo integrando o contexto de violência doméstica à compreensão psicodinâmica operacionalizada referentes à população chilena que possui características contextuais próprias, por exemplo, altos índices de depressão na população no país. Os estudos propostos desta tese são inéditos, pois há aplicabilidade do OPD-2 no contexto da violência doméstica brasileira; há associação entre as variáveis do funcionamento psicológico das mulheres e os mecanismos de defesa; bem como, há a proposta de um estudo longitudinal que avalia o resultado baseado no foco terapêutico. Dessa forma, evidencia-se a necessidade de pesquisas para a construção de evidências próximas a realidade brasileira.

5 OBJETIVOS

O objetivo central é investigar as características do funcionamento psicodinâmico de mulheres vítimas de violência por parceiro íntimo, sob uma perspectiva dimensional operacionalizada. Para atingir esse objetivo, o projeto foi composto por sete estudos.

Estudo 1: Averiguar estudos empíricos que utilizaram o OPD-2 como instrumento, verificando as temáticas e os resultados das pesquisas que utilizaram o OPD-2 empiricamente.

Estudo 2: Compreender a psicodinâmica da mulher no ciclo de violência, levando em consideração os aspectos do trauma psicológico.

Estudo 3: Elaborar a versão em português do *Module for Domestic Violence Assessment* – Eixo I do Diagnóstico Psicodinâmico Operacionalizado (OPD-2), considerando a validade de conteúdo e as propriedades psicométricas.

Estudo 4: Investigar o diagnóstico psicodinâmico operacionalizado de mulheres vítimas de violência doméstica, explorando a gravidade e a experiência da violência, funções estruturais, padrões interpessoais disfuncionais e conflitos intrapsíquicos.

Estudo 5: Analisar a classificação do texto com nuvem de palavras como ferramenta para entender o padrão de funcionamento psicológico da paciente, complementando a análise qualitativa.

Estudo 6: Identificar os mecanismos defensivos predominantes em violência por parceiro íntimo e investigar a relação entre o estilo defensivo e o funcionamento psicodinâmico baseados no OPD-2.

Estudo 7: a) avaliar o resultado terapêutico de um período de quatro meses em psicoterapia psicodinâmica em uma mulher vítima de violência por parceiro íntimo, com base no planejamento e foco terapêutico do Diagnóstico Psicodinâmico Operacionalizado (OPD-2); b) identificar alterações na sintomatologia da paciente, incluindo aspectos da dinâmica da paciente e a possível quebra do ciclo de violência.

6 MÉTODO

6.1 DELINEAMENTO

Estudo 1: Foi realizada uma revisão sistemática das produções científicas, conforme orientações da Plataforma PRISMA (*Preferred Reporting Items for Systematic Reviews*). A estratégia de buscou incluir o cruzamento dos descritores *"Operationalized and psychodynamic and diagnosis"* a partir das bases de dados *PubMed, Capes* Periódicos, Google Acadêmico, bem como em materiais não publicados provenientes do contato direto com pesquisadores na área. A busca dos artigos foi feita em janeiro de 2018. Foram incluídos os artigos, dissertações ou teses empíricas dos últimos cinco anos (2012 a 2017) que abordaram ou utilizaram o instrumento OPD-2. Foram excluídos os artigos teóricos, artigos em duplicidade, artigos que estavam em outras línguas que não fossem inglês, português ou espanhol, e artigos sem acesso ao documento completo. Foram analisados um total de 20 estudos.

Estudo 2: Trata-se de um estudo qualitativo e transversal, cujo foco foi a análise de conteúdo das entrevistas. A construção do estudo foi baseada nos Critérios Consolidados para Relato de Pesquisas Qualitativas - *Consolidated criteria for reporting qualitative research* (COREQ; TONG, SAINSBUTY, CRAIG, 2007). A amostra foi composta por 10 mulheres vítimas de violência doméstica, por saturação de dados. A coleta de dados foi baseada na Entrevista Clínica do OPD-2 no momento que estavam fazendo o exame de corpo de delito e as entrevistas foram audogravadas e transcritas. A análise de conteúdo foi realizada a partir de categorias criadas *a posteriori:* 1) História prévia; 2) aspectos comportamentais; 3) aspectos emocionais; 4) Razão para estar no relacionamento; 5) Tipo de violência e explicação para o motivo da violência; 6) Rede de apoio e atividades diárias; 7) Encaminhamento clínico e jurídico.

Estudo 3: Este estudo foi delineado com base no Método de Adaptação Transcultural e Validação, segundo as recomendações do *Guidelines for the Process of Cross-Cultural Adaptation of Self-Report Measures*, que consistem em seis etapas interdependentes: 1) tradução inicial para o português brasileiro; 2) síntese das traduções; 3) retrotradução; 4) avaliação da documentação por comitê de juízes especialistas; 5) pré-teste; 6) apresentação da documentação aos juízes especialistas e ao autor do instrumento original (BEATON *et al.,* 2000; 2007). Participaram 56 mulheres vítimas de violência doméstica.

Estudo 4: Estudo exploratório (GIL, 2002), quantitativo (CRESWELL, 2010), transversal (SANTOS, 1999), com desenho de confiabilidade entre juízes (CUNHA, 2000). Participaram 56 mulheres vítimas de violência doméstica de um serviço público especializado no sul do Brasil. Foram incluídas mulheres de 18 a 65 anos vítimas de violência doméstica autorreferida que procuraram o serviço durante o período de coleta de dados em que o pesquisador estava presente, em dezembro de 2017.

Estudo 5: Trata-se de um estudo de classificação de texto com uma técnica de análise de nuvem de palavras, complementar à análise qualitativa. Participaram 56 mulheres vítimas de violência doméstica autorreferida, provenientes de um serviço público no sul do Brasil. Foram incluídas todas as mulheres que estavam presentes nos dias de coleta em dezembro de 2017 e concordaram em participar do estudo. O código Python foi usado como base para o desenvolvimento da nuvem de palavras.

Estudo 6: Estudo quantitativo e transversal. Participaram 42 mulheres vítimas de violência doméstica autodeclarada oriundas de um serviço público no sul do Brasil. Foi utilizado um questionário sócio demográfico, o *Defensive Style Questionnaire* (DSQ-40) e a Entrevista Clínica do OPD-2 – audiogravadas, transcritas e codificadas.

Estudo 7: Trata-se de um estudo de caso que avalia processos inter-relacionados em uma perspectiva temporal (SERRALTA, NUNES, EIZIRICK, 2011) com vítima de violência por parceiro íntimo. Os dados iniciais e finais foram selecionados para análise (análise de resultado), cujo foco terapêutico se deu no desenvolvimento da capacidade de autopercepção e percepção do objeto.

6.2 CARACTERIZAÇÃO DA AMOSTRA

Estudo 1: A seleção dos 155 estudos localizados se deu em duas etapas: *screened 1* com leitura apenas dos resumos; *screened 2* com a leitura na íntegra da pesquisa. Dessa forma foram excluídos 145, e em seguida, foram incluídos quatro estudos não publicados nas bases de dados. Dessa forma, foram analisados um total de 20 estudos.

Estudo 2: Foram incluídas as 10 primeiras mulheres entrevistadas oriundos do estudo maior com 56 mulheres.

Estudos 3, 4, 5: Foram incluídas 56 mulheres vítimas de violência autodeclarada entre 18 e 65 anos de idade oriundas de um serviço público pericial e de acolhimento da capital do Rio Grande do Sul, Brasil. Trata-se de uma amostra por conveniência, conforme o dia que a pesquisadora estava presente no plantão do serviço. As participantes

buscaram o serviço com o intuito de realizar a perícia médica para compor a denúncia contra o marido e, na maioria dos casos, solicitar a medida protetiva oriunda da Lei Maria da Penha (Lei 11.340/06; BRASIL, 2006). Ainda, tal serviço caracteriza-se pelo acolhimento psicossocial das vítimas, oferecendo uma escuta e orientações de procedimentos legais e encaminhamentos assistenciais e terapêuticos necessários.

Foi considerado o cálculo amostral utilizado por Krieger (2013) na validação do instrumento. O cálculo foi realizado pelo Hospital de Clínicas de Porto Alegre, em que se considerou o número de itens do instrumento OPD-2 e os dados da literatura sobre a concordância entre juízes avaliadores para os diferentes eixos do instrumento. Dessa forma, o número de entrevistas foi calculado para cada eixo independentemente: Eixo 1: 53 entrevistas; Eixo 2: 52 entrevistas; Eixo 3: 53 entrevistas; Eixo 4: 25 entrevistas. Dessa forma, serão considerados um mínimo de 53 participantes para compor a amostra desses estudos.

Estudo 6: Das 56 mulheres da amostra completa, foram incluídas apenas 42 mulheres que responderam ao DSQ-40, já que nem todas as mulheres possuíam uma formação escolar para a compreensão de um instrumento autoaplicável.

Estudo 7: Foi incluído um caso que participou do Estudo 3, 4 e 5. A escolha da paciente foi realizada por disponibilidade e motivação ao tratamento, já que, conforme a literatura, mulheres vítimas de violência são pacientes de difícil aderência psicoterapêutica. A paciente permaneceu em psicoterapia ao longo de quatro meses.

6.3 INSTRUMENTOS

6.3.1 Dados Sociodemográficos

Foi utilizado um levantamento de dados sociodemográficos referente às características pertinentes para o estudo, tais como: idade, nível de escolaridade, renda familiar, tempo de relacionamento conjugal, com que vive, uso de drogas, existência de violência parental (transgeracionalidade da violência), entre outros (ANEXO A). O questionário foi baseado no estudo desenvolvido por Lourenço e Baptista (2013) na sua pesquisa para validação da Escala de Violência entre Parceiros Íntimos.

6.3.2 Diagnóstico Psicodinâmico Operacionalizado (OPD-2)

Para os estudos 3, 4, 5, 6 e 7 foi utilizado o OPD-2 que possui como objetivo a operacionalização de constructos psicodinâmicos e formulação de um diagnóstico psicodinâmico multiaxial, bem como planejamento e foco terapêuticos (TASK FORCE, 2016). E para o Eixo I, foi utilizado a adaptação e validação cultural do Eixo, *"Módulo de Evaluación de Violencia Doméstica"* da professora Carla Crempien (2009) da Pontificia Universidad Católica de Chile.

O OPD-2 compreende uma entrevista semiestruturada com ferramentas de entrevista específicas para a exploração de cada eixo, descritas no manual nas páginas 498 a 524; assim foi utilizada a chamada *Entrevista Clínica do OPD-2* (ANEXO B). Essa entrevista tem duração de aproximadamente uma hora. Para a codificação, há critérios para a pontuação de cada item conforme o manual e ao final codifica-se na planilha de avaliação arrimo o ANEXO C (TASK FORCE, 2016). E, especificamente para a codificação no contexto da violência doméstica, utilizou-se o Eixo I anexado no ANEXO D. Por fim, o foco terapêutico do Estudo 3 baseou-se nas indicações descritas no OPD-2 (TASK FORCE, 2016) em que se planificou conforme o ANEXO E.

Os juízes avaliadores foram duas psicólogas que realizaram o curso de formação no OPD-2 na *Pontificia Universidad Católica de Chile*. Cada um dos juízes avaliadores codificou os variados aspectos psicodinâmicos a partir das dimensões e indicadores descritos no manual independentemente (ANEXO F). Para cada um dos indicadores, avaliou-se as pontuações: 0 (ausente), 1 (leve/insignificante), 2 (moderado), 3 (elevado/significativo), 4 (muito grave/muito significativo), 9 (não-avaliável); conforme planilha de codificação apresentada, cujo manual detalha e descreve cada pontuação. Estimou-se uma hora para realizar o diagnóstico completo (PÉREZ *et al.,* 2009).

A validação chilena do OPD-2 apresentou significativa concordância entre juízes avaliadores: 75% no eixo II, 73,3 no eixo III, 62% no eixo I e 53,3 no eixo IV (PÉREZ *et al.,* 2009). Em Brasil/Portugal: 78% no eixo IV, 66% no eixo I, 57,7% no eixo III e o eixo II foi excluído (VICENTE *et al.,* 2012). E. tal versão em português, conforme Krieger (2013), há propriedades psicométricas adequadas para a aplicabilidade do OPD-2 na população brasileira.

Nesta presente tese, a concordância entre os juízes foi substancial em cada eixo; 63% no módulo de violência do Eixo I, 73% no Eixo III, 82% no Eixo IV e 100% no Eixo V. No Eixo II, foi considerado os itens mais pontuados pelos juízes a partir da análise

descritiva dos itens. E no Eixo V, o diagnóstico descritivo foi identificado pela observação clínica do paciente.

6.3.3 Defensive Style Questionnaire (DSQ-40)

No Estudo 6 também foi utilizado o *Defensive Style Questionnaire* - DSQ-40 (ANEXO G). O instrumento foi desenvolvido para avaliar os derivativos conscientes dos mecanismos de defesa. A validação oficial e reorganização do instrumento na sua forma atual foi realizada por Andrews, Singh e Bond (1993).

O DSQ-40 é um questionário autoaplicável de estilos defensivos compostos por 40 itens relacionados às defesas descritas no DSM-III-R. Cada item é pontuado de 1 a 9 em conformidade com o grau de concordância às assertivas. O instrumento avalia 20 tipos de defesa (2 itens para cada) cuja pontuação corresponde à média dos escores daquele fator. O instrumento avalia cinco defesas maduras (sublimação, humor, antecipação, supressão e racionalização), quatro estilos de defesa neurótica (anulação, pseudoaltruísmo, idealização e formação reativa) e as onze restantes são consideradas imaturas (projeção, agressão passiva, atuação, isolamento, desvalorização, fantasia, deslocamento, dissociação, cisão, racionalização e somatização).

O DSQ-40 já foi traduzido e validado em diferentes países. A versão adaptada para o Brasil foi desenvolvida por Blaya e mostrou índices de fidedignidade avaliada pelo coeficiente alpha de Cronbach de 0,77 para o estilo imaturo, de 0,68 para o estilo maduro, e de 0,71 para o estilo neurótico. A estabilidade temporal (teste-reteste de quatro meses) exibiu os seguintes coeficientes: 0,81 (estilo imaturo); 0,68 (estilo maduro) e 0,71 (estilo neurótico; BLAYA, 2005).

6.4 PROCEDIMENTOS DE COLETA DE DADOS

No momento da triagem a vítima foi convidada a participar voluntariamente da pesquisa durante o serviço especializado. A paciente respondeu a ficha de dados sociodemográficos e o DSQ-40. Na sala do especialista, a pesquisadora realizou uma entrevista, a Entrevista Clínica do OPD-2, bem como proporcionou orientações sobre procedimentos de segurança e os direitos garantidos pela Lei Maria da Penha para as vítimas (BRASIL, 2006). Essas entrevistas foram gravadas em áudio e transcritas. Especialmente nos Estudos 2 ao 6, considerou-se a entrevista inicial e no Estudo 7 foram avaliadas as entrevistas durante o período de atendimento com a paciente em questão.

6.5 PROCEDIMENTOS ÉTICOS

O estudo está de acordo com Resolução nº. 466/12 do Conselho Nacional de Saúde (CNS; BRASIL, 2012). Este estudo foi aprovado pelo Comitê de Ética da Universidade Federal do Rio Grande do Sul (CAAE 68271917.7.0000.5347; parecer no. 2.412.749; ANEXO H). Assim como houve anuência do Departamento Médico Legal de Porto Alegre para a realização da coleta de dados no local (ANEXO I).

Os sujeitos participantes neste trabalho foram informados dos objetivos da pesquisa e foram convidadas a participar do trabalho de forma voluntária. Àqueles que demonstrarem interesse em participar assinaram o Termo de Consentimento Livre e Esclarecido (TCLE). O anonimato das participantes foi assegurado, bem como o pedido para sair do estudo a qualquer momento do andamento da pesquisa. Destaca-se que o tema em questão é bastante delicado para as pacientes, podendo haver, durante a coleta de dados, mobilizações ou algum desconforto; assim, foi oferecido um espaço de escuta e acolhimento durante a coleta de dados. Também, neste caso, foi frisado à paciente a necessidade de acompanhamento psiquiátrico e/ou psicológico, pois são mulheres oriundas do ambulatório que já possuem encaminhamento para atendimento. Os dados serão guardados por cinco anos, sob posse exclusivamente das pesquisadoras.

Em relação ao instrumento, foi solicitada a autorização para a utilização do *Operationalized Psychodynamic Diagnosis* no Brasil ao presidente do *OPD Group*, Dr. Manfred Cierpka e da Carla Crempien que realizou a adaptação do Eixo I para avaliar as mulheres que sofreram violência doméstica. Foi solicitado a autorização para tradução e adaptação cultural à Carla Crempien para o Eixo 1. A autora do instrumento permitiu a tradução e adaptação do instrumento, em que também aprovou a versão final da tradução, sendo coautora do respectivo artigo – Estudo 3.

6.6 PROCEDIMENTOS DE ANÁLISE DE DADOS

Em relação as variáveis sociodemográficas foi realizada a caracterização da amostra. As entrevistas foram distribuídas a dois juízes avaliadores para operacionalizar a Entrevista Clínica do OPD conforme a planilha de codificação com os indicadores do manual. Os juízes avaliadores são *experts* no OPD-2 que já obtiveram treinamento específico no sistema multiaxial. Um dos juízes foi a pesquisadora que coletou, porém, o

manual do OPD possui indicadores muito objetivos de codificação e há outro juiz balizador para assegurar a fidedignidade e confiabilidade de tais indicadores.

Dessa forma, as entrevistas foram avaliadas a confiabilidade entre juízes, com reprodução de uma medida com avaliadores diferentes através do cálculo do coeficiente *Kappa* (PERROCA, GAIDZINSKI, 2003). Analisou-se a confiabilidade de cada entrevista e de cada eixo separadamente, especialmente o Eixo I, na concordância entre os juízes. A análise estatística sobre confiabilidade e consistência interna do instrumento, segundo Pasquali (2009), é fundamental para a confiabilidade e fidedignidade do instrumento. Estimou-se que o estudo tivesse poder de 70% e $p<0,05$.

Posteriormente, todas as variáveis sociodemográficas, do OPD-2 e do DSQ-40 foram inseridas em um banco de dados no SPSS (*Statistical Package for the Social Science;* IBM, 2014). Foram realizadas análises descritivas, bivariadas e multivariadas para investigar as relações e consequentemente aprofundar a compreensão dinâmica das mulheres vítimas de violência por parceiro íntimo, conforme o objetivo de cada estudo.

7 ARTIGO 1. OPERATIONALIZED PSYCHODYNAMIC DIAGNOSIS: A Systematic Review of the Literature

- Revista: ***Trends in Psychiatry and Psychotherapy***
- Qualis na Área de Medicina II – Classificação de Periódicos Quadriênio 2013-2016: **B3**
- http://dx.doi.org/10.1590/2237-6089-2018-0020

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ABSTRACT

Introduction: The Operationalized Psychodynamic Diagnosis (OPD-2) is an operational multiaxial diagnostic assessment and treatment planning tool. This systematic review sought to analyze empirical studies that used the OPD as an instrument. In addition to identifying the studies, we analyzed the topics covered and the results of research that used the OPD empirically.

Method: Articles, dissertations and empirical theses that mentioned or used the OPD instrument in the last five years (2012-2017) were included in this review. The strategy included searching with combinations of the descriptors "Operationalized and psychodynamic and diagnosis" from the Portal de Periódicos CAPES on the PubMed, Google Scholar, and ResearchGate databases for work published in English, Portuguese or Spanish in the last five years.

Results: The search returned a total of 189 papers, but only 20 were included. The studies selected discussed the validity and reliability of the instrument, the therapeutic process and analysis of outcomes, assessment of different mental disorders, and also included studies comparing different instruments and techniques. Considerable scientific effort has evidently been dedicated to accumulating more consistent data on psychodynamic diagnosis.

Conclusion: It was demonstrated that the OPD is an essential clinical tool for dimensional comprehension of the subject and for scientific research. However, the number of publications on the subject is not yet significant and the methods employed are diverse. Nevertheless, there is a growing body of data on topics such as applicability in different contexts and to different pathologies, promoting greater visibility and with greater representativeness of professionals who have experience with the instrument.

Keywords: Diagnosis, assessment, psychodynamics, review.

RESUMO

Introdução: O Diagnóstico Psicodinâmico Operacional (OPD-2) é uma ferramenta operacional de avaliação diagnóstica multiaxial e planejamento terapêutico. Esta revisão sistemática buscou analisar estudos empíricos que utilizassem o OPD como instrumento; além de identificar os estudos, foram verificados os tópicos e resultados de pesquisa que utilizaram empiricamente o OPD.

Método: Foram incluídos os artigos, dissertações e teses empíricas dos últimos cinco anos (2012 a 2017) que abordaram ou utilizaram o instrumento OPD. A estratégia de busca incluiu o cruzamento dos descritores "Operacionalizado e Psicodinâmico e Diagnóstico", do Portal de Periódicos CAPES, nas bases de dados do PubMed, Google Scholar, ResearchGate, publicado em inglês, português ou espanhol nos últimos cinco anos.
Resultados: A busca resultou em um total de 189 artigos, mas apenas 20 foram incluídos. Os estudos selecionados trataram da validade e confiabilidade do instrumento, processo terapêutico e análise de resultados, avaliação de diferentes transtornos mentais e estudos comparativos com diferentes instrumentos ou técnicas. Um notável esforço científico no desenvolvimento de dados mais consistentes sobre o diagnóstico psicodinâmico.
Conclusão: Demonstrou-se que a OPD é uma ferramenta clínica essencial em relação à compreensão dimensional do sujeito e em pesquisas científicas. No entanto, o número de produções sobre o assunto ainda não é significativo, os métodos são diversos, mas os dados estão crescendo, como: a aplicabilidade em diferentes contextos, diferentes patologias, promover maior visibilidade com maior representatividade de profissionais que possuem conhecimento do instrumento.
Descritores: Diagnóstico, avaliação, psicodinâmica, revisão.

Introduction

An instrument called the Operationalized Psychodynamic Diagnosis was created in Germany in 1992 (*Operationalisierte Psychodynamische Diagnostik*, OPD), integrating the psychodynamic dimension with descriptive symptomatology. One of the reasons for creating the OPD was the existence of limitations affecting previous diagnostic classifications such as the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases and Related Health Problems (ICD-10), which employ symptom-centered diagnosis. The current version of the operationalized manual is the 2nd edition and it has been validated in the following languages: German, Spanish, Portuguese (Portugal and Brazil),[1-3] and English.

The OPD-2 is a multiaxial diagnostic system comprising five axes; the first four focused on psychodynamic understanding and the last one on description, as follows: I) experience of illness and prerequisites for treatment; II) interpersonal relationships; III) psychic conflict; IV) psychic structure; V) traditional nosological diagnosis, such as DSM-5 and ICD-10. Each axis has specific assessment categories, as shown in Table 1. The objective of the OPD-2 is a psychodynamic formulation, describing the patient's

main problems and identifying their resources and skills. More specifically, the OPD complements the descriptive indicators of the DSM and ICD from a psychodynamic point of view, proposing therapeutic foci and treatment plans tailored to each patient, linking a cross-sectional diagnostic evaluation (five diagnostic axes) with a longitudinal evaluation (assessment of the process of change in each axis with treatment planning) and supporting a diagnostic and therapeutic classification of change in empirical investigations with a psychoanalytic focus.[1-6]

Table 1 - Description of the axes of the Operationalized Psychodynamic Diagnosis (OPD-2)

Axes	**Dimension**	**Indicator**
Axis I - Illness experience and prerequisites for treatment	Objective assessment of illness/problem	1.Current severity of illness/ problem
		2. Period of illness/problem
	Patient experience, presentation and conceptualization of the illness	3. Experience and presentation of the disease
		4. Conceptualization of the illness by the patient
		5. Conceptualization of change by the patient
	Resources and resistance to change	6. Resources for change
		7. Resistances to change
Axis II - Interpersonal relations	Perspective A: Patient experience	The patient perceives himself as...
		The patient perceives others as...
	Perspective B: The perception of others (including of the researcher)	Others perceive the patient as...
		Others perceive themselves as...
Axis III - Conflict	Repetitive dysfunctional conflicts	1. Individuation versus dependency
		2. Submission versus control
		3. The need for care versus self-sufficiency
		4. Conflict of self-esteem
		5. Conflict of guilt
		6. Oedipal conflict
		7. Identity conflict
	How the main conflict is handled	Predominantly active
		Mixed more active
		Mixed more passive
		Predominantly passive
Axis IV - Structure	Cognitive abilities	1a. Self-perception
		1b. Perception of the object
	Regulation	2a. Self-regulation
		2b. Regulation of the object relation
	Emotional communication	3a. Internal communication
		3b. Communication with the outside world
	Attachment	4a. Internal objects
		4b. External objects
Axis V - Mental and psychosomatic disorders	Mental disorders	Main/additional diagnostics
	Personality disorders	Main/additional diagnostics

Note: Vicente et al.[3]

The OPD-2 is considered one of the main instruments for clinical diagnosis, planning, and scientific research in the international context. It's also used for training future psychotherapists.[3] It is a rigorous and standardized psychodynamic diagnostic method with specific assessment criteria to facilitate communication in the scientific community and for applying research to clinical practice.[5] In Germany and Switzerland, the OPD-2 is considered an essential resource for certifying the quality of interventions, both in the hospital setting and in the traditional clinic, to assess the evolution and progress of treatment, and from this point on provide a new plan and psychodynamic understanding of the patient.[3] This diagnostic tool enables assessment, both quantitatively and qualitatively, of change variables (symptoms, relational patterns, conflicts, and structure), efficacy, and the therapeutic relationship in an operationalized form, and also adjustment of treatment planning; it therefore enables process and outcome research.[1]

Considering the important contribution made by the OPD, from the perspectives of both diagnostic assessment and of psychotherapeutic planning, and also to operationalization of psychodynamic concepts, this systematic review sought to analyze empirical studies that used the OPD as an instrument. Therefore, in addition to identifying the studies, we also analyzed the topics covered and the results of research that used OPD empirically.

Method

A systematic review of the scientific production was carried out according to PRISMA Platform guidelines. The strategy involved searching for combinations of the descriptors "Operationalized and psychodynamic and diagnosis" from Portal de Periódicos CAPES on PubMed, Google Scholar, and ResearchGate as well as in unpublished studies identified by direct contact with researchers in the area. The search for articles was performed in January 2018.

Articles, dissertations and empirical theses that mentioned or used the OPD instrument in the last five years (2012-2017) were included in this review. Theoretical articles, duplicated articles, articles in languages other than English, Portuguese or Spanish, and articles without access to the complete document were excluded from this review.

We sought to control for possible selection biases by searching the databases at two different times using the same descriptors. Also, authors on the subject were contacted about possible unpublished articles to include in this review; however, we are

cannot be sure to have contacted all authors, because of the vast number of researchers on the matter. Another issue is the exclusion of articles in foreign languages such as German and French, which could possibly have enriched the discussion in this review. In relation to assessment of articles included, each article was analyzed separately, seeking to understand how the OPD was used in each study. One important limitation is the fact that the researchers are not specialized in the neurobiological aspects that some articles elaborate further on; in this sense, some aspects have been described-superficially.

Results

Selection of studies from among the 189 identified by searches took place in two stages: 1st screening, reading of abstracts only; 2nd screening, a complete reading of the study. Thus, 166 studies were excluded, and then four unpublished studies were included in the databases. Hence, a total of 20 studies were analyzed (Figure 1).

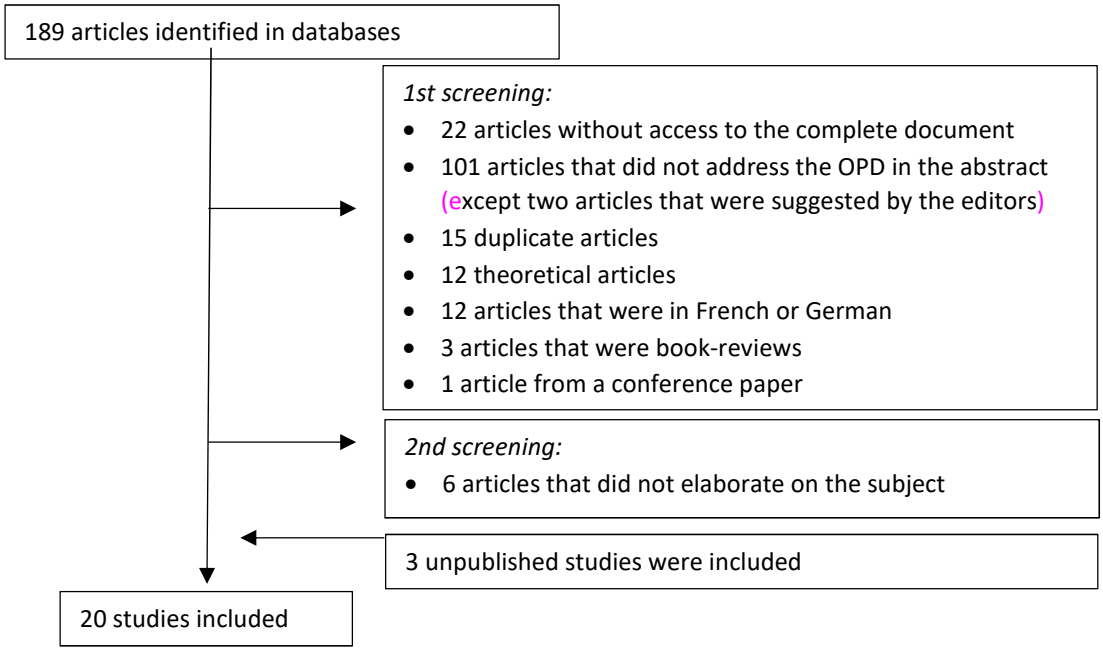

Figure 1 - Selection of articles included in and excluded from the systematic review.

The central theme addressed in relation to the OPD instrument varied. There were articles on psychometric validation of the instrument (n = 2), studies in different contexts and with a variety of psychopathologies – PTSD, depression, personality disorder, eating disorder, conduct disorder – (n = 13), and comparative studies or studies proposing new techniques (n = 5). In regards to the locations where research was conducted, it was found that Chile (n = 6), Germany (n = 5) and Brazil (n = 3) lead in empirical research with the OPD, although one Brazilian publication is still in the editorial process, with submission approved; followed by Italy (n = 1), Portugal (n = 1), Argentina (n = 1), the United States (n = 1), and Australia (n = 1). It should be considered that these data would be different if articles in German had not been excluded. The periods in which the greatest numbers of articles were published were from 2012 to 2014 and 2017. It is evident that investigation of the operationalized psychodynamic diagnosis is a fertile field for research development.

Table 2 - Description of the selected articles

Article	Objective	Method	Results	Conclusion
Alvarado[7]	To identify the psychodynamic and cognitive factors associated with adherence to medical treatment in non-refractory epileptic outpatients.	Non-experimental, comparative and cross-sectional study. 33 Chilean epilepsy patients (23 adherents, 10 non-adherents). Instruments: Morisky Medication Assessment Scale-4, OPD-2.	Adherent patients were: younger; had higher education; had higher GAF scores, suggesting better psychosocial adjustment; and lower scores on the EQ-5D; they express their disorder mainly psychologically, while non-adherent patients tend to express themselves in somatic ways. The main conflict for both groups was "Need for care versus self-sufficiency".	Adherence to treatment has become an issue on its own. There are seven variables associated with adherence to medical treatment: years of education attained, psychosocial adjustment, health-related quality of life, psychological and social concept of illness, desired psychological treatment, and submission/control conflict.
Both[8]	To identify psychodynamic characteristics from an audio-recorded treatment session with an 18-year-old teenager in conflict with the law, serving detention Without the Possibility of External Activities.	Systematic case of an 18-year-old. Fonagy Mentalization-Based Treatment. Instrument: OPD-2. Analysis of a 45-minute session.	Median problem severity, but with almost no suffering. Experiences others as controllers, who disqualify and neglect him, thus, keeps to himself by maintaining distance; there are uncontrolled impulses and exposures to risk. Conflict: "need for care versus self-sufficiency". Median structure level. ICD F91.	It was possible to develop a dimensional understanding of the adolescent, to complement the nosological diagnosis, from the OPD-2. The instrument was useful in assessment and treatment planning of adolescents in conflict with the law.
Both[9]	To assess the psychodynamic functioning of patients with stress disorder through OPD-2, regarding the structure, intrapsychic conflict, and interactional pattern of the subject.	Cross-sectional quantitative study. Three patients with PTSD or ASD symptoms, selected by convenience. Instrument: OPD-2. Test-retest reliability.	Moderate level of subjective suffering, with limitations in daily activities. Excessive self-care and constant state of alert. Remains distant from others. Conflict: "need for care versus self-sufficiency". Median structure level. ASD or PTSD.	OPD provided an understanding of the patients' psychodynamic functioning in a clearer form that may facilitate the understanding of the clinical context of stress.

Article	Objective	Method	Results	Conclusion
Crempien[6]	To characterize a Chilean sample of victims of domestic violence through an operationalized psychodynamic diagnosis, exploring structural functions, interpersonal dysfunctions and intrapsychic conflicts.	Non-experimental, correlational and cross-sectional study Instrument: OPD. 28 women from a care center for domestic violence victims in Santiago.	Women with greater severity of violence reported higher levels of depressive symptoms, PTSD and low education. Conflict: "need for care versus self-sufficiency". Vulnerable structure level.	Understanding of the psychological difficulties and vulnerable relationships of the victims associated with their traumatic experiences promotes more systematized care that prevents the re-victimization, based on the therapeutic focus and planning.
Crempien[10]	To analyze the effects of personality functioning on the quality of life in depressed patients.	Cross-sectional, correlational study. 84 outpatients from Santiago, mean age 45 years, 89.3% women. Instruments: BDI, OPD Structure Questionnaire and Medical Outcome Study SF-36.	High level depressive severity symptoms are associated with low levels of personality functioning and poor quality of life. Sociodemographic variables showed no effect on quality of life.	Depressive symptoms mediate the effect of personality functioning on mental quality of life of depressive patients. The lower the level of personality functioning, the higher the severity of depressive symptoms, and the latter have a detrimental effect on patients' quality of life. The specific contribution of each structural function to this impairment should be further studied.
Dagnino[11]	To describe the therapeutic process of four successful therapies, considering the change with reference to the subjective theory and integration of therapeutic foci and to compare and relate the two methods for	4 women with individual brief dynamic psychotherapy sessions, therapists with over 30 years of experience. Instruments: Generic Indicators of Therapeutic Change, Scale of Structural Change, OPD-2.	The change, in subjective theory, proved to be an irregular but progressive process, with integration of the therapeutic foci. There is a significant relationship between the models of assessing therapeutic change.	It is suggested that foci should be identified in each episode of change that the patient and the therapist are working on, in order to establish a relationship between a specific focus, its level of integration and the

Article	Objective	Method	Results	Conclusion
	assessing therapeutic change.			subjective change in the patient.
Dagnino[12]	To determine the presence of therapeutic foci, their level of integration and their relationship with subjective change in four successful brief dynamic psychotherapies.	Study of multiple unique cases. 4 brief dynamic psychotherapies. Instruments: Generic Change Indicators, OPD-2, Heidelberg Structural Change Scale, Foci Presence Scale, Outcome Questionnaire.	The focus of OPD was identified in all the occurrences of therapeutic change. The focus on the relational pattern is more present in early stages, while the focus on structural vulnerabilities predominates in the final stage.	The consistency of successful psychotherapeutic processes allowed conclusions on certain common aspects of focalizations, their level of integration and their evolution during the process. The focus was the need to abbreviate the therapeutic processes.
Dagnino[13]	To explore the association between structural functions and self-criticism and dependency dimensions of depressive experience.	Cross-sectional, non-experimental study. 43 Chilean depressive patients (83.7% women) Instruments: BDI, Depressive Experiences Questionnaire, OPD-SQ.	More severe depressive symptomatology, especially in the self-criticism dimension, is associated with worse structural functioning. Vulnerability in the self-regulation function was a predictor of depressive symptomatology.	The foundation of depression is heterogeneous, requiring different therapeutic strategies.
Dinger[14]	To investigate the OPD classification of levels of personality functioning from different perspectives. To investigate the predictive value of classification of interviews for PD according to the DSM-IV.	79 clinical and 22 non-clinical depressive patients. Mean age 32 years, 70% women, 53% with comorbidity (PD). Measurements: OPD-LSIA corresponding to Axis IV from the Clinical Interview of the OPD. And OPD-SQ.	OPD-SQ correlated significantly with OPD-LSIA. The non-clinical classification was significantly lower than the depressive patients. OPD-SQ and OPD-LSIA were predictors for DSM-IV PDs.	There is agreement between OPD- LSIA and OPD-SQ regarding the assessment of personality functioning.
Doering[15]	To evaluate the reliability and validity of the OPD-2	124 psychiatric patients. Instruments: Structured Clinical Interview for DSM-IV, OPD-2.	The OPD-2 structure axis shows good interrater reliability. Patients with a PD showed significantly	The OPD-2 structure axis shows good reliability as well as concurrent and

Article	Objective	Method	Results	Conclusion
	structure axis in 124 psychiatric patients.		worse personality functioning than those without. In cluster B PD, personality functioning was more severely impaired than in cluster C PD.	discriminant validity and can be recommended for clinical use and research purposes.
Gordon & Stoffey[16]	To evaluate the stability and validity of the PDC as an operationalization of the PDM.	104 subjects, 43 women, mean age 40.6 years. Instruments: MMPI-2; Karolinska Psychodynamic Profile; Axis IV from OPD.	The PDC contains the Overall Personality Organization Scale with 7 subscales and the Mental Functioning Scale with 9 subscales. Both were negatively correlated with MMPI-2, OPD, and the DSM-IV GAF scale ($p<0.001$).	PDC scales had high internal consistency, reliability and validity. The PDC can be used for diagnosis, treatment, psychodynamic formulation, outcome and process research based on PDM.
Juan[4]	To use the OPD-2 criteria for a secondary analysis of 15 psychoanalytic interviews conducted previously, using the multiaxial diagnostic classification.	15 psychoanalytic therapists, mean age 49 years, proposed prognostic inferences and a conceptualization of the case of a patient with GAD. Instrument: OPD-2.	Preliminary results indicated that axes III and IV predominated in identifying the problem (conflict x structure) and axis II in the patient's expectations regarding treatment.	OPD-2 was useful in classifying key elements of the conceptualization process of a GAD case and was sensitive to identify patient's particularities.
Kehyayan[17]	To investigate the concept of "psychodynamic conflict" using a method of free association to potentially conflict-related contents inside a functional MRI scanner.	18 participants, 10 women, mean age of 25.9 years. Instruments: OPD – conflict sentences –, SCL-90, BDI and DSQ-40. 24 stimulus sentences: 6 were "neutral", 6 were "negative", 12 were "conflict-related".	There was agreement between the report of conflict-related sentences, with high levels of behavioral, neural reactions, mainly in the anterior cingulate cortex, involving emotional processing, monitoring of conflict and the problems mentioned.	Free association has shown to be a powerful technique for investigating conflict with neuroimaging.
Kessler[18]	Operationalizing repression using individualized experimental conditions, observing behavioral potential (memory and	29 healthy women were invited to associate to cue sentences. Instrument: OPD.	The OPD interview enabled identification of the psychodynamic conflicts. Associations to conflict-related sentences were associated with longer reaction times and	The results were interpreted as possible correlates of repression. It is suggested that this experimental paradigm may serve to

Article	Objective	Method	Results	Conclusion
	reaction time) and psychophysiological correlates (skin conductance response).		increased skin conductance responses.	investigate repression in clinical populations.
Krieger[2]	To present the Brazilian version of the OPD-2 and conduct initial studies of content validity, concurrent validity and inter-rater reliability with the Brazilian version of the OPD-2.	Content assessment. Reliability: inter-rater agreement and test-retest of 53 interviews of psychodynamic psychotherapy. Concurrent validity: compared OPD-2 items to the results of WHOQOL-bref and SCL-90-R.	The Brazilian OPD was created by adapting the Portuguese version. The content assessment considered the items clear in terms of language and theoretically pertinent. Axes III and IV showed greater inter-rater agreement. Axes I, III and IV obtained a significant correlation in some categories with the results of SCL-90-R and WHOQOL-bref.	The psychometric properties of the OPD-2 are adequate for application to the Brazilian population.
Paulo & Pires[5]	To test diagnostic assessment using the notes from a patient's psychoanalysis sessions.	One patient, 40 years old, with higher education. Descriptive notes from psychoanalysis sessions. Treatment period: 3 years and 8 months with frequency of three times a week. The first 10 and the last 12 sessions were analyzed.	The patient had a lot of counseled psychological suffering, dysfunctional relational patterns, oedipal conflict and structural level that varied between moderate/high. There was significant improvement at the end of treatment on all axes.	OPD can be applied to descriptive notes of psychoanalytic sessions.
Vicente[3]	To describe the methodological aspects of the process of cross-cultural adaptation of the OPD-2 to the Portuguese language (Portugal and Brazil). To evaluate inter-rater agreement for the different axes of the instrument in	Independent translation and comparison of the different versions of the final version in Portuguese. Agreement between three independent evaluators of two interviews of five participants with mean age of 40 years.	Inter-rater agreement of Axis I was 66%, Axis III was 57.7%, and Axis IV was 78%. Axis II was not evaluated.	Results are similar to other studies with an acceptable inter-rater agreement. Further studies are recommended to investigate the instrument's reliability.

Article	Objective	Method	Results	Conclusion
	the scoring of clinical interviews.			
Wiswede[19]	To compare the changes in depressive patients' brain reactions before and after eight months of psychodynamic psychotherapy.	Experimental study with 18 patients with major depressive disorder, mean age of 39.8 years, not on medication, who underwent MRI before (T1) and 8 months after (T2) psychodynamic psychotherapeutic treatment. A control group of 17 subjects who were tested twice without intervention, mean age of 38 years. Instruments: BDI, OPD.	When confronted with the sentences from the OPD (as stimulus) at T1, the patients showed greater activation in the limbic system and in the subcortical regions compared to the control group. At T2, the differences in brain activities between the control group and the patients were no longer significant. The patient group's depression score improved.	Brain activity of depressive patients, in the case of hyperactivity of the limbic system, normalized after treatment; changes were attributed to psychodynamic psychotherapy.
Zimmermann[20]	To contribute to the conceptual and empirical discussion of the Levels of Personality Functioning Scale from the perspective of the OPD system	Review of studies that used OPD-LSIA to investigate reliability and validity. A meta-analysis was conducted of 8 studies that assessed the association between the overall OPD-LSIA score and PDs.	OPD-LSIA is reliable and valid for the assessment of personality structure and has a high association with classification of PDs (severity).	Highlights implications of OPD-LSIA for future revisions to the DSM-5 proposal.
Zuccarino[21]	This ongoing study aimed to investigate the existence of psychopathologically significant dimensions in a sample of patients with eating disorders, using the OPD-2 system.	50 young women with eating disorders. Instrument: OPD-2, Eating Disorder Inventory 2.	Most patients were subjectively experiencing psychological suffering. The patients tended to perceive others as reproachful, controlling, belittling, and neglectful. The predominant conflict was the need for care versus self-sufficiency. Most of the sample showed poorly integrated functioning.	The existence of different subgroups of patients with eating disorders differing from each other in respect to psychodynamic features. These data suggest that tailoring therapeutic approaches to the patients' individual profiles could improve outcomes.

ASD = acute stress disorder; BDI = Beck Depression Inventory; DSM = Diagnostic and Statistical Manual of Mental Disorders; DSQ-40 = Defense Style Questionnaire; EQ-5D = EuroQol-5D; F91 = conduct disorder; GAD = generalized anxiety disorder; GAF = global assessment functioning; ICD-10 = International Classification of Diseases and Related Health Problems; MMPI-2 = Minnesota Multiphasic Personality Inventory-2; MRI = magnetic resonance imaging; OPD-2 = Operationalized Psychodynamic Diagnosis; OPD-LSIA = OPD Levels of Structural Integration Axis; OPD-SQ = OPD Structure Questionnaire; PD = personality disorders; PDC =

Psychodiagnostic Chart; PDM = Psychodynamic Diagnostic Manual; PTSD = posttraumatic stress disorder; SCL-90 = Symptom Checklist-90; SF-36 = Medical Outcome Study 36-item Short-Form; WHOQOL-bref = World Health Organization Quality of Life instrument-Abbreviated version.

Discussion

In the last five years, the OPD-2 has spread nationally and internationally and has been applied in validity and reliability studies,[2,3] in empirical studies with process analysis and treatment outcome, in studies assessing different mental disorders,[4-6,8-10,13-15,19-21] and in comparative studies with different instruments and techniques or proposing new techniques.[11,12,16-18]

Traditionally, the use of the instrument is operationalized from audio recordings of semi-structured interviews. Thus, Paulo & Pires, investigated the possibility of applying the instrument to psychoanalytic session notes of a patient when the follow-ups had already been completed. It proved possible to validate application of the OPD in this context. This type of assessment offers a more natural study that allows an independent assessment of the therapist, without the need to record the treatment; since recording can cause unnecessary anxiety in the patient and affect the treatment outcome.[5]

It was also demonstrated that the OPD was sensitive for identifying the particularities of the patients and the construction of the conceptualization of the case (hypotheses, maintaining and precipitating influences of the psychological, interpersonal, and conflictual problems).[4] In the study by Kehyayan et al., it proved possible to use the free association technique to identify unconscious conflict, with concurrent observation of neural behavior, along with psychological behavior; and the usefulness of this technique was confirmed in investigation of axis III.[17] Observation of the brain during a psychoanalytic treatment is a fertile field of investigation.[16,19] However, it is also considered a challenge, since it requires operationalization of psychodynamic constructs, and the OPD provides a method for this type of research, developing and proving the effectiveness of this approach.

It was observed that the OPD system has been used to understand the structural functions of the personalities of depressive patients in terms of assessing their mental capacity for emotional regulation, cognitive abilities, internalized objects, and internal and external communication. In one study, it was observed that the structural level of personality function described in the OPD [Structure?] Questionnaire (OPD-SQ) is associated with the quality of life of patients with depressive symptoms; data from the Chilean group study focused on the issue of depression because of its high prevalence in the country. Low levels of personality functioning correlated with high depressive severity and low quality of life. These results suggest a need to understand the detriment to quality of life of patients with depression, especially the most serious, in relation to their overall functioning of personality.[10] Also, the Chilean research group suggested that depression has a heterogeneous basis, requiring a

different therapeutic plan for each patient. The severity of depressive symptomatology is influenced by the greater structural vulnerability of emotional self-regulation.[13]

Regarding the neurobiology of these cases, it was possible to observe that depressive patients in psychodynamic psychotherapy treatment normalized their brain activity, characterized by hyperactivity of the limbic system, after 8 months of treatment, without medication. This study used sentences from the OPD as a stimulus for the assessment of brain activity in the patients and control group.[19]

In psychiatric patients, Axis IV of the instrument showed good reliability; results demonstrated that patients with personality disorders have the most vulnerable mental functions.[15] From the perspective of personality disorders in the DSM-IV classification, Dinger et al. investigated depressive patients, and part of the sample also had personality disorder when assessed with the OPD (Axis IV) and OPD-SQ. It is noteworthy that both the OPD-SQ and the OPD Levels of Structural Integration Axis (OPD-LSIA) were useful for assessing the personality functioning of depressed patients with or without Personality Disorders according to DSM-IV diagnostic criteria.[14]

Regarding personality disorders, in studies conducted prior to publication of the DSM-5, Zimmermann et al. pointed out a possibility for better evaluation of these patients. They integrated the OPD perspective into the understanding of personality from the OPD-LSIA. The overall OPD-LSIA score was associated with severity of personality disorder, showing it to be a reliable and valid measure for assessment of personality structure.[20]

The studies cited are German,[14,19,20] where it can be observed that researchers are currently more focused on understanding the personality and subject structure. Concomitant with this, Germans have also conducted research on unconscious conflicts – Axis III –the understanding of which is identified as a fundamental factor in understanding of the genesis and maintenance of mental disorders, since they provoke behavioral, emotional and neural reactions. Each conflict comprises affections, thoughts, beliefs, behavior, relationship, and transference-countertransference characteristics, among others.[17] In this sense, conflict was also used in an attempt to investigate repression; a central concept in psychodynamic theory. It proved possible to propose a way to assess repression using free association of sentences related to the intrapsychic conflict.[18]

It can be observed that these studies are developing each dimensional axis separately and in the most varied of contexts: neuroscience, OPD-SQ, and OPD-LSIA. Additionally, in an attempt to correlate the OPD constructs with another instrument, the Americans Gordon and Stoffey chose the Psychodiagnostic Chart (PDC), a preliminary instrument developed to

operationalize the Psychodynamic Diagnostic Manual (PDM). In their results, the PDC correlated significantly with the OPD-Axis IV.[16]

The OPD-2 was also used to assess adherence to treatment among epileptic patients. In this study, the authors found that adherence to treatment is influenced by aspects of experience of the disease – Axis I – and by conflict – Axis III – in epileptic patients.[7] Chilean research, especially that involving the researcher Paula Dagnino, investigated the context of therapeutic focus and change. The authors pointed out that the focus on the OPD promoted therapeutic change[12] and this change was progressive and irregular.[11]

In another Chilean context, the OPD was adapted to domestic violence, using Axis I. Here, the author evaluated the psychodynamic functioning of 28 women recruited from a center for domestic violence victims in Santiago. The women who demonstrated the greatest severity of violence were those who reported higher presence of depressive symptoms, PTSD, and low education. Complementarily, the main conflict that prevailed was need for care versus self-sufficiency (39%), followed by the secondary conflict submission vs. control (50%), which may be related to re-victimization. Also, the overall functioning of women who had been victims of sexual violence was worse than that of other victims, because they suffered from psychological and physical violence concurrently; with an accumulation of multiple traumas. Furthermore, the vulnerable structure due to the trauma suffered is considered an obstacle to victims dealing with their emotions and stress.[6]

Also in the context of violence, in Brazil the OPD-2 also proved useful with adolescents in conflict with the law, for identifying the psychodynamic characteristics of the case, complementing the diagnosis of Conduct Disorder. These authors developed an evaluative comprehension of the adolescent, pointing out that the predominant intrapsychic conflict was his need for care versus self-sufficiency active mode. He sought independence because of fragile primary affective bonds; which led him to perceive others as controllers and so he isolated himself or acted impulsively, perhaps as an attempt to avoid another possible abandonment. Nevertheless, the patient presented a median psychic structure, which did not lack mentalization ability. These aspects demonstrate the complexity of the psychodynamic diagnostic assessment that surpasses the common psychiatric diagnosis.[8]

In diagnosis of acute stress disorder (ASD) and posttraumatic stress disorder (PTSD) it was observed that patients presented peculiar characteristics due to urban violence. The three patients assessed in the study by Both et al. from the perspective of the OPD-2 exhibited moderate subjective distress, with emotional and social difficulties, modifying their relational behavior: hypervigilance, and care of others as support. The main conflict was around the

need for care versus self-sufficiency in the active and passive mode. Thus, they certify the attention and care they receive or give – submissive or self-sufficient – with a desire for care and security or as a defense against them. Both participants demonstrated difficulty with mentalization and trying to remain stable by avoiding affection; nevertheless, there was emotional inflexibility. General assessment of patients using the OPD enriched the understanding of patients, facilitating comprehension of the clinical context of stress.[9]

Only one study of eating disorders was found. These authors explored the psychodynamic diagnosis of 50 young women with eating disorders. The patients tended to perceive others as reproachful, controlling, belittling and neglectful. The predominant conflict was the need for care versus self-sufficiency. Most of the sample showed poorly integrated functioning. They pointed out that there is a need to consider the peculiarities of each patient, in addition to the nosological diagnosis.[21]

In several studies reviewed, when conflicts were evaluated with the OPD, the conflict need for care versus self sufficiency was the most frequent. This was observed in patients with eating disorder,[21] acute stress disorder and posttraumatic stress disorder,[6,9] and conduct disorder.[8] These data raise the hypothesis that there are common characteristics among different pathologies that need to be better investigated, including through use of OPD in different contexts.

Finally, another Brazilian study from the Universidade Federal do Rio Grande do Sul (UFRGS) complemented the Portuguese sample and presented the Brazilian version of the instrument.[2] The validation study found agreement between judges. In this validation study for Portugal/Brazil, reliability was calculated for each axis as follows: 78% in axis IV, 66% in axis I, 57.7% in axis III, and axis II was excluded.[3] We questioned the exclusion of axis II, but it is understood that the 32 categories make reliability difficult to achieve. Nevertheless, the instrument was validated for use in Brazil.

It was observed that empirical production is increasing, since this is a recent instrument and it is increasingly spreading internationally. Chile and Germany are leading research on the subject. In Germany this is possibly because the group that created this instrument is from Germany and because it is already more widespread in their scientific community. Next is Brazil, where production is concentrated on understanding psychodynamic functioning in situations of stress, besides proposing its applicability to psychoanalysis notes.

Another aspect that is notable is related to academic courses. For example, in Latin America, there is only an academic course in Santiago, Chile; which limits expansion of the pool of professionals who have access to and permission to use the OPD as a clinical and

research tool. Chile was the first country in America to introduce the OPD-2. Chilean studies of note prior to this review include one by Pérez et al., in which they advanced understanding of the OPD and achieved excellent agreement among judges,[22] and Chilean researchers are also a reference in studies with depressive patients and, more recently, with women who have been victims of domestic violence.[6] In Uruguay, Bernardi has made a relevant contribution in the area, with research that compares the personality diagnosis systems in the PDM, DSM, and OPD.[23] In Argentina, relevant contributions to diagnosis of GADs have been made by Roussos.[4]

Dimensional diagnosis in addition to descriptive diagnosis is a clinical necessity that facilitates both understanding of the subject and clinical planning, offering an assessment of the internal dynamics and the meaning of the symptomatology exhibited. Therefore, the OPD is an instrument that integrates psychodynamic constructs in an operationalized manner using multiaxial assessment forms. This operationalization provides understanding of and application to the psychodynamics of the patient, offering greater clarity in planning of treatment for the subject and also facilitating communication within the scientific community.[1] There are few instruments that operationalize the psychodynamic constructs, whether internationally or domestically.[2] Therefore, we emphasize the need for research using the OPD instrument in the most varied of contexts, since the results can serve as tools for diagnostic investigation, contributing to improvement of psychotherapy and to understanding patients' dynamic functioning.

Conclusion

Analyses of studies related to the OPD showed that the number of publications on the subject is not yet significant and the methods employed are diverse, but there is a growing body of data on topics such as applicability in different contexts and to different pathologies, promoting greater visibility and with greater representativeness of professionals who understand the instrument We emphasize the importance of investing in research on the subject and of setting up academic courses in different countries in order to promote greater visibility and development of knowledge in this area. There is a scientific effort in the development of assessment and interventional processes using psychodynamic constructs, under a multiaxial diagnosis, whose priority is to create empirical evidence of the use of OPD in different contexts, with different pathologies, and with adaptations and comparisons to various other techniques.

The OPD-2 is being used in several different countries and cultures, such as Germany, England, Italy, Chile, Australia, Portugal, and Brazil, not all of which are represented in the studies selected for this review, and in different clinical contexts. The instrument provides a deeper understanding of the patient in terms of identification of the patient's psychic suffering (axis I), dysfunctional relational patterns (axis II), predominant motivational conflict (axis III) and structural conditions (axis IV), which is complementary to the description of the patient's symptoms. With regards to treatment, it is possible to determine the most appropriate treatment indication for the subject and to carry out treatment planning and define the focus of treatment. Finally, it also contributes to scientific research and communication, since it presents psychodynamic aspects codified in clear and specific worksheets, as well being useful for training future therapists.

Acknowledgements

This study received financial support from Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES).

Disclosure

No conflicts of interest declared concerning the publication of this article.

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8 ARTIGO 2. CYCLE OF VIOLENCE IN WOMEN VICTIMS OF DOMESTIC VIOLENCE: qualitative analysis of the psychodynamic approach through the OPD 2 interview

- Revista: ***Brain and Behavior***
- Qualis na Área de Medicina II – Classificação de Periódicos Quadriênio 2013-2016: **B1**
- https://doi.org/10.1002/brb3.1430

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ABSTRACT

Introduction: Domestic violence places woman as the victim and man as the aggressor in the family environment. There is limited consistent and clear information based on empirical evidence on the dynamic functioning of the victims.

Objective: To further understand the psychodynamics of women in the cycle of violence taking into account the aspects of psychological trauma. It's transversal research design. The sample was composed by ten women victim of domestic violence. Data collection was based on the OPD-2 Clinical Interview. Content analysis was performed from categories created by *a posteriori*: 1)Previous history; 2)Behavioral aspects; 3)Emotional aspects; 4)Reason for being in the relationship; 5)Type of violence and explanation for the reason of violence; 6)Support network and daily activities; 7)Clinical and legal referral.

Results: Constant violence causes changes in the structural functioning and psychological conflict of the victims: difficulties in mentalization, instability in relationships, emotional dependence, abandonment of her own life for her partner's, difficulty in having a sense of identity. Victims presented difficulties in making significant changes in daily life to break the cycle of violence.

Conclusion: The research sought to collaborate with more evidence on the subject, suggesting a reformulation on forms of encounter to break the cycle of violence.

Key words: domestic violence, cycle violence against women, psychological trauma, psychodynamics, qualitative research.

INTRODUCTION

Violence refers to the concept of power and the use of superiority over the other (Minayo, *et al.,* 2018). More specifically, domestic violence places women as victim and man as the aggressor and there is damage or lack of physical and psychological well-being –Maria da Penha Law (Brazil, 2006; Cortez, Souza & Queiróz, 2010): physical violence, psychological violence or sexual violence. It is considered a subcategory of gender violence (Lourenço *et al.*, 2013) and a serious social phenomenon to be combated by public health (Bins, Telles & Panichi, 2015, Rafael & Moura, 2013) and by human rights services around the world. However, it is a challenge to the healthcare sector due to the high statistical incidence and severe outcomes (Osis, Duarte & Faúndes, 2012). In Brazilian context there is trivialization and even acceptance of violent behavior against women in some subcultures of society (Bins *et al.,* 2015; Falcke & Féres-Carneiro, 2011; Minayo *et al.,* 2018).

Statistical data shows that 23% of women suffer from their partners (WHO, 2019). The global prevalence of domestic violence estimates that approximately 30% of women suffer this type of violence throughout their lives (WHO, 2013). Also, violence against women is calculated by the number of female homicides committed by their partners - uxoricides. In 2017, it was estimated that 2,795 women were victims of femicide in the 23 countries of Latin America and the Caribbean. This is data from the latest report of the recently published Gender Equality Observatory of the Economic Commission for Latin America and the Caribbean (ECLAC). Brazil holds the unfortunate record of the highest absolute number of femicides, with 1,133 victims confirmed in 2017 (WHO, 2019). According to data from the Public Security Secretariat of *Rio Grande do Sul* (2014), at the end of 2014 there were 75 women murdered by their partners and 287 attempts. No data was reported on the homicide of men committed by their partners. The capital city, Porto Alegre was number on in the ranking of women victim in the state.

As a whole, violence can cause serious trauma to the victim. Psychological trauma is considered to be the results of physical and/or psychological threat (Eizirik *Et Al,* 2006; Peres, 2009). The way each subject deals with and represents the traumatic events is linked to the intensity and severity of the incident. Thus, the violent act felt as trauma, triggers preexisting conflicts (Garland, 2015). In this way, care for the trauma is mainly provided by the family, primary caregivers, assisting in the structuring of safer and more stable subjects (Winnicott, 1993). With a safe foundation, the subject will develop a capacity for mentalization – the ability to discriminate internal and external aspects of reality and to understand self and others' mental states and the capacity for emotional regulation; considered vital for the organization of self (Fonagy & Allison, 2012; Bateman & Fonagy, 2016).

The psychoanalytic oriented treatment for victims of domestic violence is considered a challenge due to the adherence of the victim and the countertransference of the professional. Dealing with strong emotional demands from the violent events, as well providing competent treatment can be difficult for the therapist. Thus, a consistent and clear understanding, based on empirical evidence on the dynamic functioning to focus on pertinent and specific issues of this population becomes extremely important. These victims are characterized by constant traumatic situations that affect psychological and emotional functioning (Crempien, 2009). In this sense, there is a lack of studies with psychodynamic focus in the domestic violence context.

Dynamics of domestic violence implies repetitive behavioral patterns in relationships, maintaining the cycle of violence. Usually it is presented with a slow and silent beginning

without physical aggression; gradually progressing to actions with greater intensity to humiliation beatings, as well as even public manifestations of aggression. Moreover, it can be aggravated by women's shame when reporting violence, lack of educational means and access to legal information and poor assistance and protection (Falkinger, Boeckel & Wagner, 2017). Moreover, why do these women remain in this cycle of violence? What does it take to break it? From the diversity present in gender studies, we consider it fundamental to highlight their involvement in maintaining the cycle of violence.

Therefore, the present study has the objective to increase the psychodynamical understanding of woman living in cycle of violence, considering the psychological trauma as an important part of the abusive situation. More specifically, explore the previous history, the behavioral and emotional aspects involved, the reasons why they stay and allow the perpetuation of the cycle of violence, the existence of social network, the meanings attributed to violence, and possible referrals.

METHOD

This is a qualitative and transversal study whose focus was the content analysis of the interviews. The construction of the study was based on the Consolidated criteria for reporting qualitative research (COREQ*;* Tong, Sainsbuty & Craig, 2007). Finally, this research is part of a larger study project of violence against Brazilian women.

Participants

Ten women victims of domestic violence participated in this study. They had medical examination for legal purposes- in a public health service in the capital of *Rio Grande do Sul*, Brazil. After the medical examination, they were invited to participate in the research. All victims had already reported their partner to the police station and had the medical examination in the same place for legal reasons. The selection of women was by convenience, because only the women who were present on the day of collection were invited to participate. The number of participants was due to the abundance of data generated by qualitative research method. The women authorized their participation voluntarily in the research and signed an Informed Consent Form. The identities of the participants were protected. All recordings of the interviews were numbered, in a way that the researcher could no longer identify them later.

Characteristics aspects

The collection site was held in the psychosocial room, where the woman receives guidance on possible referrals. In this room, the interviewer and the participant were alone. It is a welcoming space where victims are heard and encouraged to reflect on: their situation,

the reasons for the violence, the behavioral, and emotional patterns that contributed to the occurrence of the aggression, the social support network of each victim that could assist them at this time, among others. First of all, the victim safety is prioritized, removing her from places of risk, if necessary, away from the offender –Maria da Penha Law (Brazil, 2006). Also, counselling on possible legal procedures regarding assets, custody of children, among other information is provided.

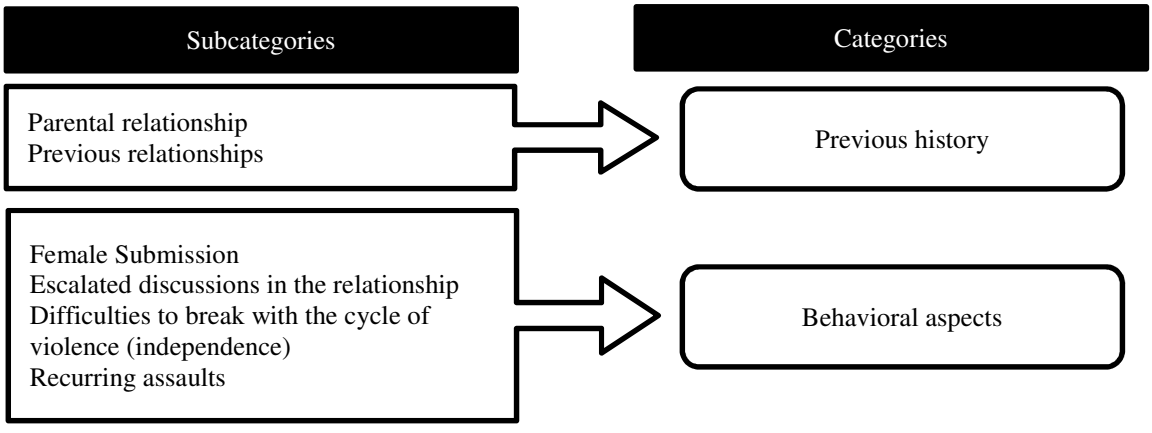
Procedures for data collection and analysis

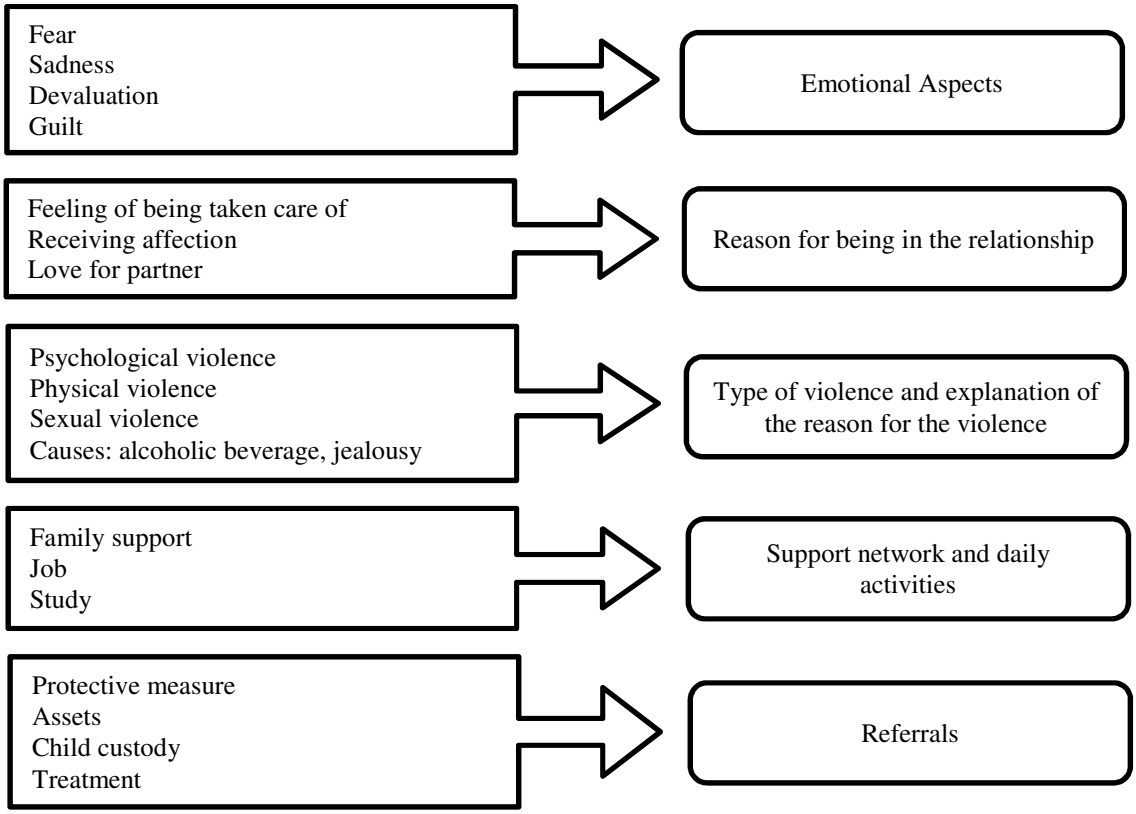
Data collection was performed by a psychologist researcher. The women answered a questionnaire on sociodemographic data. Later, they participated in a semi-structured interview of OPD-2 Clinical Interview, that was recorded and transcribed. This interview is composed of five axes with themes that should be explored: assessment of domestic violence, interpersonal relations, conflict, structure, and mental and psychosomatic disorders (Task Force, 2008).

A descriptive analysis was done to characterize the sample. The analysis of the interviews was carried out by two researchers who were independent psychologist. Then the interviews were read incessantly. As proposed by Bardin (1994), the categories of analysis were created by *a posteriori* and the content analyzes of the categories were performed. These categories were divided according to the thematic modalities of the subcategories identified in the interviews (Figure 1).

We subdivide the discussion in categories, contrasting the results with the existing literature pertinent to the theme. In addition, the classic scientific production of the domestic violence and psychodynamic functioning, international studies and the investigations of local researchers on domestic violence, such as Lisieux E. de Borba Telles *(UFRGS* – Universidade Federal do Rio Grande do Sul*)* and Denise Falcke (*UNISINOS* – Universidade do Vale do Rio dos Sinos), were also used. These researchers are local references on the subject, since domestic violence has local social attributes to be considered.

Figure 1. Categories of the study.





HYPOTHESES

Hypotheses were created for each category. It is believed that cycle of violence is permeated by:

- Previous history: has transgenerational factors of violence and violent traumatic experiences in the victims;
- Emotional and behavioral aspects: feelings of dependence and fear of loss of the object because of their diffused identities; difficulties of mentalization; relationship instability; isolation;
- Type of violence and explanation of the reason for the violence: persistent psychology violence; alcohol abuse by partner;
- Referring: protective measures; lack of treatment desire.

RESULTS

Characterization of participants: sociodemographic data

Ten women victims of domestic violence participated. They were mostly white women (n = 7), with a predominant age of less than 35 years (n = 6), half of them didn't have a religion and had completed High School (n = 5), with income between 1 and 2 monthly minimum wages (n = 6). Among mates, the majority were white (n = 6), primary education (n = 4), income between 1 and 2 monthly minimum wages (n = 7) and half did not have a religion (n = 5). Most women didn't use substances: alcohol (n = 9) or drugs (n = 8). However, half (n = 5) of the partners presented alcohol abuse, and most didn't use drugs (n = 7; Table 1).

The type of relationship was variable, 4 women had stable union, 3 were dating, 2 are separated from their partners and 1 of them had a virtual relationship with only 1 personal encounter (Table 2). Regarding the care of the parents, half of them (n = 5) reported that they experienced, as children, fights and parents' discussion frequently; but they evaluated their parents as loving and caring.

Categories

The analysis of interviews and categories findings are listed below. Some aspects are overlapping in more than one category, because there is no way to isolate the dynamics in independent thematic modalities.

1) Previous history

In recalling the **parental marital relationship**, four participants (Participants 3, 5, 6 and 7) comment on **good relationships**, as represented by participant 5: *"Yes, yes, until today, they are married to 38 years old, never quarreled".* In contrast, participants 8 and 9 lived only with their mother, participant 8 states: *"My mother was separated from my father… I raised was my mother. My father always wants other woman and forgets the children. I was very happy created by my mother, she fought to create me and had 4 brothers";* and participant 9 says: *"I never had a father"*. Participants 2 and 10, however, remember **conflict with their parents**, as observed in participant's speech 10: *"She abandoned me because my father drank too".* And, some others do not bring experiences in relation to the conviviality between their parents (Participants 1, 4 and 7). Finally, participant 6 was the one who sustained the house since the 13 years of age, because the parents were separated: the mother abandoned her when she left with a lover and the father was an alcoholic and did not care about the care of the children.

About their life histories, it is verified that in their **previous relationships** they suffered aggressions (Participants 1, 2 and 5). Participant 1 reveals about the previous partner:

"It was terrible too, I separated in the Forum, it is the father of my daughters". In the same way participant 2: *"The other partner I had, thank God already died, he beat me"* and participant 5: "*No one likes, no one, no one, not his family, nobody, because he is a aggressive person, only he thought he was right, my ex-partner".* On the contrary, participant 9 and 10 tell about positive relationships, an example is participant 10: *"We live together, he is very good, he does not lack anything*".

2) Behavioral aspects

About that, it is reflected on the behavioral aspects of partner during relationship. It is perceived that prevalent characteristic in the participating women is **submission** to dominant "power" of the man, since they remain in the relationship and support the violence and frustrations. Also coming from the parental model: submission *versus* independence.

It is not possible to isolate this thematic field from the previous one, as in the following example: Participant 3 claims: *"My mother was always very independent, she always worked out, she always, always, understood? And she always gave me this, which never depends on man, I have to always have my independence (...), then that independence that I have always had all my life, suddenly I have no more, I become dependent, both is that he left at dawn on Wednesday, I screamed so much, so much, that he was scared".* It may be noted the need to have time of your life, such as financial independence gained by the participants 2 and 6. On the other hand there are those submissive to fellow wills (Participants 1, 3, 4, 5, 7, 8, 9 and 10), as commented by participant 2: *"I don't know (...) my mother was one of those who asked my father that way: father gives me 10 reais to buy 1 kilo of rice? then I buy the kilo of rice, I had to give back the rest of the money to dad, I found it, I think it's awful".*

In previous history, it was evident that the **beginning** of their **conjugal relations** took place in a harmonious way, being able to carry out joint activities, as observed in participant 2: *"No, in the beginning, you are looking at the picture when we were well*" and participant 5: *"We went out, had fun, we went to the bar, we talked, we went"*. It is observed that with the passage of time socializing couples began to have **discussions** and demonstrations of **jealousy** as participant 3. It reveals that jealousy was so intense that his partner did not allow her to work: *"I work at home since I married him, I had to stop working because he did not accept"*.

One question raised by three women is that such **difficulties intensified** after they had moved in with their partners (Participants 1, 7 and 10). The reasons for changes have given up by problems have related to marriage union or labor issues as the participant 1: *"I moved to Gravataí, because he had a problem, what happened to him at that time my house here in*

Porto Alegre, near the police station. I sold there, now I moved to Gravataí, I've been in Gravataí for 18 months (...) he got me at the police station in Porto Alegre (...) I threatened and I was horrible on this side".

In face of behaviors experienced in the relationship, participants 2, 3 and 5 reported difficulties in achieving an attitude to **break the cycle of violence**: Participant 2: *"I don't do anything, I will do what?"*. Participant 3: *"Then I stopped living, because then I, my mother lives on the third floor, I in the second, I couldn't go up to my mother anymore. But what are you going to do there? So he thought, I'd go to my mother to talk to someone on my cell phone"*. Participant 6: "*I don't know where else I, you know? where that I, where, where, I had to have the cut, my head is totally confused now"*. When there are attempts to independence, the partner-rebels, as experienced by the participant 6, who despite making some moves, no success: *"Twice I've left home, since rented an apartment, it was back and tuck in from the apartment"*.

Some women reported that aggressions were **recurrent**, both physical and verbal (Participants 1, 2, 5, 6 and 10). Still others have pointed out that they were also physical aggressors as a form of **defense** (Participants 1, 2, 4 and 6), or they ran away in the face of partner's aggression - fleeing (Participant 5). Participant 8 states, *"What he did to me? because my mother didn't raise me for him to beat me up, and he picks up from anyone, I would not accept that my mother beat me, now I'll accept from shit hit me"*; using the law to protect themselves and put a limit.

3) Emotional aspects

Participants 1, 3, 9 indicate feelings of **fear** in relation to what was experienced and feelings of incapacity in the face of the situation. Participant 1 says: *"For fear, he is very "barreiro", very bad, very bad, only that my life has become a hell, he threatens me every day, as if it were terrorism"*. In the same way participant 5 said: *"I slept with an enemy like this, I was afraid of death"*. There were still aspects of **sadness** in participants 4, 5 and 10. Participant 4: *"I was very nervous, I cried, I was worried"*. Participant 10: *"I cry every day"*. As well as, participants 4 and 5 respectively bring feelings of **devaluation** in front of themselves: *"He manipulated me I felt like a poor person, I felt the worst, I felt ah I did not even, I felt worse, nobody can help me"*, *"I felt like crap, it made me feel like crap"*. It is also possible to raise in participant 5 feelings of **guilt** in relation to the fights and attitudes of the comrades: *"I feel guilty (...) it is something that hurts me to do this for him, I feel sorry for him"*, referring to guilt in complaint.

In addition, there are interviewees who feel **guilty** (Participants 4, 6, 8 and 9), as shown in the speech: participant 4: *"So, everything that happened was my fault, I was with the boy, if I had not stay with he, involved me with him, impregnate (…) I was feeling guilty, very, very, very much, if I knew that all this would happen, I would have turned into a hurricane, I had not even looked at it, passed straight".* Participant 6: *"It's so oh, I'm sorry today for not the first time, so oh, that he had some crisis, so oh, that he had said did not arrive, give limit, I repent a lot yes, so oh, I should have said no, you there, I'm here and you get it, I regret it a lot, if I did not do it at the beginning, I left it, I did not stop at the beginning."* Participant 8: *"I feel guilty for believing all this".*

4) Reason for being in the relationship

A common feature of the study participants is the permanence in the relationship, even qualified as abusive and violent. They remain due to the feeling of **being cared for and receive affection** (Participants 1, 3, 4, 5, 7, 8 and 9) and / or because they **felt love from their partner**, stressing these violent moments (Participants 2, 5 and 8) like the participant 2: "*Because I liked him, was afraid of losing him"* and participant 5: *"That thing so I will not have anyone to help me".* Some had the hope that the partner could change his attitudes (participant 3 and 10), participant 3: *"Hope he changed, because after all he did, he would fight all night, but we got it right."*

Another issue that can be raised that influenced the continuity of the relationship refers to health issues (Participants 1 and 5), both of women and their children, observed in following statements: participant 1: *"I have problems in the knees, a disease that has no healing in the bones, hence I am leaning against it. I could not drive the van. He did the races for me*". Participant 5: *"I was already depressed, because of this, that I was not even working".* Participant 6: *"Her well-being (daughter) so oh, it's been 6 months now that she's doing this treatment right".*

5) Type of violence and explanation of the reason for the violence

The majority reported having suffered **physical** aggression from partners (Participants 1, 2, 4, 5, 6, 7, 8 and 10), **psychological** violence - humiliations and insults - (Participants 3, 4, 5, 6 and 7) with case threat (Participants 1, 9) or in case of separation (participant 6). Participant 6 exemplifies this question: *"I will take our daughter if you separate from me, you will never see her again, I will not appear again, I will not see her again* (cry)*"* or participant 3: "*such a knife to cut meat, stab you all, then I'll kill you, I'll show you, if you do not stay with me, you will not stay with anyone in this life".* One of them reported **sexual** violence of a

seductive boy from a virtual relationship (participant 9). Participant 9: *"I didn't know that, he used drugs, he was aggressive (...) He put a gun on the side of the bed, I've never seen a gun in my life".*

Regarding the **verbal threats**, participants 1, 2, 3, 4, 5, 8, 9 and 10 suffered constantly, as exemplified in the following lines: participant 1: *"Because you are old, I'm sick of this old , because I can't stand the voice of this old woman, he was already mistreating me understood, little by little*". Participant 5 *"After about 2 months, when we were together, he showed me who he was (...) we fought, he used to scold me for a lot of things, he used to spit on me, he used to call me junk".*

For participants 1, 4, 5 and 9 the aggressions became physical as revealed: participant 1: *"Bah, it was horrible, it was very ugly there (...) I was horrible on this side, this time I was disfigured (...) he drops me and had the courage to sit on top and I get on the same side all the time, I leave horrible"*. Participant 2: *"it's been almost 2 years, I'm trying to get my partner out of the house, because he drinks too much, and now he starts assaulting me, he bounces on me with a knife"*. Participant 5: *"He knocked me, gave two punches and I managed to get out running like that, between the room and I knocked the child on the ground, that I purposely threw my daughter on the ground, to him at the moment he can get up right. He brushed my hair so he could get it, and it was the moment I got out of the door, and I ran away".*

The **causes** pointed out by the women participants were practically unanimous: use of **alcohol** by the partner (Participants 1, 2, 9 and 10) and / or **jealousy** of the partner (Participants 2, 3, 4, 5, 6, 7 and 8). She couldn't talk to other people, especially men, or wear some specific clothing. Example of participant's talk 10: *"Yes, yes, with a drink, he spent a lot of money, every weekend"*. Participant 8 and 9, however, reveal the use of marijuana and cocaine by their partners, as reported by participant 8: *"He smelled cocaine and marijuana".*

6) Support network and daily activities

The support network and work and study activities are variable in these women. Some women reported having **family support** in crisis situations (Participants 3 and 4) and help from **co-workers** (Participant 7). However, some do not feel they have anyone other than their partners (Participants 1, 5 and 10), as in participant 5: *"He has an abusive relationship, he gives me psychological pressure, nobody will help me, that no one likes me, you know, that thing like that, that I will not have anyone to help me, right?"*. Or they have only **children** as the only source of fulfillment in their lives (Participants 2, 6 and 8). The response of participants 7 and 9 is highlighted when asked about who helps or cares for her when necessary: *"Myself", "I and God"*, respectively. Three of them said they did not want to disturb

or worry their relatives (Participants 5, 7 and 8), so they did not seek help, isolating themselves from the others. Some women are without paid **work**, not always meaning financial dependency, but without a work activity in which they feel useful (Participants 1, 8 and 9). Also, the **study** is an activity practiced by only one participant (Participant 6) and desired by some (Participants 7 and 8).

Another factor to be considered relates to the feeling of lack of acceptance (Participants 1 and 4) by the responsible authorities or sectors in being able to report the aggressions they suffered: participant 1: *"When I went there at the police station (...) he* (partner) *arrived at the same time and the guy* (police officer) *is sorry. I don't know what it was, he said: why you no talk with other? Sit there. And it doesn't give anything"*. Subsequently, when making a phone call denouncing his partner because he already had a protective measure and was at home, participant 1 also says: *"He was very stupid* (police). *He gets really angry, I have so much to do, and I have to come here"*. Participant 4 also points out this difficulty when registering a complaint about the verbal / psychological violence she suffered: *"And the policeman said, I do not even want to hear the recording! I did not understand until today"*.

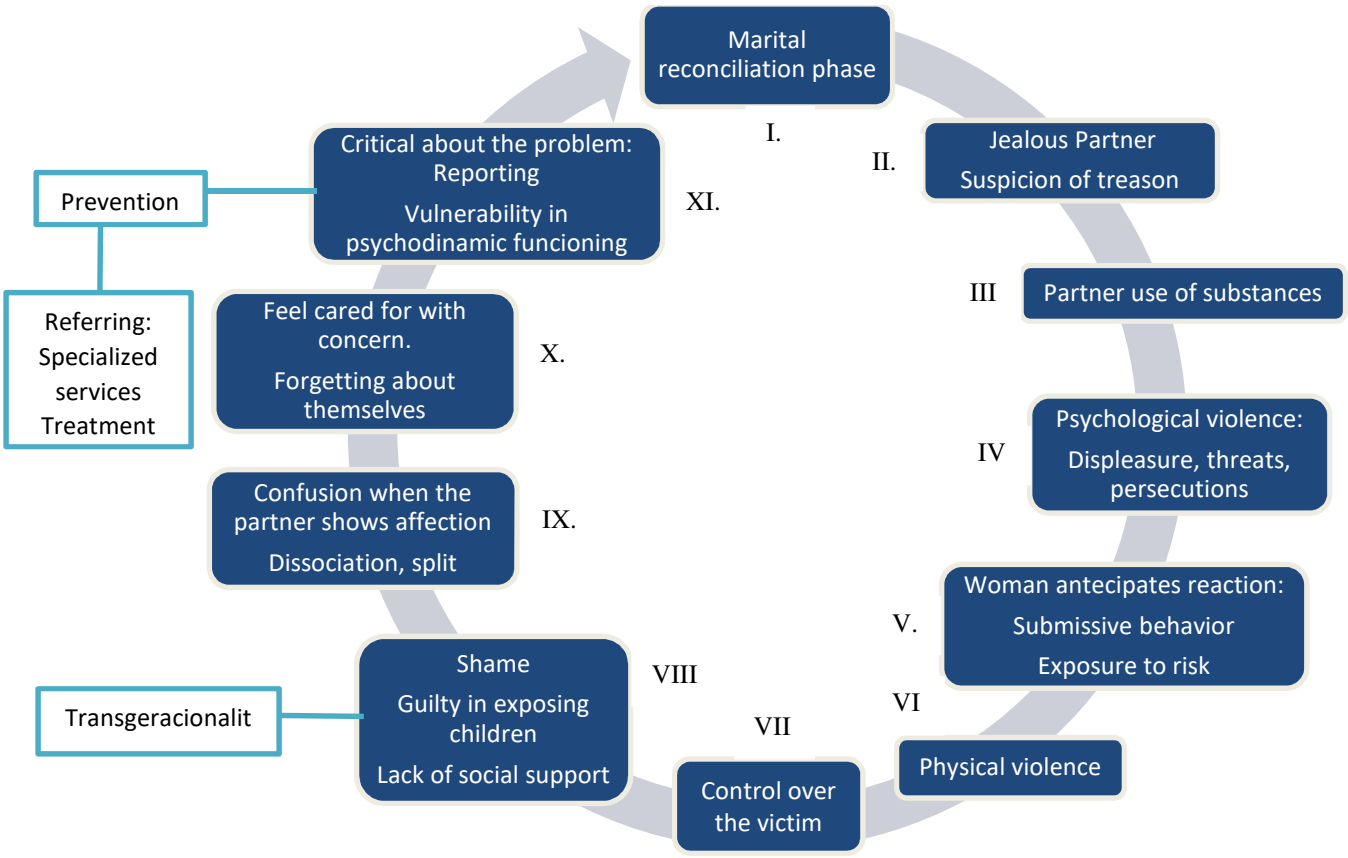
7) Clinical and legal referral

Most of the women (n = 8) made the referral of the **protective measure** guaranteed by the Maria da Penha Law (BRAZIL, 2006) and remained in their homes while the partners sought another place to live. However, with regard to **assets** in common with the partners, one of them requested a measure and seizure of the car that the partner stayed (Participant 1). In relation to the **children,** one of women intends to prevent contact with the father (Participant 3), there is one interviewee who awaits the judicial decision to regulate visits for the children to have contact with the father again (Participant 4) and, unlike, there is another who can not see the children who stayed in the partner's house (Participant 10). About motivation for psychological or psychiatric **treatment**, few have shown interest; only three would like to return to treatment, since they have had prior treatment experience (Participants 5, 6 and 9).

DISCUSSION

We believe that there is a cycle in the context of domestic violence, from a traumatic perspective, which will be explored (Figure 2), confirming the hypotheses.

Figure 2. Stages of cycle of violence.



This figure shows an outline of the cycle of violence algorithm proposal. At stage number I there is what is called the honeymoon phase of the relationship, when the couple is still in harmony. However, according to the perception of the female victims, the partner are very jealous, since they suspect betrayal (Stage II). Then, in order for the partner to calm down. A partner who turns out to be violent usually abuse substances, mainly alcohol (Stage III), according to the victims' perception. As a consequence, lack of control of the partners' violent impulses and emotions that he already possesses in a latent form that will then pass to actions. Threats, persecutions; psychological violence begins to happen (Stage IV). With that, the women start anticipating violent reactions, and end up behaving in submissive ways to please their partners. Thus they remain in the relationship and are continually exposed to risk (Stage V).

At the Stage VI, physical aggression will take place, as partners form of reestablishing control of the relationship (Stage VII) with progression of the cycle of violence and greater impulsivity from the men. Dealing with this situation, at the Stage VIII the victim feels

ashamed to expose themselves and ask for help to break the cycle of violence. Consequently, there is the isolation due to the woman's shame and jealousy of the husband that prevents her from working or meeting with friends and family. Also, they feel guilty for exposing their children to situations of violence, in which can have transgenerational effects by promoting a parental model that is being repeated by them and will be repeated by their children. However, in different stages of the cycle of violence, some women manage to find the strength to seek help.

According to the report of the National Council of Justice, the number of protective measures during the year 2017 increased considerably. Throughout Brazil, 236,641 measures were issued in 2017, an increase of 21% compared to 2016. Specifically, Rio Grande do Sul was the State that issued the most protective measures based on the Maria da Penha Law in 2017 (CNJ, 2018). Despite this, in ten years, there is a 6.4% increase in Brazilian femicides (IPEA, 2018).

However, when woman thinks about taking action to protect themselves and the partner shows affection again the victims become confused by the care they are receiving. Dissociation and division occurs when they dominate the minds of victims all aspects of violence are disregarded or even seems to disappear (Stage IX). Besides that, the partner's concern expressed as jealousy and control over the victim are misunderstood by women who feel cared for. The victims forget about themselves and dedicate most of their time taking care of others as a way to feel cared for (Stage X). When the victims become aware of the violence to which they are subjected to, obtaining insight of the cycle of violence as a whole, they find courage to report the partner. It's in this moment of rationality that occurs the possibility to break the cycle of violence. When victims recognized all their suffering they finally seek some kind of support and assistance breaking the pattern of isolation and shame. In any case, such victims present a vulnerability in the psychodynamic functioning that needs to be strengthened to break the cycle of violence (Stage XI). However, not all victims continue with the legal procedure because they reconcile with the aggressive partner and start to relive the cycle of violence sometimes without realizing that they are returning to Stage I.

Sociodemographic data

The study was conducted with women victims of domestic violence who sought out public service for medical examination. Most were white, aged 18 to 35, complete high school education and with income between 1 and 2 minimum wages. Their partners were also whites with predominance of Elementary Level of schooling and income also between 1 to 2

minimum wages. This profile is observed in different studies, as risk factors associated with domestic violence (Audi *et al.,* 2008; Silva, Falbo, Figueiroa & Cabral, 2010).

However, this data shows consistency with the local study of 751 couples that mapped marital violence in the South of Brazil (Rio Grande do Sul state). The authors pointed out that higher schooling was associated with a lower level of violence, since it aids in talking and negotiation for conflict resolution; the sample of this study presented median schooling, and incomplete high school education. Income was not a significant factor, since there were high levels of violence in both contexts, despite the majority being of low income. Lower ages were associated with higher levels of violence (Falcke *et al.,* 2017).

Previous history

The present study showed that participants had differences in their previous history, some of them lived traumatic experiences while others healthy experiences. In the literature, adverse experiences in the family of origin is not a determinant factor for the pattern to reoccur in adult life (Yoshihma & Horrocks, 2010). Personality disorder in women is considered to be a mediating variable in relationships between experiences in the family of origin and conjugal violence (Ehrensaft, Cohen & Johnson, 2006; Madalena, Carvalho & Falcke, 2018). The participants who grow up in a violent environment could repeat parental patterns and developed a more serious pathology, but issues in the family origin are not the only determinant in current cycles of domestic violence.

In stress and crisis situations, participants presented difficulties to make significant changes in their daily life to break the established cycle. In this sense, it can be understood that the aggressions suffered, recurrent or isolated, are characterized as stressful traumatic situations in their lives, the trauma overwhelms the capacity of the ego to process anxiety and pain (Zimerman, 2001) producing disruption or distortion (Benyakar, 2002). Thus, the use of defensive mechanisms such as dissociation, repression against traumatic memories are common in these cases as was observed in the participating victims.

Attitudes toward trauma/violence demonstrate a lower or less structured personality associated with unsafe primary psychic representations. It is observed in the stories of the victims that experienced fights and discussions during their development, these characteristics can be a transgenerational aspect also having influence when choosing partners (Coimbra & Levy, 2015). In these cases, there is identification with the victim's role and a repetition of parental patterns. Several studies point out that involvement in contexts of family violence as a victim or being a direct witness increases the possibility of establishing a violent conjugal relationship in their own adult life (Falcke, 2006; Milner *et al.*, 2010; Zancan, Wassermann &

Lima, 2013). Another study found that women who experienced domestic violence, whose mother had been beaten by their father, were three times more likely to suffer domestic violence than women who did not witness such aggression (Adjah & Agbemafle, 2016).

Behavioral and Emotional: cycle of violence maintenance

Anthropologically, when thinking about the construction of the phenomenon of violence against women, we must highlight the historical and cultural factors involved, in which domestic violence against women is trivialized and naturalized in today's society and among different cultures. In this sense, men's desires and wishes must dictate over submissive and subordinate women, generally having inequalities in different contexts such as social, work, family. Domestic violence against women studied here has issues of great magnitude, since the aggressions were recurrent and the women remained silent, perhaps not only for psychological reasons (Bins *et al.,* 2015).

The aggressions often start from a repetitive and recurring pattern of control and domination. This control and the control over the life of the victim is called *Stalking;* defined as the perpetrator's imposition of unwanted approach and communication behaviors that induce fear in the victim. It involves intrusive, obsessive, and unwanted acts. These characteristic are common behaviors related to psychiatric disorders (Bins *et al.,* 2015). These aspects were very present in the stories of the interviewed women, in which the partners controlled their lives, preventing them from living.

Some of the victim's reaction to violence were: defending themselves of the aggression, fleeing, isolating themselves and/or grieving. However, most of the time they felt intimidated to break the cycle of violence. The victims remained in the relationship due to fear of future aggression or of risking their lives or their children's if reporting (Zancan *et al.,* 2013). However, there is a feeling of guilt for exposing their children to situations of violence, due to the considerable effects on mental health and performance in school activities (Carneiro *et al.*, 2017).

Also, victims often do not break the cycle or report the partners' due to difficulty in recognizing their interactions as violent (Garcia *et al.*, 2008), especially in cases of psychological aggression. Emotional abuse, studied by Bins (2012), is considered one of the most difficult types to be identified, but increasingly studied and associated with the development of psychopathologies.

In addition, it can be hypothesized that trauma, due to constant violence, causes changes in structural functioning and intrapsychic conflict (OPD Task Force, 2008). Violent actions damage the ability to think and comprehend (Souza, Martins & Araújo, 2011).

According to the theoretical and clinical reference of the theory of mentalization of Bateman and Fonagy (2010; 2016), it is observed that the participants have difficulties in mentalization. In this case, hypermentalization occurs due to trauma, in which excessive interpretations of the mental states of others occur, and the subject distorts and interprets reality in a wrong way; a vulnerable mentalization. The predominance of unreflective, rigid and automatic assumptions sustained with the unjustified certainties of internal and other mental states is common. Moreover, they focus on their external aspects too much (Sharp *et al.*, 2011, 2013, 2016). In this way, there is instability in the relationships with psychological conflict focused on emotional dependence on the other.

As a consequence, they become submissive, abandon their desires, and projects due to their partner's life and there is difficulty in having a sense of identity. Thus they present a diffused identity with difficulties to described themselves over time in a consistent and coherent way, as observed in the participants. According to Kernberg, Selzer, Koenigsberg, Carr, and Appelbaum (1991), identity diffusion is defined as the lack of integration of the concept of self, from the patient's subjective experience of chronic emptiness and self-perceptions and contradictory behaviors.

Concerning submission to psychological violence by the participants, most of the participants in the study mentioned that such violence increased their feelings of incapacity. This fact is pointed out by Guimarães and Pedroza (2015) as an abandonment of a self-sense of dignity, since this dignity is denied by the other, the aggressor. According to the Maria da Penha Law (Brazil, 2006), psychological violence is any action that will cause emotional damage and decrease self-esteem, that harms and disrupts development or that seeks to degrade or control the actions of women and their behaviors, through threat, embarrassment, humiliation.

Regarding the emotional aspects identified, the predominant feelings pointed out by the participants were fear, anxiety, anguish, and even guilt, affirming the complex unconscious dynamics and the contradictory feelings present in the relationships. In relation to the defense mechanisms, it is observed that the use of dissociation prevailed as a way of retaining an illusory control in the face of helplessness and lack of control; the split, since they perceived the partners as good objects or bad and aggressive; denial, in which they avoided awareness of the difficult aspects of relationship and past history. Some showed somatization, which is characterized by the conversion of affective states into physical symptoms (Gabbard, 2016).

Type of violence and explanation of the reason for the violence

According to Bins, Telles and Panichi (2015), violence against women is a multi-causal phenomenon: a) community factors: poverty, unemployment, family isolation; b) factors of society: naturalization of violence to resolve conflicts, male domination, stereotyped gender roles; c) factors of the aggressor: use of substance, transgenerationality of violence. These issues were observed in the participants' stories.

In regards to the causes of the aggressions, it is consistent with reviewed literature, such as the use of alcohol and drugs, jealousy of the partner with suspicion of treason; as reported by the participants (Zancan *et al.,* 2013). The use of substances by their current partners made the possibility of dialogue and understanding even more difficult, factors that concluded in different forms of violence: threats to physical integrity, physical aggression, psychological, and even sexual violence. However, another discussion raised by Falcke, Boeckel, and Wagner (2017) states that the phenomenon of violence is interactional, with high rates of mutual and equal violence between the partners. In the literature it is pointed out that the women practice more psychological violence, while men more physical aggression.

Still, Chauí (2003) complements affirming that the aggressor, denies a sense of purpose, wishes, freedom, and responsibility of the victim, treating women as objects, paralyzing them so much the victim feels like “trash”. According to Saffioti (1999) violent actions will occur when the aggressor perceives that he is losing power or feels incompetent in front of the other, attacking and seeking to destroy capacity of choosing, a hypothesis experienced by a participant. In some interviews, in which there are attempts of independence, in these moments partners present aggression when feeling threatened of losing the object (woman). Thus, in the face of such traumatic events experienced continuously, relationships were maintained even if they suffered or felt angry.

Support network and daily activities

As justifications by the participants for staying in the relationships, we can point out the psychosocial difficulties, such as lack of social support and the community's protective network, financial dependence for children’s needs and household maintenance and food expenses (Amaral *et al.*, 2016; Bins *et al.,* 2015), lack of information and counselling on legal procedures, to the public health networks, to shelters (Cunha & Pinto, 2015).

On the other hand, other participants report having financial independence, which suggests that there are other elements in staying in the abusive relationship, such as low self-esteem, allowing themselves to be controlled, and even manipulated by their partners, feeling “imprisoned” in the relationship, adapting to that reality. In addition, it is noted that some have

remained in the relationship because they feel at least their receiving care from someone. In this sense, it reinforces the hypothesis of the establishment of an insecure attachment in previous history, with ties a dependence in relation to the other, common in women who suffer violence (Montero, 2001). Another hypothesis, this "care" may be due to the sadomasochistic aspects of the aggressor, in which this characteristic is considered to be a high risk for aggression, even fatal (Bins *et al.,* 2015).

In this way, they lose interest in social interactions and other daily activities (Falcke & Feres-Carneiro, 2011; Carneiro *et al.*, 2017), diminishing affection, both in relation to negative and positive emotions, which makes it even more difficult to social contact and future planning (BARLOW, 2016). Only after being able perceive and work on these dynamics do they begin to see other perspectives and start activities such as studying and working, as observed in participants or viewing such activities in another way, towards independence, freedom, and autonomy.

One study presented evidence that higher frequency of social contact was associated with less injury to the victims (Kane *et al.*, 2016). However, the participants in this study reported not seeking family and friends so as not to disturb them, isolating themselves more and more; as well as, not working or doing other activities.

Access to the support network and specialized services is indispensable to assist such women in reflecting on their lives, their choices, and ways of breaking the cycle of violence. Participants reported that when they went for help they went to family or friends at work. The lack of social support and in some cases the difficulty in asking for help, as well as a prejudiced attitude from those who should show support, resulted in increased suffering and the progression of more serious aggressions (Meneghel *et al.,* 2011), as observed in the study, in which there is a progression of psychological violence to physical (Bins *et al.,* 2015). Some of the women pointed out that they do not want to bother anyone, so they remain quiet and handle the situation on their own.

Referring and Prevention

It is noteworthy that all participants in the study had already filed a report of aggression at the police station; but the majority did not have information of security and protection rights that they are entitled to according to the Maria da Penha Law (Brazil, 2006). Access to information is still a flaw in the community, and this is an important point for the prevention and eradication of domestic violence (Cunha & Pinto, 2015).

According to Signori and Madureira (2007), the situation of violence in a relationship is also aggravated by the shame women have in reporting it, the lack of educational means,

and lack access to legal information and of assistance and protection. In the participants, the aggressions were recurrent, only reporting it when it reached their limit of frustration. In this sense, the participants demonstrated confidence in the protective measures as a way to ensure their protection; an initiative to break the cycle of violence. However, few of them had the desire for treatment, to change these dynamics, maybe because of the difficulty of mentalization in reflecting and perceiving themselves or the other in the relationship, the future of their choices and the consequences of their actions.

As well, another issue raised by Signorelli, Taft and Pereira (2018) refers to the existing gap in the implementation of Brazilian public policies, despite the benefits of including women in these services and listening to them. The psychosocial reception of the service has helped the victims to reflect on the choices and attitudes in their lives; however, there are still many deficiencies in the public service that need to be discussed: not all women are listened to and given guidance due to the dynamics of the service, since only the medical exam is mandatory for the report, so the focus of process remains with physician, the psychosocial team can only approach the victim after the exam. Thus, we suggest a reformulation of the dynamics of the services for the better care of these women, taking into account the needs that go beyond legal and police guidelines, because only then will it be possible to promote a significant change in the cycle of violence. We suggested the implementation of waiting room groups, for a more inclusive support network, among others.

With this, we can think of prevention from three perspectives: primary, secondary and tertiary. Primary prevention is more focused in a macro level, when violence has not yet occurred. It is important to note that in the case of anthropological issues of power and gender, women have a more submissive and adaptive attitude towards abusive and coercive behavior (Cortez *et al.*, 2010). In this sense, it is possible to facilitate access to the information and procedures regarding domestic violence supported by media and communication networks on protection rights; to eradicate the socio-cultural pattern of stereotyped gender roles (Brazil, 2006; Cunha & Pinto, 2015).

Secondary prevention is when it is happening, so what can be done? From this perspective it is thought at the micro level, with the strengthening of the individual resources of the victims to assist in the management of the traumatic event. This proposal is based on therapeutic listening and specialized health services that promote psychological changes in these women (Garland, 2015). However, this is not a right entitled in the assistance of women insured under the Maria da Penha Law (Brazil, 2006). There are legal guidelines that ensure mechanisms such as: a) social, with the registration on public programs with housing benefits,

maintenance of employment bond; b) health, with free contraceptive methods for cases of sexual violence; c) public security, guaranteeing victim protection.

And finally, tertiary prevention, regarding aggressions that occurred in the past. This perspective is similar to the secondary interventions, which we seek to emotionally strengthen the victims. Also, it is suggested the creation of a program for aggressors, an example to those done internationally (Barin, 2016); after all, these aggressors are also suffering and have their difficulties (Bins *et al.,* 2015).

LIMITATIONS

The biases were controlled as much as was possible. This research is a qualitative research, in which the researcher's subjectivity can measure results, thus all interviews were analyzed by two independent judges. And we base the data on the guideline Consolidated criteria for reporting qualitative research (COREQ*;* Tong *et al.,* 2007) so that there would be greater methodological consistency.

In addition, the interviews were performed only from the audio transcription, so non-verbal behavior of the patient was not evaluated. Sometimes, the expressiveness was kept in report, such as crying, anger, among others. Also, part of the interview was dedicated on counselling the victims on legal procedures.

About the collection place, it was not a clinical setting, but a police station with the intention of filing a report against someone and also seeking protection. Thus, in some cases, there was a high amount of defense mechanisms or even dissociative defenses that could distort the facts. Regarding the sample number, there are only 10 women, but the data saturation criterion was used, so it is evident that the data collected are consistent with reality.

CONCLUSIONS

The present study collaborated to the understanding of the psychodynamic issues of the cycle of domestic violence against women. The dynamics of violence reported by the interviewees is observed in other studies on this subject. However, there are few studies that focus on aspects of psychodynamic theory on the cycle of violence. It is necessary to understand this cycle of violence to create more effective coping mechanisms. What is innovating in this article is the construction of this cycle of violence. Adverse experiences were observed during the development of the victims, generating feelings of dependence and fear of loss of the object because of their diffuse identities. Even when the participants demonstrated a more integrated psychic structure, the trauma caused difficulties of

mentalization, emotional dependence, and relationship instability. Such understandings have enabled us to reflect on the definitions and patterns of violence against women emphasized in the literature, identifying the relevance of this clear conceptualization to (re) affirm the breadth and diversity by which such violence can express itself.

Tackling violence involves new ways of offering support to women, allowing a space for listening and working not just for the legal procedures, but as an attempt to stop the cycle of violence. Therefore, a specific assessment of the patient's, seeking to identify the psychological and social resources and obstacles of the patient, her personal understanding of the symptoms and the characteristics of the psychodynamic functioning. Likewise, it is important to extend the educational work seeking the deconstruction of cultural and social standards instituted in relation to the gender that authorize and naturalizes male domination.

Many issues still need further studies, specifically in psychodynamics perspective about the cycle of violence. However, the research seems to collaborated with greater evidences on the subject, especially in the context of the metropolitan region of the South of Brazil (Rio Grande do Sul, state). It is pointed out as limitation the fact that the participants came from police station, whose victims filed a report to the police, different from those who are still "imprisoned" inside the family. As well as, the present study has a cross-sectional investigation design so lacking the long-term feedback from the participants. Future studies investigating a longitudinal sample would have a greater potential to understand the complexity of the phenomena involved in the cycle of violence against women increasing understanding in this very important field.

Acknowledgment

This study was supported by the Legal Medical Department of *Rio Grande do Sul*, especially by Dr. Anlelita Rios, who invited and made collection possible at the institution. Also, a teacher Carla Crempien by *Pontificia Universidad Católica de Chile*, who cooperated with support for OPD. And the researches Lisieux E. de Borba Telles (UFRGS) and Denise Falcke (UNISINOS) who are a reference in the local scientific production on the subject.

Ethical observations

1. Conflicts of interest. There are no conflicts of interest.

2. Ethical Approval. The study received the approval of an institutional ethics committee and authorization for data collection.

3. Consent. The victims were invited and authorized their participation in the research by signing the Informed Consent Form.

4. Omission: All data that could identify participants was omitted.

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9 ARTIGO 3. CROSS-CULTURAL ADAPTATION OF THE *MODULE FOR ASSESSMENT OF DOMESTIC VIOLENCE* ADAPTED FROM AXIS I OF THE OPERATIONALIZED PSYCHODYNAMIC DIAGNOSIS (OPD-2) IN A SAMPLE OF BRAZILIAN WOMEN VICTIMS OF DOMESTIC VIOLENCE

- Revista: ***Trends in Psychiatry and Psychotherapy***
- Qualis na Área de Medicina II – Classificação de Periódicos Quadriênio 2013-2016: **B3**
- http://dx.doi.org/10.1590/2237-6089-2018-0075

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Abstract

Introduction: Intimate partner domestic violence against women causes physical and psychological harm to the victims. The relevance of this topic is indisputable as well as to identify in further detail how these women experience violence since such factors present strong clinical implications.

Objective: To develop the Portuguese version of the *Module for the Assessment of Domestic Violence,* adapted from OPD-2 Axis I, considering content validity and psychometric characteristics.

Method: Cross-Cultural adaptation based on *Guidelines for the Process of Cross-Cultural Adaptation of Self-Report Measures*. OPD Clinical Interviews were recorded and transcribed. Those interviews were analyzed by two independent judges who were trained in the OPD-2.

Results: The sample was composed by fifty-six women victims of domestic violence with a mean age of 30.07 years (SD = 9.65). There was content validity and good psychometric characteristics. The evaluation of the semantic equivalence took into account the psychodynamic referential, using the same ideas as the original instrument. Reliability among the judges was substantial (k = 0.63) and Cronbach's alpha of the version indicates a good reliability.

Discussion: OPD-2 offers a psychodynamic diagnosis of the victim which is a complement for the traditional nosological diagnosis, particularly in the context of domestic violence with the adaptation of Axis I. Biases could be determinant aspects in the study, however they were controlled.

Conclusion: The objective of the study was achieved and the Module was successfully adapted to Brazilian Portuguese. The results conclude in line with the original study.

Keywords: psychodynamic, diagnosis, cross-cultural adaptation, domestic violence against women, assessment.

Introduction

Violence against women is unquestionably a public health problem. Data shows that 35% of women around the world are victim of physical and/or sexual violence at some point in their lives.[1] According the Atlas of Violence 2018 developed by the Brazilian Forum of Public Security and Institute of Applied Economic Research (IPEA) in 2016, 4,645 women were murdered in Brazil, representing a rate of 4.5 homicides per 100,000 Brazilians women.

Furthermore, data shows that in the next ten years there will be a 6.4% increase of violence against women.[2]

It's observed that the statistics of domestic violence against women is alarming. It is important to consider that the majority of women who suffer domestic violence do not report it. Underestimating the statistics behind domestic violence against women. In the European Union 14% of women only reported violence to the police when the incident by the partner was the most serious act ever committed.[3] Among 83 countries, Brazil occupies the 5th place in domestic violence against women. Besides that, 4,762 cases of femicide committed in 2013, of which 33.2% were carried out by intimate partners or former partners.[4]

Intimate partner domestic violence against women causes physical and psychological harm to the victims, threatening their well-being.[5-6] Usually presents with a slow and silent beginning without presenting physical aggression; gradually progresses to actions with greater intensity and humiliation, even public manifestations of aggression.[7] And yet, it can worsen due to shame women feel when reporting to authorities. Women who suffer violence do not seek help since frequently they feel guilty and stigmatized.[8]

Another factor is due to the social tolerance of violence against women, based on inequalities between men and women, rigid gender roles, cultural influences subordinate women and there are insufficient legal penalties to restrain this type of behavior. It is difficult for women to leave abusive relationships, because they don't have the guarantee to be safe from abusive partner.[9] It is noted that legislation that protects victims of violence has been widely disseminated, but the establishment of standards and compliance to the law are not yet as satisfactory.[10] Is important to mention the financial insecurity, when children are involved, how will they provide for them and where will they live? Some of them remain in the violent relationships, thinking that it will be safer for their children and their own lives.

According to the World Health Organization, acts of violence against women, can produce varying consequences from small to large magnitude. For example: physical injuries, mental disorders such as depression that can lead to suicide, anxiety, post-traumatic stress disorder and increase clinical diseases such as hypertension and cardiac problems, among others.[11]

Carla Crempien, in her studies, point out the necessity of clearly identifying characteristics of violence against women because these factors have clinical consequences in therapeutic results. So, she developed the *Module for Domestic Violence Assessment*, that evaluate the severity, type and duration of violence, women's suffering, resources and obstacles to break cycle of violence based on Axis 1 of Operationalized Psychodynamic

Diagnosis (OPD-2).[12,13] In her empirical study with a sample of 26 women victims of domestic violence, the high vulnerability of the self-capacities of women victims of violence was proportional to the high severity of violence and greater therapeutic obstacles.[14]

The present study describes the adaptation of the English version of the *Module for Domestic Violence Assessment*,[12] adapted from Axis 1 of Operationalized Psychodynamic Diagnosis[13] to the Brazilian Portuguese version, the manual and the scoring form. The adaptation of Axis I ("Experience of illness and prerequisites for treatment") of the OPD-2 to the Module for the Assessment of Domestic Violence was proposed by researcher Carla Crempien in 2009 in her doctoral thesis.[12,14]

The Operationalized Psychodynamic Diagnosis was created in 1992 in Germany by a group of psychoanalysts, psychosomatic therapists and psychiatrists, to complement and enrich the symptom-based and description for the classification of mental disorders by adding a fundamental psychodynamic dimensions. Currently, there is a 2nd version of the operative manual, the OPD-2, which is validated in Portuguese (Portugal),[15] with the inclusion of Portuguese (Brazil) by a study from the *Federal University of Rio Grande do Sul* (UFRGS).[16] The OPD-2 is a multiaxial diagnostic system and comprises five axes, four of them are psychodynamic and the last one is descriptive: (I) experience of illness and prerequisites for treatment, specifically in this study domestic violence assessment module; (II) interpersonal relationships; (III) psychic conflict; (IV) psychic structure; (V) traditional nosological diagnosis, such as DSM and ICD. The instrument aims to formulate, identify, and center treatment planning.[13]

In terms of cross-cultural adaptation, it's necessary to take in account the conceptual and linguistic equivalence between the original and translated versions, in order to validate the resulting instrument, considering the cultural context to be placed.[17] The Portuguese and Brazilian adaptation of OPD-2 was carried out by experienced clinical psychologists trained in the use of the instrument, respecting the cultural aspects of these countries. However, empirical evidence is necessary to better support the validity of the adaptations made.[15]

Objective

The aim of this investigation is to develop the Portuguese version of the *Module for Domestic Violence Assessment*, adapted from Axis I of OPD-2, considering content validity and psychometric characteristics.

Method

The study design was based on the *Guidelines for the Process of Cross-Cultural Adaptation of Self-Report Measures*, which consist of six interdependent stages: 1) initial translation into Brazilian Portuguese; 2) synthesis; 3) back-translation; 4) expert committee; 5) pre-test; 6) submission of documentation to the developers and the author of the original instrument.[18]

Instrument

The *Module for the Assessment of Domestic Violence*,[12,14] has 16 items subdivided into six categories:

a) Type of violence (emotional, physical, sexual): These items refer to the different forms of expression or manifestations that domestic violence may have, and to the severity level of each type of violence, as well as to the gravity of violence as a whole.

b) Duration of the domestic violence situation: This is an indicator of the chronicity of domestic violence, so it also provides important information about the of the problem severity.

c) Intensity of subjective suffering: This item refers to the subjective suffering expressed by the victim due to the partner violence. This suffering must be verbalized by the woman or expressed via her gestures and/or behavior.

d) Personal concept of domestic violence: This element refers to the reasons woman provides to explain herself or to others why she is currently experiencing or has experienced domestic violence.

e) Concept of change: The victim's personal concept of change has to do with what she thinks that would it be needed for her to put an end in the situation of violence that she is experiencing.

a) Resources and obstacles for change. The following items are aimed at assessing: First, the internal and external (environmental) resources that a victim of couple violence has for stopping the violence or overcoming the problem. Secondly is to estimate the level of the obstacles, both internal and external, that keep the woman from generating changes in the situation of violence and hinder her escape from it.

These aspects are collected and explored in the OPD Clinical Interview. Clinical Interview of the OPD comprises a semi-structured interview with specific tools for the exploration of each axis. This interview lasts approximately one hour.[13] For coding, there are

criteria for scoring each item according to the manual and at the end it is codified on the scoring form. In Axis I, the evaluating judges will code the various dimensions and indicators described, in a scale which goes from 0 (absent), 1 (light / insignificant), 2 (moderate), 3 (high / significant), 4 (very severe / very significant), to 9 (Non-assessable).[12,14]

Ethical Considerations

This study was approved by the Ethics Committee of the Federal University of Rio Grande do Sul (CAAE 68271917.7.0000.5347, No. 2,412,749), as well as the consent of the Legal Medical Department of Porto Alegre for the collection of data. The author of the instrument allowed the translating and adapting of the instrument and approved the final version of the translation.

On the fifth stage, data collection took place with the voluntary participation of the victims, who signed the Informed Consent Form, authorizing the inclusion of their data in the research. Their identities have been protected. They answered a sociodemographic questionnaire and soon after the medical evaluation they were invited to an interview. All interviews were recorded and transcribed for further analysis.

Participants

The sample comprised fifty-six women who self-reported being a domestic violence victim, ages between 18 and 65 years from a public service in South of Brazil. The sample was carried out by convenience. The subjects sought the service in order to obtain medical evaluation to use as proof against their partners. In most cases, they request protective rights from the Maria da Penha Law (Law 11.340/2006).[19] Moreover, such services provide psychosocial care for the victims, offering attention and counselling of future legal procedures and treatment.

The sample calculation was based on Krieger's study for the OPD-2 Brazilian validation, with a minimum of 53 subjects for OPD-2 Axis 1, performed by the GPPG of the Clinical Hospital of Porto Alegre. Were considering the number of instrument items and the literature data on the inter-rater agreement for the different axes of the instrument. Thus, the number of interviews was calculated for eachaxis.[16] The Module for the Assessment of Domestic Violence has similar numbers and structure of items to the original OPD-2 Axis 1. Also, in original research about the violence adaptation, the sample was 28 Chilean women patients attending to DV treatment centres.[12]

Procedures

First, the translators were two Brazilian clinical psychologists proficient in English, trained in the use of OPD-2 and familiar with psychodynamic studies. In this stage, both the manual and the scoring forms were translated from English to Portuguese. Translators were health experts, because the language needed to reflect the clinical perspective proposed by the author. Different from a self-report scale, when the recommendation is to not use a health care professional to translate, being the objective to use terms that are common to the general population.[18]

The equivalences proposed by the Guideline were analyzed regarding the content validity. Thus, equivalences were considered: semantic (equivalence in the meaning of words), idiomatic (peculiar to a language), experimental (adaptation for cultural context, respecting that proposed by the original instrument), conceptual (concepts validity), which provide instrument validation. The psychodynamic references were considered, seeking to refer to the same ideas or objects as the original. Therefore, corresponding to the original version proposed by the author. In case of divergences in relation to the translation, it was discussed with other experts in OPD-2 and the author for clarification.

In second stage, after evaluating the divergences and equivalences of the translations from the previous stage, the two translators produced a single translated instrument, concluding the synthesis version of the translations. There weren't divergences in these stage.

In the back-translation – third stage – it was possible to compare the original and the translation, considering content and semantic analysis.[20] Similarly, to the previous step, there was consensus among the back-translations. The back-translation stage is important because it reflects the conceptual equivalence of the original version.[18] In the fourth stage, the committee of expert judges (n = 3) verified the final version, approving it for the pilot application in the pre-test.

The fifth stage, pre-test, was composed of two phases. First, the judges were trained to code the interviews with the new instrument. These judges already had experience from the use of OPD-2 in the *Pontificia Universidad Católica de Chile* of Santiago – Chile.[1]

Subsequently, OPD Clinical Interviews were conducted with 56 women victims of domestic violence. After interviews were transcribed. Two independent judges coded the

[1] http://diplomados.uc.cl/28618-ficha-diplomado-en-diagnostico-indicacion-y-estrategias-en-psicoterapia-diagnostico-psicodinamico-operacionalizado-opd-2

interviews according to the manual in the scoring form. At this time, it was possible to evaluate the clarity of their translated variables.

The reliability between judges was evaluated by Kappa coefficient, according to Perroca and Gaidzinski.[21] The database was set up for analysis of the reliability of psychometric characteristics of the instrument and the descriptive analysis of the sample. A reliability of at least 0.60 was expected in the present study.

The final stage of the process of cross-cultural adaptation and validation, the sixth stage, consisted in the submission of all reports, forms and the final version of the instrument. The original author of the instrument and the other professionals of the research group of the investigators approved the final version of the *Module for Domestic Violence Assessment* in Brazilian Portuguese.

Results

Content Validity

Content validity refers to the theoretical analysis on semantic aspects and judge's analyses.[22] Semantic analysis considered the understanding of the items, the explanation in the manual, and the judge's analysis to evaluate the relevance of the items corresponding to the concept that they represent. The final version was revised in Portuguese for minor adjustments in writing and verbal agreement.

It is observed that there is good content validity on the final version produced by this study. Thus, it is possible to comprehensibly apply the instrument in the new language, with a consistent internal adaptation of linguistics and culture. With this, there is the assurance that the impact assessment of the context of violence will be consistent to reality.[23]

Sample Characterization

Referring to sociodemographic data, the sample had a normal distribution, according to the Kolmogorov-Smirnov normality test ($p < 0.05$). Victim women presented a mean age of 30.07 (SD = 9.65) years and the perpetrator men presented a mean age of 34.8 (SD = 10.86) years. From the descriptive analyzes it is observed there was a predominance of white race, high school diploma, income between 1 and 2 monthly minimum wages in both sexes of the sample. Particularly, women presented themselves as more religious than men, despite the high number of participants declaring themselves to be atheists, and men had greater substance addictions (Table 1). Regarding the type of relationship, for the most part women were

separated from their partners less than six months, from a marriage that lasted 3 to 10 years (Table 2).

Table 1. Sociodemographic Data.

Category	Subcategory	Women	Men
Age	18 to 20 years old	8 (14,3%)	3 (5,4%)
	21 to 25 years old	16 (28,6%)	5 (8,9%)
	26 to 30 years old	8 (14,3%)	16 (28,6%)
	31 to 35 years old	9 (16,1%)	13 (23,2%)
	36 to 40 years old	8 (14,3%)	4 (7,1%)
	41 to 45 years old	2 (3,6%)	5 (8,9%)
	46 to 50 years old	3 (5,4%)	5 (8,9%)
	51 to 55 years old	1 (1,8%)	1 (1,8%)
	56 to 60 years old	1 (1,8%)	2 (3,6%)
	61 to 65 years old	0	2 (3,6%)
Race	White	37 (66,1%)	35 (62,5%)
	Black	21 (21,4%)	13 (23,3%)
	Brown	6 (10,7%)	7 (12,5%)
	Indigenous	1 (1,8%)	1 (1,8%)
Scholarity	Illiterate	0	1 (1,8%)
	Incomplete elementary school	15 (26,8%)	17 (30,4%)
	Complete primary education	6 (10,7%)	6 (10,7%)
	Incomplete high school	8 (14,3%)	7 (12,5%)
	Complete high school	22 (39,3%)	22 (39,3%)
	Incomplete higher education	3 (5,4%)	1 (1,8%)
	Complete higher education	1 (1,8%)	2 (3,6%)
	Postgraduate studies	1 (1,8%)	0
Income	None	13 (23,2%)	8 (14,3%)
	Less than 1 salary	8 (14,3%)	1 (1,8%)
	Between 1 and 2 salaries	31 (55,4%)	35 (62,5%)
	Between 3 and 6 salaries	2 (3,6%)	5 (8,9%)
	Between 7 and 12 salaries	1 (1,8%)	2 (3,6%)
	More than 12 salaries	1 (1,8%)	4 (7,1%)
Religion	Godless	22 (39,3%)	26 (46,4%)
	Catholic	19 (33,9%)	15 (26,8%)
	Spititist	4 (7,1%)	3 (5,4%)
	Afro-Brazilian	3 (5,4%)	6 (10,7%)
	Evangelical	0	6 (10,7%)
Addiction	Alcohol	3 (5,4%)	25 (44,6%)
	Drug	2 (3,6%)	0
	Tobacco	8 (14,3%)	7 (12,5%)
	Marijuana	1 (1,8%)	7 (12,5%)
	Cocaine	0	3 (5,4%)
	Marijuana and Cocaine	0	7 (12,5%)
	Anabolic	0	1 (1,8%)

Table 2. Relationship.

Category	Subcategory	Women
Type of relationship	Date	1 (1,8%)
	Dating	9 (16,1%)
	Marriage	5 (8,9%)
	Stable union	8 (14,3%)
	Divorced	7 (12,5%)
	Separated in less than 6 months	26 (46,4%)
Time of relationship	Less than 6 months	3 (5,4%)
	Between 6 months and 1 year	6 (10,7%)
	Between 1 and 2 years	11 (19,6%)
	Between 3 and 5 years	13 (23,2%)

Between 6 and 10 years	15 (26,8%)
Between 11 and 15 years	2 (3,6)
Between 16 and 20 years	4 (7,1%)
Between 21 and 30 year	2 (3,6%)

Regarding the types of violence, the participants suffered severe emotional violence, followed by moderate physical violence. The suffering was intense, although the complaints during the interview about this did not overbear. The personal explanation of domestic violence refers to both internal and external factors, but women believe in external change to resolve the violence. They presented moderate levels of internal and external resources to solve the problem, while presenting obstacles to cope with it. (Table 3). The relationships are short, less than 6 months (Table 4) and the first episode of violence was on average at the age of 25.52 years.

Table 3. Frequency of items assessed in Module for the Assessment of Domestic Violence.

Variables	**Frequency**			
	1	**2**	**3**	**4**
Type and severity of violence				
Emocional Violence	0	23(41,1%)	32(57,1%)	1(1,8%)
Physical Violence	2(3,6%)	33(58,9%)	19(33,9%)	2(3,6%)
Sexual Violence	51(91,1%)	1(1,8%)	2(3,6%)	1(1,8%)
Global Severity Index	1(1,8%)	30(53,6%)	23(41,1%)	2(3,6%)
Subjective experience, presentation of the problem				
Intensity of subjective suffering	0	24(42,9%)	31(55,4%)	1(1,8%)
Presentation of complaints on domestic violence	1(1,8%)	32(57,1%)	23(41,1%)	0
Personal explanation of domestic violence				
Oriented to external causes	3(5,4%)	32(57,1%)	20(35,7%)	1(1,8%)
Oriented to psychological/interpersonal causes	9(16,1%)	38(67,9%)	9(16,1%)	0
Change concept				
Oriented to external modifications	0	33(58,9%)	22(39,3%)	1(1,8%)
Oriented to personal changes	17(30,4%)	22(39,3%)	17(30,4%)	0
Personal and external resouces and obstacles to change				
Personal resources	13(23,2%)	35(62,5%)	8(14,3%)	0
Personal obstacles	6(10,7%)	34(60,7%)	16(28,6%)	0
External resources	4(7,1%)	45(80,4%)	7(12,5%)	0
External obstacles	4(7,1%)	48(85,7%)	4(7,1%)	0

Note. The higher the score is the higher the severity or the presence of the variable.

Table 4. Duration of domestic violence problem.

Time	**Frequency (%)**
<6 months	18(32,1%)
6-24 months	8(14,3%)
2-5 years	14(25%)
5-10 years	6(10,7%)
>10 years	10(17,9%)

Psychometric Characteristics

The reliability between judges was substantial (k = 0.63, minimum 0.43 and maximum 1), indicating that agreement wasn't by chance. Therefore, the instrument is accurate

regarding the assessment criteria for the Brazilian population, more specifically *gaucho* women victim of violence – South of Brazil. In study of OPD Brazilian adaptation, kappa varied between 57,1% and 77,7% in inter-rater agreement.[16] So, our results point in the same direction as previous studies conducted in other countries.

In regards to internal consistency, the instrument demonstrated a Cronbach's alpha of the version of 0.63, which indicates that it is trustworthy. Table 5 presents the individual scores of the items and points out what would be the Cronbach's alpha if an item were deleted, but there was not a big variation if an item were excluded.

Table 5. Mean, correlation of item-total adjusted, Cronbach's alpha if the item to be deleted.

Variables	Mean (SD)	Correlation of item-total adjusted	Cronbach's alpha if the item to be deleted
Type and severity of violence			
Emocional Violence	2,61(0,53)	0,54	0,58
Physical Violence	2,38(0,62)	0,33	0,61
Sexual Violence	0,23(0,81)	0,05	0,65
Global Severity Index	2,46(0,60)	0,60	0,57
Duration of domestic violence problem			
Durationof domestic violence	2,68(1,48)	0,29	0,64
Age at first episode	25,52(7,93)	-0,13	0,63
Subjective experience, presentation of the problem			
Intensity of subjective suffering	2,59(0,53)	0,56	0,58
Presentation of cpmplaints on domestic violence	2,39(0,53)	0,55	0,58
Personal explanation of domestic violence			
Oriented to external causes	2,34(0,61)	0,17	0,63
Oriented to psychological/interpersonal causes	2,00(0,57)	0,26	0,62
Change concept			
Oriented to external modifications	2,43(0,53)	0,34	0,61
Oriented to personal changes	2,00(0,79)	0,32	0,60
Personal and external resouces and obstacles to change			
Personal resouces	1,91(0,61)	-0,20	0,68
Personal obstacles	2,18(0,61)	0,28	0,61
External resouces	2,05(0,44)	0,01	0,64
External obstacles	2,00(0,38)	0,15	0,63

Discussion

The cross-cultural adaptation of health instruments for use in a new country requires a rigorous methodology. It's necessary to keep the content validity with linguistic and cultural adaptation. Thus, having assurance that assessment of disease impact or treatment will be similarly described in multinational trials.[23] The psychometric characteristics, in the pre-test, was adequate.

The present study had the proposal to develop the Brazilian Portuguese version of the *Module for the Assessment of Domestic Violence,* adapted from Axis I of the OPD-2. The recommendations of the *Guidelines for the Process of Cross-Cultural Adaptation of Self-*

Report Measures were followed. Thus, good content validity and satisfactory psychometric characteristics were achieved with internal consistency of 0.63. Different from the original study, where the internal consistency was really good: k = 0.834 (0.483 - 0.972).[14] However, in the Portugal and Brazilian validation study of the OPD-2, the mean remained 0.66 in Axis I – Experience of Illness and prerequisites for treatment.[15]

No studies were found with the use of the *Module for Domestic Violence Assessment* beside the study of the author of the original instrument. The reason for this could be that it was recently published and not well disseminated. In addition, the use of OPD-2 requires specific training, which limits the number of professionals who have access to it.

It is observed that the sample of the present study covered the different peculiarities of the population, both in regards to sociodemographic data and the experience of violence. There are differences in age, schooling, race, income, time and type of marital relationship. In regards to violence, there is also divergences, since there were victims who suffered intensely and for a long period, to women who encountered their first violent act from their partner and reported it. The explanation of violence also varied, as well as the resources and obstacles presented. This data indicates that the instrument is suitable for use in the South of Brazil realities in the context of domestic violence.

Clinical Implications

In general, it is noted that OPD-2 operated psychodynamic constructs, which provides greater precision and evidence for the field, a difficulty found in psychoanalysis to date. According to Krieger, the OPD's operationalization provides a clinical diagnosis opened to therapist's interpretation. Also, it is useful for the training of psychotherapist, psychotherapists beginning with phenomenological classifications, improves communication between the scientific community. Furthermore, in the research field, provides more homogeneous samples than those based only on the descriptive diagnosis. And yet, assists in the therapeutic planning from the most relevant psychodynamic foci.[16] According Vicente *et al*., the OPD-2 still allows a detailed description of the symptoms, the results of the therapeutic process in a documented and operationalized way – investigating the therapeutic process empirically.[15]

Specifically, for the context of domestic violence against women, the adaptation of the Axis I – "Experience of Illness and prerequisites for treatment" of the OPD-2 to the *Module for Assessment of Domestic Violence* is extremely relevant to clearly identify the victim's experience under violence: What was the severity and type of violence suffered? How did they experience this situation? For how long? What is their explanation for the reasons that

led to the violence? What were recourses and obstacles for coping? These issues, combined with the other axes of OPD-2, provide a psychodynamic diagnosis of the victim that complements the traditional nosological diagnosis. In addition, understanding subjects functioning from these notes, it is possible to carry out a more effective therapeutic treatment planning, since treatment adherence in women victims of domestic violence is unsatisfactory.[12]

Limitations

A number of biases can be brought to attention that may be determinant in the results of the research. However, many of them were controlled, as much as was possible. The biases were related to reliability between judges, sample, procedures and location of collection, evaluation and translation.

In respects to judge's reliability, some interviews didn't have a good coefficient between judges: lower than 0.60. In this cases, we decided not to repeat the codification in order to not condition the evaluation of the items or to infer a certain interpretation from the judge. Also, the sample, there is not a significant amount of sexual violence victims, so the evidence in this context was insufficient, since the literature shows peculiarities in this population in terms of greater severity. Another aspect regarding the sample is the very low education level in some women, which could have limited the ability to completely express themselves and be well understood.

In addition, the coding of the interviews was performed only from the audio transcription, so non-verbal behavior of the patient was not evaluated. Sometimes, the expressiveness was kept in report, such as crying, anger, among others. The collection place must also be taken into account, because it was not a clinical setting, but a police station with the intention of filing a report against someone and also seeking protection. Thus, in some cases, there was a high amount of defense mechanisms or even dissociative defenses that could distort the facts. Though this issues reveal how such victims experience violence. Also, part of the interview was dedicated on counselling the victims on legal procedures. Nevertheless, the victim's demands were met, but always based on the OPD Clinical Interview.

As well, the instrument translation – scoring form and manual - were done by two Brazilian psychologists proficient in English, but not by professional translators. This aspect was chosen to ensure the psychodynamic terms, but could have distorted terms in the final version. In this sense, it is vital that the professional that will use the adaptation of the OPD-

2 has prior knowledge of the theoretical approach and has training in the OPD-2 Task Force so the assessment is consistent with the patient's reality.

Conclusion

OPD-2 was validated in several countries and cultures (Germany, England, Italy, Chile, Australia, Portugal, Brazil) and now there is an opportunity to use an adaptation of Axis I to the domestic violence context, adapted from the original *Experience of illness and prerequisites for treatment*. The cross-cultural adaptation of the *Module for Domestic Violence Assessment* adapted from OPD-2 Axis 1 with Brazilian women domestic violence victims, based in *Guidelines for the Process of Cross-Cultural Adaptation of Self-Report Measures*.

The study objective was reached and the *Module for Domestic Violence Assessment* from the OPD Clinical Interview was successfully adapted to Brazilian Portuguese. The final version of the instrument demonstrated applicability in women with different sociodemographic characteristics - age, income, schooling, type of relationship - even though the collection occurred in the southern region of Brazil. So, the study guaranteed applicability to the population of Rio Grande do Sul and that further research will be carried out in order to increase validation for the Brazilian population.

According to the first empirical evidence described here, the adaptation of the instrument is adequate and presents a good reliability. The results are consistent to the original study. The instrument translation comprised a satisfactory content validity. And the internal consistency suggested that the instrument has adequate psychometric characteristics. However, further studies are still needed to confirm the validity and reliability of the version developed in the present study. The need for further studies with more extensive samples is emphasized, considering the inclusion of other variables in order to achieve external validity and considering other regions of the country should be performed in order to obtain more reliable indicators of validity of the instrument.

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10 ARTIGO 4. INTIMATE PARTNER VIOLENCE AGAINST WOMEN: Operationalized Psychodynamic Diagnosis (OPD-2)

- Revista: ***Plos One***
- Qualis na Área de Medicina II – Classificação de Periódicos Quadriênio 2013-2016: **A2**
- https://doi.org/10.1371/journal.pone.0239708
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Abstract

Introduction: Intimate partner violence against women is one of the most common forms of violence. Different research fields are trying to understand the cycle of violence, such as the psychological field, to understand how these women's relational patterns and intrapsychic conflict function in the cycle of violence.

Objective: To investigate the operationalized psychodynamic diagnosis of women victims of domestic violence, exploring the severity and experience of violence, structural functions, dysfunctional interpersonal patterns, and intrapsychic conflicts.

Method: We conducted a cross-sectional quantitative study using the OPD-2 Clinical Interviews, which were recorded and transcribed. The sample was composed by 56 women victims of domestic violence, mean age 30.07 (SD=±9.65). Reliability was satisfactory for judges interviews(k>0,6).

Results: According to the OPD-2 evaluation, we found that the severity of the violence was associated with the intensity of women's subjective suffering. In the relational pattern, they stay in the relationship, leaving themselves vulnerable; perceive the partner as controlling, aggressive, offensive, and fear abandonment. As a defensive mechanism to relational discomfort and suffering victims anticipate the aggressor's desire, resulting in submissive behavior. The main psychic conflict was the "need for care versus self-sufficiency" (78.6%). And medium was the predominant structure level, in which they presented insecure internal objects, presenting difficulties in emotional regulation and perceiving reality in a distorted way. Hence, they do not recognize their limitations and needs. We found that 78.6% of the cases had some psychiatric disorder: MDD, PTSD.

Conclusion: This study provides empirical evidence on clinical observations on the psychological functioning of this population and the issues that make up the maintenance of domestic violence against women. The understanding of internalized patterns, structural functions, and motivational tensions are fundamental for the prevention of re-victimization and improving coping mechanisms, as well as promoting greater adherence to treatment.

Key words: intimate partner violence, domestic violence, evaluation, clinical psychology, psychodynamics.

Introduction

Intimate partner violence (IPV) against women, often called domestic violence, is one of the most common forms of violence. Refers to any behavior by an intimate partner or ex-

partner that causes physical, sexual or emotional abuse, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors, where one partner exercises power and control over the other. It occurs in all settings and among all socioeconomic, religious, and cultural contexts. Women bear the overwhelming global burden of IPV [1]. It is a human rights violation with significant health consequences [2], like mental health problems, sexual and reproductive problems, and chronic conditions—and represent a significant health burden for women [3].

There is a substantial body of literature documenting the prevalence of violence against women. International evidence suggests that domestic violence against women constitutes a global public health problem. Male partners commit approximately 38% of all murders of women [1]. More specifically, 23% of women suffer violence from their partners [4].

Data from the latest Institute for Applied Economic Research (*Instituto de Pesquisa Econômica Aplicada*–IPEA) report on the Atlas of Violence [5], which provides information on the number of femicides, show that in 2016 alone, 4,645 women were murdered in Brazil, corresponding to 4.5 deaths per 100,000 women. And data from 2017 indicate that the number of femicides in absolute terms in Brazil, with 1,133 victims confirmed in 2017 [4].

The dynamics of victimization through abusive relationships imply repetitive behavioral patterns, maintaining the cycle of violence. Usually it presents itself with a slow and silent beginning followed by gradual progress towards acts of humiliating beatings, physical violence, public manifestations of aggression. Moreover, to make matters worse, some victims' responses to coping with constant threats such as shame and isolation reinforce the cycle of violence. These women have difficulty in reporting violence and accessing legal information. In general, care services are of low quality and cannot protect victims [6].

There is strong evidence supporting the possibility of reducing the indices through effective prevention strategies [7]. So, understanding the victim’s perspective is essential to developing policy and practice standards, as well as instructing professionals working in the justice system and policy-making. It is necessary to understand the psychodynamic mechanisms underlying these women's behaviors, from the Operationalized Psychodynamic Diagnosis [8]. Many women remain and repeat abusive relationships, but the motives behind these are unclear. Thus, this study aims to investigate the operationalized psychodynamic diagnosis of women victims of domestic violence, exploring the severity and experience of violence, structural functions, dysfunctional interpersonal patterns, and intrapsychic conflicts.

Hypotheses

We expect to find a dysfunctional interpersonal functioning with a history of violence or family neglect in childhood (transgenerationality), which ultimately creates a bond of dependency, and the partner abuses this power. These aspects are associated with conflicts, Axis III, based on the predominance of conflicts: autonomy x dependency, the need for care x self-sufficiency, and submission x control. However, it also indicates the conflict of self-esteem, guilt, oedipal, and identity.

Regarding Axis I, we hypothesize intense suffering, few resources available due to PTSD, and resistance to change in family dynamics, and maintenance of violence. In Axis II, we predict interpersonal relationships permeated by abandonment, devaluation, censorship. In Axis IV, we expect to find a more disintegrated structure, emotional dysregulation, emotional inflexibility, negative internal representations, and non-self-object differentiation. And in Axis V, we believe that there will be PTSD with comorbidities such as major depressive disorder, generalized anxiety, among other problems. We expect to find sociodemographic variables, low income, and low educational level of the victims.

Methods

Study design

This is a quantitative cross-sectional study, developed from the Diagnostic Psychodynamic Operationalized (OPD-2). It is part of a larger study still in progress about IPV in general.

Sample

Fifty-six women victims of domestic violence from a specialized public service in southern Brazil participated in the study. We included women 18 to 65 years of age who were victims of self-reported domestic violence who sought the service along the data collection period during the on-call researcher's shift.

The sample calculation used was based on the validation study by Krieger [9]. Porto Alegre Clinical Hospital (*Hospital de Clínicas de Porto Alegre*) calculated the sample size, where we considered the number of items of the OPD instrument and the literature data on the agreement between evaluating judges for the different axes of the instrument. Thus, the number of interviews was calculated for each axis independently: Axis 1: 53 interviews; Axis 2: 52 interviews; Axis 3: 53 interviews; Axis 4: 25 interviews. Thus, to compose the sample of this study, a minimum of 53 participants.

Instrument

We applied the sociodemographic data survey regarding characteristics relevant to the study, such as age, educational, family income, the period of marital relationship, living situation, the use of drugs, the existence of parental violence (transgenerationality of violence), and so forth. We used the sociodemographic questionnaire based on the study developed by Lourenço and Baptista [10].

The Operationalized Psychodynamic Diagnosis (OPD-2) was used to operationalize psychodynamic constructs, to formulate a multiaxial psychodynamic diagnosis, and for therapeutic planning and focus. The OPD-2 is composed of five axes. In Axis I, we evaluated therapeutic indication and motivation, then the diagnosis is made. In Axis II - Relational, in the manifestation of conflicts or vulnerabilities of the interpersonal representations -, Axis III - Conflict - and Axis IV - Structural vulnerabilities and capacities. And Axis V - Nosological diagnosis [8]. However, the adaptation of Axis I, "Module for the Evaluation of Domestic Violence OPD" proposed by the Chilean researcher Carla Crempien in 2009 in her Ph.D. thesis [11,12] and adapted to Brazil [13].

We used the OPD Clinical Interview, a semi-structured interview with specific interviewing tools for the analysis of each axis, described in the manual on pages 498 to 524. For coding, two expert judges trained in the use of the OPD system scored each item according to the criteria specified in the OPD-2 Manual [8].

The Chilean validation of the OPD-2 showed a significant agreement between evaluating judges: 75% in axis II, 73.3% in axis III, 62% in axis I, and 53.3% in axis IV [14]. In Portugal and Brazil: 78% in axis IV, 66% in axis I, 57.7% in axis III, and axis II was excluded [15]. Particularly in Brazil, according to Krieger [9], there are adequate psychometric properties for the applicability of OPD-2 in the Brazilian population.

Authorization for the use of Operationalized Psychodynamic Diagnosis in Brazil was requested from the president of the OPD Group, Dr. Manfred Cierpka and Carla Crempien who carried out the adaptation of Axis I to assess women who suffered domestic violence.

Procedures for collecting and setting

We invited the victims of violence to participate voluntarily in the research during the specialized service during the months of November and December 2017. While waiting for their screening, the victims answered the sociodemographic data sheet. Later, in the specialist's room, the researcher conducted the OPD Clinical Interview and provided information on safety procedures and the rights guaranteed by the Maria da Penha Law for

victims [16]. Each interview lasted approximately one hour [14]. Only one researcher did the interviews. These interviews were audio-recorded and transcribed. Also, using the sociodemographic datasheet to characterize the sample.

Data analysis

Firstly, data analysis was done by two independent trained judges who coded the interviews in the OPD worksheet. The evaluating judge codified the various psychodynamic aspects from the dimensions and indicators described in the manual that integrate the scores: 0 (absent), 1 (mild/insignificant), 2 (moderate), 3 (high/significant), 4 (very significant), 9 (non-assessable). All the evaluating judges completed specific training in the instrument: "Diploma in Diagnosis, Indication, and Strategies in Psychotherapy: Operationalized Psychodynamic Diagnosis (OPD-2)", organized by the School of Medicine of Pontificia Universidad Católica de Chile.

The kappa coefficient of each axis was calculated independently for each interview. Later, analyses conducted by SPSS software. We considered p<0,05 to define statistical significance. In this study, concordance between the judges was substantial in each axis; 63% in Axis I violence module, 73% in Axis III, 82% in Axis IV, and 100% in Axis V. For Axis II, we considered the items scored more frequently by judges.

Ethics Statement

This study was approved by the Federal University at Rio Grande do Sul ethics committee (CAAE 68271917.7.0000.5347, No. 2,412,749) and permission for collection of data was obtained from the Legal Medical Department of Porto Alegre. All participants were invited voluntarily and authorized their participation in the research by signing the Term of Free and Informed Consent. All data that could identify participants was omitted.

Results

Study population

The sample had a normal distribution, according to the Kolmogorov-Smirnov normality test (p <0.05). The mean age of women was 30.07 (SD = ± 9.65) years, and men presented a mean of 34.8 (SD = ± 10.86) years (Table 1). In the sample, 46,4% ended their relationship in less than six months (Table 2).

Table 1. Sociodemographic Data.

Category	Subcategory	Women	Men
Age	18 to 20 years old	8 (14,3%)	3 (5,4%)
	21 to 25 years old	16 (28,6%)	5 (8,9%)
	26 to 30 years old	8 (14,3%)	16 (28,6%)
	31 to 35 years old	9 (16,1%)	13 (23,2%)
	36 to 40 years old	8 (14,3%)	4 (7,1%)
	41 to 45 years old	2 (3,6%)	5 (8,9%)
	46 to 50 years old	3 (5,4%)	5 (8,9%)
	51 to 55 years old	1 (1,8%)	1 (1,8%)
	56 to 60 years old	1 (1,8%)	2 (3,6%)
	61 to 65 years old	0	2 (3,6%)
Race	White	37 (66,1%)	35 (62,5%)
	Black	21 (21,4%)	13 (23,3%)
	Brown	6 (10,7%)	7 (12,5%)
	Indigenous	1 (1,8%)	1 (1,8%)
Scholarity	Illiterate	0	1 (1,8%)
	Incomplete elementary school	15 (26,8%)	17 (30,4%)
	Complete primary education	6 (10,7%)	6 (10,7%)
	Incomplete high school	8 (14,3%)	7 (12,5%)
	Complete high school	22 (39,3%)	22 (39,3%)
	Incomplete higher education	3 (5,4%)	1 (1,8%)
	Complete higher education	1 (1,8%)	2 (3,6%)
	Postgraduate studies	1 (1,8%)	0
Income[a]	None	13 (23,2%)	8 (14,3%)
	Less than 1 salary	8 (14,3%)	1 (1,8%)
	Between 1 and 2 salaries	31 (55,4%)	35 (62,5%)
	Between 3 and 6 salaries	2 (3,6%)	5 (8,9%)
	Between 7 and 12 salaries	1 (1,8%)	2 (3,6%)
	More than 12 salaries	1 (1,8%)	4 (7,1%)
Religion	Godless[b]	22 (39,3%)	26 (46,4%)
	Catholic	19 (33,9%)	15 (26,8%)
	Spiritism[c]	4 (7,1%)	3 (5,4%)
	Afro-Brazilian	3 (5,4%)	6 (10,7%)
	Evangelical	0	6 (10,7%)
Addiction	Alcohol	3 (5,4%)	25 (44,6%)
	Drug	2 (3,6%)	0
	Tobacco	8 (14,3%)	7 (12,5%)
	Marijuana	1 (1,8%)	7 (12,5%)
	Cocaine	0	3 (5,4%)
	Marijuana and Cocaine	0	7 (12,5%)
	Anabolic	0	1 (1,8%)

[a]One salary is a basic remuneration to the worker.
[b]Godless is the person who do not believe in God.
[c]Spiritism is the person who believe in life after death.

Table 2. Relationship.

Category	Subcategory	Women
Type of relationship	Date	1 (1,8%)
	Courtship	9 (16,1%)
	Marriage	5 (8,9%)
	Stable union	8 (14,3%)
	Divorced	7 (12,5%)
	Separated in less than 6 months	26 (46,4%)
Time of relationship	Less than 6 months	3 (5,4%)
	Between 6 months and 1 year	6 (10,7%)
	Between 1 and 2 years	11 (19,6%)
	Between 3 and 5 years	13 (23,2%)
	Between 6 and 10 years	15 (26,8%)

Between 11 and 15 years	2 (3,6)
Between 16 and 20 years	4 (7,1%)
Between 21 and 30 year	2 (3,6%)

Still, on the checklist questions with options to mark "yes" or "no" if the parents had a violent relational dynamic, 32 (57.1%) women reported not having witnessed discussions between their parents or suffered any situation of violence in childhood. Among the other women, 17.9% experienced daily violence between their parents. Despite this, most of them, 41 (73.2%), rated their father as loving and caring; and 43 (76.8%) evaluated mother's care in the same way. However, these data did not corroborate with the self-report part of the interview on situations in childhood, women described situations of violence in the parental dynamics. The univariate analysis did not indicate significant differences between the type of parental care and the psychodynamic dimensions.

Main analysis

All women suffered both emotional and physical violence at relatively high intensities, corresponding to the severity of the violence. The victims' suffering was distressing, they reported very difficult situations, they mentioned things they didn't do out of fear, or because they felt unable to do so. During a lengthy interview, they complained and described the violent situations they experienced. They believed that violence occurred due to external factors, such as the husband's use of alcohol, in consequence of personal situations, or relational factors. Victims believe that external measures were necessary to overcome the cycle of violence, such as the protective measures provided by the protective organs in the court of law (Table 3). The first episode of violence was on average with 25.52 years of age, and 25% of the sample this violence occurred about 2-5 years ago (Table 4).

In the relational formulation of the patient - Axis II - was observed: 1. (how the victim sees others) Women repeatedly experience others as controlling, bossy, demanding, and aggressive. The other despise, belittle them, restrict their freedom, and neglect their needs. 2. (how the victim sees herself) Thus, given this attitude, the victims allow the aggressor to act autonomously and isolate themselves from other social activities. 3. (what she does but is unaware) The victims protect themselves indequally, allowing dangerous progression. They feel confused when the other shows affection, 4. (how the other reacts to victims' unconscious proposal) Therefore, it induces an unconscious response to the other, who defies and imposes himself aggressively. The victim anticipates the aggressor's desire, as a defensive response to discomfort, and relational distress, therefore becomes submissive, thus keeping the

relationship abusive. Sometimes, others (as well as the evaluator) noticed that repeatedly the patient, who cares and worries excessively about the aggressor, does not give him space and is intrusive, at the same time showing submissive attitudes and dependency.

Table 3. Axis I - Mean and intensity of items assessed in the Domestic Violence Module.

		Intensity[a]			
	Mean (SD)	**1**	**2**	**3**	**4**
Type and severity of violence					
Emotional violence	2,61(0,53)	0	23(41,1%)	32(57,1%)	1(1,8%)
Physic violence	2,38(0,62)	2(3,6%)	33(58,9%)	19(33,9%)	2(3,6%)
Sexual violence	0,23(0,81)	52(91,1%)	1(1,8%)	2(3,6%)	1(1,8%)
Global Severity Index	2,47(0,60)	1(1,8%)	30(53,6%)	23(41,1%)	2(3,6%)
Subjective experience, presentation of the problem and personal concept					
Intensity of subjective suffering	2,59(0,53)	0	24(42,9%)	31(55,4%)	1(1,8%)
Presentation of complaints on DV	2,39(0,53)	1(1,8%)	32(57,1%)	23(41,1%)	0
Personal explanation of DV					
Oriented to external causes	2,34(0,61)	3(5,4%)	32(57,1%)	20(35,7%)	1(1,8%)
Oriented to psychological/interpersonal causes	2,00(0,57)	9(16,1%)	38(67,9%)	9(16,1%)	0
Change concept					
Oriented to external modifications	2,43(0,53)	0	33(58,9%)	22(39,3%)	1(1,8%)
Oriented to personal changes	2,00(0,79)	17(30,4%)	22(39,3%)	17(30,4%)	0
Personal resources and obstacles to change					
Personal resources	1,91(0,61)	13(23,2%)	35(62,5%)	8(14,3%)	0
Personal obstacles	2,18(0,61)	6(10,7%)	34(60,7%)	16(28,6%)	0
External resources	2,05(0,44)	4(7,1%)	45(80,4%)	7(12,5%)	0
External obstacles	2,00(0,38)	4(7,1%)	48(85,7%)	4(7,1%)	0

[a]The higher the score is the higher the severity.

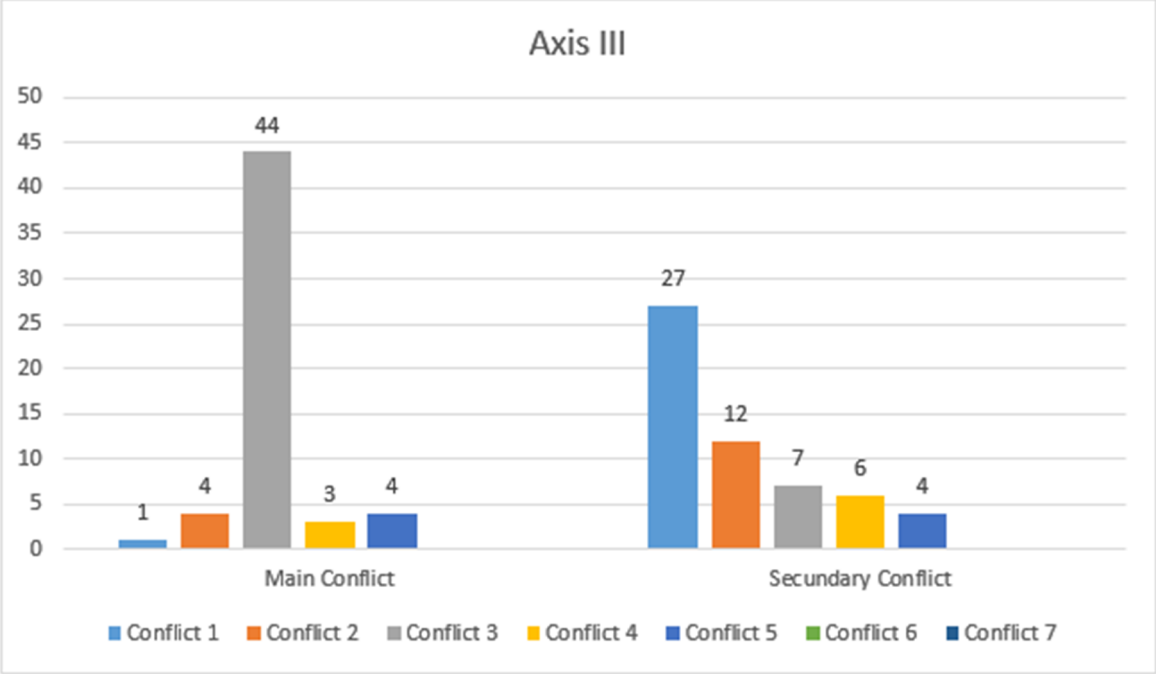
Table 4. Duration of violence.

Time	**Frequency (%)**
<6 months	18(32,1%)
6-24 months	8(14,3%)
2-5 years	14(25%)
5-10 years	6(10,7%)
>10 years	10(17,9%)

In the main and secondary conflicts, there was a significant difference between the frequency of the other conflicts (p <0.05) - Axis III. Thus, the main conflict identified was the "need for care versus self-sufficiency" (78.6%), and the second one was "individuation versus dependence" (48.2%), with a predominantly active mixed mode of actions (58.9%), as noted in Fig 1. The main conflict *"need for care versus self-reliance"* focuses on the fundamental needs of individuals to take or give in the exchange of security and care. Thus, they were very concerned about the other, whereas latent depressive feelings were a defense mechanism

against the feeling of emptiness. They pretend to be self-sufficient, but the desire for care predominates. They desire for retribution for the dedication they gave.

Fig 1. Axix III



We observed a level of median psychic structure - Axis IV, the reflexive perception of the reduced self. Introspection about one's present state was limited. Situations and events that generate tension weakened the coherence of self-image. The differentiation between what was personal and what was of the other is difficult. While questioning them, women did not describe themselves at a disadvantage in any situation. Situations and moods influenced them strongly, and they tried to remain stable by avoiding affection (Table 5).

Table 5. Axis IV – Structure.

	Minimum	Maximum	Mean[a]	SD
Cognitive abilities				
1a Self-perception	1,50	2,50	2,05	0,33
1b Object perception	1,50	2,50	2,14	0,31
Regulation				
2a Self regulation	1,50	2,50	2,16	0,25
2b Regulation of object relationship	1,50	2,50	2,21	0,27
Emotional communication				
3a Internal communication	1,50	2,50	2,07	0,23
3b Communication with the external world	1,50	2,50	2,08	0,23
Attachment				
4a Attachment to internal objects	1,50	3,00	2,23	0,32
4b Attachment to external objects	2,00	2,50	2,09	0,19
5 Total structure	1,50	2,50	2,10	0,22

[a]The closer to 1, the greater the structural integration. And closer to 4, greater disintegration.

In this study, Axis 5 is based on the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). In 78.6% of cases had some psychiatric disorders. The majority presented Major Depressive Disorder (MDD, 51.8%), as the only diagnosis (41.1%) or associated with another psychopathology (10.7%). Furthermore, 23.3% of the participants corresponded to the diagnostic criteria of Post Traumatic or Acute Stress Disorder as the only diagnosis or 10.7% associated with MDD or Borderline. Finally, one of the participants intoxicated herself, attempting to numb her suffering (Table 6).

Table 6. Axis V.

Disorder	**Frequency(%)**
No disorder	12 (21,4%)
Major Depressive Disorder	23 (41,1%)
Post Traumatic Stress Disorder	10 (17,9%)
Acute Stress Disorder	3 (5,4%)
Intoxication by sedatives, hypnotics or anxiolytics without use disorder	1 (1,8%)
Major Depressive Disorder + Post Traumatic Stress Disorder	5 (8,9%)
Major Depressive Disorder + Tobacco-Related Disorder	1 (1,8%)
Acute Stress Disorder + Borderline Personality Disorder	1 (1,8%)

In the bivariate analysis with sociodemographic data, we verified that the age of the victim and the partner were factors associated with the presence of physical violence and period of the violence, whose intensity and duration increases with the age of both. There is a correlation between the educational level of women and the perception that the reasons for violence were not due to external factors, presenting more resources to deal with the situation of violence. Income was not a very significant factor in maintaining the cycle of violence (Table 7). However, for the subject's level of psychic structure and the victim's educational level was important in the capacity to regulate the relationship, whose abilities decrease with the increase of educational level. Income and relationship periods correlated negatively with emotional self-regulation, with lower income and shorter relationships, better self-regulation (Table 8).

Table 7. Bivariate analyzes: Correlation of Demographic Partner Data with Axis I.

	Age	Scholarity	Income	Time of relationship	Partner's age	Partner's Scholarity	Partner's income	Emotional violence	Physical violence	Sexual violence	Global Severity Index	Duration of violence	Age 1 episode	Intensity of subjective suffering	Presentation of complaints on DV	Oriented to external causes	Oriented to psychological causes	Oriented to external modifications	Oriented to personal changes	Personal resources	Personal obstacles	External resources	External obstacles
Age	1																						
Scholarity	0,11	1																					
Income	,34*	,34*	1																				
Time of relat.	,21	-,13	,19	1																			
Partner's age	,60**	-,76	,61	,33*	1																		
Partner's sch.	-,14	,37**	,29*	,12	,72	1																	
Partner's inc.	,16	,54**	,25	,42	,15	,44**	1																
Emotional	,10	-,06	,01	,15	-,03	,02	-,01	1															
Physical	,39**	,01	-,22	,34	,31*	-,14	-,01	,24	1														
Sexual	-,15	-,26	-,10	,39**	-,04	,15	,09	,22	-,10	1													
Global sev. I.	,18	-,05	-,18	,30*	,10	,10	,28	,76**	,40**	,41**	1												
Duration	,44**	-,25	,15	,27*	,33*	-,23	-,24	,35**	,29**	-,06	,27*	1											
Age 1° ep.	,79**	,15	,20	,003	,44**	,03	,05	-,09	,23	-,21	,006	-,09	1										
Int. sub. suff.	,02	-,05	,29	,17	-,01	,22	,19	,52**	,15	,23	,49**	,25	,13	1									
Pres. comp.	,19	,03	,09	,05	,27*	,28*	,10	,30*	,32*	,12	,33*	,21	,11	,46**	1								
Ext. causes	,54	-,37**	-,16	,007	,07	-,09	-,38**	,08	-,28**	-,24	,06	,24	-,04	,21	,14	1							
Psic. causes	-,05	,17	,0	,03	-,08	,32*	,29*	,0	,0	,28*	,16	-,02	-,12	,36**	,36**	,0	1						
Orient. ext.	,13	,15	-,01	-,03	,05	-,17	-,08	,22	,22	,02	,27*	,20	-,05	-,01	,29*	-,01	,06	1					
Orient. pers.	-,26	,05	-,07	-,20	-,28*	,15	-,02	,18	-,11	,03	,08	,03	,32*	,39*	,35*	,19	,44**	,17	1				
Pers. recourses	,25	,63**	,27*	-,18	,07	,21	,31*	-,17	,04	-,22	-,18	-,19	,31*	-,17	-,06	-,31*	-,10	,12	,04	1			
Pers. obstacles	-,29*	-,24	-,40**	,12	,0	-,23	-,09	,22	,60	,14	,32*	,13	-,39*	,23	,17	,28*	,11	,15	,23	-,35**	1		
Ext. recourses	,26	,33*	,17	,03	,12	,05	,13	-,06	,19	-,39**	,16	,11	,18	-,06	,06	-,07	-,14	,21	,10	,62**	-,31*	1	
Ext. obstacles	-,03	-,13	-,18	-,12	-,04	-,16	-,04	,09	-,08	,0	,24	,03	-,02	,18	,18	-,08	,08	,09	,12	-,78	,32*	-0,11	1

Table 8. Bivariate analyzes: Correlation of Socio Demographic data with Axis IV.

	Age	Scholarity	Income	Time of relationship	Partner's age	Partner's scholarity	Partner's income	1a Self-perception	1b Object perception	2a Self regulation	2b Regulation of object relationship	3a Internal communication	3b Communication with the external world	4a Attachment to internal objects	4b Attachment to external objects	5 Total structure
Age	1															
Scholarity	0,11	1														
Income	,34*	,34*	1													
Time of relationship	,21	-,13	,19	1												
Partner's age	,60**	-,76	,61	,33*	1											
Partner's scholarity	-,14	,37**	,29*	,12	,72	1										
Partner's income	,16	,54**	,25	,42	,15	,44**	1									
1a Self-perception o	,03	-,26	-,21	,005	,008	-,07	-,26	1								
1b Object perception	-,13	-,23	-,20	-,06	-,05	,01	-,20	,55**	1							
2a Self regulation	-,23	-,04	-,28*	-,27*	-,23	-,04	,08	,39**	,39**	1						
2b Regulation of object relationship	-,01	-,31*	-,19	-,05	,27*	,08	-,05	,40**	,46**	,31*	1					
3a Internal communication	-,02	-,21	-,12	-,08	,02	-,06	-,05	,39**	,51**	,36**	,36**	1				
3b Communication with the external world	-,09	-34*	-,17	,01	-,02	-,32*	-,09	,37**	,54**	,32*	,32*	,51**	1			
4a Attachment to internal objects	-,05	-,16	-,09	-,13	-,06	,02	,006	,32*	,58**	,38**	,51**	,41**	,49**	1		
4b Attachment to external objects	-,09	-,15	-,01	-,22	-,10	-,15	-,07	-,21	,31*	,26	,26	,48**	,35**	,55**	1	
5 Total structure	,01	-,16	-,14	,03	,08	-,09	,04	,43**	,65**	,44**	,42**	,59**	,65**	,58**	,53**	1

In the multivariate analysis, the other axes or sociodemographic data do not explain the main conflict and period of the disease. The sociodemographic variables influence the overall severity of violence those being age, income, and educational level of the victim and partner ($F = 2.41$, $p < 0.05$), the severity of the other items of Axis I ($F = 9.66$, $p < 0.05$), and by the existence of psychopathology – Axis V ($F = 3.71$, $p < 0.05$). And the level of total structure was influenced by Axis V ($F = 3.22$, $p < 0.05$) and by the items of Axis II: "Staying in the relationship and letting others act autonomously" and "Controlling, making orders and demands" from perspective B to the others ($F = 9.42$, $p < 0.001$).

Discussion

This cross-sectional study with fifty-six women victims of domestic violence from the South of Brazil showed that age, educational level, and income are determinants for some aspects of IPV against women. It was possible to build a psychodynamic diagnosis of them using the OPD-2 evaluation. They presented a median level of psychic structure, with conflict centered on the possibility of receiving care in exchange for tending to others and submissive in interpersonal relationships as a defense mechanism. 78.6% of the cases had some psychiatric disorder, like Major Depressive Disorder and Posttraumatic Stress Disorder.

Comparison with other studies

Our findings are consistent with a Chilean study using OPD-2. Only one study on the applicability of OPD in the context of violence was found, which was a Chilean study with a sample of 28 women from a domestic violence care center in Santiago. The women that demonstrated the greatest severity of violence were those who reported a higher presence of depressive symptoms, PTSD, and lower educational level. Complementary, the main conflict prevailed: the “need for x self-sufficiency” (39%), followed by “submission x control” (50%) that may be related to revictimization. As well, the overall functioning of women victims of sexual violence is worse than other victims, since they suffer psychological and physical violence simultaneously, resulting in an accumulation of multiple traumas. The author still estimates that with the interruption of violence with the recovery process of the patient, these women will be able to recover their internal resources, since the psychic structure is a dynamic organization. Thus, the vulnerable structure due to the trauma suffered is

considered an obstacle for the victims to manage their emotions and stress [12]. In this sense, there is an association between trauma experienced in childhood and occurrence of domestic violence [17,18], since these subjects establish a bond of dependence with the other, in which the other takes advantage of this to a point where it becomes painful and degrading [19]. In this study, 57.1% of women reported not having witnessed discussions between parents during childhood when asked to mark the option "yes" or "no". A limitation with this process was women recognizing this issue, blaming only the partner and not associating it with the repetition of parental models. During the interview they described situations of childhood violence. This data was observed in the psychic structure (S4 Table) in which insecure internal objects were identified, difficulties in emotional regulation, perception of reality in a distorted way, and difficulties in recognizing their limitations and needs.

According to Caligor, Kernberg, and Clarkin [20], conflicts - conflicting motivations or impulses - are internalized patterns of relationships kept out of consciousness by defensive mechanisms, protecting the individual from threatening and painful aspects. In the case of these women, the main conflict "need for care x self-sufficiency" is in conformity with the literature, whose influence of social norms reinforces the submissive behavior of women in the face of coercive behavior of man [21]. However, studies show that women become submissive as a defense mechanism since they are afraid to suffer violence if they don't act accordingly.

The dynamics of domestic violence implies a repetitive behavior pattern in relationships. The male perspective is characterized by abusive and coercive physical or non-physical conduct, with a recognizable inequality of powers and a set of forces. And concerning the female behavior, there is a presence of fear with a response of avoidance, adaptation, and submission. The dynamics established between the couple are cyclical: accumulation of tensions, conflict, and reconciliation phase [18, 22].

The structural axis - Axis IV - evaluates the level of integration of the patient's abilities or limitations in the regulation of mental functions capable of establishing internal homeostasis in the last two years. These functions integrate with capacities of the self, in the regulation of their internal experience, management of overload, and stress, allowing elaboration and adaptation. It is the result of a process of maturation and the development of internal representations of the world [8]. Their understanding integrates early attachment patterns from the internalization of mental representations [9]. In traumatic situations, evaluated in this axis, show deficits in mentalization

capacity. In traumatic situations like violence in general, there may be the establishment of disorganized psychic structures. The division of object representations, instability in relationships, difficulty in the organization of a sense of identity, and failures in the capacity for mentalization/reflective function characterize psychological functioning [23]. Therefore, there are ruptures in the ability to think and reflect on the mental states of oneself and others [24].

Given this, victims list external causes to justify the IPV since their structural capacities are medium. The risk factors listed in the literature are related to the perpetrator are temperamental attitude, substance abuse like alcohol, witnessing family violence, and gender ideologies [18,25].

Literature is controversial in some aspects of sociodemographic characteristics. Our research did not correspond to the sociodemographic data presented in literature [26,27]; the crossing of class, race, and ethnic; showed that black women with lower educational level with poor living conditions were the main victims of violence and homicide. However, it corresponds to some of the aspects pointed out by the study Aziz et al. [25] regarding resources such as education, earnings, employment, and positive attitude towards beating women.

Psychiatric Diagnosis: Battered Woman Syndrome

78.6% of the cases suffered from some psychiatric disorder: Major Depressive Disorder (41.1%), Posttraumatic Stress Disorder (19.9%), and so forth. On these diagnoses, the research Lenore Walker created the “Battered Woman Syndrome” (BWS) [18]. The term appeared as a subcategory of Posttraumatic Stress Disorder. BWS consists of a pattern of signs and symptoms after a woman had an intimate relationship when the partner exercised power and control over the woman. Seven factors present in this study identify BWS, a) intrusive recollections of traumatic events, b) high levels of arousal and anxiety, c) avoidance behavior and emotional numbing usually expressed as depression, denial, minimization, and dissociation, d) disruption in interpersonal relationships of partner power.

Strengths and limitations

We designed this study to reduce bias and provide aspects linking IPV against women. Firstly, we used the OPD-2 in the context of violence in Brazil, especially with the OPD Domestic Violence Assessment Module, the agreement between the judges was substantial. A limitation in some interviews was a coefficient between the

judges lower than 0.60; however, we decided not to repeat the codification in order not to condition the evaluation of the items or to infer a certain interpretation on the judges.

Another strength of our study was the exploration of operationalized psychodynamic diagnosis of women victims of domestic violence, exploring the severity and experience of violence, structural functions, dysfunctional interpersonal patterns, and intrapsychic conflicts. Researchers point out that trauma, due to constant violence, causes changes in structural functioning and conflict [8].

Finally, our study population was representative of all social characteristics of Southern Brazil, which makes the findings generalizable. In numerous countries, IPV is common in many cases. Romagnoli [28] points out that this is a social and public health problem since it generates a high burden on the health system - calculated in terms of mortality/morbidity, quality of life, and cost; primarily affects minorities and disadvantaged individuals. Despite the protection and reception services, women remain in the cycle of violence, either with the same partner or with another, repeating the same behavioral patterns. It is important to identify the characteristics of the psychological functioning of these women to understand how and when they will break the cycle of victimization. However, this study did not intend to trace a single profile of women victims of violence, on the contrary, presenting different epidemiological characteristics.

Brazil faces several barriers in the Brazilian context since there is a social permissiveness in relation to aggression with the banalization of violent behavior against women. That is, it is naturalized in society [28, 29]. The culture of patriarchy is present, which was culturally created that male honor allows women to be beaten, threatened, and killed. In view of this, Law 11.340/06, known as Maria da Penha was created, which integrates principles regarding violence against women or gender violence. It creates legal mechanisms to prevent and punish domestic violence against women, that is domestic violence ceases to be a crime of minor offense to a criminal level of human rights violation [16].

Implications for clinical practice and public health

According to Falcke and Féres-Carneiro [30] and Walker [18], women who suffer domestic violence are not easy to identify, since they hide the signs due to shame, but there is an immense change in personality. This violence reveals imprisonment in themselves, as they lose interest in social activities in preference to

staying in the home environment and even naturalize violent behavior. Socially, there is the massive presence of the patriarchal ideology in the world, whose violence is associated with masculinity. The authors discuss the dynamics of partner violence since partner selection is a reproduction of violent behavioral patterns experienced in childhood and women's inability to reflect on their relationship choices due to traumatic events and lack of meaningful emotional experiences [31].

Victims of violence are considered hard patients because of their countertransference feelings of frustration [11]. Also, a source of psychic suffering for the therapist is treating traumatized patients since they have an intense and significant emotional load [32]. Therefore, a specific evaluation of the patient's violent context is necessary; identifying the patient's resources and obstacles; the personal explanation for victimization; the possible secondary gain, that is, investigating the characteristics and the psychodynamic functioning; and clinical understanding of these patients; the dimension axes of the OPD-2 can perform this analysis. During the psychotherapeutic process, stimulating the event through reflection and mentalization can trigger a traumatic reenactment. This can provide a new understanding of the violence experienced, producing new representations [33].

Regarding the individual resources, some characteristics help in the elaboration of the traumatic event, such as resilience capacity, the phase of life that the event occurred, and the previous history. The internalization of references to good relationships in childhood aid in the structuring of safer and more stable subjects. After a stressful occurrence, there may be the development of hyperstimulation, where anxiety is prevalent or dissociation, in which the individual seems to be numbed, but hides great inner suffering [34].

Due to violence, there is a change in the capacity of the self to handle the internal experience and the interaction with others; they have negative attitudes, shame, stigma, and difficulties in regulating their emotions in relationships with others [35]. For Johnson and Benight [36], the ability to tolerate trauma, due to domestic violence, refers to Bandura's self-efficacy; since, according to Campos, Faria, Zanini, and Peixoto [37], self-efficacy interferes with the individual's ability to produce certain results, overcoming difficulties and presenting control over the environment. And for Kane et al. [38], victims of trauma due to domestic violence who had greater social contact showed less effect in daily activities such as cooking, caring for family members, and work. Thus, aspects that interfere in the relationship between

traumatization and illness, social support, social protection network, type of victimization, age, gender, perceived self-efficacy, and so forth [39]. Low levels of social support are related to higher rates of IPV [40]. Also, there are side effects on child care, mothers who have greater difficulties in showing affection to their child's needs, and some mother-child relationships become more tense and distant than others in domestic violence contexts [22].

Scientific evidence points to the association between domestic violence and mental health problems, such as depression, anxiety, suicide attempts, posttraumatic stress symptoms [1], as pointed out in this study. The results of the study by Schultz and co-workers [40] point to broad implications for IPV survivors in addition to increased depression, health conditions associated with type 2 diabetes (cardiovascular, ocular, urinary and circulatory) and drug abuse, quality of life in this population. Thus, the dimensional diagnosis complements the nosological diagnosis, which consequently facilitates the clinic.

Conclusion

This study built empirical evidence on clinical observations regarding the psychological functioning of this population and the issues that make up the maintenance of domestic violence against women. The dynamics of victimization are hard to identify because victims are embarrassed to report or are not critical about the problem. The understanding of internalized patterns (Axis II), structural functions (Table 5), and motivational tensions (Fig 1) are fundamental for the prevention of re-victimization, and the construction of more adaptive coping mechanisms, as well as to promote greater adherence to treatment. The psychodynamic dimensional identification is a useful tool for therapeutic planning and focus of the demands that constitute the obstacles and impasses of the interruption of the cycle of violence.

It is noteworthy that women suffered very difficult situations and mentioned that they did not react out of fear or because they felt unable to do so (Table 1). They put themselves in a submissive position (Fig 1) as a way to anticipate the partners' reaction. They perceive others as controlling and aggressive and, as a consequence, victims are insufficiently protected, allowing dangerous progression. They feel confused when the other shows affection, holding on and being dependent on the other. (Axis II). They do not recognize their limitations and needs due to IPV. Few perceive the similarity of repetition of parental patterns of violence. The situations and events

that generate tension weaken the coherence of the self-image (Table 5). The victims believe that external measures were needed to overcome the cycle of violence, such as the protective measures provided by the protection agencies in the court (Table 3). Income was not a very significant factor in maintaining the cycle of violence, but the level of education influenced their perception and resources to deal with the situation of violence (Table 8).

Unanswered questions and future research

Intimate partner violence against women is a cyclical phenomenon, so to conduct a cohort study to observe the particularities of victimization using a large sample and the OPD-2 to plan treatment would be interesting. Studies based on long-period follow-ups would make it possible to evaluate the evolution of the psychological functioning of women victims of IPV, especially after violence has ended or after the therapeutic process.

Future research should also include the effects of IPV on child-rearing since studies are pointing to the phenomenon of transgenerationality. As well as, investigate the influence of social support and specialized services, as well as the ability to soften the effects of traumatic stressors on health outcomes.

Acknowledgment

This study was supported by the Legal Medical Department of *Rio Grande do Sul*, especially by Dr. Anlelita Rios, who invited and made collection possible at the institution. Also, teacher Carla Crempien by *Pontificia Universidad Católica de Chile*, who cooperated with support for OPD and teacher Sílvia Benetti who enriched the study.

Funding information

This study was financed in part by the *Coordenação de Aperfeiçoamento de Pessoal de Nível Superior - Brasil (CAPES)* - Finance Code 001.

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11 ARTIGO 5. CLINICAL SIGNATURE AMONG VICTIMS OF DOMESTIC VIOLENCE: A study using text classification tools

- Revista: ***Global Journal of Medical Research***
- Qualis na Área de Medicina II – Classificação de Periódicos Quadriênio 2013-2016: **C**
- https://medicalresearchjournal.org/index.php/GJMR/article/view/1990
- Autores: BOTH, L. M. FREITAS, L. H. M., PASSOS, I.

ABSTRACT

Introduction: Intimate partner violence is a major public health problem and a violation of women's human rights. It is important to explore the speech of the victim at the time of the complaint.

Objective: To analyze the text classification with word cloud as a tool to understand the pattern of patient functioning, complementing the qualitative analysis.

Method: It is a text classification study with a word cloud analysis technique, complementing the qualitative analysis. The sample is fifty-six women victims of self-reported domestic violence, who came from a public service in South of Brazil.

Results: A word cloud was developed from the text classification with word cloud from the speech of the 56 participants.

Discussion: The women's discourse in the interviews had focused on understanding what had really happened in their relationship, reporting their abusive situations. Studies using this technique benefit from including heterogeneous patients considering their idiosyncrasies to develop a complex non-linear pattern relating predictors to the clinical outcome.

Conclusion: This study was bold because it used text classification as a method of qualitative analysis. It was possible to understand the pattern of patient functioning from the text classification tool.

Key words: Intimate partner violence, word cloud, qualitative research.

INTRODUCTION

Violence against women, particularly intimate partner violence (IPV) is a major public health problem and a violation of women's human rights. Worldwide, 35% of women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner. Based on World Health Organization data, women’s lifetime exposure to intimate partner violence is associated with myriad health outcomes, like fatal outcomes, lead to injuries, depression, post-traumatic stress and other anxiety disorders, sleep difficulties, eating disorders, and suicide attempts (WHO, 2017). Not surprisingly, IPV is the second most common risk factor for disability-adjusted life years globally in women aged 20–24 years (Mokdad, 2016).

IPV is challenging to identify and address. Healthcare professionals play a significant role in identifying women who are usually exposed to domestic violence, identifying the signs of violence, protecting victims from experiencing violence again,

and providing support to victims (Yaman Efe, 2012). Considering the significance of the issue, it is important to explore the speech of the victim at the time of the complaint, what are the most representative aspects in his speech, since it has been about violence for years. Why did you report it now? Which treatment is best suited to your needs?

We began to explore the victim's discourse to develop a model to understand the real needs of these victims at the time of reporting. Thus, patients benefit from more accurate treatment plans, avoiding prolonged periods of "trial and error" seeking the correct treatment to avoid revictimization, because women victims of domestic violence have difficulties in adhering to some treatment. The present study aims to analyze the text classification with word cloud as a tool to understand the pattern of patient functioning, complementing the qualitative analysis.

METHODS

Study design

It is a text classification study with a word cloud analysis technique, complementing the qualitative analysis. It is complementary to a larger research, still in progress.

Sample

Fifty-six women victims of self-reported domestic violence, who came from a public service in South of Brazil. We included all women who were present on collection days in December 2017 and agreed to participate in the study.

Instrument

We collect sociodemographic data from women such as: age, schooling level, family income, time of marital relationship, living with, use of drugs, existence of parental violence (transgenerationality of violence), among others. We also conducted the Operationalized Psychodynamic Diagnosis (OPD-2) Clinical Interview (Task Force, 2016). It is a semi-structured interview with specific interviewing tools for the exploration of each axis: I) "Module for the Evaluation of Domestic Violence OPD" proposed by the Chilean researcher Carla Crempien in 2009 in her PhD thesis (Crempien, 2009, 2012) and adapted to Brazil (Both et al. 2019), II) dysfunctional

interpersonal pattern, III) intrapsychic conflicts, IV) structural functions (Task Force, 2016).

Data analysis

Python code was used as a base, which is available through the link https://www.geeksforgeeks.org/generating-word-cloud-python/. All prepositions and conjunctions were removed for the construction of the cloud.

RESULTS

Study population

The sample had normal distribution ($p < 0.05$). The participants were 56 women aged 18-65 years (mean: 30,07 years) who educational levels ranged from high school, income between 1 and 2 salaries. Table 1 presents the socio-demographic characteristics of the participants. The length of the marriages was in the range of 1-30 years, and 46,4% were separated in less than 6 months (Table 2). Duration of violence is described in Table 3.

Table 1. Sociodemographic Data.

Category	Subcategory	Women	Men
Age	18 to 20 years old	8 (14,3%)	3 (5,4%)
	21 to 25 years old	16 (28,6%)	5 (8,9%)
	26 to 30 years old	8 (14,3%)	16 (28,6%)
	31 to 35 years old	9 (16,1%)	13 (23,2%)
	36 to 40 years old	8 (14,3%)	4 (7,1%)
	41 to 45 years old	2 (3,6%)	5 (8,9%)
	46 to 50 years old	3 (5,4%)	5 (8,9%)
	51 to 55 years old	1 (1,8%)	1 (1,8%)
	56 to 60 years old	1 (1,8%)	2 (3,6%)
	61 to 65 years old	0	2 (3,6%)
Race	White	37 (66,1%)	35 (62,5%)
	Black	21 (21,4%)	13 (23,3%)
	Brown	6 (10,7%)	7 (12,5%)
	Indigenous	1 (1,8%)	1 (1,8%)
Scholarity	Illiterate	0	1 (1,8%)
	Incomplete elementary school	15 (26,8%)	17 (30,4%)
	Complete primary education	6 (10,7%)	6 (10,7%)
	Incomplete high school	8 (14,3%)	7 (12,5%)
	Complete high school	22 (39,3%)	22 (39,3%)
	Incomplete higher education	3 (5,4%)	1 (1,8%)
	Complete higher education	1 (1,8%)	2 (3,6%)
	Postgraduate studies	1 (1,8%)	0
Income	None	13 (23,2%)	8 (14,3%)
	Less than 1 salary	8 (14,3%)	1 (1,8%)
	Between 1 and 2 salaries	31 (55,4%)	35 (62,5%)
	Between 3 and 6 salaries	2 (3,6%)	5 (8,9%)
	Between 7 and 12 salaries	1 (1,8%)	2 (3,6%)
	More than 12 salaries	1 (1,8%)	4 (7,1%)
Religion	Godless	22 (39,3%)	26 (46,4%)

	Catholic	19 (33,9%)	15 (26,8%)
	Spititist	4 (7,1%)	3 (5,4%)
	Afro-Brazilian	3 (5,4%)	6 (10,7%)
	Evangelical	0	6 (10,7%)
Addiction	Alcohol	3 (5,4%)	25 (44,6%)
	Drug	2 (3,6%)	0
	Tobacco	8 (14,3%)	7 (12,5%)
	Marijuana	1 (1,8%)	7 (12,5%)
	Cocaine	0	3 (5,4%)
	Marijuana and Cocaine	0	7 (12,5%)
	Anabolic	0	1 (1,8%)

Note. Income: 1 salary is a basic remuneration to the worker. Religion: Godless is the person who do not believe in God. Spiritism is the person who believe in life after death. Umbanda is the person who has several cults influenced by Indians.

Table 2. Relationship.

Category	Subcategory	Women
Type of relationship	Date	1 (1,8%)
	Dating	9 (16,1%)
	Marriage	5 (8,9%)
	Stable union	8 (14,3%)
	Divorced	7 (12,5%)
	Separated in less than 6 months	26 (46,4%)
Time of relationship	Less than 6 months	3 (5,4%)
	Between 6 months and 1 year	6 (10,7%)
	Between 1 and 2 years	11 (19,6%)
	Between 3 and 5 years	13 (23,2%)
	Between 6 and 10 years	15 (26,8%)
	Between 11 and 15 years	2 (3,6)
	Between 16 and 20 years	4 (7,1%)
	Between 21 and 30 year	2 (3,6%)

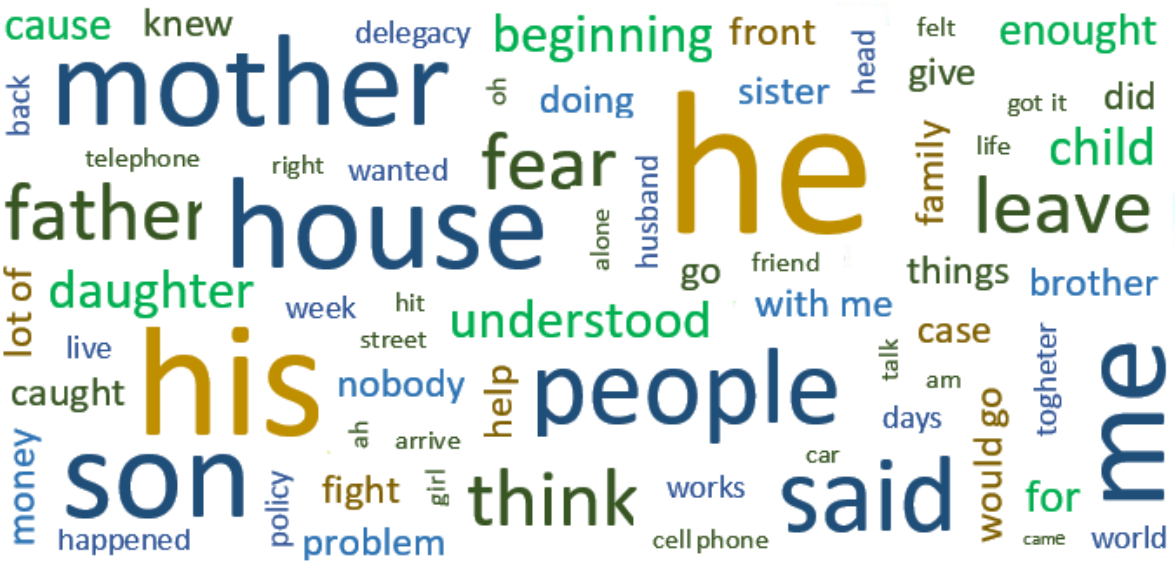
Table 3. Duration of violence.

Category	Frequency
< 6 months	18 (32,1%)
6-24 years	8 (14,3%)
2-5 years	14 (25%)
5-10 years	6 (10,7%)
> 10 years	10 (17,9%)

Word Cloud

Figure 1 shows the word cloud from the text classification with word cloud from the speech of the 56 participants.

Fig. 1. Word Cloud (n=56).



DISCUSSION

According to Wild and collaborators (2018), evidence suggests that knowledge and skills rarely translate international guidelines and sustainable good practice. It is necessary to change support training and health leadership. For example, the National Action Plan on Gender-based Violence in Timor-Leste for training of trainers (SEM, 2017), WHO handbook for engaging health (WHO, 2017). Therefore, professionals and researchers need to understand the real needs during the reception and identification of women suffering from IPV.

The women's discourse in the interviews had focused on understanding what had really happened in their relationship, reporting their abusive situations. In this sense we highlight the words “problem”, “people” referring to the couple, “he”, “his”, what was said (“said”), the children involved (“son”, “daughter”, "child").

All women referred to the "beginning" of the relationship as different, whose husband was affectionate and caring, but over time this behavior changed. The husband had jealous and controlling behavior. This aspect is observed in the cycle of violence. Intimate partner violence tends to be systematic and chronic, the maltreatment goes through cycles in which violence episodes alternate with remorse and recompense; this has been described as the “cycle of violence”. IPV increases on severity along time (Walker, 2016).

In this sense, they concentrate part of the discourse reporting the cause (“cause”) of the violence. They attributed her husband's use of alcohol and drugs and

her husband's jealousy that provoked aggression in his behavior. According to Zacan *et al.* (2013) and Crempien (2009) husband's drug use and jealousy is a relevant factor in IPV. This control is called psychological violence (Brasil, 2006). Women who suffered psychological violence reported significantly more controlling behaviors from their partners than non-victims. And from a clinical perspective, it has been reported its impact on women's mental health, and its associations with depression, anxiety and posttraumatic stress disorder (García-Moreno, Jansen, Ellsberg, Heise, *et al,* 2006). The cause is also noted by the word "think" in the word cloud, in which participants tried to exploit partner violence.

Research suggested that social support is associated with less severe IPV (Schultz, Walls, & Grana, 2019, Crempien, 2012), specially with family (Wright, 2015). However, it is observed that the victim's speech was organized around the husband (words "he", "his", "father" of the children). Little said too much social relationships with friends or family. Another prevalent speech was the word "mother", but they referred in a negative sense, angry at early abandonment, lack of support. Also, companions limit them in relation to having a job, where they remain focused on raising children at home (Blanchard *et al.,* 2018).

Studies point to the trangerationality of violence, whose father's perpetration of violence against the mother and child (Chiesa *et al.,* 2018), with a co-occurrence rate of 75% (range 11–97%; Jouriles, McDonald, Slep, Heyman, & Garrido, 2008). There are many consequences for children exposed to IPV in mental and behavioral health (Johnson *et al.,* 2002, Lapierre, 2010, Crempien, 2012).

Another word that stood out in the word cloud was the word "fear." The male perspective is characterized by abusive and coercive physical or non-physical conduct, with recognizable inequality of powers and play of forces. And regarding female behavior, there is the presence of fear with response of avoidance, adaptation and submission (Crempien, 2009; Blanchard *et al.,* 2018). IPV presents with a slow and silent onset without physical aggression and gradually progresses to actions with greater intensity and humiliation (Leôncio *et al.,* 2008). However, violence can be aggravated due to women's shame in reporting, lack of educational means and access to legal information and lack of assistance and protection (Signori, & Madureira, 2007). In this sense, it is necessary to combine effective assessment practices with preventive measures, such as psychoeducation and other screenings.

TEXT CLASSIFICATION TOOLS

In our previous reviews, the qualitative researches use content analysis about social and cultural issues (Hays & Emelianchik, 2009; Souto *et al.,* 2019), program planners by thematic content analysis (coding and categorization for each interview question) in NVivo 10.0 (Blanchard *et al.,* 2018), representations of domestic violence against women by software EVOC - Ensemble de Programmes Pemettant L´Analyse des Evocations (Silva et al., 2018; Gomes *et al.,* 2015), describe the general violence situation by coding and recognizing themes or categories (Taherkhani *et al.,* 2014), understand of pregnancy's experiences IPV by recognizing themes (Baird, Creedy, & Mitchell, 2017).

The aim of this study was to analyze the text classification with word cloud as a tool to understand the pattern of patient functioning, complementing the qualitative analysis. Thus, it was observed that it was possible to explore various questions of the participants using the word cloud.

IMPLICATIONS FOR CLINICAL PRACTICE AND PUBLIC HEALTHY

According to a meta-analysis, there is an association between IPV and mental health problems (Bacchus, Ranganathan, Watts, Devries, 2018). The most important mental illnesses seen in women after domestic violence are post-traumatic stress disorder, anxiety disorder, and depression (Cengiz *et al.,* 2014). High levels of IPV are associated with moderate suicide risks (Kavak *et al*., 2018).

During the reception of women, it is important to differentiate episodes of recent violence and violence that has occurred historically in women's lives, the duration and severity of IPV, risks of alcohol and other substance use, support network (Bacchus, Ranganathan, Watts, Devries, 2018). IPV is associated with a history of childhood trauma. Abusive experiences during childhood predispose victims to a higher risk of later revictimization. Thus, previous traumas resurface in current traumas that need to be elaborated and overcome dependence valuing their self-esteem (Sahin, Timur, Ergin, Taspinar, Balkaya, Cubukcu, 2010).

CONCLUSION

This study was bold because it used text classification as a method of qualitative analysis. It was possible to understand the pattern of patient functioning from the text classification tool. Of particular importance to the population of this

study, more research using word cloud to understand the mechanisms by which IPV may influence mental health.

A limitation of this study is its cross-sectional nature which impedes the establishment of temporal relations between the studied variables or the study of the self capacities, later to victims' reparation therapy and interdisciplinary interventions. Another limitation is the small sample size, where there are no subgroups to compare variables.

The risk for IPV and the ability to buffer effects of traumatic stressors on health outcomes is higher when the discourse of victim focuses only on the traumatic event. It is necessary to accommodate the patient's demand to understand the situation of violence, elaborate these issues and insert different interests (work, protection services, support network). Thus, it was possible to contribute to the enrichment of their difficulties and the treatment obstacles. Working through with the victim on these aspects, could lead to a more complete and realistic perception of herself and the others', as well as promoting her reflective function and affective regulation.

The violence or a consequence of it represents internal obstacles of the victim to regulate her emotional experience and stress. The treatment could contribute to the management in a differentiated way, diverse self capacities. Future research is recommendable to include a larger number of participants in order to go further in the study of these possible associations. Likewise, longitudinal studies are interesting to examine changes in self capacities during interventions.

Ethical observations

1. Conflicts of interest. There are no conflicts of interest.

2. Ethical Approval. The work was approved by an institutional ethics committee and authorized to collect data at the corresponding institution.

3. Consent. The victims were invited voluntarily and authorized their participation in the research by signing the Term of Free and Informed Consent.

4. Omission: All data that could identify participants was omitted.

Acknowledgment

This study was supported by the Legal Medical Department of *Rio Grande do Sul*, especially by Dr. Anlelita Rios, who invited and made collection possible at the institution.

Funding information

This study was financed in part by the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior - Brasil (CAPES) - Finance Code 001.

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12 ARTIGO 6. DEFENSE STYLE IN INTIMATE PARTNER VIOLENCE AGAINST WOMEN

ABSTRACT

Introduction: The defense mechanisms are unconscious psychic processes that relieve the ego from the state of psychic tension emanate from the external reality, as in the case of traumatic situations of domestic violence - Intimate partner violence (IPV).

Objective: To identify the predominant defense mechanisms in IPV and to investigate the relationship between the defensive style of women victims of IPV and psychodynamic functioning based of OPD-2.

Method: It is a quantitative and cross-sectional study. Participated in the study forty-two women victims of self-reported domestic violence who came from an expert public service in South of Brazil. Was used sociodemographic questionnaire, Defensive Style Questionnaire (DSQ-40) and OPD-2 Clinical Interview.

Results: The use of mature defenses was prevalent, level of compromised psychic structure, “need to be cared for versus autarky” as the main intrapsychic conflict and 42.8% of the participants had a diagnosis of Major Depressive Disorder.

Conclusion: Victims of IPV have characteristics of PTSD. Thus, the understanding of the patient's psychodynamic functioning in the sense of which interpersonal relationship pattern, level of structure and intrapsychic conflict are determining aspects for the defensive style to be used by the victim. Recommendations for practitioners and future research have been explored.

Key words: Intimate partner violence (IPV), defensive style, post-traumatic stress disorder (PTSD).

RESUMO:

Introdução: Os mecanismos de defesa são processos psíquicos inconscientes que aliviam o ego do estado de tensão psíquica emanadas da realidade externa, como no caso de situações traumáticas de violência doméstica – Violência por parceiro íntimo (IPV).

Objetivo: Identificar os mecanismos defensivos predominantes em IPV e investigar a relação entre o estilo defensivo de mulheres vítimas de IPV e o funcionamento psicodinâmico baseados no OPD-2.

Método: É um estudo quantitativo e transversal. Participaram 42 mulheres vítimas de violência doméstica autodeclarada oriundas de um serviço público no sul do Brasil. Foi utilizado um questionário sócio demográfico, o *Defensive Style Questionnaire* (DSQ-40) e a Entrevista Clínica do OPD-2**.**

Resultados: Prevaleceu o uso de defesas maduras, nível de estrutura psíquica comprometida, "necessidade de ser cuidado versus auto-suficiência" como conflito intrapsíquico principal e 42,8% das participantes possuíam diagnóstico de Transtorno Depressivo Maior.

Conclusão: Vítimas de IPV possuem características de TEPT. Dessa forma, a compreensão do funcionamento psicodinâmico da paciente no sentido de qual padrão de relacionamento interpessoal, nível de estrutura e conflito intrapsíquico são aspectos determinantes para o estilo defensivo a ser utilizado pela vítima. Recomendações para profissionais e pesquisas futuras foram exploradas.

Palavras-Chave: Violência por parceiro íntimo, estilo defensivo, transtorno de estresse pós-traumático (TEPT).

INTRODUCTION

The concept of defense was first described by Sigmund Freud in his work on "The Neuropsychoses of Defense" (1894). Defenses were described by Freud as unconscious psychic processes that relieve the ego from the state of psychic tension between the intrusive id, the threatening superego and the pressures emanating from external reality. Defenses are the mediators between the internal world (desires, drives and anxieties) and the individual's external world, thus determining the type of relationship between the individual and the environment (FREUD, 1926/1996; LAPLANCHE, PONTALIS, 1991).

In 1936, Anna Freud, in her book "The Ego and the Defense Mechanisms" (FREUD, 2006), outlines the concept of a classification in which the defense mechanisms would have a "continuum" from the most primitive, such as repression and projection, even others more evolved "that develop from the maturation of structures, ego and superego", such as sublimation and altruism. The defensive style is expressed as continued models of character reaction, which are repeated throughout life. This pattern works as a risk or protection factor for the subjects (FREUD, 1926/1996).

The specific defense mechanisms may be related to the manifestation of psychiatric symptoms. In situations of stress or trauma, there is a predisposition for non-adaptive defense styles (BOND, PERRY, 2004; YONG JUN, 2015). In the initial conception of DSM-III, the traumatic event was defined as a catastrophic stressor outside the scope of experiences expected for someone's life (APA, 1980).

A phenomenon characterized by recurrent stressful situations is domestic violence. Intimate partner violence (IPV) is characterized by an attempt to harm or control your current or former romantic partners against your will. Also, it is referred to as the paradoxical combination of affection and aggression (CHESTER, DEWALL, 2018).

In Brazil, the Ministry of Health records that every four minutes a woman is assaulted by at least one man and survives; most of the time the aggressor is the ex or current partner (CUBAS, ZARAMBA, AMÂNCIO, 2019). According to the 2019 Atlas of Violence conducted by the Institute of Economic and Applied Research, the indicator of femicide is 31.6 cases per 100 thousand inhabitants. Of the total homicides against women in Brazil, 28.5% occur inside the home, cases resulting from IPV (ATLAS DA VIOLÊNCIA, 2019).

In view of these issues, the need to understand this context of violence is undeniable due to the high prevalence of cases. The defense mechanisms used by victims of domestic violence characterized by the diagnosis of PTSD are not clear in the literature. Based on the prior studies in that population, the current study hypothesizes that maladaptive styles was prevalent. Thus, the primary aim of the present study was to identify the predominant defense mechanisms in IPV. Later, the second aim was to investigate the relationship between the defensive style of women victims of IPV and psychodynamic functioning (interpersonal relationship patterns, intrapsychic conflict and psychic structure).

METHODS

Study design

It is a quantitative and cross-sectional study. It is complementary to a larger research, still in progress.

Sample

Participated in the study forty-two women victims of self-reported domestic violence who came from an expert public service in South of Brazil. All of them sought the service during the data collection period were included during the on-call researcher's shift. Women aged 18 to 65 years were included.

Instrument

The sociodemographic questionnaire was based on the study developed by Lourenço and Baptista (2013). Also, OPD-2 Clinical Interview (TASK FORCE, 2016) and Defensive Style Questionnaire (DSQ-40; ANDREWS, SINGH, BOND, 1993) was used.

OPD-2 Clinical Interview is a semi-structured interview with specific interviewing tools for the exploration of each axis of Operationalized Psychodynamic Diagnosis (OPD-2): Axis I) “Module for the Evaluation of Domestic Violence OPD” (BOTH, FAVARETTO, FREITAS, CREMPIEN, 2019), Axis II) dysfunctional interpersonal pattern, Axis III) intrapsychic conflicts, Axis IV) structural functions, and Axis V) nosological diagnosis (TASK FORCE, 2016).

The DSQ-40 is an instrument developed to evaluate derivatives aware of defense mechanisms. The official validation and reorganization of the instrument in its current form was carried out by Andrews, Singh, & Bond (1993). The DSQ-40 is a self-administered questionnaire of defensive styles composed of 40 items related to the defenses described in the DSM-III-R. Each item is scored from 1 to 9 according to the degree of agreement with the statements. The instrument assesses 20 types of defense (2 items for each) whose score corresponds to the average of the scores for that factor. The instrument evaluates five mature defenses (sublimation, humor, anticipation and suppression, racionalization), four neurotic defense styles (undoing, pseudoaltruism, idealization and reaction formation) and the remaining eleven are considered immature (projection, passive-aggression, acting out, isolation, devaluation, fantasy, displacement, dissociation, splitting, rationalization and somatization). The DSQ-40 has already been translated and validated in different countries. The version adapted for Brazil was developed by (BLAYA, 2005) and showed reliability indexes evaluated by Cronbach's alpha coefficient of 0.77 for the immature style, 0.68 for the mature style, and 0.71 for the mature style. neurotic style. Temporal stability (four-month test-retest) showed the following coefficients: 0.81 (immature style); 0.68 (mature style) and 0.71 (neurotic style).

Procedures for collecting and setting

The victim of violence was invited voluntary to participate in the survey during expert service. In the expert room, the victim answered the instruments. The researcher conducts an interview and these interviews were recorded in audio and transcribed.

Data analysis

Firstly, data analysis was done by two independent trained judges who coded the interviews in the OPD-2 worksheet. The kappa coefficient of each axis was calculated independently for each interview. In this study, concordance between the judges was substantial in each axis; 63% in the Axis I violence module, 73% in Axis III, 82% in Axis IV, and 100% in Axis V. For Axis II, we considered the items scored more frequently by judges.

Later, analyses were conducted with SPSS software. It was considered $p<0,05$ to define significance. The Cronbach's Alpha of DSQ-40 was 0,893 in this study, very good reliability statistics.

RESULTS

Study population

The sample had normal distribution, according to the Kolmogorov-Smirnov normality test. These were women with a mean of 28 (SD = 8,08) years and men presented a mean of 32,77 (SD = 9,65) years of age (Table 1). The relationship, 42,9% were separated in less than 6 months (Table 2).

Table 1. Sociodemographic Data.

Category	Subcategory	Women	Men
Age	18 to 20 years old	8 (19%)	3 (7,1%)
	21 to 25 years old	13 (31%)	4 (9,5%)
	26 to 30 years old	6 (14,3%)	16 (38,1%)
	31 to 35 years old	8 (19%)	7 (16,7%)
	36 to 40 years old	4 (9,5%)	3 (7,1%)
	41 to 45 years old	1 (2,4%)	3 (7,1%)
	46 to 50 years old	2 (4,8%)	4 (9,5%)
	51 to 55 years old	0	1 (2,4%)
	56 to 60 years old	0	1 (2,4%)
Race	White	27 (64,3%)	25 (59,5%)
	Black	8 (19%)	10 (23,8%)
	Brown	6 (14,3%)	6 (14,3%)

	Indigenous	1 (2,4%)	1 (2,4%)
Scholarity	Illiterate	0	1 (2,4%)
	Incomplete elementary school	9 (21,4%)	11 (26,2%)
	Complete primary education	4 (9,5%)	5 (11,9%)
	Incomplete high school	6 (14,3%)	5 (11,9%)
	Complete high school	20 (47,6%)	20 (47,6%)
	Incomplete higher education	1 (2,4%)	0
	Complete higher education	1 (2,4%)	0
	Postgraduate studies	1 (2,4%)	0
Income	None	11 (26,2%)	4 (9,5%)
	Less than 1 salary	6 (14,3%)	1 (2,4%)
	Between 1 and 2 salaries	22 (52,4%)	28 (66,7%)
	Between 3 and 6 salaries	1 (2,4%)	4 (9,5%)
	Between 7 and 12 salaries	1 (2,4%)	1 (2,4%)
	More than 12 salaries	1 (2,4%)	4 (9,5%)
Religion	Godless	17 (40,5%)	18 (42,9%)
	Catholic	11 (26,2%)	11 (26,2%)
	Spiritism	4 (9,5%)	3 (7,1%)
	Afro-Brazilian	3 (7,2%)	5 (11,9%)
	Evangelical	7 (16,7%)	5 (11,19%)
Addiction	Alcohol	3 (7,1%)	25 (44,6%)
	Tobacco	5 (11,9%)	7 (12,5%)
	Marijuana	1 (2,4%)	7 (12,5%)
	Cocaine	0	3 (5,4%)
	Marijuana and Cocaine	0	7 (12,5%)
	Anabolic	0	1 (1,8%)

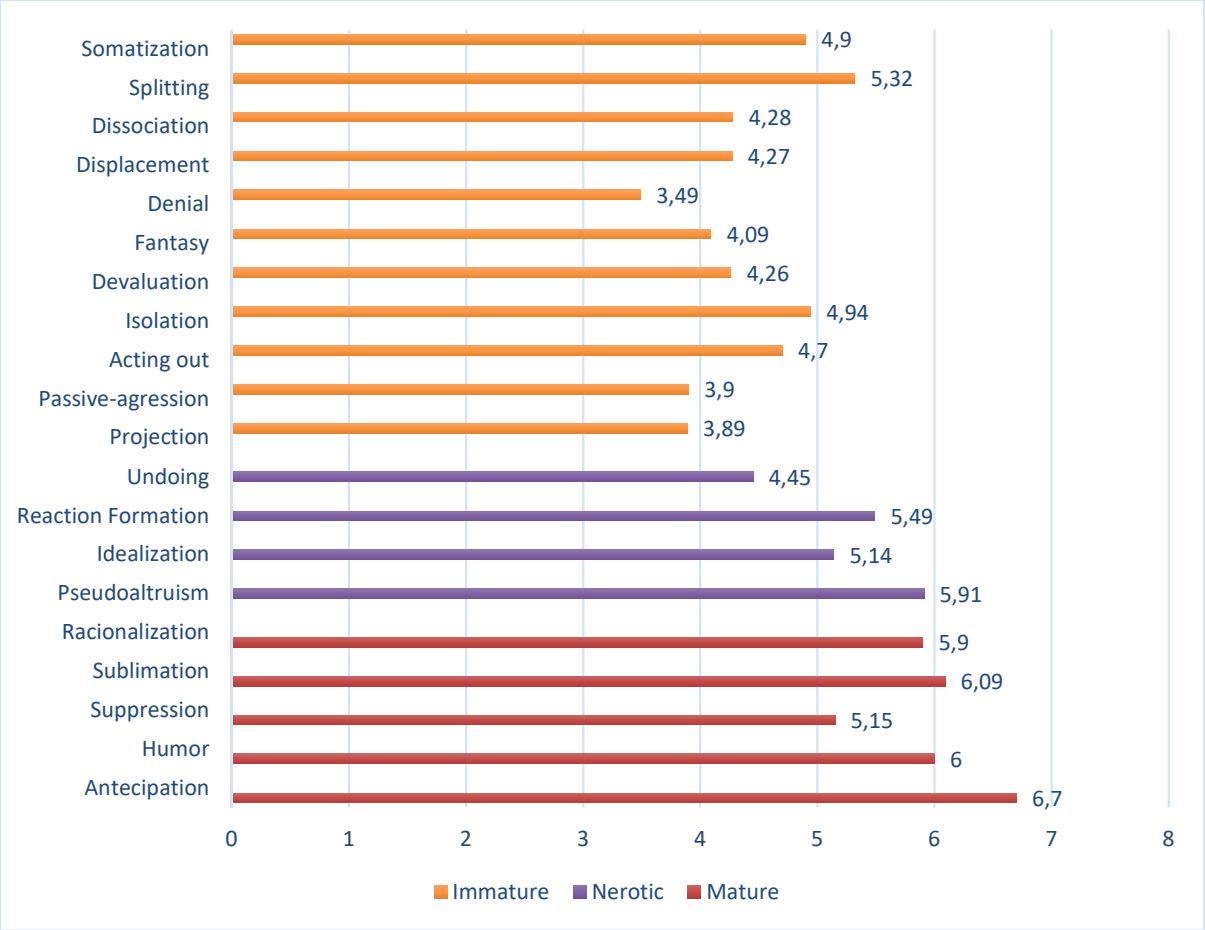
Note. Income: 1 salary is a basic remuneration to the worker. Religion: Godless is the person who do not believe in God. Spiritism is the person who believe in life after death. Umbanda is the person who has several cults influenced by Indians.

Table 2. Relationship.

Category	Subcategory	Women
Type of relationship	Date	1 (2,4%)
	Courtship	8 (19%)
	Marriage	4 (9,5%)
	Stable union	7 (16,4%)
	Divorced	3 (7,1%)
	Separated in less than 6 months	18 (42,9%)
Time of relationship	Less than 6 months	3 (7,1%)
	Between 6 months and 1 year	6 (14,3%)
	Between 1 and 2 years	10 (23,8%)
	Between 3 and 5 years	7 (16,4%)
	Between 6 and 10 years	12 (28,6%)
	Between 11 and 15 years	2 (4,8%)
	Between 16 and 20 years	1 (2,4%)
	Between 21 and 30 year	1 (2,4%)

Main analysis of DSQ-40

Figure 1. Descriptive analysis of the DSQ-40.



The defense mechanisms are classified by maturity levels into: mature, neurotic or immature defenses. **Mature defenses** (sublimation, humor, anticipation and suppression) help the ego to adjust to the demands, indicating a coping better adapted to different life situations. In this condition, the ego will adequately integrate the past and the present, as well as the internal and external realities (VAILLANT, 1973; ANDREWS; SING; BOND, 1993; KIPPER *et al.,* 2004).

In this study, **anticipation** prevailed. it is observed that the participants anticipating her husband's behavior and behaved in submissive mode as a subtle interpersonal pressure. They portrayed instant gratification when planning and thinking about future achievements.

Then s**ublimation** was self-described by the participants. They referred to transforming the situation they experienced into something socially acceptable and

beneficial to the other, for example: one of them idealizes being a police officer to protect other women who suffer from this situation. According to Fenichel (2000), sublimation is the most effective of the defense mechanisms, insofar as it channels libidinal impulses to a socially useful and acceptable posture, whose purpose or object (or one and the other) is transformed, without block proper discharge under the influence of the ego.

Humor was described as a defense used in the sense of finding comical and / or ironic elements in situations of violence in order to reduce unpleasant affects and personal discomfort. This mechanism also allows for some distance and objectivity in relation to the events, so that the individual can reflect on what is happening. Or even the use of **suppression**, in which the participant made the conscious decision not to give vent to a feeling consciously, in which she decided that the feelings resulting from the aggression would no longer be active in her life.

Finally, **rationalization** is also classified in mature defenses. Several participants sought justifications for their partner's behavior, since it was unacceptable to conceive of the violence suffered by them. According to Almeida (1996), it is the defense mechanism that comprises a psychic need that motivates the organism towards the goal to be achieved, there may be a desire arising from the desire to want conscious greed, or more primitive, unconscious desires related to sexual drive.

Freud (1894/1996) highlighted that the **neurotic defense mechanisms** (undoing, pseudoaltruism, idealization and reactive formation) allow some components of undesirable mental contents to come to consciousness in a covert and / or distorted way from the compromise formations of the psychic conflict (ANDREWS; SING; BOND, 1993). In this way, the individual is able to keep out of consciousness anxieties, emotions, ideas, memories, desires, fears, that is, all those potentially threatening contents. It is the defenses that alter the internal contents and the expression of the drives. Regarding the strengthening of the ego, the efficiency of these mechanisms depends on how successfully this greater or lesser integration of these conflicting mental forces. The various methods of compromise formation may (or may not) turn out to become psychoneurotic symptoms. This defensive style is often manifested in neurosis or in situations of acute anxiety in adults (VAILLANT, 1973).

Reactive formation is a defense widely used by trauma victims, defined by Fenichel (2005), as reactions in the evident attempt to deny or suppress intolerable aspects, or to defend the person against a pulsating danger. Bergeret (2006) points out

that reactive formation as a functional and useful aspect, contributing to the adaptation of the subject to the reality of the environment. Reactive formations are capable of using impulses whose objectives are opposed to the objectives of the original impulse, that is, their expression is directly opposite to what remains obscure. According to Gabbard (2005, p. 38), reactive formation is described as "turning a desire or impulse into its opposite."

Pseudo-altruism was characteristic of the participants in the sense of committing themselves to the needs of others more than to their own needs. **Idealization** was not widely used, few even mentioned the spouse with a certain idealization, attributing qualities to them as a way to avoid the emergence of the negative feelings they felt. And **undoing** was used to erase the trail of the previous impulse or action, as an apology that immediately annuls the previous destructive action.

On the other hand, when the ego is fragile, a process of regression to previous levels of functioning will occur due to the fixation points of the libido, produced during the stages of its development (KAHN, 2003). If the objects internalized by the individual have primitive, persecutory and feared characteristics, the ego will become impoverished and, as a consequence, stressors aggravate even more The ego is blocked in its development, because it is entangled in old conflicts or fixations, clinging to forms archaic functioning, the greater the possibility of succumbing to these forces (GARLAND, 2015). According to Andrews, Sing and Bond (1993), the **immature defense mechanisms** are: projection, passive aggression, performance, isolation, devaluation, fantasy, denial, displacement, dissociation, splitting, rationalization and somatization. Immature defenses can represent a distortion of reality, preventing the person from seeing him with clarity and discernment (HOLI, SAMMALLAHTI, AALBERG, 1999). They are characterized by controlling anxiety, keeping stressors and unpleasant or unacceptable mental components out of consciousness. Immature defenses may have different perceptions of incorrect perceptions, relating them to external causes and, thus, provide worse adaptation to the subject (VAILLANT, 1934; APA, 1994).

Among the immature defenses, **splitting** prevailed, in which there was no integration between perception of reality and the experience by the victim. The participants perceived their situation, at a given moment as “normal”, not evaluating the recurrent situation of violence as a bad thing. However, it was noticed that when

the complaint was made, the bad aspects of the marital and husband relationship were prioritized. Also, in some women, there were discrepancies in relation to the feeling about the husband and the behavioral performance. The individual will deal with the emotional conflict or internal / external stressors by compartmentalizing opposite affective states, failing to integrate, to gather the positive and negative qualities of themselves or others, simultaneously, in coherent images (BERGERET, 2006).

Isolation was used by most participants in order to isolate an idea of the affective state in order to avoid emotional turbulence, for example: several women could not be away from the partner in an affective way, they appreciated the affection and attention, however, intellectually they knew they would be beaten if they stayed with him. In "Inhibitions, symptoms and anxieties" (1926), Freud describes isolation as a typical mechanism of obsessional neurosis. Isolate a thought from the other, a behavior from the other and separate an idea from its associated affective state to avoid an emotional turmoil.

Somatization was used by a few women. They converted emotional pain into some physical symptom such as rheumatism, eating disorders and somatic concerns. The conversion of emotional pain or other affective states into physical symptoms, focusing on somatic rather than intra-psychological concerns. Somatic complacency is the expression used by Freud in the famous Dora Case (FREUD, 1905/1969), to refer to the choice of the organ or organic system on which hysterical conversion occurs. Freud considered that the libidinal investment of an erogenous zone can move to other body regions, which requires a certain complacency (a kind of collusion) that allows the organs that symbolize the repressed conflict to try to satisfy the forbidden desire in a disguised way.

A**cting out** was perceived by few who reacted to violence as a way to avoid negative feelings, both against the husband with fights and aggressions as a defense; but also against himself, taking medication and attempting suicide.

In **dissociation**, it was found that some women perceived that there were changes in the way they experienced the marital relationship as a way of retaining an illusion of control of the situation in the face of the helplessness they felt. In this way, the recurrent violence they experienced was disconnected from reality as a way of supporting the situation. Within the hierarchy of defense mechanisms, it is classified as decoupling as one of the primitive defenses. Gabbard (2005, p. 38) describes it this way: "Interrupting the personal sense of continuity in the areas of identity, memory,

awareness or perception as a way to preserve an illusion of psychological control in the face of helplessness and loss of control." It can be confused with splitting, but in dissociation it is possible to involve altering the memory of events due to the disconnection of the self in the event.

D**isplacement** was observed in a few moments. It happens when a feeling or impulse is transferred from one part to a whole and vice versa Fenichel (2000). For example, when a woman has a bad experience with a man and says that all men are no good. When we choose a loved one with the original characteristic of our parents (fetishes). Or, when a person who has been abused shifts the fear of the aggressor to a phobia of an initially harmless figure (clown).

Devaluation consists of attributing extremely negative characteristics to oneself and to others, in which the participants acted without valuing themselves and had low self-esteem. **Fantasy** happened when the participant created an image or story that brought satisfaction from an impulse originally frustrated, she retired to a fantasy world, in order to escape internal conflicts. Passive aggression has been observed in the procrastination of actually doing something to protect yourself and in passivity in doing something.

The **projection** was observed in some women who projected unacceptable internal aspects in others, accusing other women of promiscuous involvement with their husbands or accusing their partner of not paying attention to them. It is a way of allowing the expression of unconscious forces, thus, making the conscious mind not recognize them. The ego projects, puts out, what is unacceptable and distressing. The price of this for the psychic apparatus is that when the projection is used intensively, the ego starts to be weakened, because a good part of it and its functions is now in the external. This mechanism is articulated in an important way with the dissociation and denial (BERGERET, 2006).

And the least used defense was **denial**. There was the avoidance of awareness of aspects of reality, in which they claimed that their partner always helped them and never disrespected them. The denial of reality, postponement of commitments, refusal to face unpleasant confrontations, imaginary diseases, create false situations to avoid reality in this defense mechanism (ALMEIDA, 1996).

Main analysis of OPD-2

From the analysis of the multiaxial diagnostic system OPD-2 (TASK FORCE, 2016), it is possible to describe the psychodynamic functioning of the participants: Axis I, "Module for the Evaluation of Domestic Violence OPD" (Table 3 and 4), Axis II, dysfunctional interpersonal pattern (Table 5), Axis III, intrapsychic conflicts (Figure 2), Axis IV, structural functions (Table 6), and Axis V, nosological diagnosis (Table 7).

Table 3. Axis I - Mean and intensity of items assessed in the Domestic Violence Module.

		Intensity			
	Mean (SD)	**1**	**2**	**3**	**4**
Type and severity of violence					
Emotional violence	2,52(0,50)	0	20(47,6%)	22(52,4%)	0
Physic violence	2,36(0,61)	2(4,8%)	24(57,1%)	15(35,7%)	1(2,4%)
Sexual violence	0,23(0,87)	0	0	2(4,8%)	1(2,4%)
Global Severity Index	2,40(0,58)	1(2,4%)	24(57,1%)	16(38,1%)	1(2,4%)
Subjective experience, presentation of the problem and personal concept					
Intensity of subjective suffering	2,50(0,50)	0	21(50%)	11(50%)	0
Presentation of complaints on DV	2,38(0,53)	1(2,4%)	24(57,1%)	17(40,5%)	0
Personal explanation of DV					
Oriented to external causes	2,23(0,57)	3(7,1%)	26(61,9%)	13(31%)	0
Oriented to psychological/interpersonal causes	2,04(0,62)	7(16,7%)	26(61,9%)	9(21,4%)	0
Change concept					
Oriented to external modifications	2,47(0,55)	0	23(54,8%)	18(42,9%)	1(2,4%)
Oriented to personal changes	2,02(0,81)	13(31%)	15(35,7%)	14(33,3%)	0
Personal resources and obstacles to change					
Personal resources	2,00(0,58)	7(16,7%)	28(66,7%)	7(16,7%)	0
Personal obstacles	2,12(0,63)	6(14,3%)	25(59,5%)	11(26,2%)	0
External resources	2,07(0,46)	3(7,1%)	33(78,6%)	6(14,3%)	0
External obstacles	1,98(0,41)	4(9,5%)	35(83,3%)	3(7,1%)	0

Note: The higher the score is the higher the severity.

Table 4. Duration of violence.

Time	**Frequency (%)**
<6 months	17(40,5%)
6-24 months	7(16,7%)
2-5 years	8(19%)
5-10 years	5(11,9%)
>10 years	5(11,9%)

Table 5. Axis II. Dysfunctional interpersonal pattern.

Perspectiva A: Vivência da paciente	
How the victim sees herself: given this attitude, the victims allow the aggressor to act autonomously and isolate themselves from other social activities	**What she does but is unaware:** The victims protect themselves insufficiently, allowing dangerous progression. They feel confused when the other shows affection, clinging on and being dependent on the other

Perspectiva B: Experiência dos outros (incluindo o investigador)	
How the victim sees others: Women repeatedly experience others as controlling, bossy, demanding, and aggressive. The other despise, belittle them, restrict their freedom, and neglect their needs	**How others react to victims' unconscious proposal:** it induces an unconscious response to the other, who defies and imposes himself aggressively

Figure 2. Axis III. Conflict.

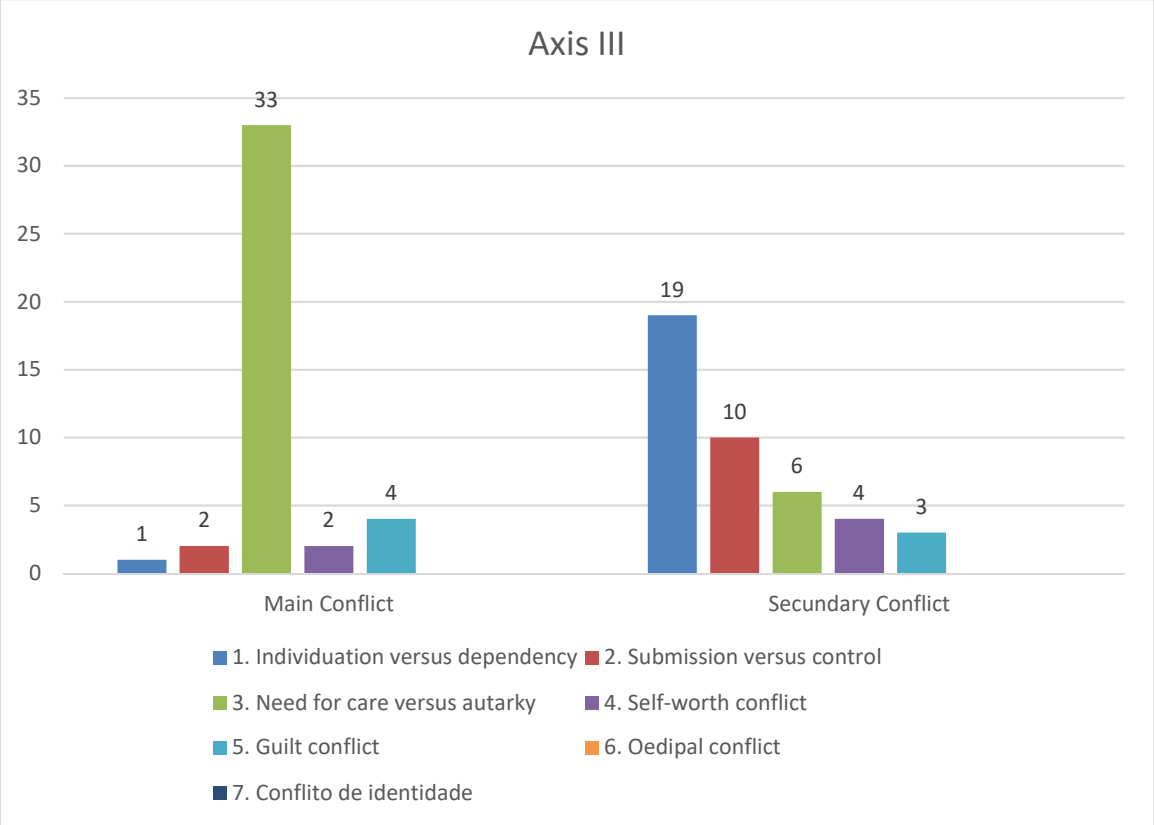


Table 6. Axis IV. Structure.

	Minimum	Maximum	Mean	SD
Cognitive abilities				
1a Self-perception	1,50	2,50	2,03	0,36
1b Object perception	1,50	2,50	2,09	0,32
Regulation				
2a Self regulation	1,50	2,50	2,15	0,26
2b Regulation of object relationship	1,50	2,50	2,20	0,27
Emotional communication				
3a Internal communication	1,50	2,50	2,07	0,24
3b Communication with the external world	1,50	3,00	2,04	0,22
Attachment				
4a Attachment to internal objects	1,50	3,00	2,19	0,31
4b Attachment to external objects	2,00	2,50	2,08	0,19
5 Total structure	1,50	2,50	2,08	0,21

Note. The closer to 1, the greater the structural integration. And closer to 4, greater disintegration.

Table 7. Axis V. Mental and psychosomatic disorder.

Disorder	Frequency(%)
No disorder	11 (26,2%)
Major Depressive Disorder	15 (35,7%)

Post-Traumatic Stress Disorder	9 (21,6%)
Acute Stress Disorder	3 (7,1%)
Major Depressive Disorder + Post Traumatic Stress Disorder	3 (7,1%)
Acute Stress Disorder + Borderline Personality Disorder	1 (2,4%)

Bivariavel analysis

Bivariate analyzes were performed between the DSQ-40 variables and the OPD-2 variables and sociodemographic variables in which there was significance in:

- Correlation between structure level and acting out (r = 0.31; p = 0.049);
- The woman's education level was correlated with: splitting (r = -0.34; p = 0.038), rationalization (r = -0.38; p = 0.015) and acting-out (r = -0.31; p = 0.045);
- The woman's age was correlated with: use of humor (r = -0.36; p = 0.022) and isolation (r = -0.36; p = 0.021);
- Relationship time is associated with the level of: anticipation (r = -0.33; p = 0.032) and reactive formation (r = -0.33; p = 0.032).

In the multiple regression analyzes (Stepwise method) between DSQ-40 variables and OPD-2 variables and sociodemographic variables, it was found that:

- the defenses called reactive formation, pseudo altruism and humor were predictors of the main conflict (Table 8). The relationship between the pseudo altruism variable is an inverse relationship (negative b), that is, the non-use of defense causes conflict to predominate. Thus, the procedure provided an explained variance coefficient (R2) of 0.564, which determines that the independent variables selected explained 56.4% of the predominance of the participants' need for care versus autarky conflict;
- the use of defenses called reactive formation and pseudo altruism and non-use of displacement proved to be predictors of the level of structure (Table 9). The explained variance coefficient (R2) of 0.518 indicates that the selected independent variables explained 51.8% of the participants' structure level;
- Axis II variables “Others perceive themselves as being overly affectionate towards the patient” and “Patient perceives himself as being able to allow plenty of space for others to act autonomously” were not predictors for immature defenses (Table 10). The explained variance coefficient (R2) of

0.436 indicates that the independent variables selected did not explain 43.6% of the use of immature defenses;

- how to perceive others "Others perceive themselves as being overly affectionate with the patient" had shown to be a predictor of the use of neurotic defenses (Table 11). The explained variance coefficient (R2) of 0.148 indicates that the independent variables selected explained 14.8% of the use of neurotic defenses;
- Axis I variables such as the absence of physical or sexual aggression, having a "psychological reason that the victim explained the husband's violence", and Axis II variables such as not perceiving themselves "Patient perceives himself as restricting and interfering in the victim's space" and "Patient perceives himself as neglecting and abandoning the victim" are predictors of the use of mature defenses (Table 12). The explained variance coefficient (R2) of 0.973 indicates that the independent variables selected explained 97.3% of the use of mature defenses.

Tabela 8 – Main conflict predictor variables (Axis 3).

Model	**Unstandardized Coefficients**		**Standardized Coefficients**		
	B	Std. Error	Beta	T	Sig
Reaction formation	,076	,017	,653	4,536	,000
Pseudoaltruism	-,069	,017	-,583	-3,979	,001
Humor	,043	,018	,337	2,350	,028

R=0,751; R^2=0,564; R^2ajusted=0,507.

Tabela 9 – Predictor variables of the structure level (Axis 4).

Model	**Unstandardized Coefficients**		**Standardized Coefficients**		
	B	Std. Error	Beta	T	Sig
Reaction formation	,026	,008	,469	3,080	,005
Displacement	-,032	,008	-,642	-3,895	,001
Pseudoaltruism	,026	,009	,466	2,861	,009

R=0,719; R^2=0,518; R^2ajusted=0,455.

Tabela 10 – Predictor variables of immature defenses.

Model	**Unstandardized Coefficients**		**Standardized Coefficients**		
	B	Std. Error	Beta	T	Sig
Eixo II – Others perceive themselves as being overly affectionate with the patient.	-3,311	,986	-,528	-3,357	,003
Eixo II - Patient perceives himself as capable of allowing plenty of space for others to act autonomously.	-,148	,066	-,352	-2,240	,035

R=0,66; R^2=0,436; R^2ajusted=0,387.

Tabela 11 – Predictor variables of neurotic defenses.

Model	**Unstandardized Coefficients**		**Standardized Coefficients**		
	B	Std. Error	Beta	T	Sig

Eixo II – Others perceive themselves as being overly affectionate with the patient.	,450	,194	,384	2,316	,027

R=0,384; R^2=0,148; R^2ajusted=0,120.

Tabela 12 – Predictor variables of mature defenses.

Model	**Unstandardized Coefficients**		**Standardized Coefficients**		
	B	Std. Error	Beta	T	Sig
Axis I - physical aggression	-1,382	,197	-,320	-7,032	,000
Axis I - Having suffered sexual assault	-,736	,141	-,265	-5,233	,000
Axis I - Psychological reason that the victim explained her husband's violence.	,638	,241	,149	2,643	,017
Axis II - Patient perceives himself as restricting and interfering in the victim's space.	-1,932	,388	-,292	-4,977	,000
Axis II - Patient perceives himself as neglecting and abandoning the victim.	-1,142	,293	-,231	-3,899	,001

R=0,986; R^2=0,973; R^2ajusted=0,962.

DISCUSSION

This cross-sectional study based on forty-two women victims of domestic violence from South of Brazil showed that the age, scholarity, relationship time, dysfunctional interpersonal pattern, intrapsychic conflicts and structural functions are determinant for some aspects to the defensive style of victims of IPV. According to the DSQ-40 the use of mature defenses prevailed.

Defense mechanisms can be adaptive and protective to ego conflicts (BOND, GARDNER, CHRISTIAN, SIGAL, 1983). Mature defenses are considered successful because they achieve better adaptation between the internal and external world. Neurotics allow some components of undesirable mental contents to reach consciousness in a covert and / or distorted way through the compromise formations of psychic conflict. The immature or ineffective defense mechanisms are those that end up constituting a cycle of repetitions, which is characteristic in neuroses and other pathologies (ANDREWS, SINGH, BOND, 1993; BOND, PERRY 2004).

According to the trauma model, splitting is the most common defense mechanism against IPV, whose anxiety and the experience of danger resulting from trauma can lead to emotional dysregulation. Splitting has the potential to alter the individual's self-perception in a way that the victim considers useless or responsible for the violence. And such cognitive distortions, in turn, can lead to negative moods

and dysfunctional behaviors (SIGIEL, FORERO, 2012). In this study, splitting was the seventh most used defense by women, in which it can be related that they could not integrate the image of the evil and coercive husband with the husband who gives him affection; in this way, they distorted reality and managed their behavior so that they could endure such a situation.

According to the literature, the most used defenses in trauma-related disorders are projection, passive aggression, performance, displacement and somatization, in order to keep the emotions produced away (SANTANA, 2015). In patients with Acute Stress Disorder, the use of undoing, projection, passive aggression, acting out, fantasy, displacement and somatization prevailed (SANTANA *et al.,* 2017). In veterans of war with PTSD, the most common defenses used were withdrawal, regression, acting out, projection, inhibition, and passive – aggression (SILVERSTEIN, 1996). However, in this study, such defenses did not prevail. IPV victims used more anticipation, sublimation, humor and pseudo-altruism, perhaps due to the situation of recurrent and lasting violence. This assumption was associated with the relationship time and the use of anticipation ($r = -0.33$; $p = 0.032$). As well, the use of mature defenses is also related to the absence of physical or sexual aggression or to having a "psychological reason that the victim explained her husband's violence", they have already attributed the use of alcohol as a way to explain the violence. Thus, it is suggested that victims of IPV adapt to their reality, using different defense mechanisms, perhaps characteristic of PTSD. Considering that defense mechanisms are adaptive, the prevalence of the use of mature defense mechanisms does not necessarily mean that they are healthy.

Our data are close to the trauma data in North Korean Refugees, which suggest that mature defenses reduce anxiety when victims are exposed to traumatic stressful events (JUN *et al*., 2015). And specifically, in the context of domestic violence, the use of anticipation - mature defense - is correlated with the result of the study by Petit, Knee, Hadden and Rodriguez (2017), in which the satisfaction of women's needs acted as a protective factor against the perpetration of the IPV. Still, one can relate the predominance of the main conflict "need for care versus autarky" - Axis III - in this description, whose care for the husband prevails over his needs in order to avoid violence. In this sense, the non-use of pseudo altruism and the use of humor and reactive training preside over 56.4% of this intrapsychic conflict. The non-use of pseudo altruism can be related to the moment of the complaint against the husband in the police (data collection moment), because in this situation they are aware of their

dysfunctional behavior, relatively. It also meets the use of reactive training, since they suppressed intolerable aspects, perhaps using humor to survive in this traumatic context. Finally, the use of reactive training is related to the level of psychic structure (cognitive functions, emotional regulation, emotional communication and attachment). No data were found in the literature to complement this issue.

According to Slootmaeckers and Migerode, 2019, conjugal violence has maladaptive relationship patterns with negative interaction cycles. Johnson (2004) points out the existence of negative patterns of self-confirmation of interaction, in which there is coercive control over the victim. In this sense, violence arises when one of the partner's self-defense mechanisms fails to provide the necessary protection strategies to deny and avoid emotions. Consequently, the victim uses the resources he has to protect himself from external threats.

Regarding this pattern of interpersonal relationships, our study demonstrates that the victim's perception as “Others perceive themselves as being overly affectionate towards the patient” and “Patient perceives himself as being able to allow a lot of space for others to act autonomously” explain 43.5% did not use immature defenses. The variable “Others perceive themselves as being overly affectionate towards the patient” explains in 14.8% the use of neurotic defenses. And the not perceiving oneself “Patient perceives himself as restricting and interfering in the victim's space” and “Patient perceives himself as neglecting and abandoning the victim”, the absence of physical or sexual aggression and having a “psychological reason that the victim explained her husband's violence” explain 97.3% of the use of mature defenses. In other words, the predominance of the use of mature defenses is related to the victim's perception of just caring, not in a controlled and coercive way, the husband and perceiving himself loved and valued, as in cases where jealousy represents a form of affection at high levels. It is noteworthy that there is an important cognitive distortion as mentioned in the studies by Andrews, Singh and Bond (1993), Bond (2004), Sigiel, Forero (2012) and Holi, Sammallahti and Aalberg (1999).

Concomitant to this, we can relate the use of mature defenses to what Winnicott pointed out as a false-self. It can be said that there is an "illusory integration that falls apart as soon as it is accepted as real and called to contribute" (Winnicott, 1965 / 2001, p. 223), but that, in some cases, can guarantee the person, sometimes for a long time or even a lifetime, "an apparent health" (Winnicott, 1955 / 2000, p. 385). Saying this in terms of integration and in language of the ego, we see that this apparent health is

worthless for maintaining integration and strengthening of the ego, predominantly in terms of personality a state of distortion of the ego. The person lives propped up in a false personality.

There is an association between the severity of psychological results and the characteristics of victimization (severity, duration, frequency, severity; BRIERE, JORDAN, 2004). Likewise, the higher frequency of traumatic incidents results in more experiences of PTSD, depression and substance abuse (OZUKA *et al*., 2011). Victims of physical violence in the marital relationship develop pathologies such as depression and anxiety, including the risk of suicide (DELARA, 2016). About depressive symptoms, the literature have reported a relationship between depression and immature defense styles, such as projection or splitting (BOND, PERRY, 2004, AKKERMAN, LEWIN, CARR, 1999). Depressive symptoms in PTSD victims are also characterized by an elusive coping style, guilt, is particularly associated with symptoms of depression (RADOŠ, SAWYER, AYERS, BURN, 2018). Individuals with PTSD-C are characterized by the existence of depression (APA, 2013). Our study indicates that 42.8% of the participants had a diagnosis of Major Depressive Disorder, perhaps due to the constant violence suffered, level of psychic structure in the range of 2 points according to OPD-2, which represent poorer attachment figures, level of communication precarious, undefined self-perception and impaired emotional regulation.

Implications for clinical practice and public healthy

According to the literature, clinical interventions to reduce IPV have been shown to be limited and ineffective (PETIT, KNEE, HADDEN, RODRIGUEZ, 2017). Speculatively, our findings may have clinical significance for victims of IPV. Identifying and managing the predominant defense mechanism would be constructive in the course of psychotherapy. For depressive IPV, it would be useful to focus on helplessness and hopelessness, in which they care for their husbands in order to receive some comfort. And for IPV who complain of PTSD symptoms, working with restricted affects due to undoing and isolation would be crucial in the psychotherapeutic procedure. Helping victims to adequately express their feelings about their traumatic experiences, developing higher levels of mentality, can help in the elaboration of situations of violence.

In the perspective of Bergeret (2006), the ideal is to have distinct and flexible defenses for the drive game to occur: do not oppress the id, take into account the reality of the ego and without disturbing the superego. Defense mechanisms are also a form of adequacy. On the other hand, what makes defenses a harmful aspect is their ineffective use or their non-adaptation to reality. Therefore, an individual will become ill because the defenses that he habitually uses prove to be ineffective, rigid or poorly adapted to internal and external realities. The unique pattern of mental functioning and for a long time prevents the person from seeking more effective ways to face different situations. Thus, expanding the forms of reaction of women suffering from IPV, not only adapting dysfunctionally and becoming submissive to the husband, but respecting their own desires and needs.

Confering to Santana and collaborators (2017), the early detection of symptoms is extremely important in order to avoid other injuries related to trauma and, thus, enabling early treatment. Such prevention represents an important evolution in terms of public health in assisting victims. of trauma.

Strenghts and limitations

Due to the cross-sectional assessment of the present study, it was not possible to reveal what the defenses are before the trauma and which defenses are after the trauma, not least because it is a recurrent violence in the marital relationship. Likewise, the outcome of the situation of violence was not followed up after the complaint at the time of collection.

The fact that the patients are in a moment of emotional shock due to the complaint of the husband, may have influenced the way they filled out the instruments, altering measures of psychological disorders and defensive styles. However, it must be considered that all patients were victims of IPV, so the sample is biased by this common denominator. Just as, in the face of a trauma, each person has a different way of reacting, according to their past history and psychological functioning, so they do not necessarily use pathological defenses.

CONCLUSION

IPV is deeply rooted in evolutionary and cultural issues, which explains its universal and persistent nature. It is a paradoxical combination of aggression and affection. Many theories have been constructed in an effort to explain the complex

trauma and IPV, including the defensive style used. Defense mechanism may contribute to psychiatric symptoms.

Our results indicate that victims of IPV have characteristics of PTSD. Thus, the understanding of the patient's psychodynamic functioning in the sense of which interpersonal relationship pattern, level of structure and intrapsychic conflict are determining aspects for the defensive style to be used by the victim. Regarding the defense mechanisms, it is reinforced that they are adaptive, so the prevalence of the use of mature defense mechanisms does not necessarily mean that they are healthy.

Thus, understanding the way victims of IPV work is essential for therapeutic planning and the implementation of prophylactic measures at the social and community level, since intimate partner violence is based on recognized risk factors. Recurrent trauma changes the subject's psychological functioning and certainly worsens the quality of life of those involved.

In general, it can be related that violence has strong implications for the development of the country, since it involves losses of productivity of the victims, possible costs with treatment in the health system and less participation of women in the labor market. Children living in homes where domestic violence prevails are more likely to develop behavioral problems in early childhood and, from adolescence, to engage in criminal activities.

Acknowledgment

This study was financed in part by the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior - Brasil (CAPES) - Finance Code 001.

This study was supported by the Legal Medical Department of *Rio Grande do Sul*, especially by Dr. Anlelita Rios, who invited and made collection possible at the institution. Also, teacher Carla Crempien by *Pontificia Universidad Católica de Chile*, who cooperated with support for OPD-2 and teacher Sílvia Benetti who enriched the study.

Ethical observations

1. Conflicts of interest. There are no conflicts of interest.

2. Ethical Approval. The work was approved by an institutional ethics committee and authorized to collect data at the corresponding institution.

3. Consent. The victims participants were invited voluntarily and authorized their participation in the research by signing the Term of Free and Informed Consent.

4. Omission: All data that could identify participants was omitted.

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13 ARTIGO 7. THERAPEUTIC PLANNING OF A CASE OF VICTIM OF INTIMATE PARTNER VIOLENCE

Abstract

Introduction: Victims of intimate partner violence are more likely to develop some type of mental illness; however, due to guilt and shame, they have difficulty in adhering to the treatment. Thus, specific therapeutic planning is necessary.

Objective: a) to evaluate the therapeutic result in psychodynamic psychotherapy in a woman victim of violence by an intimate partner, based on the therapeutic planning of Psychodynamic Diagnosis Operationalized (OPD-2); b) to identify therapeutic changes in the patient's symptoms, including aspects of the patient's dynamics and the possible break in the cycle of violence.

Method: Initial and final care were analyzed after four months of treatment - result analysis, by two independent judges. The Kappa coefficient was substantial.

Results: In Axis I there was a decrease in subjective suffering and an understanding that changing the situation does not depend so much on external factors. In Axis II, it seeks not to depend on others, to be self-confident, they are exposed to risk, but there is greater criticism about their actions. In Axis III, conflicts were less intense, with the need for care versus self-sufficiency prevailing. In Axis IV, with a medium level of structure, it showed improved capacity for self-perception and perception of the object. In Axis V, depressive symptoms were identified.

Conclusion: Based on the OPD-2 evaluation criteria, it was possible to verify a symptomatic improvement in general in the participant, and verifying the OPD-2 is a useful therapeutic planning tool.

Keywords: intimate partner violence, violence, psychotherapy, psychodynamics.

Introduction

Violence against women is an extremely complex phenomenon that has roots in the power relations between gender - men and women - and presents itself as a set of deliberate, authoritarian and progressive behaviors based on threats and aggressions (LEÔNCIO et al., 2008). And yet, it has stood out among researchers on the international stage as one of the main problems of society. It is a phenomenon that seriously impacts the quality of life and health of victims and those close to them (LOURENÇO; BAPTISTA, 2013).

According to Bins, Telles and Panichi (2015), violence against women is a multi-causal phenomenon: a) community factors: poverty, unemployment, family isolation; b) factors of society: naturalization of violence to resolve conflicts, male domination, stereotyped gender roles; c) factors of the aggressor: use of substance, transgenerationality of violence.

A systematic review of the literature highlighted that victims of intimate partner violence are more likely to develop some type of mental illness when compared to individuals who do not experience such situations of violence (TREVILLION, ORAM, FEDER, HOWARD, 2012). Thus, care for women's mental health needs to gain adequate space, one of which may be psychotherapy (BERMANN, GRAFF, 2015; ORTIZ *et al.,* 2011). However, adherence to psychotherapy is a difficulty, as the woman who comes to psychological care, feels guilt and shame. The unprepared professional performance and not focused on the establishment of an adequate therapeutic bond, puts the woman's adherence to psychological treatment at risk (MOZZAMBANI, 2011). Thus, to facilitate adherence to treatment, it is necessary, in addition to welcoming and listening to therapy, to understand the context of violence and plan treatment according to the participant's need.

A proposal for such planning is the use of the Operationalized Dimensional Diagnosis (OPD-2, TASK FORCE, 2016). OPD-2 can be used in different clinical contexts and psychological disorders (PAULO, PIRES, 2013). Through the dimensional understanding of OPD-2, it is possible to identify resources and obstacles to be worked on in psychotherapy, whose therapeutic relationship can be an opportunity for a relational configuration that offers the development of internal representations of a secure bond. Thus, treatment is also a way of preventing revictimization and building more adaptive coping mechanisms (CREMPIEN, 2012).

The data resulting from the OPD-2 Clinical Interview comprise a diagnostic and investigative system relevant to the clinical-psychotherapeutic scope (CIERPKA *et al.,* 2010), which assists in the planning of interventions and is also used for training future psychotherapists (VICENTE *et al.,* 2012). Thus, the indication, focus and therapeutic planning are given by the integration of the respective axes: Axis I comprises the therapeutic indication and motivation, then the diagnosis is made (Axis II - Relational, in which conflicts are expressed or vulnerabilities of interpersonal representations -, Axis III - Conflict - and Axis IV - Vulnerabilities and structural capabilities). In view of this dimensional diagnosis, the focus is selected: conflict,

structure or both; but always choosing the structural focus (Axis IV) first if there is disintegration, as it is a prerequisite for the development of the conflict (Axis III) and consequently the dysfunctional relational pattern (Axis II). Thus, when therapy is oriented towards conflict, more expressive intervention strategies are used, while structure-oriented therapy has more supportive strategies (PARRA *et al.,* In press).

In this sense, it is pertinent to question whether the OPD-2 instrument can assess or constitute itself as a useful tool in the diagnosis and therapeutic planning for women victims of domestic violence, since such patients may have a more fragile structure or be in stressful situations. Thus, based on the interest of deepening on therapeutic planning based on OPD-2, this study aims: a) to evaluate the therapeutic result in psychodynamic psychotherapy in a woman victim of violence by an intimate partner, based on the therapeutic planning of Psychodynamic Diagnosis Operationalized (OPD-2); b) to identify therapeutic changes in the patient's symptoms, including aspects of the patient's dynamics and the possible break in the cycle of violence.

Method

This is a case study that evaluates interrelated processes in a time perspective (SERRALTA, NUNES, EIZIRICK, 2011) with victim of violence by an intimate partner. Initial and final care were selected for analysis (result analysis). In total, there were 11 sessions, during 4 months.

Participant

The participant is a middle-aged woman, retired police officer, white with blond hair and light eyes. Married for 27 years to a professional in the prison system. She has a daughter in her early adulthood.

Instruments

A sociodemographic data sheet was used to characterize the participant. The study was developed from the Operationalized Psychodynamic Diagnosis (OPD-2). The Operationalized Psychodynamic Diagnosis (*Operationalisierte Psychodynamische Diagnostik,* OPD) is an instrument created in Germany, with the aim of expanding the classification of psychiatric disorders of the ICD-10 in the description of symptoms introducing psychodynamic dimensions. The OPD-2 was used to operationalize psychodynamic constructs, to formulate a multiaxial psychodynamic diagnosis, and for therapeutic planning and focus (TASK FORCE,

2016). In this study, the Brazilian version of the instrument was used (VICENTE et al., 2012). Table 1 presents a detailed description of the Axes, assessed dimensions and indicators. And the adaptation of Axis I, "Module for the Evaluation of Domestic Violence OPD" proposed by the Chilean researcher Carla Crempien in 2009 in her Ph.D. thesis (CREMPIEN, 2009, 2012) and adapted to Brazil (BOTH *et al.,* 2019a), shown in Table 2.

Table 1. Description of the OPD-2 axes.

Axis	Dimension	Indicador
Axis I - Experience of the disease and prerequisites for treatment	Objective assessment of the disease / problem	1. Current severity of the disease / problem 2. Duration of illness / problem
	Patient experience, form of presentation and conceptualization of the disease	3. Experience and form of presentation of the disease 4. Conceptualization of the disease by the patient 5. Conceptualization of change by the patient
	Resources and resistance to change	6. Resources for change (last 6 months) 7. Resistance to change
Axis II - Interpersonal Relations	Perspective A: Experience by the patient	The patient perceives himself as ... The patient perceives others as ...
	Perspective B: The perception of others (including that of the researcher)	Others perceive the patient as ... Others perceive themselves as ...
Axis III - Conflict	Repetitive dysfunctional conflicts	1. Individuation versus Dependence 2. Submission versus Control 3. Need to be cared for versus self-sufficiency 4. Self-esteem conflict 5. Conflict of guilt 6. Oedipal conflict 7. Conflict of identity
	How the main conflict is handled	Predominantly active Most active mixed Most passive mixed Predominantly passive Not classifiable
Axis IV - Structure	Cognitive abilities	1st Self perception 1b Perception of the object
	Regulation	2a Self regulation 2b Regulation of the object relation
	Emotional communication	3rd Internal Communication 3b Communication with the outside world

	Vinculation	4a Ability to vinculation: internal objects 4b Ability to vinculation: external objects
Axis V - Mental and psychosomatic disorders	Mental disorders Personality Disorders	Main / additional diagnosis Main / additional diagnosis

Note. Vicente et al (2012).

Table 2. Items assessed in the Domestic Violence Module.

Axis	Dimentions	Indicador
Axis I - Module for the Evaluation of Domestic Violence OPD	Type and severity of violence	Emocional Violence Physical Violence Sexual Violence Global Severity Index
	Duration of domestic violence problem	Durationof domestic violence Age at first episode
	Subjective experience, presentation of the problem	Intensity of subjective suffering Presentation of complaints on domestic violence
	Personal explanation of domestic violence	Oriented to external causes Oriented to psychological/interpersonal causes
	Change concept	Oriented to external modifications Oriented to personal changes
	Personal and external resources and obstacles to change	Personal resources Personal obstacles External resources External obstacles

Data collection and analysis procedures

The participant was invited to participate in the research on a voluntary basis. The treatment was carried out with individual weekly sessions lasting 50 minutes. They were audio recorded for later analysis. The sessions were held at the police station in a service room used by psychologists. The consultations took place over a period of four months. The analysis of OPD-2 variables focused on the comparison between initial and final care.

Data analysis was carried out by two independent judges, with a training course in Operationalized Psychodynamic Diagnosis (OPD-2). One of the evaluators was the participant's psychotherapist. The interviews were coded and the Kappa coefficient of each axis was calculated, in each interview, independently. Axis II was specifically analyzed in a different way, a descriptive analysis of the items was performed, since this axis has 32 items and it is necessary to choose only three items that describe the patient. Such a procedure was also presented in the validation study, in which the Axis had not even been evaluated, as performed in a similar study (BOTH *et al.,* 2020).

Agreement between judges

The evaluating judges were two psychologists who took the training course at OPD-2 at the Pontificia Universidad Católica de Chile. Each of the evaluating judges codified the various psychodynamic aspects from the dimensions and indicators of each axis separately. Then, the kappa coefficient was calculated to assess the reliability between the judges. The average of the Kappa coefficients achieved in each axis was substantial, above 0.60, as shown in Table 3.

Table 3. Kappa coefficients.

Axis	K
Axis I	0,76
Axis III	0,68
Axis IV	0,61
Axis V	1

Ethical procedures

This study was approved by the Federal University at Rio Grande do Sul ethics committee (CAAE 68271917.7.0000.5347, No. 2,412,749) and permission for collection of data was obtained from the Legal Medical Department of Porto Alegre. The participant was invited and authorized her participation in the research by signing the Informed Consent Form and all data that could identify the participant was omitted.

Results

Case description

The participant comes from a family and comes from the countryside, but even as a child her parents tried to have a better life near the state capital. With the separation of her parents at the age of 12, she assumed a lot of responsibility at home. She started her work activities at the age of 13. Her mother soon became involved with another man with whom the participant did not have a good relationship. Her father was the one who raised her, but he always attacked her verbally, he was an ignorant person, according to the participant. She doesn't keep in touch with him today. Her sister, two years younger, did not have the same responsibility requirements, so much so that today she has five children from different parents, despite the participant's advice. Today, she helps the family financially, is an aunt present to her nephews and a concerned daughter for her mother. She understands that the mother has her difficulties.

The participant has a 27-year marriage. They met in high school. At the time he was very affectionate, but over time he gradually proved to be a different person. When the husband feels safe, he does not value her, he challenges her autonomy, he is jealous and controlling. In police work he treated victims of domestic violence and identified with the reports. She was ashamed to be in the same situation. During work, she needed to assume a self-confident and secure posture.

She has already tried to separate twice, when she actually left the house. She blames herself for not breaking up the first time there was a physical assault. Previously, in the first assaults she remained in the marriage due to financial dependence, but today she is retired by the police and manages to support herself financially. She says she gave up her life because of her daughter.

Her husband's family history is complicated, as the grandmother and the older brother are diagnosed with schizophrenia and the mother is demented. The mother has 5 children and he is the youngest, he was born without planning and he was always despised, but he is the only son who was always present and worried about the mother. His father was 20 years older than his mother and was killed during a robbery at the family bar where he worked. Today, her husband works in the prison system and has a gun. At work he is seen as a very playful, partner.

The daughter is in her early adulthood, is attending college and is very dedicated to studies. She has a boyfriend the same age. She tries to reconcile her personal life with her parents' life, playing an intermediate role between the couple, with fights since she was 5 years old. She has nightmares about her father stabbing her mother. Such stress made her develop panic disorder, requiring psychiatric follow-up to be able to maintain her responsibilities. Her father never credited his daughter's symptoms.

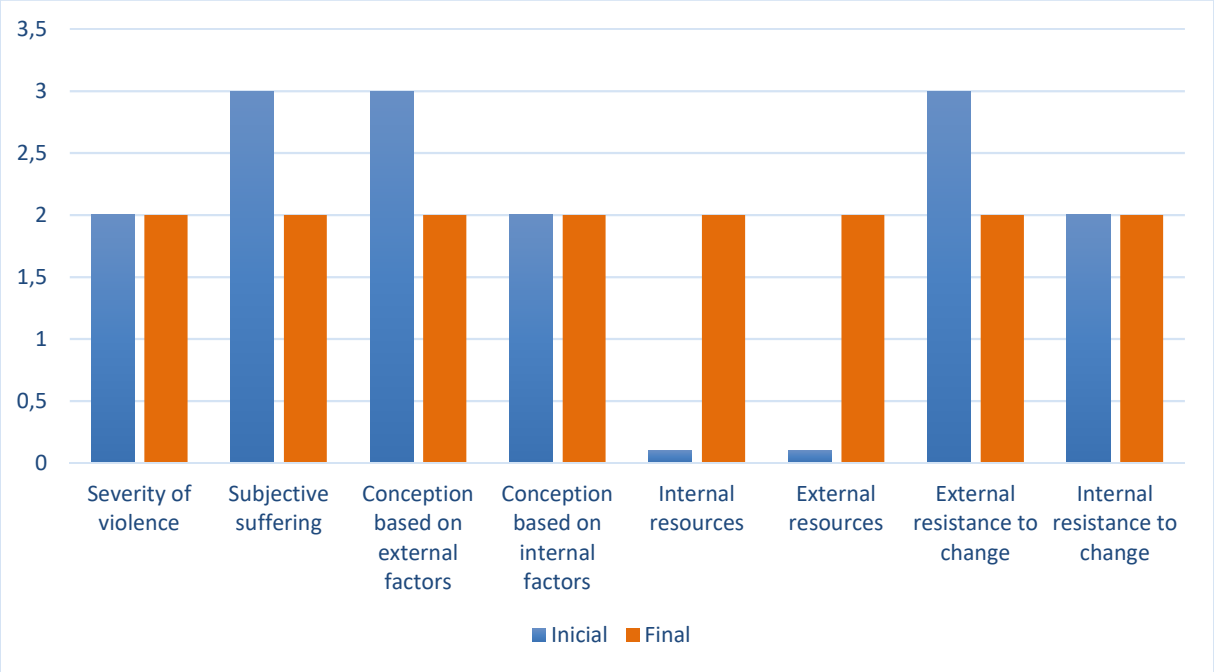
Today, the participant intends to separate from her husband, but due to the change in her husband's behavior, she remains at home, but totally ignores him. She continues to do household chores, including “taking care” of the clothes and food of everyone in the house. She is looking for an apartment to effect the separation and has contacted the lawyer. She thinks that her daughter, already an adult, is no longer an obstacle. She started to study higher education. During the appointments, she was resistant at different times to reflect on all these issues of marriage, as they are issues that cause discomfort and suffering. Thus, she postponed 4 sessions.

Axis Characterization

The case will be presented according to the five axes of OPD-2, in which the items will be described comparatively between the results of the initial and final treatment of psychotherapy. Therapeutic planning focused on developing the ability to self-perception perceive the object (itens on Axis IV), mainly on the situation of the daughter, as the daughter who suffered the greatest consequence of the parents' violent relationship, eventually developing a psychiatric disorder. Likewise, it focused on the main conflict, in which the victim places himself as a caregiver for family members, for victims he attended in the work environment, as a way of taking care of himself.

In Axis I - Module for the Evaluation of Domestic Violence OPD - the participant initially presented moderate symptoms and moderate subjective suffering, being moved at different times when remembering situations that suffered violence from her husband. She had no physical, psychological or social problems, she did not express herself, she is very ashamed of experiencing violence. She always tried to be strong, without a space for listening and welcoming so that she could be cared for, on the contrary, she always repressed suffering. She attributes the resolution of her problem to external factors, hoping that the husband will perceive the problematic environment in which they lived and accept the separation. In the final session, there was a decrease in the severity of symptoms with greater experience of the participant, the level of suffering being equivalent to the level of severity. There is a slight anxiety about the future; but she demonstrated greater organization, with concrete plans to continue her studies. Still, there is an attempt to hide the past and the social stigma of her involvement with intimate partner violence. External resistance to change remains, but it has moved to look for a place to live and the legal search for separation (Graph 1).

Graph 1. Main items of Axis I.



Note. Higher score corresponds to greater intensity of the variable.

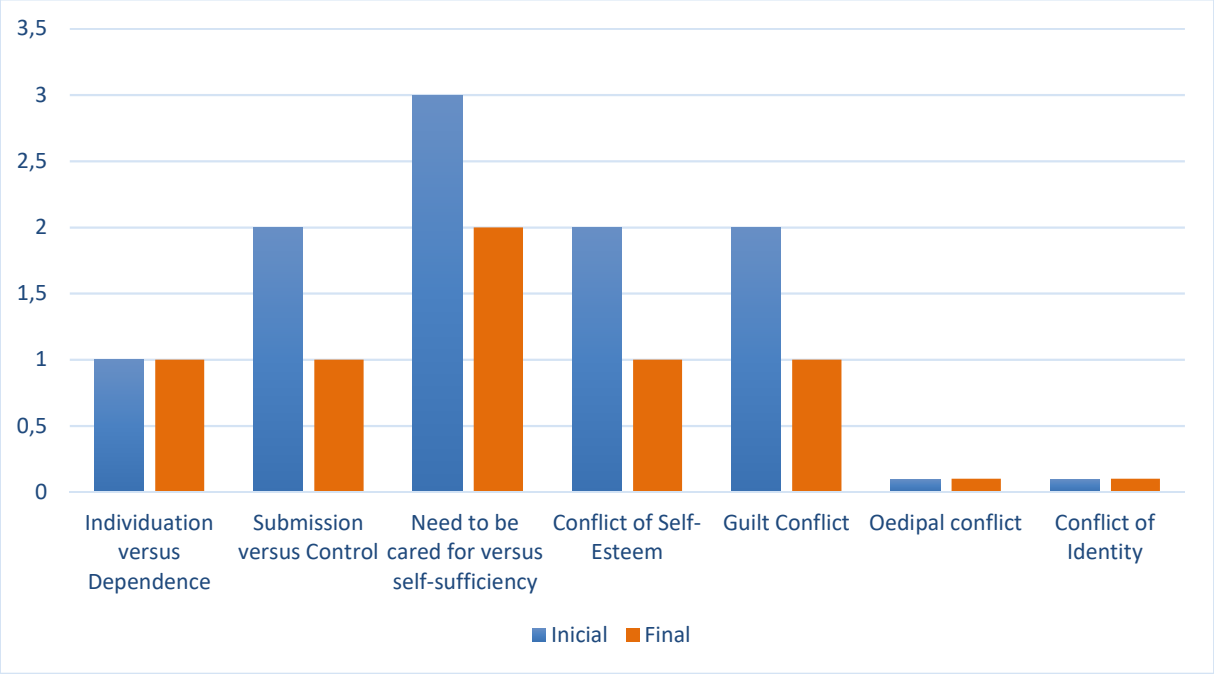
On the relational axis - Axis II - the participant, in the initial service, perceived the others as dominators and controllers, allowing a lot of space to act autonomously. The participant avoids the situation, until she explodes impulsively, exposing herself to risky situations or else, ignoring the others and withdrawing; thus, she placed the daughter as an intermediary in the couple's situation. To compensate for this lack of care, she was overly concerned with the well-being of her daughter and other family members. In the final session, the participant presented a different relational dynamic: for her, she apparently adapted to her husband's demands but started to work autonomously, since she started an undergraduate course, looked for an apartment to live in and a lawyer to legalize the separation. Thus, the participant tried not to depend on others, to be self-confident, often still exposing herself to risk, remaining in the house with her husband who had a firearm. However, there is greater criticism about her actions. With that, she got closer to her daughter, encouraging her daughter to have a more active life externally with friends, boyfriend. As well, she got closer to the family, trying to understand the difficulties of each one. She was still afraid of her husband and ashamed of the situation, which paralyzed her a little, inhibiting the feeling that came from it.

In Axis III, the predominant intrapsychic conflict was initially the need to be cared for versus self-sufficiency in active mode, whose participant sought to be self-sufficient, distancing himself early from the family of origin. However, her low

criticism made her emotionally involved with an aggressive and possessive man, similar to her father's characteristics. She cared and took care of her daughter as an unconscious way of obtaining care, abdicating her life in favor of her daughter's life. She had underlying depressive feelings that are repressed defensively, not facing the pain of helplessness. As a secondary conflict, she presented the passive guilt conflict, which indicates that the participant blamed herself for not deciding to separate in the initial moments of the violence or for having managed to support herself financially so as not to expose her daughter to these situations. The other conflicts were not scored significantly, although they exist: the conflict between submission versus control, where the participant sought to behave in a submissive manner; the conflict of self-esteem, whose participant did not value their skills and their value; and the Oedipal conflict, in which female characteristics were drowned out by violence. There is no impending identity conflict.

In the final care, the participant remained with these conflicts, but they acted with less intensity. There was still a prevalence of the need to be cared for versus self-sufficiency in an active manner, but with more concrete plans for achieving autonomy, with a focus on self-care by investing in studies and in an independent life (Graph 2).

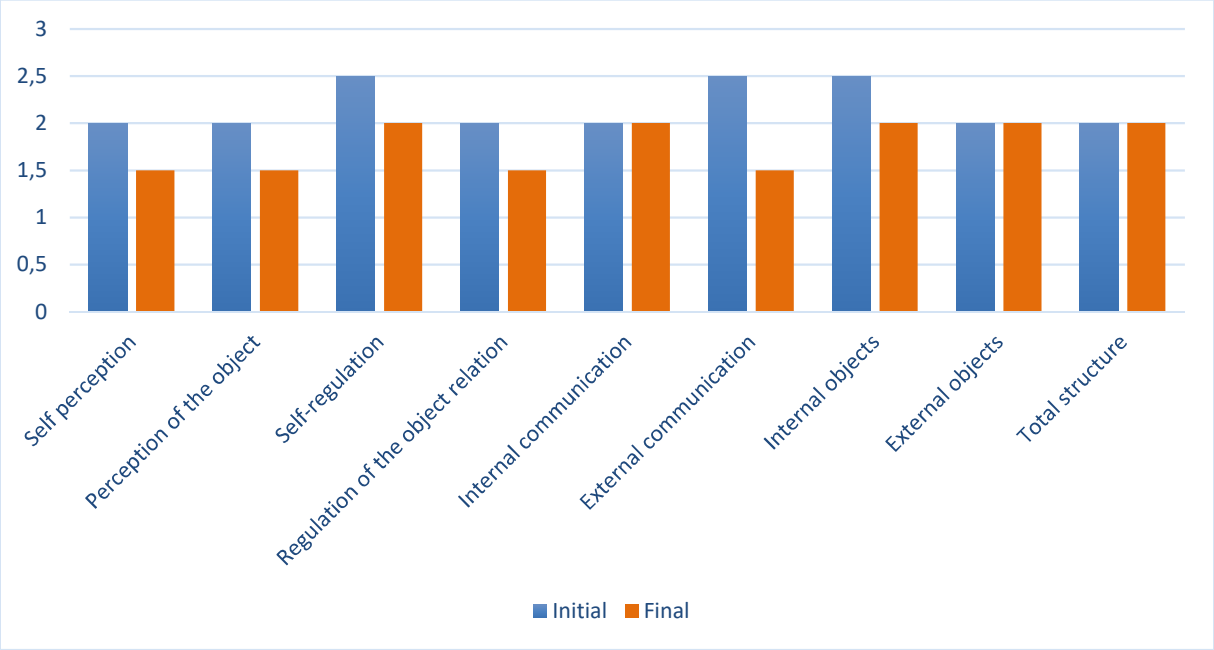
Graph 2. Axis III items.



Note. Higher score corresponds to greater intrapsychic conflict.

Regarding the psychological structure - Axis IV - the participant, despite remaining at a medium level, showed improvements with regard to self-perception, with the development of mentalization, perceiving her mental and emotional states more coherently, as well as the others - self-perception and perception of the object. Regarding the regulation of the object relationship, the participant was able to weigh her interests with the others, as well as the reactions of others began to be anticipated. The internal objects were still unsteadily consolidated, but she was able to calm herself down (Graph 3).

Graph 3. Axis IV items.



Note. Higher score corresponds to greater disintegration of the structure.

Finally, Axis V, the participant had depressive symptoms, but without closing the diagnostic criteria for psychiatric disorder.

Limitations

The participant showed symptomatic improvement in general, as observed in the results; however, it should be noted that although there was such an evolution, other aspects still need to be addressed. Just as there is no intention to generalize the results as characteristics of women victims of intimate partner violence.

The use of OPD-2 as a tool for therapeutic planning stands out, but due to time limitation, it was not possible to observe the outcome of the situation of violence. This

case in study was a pilot to the therapist, but it was sought, from the periodic supervision, the adequacy of posture and interventions in relation to the determined patient. Likewise, one of the evaluating judges was the therapist, whose measurement was controlled by the second judge, with substantial agreement.

Discussion

The results of OPD-2 integrate clinical information that helps in the indication and planning of therapy, providing a clearer understanding of the psychodynamic functioning of the patient that can facilitate the understanding of the clinical context of victims of violence. Thus, the study carried out with a victim of violence by an intimate partner showed the applicability of the participant's therapeutic planning. The evaluation of its psychodynamic characteristics, based on the diagnostic criteria of OPD-2, was carried out in two different moments: at the beginning of psychotherapeutic treatment and after four months, the final period of care. The *Kappa* coefficient found in each axis was substantial, above 0.60. This data shows that there was reliability in the data measured by the judges.

Psychotherapy research is a fertile field for investigation, since it improves clinical work (PEUKER *et al.,* 2009). It is evident that the participant improved in several aspects. When assessing Axis I, it was possible to verify the decrease in the severity of symptoms, with greater awareness of suffering. Cognitive and reflective skills are factors that are considered to have a positive impact on the maintenance of treatment and therapeutic efficacy, helping to change behavior (TASK FORCE, 2016). However, the participant demonstrated resistance to treatment adherence.

It is believed that exposure to violence can impair autonomy and cause feelings of incompetence, insecurity, loss of self-worth and social isolation (BRASIL, 2011; RIBEIRO, ANDREOLI, FERRI, PRINCE, MARI, 2009). In addition, the constant violence causes changes in structural functioning and intrapsychic conflict (TASK FORCE, 2016).

In relation to the conflict and the structure respectively, according to Boeker *et al.* (2008), in correlation studies between axes III and IV, they point out that the conflict “need to be cared for x self-sufficiency” was associated with moderate or good levels of structural integration; which is considered a positive factor for the subject's organization and ability to change. Thus, a greater perception of himself and others was evidenced, with an increase in coherence in relation to his mental and emotional

states as well as that of the others. Likewise, its structuring also refers to interpersonal functioning that is based on the notion of empathy and intimacy, where the ability to recognize the expectations of others and to establish closer relationships is developed (SCHMECK, SCHLÜTER-MÜLLER, FOELSCH, DOERING, 2013), which was also observed in the participant.

The participant had depressive symptoms. Studies indicate that patients with major depressive disorder have significantly higher indicators both in the level of dependence and in self-criticism in relation to a control group (LUYTEN *et al.,* 2007, KANNAN, LEVITT, 2013). Thus, focusing on the development of self-perception and perception of the goal are indicators for improving such conflict. In the study by Crempien *et al.* (2017), it was observed that the structural level of personality functions described in OPD-Questionnaire (mental capacity for emotional regulation, cognitive abilities, internalized objects and internal and external communication) correlated with high depressive severity and low quality of life.

Another factor that reinforces the participant's fear is the existence of her husband's gun, with a coercion to try to break the cycle of violence. According to the literature, the use of firearms by intimate partners causes victims to be shot with the outcome of hospital admissions or death (DUNCAN *et al.,* 2020). Statistical data indicate that when the aggressor has a firearm, victims of IPV are five times more likely to be killed (JOSEPH *et al.* 2015). In this sense, the participant did not report to almost anyone what was happening, including in the work environment, she avoided exposing aspects of her personal life, both out of fear and shame.

The participant reported that at the beginning of the relationship, the husband's behavior was different, but that it gradually changed and the violence worsened, as observed in the study by BOTH and collaborators (2019b). It is believed that her abandonment of treatment is related to her availability to remember situations of violence and relive the suffering that she has so repressed.

A study that used OPD in psychodynamic treatment of psychodynamic orientation with depressed patients and it was possible to observe that patients normalize their brain activity, characterized by hyperactivation of the limbic system, after 8 months of treatment, without the use of medication (WISWEDE *et al.,* 2014). Thus, it is believed that the treatment offered to the patient helped to improve the patient's diagnosis, as shown in the results.

Likewise, the violence perpetrated by parents leads to the exposure of children and adolescents to trauma, a factor that hinders emotional regulation, with problems for the expression of negative emotions in response to stress (YAHYA, KHAWAJA, CHUWUMA, [s.d]). It is also evident that these are more likely to become victims of bullying or cyberbullying (CLARKE *et al.,* 2020). In addition to such individual effects, victims of violence tend to reproduce it in their future relationships. In this sense, the participant reported a lot of concern about the consequences already evident in her daughter's life. It is evident that the daughter who was stifled for a long time, resurfaced in her perception with the development of the capacity for self-perception and perception of the object.

Conclusion

Therapeutic planning is essential for therapeutic effectiveness and compliance. A dimensional diagnosis in addition to the descriptive is a clinical need that facilitates the understanding of the subject and clinical planning, offering an estimate of the internal dynamics and the meaning of the symptoms presented. Therefore, the OPD-2 is an instrument that integrates psychodynamic constructs in an operationalized way in multiaxial assessment forms. The operationalization provides knowledge and practice about the patient's psychodynamics, with more clarity in the subject's therapeutic planning, as well as facilitating communication between the scientific community.

The complexity of situations of violence requires that the professional who will assist the victim be trained to meet the demands of welcoming and guidance, as well as being able to assess in a practical way the resources and obstacles of the victim, understand the dynamics of functioning and thus plan an appropriate treatment for it. It can be said that OPD-2 made it possible to raise substantially, data on symptoms, structure, conflict and interpersonal relationships, relevant to therapeutic planning.

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14 DISCUSSÃO

14.1 INTEGRAÇÃO DOS ESTUDOS

A presente tese procurou investigar as características do funcionamento psicodinâmico de mulheres vítimas de violência por parceiro íntimo, sob uma perspectiva dimensional operacionalizada. Para isso, foi utilizado o OPD-2, instrumento chamado Diagnóstico Psicodinâmico Operacionalizado (*Operationalisierte Psychodynamische Diagnostik*, OPD), que integra a dimensão psicodinâmica à sintomatologia descritiva. É um sistema de diagnóstico multiaxial e compreende cinco eixos; os primeiros quatro voltado à compreensão psicodinâmica e o último é descritivo: (I) vivência da doença e pré-requisitos para o tratamento; (II) relações interpessoais; (III) conflito psíquico; (IV) estrutura psíquica; (V) diagnóstico nosológico tradicional, como o DSM-5 e o CID-10.

Em um primeiro momento, revisou-se a literatura acerca do uso do OPD-2 e verificou-se o instrumento como uma ferramenta essencial na clínica no que se refere a compreensão dimensional do sujeito e na pesquisa científica. Entretanto, ainda não é significativo o número de produções acerca da temática, não havendo um conhecimento consistente em diversos aspectos; como no caso da violência por parceiro íntimo. Há estudos especulando o *OPD–Questionaire*, outros avaliando os efeitos do tratamento a partir dos descritos do OPD associados às alterações cerebrais, entre outros.

Sobre esse contexto, a chilena Carla Crempien adaptou o Eixo I do OPD-2 para o contexto da violência doméstica – "*Module for Domestic Violence Assessment"*. Assim o Estudo 3 realizou a adaptação transcultural para a língua portuguesa de forma satisfatória para a utilização do instrumento na pesquisa e para a população brasileira.

Concomitante à adaptação, foi realizada uma análise prévia das primeiras entrevistadas para a compreensão do ciclo da violência e o porquê não conseguem romper esse ciclo, no Estudo 2. Conforme o relato das vítimas, os companheiros possuem muito ciúmes, já que suspeitam de traição e para acalmar-se, o companheiro faz o uso de substâncias, principalmente o álcool; consequentemente, há um descontrole do marido, e, a mulher antecipa a reação de um prejuízo maior e acaba comportando-se de forma submissa para agradar seu companheiro. Porém, com o agravamento da violência, a vítima dissocia e cinde a situação. Observou-se que a violência constante causa mudanças no funcionamento estrutural e no conflito

psicológico das vítimas: dificuldades de mentalização, instabilidade nos relacionamentos, dependência emocional, abandono da própria vida pelo parceiro, dificuldade em ter um senso de identidade. As vítimas esquecem-se de si mesmas e dedicam-se muito ao cuidado dos demais, pois cuidando dos demais elas mesmas se sentem cuidadas.

Conforme o Estudo 5, o discurso das mulheres nas entrevistas concentrou-se em entender o que realmente havia acontecido em seu relacionamento, relatando suas situações abusivas. As vítimas tentaram compreender o motivo que levou a violência e relacionaram os eventos da violência sofrida com sua própria história permeada por demais traumas.

O funcionamento psicológico foi mais explorado no Estudo 4, em que foi realizada a avaliação dos cinco eixos do OPD-2. No Eixo I foi identificado que todas as mulheres sofreram violência emocional e física em intensidades relativamente altas. O sofrimento das vítimas foi angustiante, relataram situações muito difíceis, mencionaram coisas que não fizeram por medo ou porque se sentiram incapazes de fazê-las. Reforçou-se que elas acreditavam que a violência ocorria devido a fatores externos, como o uso de álcool pelo marido, em consequência de situações pessoais ou fatores relacionais. As vítimas acreditam que foram necessárias medidas externas para superar o ciclo de violência, como as medidas de proteção fornecidas pelos órgãos de proteção no tribunal. No Eixo II, padrão relacional, elas permanecem no relacionamento, deixando-se vulneráveis; percebem o parceiro como controlador, agressivo, ofensivo e com medo do abandono. A vítima antecipa o desejo do agressor, como um mecanismo defensivo de desconforto e sofrimento relacionais, tornando-se, portanto, submissas, como já mencionado. No Eixo III, o principal conflito psíquico foi a "necessidade de cuidado *versus* autossuficiência" (78,6%), que se concentra em proporcionar o cuidado aos demais para se sentirem cuidadas e seguras. Assim, elas estavam muito preocupadas com o outro, encobrindo os sentimentos depressivos latentes, o cuidado ao outro foi um mecanismo contra o sentimento de vazio. Elas fingem ser autossuficientes, mas predomina o desejo de cuidar para se sentirem cuidadas. No Eixo IV, prevaleceu o nível de estrutura mediano, no qual eles têm objetos internos inseguros, apresentando dificuldades na regulação emocional e percebendo a realidade de maneira distorcida. Portanto, elas não reconhecem suas limitações e necessidades. E por fim, o Eixo V, constatou-se que 78,6% dos casos

apresentavam algum distúrbio psiquiátrico: Transtorno Depressivo Maior (TDM) e Transtorno de Estresse Pós-Traumático (TEPT).

Finalmente, o Estudo 6 integrou o estilo defensivo utilizado pelas vítimas. Predominou o uso de defesas maduras como a antecipação. Entretanto, reforça-se que mecanismos de defesa são adaptativos, portanto a prevalência do uso de mecanismos de defesa maduros não significa necessariamente que sejam saudáveis. Ainda, pode-se relacionar a predominância do conflito principal "necessidade de ser cuidado *versus* autossuficiência" – Eixo III – nesta descrição, cujo cuidado ao marido prevalece sobre suas necessidades com o intuito de evitar a violência. Nesse sentido, o não uso de pseudoaltruísmo e o uso de humor e formação reativa preveem em 56,4% tal conflito intrapsíquico.

No Estudo 7, o estudo de caso, pode-se oportunizar a construção do planejamento terapêutico. Como resultado, foi possível verificar uma melhora sintomática da participante, em que a vítima aumentou a compreensão empática em relação à filha e ao marido. Nesse sentido, o OPD-2 é uma ferramenta de planejamento terapêutico útil.

14.2 IMPLICAÇÕES CLÍNICAS

14.2.1 Avaliação e Intervenção da IPV

As intervenções clínicas para reduzir a IPV têm se demonstrado limitada e ineficaz (PETIT, KNEE, HADDEN, RODRIGUEZ, 2017). Durante a recepção e o acolhimento das mulheres é importante investigar os episódios de violência recentes, as situações que ocorreram historicamente na vida das mulheres, a duração e gravidade da IPV, os riscos de uso de álcool e outras substâncias, a rede de apoio, entre outros (BACCHUS, RANGANATHAN, WATTS, DEVRIES, 2018). A IPV está associada a uma história de trauma na infância. Experiências abusivas durante a infância predispõem as vítimas a um risco maior de revitimização posterior. Assim, traumas anteriores ressurgem nos traumas atuais que precisam ser elaborados e superam a dependência, valorizando sua autoestima (SAHIN *et al.,* 2010), como foi observado nas participantes da pesquisa, cujas representações de objetos internalizados eram inseguras permeadas por traumas anteriores.

Existe uma associação entre a IPV e os problemas de saúde mental (BACCHUS, RANGANATHAN, WATTS, DEVRIES, 2018). As doenças mentais

mais importantes vistas nas mulheres após a violência doméstica são transtorno de estresse pós-traumático, transtorno de ansiedade e depressão (CENGIZ *et al.,* 2014; EL-SERAG, THURSTON, 2020), uso indevido de substâncias, suicídio (GULATI, KELLY, 2020), distúrbios alimentares, distúrbios do sono (EL-SERAG, THURSTON, 2020). Tal população possui três vezes maior risco de desenvolver depressão ou uma doença mental grave (YAHYA, KHAWAJA, CHUWUMA, 2020), assim como também identificados na presente tese. Também, a pesquisadora Lenore Walker criou a "Síndrome da Mulher Espancada" (BWS), cujo termo apareceu como uma subcategoria de Transtorno de Estresse Pós-Traumático. Conforme ela, há alguns fatores, também presentes nas participantes desse estudo, que identificam BWS: a) lembranças intrusivas de eventos traumáticos, b) altos níveis de excitação e ansiedade, c) comportamento de evitação e entorpecimento emocional geralmente expresso como depressão, negação, minimização e dissociação, d) ruptura no relacionamento interpessoal relações de poder do parceiro (WALKER, 2016).

Altos níveis de IPV estão associados a riscos moderados de suicídio (KAVAK *et al.,* 2018). Dessa forma, compreender a maneira como vítimas de IPV funcionam é fundamental para a planejamento terapêutico e a implantação de medidas profiláticas a nível social e comunitário, já que a violência por parceiro íntimo se baseia nos fatores de risco reconhecidos.

O trauma recorrente modifica o funcionamento psicológico do sujeito e certamente piora a qualidade de vida dos envolvidos, também observado na pesquisa. Tal dado aproxima-se dos dados de traumas em North Korean Refugees, que sugerem que as defesas maduras reduzem a ansiedade quando as vítimas são expostas a eventos estressantes traumáticos (JUN *et al,* 2015). E, especificamente no contexto da violência por parceiro íntimo, o uso da antecipação – defesa madura – correlaciona-se ao resultado do estudo de Petit, Knee, Hadden and Rodriguez (2017), em que a satisfação da necessidade das mulheres atuava como um fator de proteção contra a perpetração da IPV.

De forma especulativa, os achados dessa tese podem ter significado clínico para vítimas de IPV. Identificar e manejar o mecanismo de defesa predominante seria construtivo no curso da psicoterapia. Para IPV depressivos, seria útil concentrar-se no desamparo e na desesperança, em que cuidam dos maridos com o intuito de receber algum conforto. E para IPV que se queixam de sintomas de TEPT, trabalhar com afetos restritos por anulação e isolamento seria crucial no procedimento psicoterapêutico.

Ajudar as vítimas a expressar adequadamente seus sentimentos sobre suas experiências traumáticas, desenvolvendo maiores níveis de mentalização, pode ajudar na elaboração das situações de violência, como apresentado no estudo de caso.

No geral, pode-se relacionar que a violência possui fortes implicações para o desenvolvimento social e econômico do país, uma vez que envolvem sofrimento subjetivo das vítimas, afastamento interrelacional, adoecimento psíquico e eventuais custos com tratamento no sistema de saúde, perdas de produtividade das vítimas, afastamento do trabalho, necessidade de seguro social e ainda, menor participação da mulher no mercado de trabalho e nas relações sociais devido à proibições do parceiro íntimo, interferindo na expressão de suas subjetividades. Tudo isso, culmina com agressões psicológicas e físicas que podem levar a internação hospitalar e infelizmente mortes por feminicídio.

Dessa maneira, a violência perpetrada pelos pais de crianças que vivenciaram junto a IPV leva à exposição de crianças e adolescentes ao trauma, como consequência ao estresse, há dificuldade na regulação emocional e na expressão de emoções negativas (KATZ, HESSLER, ANNEST, 2007; YAHYA, KHAWAJA, CHUWUMA, [s.d]); como apontado pelas participantes desta tese, cujo ambiente familiar infantil era perpetrado por situações de violência. A literatura aponta, ainda, que ao sofrer violência do parceiro, a mãe aumenta a probabilidade de perpetrar maus-tratos contar seus filhos (D'AFFONSECA, 2013).

Crianças que vivem em lares onde prevalece a violência doméstica possuem maior probabilidade de desenvolver problemas comportamentais na primeira infância referentes a aprendizagem, enfrentamento da lei, tristeza, depressão (CUARTAS, 2020; MAZZA *et al.,* 2020). E, a partir da adolescência, apresentarem comportamentos agressivos relacionados a si, autolesão não suicida, tristeza, depressão, afastamento escolar, uso de substâncias psicoativas e aos outros, envolvimento em brigas, baixa empatia e reconhecimento do outro levando, em casos extremos, a envolvimentos em atos infracionais (ARTZ, JACKSON, ROSSITER, NIJDAM-JONES, GÉCZY, PORTEOUS, 2014). Tais jovens expostos às situações de IPV tendem a reproduzir os padrões de relacionamento violentos e abusivos em seus relacionamentos futuros (GADONI-COSTA, DELL'AGLIO, 2015). Assim, torna-se mais evidente a necessidade de quebrar o ciclo da violência, investir em prevenção, como já citado.

Muitas vezes as vítimas não quebram o ciclo ou denunciam os parceiros devido à dificuldade em reconhecer suas interações como violentas (GARCIA *et al.,* 2008),

principalmente nos casos de agressão psicológica. Em relação aos aspectos emocionais identificados, os sentimentos predominantes apontados pelos participantes foram medo, ansiedade, angústia e até culpa, afirmando a complexa dinâmica do inconsciente e os sentimentos contraditórios presentes nas relações. O abuso emocional, estudado por Bins (2012), é considerado um dos tipos mais difíceis de ser identificado, mas cada vez mais estudado e associado ao desenvolvimento de psicopatologias. Conforme Rios e colaboradores (2019), os psiquiatras possuem papel fundamental na detecção da violência. Ainda, outra pesquisa mostrou que 45% das mulheres assassinadas por um parceiro íntimo compareceram a um profissional de saúde para tratar uma lesão causada por violência doméstica nos 2 anos anteriores à sua morte (BHANDARI *et al.,* 2006). Entretanto, apenas 14% das pacientes que se apresentam à profissionais da saúde com tais lesões são de fato questionadas em relação às possíveis agressões sofridas e recebem suporte adequado (BRADLEY *et al.,* 2020). Esses dados evidenciam a necessidade de treinar profissionais de linha de frente para reconhecer os sinais de violência familiar e aplicar as melhores práticas no atendimento às vítimas dessa violência (van GELDER *et al.,* 2020).

O acesso à rede de apoio e aos serviços especializados é imprescindível para auxiliar essas mulheres na reflexão sobre sua vida, suas escolhas e formas de romper o ciclo da violência. As participantes relataram que, quando buscavam ajuda, procuravam familiares ou amigos no trabalho. A falta de apoio social e, em alguns casos, a dificuldade de pedir ajuda, bem como a atitude preconceituosa de quem deveria apoiar, resultou em aumento do sofrimento e progressão de agressões mais graves (MENEGHEL *et al.,* 2011). Dessa maneira, é indispensável avaliar de maneira precisa e intervir de maneira efetiva para que tais mulheres consigam quebrar o ciclo realmente, procurando aumentar a rede de apoio da vítima.

14.2.2 Prevenção da IPV

Existem fortes evidências de que é possível reduzir os índices por meio de estratégias eficazes de prevenção (ROMAGNOLI, 2015). Conforme Santana e colaboradores (2017), é extremamente importante a detecção precoce de sintomas a fim de evitar outros agravos relacionados ao trauma e, assim, possibilitando o tratamento precoce. Tal prevenção representa uma importante evolução em termos de saúde pública na assistência às vítimas de trauma. Em geral, os serviços de assistência

são de baixa qualidade e não podem proteger as vítimas (FALCKE, BOECKEL, WAGNER, 2017). Ressalta-se que todas as participantes do estudo já haviam protocolado denúncia de agressão na delegacia; mas a maioria não possuía informações sobre os direitos de segurança e proteção que lhes cabem de acordo com a Lei Maria da Penha (BRASIL, 2006).

A situação de violência no relacionamento é agravada pela vergonha das mulheres em denunciá-la, pela falta de meios de educação e de acesso a informações jurídicas e de assistência e proteção (SIGNORI, MADUREIRA, 2007). O acesso à informação ainda é uma falha na comunidade, sendo este um ponto importante para a prevenção e erradicação da violência doméstica (CUNHA, PINTO, 2015). O acolhimento psicossocial do serviço tem ajudado as vítimas a refletirem sobre as escolhas e atitudes em suas vidas; porém, ainda existem muitas deficiências no serviço público que precisam ser discutidas: nem todas as mulheres são ouvidas e orientadas devido à dinâmica do serviço, já que apenas o exame médico é obrigatório para o laudo.

Portanto, entender a perspectiva da vítima é essencial para o desenvolvimento de padrões de políticas e práticas, além de informar os profissionais que trabalham no sistema de justiça e na formulação de políticas. É necessário entender os mecanismos psicodinâmicos subjacentes ao comportamento dessas mulheres. Muitas mulheres permanecem e repetem relacionamentos abusivos, mas os motivos por trás deles não são claros. Essas mulheres têm dificuldade em relatar violência e acesso a informações legais. É necessário compreender este ciclo de violência para criar mecanismos de enfrentamento mais eficazes.

A respeito da naturalização da violência, segundo Bins, Telles e Panichi (2015), há banalização e até aceitação de comportamentos violentos contra mulheres em algumas subculturas da sociedade no contexto brasileiro. Há questões antropológicas de poder e gênero, cujas mulheres têm uma atitude naturalizada de maior submissão e adaptação ao comportamento abusivo e coercitivo (CORTEZ *et al.,* 2010). Nesse sentido, é indispensável facilitar o acesso às informações e discutir os papeis de gênero principalmente como conteúdo da educação escolar para erradicar o padrão sociocultural de papéis estereotipados de gênero (BRASIL, 2006; CUNHA, PINTO, 2015; RIOS, MAGALHÃES, TELLES, 2019).

Sugere-se inclusive maiores campanhas de redução da bebida alcoólica. Pois, como citado pelas mulheres no Estudo 2, é a substância que acaba provocando uma

alteração maior no parceiro e consequentemente a violência contra a mulher e aos filhos envolvidos. Dessa forma, o uso de substâncias pelo parceiro é um fator importante que precisa ser considerado na IPV.

Em um momento de pandemia como atualmente, os esforços para enfrentar a violência contra as mulheres devem se concentrar não apenas no recebimento de reclamações e relatórios, mas também no aumento da equipe de linhas diretas de prevenção e resposta à violência, treinamento de profissionais de saúde para identificar situações de alto risco e fortalecimento das redes de apoio. Incentivar o apoio por meio de redes sociais informais e virtuais de apoio também é vital, pois são meios que ajudam as mulheres a se sentirem amparadas e servem de alerta aos abusadores de que as mulheres não estão totalmente isoladas (VIEIRA *et al.,* 2020).

14.2.3 Aplicabilidade do OPD-2

O OPD-2 é uma ferramenta diagnóstica que integra a informação clínica do paciente e do planejamento terapêutico. É muito útil para a avaliação de pacientes em variados contextos e possui evidências empíricas em: violência entre parceiro íntimo como nesse estudo e no estudo chileno (CREMPIEN, 2012); pacientes com transtorno mental grave (REBOUÇAS, 2018); pacientes depressivos (DINGER *et al.* 2014; DAGNINO *et al.,* 2017); pacientes com transtornos de personalidade (ZIMMERMANN *et al.,* 2012); pacientes com transtorno de conduta (BOTH *et al.,* 2017); paciente com TEA ou TEPT (BOTH, MALGARIM, FREITAS, 2018); pacientes com epilepsia (ALVARADO, 2015); pacientes com transtorno de ansiedade generalizada (JUAN *et al.,* 2013); pacientes com transtornos alimentares (ZUCCARINO *et al.,* 2012).

Os resultados do OPD-2 integram a dimensão psicodinâmica à sintomatologia descritiva comum dos manuais diagnósticos. O diagnóstico dimensional em complemento ao descritivo é uma necessidade clínica que facilita a compreensão do sujeito e planejamento clínico, oferecendo uma estimativa da dinâmica interna e sobre o significado da sintomatologia apresentada. Tais informações são apresentadas de uma forma operacionalizada em formulários de avaliação multiaxial. A operacionalização oportuniza um conhecimento e prática a respeito da psicodinâmica do paciente, havendo mais clareza no planejamento terapêutico do sujeito (TASK FORCE, 2016).

É escasso os instrumentos que operacionalizem os constructos psicodinâmicos; porém, apesar de ser um instrumento recente, a sua difusão está ampliando-se. Observa-se que a produção empírica é crescente. Assim como, o sistema diagnóstico proposto pelo OPD-2 tem demonstrado que tal operacionalização de constructos facilitam a comunicação entre a comunidade científica, tanto no contexto clínico ou de pesquisa acadêmica, já que possui critérios e indicadores muito específicos que padronizam as observações de avaliação diagnóstica. Da mesma forma, o OPD-2 tem sido utilizado como um recurso de cunho educativo para futuros terapeutas, pois, a partir do instrumento, é possível treinar e avaliar o processo terapêutico, embasando o processo de supervisão clínica.

Outro aspecto que se destaca sobre o OPD-2 é o resultado da dissertação de Mestrado da aluna Cinthia Danielle Araújo Vasconcelos Rebouças, sob orientação da Profa. Dra. Neusa Sica da Rocha e André Goettems Bastos. O respectivo estudo demonstrou que a avaliação realizada pelo OPD-2 é coerente à demais resultados de instrumentos autoaplicáveis já validados nacionalmente – WHOQOL-BREF (*The World Health Organization Quality of Life – brief version);* SCL-90 (*Symptom Check-List-90-Revised)* e BDI (*Inventário de Depressão de Beck*). O OPD-2, apresentou propriedades psicométricas de validade de critério e fidedignidade satisfatórias quando aplicado em uma amostra brasileira de 80 pacientes com transtorno mental grave atendidos em psicoterapia e administrado por avaliadores preparados e treinados para o preenchimento preconizado pelo manual o OPD-2 (REBOUÇAS, 2018).

E por fim, reforça-se o contexto da avaliação do paciente no contexto de violência com a elaboração do *"Module for Domestic Violence Assessment"* elaborado pela professora Dra. Carla Crempien (2009) e adaptado transculturalmente para a população brasileira (BOTH, FAVARETTO, FREITAS, CREMPIEN, 2019). Dessa maneira, a versão brasileira do OPD-2 apresenta boas condições de avaliar propriedades psicodinâmicas complementares à sintomatologia descritiva dos pacientes, tanto no contexto de saúde-doença, como da violência doméstica.

14.3 LIMITAÇÕES E FUTUROS ESTUDOS

O fato das pacientes estarem em um momento de sofrimento emocional pela denúncia do marido, pode ter influenciado o modo como preencheram os intrumentos, alterando medidas das variáveis dos instrumentos. Porém, deve ser considerado que

todas as pacientes eram vítimas de IPV, sendo então a amostra está enviesada por esse denominador comum. Assim como, diante um trauma, cada pessoa possui uma maneira distinta de reagir, conforme sua história pregressa e funcionamento psicológico, não usando necessariamente defesas patológicas. Dessa forma, por mais que o trauma recorrente possa causar vulnerabilidade na estrutura psíquica, houve confiabilidade entre juízes e optou-se por manter a compreensão do Eixo IV conseiderando essa possbilidade de vulnerabilidade; assim como o DSQ-40 apresentou um alpha satisfatório.

Também em relação à amostra, praticamente não houve mulheres vítimas de violência sexual; dessa forma, os resultados dessa pesquisa não caracterizam essa população. De qualquer maneira, mulheres vítimas de violência psicológica e/ou física são vítimas que se enquadram dentro da IPV.

As entrevistas foram realizadas apenas a partir da transcrição do áudio, portanto, o comportamento não verbal do paciente não foi avaliado. Às vezes, a expressividade era mantida em relatório transcrito, como observações de choro, raiva, entre outros. Além disso, parte da entrevista foi dedicada ao aconselhamento das vítimas em procedimentos legais, porém, isso não influencio a compreensão psicodinâmica das pacientes.

Sobre o local da coleta, não era um local clínico, mas sim um departamento médico legal da polícia com a intenção de: a) realizar o exame de corpo de delito que compõem o registro da denúncia contra alguém; e b) buscar proteção a si mesma e aos filhos. Assim, em alguns casos, havia uma grande quantidade de mecanismos de defesa ou mesmo defesas dissociativas que poderiam distorcer os fatos; dessa forma, reforça-se o fato disso ser o denominador comum da amostra, cujo momento da violência também é necessário ser investigado.

A violência por parceiro íntimo contra as mulheres é um fenômeno cíclico, portanto, seria interessante realizar um estudo de coorte para observar as nuances da vitimização com uma amostra maior e usar o OPD-2 para planejar o tratamento desses casos. Estudos baseados em acompanhamentos de longo período possibilitariam avaliar a evolução do funcionamento psicológico das mulheres vítimas de violência doméstica, principalmente após o término da violência ou após o processo terapêutico, como foi realizado no breve estudo de caso – Estudo 7.

Pesquisas futuras também devem incluir os efeitos da IPV na educação dos filhos, uma vez que os estudos apontam para o fenômeno da transgeracionalidade.

Assim como, a influência do apoio social e serviços especializados, são fundamentais para amenizar os efeitos dos estressores traumáticos nos resultados de saúde, assim investigar mais essas variáveis são necessárias.

15 CONSIDERAÇÕES FINAIS

A IPV é profundamente enraizado nas questões evolutivas e culturais, o que explica sua natureza universal e persistente. É uma combinação paradoxal de agressão e carinho. Muitas teorias foram construídas com o esforço de explicar o trauma. Destaca-se que mecanismos de prevenção e de proteção, principalmente em tempos de pandemia, devem ser investidas para o enfrentamento dessa violência, não se restringindo apenas ao acolhimento das denúncias. É preciso, além disso, direcionar esforços para o aumento das equipes nas linhas diretas de prevenção e resposta à violência, divulgar os serviços disponíveis, capacitar os trabalhadores da saúde para identificar situações de risco e expandir e fortalecer as redes de apoio na linha do serviço público atento aos direitos humanos.

Assim como, é necessário incentivar a modificação cultural dos papéis de gênero por meio da educação, cujo reforço do lugar da mulher como sujeito de direito em detrimento ao lugar inferior, subordinado ou de propriedade do homem sobre seu corpo e consequentemente a sua vida. Ou seja, fortalecer a autonomia dessas mulheres para além da dependência emocional.

Estes estudos da presente tese forneceram evidências empíricas inéditas sobre observações clínicas sobre o funcionamento psicológico dessa população e as questões que compõem a manutenção da violência por parceiro íntimo. A pesquisa buscou colaborar com mais evidências sobre o assunto, sugerindo uma reformulação nas formas de encontro para romper o ciclo de violência. A compreensão de padrões internalizados, funções estruturais e tensões motivacionais são fundamentais para a prevenção da revitimização e a construção de mecanismos de enfrentamento mais adaptativos, além de promover maior adesão ao tratamento. A identificação dimensional psicodinâmica é uma ferramenta útil para o planejamento e o foco terapêutico, para superar obstáculos e impasses na interrupção do ciclo de violência.

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APÊNDICE A – RELAÇÃO DAS PRODUÇÕES COMPLEMENTARES À PESQUISA

ARTIGOS PUBLICADOS

- BOTH, L. M.; MALGARIM, B. G.; FREITAS, L. H. Avaliação psicodinâmica de pacientes com Transtorno de Estresse Agudo e Pós-Traumático em uma instituição pública. ISSN: 0103-5665. Revista Psicologia Clínica, 2018; 30(3):579-593. http://dx.doi.org/10.33208/PC1980-5438v0030n03A09
  Resumo: Este estudo avaliou o funcionamento psicodinâmico de pacientes com Transtorno de Estresse por meio do Diagnóstico Operacionalizado Psicodinâmico (OPD-2), no que se refere à estrutura, conflito intrapsíquico e padrão interacional do sujeito. Foram avaliados três pacientes com diagnóstico de Transtorno de Estresse, seja Transtorno de Estresse Agudo, seja Transtorno de Estresse Pós-Traumático. As entrevistas foram transcritas e codificadas conforme o OPD-2, considerando a confiabilidade teste–reteste para a codificação dos itens. Todos os participantes apresentaram níveis moderados de sofrimento subjetivo, com limitações na continuidade de atividades cotidianas. O conflito prevalente foi a necessidade de ser cuidado *versus* a autossuficiência. O nível de estrutura psíquica foi avaliado como moderado, cujo receio principal é a perda de um objeto importante ou separação significativa de apoio e há dificuldade de regulação emocional. A compreensão dimensional do OPD permitiu uma compreensão do funcionamento psicodinâmico dos pacientes de forma mais clara, o que pode facilitar o entendimento do contexto clínico de estresse.
  Palavras-chave: avaliação; psicodinâmica; estresse.

ARTIGOS APROVADOS

- BOTH, L. M., ZORATTO G., CALEGARO, V. C., RAMOS-LIMA, L. F., NEGRETTO, B. L., HAUCK, S., FREITAS, L. H. M. Covid-19 pandemic and social distance: economic, psychological, family and technological effects. Trends in Psychiatry and Psychotherapy.
  Resumo:
  Objetivo: contemplar e sintetizar a produção da literatura no decorrer da pandemia da Covid-19 no ano de 2020 relacionados ao isolamento social. **Método:** revisão narrativa da literatura sobre isolamento social no contexto da pandemia pelo COVID-19 de artigos publicados até Maio de 2020. Os descritores "pandemia", "COVID-19" e "isolamento social" foram utilizados. A pesquisa foi realizada em consulta ao banco de dados Capes Periódicos, Pubmed, SciELO and Google Scholar **Resultados:** o conceito de isolamento social é, neste momento, entendido como uma medida de contenção epidemiológica que visa diminuir a velocidade de disseminação da doença, permitindo aos serviços de saúde que preparem os recursos necessários para abarcar o provável aumento da demanda; além disso, busca proporcionar proteção adicional aos grupos considerados de maior risco. As medidas de isolamento, adotadas em caráter de urgência e em larga escala nos últimos meses, podem ter despertado temores e gerar sofrimento psíquico, além de prováveis impactos econômicos e no sistema de saúde, mudanças no relacionamento familiar e no cenário do uso da tecnologia. **Conclusão:** o

isolamento social traz consigo a possibilidade de sofrimento psíquico e demais impactos socioeconômicos, o que demonstra a importância de entender melhor as bases e implicações desta medida através de um referencial científico.
Palavras-chave: coronavírus, COVID-19, pandemia, distanciamento social.

- ZATTI, Cleonice; BOTH, Luciane; OLIVEIRA, Sérgio; FAVARETTO, Taís; BASTOS, Andre; GUIMARÃES, Luciano; FREITAS, Lúcia Helena. Diagnóstico Psicodinâmico Operacionalizado (OPD-2) em pacientes com comportamento suicida prévio: Follow up do sul do Brasil. Jornal Brasileiro de Psiquiatria.
  Resumo:
  Objetivo: Avaliar o funcionamento psicodinâmico de pacientes pós-tentativa de suicídio, através do Diagnóstico Operacionalizado Psicodinâmico (OPD-2) e de outros instrumentos complementares. **Métodos**: Estudo de caso segmentado, utilizando métodos mistos de análise (quali-quantitativa). Os pacientes foram avaliados em *follow up* 3 anos após a 1ª entrevista (que ocorreu logo após a tentativa de suicídio). Os casos que concordaram em participar no *follow up* foram dois participantes. **Resultados:** Observou-se nível moderado de funcionamento global nos pacientes. Os conflitos psíquicos com maior prevalência foram o de 'autoestima' e 'necessidade de ser cuidado' x 'autossuficiência'. Em suas relações, mostraram-se dependentes, impulsivos e exigentes, o que ocasiona sensação constante de abandono. O medo de ser abandonado faz com que se distanciem e se isolem. Em análise, os fatores protetivos de tendências suicidas foram à qualidade da rede de apoio (MOS), maior interação social, maior estabilidade do *self,* nível de defesas maduras e o tratamento em saúde mental posterior à alta hospitalar. **Conclusão**: O OPD-2 demonstrou-se um instrumento apropriado para uma ampla compreensão de pessoas que tiveram tentativas de suicídio e suas buscas de organização psíquica.
  Palavras-chave: Tentativa de suicídio, Apoio Social, Fatores Protetivos, Saúde Pública.

ARTIGOS SUBMETIDOS

- FAVARETTO, T. C., BOTH, L.M., CEITLIN, L.H.F. Psychodynamic understanding of trauma patients: qualitative analysis of the Operationalized Psychodynamic Diagnosis interview. Brain and Behavior.

  Abstract:
  Introduction: Trauma, a violent event of strong emotion, produces intolerable excitations to the psychic apparatus that seeks to discharge them, leading to the formation of symptoms. When Post-Traumatic Stress Disorder (PTSD) and Complex Post-Traumatic Stress Disorder (PTSD-C) are established, they can produce fundamental disturbances of itself, in interpersonal relationships and the significance of the world. **Objective:** To understand the psychodynamic characteristics of women victims of interpersonal and urban violence through their life histories, behavioral, emotional and defensive aspects, perception of the disease, support network and future. **Method:** The study consisted of seven women with PTSD and three with PTSD-C. Data collection was performed through the clinical interview of the Operationalized Psychodynamic Diagnosis 2 (OPD-2). In the content analysis were created posteriori categories: past history, functioning characteristics, perception of the disease, treatment and future and social support

network. **Results:** Early traumas such as verbal, physical and sexual aggressions, feelings of rejection and emotional detachment generate unstable representations of the self, difficulties in emotional regulation, dependence on the object, isolation, low reflection and somatization. During its development, a cycle of adverse events destabilizes and intensifies symptoms. Women who mentioned loving and welcoming parents keep performing some activities, with more positive and optimistic emotions. Conflicts maintain a repetitive pattern, individuation versus dependence and care versus self-sufficiency. Subjective suffering was considered moderate with anxious or depressive symptoms and difficulties in seeking treatment. Future planning related to symptom reduction. Patterns of transgenerational violence and urban violence are pointed out as risk factors. **Conclusion:** The research brought evidence on the topic, helping in the psychodynamic understanding of traumatized women, which can help in the break with violence and in the search for a better quality of life.
Keywords: Psychological trauma, post-traumatic stress disorder, complex post-traumatic stress disorder, violence, qualitative research.

- FAVARETTO, T. C., BOTH, L.M., RAMOS-LIMA, L. F., CEITLIN, L.H.F. Psychodynamic functioning in complex trauma: Case report. The Journals of Nervous and Mental Disease.

Abstract:
Objective: A female patient with PTSD-C was evaluated using the Operationalized Psychodynamic Diagnosis (OPD-2) at the beginning of treatment and after four months.
Method: PTSD Scale for DSM-5 (CAPS-5), Sel-report Questionnaire (SRQ-20), Defensive Style Questionnaire (DSQ-40) and OPD-2 were used.
Results: CAPS-5, it presented 45 points and then 27 points. On the SRQ-20, the scores were 16 to 8. On the DSQ-40, the use of the maturity level of the defenses increased. In OPD-2, she experienced intense subjective suffering with a slight decrease in the course of treatment. In relationships, she is dependent and isolated. The intrapsychic conflict has changed to submission versus control. Its structure was of a medium low to medium level. Comorbidities had partial improvement of symptoms. **Conclusion:** OPD-2 proved to be effective in the psychodynamic evaluation of the patient. The complexity and the need to identify the most relevant therapeutic components for the treatment are observed.
Keywords: stress disorders, post-traumatic, case report, psychodynamic assessment, defense mechanisms

- BOTH, L. M., SANTI, S. S., KERBER, N. ZORATTO G., FAVARETTO, T. C., ZATTI, C., CALEGARO, V. C., FREITAS, L. H. M. Violent situations during the COVID-19 pandemic. Revista Brasileira de Psicoterapia.

Abstract:
Introduction: The pandemic caused by the new coronavirus (SARS-CoV-2) has changed the lifestyle of the general population, mainly through the measures of distance and isolation adopted to contain the progress of the disease. These measures generated a series of stressors, including the increase in domestic violence.
Objective: To identify the impact of violence on mental health, more specifically on the worsening of mental disorders, as well as to analyze the poorly adaptive

personality traits related to situations of violence during isolation resulting from the COVID-19 pandemic in Brazil.
Method: Non-probabilistic study, composed of a sample of 3,041 participants who were assessed using the PCL-5, DASS-21, PID-5-BF and AUDIT-C. Instruments applied in the period between April 22, 2020 to May 8, 2020.
Results: 379 (13%) of the sample suffered some type of adverse situation during social distance. Participants who experienced violence have higher alcohol consumption (p=0.004), greater severity of symptoms related to the diagnosis of PTSD (p <0.01), greater presence of anxiety symptoms (p<0.001), depression (p<0.001), in relation to those who did not suffer.
Conclusion: Isolation due to the pandemic is having a great impact on people's mental health, exclusively on those who have suffered violence. It is necessary, together with public and private agencies, to create strategies aimed at scaling up interventions related to the impact of the pandemic, especially by expanding listening spaces in the health sector and social assistance.
Keywords: violence; depression; anxiety; coronavirus infections.

- BOTH, L. M., FREITAS, L. H. M. Os sons do trauma coletivo. Psicologia: Teoria e Pesquisa.
Resumo:
O trauma coletivo é definido como um golpe nos tecidos básicos da vida social, que prejudica os laços que unem as pessoas e prejudica o senso de comunidade; dessa forma, a música pode ser usada com o cunho terapêutico e é considerada uma linguagem universal, no qual se tornou um dos principais meios de comunicação da atualidade, ultrapassando as diferenças ideológicas. Nesse sentido, esse estudo tem o intuito de refletir sobre a relação entre a música e o trauma coletivo. A possibilidade de criação dos símbolos necessários para tapar o vazio deixado pelo trauma alivia-o, como é o caso da arte, que se torna essencial para cobrir a própria lacuna mnésica ocasionada pelo trauma. A música é uma forma de criação, principalmente na improvisação, que auxilia o psiquismo a conter fortes emoções e a expressá-las. A riqueza das artes pode criar uma nova experiência significativa de os eventos traumáticos e ajudam a aprender novos métodos de enfrentamento. Nesse sentido a música é considerado um elemento indispensável de elaboração do conteúdo não elaborado.
Palavras-chave: Trauma coletivo, música, linguagem.

- FAVARETTO, T. C., BOTH, L.M., FERITAS, L.H. Mulheres aposentadas vítimas de violência doméstica: Diagnóstico Psicodinâmico Operacionalizado.
Resumo: A violência doméstica contra mulheres de meia idade e idosas é um fenômeno complexo devido a maior fragilidade física, dificuldade em romper com a violência, baixo apoio social. Há necessidade de maior investigação sobre os fatores associados e o mapeamento de terapêuticas para mulheres dessa faixa etária. Assim, esta pesquisa, quantitativa e transversal, com cinco mulheres aposentadas, vítimas de violência doméstica, objetivou identificar aspectos da vivência da violência, dinâmica relacional, conflito intrapsíquico e estrutura psicológica. As entrevistas e análise basearam-se no Diagnóstico Psicodinâmico Operacionalizado (OPD-2). O coeficiente Kappa nos eixos foi substancial. No Eixo I, verificou-se que todas sofreram severas violências psicológicas e físicas com intenso sofrimento, tempo ocioso e baixo apoio social. No Eixo II, os outros são percebidos como controladores e exigentes, impondo-se agressivamente, negligenciando-as e

abandonando-as. Assim, elas permitem muito espaço e protegem-se insuficientemente, expondo-se ao risco (violência). No Eixo III, o conflito principal identificado foi *necessidade de ser cuidado versus autossuficiência*, em que prevaleceu a renúncia sem exigências na busca de agradar o outro. No Eixo IV as participantes apresentaram nível moderado de integração estrutural, com dificuldades de mentalização. E, no Eixo V preencheram os critérios diagnósticos do Transtorno de Estresse Pós-Traumático. Apesar da renda financeira – aposentadoria – as participantes sentem-se sozinhas e estão em intenso sofrimento psíquico submetendo-se à relacionamentos abusivos. A escuta empática e o acolhimento auxiliam as mulheres na compreensão de suas dificuldades, na promoção da autonomia e no resgate da autovalorização a partir da atribuição do novo significado para a conquista da independência almejada.
Palavras-Chave: violência doméstica, idoso, avaliação, psicologia clínica, psicodinâmica.

TRABALHOS APRESENTADOS EM EVENTOS

- *Situações de violência durante a pandemia da COVID-19.* Congress on Brain Behavior and Emotions 2020, 27 a 30 de novembro de 2020 na modalidade Online;
- *Os padrões relacionais disfuncionais e o conflito intrapsíquico em mulheres vítimas de violência doméstica: a dinâmica da vitimização.* Congresso "48ª Reunião Anual da Sociedade Brasileira de Psicologia – Psicologia para um mundo em transformação" – UNISINOS, out 2018;
- *Diagnóstico Psicodinâmico Operacionalizado (OPD-2) de mulheres vítimas de violência doméstica.* Jornada CELG 2018 "Mente e Corpo: diálogos contemporâneos", Canela, ago 2018;
- *Mulheres aposentadas vítimas de violência doméstica: Diagnóstico Psicodinâmico Operacionalizado.* IV Congresso Internacional de Estudos do Envelhecimento Humano 2018, Passo Fundo;
- *Operative psychodynamic diagnosis (OPD-2) of a teenager in conflict with the law.* Congresso SPR, Toronto, 2017;

PREMIAÇÕES

- **Artigo** na *Brain and Behavior.* Cycle of violence in women victims of domestic violence: qualitative analysis of the psychodynamic approach through the OPD 2 interview. Autoras: BOTH, L. M.; FAVARETTO, T. C., FREITAS, L. H. ISSN 2162-3279. Brain Behav. 2019;00:e01430. https://doi.org/10.1002/brb3.1430
    - **This work was one of the <u>top downloaded</u> in recent publication history in** published in *Brain and Behavior* (is among the top 10% most downloaded papers). Among work published between January 2018 and December 2019, yours received some of the most downloads in the 12 months following online publication.

ANEXO A – DADOS SOCIODEMOGRÁGICOS

QUESTIONÁRIO DE IDENTIFICAÇÃO
(Lourenço & Baptista, 2013)

DATA: ____/_____/____ **APLICADOR:**

SEXO
( ) Feminino
( ) Masculino

COR/ RAÇA/ETNIA
( ) Branco ( ) Amarelo
( ) Preto ( ) Indígena
( ) Pardo ( ) Outro

IDADE _____ anos

ESCOLARIDADE
( ) Analfabeto
( ) Ensino Fundamental Incompleto
( ) Ensino Fundamental Completo
( ) Ensino Médio Incompleto
( ) Ensino Médio Completo
( ) Ensino Superior Incompleto
( ) Ensino Superior Completo
( ) Pós-graduação

RENDA INDIVIDUAL MENSAL
( ) Nenhuma
( ) Menor que 1 salário mínimo
( ) Entre 1 e 2 salários mínimos
( ) Entre 3 e 6 salários mínimos
( ) Entre 7 e 12 salários mínimos
( ) Acima de 12 salários mínimos

RELIGIÃO
( ) Católica
( ) Evangélica/Protestante
( ) Espírita
( ) Judaica
( ) Afro-brasileira
( ) Oriental/Budismo
( ) Não tem
( ) Outra:_____

QUAL O NÚMERO DE PESSOAS QUE VIVE EM SUA CASA CONTANDO COM VOCÊ?
( ) 1 Pessoa
( ) Entre 2 e 5 pessoas
( ) Entre 6 e 10 pessoas
( ) Acima de 11 pessoas. Quantas? _____

QUEM SÃO ESSAS PESSOAS QUE VIVEM COM VOCÊ? (Marque um x em uma ou mais opções).
( ) Cônjuge ( ) Primo (a/os/as)
( ) Filho (a/os/as) ( ) Amigo (a/os/as)
( ) Irmão(a/os/as) ( ) Sogro (a)
( ) Pai ( ) Tio (a/os/as)
( ) Mãe ( ) Outros. Qual? _____
( ) Avô (ó/ós)

VOCÊ FAZ USO DE BEBIDA ALCOÓLICA?
( ) Sim ( ) Não

Com que frequência?
( ) 1 ou 2 vezes por mês
( ) 3 ou 4 vezes por mês
( ) Fins de semana
( ) Todos os dias
( ) Outras. Quantas? _____

VOCÊ FAZ USO DE ALGUM TIPO DE DROGA?
( ) Sim ( ) Não

Qual? (Marque um x em uma ou mais opções)
( ) Tabaco
( ) Fármacos
( ) Maconha
( ) Cocaína
( ) Crack
( ) Outras. Qual? _____

Com que frequência?
( ) 1 ou 2 vezes por mês
( ) 3 ou 4 vezes por mês
( ) Fins de semana
( ) Todos os dias
( ) Outras Quantas? _____

COM QUE IDADE VOCÊ COMEÇOU A FAZER USO DE:

Bebida alcoólica: _____ anos **Drogas:** _____ anos

VOCÊ TEM OU JÁ TEVE ALGUM DIAGNÓSTICO DE DISTÚRBIO PSIQUIÁTRICO?

( ) Sim. Qual? _____ ( ) Não

TIPO DE RELACIONAMENTO

( ) Namoro
( ) Casamento
( ) União estável
( ) Viúvo
( ) Divorciado
( ) Desquitado
( ) Separados há menos de 6 meses
( ) Outro: _____

TEMPO DE RELACIONAMENTO

( ) Entre 6 meses e 1 ano
( ) Entre 1 e 2 anos
( ) Entre 3 e 5 anos
( ) Entre 6 e 10 anos
( ) Entre 11 e 15 anos
( ) Entre 16 e 20 anos
( ) Entre 21 e 30 anos
( ) Entre 31 e 40 anos
( ) Outro: _____

SEXO DO PARCEIRO

( ) Feminino
( ) Masculino

COR/ RAÇA/ETNIA DO PARCEIRO

( ) Branco ( ) Amarelo
( ) Preto ( ) Indígena
( ) Pardo ( ) Outro

IDADE DO PARCEIRO

( ) 18 a 20 anos ( ) 46 a 50 anos
( ) 21 a 25 anos ( ) 51 a 55 anos
( ) 26 a 30 anos ( ) 56 a 60 anos
( ) 31 a 35 anos ( ) 61 a 65 anos
( ) 36 a 40 anos ( ) Acima de 66 anos
( ) 41 a 45 anos

ESCOLARIDADE DO PARCEIRO

( ) Analfabeto
( ) Ensino Fundamental Incompleto
( ) Ensino Fundamental Completo
( ) Ensino Médio Incompleto
( ) Ensino Médio Completo
( ) Ensino Superior Incompleto
( ) Ensino Superior Completo
( ) Pós-graduação

RENDA INDIVIDUAL MENSAL DO PARCEIRO

( ) Nenhuma
( ) Menor que 1 salário mínimo
( ) Entre 1 e 2 salários mínimos
( ) Entre 3 e 6 salários mínimos
( ) Entre 7 e 12 salários mínimos
( ) Acima de 12 salários mínimos

RELIGIÃO DO PARCEIRO

( ) Católica
( ) Evangélica/Protestante
( ) Espírita
( ) Judaica
( ) Afro-brasileira
( ) Oriental/Budismo
( ) Não tem
( ) Outra:_____

SEU PARCEIRO FAZ USO DE BEBIDA ALCOÓLICA?

( ) Sim ( ) Não

Com que frequência?
( ) 1 ou 2 vezes por mês
( ) 3 ou 4 vezes por mês
( ) Fins de semana
( ) Todos os dias
( ) Outras. Quantas? _____

SEU PARCEIRO FAZ USO DE ALGUM TIPO DE DROGA?

( ) Sim ( ) Não

Qual? (Marque um x em uma ou mais opções)
( ) Tabaco
( ) Fármacos
( ) Maconha
( ) Cocaína
( ) Crack
( ) Outras. Qual? _____

Com que frequência?
( ) 1 ou 2 vezes por mês

( ) 3 ou 4 vezes por mês
( ) Fins de semana
( ) Todos os dias
( ) Outras Quantas? _____

Em relação a sua vida quando criança, você lembra dos seus pais brigando e discutindo?		**Como era os seus pais quando você era criança? (Marque um x em uma ou mais opções)**
( ) Sim	( ) Não	( ) Amorosos e carinhosos ( ) Não davam afeto ( ) Não cuidavam como você gostaria ( ) Eram violentos com você ( ) Outros: _____
Com que frequência? ( ) 1 ou 2 vezes por mês ( ) 3 ou 4 vezes por mês ( ) Fins de semana ( ) Todos os dias ( ) Outras. Quantas? _____		

ANEXO B - ENTREVISTA CLÍNICA DO OPD-2

OPD-2

ENTREVISTA CLÍNICA OPD

LUCIANE MARIA BOTH
LÚCIA HELENA FREITAS

Fase de abertura	**Eixo I** • Vivência e apresentação da doença, sofrimento subjetivo
Fase de exploração de episódios relacionais	**Eixo II** • Identifica descrições de interações relevantes com outras pessoas importantes (episódio de relação)
Fase de exploração da vivência a respeito dos objetos e dos modos vivenciados e concretos de configurar a vida	**Eixo III** • Percepção e vivência dos objetos em diferentes contextos (familiar, laboral, social, amoroso) • Explorar os conflitos determinantes de sua vida • Em pacientes com baixo nível de integração estrutural é necessário um estilo mais dirigido. • Negligencia os conflitos e têm dificuldade no reconhecimento de sentimentos e necessidades delas mesmas e dos outros? • Conflito induzido por estresse • Conflito 1: Individuação x dependência • Conflito 2: Submissão x controle • Conflito 3: necessidade de cuidado x autossuficiência • Conflito 4: Conflito de autoestima • Conflito 5: Conflito de culpa • Conflito 6: Conflito edípico • Conflito 7: Conflito de identidade

Fase de exploração das vivências pessoais do paciente – Características estruturais	**Eixo IV**
	• Anamnese biográfica: autodescrição, descrição dos objetos, informações sobre as áreas da vida vivenciadas ou concretas (família de origem, família atual, trabalho);
	• Competências cognitivas
	  ○ Autopercepção
	  ○ percepção do objeto
	• Competência para autocontrole
	  ○ Autorregulação
	  ○ Regulação da relação com o objeto
	• Competências emocionais
	  ○ Comunicação interna
	  ○ Comunicação com o mundo interno
	• Capacidade para formar vínculo
	  ○ Objetos internos
	  ○ Objetos externos

Fase final	**Eixo I**

OPD-2

	• Conceito de mudança do paciente, tipo de tratamento desejado • Recursos e impedimentos para a mudança, suporte social, ganho secundário • Motivação à psicoterapia, pré-requisitos para o tratamento e capacidade de introspecção

A) Fase de abertura:

- Esclarecer o objetivo da entrevista (compreender contigo teu problema/enfermidade. Cerca de 1h);
- Avaliar o grau de complicação da enfermidade e o nível de sofrimento do paciente. Situação desencadeante
- Situação atual: relacionamentos, trabalho, estudos...

1) Eixo I

Compreende aspectos dos momentos iniciais da entrevista e finais do exame multiaxial. Refere-se tanto a doença ou a situação atual (violência...).

a) Vivência e apresentação da doença, sofrimento subjetivo

- Por favor, descreva as suas queixas, os seus problemas e suas preocupações.
- Por que marcou a consulta agora?
- Até que grau a doença limita a tua vida?
- Que efeitos têm a doença especificamente sobre você? Socialmente? Profissionalmente?

Obs: observar se as expressões e gestos são congruentes ao sofrimento relatado e qual o sentimento que provoca no terapeuta (contratransferência).

E) Fase final: Motivação à psicoterapia, pré-requisitos para o tratamento e capacidade de introspecção

- Fazer um resumo do conflito principal: "você deseja viver de forma mais autônoma...", "tem guardado muita tristeza pela perda da sua mãe..." e estudar as reações do paciente frente a isso;
- Certificar-se se há uma boa impressão da estrutura, conflitos, relações e vivência da enfermidade para finalizar o exame;
- Analisar até que ponto é possível trabalhar com o paciente, com os pontos identificados a serem trabalhados, estabelecer uma indicação a psicoterapia e comunica-la ao paciente.

b) Conceito de mudança do paciente, tipo de tratamento desejado

- O que você acha que poderia ajudá-lo(a)?
- Consegue imaginar a psicoterapia como um possível tratamento para você?

Obs: o paciente questiona diretamente certas formas de tratamento? Mostra interesse e faz perguntas? O desejo urgente de uma forma específica poderá esconder uma baixa motivação para a mudança.

c) Recursos e impedimentos para a mudança, suporte social, ganho secundário

- Quem ou o que está ajudando você a lidar com a sua doença?

- Pode descrever com mais detalhes como é que a sua família reage cada vez que a dor fica muito forte?
- Você se referiu que já sofreu sintomas semelhantes no passado. O que você fez então para sentir-se melhor?
- Você tem plano de saúde? Pediu benefícios sociais?

Obs: quem marcou a entrevista? Veio acompanhado? Demonstra resistência?

B) Fase de exploração de episódios relacionais

- Considerar a perspectiva transferencial/contratransferencial e facilitar a análise das experiências relacionais atuais ou biográficas (foco nas relações disfuncionais. Em primeiro lugar fixar-se nas relações neuróticas repetitivas que se generalizam, rupturas, contradições dos demais: padrões repetitivos);
- Obtenção de episódios relacionais, ao menos três. Perguntar por situações relacionais concretas baseadas em relatos anteriores, ou sobre reações dos demais ante sua enfermidade;
- Pode explorar de maneira mais exata a dinâmica relacional, perguntando sobre expectativas, medos, desejos em relação a si e aos demais: "poderia me relatar o que espera ou teme neste momento x?".

2) Eixo II

a) Identifica descrições de interações relevantes com outras pessoas importantes (episódio de relação)

- Se o paciente já tiver mencionado pessoas importantes, pode ser estabelecido um seguimento direto: Eu não consigo imaginar como é a relação com X, talvez você consiga me esclarecer isso, descrevendo uma situação especialmente estressante, difícil e conflituosa com X?
- Se depois de algum tempo não estiver disponível a informação suficiente de relacionamentos relevantes, o terapeuta pode perguntar diretamente: Quem são as pessoas mais importantes na sua vida? Quem é essencialmente próximo de você?
- Ou: Poderia descrever uma situação atual que viveu com X e que tenha sido particularmente estressante, difícil e conflituosa para você?
- Consegue dizer-me o que é que esperou ou temeu de X naquele momento?
- ... o que é que X fez naquele momento, ou que poderá ter sentido e/ou pensado?
- ... o que é que você sentiu naquele momento e acabou por dizer ou fazer a X?
- Você acha que os outros reagem, a você sempre da mesma forma?
- Eu tenho a impressão de que você se comporta desta forma porque secretamente você teme que de outra forma...

Obs: É importante fazer a distinção entre o conflito atual e os padrões repetitivos e disfuncionais (Eixo III). Há discrepâncias entre a autopercepção do narrador e a percepção dos outros que participam da interação? (Eixo IV).

C) Fase de exploração da vivência a respeito dos objetos e dos modos vivenciados e concretos de configurar a vida

- Está relacionada com a fase anterior, mas concentra-se na percepção e vivência dos objetos em diferentes contextos (familiar, laboral, social, amoroso) "aqui e agora" e "lá e então": "poderia me contar de maneira mais específica como vê a x?"; "poderia me explicar melhor como escolheu este trabalho e como se sente hoje em dia com ele?";
- Explorar os conflitos determinantes de sua vida: "Você fez uma boa descrição de sua vida em família, mas ainda sinto falta de uma ideia de como você leva seu trabalho. Você pode me dar uma ideia acerca de como você é no seu trabalho?";
- Em pacientes com baixo nível de integração estrutural é necessário um estilo mais dirigido.

3) Eixo III

a) Pessoas que tendem a negligenciar os conflitos e têm dificuldade no reconhecimento de sentimentos e necessidades delas mesmas e dos outros

- Pode me falar de situações nas quais reagiu de forma emocionalmente intensa?
- Eu tenho a impressão de que a sua vida corre de forma tranquila e sem problemas, sem grandes variações emocionais. É esta a forma como você a vê?
- Alguém já lhe disse que é demasiado racional e/ou que mostra pouco o seu lado emocional?
- Eu tenho a impressão de que você se esforça para eliminar as dificuldades e os problemas rapidamente com outros, em vez de permitir que surjam fortes sentimentos. Como é que você experencia isso?
- Tenho a impressão de que é muito importante para você que as suas relações com os outros sejam as mais harmoniosas possível e sem conflitos. É verdade?
- Você sabe, a partir das suas relações próximas, que tende a assumir o lado mais racional, deixando o mais emocional para os outros?
- Você às vezes fica surpreendido quando os outros reagem de forma insensata, forte, ou emocional?
- Fiquei com a impressão de que você está convencido de que há soluções razoáveis para todos os problemas e dificuldades, independentemente do que sejam. Como é que você experencia isso?

Obs: contratransferência: experencio o paciente como inerte, racional, harmonioso, que enfatiza soluções rápidas? Tendência a racionalizar e harmonizar?

b) **Conflito induzido por estresse:** nível de estresse moderado a severo que podem levar a uma constelação conflitual no sistema motivacional do paciente. O mais importante nessa situação é o significado subjetivo da situação estressante; verificar situação desencadeadora. Passivo: regressivo (relacionado com o próprio paciente) ou ativo: contrafóbico (relacionado com o objeto)

- Ocorreu algum episódio de vida muito estressante na mesma época em que surgiram as queixas?

Obs: os conflitos traumáticos que levam a uma perturbação de TEPT representam o nível mais extremo de estresse. Nesses casos, o estresse mental é tão acentuado (excessivas exigências sobre as funções do ego, capacidades de defesa...) que um conflito motivacional dificilmente consegue se desenvolver, mas em vez disso encontram-se sintomas típicos como intrusão, ausência de sentimentos e dissociação.

c) **Conflito 1:** Individuação x dependência: a relação oscila entre os extremos da ansiedade para uma relação próxima (proximidade simbiótica: dependência) e a luta pela independência explícita (individuação). Medo de solidão e perda de relação e apego e por outro lado, medo de fusão e sentimentos de sufocamento na relação.

- Você é uma pessoa que procura relações muito próximas ou, por outro lado, precisa de espaço e independência?
- De quanta proximidade de contato com outras pessoas você precisa e quanta distância e espaço para si mesmo?
- Consegue desfrutar quando está sozinho? Você sente-se melhor se estiver sozinho? Ou sente-se facilmente solitário quando está sozinho?
- Como você se sente quando está com outras pessoas o tempo todo?
- Como é que se sente durante as mudanças que tendem a acontecer na vida, tais como saída de casa, mudança de emprego, saída de colegas e/ou patrão, separação conjugal, saída dos filhos de casa?
- É mais importante para você ficar com colegas conhecidos e na mesma empresa do que mudar-se e avançar na sua carreira em um grupo diferente de colegas de trabalho ou em uma nova empresa?
- Para você, como é ter de enfrentar doenças em que depende dos outros?
- O fato de pertencer a associações ou outras comunidades sociais fazem você sentir-se bem?
- Você reconhece o sentimento, nos relacionamentos, de que os outros estão muito próximos de você, de que você está muito preso, ou que você está sufocando?
- A partir das suas descrições, eu fiquei com a impressão de que para você é muito importante ter o seu próprio espaço, não ter relações muito próximas e manter a sua independência. Isso é verdade?
- Tal como senti durante a entrevista, você sente-se mais feliz em relações de maior proximidade com os outros. Também vê isso dessa forma?

Diagnóstico diferencial:

- Submissão x controle: o esforço de individuação ou para a dependência tem como objetivo ganhar poder e controle dos outros?
- Necessidade de cuidado x autossuficiência: o esforço para a independência leva o paciente não precisar de nada dos outros e a ser autosuficiente? O esforço para satisfazer a dependência serve para satisfazer as necessidades de cuidado?
- Conflito de autoestima: esforço para a individuação serve para encenar a sua grandiosidade, para evitar ser magoado pelos outros por meio de estabelecimento de uma distância ou para evitar uma dependência prejudicial nos outros? O esforço para a dependência é usado para camuflar sentimentos de baixa autoestima ou compartilhar sua grandeza?
- Conflito edípico: o esforço para a individualização ou para a dependência por meio do estabelecimento de uma proximidade, ou grande distância, é usado para evitar competição e rivalidade? A individuação é uma máscara para esconder uma inabilidade promiscua para estabelecer apego? Como um reconhecimento como homem ou mulher ou para controlar as tendências sexuais?

Obs: o paciente esforça em responder exatamente às questões, há proximidade ou mal-entendidos criando distância entre outros. Contratransferência: o terapeuta sente medo de sufocação/ fusão ou da solidão/ abandono

d) Conflito 2: Submissão x controle: dominância/submissão, poder/desesperança, rigidez, regras, hierarquia, resistência passiva, necessidade de ser correto, complacência

- Quão importante são as regras e os comportamentos ordeiros na sua vida?
- Como você lida com ordens e regras? Gosta/não gosta de se submeter as regras?
- Você prefere definir o tom no contato com os outros?
- Na sua vida, costuma ter problemas com autoridades?
- Você experencia repetidamente diferenças de opiniões com os outros?
- As outras pessoas costumam dizer-lhe que você é inflexível ou que você assume sempre "a linha de menor resistência"?

Diagnóstico diferencial:

- Individuação x dependência: função reguladora para estabelecer proximidade/distância nas relações
- Conflito de autoestima: protege o paciente contra o sofrimento ou para defender a própria autoestima
- Conflito de culpa: acalma/evita ou protege sentimento de culpa.

Obs: o paciente fica irritado, aborrecido ou protesta; gosta de controlar os outros

e) Conflito 3: necessidade de cuidado x autossuficiência: esforço extremo de ser cuidado, busca por segurança ou autossuficiência, altruísmo; cuidar de si mesmo, dar aos outros, defesa contra necessidade de cuidar e desilusão.

- Costuma sentir frequentemente que os outros não cuida de você o suficiente?
- Você é alguém que faz muito pelos outros mas que não reclama nada para si mesmo?
- Consegue pedir ajuda?
- Como é que você lida com o fato de alguém querer fazer algo por você, como cuidar ou cozinhar?
- É importante para você, acima de tudo, estar disponível para os outros, apoiá-los, sem ter em conta as suas necessidades?
- Você desejava ter mais apoio e segurança?
- Acha difícil deixar os outros partirem?

Diagnóstico diferencial:

- Individuação x dependência: é algo sobre obter algo do objeto ou se há objetos, existencialmente?
- Conflito de autoestima: desapontamentos são em decorrência de não conseguir o suficiente, sentimento de perda atual ou sente-se magoado, rejeitado, desvalorizado? O comportamento autossuficiente está sendo usado para se defender e compensar os desejos de ser cuidado pelos outros ou para exibir a própria grandeza e importância?
- Conflito de culpa: as exigências e censuras são usadas para culpar os outros ou elas expressam inveja de outra pessoa, o sentimento de ser tratado injustamente?

Obs: o paciente experencia desejo de ser cuidado ou fica desapontado quando os desejos de cuidar são frustrados?

f) Conflito 4: Conflito de autoestima: autoestima x estima pelo objeto, pode revelar peculiaridades da personalidade narcisista; falha, mágoa, inferioridade, idealização dos outros, grandiosidade própria, desvalorização dos outros

- Você sente-se muitas vezes inferior e malsucedido comparado com os outros?
- Experencia frequentemente situações/pensamentos/sentimentos de que tem vergonha?
- Já alguma vez lhe disseram que você tem uma opinião demasiado alta sobre si mesmo?
- Parece-me que você é uma pessoa particularmente autoconfiante. Existem situações em que você não se sinta tão seguro?
- Costuma sentir que as outras pessoas o admiram?
- Como se sente se for o centro das atenções?
- Existe alguma coisa que o magoe ou o aborreça muito?

Obs: paciente sente-se envergonhado? Parece superfialmente autoconfiante mas na realidade é muito inseguro? Contratransferência: eu sinto necessidade de apoiar ou ridicularizar? Ou de admirar?

Se "tudo" é desestabilizador, é mais provável que se esteja lidando com um problema de estrutura. Se as situações desencadeadoras são específicas, há conflito; se são generalizadas é um problema estrutural.

g) Conflito 5: Conflito de culpa: Culpar-se x culpar os outros. Tomada de responsabilidade excessiva ou transferência da culpa aos outros; autocensura, autoacusação, autojustificação, acusação dos outros

- Parece-me que você tende a procurar culpa/responsabilidade especialmente em si/nos outros por exemplo: no seu trabalho
- Você toma responsabilidade pelo seu parceiro, pelos pais, filhos, quando eles falham ou você pensa que o seu parceiro/pai/filhos são os culpados se você se sentir mal?
- Como é que você sente quando alguém o culpa por ter feito coisas malfeitas? Você defende-se ou aceita a culpa?
- Você é incomodado frequentemente por pensamentos de que você se comportou de forma errada com outras pessoas ou que os outros estavam errados sobre você?
- Você tende a aceitar doenças, negligenciar doenças sérias ou você é "um mau doente" e considera os médicos incapazes de ajudá-lo?

Diagnóstico diferencial:

- Submissão x controle: não que submeter-se ou dominar demasiadamente. As censuras servem para culpar os outros por erros?
- Necessidade de ser cuidado x autossuficiência: não cuida suficiente. Proibição do superego da ganância e inveja
- Conflito de autoestima: ter cometido erros causa sentimentos de vergonha e culpa?
- Conflito edípico: proibições do superego edípico.

h) Conflito 6: Conflito edípico: reconhecimento como homem e mulher, rivalidade x identificação com papéis de gênero; atração física/erótica; competir x concordar

- Poderia dar-me um exemplo da sua relação com os seus pais/irmãos/companheiro/colegas de trabalho/pessoas à sua volta?
- Explique, dando exemplos, o que seu relacionamento é para o seu corpo, erotismo e sexualidade/rivalidade. Como é que você lida com eles? O quanto é capaz de aproveitá-los?
- Pode dar-me exemplos do quanto você se sente realizada (o) como mulher/homem, se sente que atrai a atenção e em que grau você obtem prazer?

- Dê-me um exemplo que me ajude a compreender como é que você lida com a doença e como a enfrenta
- Será que percebi de modo correto que você em geral se experencia como fraco, desinteressante e pouco atraente como mulher/ homem, e que tende timidamente e modestamente a ficar para trás?
- Eu tenho a impressão de que você se esforça muito pela harmonia nas suas relações sociais, em especial na sua relação com os pais/irmãos/parceiro/colegas de trabalho – e por fazê-lo evita algumas tensões e discussões necessárias
- Sinto que você valoriza a segurança e o conforto em uma relação mais do que ser considerado especialmente atraente e desejado como homem/mulher. Você procura com frequência o reconhecimento e a confirmação do ser sexualmente atraente.
- Parece-me que você tende a excluir o erotismo e a sexualidade/rivalidade da sua vida, por exemplo, nas relações sociais, no seu emprego... talvez porque se preocupa em não ser adequadamente reconhecido e desejado como homem/mulher?
- Como é que você se sente no nível do pensamento e como você reage se alguém o deseja seriamente, ou pudesse desejar como homem/mulher?
- Será que compreendi corretamente que é muito importante para você estar emocionalmente próximo a sua mãe ou seu pai e que ainda hoje você compete com os seus irmãos pela posição de favorito?
- Eu tenho a impressão de que a forma e aparência do seu corpo são muito importantes e que você faz muito para cuidar dele, por exemplo, cuidado com o corpo/fitness/cirurgias estéticas, com o objetivo de ser fisicamente atraente e possivelmente superior aos outros.
- Tenho a impressão de que a doença é um acontecimento muito dramático para você e que você deseja toda a atenção e cuidado médico, mas que você fica muitas vezes desapontado pelos especialistas e sente-se incompreendido.

Diagnóstico diferencial:

- Conflito de autoestima: reconhecimento de estima ou de homem/mulher
- Conflito de culpa: culpa generalizada, sentimentos de culpa envolvida com a lealdade
- Conflito de identidade: compensação ou evitamento, não identificação com o papel de gênero

Obs: o paciente apresenta-se como tímido, infantil ou como um Don Juan; omissão ou ênfase no erótico, corpo é negligenciado ou erotizado

i) **Conflito 7: Conflito de identidade:** autorrepresentações contraditórias, dissimulação

- Você sente-se virtualmente dividido entre o seu papel como... e como...?
- Parece-me que existem situações em que as ideias que tem sobre si mesmo entram em conflito tão forte uma com as outras que você não tem certeza do que o caracteriza normalmente como pessoa, se você gosta disto ou daquilo?
- Você reconhece o sentimento de ter ideias em conflito sobre qual carreira ou que estilo de vida se adapta melhor a você?

D) Fase de exploração das vivências pessoais do paciente – Características estruturais (Eixo IV)

- Avaliação da vivência de si mesmo e das áreas vitais vivenciadas e reais;

- Anamnese biográfica: autodescrição, descrição dos objetos, informações sobre as áreas da vida vivenciadas ou concretas (família de origem, família atual, trabalho);
- Esta fase pode ser introduzida da seguinte maneira: "Você se referiu das suas moléstias e relações importantes, mas eu gostaria de compreender um pouco melhor como você se via antes e como se vê agora".

4) Eixo IV: Estrutura

a) Competências cognitivas: autopercepção: competência para formar imagem de si mesmo e dos processos internos relacionados; autorreflexão, identidade

- Você já me falou um pouco sobre si mesmo. Talvez consiga descrever-me uma vez mais, de forma que eu possa ter uma ideia sobre quem você é.
- Consegue descreve para mim como se sentia nessa situação?
- Tenho dificuldade de imaginar esse lado do seu caráter. Pode me falar um pouco mais sobre isso?
- As vezes acontece de você não saber o que está sentindo?
- Consegue refletir sobre si mesmo? Existem situações em que você não consegue fazer isso?
- Você descreveu-se como... e agora como... como é que essas descrições podem coexistir?
- Percebi que você tem dificuldade em autodescrever-se.
- Será que você pede conselhos aos outros porque não sabe o que se passa dentro de si ou o que seria melhor para você?
- A forma como você se descreve a impressão de que você não se conhece.
- Eu tenho a impressão de que você se vê e se apresenta muito diferente em diferentes situações. Você faz isso para se equiparar aos outros?
- Estes sentimentos parecem totalmente insuportáveis para você, tanto que nem quer falar sobre eles comigo.

b) Competências cognitivas: percepção do objeto: competência de formar uma ideia real do outro em uma relação; percepção do objeto como um todo.

- Mencionou repetidas vezes X e Y. Descreve-os de forma que eu tenha uma boa ideia deles?... eles também tem outras qualidades?
- Não consigo imaginar bem esse lado de X e Y, pode dizer-me mais sobre eles?
- Como descreveria X e Y comparando-os consigo?
- Algumas pessoas tem bons conhecimentos sobre a sua natureza humana. Você também tem? Pode dar-me um exemplo?
- No episódio de relação com X e Y que acabou de descrever, fiquei com a impressão de que você não compreendeu bem o que eles queriam. Consegue reconhecer isso?
- Quando descreve X e Y, eu fico com a impressão de que a sua imagem sobre eles muda, dependendo do seu estado emocional. Será que isso é possível?

c) Competência para autocontrole: autorregulação: competência para regular as experiências internas; controle de impulso, tolerância afetiva, regulação de autoestima

- Como é que lida com a pressão quando produzida internamente?
- Consegue descrever para mim uma situação em que tenha tido dificuldade em lidar com sentimentos intensos? Que sentimentos eram esses, e como lidou com eles?

- Está familiarizado com a sua mudança repentina de humor?
- Como é que você lida quando é magoado por alguém?
- Gostaria de ser mais espontâneo?
- As vezes tem o sentimento de que todas as pessoas estão contra você?
- Algumas pessoas são capazes de se acalmarem internamente como, por exemplo, em situações embaraçosas. Como é com você? Leva muito tempo até conseguir ficar tranquilo outra vez?
- Tenho a impressão de que você está tão inundado de sentimentos que tudo o que você faz é manter-se com a cabeça fora d'água.
- As vezes você foge de mim para que eu não lhe pergunte sobre isso.
- Agora fiquei surpreendido com a sua reação intensa, uma vez que não deu qualquer indicação em momento anterior de como isto o irritava.
- Estou com a sensação de que se sentiu magoado com o que eu disse a pouco. Será que a minha impressão está correta?
- Será que reagiu de forma tão impulsiva nesta situação porque não conseguia tolerar mais os seus sentimentos?
- Tenho a impressão de que você não tolera bem esse sentimento. Vamos pensar em conjunto sobre o que é tão difícil de tolerar neste sentimento.
- Se você se altera por qualquer coisa ou experiência sentimentos fortes, pode levar algum tempo até conseguir se acalmar outra vez?
- Às vezes se sente tão magoado que suspende o contato com a pessoa que fez sentir-se assim?

d) Competência para autocontrole: regulação da relação com o objeto: competência de proteger a relação dos seus impulsos pessoais enquanto salvaguarda os seus interesses pessoais; proteção da relação, equilíbrio de interesses, antecipação.

- Como é que se comporta se estiver perante um conflito de interesses com alguém?
- Tem dificuldade em imaginar como é que outra pessoa qualquer poderá reagir com você?
- Como é que você reage se alguém o aborrece muito?
- Por vezes existem situações na vida em que temos que fazer opções que são difíceis. Como são para você estas situações?
- Tenho a impressão de que as vezes você está tão sobrecarregado com os sentimentos que não consegue afastá-los da sua relação com X.
- Parece que as vezes você tem que se controlar para não se ver acidentalmente mais uma vez nas mesmas situações.
- Você sente que lhe foi feita alguma injustiça. Mas a forma como relata parece que o seu parceiro reagiu de forma tão violenta porque você foi muito agressiva com ele. O que você acha?
- Parece que você não está falando de si mesmo porque tenta não ser um fardo para os outros.
- Podemos imaginar que as vezes fazem-se acordos que todos perdem e ganham um pouco. Alguma vez já experenciou isso?
- Pode acontecer que, se alguém lhe faz uma exigência, você rapidamente sente que não há lugar para os seus direitos?

Obs: medo de errar, de fazer escolhas, paciente é exigente, se recuar, o mundo é hostil.

e) **Competência emocional: comunicação interna:** capacidade de ter diálogos internos e de entender a si mesmo. Experenciar afetos, usar fantasias, *self* corporal.

- Lembra-se dos seus sonhos?
- É fácil você perceber o que ocorre dentro de você?
- Você acha que conhece bem as suas próprias necessidades?
- As vezes consegue-se ajudar a partir de imagens internas que lhe indicam o que fazer?
- Sente-se enriquecido e realizado pelos seus sentimentos ou, pelo contrário, um pouco irritado ou limitado por eles?
- Como experencia o seu corpo?
- O seu corpo e a forma como se sente acerca do seu corpo têm um papel importante por você?
- A partir daquilo que me disse antes, fiquei com a impressão de que você não percebe realmente por que é que se comporta dessa forma.
- A forma como descreve isso é como se não se sentisse confortável no seu corpo, mas de alguma forma bastante tenso dentro dele.
- Tenho a impressão de que faz muito exercício físico, especialmente quando sente que preferia chorar.
- Tenho a impressão de que você afasta as suas fantasias e os seus sonhos.

Obs: paciente sente inundado pelos seus sentimentos, parece não habitar seu corpo, comporta-se de maneira inapropriada em relação ao seu corpo, evita sentimentos.

f) **Competência emocional: comunicação com o objeto externo:** competência para se envolver em uma troca emocional com outra pessoa; contato, comunicação de afeto, empatia.

- Acha difícil estabelecer contato com outros?
- Consegue imaginar o que a outra pessoa está sentindo em um momento particular?
- Tem dificuldade de expressar os seus sentimentos?
- Você falou sobre isso, mas ainda assim eu não consegui ficar com uma ideia clara de como se sentiu nesse momento.
- Tenho a impressão de que as vezes você se sente incompreendido.
- Tenho a impressão de que você foge da conversa quando você se sente muito pressionado internamente.
- Talvez você evita falar sobre sentimentos para não se sentir rejeitado.
- No seu trabalho, sente-se muitas vezes excluído ou rejeitado. Ao mesmo tempo parece que aprecia a sua posição de excluído, por que aprecia a sua posição de excluído, porque dessa forma não se sente tão pressionado pelas exigências dos outros.

Obs: paciente não parece envolvido, contato é difícil, não há interesse em empatizar com outros.

g) **Capacidade para formar vínculos: objetos internos:** capacidade para desenvolver imagens internas de pessoas importantes, de investi-las com afetos positivos, mantê-las e fazer-se valer delas quando precisar. Internalização, usar introjeções, variabilidade de vínculos.

- Como você lida com uma situação de estresse?

- O que faz quando enfrenta dificuldades? Consegue lembrar-se então o que alguém próximo de você lhe sugeriu?
- Já percebeu que nos seus relacionamentos os mesmos problemas continuam a surgir?
- Como se sente quando está sozinho?
- Existe a capacidade de lembrar-se de boas experiências precoces ou pessoas amadas. Você tem essa capacidade?
- Nessa situação particular assumiu que X teve sentimentos hostis em relação a você. Contudo, mais tarde percebeu-se que não era o caso. Quais os seus pensamentos hoje sobre isso?
- Tenho a impressão de que as vezes você se sente abandonado.
- Do que me disse, parece tratar a si mesmo de forma negligenciada e que negligencia os seus próprios interesses, tal como viveu no passado com os seus pais.

Obs: paciente parece perdido quando perde o apoio externo, assume postura defensiva.

h) **Capacidade para formar vínculos: objetos externos:** capacidade do sujeito de se vincular emocionalmente a outras pessoas em relação reais e depois desvincular-se delas outra vez. Capacidade de estabelecer vínculos, aceitação de ajuda, corte de vínculos.

- Sente facilidade em estabelecer vínculos?
- Como costuma viver as separações?
- Alguma vez já lhe aconteceu de não conseguir romper um relacionamento?
- É capaz de estabelecer relações de proximidade ou costuma falhar muitas vezes?
- É capaz de pedir ajuda aos outros quando está perante situações difíceis?
- Algumas pessoas conseguem relacionar-se bem com os outros, enquanto outras pessoas sentem dificuldade. A que grupo você pertence?
- Parece que você tem que deixar uma relação sempre que existem conflitos, porque não consegue lidar com um conflito.
- Percebi que você evita quaisquer sentimentos depois de uma separação, da mesma forma que não lhes era permitido falar sobre as coisas com a sua mãe após o divórcio com o seu pai.
- Parece-me que você tem que evitar relacionamentos íntimos as vezes porque, caso contrário, corre o risco de se perder?

ANEXO C – PLANILHA DE AVALIAÇÃO

Diagnóstico Psicodinâmico Operacionalizado 2
Formulários de avaliação de dados (KRIEGER, 2013)

Eixo I – Vivência da doença e pré-requisitos para o tratamento

	Eixo I – Vivência da doença e pré-requisitos para o tratamento Módulo Básico	**Nada/ Raramente presente**		**Moderado**		**Elevado**	**Não classificável**
		⓪	①	②	③	④	⑨

Avaliação objetiva da doença/problema

1. Gravidade atual da doença/problema						
1.1. Gravidade dos sintomas	⓪	①	②	③	④	⑨
1.2. GAF: máximo nos últimos 7 dias ➔ _____						⑨
1.3. EQ-5D: _____ Valores dos itens ➔	1.___	2.___	3.___	4.___	5.___	⑨
2. Duração da doença/problema						
2.1. Duração da doença	< 6 Meses	6-24 Meses	2-5 anos	5-10 anos	> 10 anos	⑨
2.2. Idade na primeira manifestação da doença	Em anos ➔ ____					⑨

Vivência, forma de apresentação e conceptualização da doença por parte do paciente

3. Vivência e forma de apresentação da doença						
3.1. Sofrimento subjetivo	⓪	①	②	③	④	⑨
3.2. Presença de problemas e queixas físicas	⓪	①	②	③	④	⑨
3.3. Presença de problemas e queixas psicológicos	⓪	①	②	③	④	⑨
3.4 Presença de problemas sociais	⓪	①	②	③	④	⑨
4. Conceptualização o da doença por parte do paciente						
4.1. Concepção da doença baseada em fatores somáticos	⓪	①	②	③	④	⑨
4.2 Concepção da doença baseada em fatores psicológicos	⓪	①	②	③	④	⑨
4.3. Concepção da doença baseada em fatores sociais	⓪	①	②	③	④	⑨
5. Conceptualização da mudança por parte do paciente						
5.1. tipo de tratamento desejado: físico/médico	⓪	①	②	③	④	⑨
5.2. tipo de tratamento desejado: psicoterapêutico	⓪	①	②	③	④	⑨
5.3. tipo de tratamento desejado: apoio social	⓪	①	②	③	④	⑨

Recursos e resistência à mudança

6. Recursos para a mudança (últimos 6 meses)						
6.1. Recursos pessoais	⓪	①	②	③	④	⑨
6.2. Apoio (Psico)Social	⓪	①	②	③	④	⑨

Resistência à mudança

7. Resistências à mudança						
7.1. Resistências externas à mudança	⓪	①	②	③	④	⑨
7.2. Resistências internos à mudança	⓪	①	②	③	④	⑨

Eixo I - Módulo Psicoterapêutico (Opcional)

	Módulo Psicoterapêutico (Opcional)	**Nada/ Raramente presente**		**Moderado**		**Elevado**	**Não classificável**
	(opcional)	⓪	①	②	③	④	⑨

Vivência, formas de apresentação e conceptualização da doença por parte do paciente

5. Concepção da mudança por parte do paciente						
5.P1. Redução de sintomas	⓪	①	②	③	④	⑨
5.P2. Predisposição para a clarificação e reflexão dos problemas/conflitos	⓪	①	②	③	④	⑨
5.P3. Intervenção de suporte emocional	⓪	①	②	③	④	⑨
5.P4. Intervenção directiva	⓪	①	②	③	④	⑨

Recursos e Resistências à mudança

6. Recursos para a mudança						
6.P1. Capacidade introspectiva	⓪	①	②	③	④	⑨
7. Resistências à mudança						
7.P1. Ganhos secundários com a doença / condições que mantêm o problema	⓪	①	②	③	④	⑨

Eixo II – Relações Interpessoais

Perspectiva A: Vivência por parte do paciente	
O paciente percepciona-se a si próprio como...	O paciente percepciona os outros como...
Ítem Nº. *Texto*	*Ítem Nº.* *Texto*

1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Perspectiva B: A percepção dos outros (incluindo a do investigador)	
Os outros percepcionam o paciente como...	Os outros percepcionam-se a si próprio como...
Ítem Nº. Texto	*Ítem Nº. Texto*
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Eixo III – Conflito

Questões preliminares que permitam ao terapeuta classificar o conflito:

A) Os conflitos não podem ser classificados por falta de segurança diagnóstica.	sim =①	não=⓪
B) Devido a um baixo nível de integração estrutural, não se reconhece um padrão distinto conflitual, mas antes padrões conflituais ténues.	sim=①	não=⓪
C) Uma vez que a percepção dos conflitos e dos afetos está condicionada por questões defensivas, o eixo do conflito não pode ser classificado.	sim =①	não=⓪
D) Stress conflitual (conflito indutor de stress) sem nenhum padrão conflitual e disfuncional repetitivo.	sim =①	não=⓪

Conflitos disfuncionais repetitivos

Conflitos disfuncionais repetitivos	**Ausente**	**Insignificante**	**Significa-tivo**	**Muito significativo**	**Não classificável**
1. Individuação versus Dependência	⓪	①	②	③	⑨
2. Submissão versus Controle	⓪	①	②	③	⑨
3. Necessidade de ser cuidado versus auto-suficiência	⓪	①	②	③	⑨
4. Conflito de Auto-estima	⓪	①	②	③	⑨
5. Conflito de culpa	⓪	①	②	③	⑨
6. Conflito edipiano	⓪	①	②	③	⑨
7. Conflito de identidade	⓪	①	②	③	⑨

Conflito principal: _____ Seguido de (por ordem de importância):

_____

Modo como o conflito principal se processa	**Predominantemente activo**	**Misto mas activo**	**Misto mas pasivo**	**Predominantemente pasivo**	**Não classificável**

	①	②	③	④	⑨

Eixo IV – Estrutura

	Nivel Alto	**1,5**	**Nivel Medio**	**2,5**	**Nivel Baixo**	**3,5**	**Nivel desinte-grado**	**Não classifi cável**
1a Auto-percepção	①		②		③		④	⑨
1b Percepção do objeto	①		②		③		④	⑨
2a Auto-regulação	①		②		③		④	⑨
2b Regulação da relação objetal	①		②		③		④	⑨
3a Comunicação Interna	①		②		③		④	⑨
3b Comunicação com o mundo externo	①		②		③		④	⑨
4a Capacidade de vinculação: objetos internos	①		②		③		④	⑨
4b Capacidade de vinculação: objetos ernos	①		②		③		④	⑨
5 Estrutura total	①		②		③		④	⑨

Eixo V – Transtornos mentais e psicossomáticos

Va: transtornos mentais:	**CID-10** (criterios de investigación)	**DSM-IV** (opcional)
Diagnóstico principal:	**F _____. _____**	**_____. ____**
Diagnóstico adicional 1:	**F _____. _____**	**_____. ____**
Diagnóstico adicional 2:	**F _____. _____**	**_____. ____**
Diagnóstico adicional 3:	**F _____. _____**	**_____. ____**

Vb: transtornos de personalidade:	**CID-10** (F60xx o F61.x)	**DSM-IV** (opcional)
Diagnóstico principal:	**F _____. _____**	**_____. ____**
Diagnóstico adicional 1:	**F _____. _____**	**_____. ____**

Para o diagnóstico dos eixos Va e Vb: **Que transtorno é clinicamente predominante?**	**①=Eixo Va** **②=Eixo Vb**

ANEXO D – PLANILHA DE AVALIAÇÃO – EIXO I: VIOLÊNCIA

Avaliação das características da violência doméstica por parte do clínico

1.- Tipo e severidade da violência

Emocional	⓪	①	②	③	④	⑨
Física	⓪	①	②	③	④	⑨
Sexual	⓪	①	②	③	④	⑨
Índice de severidade global	⓪	①	②	③	④	⑨

2. Duração da situação de violência doméstica						
2.1. Duração da violência do parceiro	< 6 Meses	6-24 Meses	2-5 anos	5-10 anos	> 10 anos	⑨
2.2. Idade do primeiro episódio	Em anos ➔ ____					⑨

3.- Vivência subjetiva do problema por parte da paciente

3.1- Intensidade do sofrimento subjetivo	⓪	①	②	③	④	⑨
3.2.- Apresentação de queixas sobre violência doméstica	⓪	①	②	③	④	⑨

4- Conceito pessoal da violência doméstica

4.1.-Orientada para fatores externos	⓪	①	②	③	④	⑨
4.2.- Orientada para fatores psicológicos	⓪	①	②	③	④	⑨

5. – Conceito de mudança

5.1.- Orientado para mudanças ou medidas externas	⓪	①	②	③	④	⑨
5.2.- Orientado para aspectos pessoais	⓪	①	②	③	④	⑨

6 – Mudanças: recursos e obstáculos

6.1.- Recursos internos	⓪	①	②	③	④	⑨
6.2.- Obstáculos internos	⓪	①	②	③	④	⑨
6.3.-Recursos externos	⓪	①	②	③	④	⑨
6.4.- Obstáculos externos	⓪	①	②	③	④	⑨

ANEXO E – PLANEJAMENTO E FOCO TERAPÊUTICOS

Elección del Foco Terapéutico

Código del paciente:_____ Sexo: F M Edad:_____
Fecha:_____

Relación siempre representa un foco.
Por favor elija cuatro focos adicionales de "Conflicto" y/o "Estructura".

Foco de la relación

Describir la formulación dinámica relacional:

Describa por favor,	
... cómo el paciente vivencia repetidamente a los otros ↓	
... cómo reacciona él respecto a eso: ↓	
... qué tipo de oferta relacional (inconsciente) le hace a otros con su reacción ↓	
... qué tipo de respuesta induce inconscientemente en otros: ↓	
... qué vivencia el paciente cuando los otros responden a lo inducido por él	

Foco del conflicto

C1. Individuación versus dependencia	C3. Deseo de protección y cuidado versus autarquía	C5. Conflicto de culpa
C2. Sumisión versus control	C4. Autovaloración	C6. Conflicto edípico
C7. Conflicto de identidad		

Foco de la estructura

Percepción de sí mismo	**Percepción del objeto**
ES1.1 Autorreflexión ES1.2 Diferenciación afectiva ES1.3 Identidad	ES1.4 Diferenciación *self*-objeto ES1.5 Percepción de objeto total ES1.6 Percepción realista del objeto
Autorregulación	**Regulación de la relación con el objeto**
ES 2.1 Manejo de impulso	ES2.4 Protección de las relaciones

ES 2.2 Tolerancia afectiva ES 2.3 Regulación de la autoestima	ES2.5 Regulación de los intereses ES2.6 Anticipación
Comunicación hacia adentro	**Comunicación hacia afuera**
ES3.1 Vivencia de los afectos ES3.2 Uso de la fantasía ES3.3 *Self* corporal	ES3.4 Establecer contacto ES3.5 Comunicación de los afectos ES3.6 Empatía
Vínculo con objetos internos	**Vínculo con objetos externos**
ES4.1 Internalización ES4.2 Uso de los introyectos ES4.3 Variedad de los vínculos	ES4.4 Capacidad de vincularse ES4.5 Aceptar ayuda ES4.6 Desprenderse de vínculos, separarse

Elección de 3 - 4 Focos

	Número (p. ej. C2 o ES3.1)	**Breve descripción**
Relación		
Conflicto o estructura		
Conflicto o estructura		
Conflicto o estructura		
Conflicto o estructura		

La psicoterapia en este paciente estará orientada a...

	Claramente	**Preferentemente**	**Mixta**	**Preferentemente**	**Claramente**	
Estructura						**Conflicto**

ANEXO F – APRESENTAÇÃO DAS DIMENSÕES E INDICADORES DO OPD-2

Presentación resumida de cada eje y sus indicadores: OPD-2

(PÉREZ, ALVARADO, PARRA, DAGNINO, 2009)

Ejes	Dimensiones	Indicadores
I. Experiencia de enfermedad y prerrequisitos de tratamiento	Evaluación objetiva de la enfermedad/del problema	1. Gravedad actual de la enfermedad/del problema 2. Duración de la enfermedad/ del problema
	Experiencia de enfermedad-concepción y definiciones del paciente	3. Experiencia de enfermedad y descripción 4. Modelo explicativo de enfermedad del paciente 5. Concepto de cambio del paciente
	Recursos para el cambio/Obstáculos para el cambio	6. Recursos para el cambio 7. Obstáculos para el cambio
	(módulo psicoterapia) Experiencia de enfermedad-descripción y conceptos del paciente	5. Concepto de cambio del paciente
	Recursos para el cambio/Obstáculos para el cambio	6. Recursos para el cambio 7. Obstáculos para el cambio
II. Relación	Perspectiva A: Vivencia del paciente	El paciente se vivencia a sí mismo El paciente vivencia a otros
	Perspectiva B: Vivencia de los otros (también del evaluador)	Otros vivencian al paciente Otros se vivencian a sí mismos
III. Conflicto	Conflicto disfuncional repetitivo	1. Dependencia *vs* individuación 2. Sumisión *vs* control 3. Deseo de ser cuidado *vs* autosuficiencia 4. Conflictos de autovaloración 5. Conflictos de culpa 6. Conflicto edípico 7. Conflictos de identidad
	Modo de elaboración	1. Predominantemente activo 2. Mixto, preferentemente activo 3. Mixto, preferentemente pasivo 4. Predominantemente pasico 5. No evaluable
IV. Estructura	Capacidades cognitivas	1a Percepción de sí mismo 1b Percepción del objeto
	Capacidad de manejo	2a Autorregulación 2b Regulación de la relación con el objeto
	Capacidad emocional	3a Comunicación hacia adentro 3b Comunicación hacia afuera
	Capacidad de vínculo	4a Vínculo con objetos internos 4b Vínculo con objetos externos
V. Trastornos psíquicos y psicosomáticos	Trastornos psíquicos	Diagnóstico principal/ Otro diagnóstico
	Trastornos de personalidad	Diagnóstico principal/ Otro diagnóstico
	Enfermedades somáticas	Diagnóstico principal/ Otro diagnóstico

ANEXO G – DSQ-40 - VERSÃO EM PORTUGUÊS DO DEFENSE STYLE QUESTIONNAIRE

Esse questionário consiste de 40 afirmativas relacionadas à como você pensa e funciona em sua vida. Não há questão certa ou errada. Marque o grau em relação ao qual você concorda ou discorda de cada afirmativa, e assinale sua resposta de 1 a 9. Por exemplo, um escore de 5, significaria que você nem concorda nem discorda da afirmativa, um escore de 3 indicaria que você discorda moderadamente, e um de 9, que você concorda fortemente.

	Discordo Plenamente								**Concordo Plenamente**
1. Eu fico satisfeito em ajudar os outros e, se eu não puder fazer isso, eu fico deprimido.	1	2	3	4	5	6	7	8	9
2. Eu consigo não me preocupar com um problema até que eu tenha tempo para lidar com ele.	1	2	3	4	5	6	7	8	9
3. Eu alivio a minha ansiedade fazendo coisas construtivas e criativas, como pintura ou trabalho em madeira.	1	2	3	4	5	6	7	8	9
4. Eu sou capaz de achar bons motivos para tudo que eu faço.	1	2	3	4	5	6	7	8	9
5. Eu sou capaz de rir de mim mesmo com bastante facilidade.	1	2	3	4	5	6	7	8	9
6. As pessoas tendem a me tratar mal.	1	2	3	4	5	6	7	8	9
7. Se alguém me assalta e rouba o meu dinheiro, eu prefiro que essa pessoa seja ajudada ao invés de punida.	1	2	3	4	5	6	7	8	9
8. As pessoas dizem que eu costumo ignorar os fatos desagradáveis como se eles não existissem.	1	2	3	4	5	6	7	8	9
9. Eu costumo ignorar o perigo como se eu fosse o Super-homem.	1	2	3	4	5	6	7	8	9
10. Eu me orgulho da minha capacidade de reduzir as pessoas aos seus devidos lugares.	1	2	3	4	5	6	7	8	9
11. Eu frequentemente ajo impulsivamente quando alguma coisa está me incomodando.	1	2	3	4	5	6	7	8	9
12. Eu fico fisicamente doente quando as coisas não estão indo bem para mim.	1	2	3	4	5	6	7	8	9
13. Eu sou uma pessoa muito inibida.	1	2	3	4	5	6	7	8	9
14. Eu fico mais satisfeito com minhas fantasias do que com a minha vida real.	1	2	3	4	5	6	7	8	9
15. Eu tenho qualidades especiais que me permitem levar a vida sem problemas.	1	2	3	4	5	6	7	8	9
16. Há sempre boas razões quando as coisas não dão certo para mim.	1	2	3	4	5	6	7	8	9
17. Eu resolvo mais as coisas sonhando acordado do que na vida real.	1	2	3	4	5	6	7	8	9
18. Eu não tenho medo de nada.	1	2	3	4	5	6	7	8	9

	Discordo Plenamente								Concordo Plenamente
19. Às vezes, eu acho que sou um anjo e, outras vezes, acho que sou um demônio.	1	2	3	4	5	6	7	8	9
20. Eu fico francamente agressivo quando me sinto magoado.	1	2	3	4	5	6	7	8	9
21. Eu sempre acho que alguém que eu conheço é como um anjo da guarda.	1	2	3	4	5	6	7	8	9
22. Tanto quanto eu sei, ou as pessoas são boas ou más.	1	2	3	4	5	6	7	8	9
23. Se o meu chefe me repreendesse, eu poderia cometer um erro ou trabalhar mais devagar só para me vingar dele.	1	2	3	4	5	6	7	8	9
24. Eu conheço alguém que é capaz de fazer qualquer coisa e é absolutamente justo e imparcial.	1	2	3	4	5	6	7	8	9
25. Eu posso controlar os meus sentimentos se eles interferirem no que eu estiver fazendo.	1	2	3	4	5	6	7	8	9
26. Eu frequentemente sou capaz de ver o lado engraçado de uma situação apesar de ela ser desagradável.	1	2	3	4	5	6	7	8	9
27. Eu sinto dor de cabeça quando tenho que fazer algo de que não gosto.	1	2	3	4	5	6	7	8	9
28. Eu frequentemente me vejo sendo muito simpático com pessoas com quem, pelo certo, eu deveria estar muito bravo.	1	2	3	4	5	6	7	8	9
29. Eu tenho certeza de que a vida é injusta comigo.	1	2	3	4	5	6	7	8	9
30. Quando eu sei que vou ter que enfrentar uma situação difícil, eu tento imaginar como isso será e planejo um jeito de lidar com a situação.	1	2	3	4	5	6	7	8	9
31. Os médicos nunca realmente entendem o que há de errado comigo.	1	2	3	4	5	6	7	8	9
32. Depois de lutar pelos meus direitos, eu tenho a tendência de me desculpar por ter sido tão firme.	1	2	3	4	5	6	7	8	9
33. Quando estou deprimido ou ansioso, comer faz com que eu me sinta melhor.	1	2	3	4	5	6	7	8	9
34. Frequentemente me dizem que eu não mostro os meus sentimentos.	1	2	3	4	5	6	7	8	9
35. Se eu puder prever que vou ficar triste mais adiante, eu poderei lidar melhor com a situação.	1	2	3	4	5	6	7	8	9
36. Não importa o quanto eu reclame, eu nunca consigo uma resposta satisfatória.	1	2	3	4	5	6	7	8	9
37. Frequentemente eu me dou conta de que eu não sinto nada em situações que deveriam me despertar fortes emoções.	1	2	3	4	5	6	7	8	9
38. Manter-me muito ocupado evita que eu me sinta deprimido ou ansioso.	1	2	3	4	5	6	7	8	9
39. Se eu estivesse passando por uma crise, eu me aproximaria de pessoas que tivessem o mesmo problema.	1	2	3	4	5	6	7	8	9
40. Se eu tenho um pensamento agressivo, eu sinto a necessidade de fazer algo para compensá-lo.	1	2	3	4	5	6	7	8	9

ANEXO H – COMITÊ DE ÉTICA

UFRGS - PRÓ-REITORIA DE PESQUISA DA UNIVERSIDADE FEDERAL DO RIO GRANDE DO

PARECER CONSUBSTANCIADO DO CEP

DADOS DO PROJETO DE PESQUISA

Título da Pesquisa: FUNCIONAMENTO PSICODINÂMICO DE MULHERES VÍTIMAS DE VIOLÊNCIA DOMÉSTICA SOB UMA PERSPECTIVA DO DIAGNÓSTICO OPERACIONALIZADO PSICODINÂMICO (OPD-2

Pesquisador: LUCIA HELENA FREITAS CEITLIN

Área Temática:

Versão: 2

CAAE: 68271917.7.0000.5347

Instituição Proponente: Universidade Federal do Rio Grande do Sul

Patrocinador Principal: Universidade Federal do Rio Grande do Sul

DADOS DO PARECER

Número do Parecer: 2.288.488

Apresentação do Projeto:

O Diagnóstico Operacionalizado Psicodinâmico (OPD), hoje na segunda versão, é um instrumento avaliativo e de planejamento terapêutico criado em decorrência do esforço científico na operacionalização de um diagnóstico psicodinâmico. Recentemente foi adaptado para o contexto da violência doméstica. A violência pode provocar traumas que afetam consideravelmente o funcionamento do sujeito. Para isso, objetiva-se investigar as características do funcionamento psicodinâmico de mulheres vítimas de violência doméstica, sob uma perspectiva dimensional operacionalizada.

Assim, o projeto será composto por três estudos:

i)tradução e adaptação cultural do Eixo I; ii)estudo exploratório e iii)estudo de caso sistemático.

Objetivo da Pesquisa:

Trata-se de um estudo que pretende investigar as características do funcionamento psicodinâmico de mulheres vítimas de violência doméstica, sob uma perspectiva dimensional operacionalizada.

Avaliação dos Riscos e Benefícios:

Os autores referem que o tema em questão é bastante delicado para as pacientes, podendo haver, durante a coleta de dados, mobilizações ou algum desconforto; assim, será oferecido um espaço

Endereço: Av. Paulo Gama, 110 - Sala 317 do Prédio Anexo 1 da Reitoria - Campus Centro
Bairro: Farroupilha **CEP:** 90.040-060
UF: RS **Município:** PORTO ALEGRE
Telefone: (51)3308-3738 **Fax:** (51)3308-4085 **E-mail:** etica@propesq.ufrgs.br

de escuta e acolhimento pelas entrevistadoras. Também, neste caso, será frisado à paciente a necessidade de acompanhamento psiquiátrico e/ou psicológico, pois são mulheres oriundas do ambulatório que já possuem encaminhamento para atendimento.

Em relação ao instrumento, será solicitada a autorização para a utilização do Operationalized Psychodynamic Diagnosis no Brasil ao presidente do OPD Group, Dr. Manfred Cierpka e da Carla Crempien Robles que realizou a adaptação do Eixo I para avaliar as mulheres que sofreram violência doméstica. Será solicitado a autorização para tradução e adaptação cultural à Carla Robles, em que já foi realizado um contato inicial com a respectiva autora; já que o treinamento da pesquisadora ao OPD-2 foi realizado com a equipe constituída por ela. Assim como, haverá auxílio do grupo de pesquisa do Chile para esclarecimento de possíveis dúvidas.

Benefícios:

Promoção mais clara do funcionamento psicodinâmico das mulheres vitimas de violência doméstica, para melhor intervenção.

Comentários e Considerações sobre a Pesquisa:

Trata-se de estudo de adaptação e validação de instrumento, cujos princípios norteadores da ética em pesquisa com seres humanos estão contemplados.

Considerações sobre os Termos de apresentação obrigatória:

OS termos obrigatórios estão presentes e em conformidade com a resolução 466/12.

Conclusões ou Pendências e Lista de Inadequações:

Projeto em conformidade com a normativa vigente em relação aos aspectos éticos em pesquisa com seres humanos.

Considerações Finais a critério do CEP:

Aprovado.

Este parecer foi elaborado baseado nos documentos abaixo relacionados:

Tipo Documento	Arquivo	Postagem	Autor	Situação
Informações Básicas do Projeto	PB_INFORMAÇÕES_BÁSICAS_DO_PROJETO_872583.pdf	23/06/2017 16:30:05		Aceito
Projeto Detalhado / Brochura Investigador	Projeto_Doutorado_Final.pdf	23/06/2017 16:29:30	LUCIANE MARIA BOTH	Aceito
TCLE / Termos de Assentimento /	TCLE_Alterado.pdf	23/06/2017 16:21:36	LUCIANE MARIA BOTH	Aceito

Justificativa de Ausência	TCLE_Alterado.pdf	23/06/2017 16:21:36	LUCIANE MARIA BOTH	Aceito
Cronograma	Cronograma_Alterado.pdf	23/06/2017 16:20:21	LUCIANE MARIA BOTH	Aceito
Folha de Rosto	Folha_de_rosto_Lucia_Helena.pdf	11/05/2017 19:46:00	LUCIANE MARIA BOTH	Aceito

Situação do Parecer:
Aprovado

Necessita Apreciação da CONEP:
Não

PORTO ALEGRE, 21 de Setembro de 2017

Assinado por:
MARIA DA GRAÇA CORSO DA MOTTA
(Coordenador)

ANEXO I – CARTA DE ANUÊNCIA

Estado do Rio Grande do Sul
Secretaria da Justiça e da Segurança
Departamento Médico Legal

Declaração de Autorização para realização de Pesquisa Acadêmica

Autorizo o desenvolvimento do projeto de pesquisa intitulado "FUNCIONAMENTO PSICODINÃMICO DE PACIENTES VÍTIMAS DE TRAUMA SOB PERSPECTIVA DO DIAGNÓSTICO OPERACIONALIZADO PSICODINÂMICO (OPD-2)" no DML de Porto Alegre. A pesquisa será realizada sob a responsabilidade das pesquisadoras Lúcia Helena de Freitas e Luciane Maria Both, da Universidade Federal do Rio grande do Sul.

Dr. Marcelo Oliveira Ferreira
Perito Médico Legista
Seção de Ensino e Pesquisa
Departamento Médico Legal de Porto Alegre/ Instituto Geral de Perícias

Porto Alegre, 08 de novembro de 2017.