

## Efficacy of a group intervention program with women victims of gender violence in the framework of contextual therapies

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**Título:** Eficacia de un programa de intervención grupal con mujeres víctimas de violencia de género en el marco de las terapias contextuales.

**Resumen:** El objetivo de este trabajo es evaluar empíricamente la eficacia de un programa de intervención con mujeres víctimas de violencia de género. El programa en conjunto se enmarca dentro de las Terapias Contextuales, específicamente se ha utilizado la Psicoterapia Analítica Funcional, combinada con la Terapia de Aceptación y Compromiso y la Activación Conductual. Se ha llevado a cabo en formato grupal, durante 11 sesiones de 2 horas cada una. Participaron un total de 21 mujeres (de una media de edad de 45 años), que habían sufrido violencia física y/o abuso emocional por parte de sus parejas, en diferente grado e intensidad, y en diferentes momentos en sus vidas. Se ha utilizado un diseño intragrupo con medidas pre-post. Se realizaron tres grupos de tratamiento en diferentes ciudades con 6 a 8 mujeres cada uno. Para medir la intervención se ha aplicado el cuestionario *Clinical Outcomes in Routine Evaluation-Outcome Measure* (CORE-OM). Los resultados han mostrado una disminución estadísticamente significativa en la severidad del malestar, han disminuido los indicadores de riesgo de suicidio, y han mejorado las conductas problemáticas dentro y fuera de las sesiones, además de incrementarse la apertura hacia los demás. Se discute la utilidad de las terapias contextuales para mejorar la calidad de vida de mujeres maltratadas, y su utilidad de aplicación en grupos en las instituciones públicas.

**Palabras clave:** mujeres maltratadas, violencia de género, terapias contextuales, intervención en grupo.

**Abstract:** The goal of this study was to empirically evaluate the efficacy of an intervention programme with women victims of gender violence. Specifically, Functional Analytic Psychotherapy (FAP) has been used, combined with Acceptance and Commitment Therapy (ACT), and Behavioural Activation (BA). This study was undertaken in an intragroup format, during 11 sessions of 2 hours each session. A total of 21 women participated (with an average age of 45 years), who had suffered physical violence and/or emotional abuse by their partners, with different degrees and intensity, and at different periods in their lives. An intra-group design with pre-post measures was used. Three treatment groups were effected in different cities with 6 to 8 women in each city. To measure the intervention, the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) questionnaire was applied. The results show a statistically significant decrease in the severity of discomfort, decreased suicide risk indicators, improved problem behaviour both inside and outside of the sessions, and increased openness to others. The usefulness of contextual therapies in improving the quality of life of battered women and the usefulness of those therapies for application in groups in public institutions are discussed.

**Keywords:** battered women; gender violence; contextual therapies; group intervention.

### Introduction

The World Health Organization published a report, which reveals that Gender Violence (GV) is a serious physical and psychological health problem that has reached epidemic proportions and affects 30% of women worldwide (WHO, 2013). Further, the United Nations General Assembly (UNGA) explicitly recognises the GV that is directed against women as a violation of human rights and fundamental freedoms (UN, 1994).

Ample empirical evidence exists in the body of literature regarding the devastating effects of the ill-treatment of women, with a consensus of opinion among authors regarding the probability of developing Post-Traumatic Stress Disorder (PTSD) (Echeburúa & Corral, 1998; Hegarty et al., 2013; Walker, 1979, 2012) and other psychological problems such as: anxiety and depression (Bermúdez, Matud & Navarro, 2009; Echeburúa & Corral, 1998; Echeburúa, Coral, Amor, Sarasua & Zubizarreta, 1997; Hegarty et al., 2013). Other side effects have also been described: loss of self-

esteem, feelings of guilt, social isolation, dependence on the abuser (Dutton, 1993); serious implications in everyday life (Menéndez, Pérez & Lorence, 2013); physical health implications such as somatisation, insomnia, medication abuse, etc. (Menéndez, Pérez & Lorence, 2013); problems with children, difficulty making plans for the future, the belief of not being able to live without the abuser (Jacobson & Gotman, 2001), a decrease in self-care behaviours and the sense of competition (Bermúdez et al., 2009; Matud, Gutiérrez & Padilla, 2004); justification of violence, exculpation of the aggressor and protective behaviour towards him (Arce & Fariñas, 2009); dissociation, conflicting interpersonal relationships and sexual problems (Walker, 2012).

Gender Violence must be understood from a multicausal perspective, taking into account cultural factors, together with historical, political and socioeconomic conditions that have provided a context where the superiority of the male has been reaffirmed and where it is very frequent and difficult to eradicate (Jacobson & Gotman, 2001). It is necessary to make a broader analysis rather than using sociological factors, whereby a functional approach to violent behaviour (Bell & Naugle, 2008; Follette, Ruzek & Abueg, 1998) and its relational dynamics (Boira, Carbajosa & Marcuello, 2013) is required. A contextual perspective is an ideal approximation to explain GV, since it permits this broader analysis.

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There is a consensus that GV is present in all cultures, social classes, ethnicities, religions and ages (Alencar-Rodrigues & Cantera, 2012) and there are different theoretical perspectives that have been aimed at offering explanations to this fact. At the present time, the most assumed consideration is that it is a multicausal phenomenon that can only be explained from the perspective of an intervention of a set of diverse elements, including individual, social and concrete context factors (Bosh, Ferrer & Alzamora, 2005). According to Bell & Naugle (2008), most of the models that are aimed at explaining GV are limited and those authors consider that it would be appropriate to use a contextual model that is more idiographic, and which should include a functional analysis of violent behaviour. In accordance with this, Follette, Ruzek & Abueg (1998) defend a contextual approach to understanding the problems that are experienced by people, which are associated with their experience of traumatic events, and which could include having suffered from GV.

Eckhardt, Whitaker, Sprunger, Dykstra & Woodard (2013) conducted a rigorous review of published studies on GV intervention and they discarded many of the studies due to their lack of experimental rigour. Those authors note that new programmes with different contents that seem to show good results have begun to emerge. They also note that many of the studies that they reviewed have a focus on reducing symptoms of PTSD and depression, with a predominant approach to cognitive behavioural therapy (CBT). In this latter line of research, Walker (1994, 2012) proposes Survivor Therapy as a valid alternative, and she herself has designed the Survivor Therapy Empowerment Program (STEP) for survivors of gender violence, which is a group treatment programme with components of feminist and trauma theory, where cognitive behavioural techniques are used. Furthermore, Tutty, Babins-Wagner & Rothery (2017) carried out a factorial study of the effectiveness of the "You're Not Alone" (YNA) programme, which is based on narrative therapy, with a large group of women and which gained statistically significant improvements regarding depression, stress and anxiety, in general. Echeburúa & Corral (1998) describe an intervention programme with individual and group sessions that includes: cognitive restructuring, and the teaching of coping skills and relaxation techniques. The team, which is led by Matud (Matud, Gutierrez & Padilla, 2004; Matud, Padilla & Gutiérrez, 2005), proposed a group intervention programme, with which they achieved therapeutic changes, whereby they fundamentally used cognitive-behavioural techniques and which they also applied individually, with good results (Matud, Fortes & Medina, 2014). In this cognitive behavioural manner, the group programme of Cognitive Trauma Therapy for Formerly Battered Women (CTT-BW) with PTSD of Kubany, Hill & Owens (2003) has obtained good results and is maintained in the follow-up. Francisco Labrador's team has applied another cognitive behavioural programme in a group format for women victims of GV who are diagnosed with PTSD, and obtained a reduc-

tion of PTSD symptoms with respect to the control group (Alonso & Labrador, 2010; Cáceres, Labrador, Ardila & Parada, 2011; Labrador & Alonso, 2007; Labrador, Fernández & Rincón, 2010). Santandreu, Torrents, Roquero & Iborra (2014) also carried out a group intervention that was aimed at improving self-esteem in women who have suffered GV and with whom they achieved changes in this sense, by applying cognitive behavioural techniques. Santos, Matos & Machado (2017) also applied a cognitive behavioural intervention in a group through an intra-group study with pre and post measures and follow-up at three months, obtaining statistically significant results in clinical symptoms and depression. Meanwhile, McWhirter (2011) conducted a study in which he compared two community group programmes, one that was focused on emotions and one that was goal-oriented, through a multiple baseline design with 46 women. The results indicated that there are differences between both groups, with the intervention focused on emotions being more effective.

As is described in the above, an adequate alternative to an epistemological perspective regarding understanding GV is the contextual psychological model. This approach understands all human activity within a context and without that context the understanding is meaningless (Fernández-Parra & Ferro-García, 2006; Pérez-Álvarez, 2014). Psychological problems are viewed from this perspective as interactive realities that are essentially dependent on cultural contexts and social interpretations.

This vision is compatible with the principles and recommendations of international organisations, that urge one to consider the violence against women by taking into account the interpersonal and social context in which that violence occurs. This concept considers that the problems must be understood within the framework of the person's biographical context and also their circumstances (González-Pardo & Pérez-Álvarez, 2007). The contextual model explains psychological disorders, which obviously include GV, in interactive, functional and contextual terms. Therapy should measure the effectiveness of the contextual model more by personal achievements in the face of personal values, than by the reduction of symptoms, and aims to resituate the person in concrete life situations, acting in the direction of the things that matter to the person (Pérez-Álvarez, 2014). The therapies that this model groups, among others are: Functional Analytical Psychotherapy (FAP, Kohlenberg & Tsai, 1991), Acceptance and Commitment Therapy (ACT, Hayes, Strosahl & Wilson, 1999), and Behavioural Activation (BA, Martell, Addis & Jacobson, 2001). Each of these therapies has proven its effectiveness in alleviating the emotional and intimacy problems of people who have suffered different traumas and after effects that also GV victims may present.

The effectiveness of the group intervention format has been demonstrated in the intervention with women victims of GV, having a positive impact on social support and on the reduction of levels of emotional distress (Eckhardt et al., 2013). There are several studies in the literature on the appli-

cation of contextual therapies in a group format, but to our knowledge they are still very scarce regarding victims of GV. Regarding *Functional Analytic Psychotherapy* (FAP), Hoekstra & Tsai (2010) have proposed a programme where some possible clinically relevant behaviours (CRBs) are presented, giving recommendations and showing that group FAP helps in these cases to: 1) evoke statements about CRBs, 2) raise an agreement with the participants to work on their concerns within the group, 3) promote self-revelations of CRBs in a group, and 4) engage the participants when the CRBs are evident within a group. At the applied level, FAP in a group has been applied with good results regarding chronic pain (Vandenberghe & Ferro, 2005; Vandenberghe, Ferro & Cruz, 2003), regarding women with depression (Vandenberghe, 2009; Vandenberghe & Rego, 2018), and in bipolar disorder (Regis and Zoéga, 2018). In Spain, FAP has been applied to a group in a Mental Health Unit (Ruiz Sánchez & Ruiz Miñarro, 2018). Since ACT was initiated, a FAP programme has been proposed and has been applied to a group with psychotic problems, and also regarding their families, in terms of anxiety problems, in contexts such as Public Mental Health Services (PMHS), which have shown good results (Ruiz et al., 2017). FAP has also been applied to children and adolescents and has produced positive results (Cobos-Sánchez, Fluja-Contreras & Gómez-Becerra, 2017; Díaz de Neira, Vidal, González & Gutiérrez, 2016; Padilla & Jiménez, 2014). FAP has even been combined with ACT, in fibromyalgia problems, with positive results (Queiroz & Vandenberghe, 2006), and there was also a FAP programme that was implemented in a group-based ACT in a hospital in Denmark for people presenting hypochondria (Eilenberg, Frostholm & Kronstrand, 2014). Group-based Behavioural Activation (BA) has also been applied regarding depression in a group format, with good results (Houghton, Curran & Saxon, 2008; Porter, Spates & Smitham, 2004).

Iverson, Shenk & Frunzetti (2009) applied a different contextual therapy, the Dialectical Behavior Therapy (DBT) which is adapted to women who have suffered GV. The programme, with which positive results have been obtained, includes objectives of the original programme of Linehan (1993) and has an interventional focus on: the validation of the person, acceptance, emotional regulation, stress tolerance and mindfulness.

The therapeutic intervention that is proposed in the present study has been derived from the contextual model, and it is idiographic and also based on the principles of Functional Behaviour Analysis (FBA). Its objectives are: to promote the validation, acceptance and activation of the participants, it aims at having women regaining control over their lives, protecting themselves, and at the same time acting in a particular direction according to the proper values and getting involved in intimate relationships based on equality and respect. It is inevitable that this therapy cannot distance itself from society and culture, which necessarily implies considering violence in the social, cultural and political context in which it occurs, and taking into account gender inequality,

discrimination and the traditional values that support it. As a final objective, it is intended to assess the degree of effectiveness of this intervention in these types of victims.

The present paper describes an intervention that was carried out within the Psychological Attention Service Group for Women Victims of Gender Violence within the Couple or Ex-couple in the Municipalities of Western Andalusia which is managed by the Official College of Psychology of Western Andalusia (COPAO is the Spanish acronym). This programme is based on a gender approach and it is governed by the Protocol for Group Psychological Intervention regarding Women Victims of Gender Violence in Andalusia under the auspices of the Andalusian Women's Institute (IAM is the Spanish acronym) (Instituto Andaluz de la Mujer, 2010). This proposal is an addition to the different therapeutic approaches that are implemented within this programme, and it conforms to an intervention protocol of 11 sessions (in a total of 22 hours) and is framed within the contextual therapies, using the combined strategies of FAP, ACT and BA.

## Method

### Participants

A total of 21 women participated in three groups having different populations: Group 1 with 8 women, Group 2 with 6 women, and Group 3 with 7 women. Initially, a total of 74 women were referred by the practitioners who attended them individually, either in therapy or in counselling. Of these participants, a total of 50 initiated the intervention, but only 21 completed and conducted all sessions. Data analysis and conclusions have been made on these 21 women and all of them had suffered psychological abuse in different degrees and intensity, while 10 of them reported having suffered physical and/or sexual abuse. The age range is from 30 to 74 years, the average age being 45 years. Five of these women were still living with the aggressor, and others were in the process of separation or were divorced, oscillating in the time range of 0 to 20 years that they had not been living with the ex-partner. The majority of the participants had a medium-low socioeconomic level, and only 14.2% had an economic situation that presented some stability.

### Instruments

The Clinical Outcomes in Routine Evaluation-Outcome Measure questionnaire (CORE-OM) was used to measure the effectiveness of the intervention. Its purpose is to evaluate the therapeutic change, and it has been translated and adapted to the Spanish population by Feixas et al. (2012). According to Trujillo et al. (2016), CORE-OM psychometric properties were excellent in the original tests in the UK and showed a high internal consistency (Cronbach's  $\alpha$  between 0.75 and 0.94 for all scores, the lowest for the Risk factor) and a test-retest stability of 0.91 (Spearman  $\rho = 0.9$ ). Dis-

criminant validity showed large differences between clinical and non-clinical samples (Cohen's  $d$  from 0.71 Risk to 1.77 Problems/Symptoms) and high correlations with conceptually close measures, Beck Depression Inventory-II (BDI-II) ( $\rho = 0.85$ ) and Symptom Checklist-90-R revised (SCL-90-R) ( $\rho = 0.88$ ). Regarding Spanish adaptation and validation, the results are similar to the English version: the internal consistency of Cronbach's  $\alpha$  between 0.7 and 0.9, test-retest stability of  $\rho = 0.87$ ; the discriminant validity between clinical and non-clinical samples (Cohen's  $d = 0.8$ , Risk at 1.4 Problems/Symptoms) and high correlations with BDI-II ( $\rho = 0.83$ ) and SCL-90-R ( $\rho = 0.79$ ) (Trujillo et al., 2016).

This questionnaire assesses the client's status and psychological distress through four scales: Subjective Well-being (W); Problems and Symptoms (P), which values depression, anxiety, physical symptoms and trauma; General Functioning (F) which evaluates intimate, social relationships and daily functioning; and the Risk (R) scale, which is a clinical indicator of suicide attempts, self-harm or acts of aggression against third parties. The CORE-OM determines the clinical and non-clinical population with a cut-off point at the score of 10. The following categories are also established: Healthy between 0-5 points; Mild discomfort between 6-10; Medium between 11-15; Moderate between 16-20; Moderate/Severe between 21-25; and Severe Discomfort when the score is greater than 26. Two indices are taken into account to assess the changes in the person: reliable change and clinically significant change. A person is considered to have made a reliable change if there is a reduction of at least 5 points. The clinically significant rate of change refers to the change of clinical to non-clinical range.

In the final session of the treatment, a User Satisfaction Questionnaire was also given to the study participants, with a scale of 15 items rated from 1 to 5, regarding: 1) the evolution perceived in different personal areas, 2) the development of the group intervention, 3) the professional that has led the group and 4) the level of overall satisfaction. The questionnaire also included open questions about what the participant liked the most and what they liked the least regarding the workshop and the usefulness they perceived it to have.

## Procedure

### Design

This study was carried out using an intra-group design having pre-post data with repeated measures, that was replicated in three equivalent groups and carried out in different populations. Each group was formed of between 6 and 8 women who had suffered GV, in different degrees and intensity, and at different times in their lives. Those women who abandoned the intervention before completing it have been excluded from the data. The previous evaluation of all participants was carried out using the multimodal CORE-OM questionnaire that has different domains: Psychological

Wellbeing, Problems/Symptoms, Psychological Risk, and General Functioning. The same treatment protocol was performed with all participants, and after the intervention, all participants were evaluated using the same questionnaire. The therapist was always the same practitioner in all groups, and she has a Master's degree in Contextual Therapies, with 25 years of clinical experience and 10 years of GV experience.

The intervention was undertaken in groups formed of between 6 and 8 women, with 11 sessions lasting 2 hours. The intervention uses principles of FAP, examples and metaphors of ACT, in addition to the use of resources and tasks from AC. The procedure and sessions carried out in this protocol are described below.

Although the therapy is idiosyncratic, it is based on some hypotheses that are in relation to the possible problematic behaviours in women who have suffered emotional and/or physical abuse which, since FAP, are known as clinically relevant behaviours (CRBs). In general, a series of therapeutic objectives was noted based on a series of problems that were common in all participants.

*Possible problem areas (possible CRB type 1, conducts needing reduction):*

- Strong feelings of guilt and being held responsible for the aggressor's behaviour.
- Justifying the violence that a man has exercised or continues to exercise against a woman.
- Not seeing the risk, or the severity that runs in their life.
- Believing that love can achieve everything and consequently trusting in being able to change the other person.
- Recognising oneself to be in love with the abuser, despite the abuse.
- Not wanting to leave the relationship despite strong emotional abuse and physical aggressions, or wanting to leave the relationship, but feeling unable to do so.
- Not recognising the effect that abuse and violence have on children.
- Considering the person who attacks them to be a good father.
- Maintaining traditional values, so that they can keep the family together above all else, which means that they must tolerate the violence that their partners exert on them for the sake of their children.
- Having a great distrust of men and thus avoiding getting involved in a relationship again.

*General objectives in the intervention (CRB type 2, improvements that need to be increased):*

- Validation of the woman by the therapist. Strengthening her sense of identity, self-awareness, decision-making, and expression of feelings and opinions.
- The woman must accept negative thoughts and aversive emotional states, and focus on acting against changing what she feels or what she thinks.

- Accepting responsibility for the changes she wants to achieve in her life.
- The women must learn to protect themselves, to value risk and, at the same time, to commit to tasks that lead them to having a more meaningful life.
- Learning to identify and recognise the indicators of control, harassment, abuse and violence in a relationship.
- Being willing to face the sensations and feelings they have when they leave a relationship with a person who hurts them.
- Increasing their contact with stable sources of positive reinforcement, those are varied and significant, which means getting involved in leisure activities, personal relationships, self-care behaviours, and others, that are consistent with the values.
- Establishing new rules or interpretations (CRB type 3) about what has happened to them, and about the concepts which they have about suffering, psychological well-being, and their own values (concerning family, relationships, etc.).
- Identifying what they want to achieve in each of the different areas of their life, and committing themselves to their vital objectives, in order to find a new meaning in their life.

### Description of the intervention programme

The selection of the women was carried out by the practitioners who attended them individually, and this would usually be a psychologist. Coordination sessions were scheduled at the beginning and at the end of the workshop, between this practitioner and the therapist who led the group.

In the first sessions, one of the fundamental objectives was identifying the CRBs and the variables with which they are related, so that the therapeutic intervention could take into account the peculiarities of each group and of the women who composed it. Regarding the FAP, the emphasis is placed on what the client does and says in the session itself (Valero & Ferro, 2015). That is, the problems and improvements must occur within the session so that the therapist has the possibility of shaping new behaviours and new verbal rules. Further, this has to occur in the most natural way possible, so that it can be generalised with respect to daily life. The group is an ideal context for therapy, and it can offer a greater number of in vivo learning opportunities than individual therapy, and is also the appropriate framework for providing social reinforcement naturally and shaping new behaviours (Hoekstra & Tsai, 2010; Vandenberghe, 2009).

Each session always began by asking the women questions regarding: 1) how they felt in the previous session, 2) how they felt throughout the week in relation to therapy, 3) what they felt about relationships with their partners and with the therapist, 4) what they felt about the reactions they had in being able to provoke certain events that occurred during the session, or by hearing the story of a partner, etc.

Each session ended by asking how they had felt throughout that session, how they had felt with their partners, how they had felt with the therapist, whether they expected anything different, etc.

### Workshop phases

The workshop consisted of two parts: The first part is known as the intervention protocol “Reflection Group”, and it is the first of three sessions. The second part, is known as the “Autonomy Workshop”, and it covers from session four to session eleven. Table 1 describes the phases of the workshop.

**Table 1.** Description of the different phases of the treatment.

Phases	Sessions
Reflection group	1. Presentation 2. The context of violence 3. The couple relationship (1)
Autonomy Workshop	4. The couple relationship (2) 5. Violence: act and protect yourself 6. Values 7. Depression 8. Self-esteem trap 9. Anxiety 10. New concept of love 11. Final and assessment

### Reflection group

The intervention programme is presented in this section, whereby, the first contact between the women and the therapist is made, and the evaluation begins. The likelihood of people leaving a session, being more emotionally altered than at the beginning, is much higher in group therapy than in individual therapy, since narrating their own experience and listening to the experiences of their group partners can cause intense emotional responses in a participant, which can be quite painful (Linehan, 1993), which can evoke avoidance behaviours with respect to the situation, and this is one of the main risks of abandonment. As Tsai and Reed (2012) maintain, an excess of CRB1 makes it likely that the client leaves the therapy prematurely but this type of risk was taken into account. However, it is very important to facilitate the expression of feelings, and is also important that both the therapist and the women who make up the group, show the appropriate sensitivity towards that group. This is a fundamental aspect for the development and maintenance of intimate relationships (Kohlenberg & Tsai, 1991, 1998). In this phase, the fundamental objective is that the workshop is a therapeutic context that does not punish but rather provides trust and security, as a basis for authentic relationships of intimacy between the people who form that workshop, and for validating the workshop participants. The fact that women begin to feel validated when they are talking about their personal history and when the organisers and participants of the workshop are considering that their suffering is real, already

has a therapeutic effect in itself (Valero & Ferro, 2015, 2018). During this phase, an attempt was made to build trust, in showing that the therapist has a genuine and positive interest, in order to evoke CRB 2 (demonstrations of affection, closeness, sadness, and compassion), and to ensure that progress is naturally reinforced.

This phase consists of three sessions. Session 1, known as the “presentation”, describes the programme and group rules concerning attendance and confidentiality. The women themselves were also presented and a brief description was made of the most relevant vital events, the problems they had, the most significant aspects of their relationship, risk situations, etc., and also what they expected from the therapy. The CORE-OM questionnaire was also applied. In general, in the following sessions, the expression of feelings was promoted, as was the establishment of affectionate and empathic relationships between the participants and the therapist, and the facing up to any avoidance (attending therapy, the suffering in their lives, etc.). In addition, they applied metaphors that would help to understand their situation and help to construct the possible solution. Session 2, known as “the context of violence”, framed violence in a socio-cultural context and analysed family, social, religious, educational and legal issues that have facilitated inequality between men and women and regarding violence. This session promotes the fact that participants should talk about their personal experiences and evolve CRB (e.g., conflicts with the family and with the values that have been transmitted to them in relation to the family and the couple, lack of support, problems with children, economic difficulties, etc.). They appeared in the CRB 1 session (avoiding talking about problems, or talking too much, feeling inferior, crying continuously, apologising to the aggressor, feeling guilty about the experiences they have lived, etc.). Session 3, known as “the couple relationship”, promotes the moulding of their vision of love, family and partner.

#### *Autonomy Workshop*

This phase consists of sessions 4 to 11 and it is aimed at evoking CRB 1, CRB 2 and CRB 3 (new interpretations of their experiences, new rules for positive action, etc.). The distribution of the sessions and the objectives of each session were not planned in advance, but rather they were adapted to the problems that the participants were presenting.

In session 4, the participants continued to shape their relationships, their evolution, and the cost to them of the emotional and physical violence. The hiker metaphor (i.e., focus on the process rather than on the result) of ACT was used, which exposes an equivalence between the participant's life as a couple and an excursion with an abusive partner, and the possible alternatives, and CRB1 (feelings of guilt, suffering from neglecting valuable experiences, fear of loneliness, etc.) was evoked.

In Session 5, which we refer to as “Violence: act and

protect yourself”, we reflected on the benefits that violence has for the person who exercises it, and the damage which the violence causes to the participants and to children. From this, we formulated that a family atmosphere of stability and love is incompatible with violence. In addition, we analysed the specific problems that are related to the consequences that arise (legal proceedings, custody of their children, and the difficulties that arise during the children's visits with the father). The risks related to living and having a meaningful life and the need to protect oneself were also discussed.

In session 6, personal values were analysed, as proposed by ACT, in relation to the significant areas of life (the couple, the family, friendships, training, employment, leisure, health, and self-care). The meaning of the participants' lives, or what they would need to do to make their lives meaningful was also questioned. In accordance with ACT, actions that are committed to the values that evolved during the intervention were also promoted, and metaphors were used to help understand these values.

In session 7, known as “depression”, we focused on perceiving what the participants felt and thought in relation to 1) the traumatic experiences they had experienced, 2) the negative thoughts they held concerning themselves, 3) feelings of depression and worthlessness, or 4) feeling that “something in particular does not work for them”. New rules based on experience were formulated, whereby one must focus on what is important in life rather than on what one is feeling. In accordance with what is proposed by BA (Barraca & Pérez Álvarez, 2015), depression is understood to be a situation in which one relates to events that occur in one's life, where attempts are made to resolve the problems, and the participants themselves are part of their own problems. The importance of taking actions that are aimed at changing and resolving the issues of life is exposed. Again, certain metaphors that were adapted to each situation were used, in order to help the participants understand all of this in the session.

Session 8 was aimed at demonstrating the self-esteem trap, whereby the majority of people believe that having good thoughts and feelings about themselves and about the future, or having high self-esteem, will lead them to act appropriately and to be happy. These individuals come to therapy with the hope of stopping suffering and having doubts, recovering their self-esteem and also seeing themselves and life in a positive way. Given the experiences that they have endured and the current situation that they are in, it is normal for them to have feelings of low self-worth, fear, anguish and hopelessness most of the time (except, of course, for specific moments of optimism). Emphasizing that these individuals must change how they feel, and that they must love and value themselves or be positive in their thinking, leads them to feel that their suffering is being trivialised. A new argument was formulated to encourage them against acting only when they feel good, and the therapy had a focus on acting in the direction of values, despite the discomfort, suffering and fear, thus validating and empowering the per-

son, and considering them capable of making changes in their lives. This session focused on promoting and concretising activation tasks in order to fulfil significant vital projects, and to shape decision-making and commitment.

Session 9 had a focus on anxiety, the problems they have had in relation to anxiety, and the efforts they have made to control and avoid that anxiety. Examples and metaphors were provided with the aim of assessing in which life situations and in what areas the control strategies would work. In the session, anxiety was raised from a contextual perspective, and it was shown how the attempts that are aimed at eliminating anxiety result in it being increased, thereby formulating that the control of emotions is the problem rather than the solution.

By using metaphors, session 10 had a focus on a new concept of love and the participants' experiences regarding love towards their particular aggressor, and the approach of that aggressor towards the participants. Similarly, there was a discussion of the fact of there being men who attack their woman and who still do not want to separate from that woman. Again, we discussed the decision-making and acting in the direction of participants' values, regardless of the feelings of love they may have for the person who is hurting them. Further, in accordance with Garrido (2001), it is important that women learn to identify signs of control and violence if that is possible, before emotionally linking with a man or acquiring a high degree of commitment that man. Using the experiences that they had already lived through, the participants were moulded into being more attentive to the indicators that should put them on the alert in the case of the people they know, who attract them and with whom they fall in love. The fear of intimacy and new relationships was also discussed.

An assessment of the workshop was carried out in session 11, regarding 1) how the participants had felt throughout the therapy, in relation to their companions and to the therapist, 2) what changes they had experienced, 3) what they had considered regarding their lives, and also 4) what it is that they actually wished to achieve. The CORE-OM evaluation questionnaire and the User Satisfaction Questionnaire were also applied.

### Data analysis

Initially, the tests of normality and homogeneity of variance of the samples were carried out using the data of the first evaluation. Once the data were verified, a comparative analysis was performed using the Student's t-test of the different sub-scales before and after the treatment. To estimate whether there could be any bias due to the characteristics of the participants in any of the groups, a comparison was made between the sub-groups of each population. In this case, an ANOVA test of repeated measures (multivariate analysis of variance, MANOVA) was used, taking the pre-post measurements as Factor 1 and the three subgroups as Factor 2. The data met the conditions of homogeneity and

normality, although they did not meet the sphericity due to the small N, hence, *Wilk's Lambda* value was used. There were no significant differences between any of the subgroups, in the pre-measures, nor in the post measures. Therefore, the subgroups can be considered as a single total group in order to obtain statistical conclusions. The analysis of the data was performed using SPSS 21.0 for Mac.

### Results

Of the total of 74 women that were selected for participation, 50 started and 21 completed the group intervention, which means a dropout rate of 56%. It is noteworthy that, of the total of 21 women, 8 of them attended more than 80% of the sessions, with an average of 17.6 hours of intervention, and 13 women attended less than 80% of the sessions, with an average of 13.8 hours of intervention.

Of the 21 women, all of them obtained pre-test scores that placed them within the clinical population, except for one participant. In addition, 57% (n = 12) of these women obtained pre-test scores that are indicative of severe discomfort on one or more of the scales; 23.8% (n = 5) were in a range of moderately severe discomfort; 9.5% (n = 2) obtained moderate scores; and 9.5% (n = 2) obtained average scores and mild discomfort. After the intervention, 62% of the women who attended more than 80% of the intervention showed a clinically significant improvement, compared to 30.7% of the women who presented among those participants who attended less than 80% of the workshop. After therapy, women who obtained scores that are indicative of severe discomfort on one or more of the scales were reduced to 23%, although this degree of severity after the intervention was only found in women who had not completed 80% of the sessions. In addition, 9.5% (n = 2) obtained scores that are indicative of moderately severe discomfort, 28% (n = 6) obtained scores corresponding to moderate discomfort, and 37.5% (n = 8) obtained scores corresponding to mild and/or elevated discomfort on average.

One hundred percent (100%) of women who attended more than 80% of the intervention (n = 8) and who had scored positively on the Risk scale, reduced their score to 0 at the end of the intervention, which is something that also happened in 46% of the women who attended less than 80% of the sessions; of these, additionally, 15.3% experienced a reliable improvement, 23% remained the same and another 15.3% worsened. Regarding the General Functioning scale, 87% of the women who attended more than 80% of the sessions experienced a significant improvement after the intervention, compared to 15% who attended less than 80% of the therapy and experienced a significant improvement; the remaining participants had no changes and a minimum percentage (4.7%) worsened. Regarding the Problems/Symptoms scale, 100% of the women who attended more than 80% of the intervention showed a significant improvement after group therapy. In addition, 87.5% of these women had obtained a very high pre-test score on the

Pscale, indicative of severe discomfort, and after the intervention, no women reached that degree of discomfort, resulting in 12.5% moderate-severe, 25% moderate, 35.5% medium, and 25% mild. Of the women who attended less than 80% of the intervention, only 7.6% obtained a degree of severe discomfort in the pre-test scores on the P scale; After the workshop, 46% showed a significant improvement in Problems/Symptoms, another 46% had not change and 4.7% worsened.

When analysing the drop-out rate, 42% abandoned the therapy after the first or second session, which was mostly due to unknown causes. The remaining 14% were already in advanced therapy, the reasons being due to work or training, care for relatives, or unknown causes. With respect to the participants who did not leave the therapy, but attended irregularly, those participants argued their lack of attendance as follows: resolving legal issues 11.4% (attendance at civil or criminal trials, interviews with lawyers or experts, etc.); attention to children or relatives 16%; appointments with other health professionals 9%; economic difficulties with respect to covering travel expenses 9%; attendance at training courses, job interviews, appointments with social workers or job counsellors 18%; intense psychological discomfort 7%; incompatibility with working hours 11.4%; and unknown causes 18%.

Regarding the satisfaction experienced by the participants after finishing the intervention, which was measured using the User Satisfaction Questionnaire, a score of 4/5 was obtained regarding the evolution perceived in the same area of the different personal areas; 4.5/5 was obtained regarding the functioning of the group, and 4.8/5 was obtained regarding the therapist who had directed the group. In response to the open questions that the participants were asked, these af-

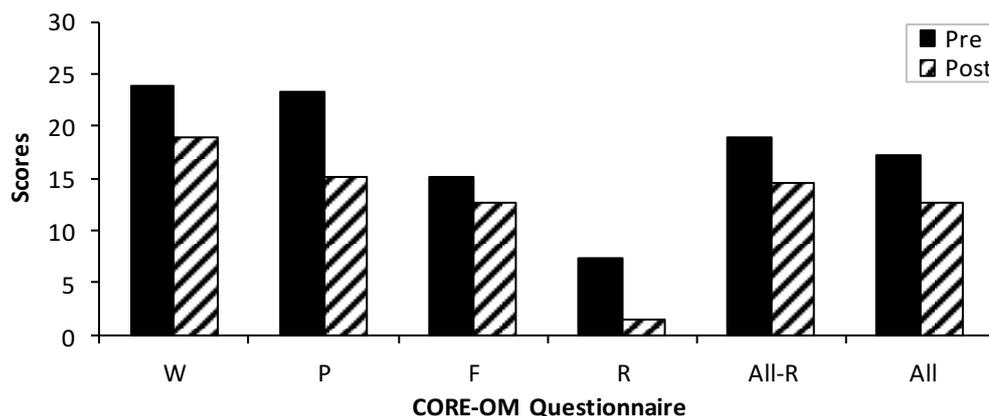
firm that 1) intense friendships have arisen, 2) they have felt valued and understood by their partners and by the therapist, 3) they have learned to make changes in their lives and to assume responsibility for what has happened to them, 4) the main complaint was that those participants who consider the intervention time to be insufficient and would like to continue the therapy.

Table 2 shows the data obtained in the sample of 21 participants before and after the intervention in the different sub-scales of the CORE-ON. The means and the standard deviations of the different scales and of the total data appear, and without taking into account the R scale. The homogeneity tests of variance and normality of the sample, as well as the comparative analyses using the *Student's t-test*, were carried out using the previous data, and as can be seen, the results are significant in all sub-scales (except General Functioning).

**Table 2.** Data from the sample, before and after the treatment, in the different sub-scales.

CORE-OM	Pre		Post		<i>t-Student</i>	<i>p</i>
	<i>M</i>	<i>DT</i>	<i>M</i>	<i>DT</i>		
<i>Well-being</i>	23.90	7.45	18.85	8.27	3.196	.005
<i>Problems</i>	23.36	7.49	15.23	6.77	4.951	.001
<i>Functioning</i>	15.05	5.70	12.62	8.23	1.337	.196
<i>Risk</i>	7.34	6.52	1.48	2.91	3.945	.001
<i>All without Risk</i>	18.86	6.39	14.63	6.96	2.925	.008
<i>Total</i>	17.23	5.92	12.75	6.58	3.023	.007

In Figure 1, the means of the data from the entire sample of participants in the pre- and post intervention measures, of each sub-scale and of the global data, except for the Risk sub-scale, can be observed.



**Figure 1.** Means of the different factors in the pre-post assessment of all the participants.

There are significant differences in the complete CORE-OM questionnaire of all items ( $t = 3.02$ ,  $gl = 20$ ,  $p = .007$ ), and all but the Risk items ( $t = 2.92$ ,  $gl = 20$ ,  $p = .008$ ). There are also significant differences in the sub-scales of: Well-being W ( $t = 3.19$ ,  $gl = 20$ ,  $p = .005$ ); Problems/Symptoms P ( $t = 4.95$ ,  $gl = 20$ ,  $p = .001$ ); Risk R ( $t = 3.94$ ,  $gl = 20$ ,  $p =$

.001). However, there are no differences in the General Functioning sub-scale F ( $t = 1.33$ ,  $gl = 20$ ,  $p = .196$ ), although the score does decrease, but it does not become significant.

An ANOVA was also performed to compare the sub-groups, taking the pre-post means as Factor 1 and the three

subgroup means as Factor 2. Significant differences only appear in the pre-post temporal comparison ( $SC = 19036$ ,  $gl = 1$ ,  $p < .001$ ) and there is no influence of the subgroups. The observed power of this pre-post comparison is also very high ( $\eta^2 = .84$ ). The analysis with this test provides the same conclusions.

## Discussion & Conclusion

In view of the results that were obtained, this group intervention with contextual therapies in GV victims has proved to be effective. The differences between the data before and after the intervention have been statistically significant for the total data, and in the sub-scales of: Subjective Wellbeing, Problems/Symptoms, and Risk. In the General Functioning sub-scale the changes are not significant, although they do decrease, and one can assume that they improve the problem with behaviours inside and outside the sessions (intimacy, openness to others, reduction of avoidance, assuming responsibility regarding one's own life). Further, there is a significant decrease in the consequences of PTSD, such as improvement in discomfort and depressive behaviours, and there is a decrease in anxiety, avoidance, and clinical indicators of suicide risk. These results are equivalent to the reviewed interventions in the body of literature that have demonstrated their effectiveness (Eckhardt, Whitaker, Sprunger, Dykstra & Woodard (2013), and which were mostly based on cognitive-behavioural techniques. The programme uses a combination of different components of three contextual therapies, and that combination is the cause of the change. It could be considered that the validations of the expressions of the participants which were given by the group, in accordance with Dialectical Behavior Therapy (DBT), and applied in this population (Iverson, Shenk & Frunzetti, 2009), and of the therapist herself in accordance with the FAP, act as a variable in this important and novel intervention.

Since this last therapy, an intervention programme has been proposed (Hoekstra & Tsai, 2010) but to the best of our knowledge, no results have been published to date, hence the present study is also novel. Further, the intervention based on the acceptance of the facts and emotions that are evoked by traumatic situations is novel in Spain. In addition, another variable of the intervention that may have influenced the results to some extent, is related to working with the values and objectives of the participants, which is something that is also novel. However, according to the results of the study by McWhirter (2011), it seems to indicate the opposite, in that focusing on emotions is more effective than focusing on objectives.

There was a very high number of dropouts from the present study, which frequently occurs in these types of programmes and this fact should be analysed, while taking into account that research and scientific studies that study violence in relationships must interpret the results from a gender perspective (Bosch & Ferrer, 2005; Ferrer & Bosch,

2019). Velasco and Hernández (2016) also studied the causes of therapeutic abandonment and irregular therapy assistance in women victims of GV. Those authors found little relationship between the lack of assistance and the care received, while noting that these dropouts were mainly due to extra-institutional factors, such as: family problems, household activities, child and family care, the fear of the couple, economic problems, work, the feeling of improvement, or the reduction of violence. They concluded that the gender culture itself and social and personal conditions make it difficult for women with GV to undertake therapy. These factors could also explain one of the results in the study by Hegarty et al. (2013), which indicates that the frequency of assistance to psychological care services for women victims of GV is low. We would also add that there is a difficulty in the follow-up of these participants that could be explained in the same way.

In the present study, there appears to be a relationship between regularly attending therapy and the improvement that is experienced. Thus, all of the women who attended more than 80% of the sessions showed significant changes, and a majority of these women also obtained scores that are indicative of a non-clinical range when considering the overall scores. Of those participants who did not complete at least 80% of the intervention, some improved and they even presented a clinically significant improvement (30.7%), but others obtained variable and irregular results. On the other hand, and according to the results of this study, a high number of women experienced significant changes in the P and R scales, which indicates that the levels of anxiety, depression and trauma, as well as suicidal ideation, were significantly reduced, with respect to whether or not they were attending regularly, in that some of the sessions could have been missed. However, for changes to occur in intimate relationships, in social relationships, in daily functioning, which are measured by using the F scale, it seems necessary for women to complete the workshop and almost in its entirety.

This study has a number of limitations. The main limitation is the high percentage of dropouts that could be explained by a number of factors. On the one hand, women victims of GV may be reluctant to participate in group therapy and expose their situation in public, since many are very sensitive to issues related to privacy, and this is understandable as their life may depend upon secrecy (Walker, 1994). On the other hand, regarding the problems presented by the participants, the homogeneous therapeutic groups facilitate emotional involvement and the feeling of being understood, but they also make it more likely that participants will empathise, suffer or "get scared" regarding the experiences that could depend on other people (Linehan, 2003). The strong feelings of guilt can be increased, compared to other women who have already solved their situation and have subsequently abandoned the aggressor (Matud, Bermúdez & Padilla, 2009), and the emotional situation of ambivalence that they still live through, makes them avoid facing up to their problems and, consequently, they can be aversive to the situation

of the group experience. These factors, which could have a greater impact in the first sessions, and can be influencing dropouts, are added because, as indicated above, the cultural and gender patterns themselves are in turn the main obstacles to the care of women victims of GV (Velasco & Hernández, 2016). These factors should be considered in future programmes, as they are important influencers of the first sessions, whereby they normalise and validate the participants, so that they do not run away from this group situation.

Another limitation of this study is that the sample can be considered as small, which is a fact that we would aim to correct in the future, by expanding the sample with new intervention groups that are currently on-going. Notwithstanding, the total sample of 21 people meets the requirements for the application of standardised statistical tests, hence the conclusions can be considered as reliable.

The lack of following data of the results would be another limitation, and this can be explained by the great difficulty in contacting the participants that the researchers have recruited. Users often stop contacting the Services where they

have been treated, and this can sometimes be because their problems begin to be resolved and normalised, but with others this could be because they either do not want to keep in touch or they do not find this to be necessary.

For future studies, a randomised inter-group design with waiting list control groups (or wait-list comparison) and/or standard treatment based on cognitive-behavioural techniques could be applied, as this would provide a more reliable possibility of evaluating the effectiveness of this programme. On the other hand, it would also be interesting to conduct a study of its components and phases to assess what effect they have on the effectiveness of the intervention; and even to study each phase in detail, and assess which components of contextual therapies could have the most comparative effect.

This study is a pilot programme, based on contextual therapies, which has some similarities with other programmes that have been applied to groups, but whose contribution to research is that until now this programme had not been applied, to the best of our knowledge, to the problem of battered women and who suffer GV.

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