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Clinical Case

ACT-Based Contextual Intervention in a Case of Intimate Partner Violence

Antonio Blanco Guerrero

Clinical Psychologist. Health Service of the Balearic Island (Spain)

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ABSTRACT

Intimate partner violence is a persistent issue both in Spain and globally, resulting in psychological consequences for women affected by it. Among these repercussions, we can find difficulties associated with experiential avoidance, lack of connection with personal values, and a decline in quality of life. Contextual psychological interventions have been proposed as ideal for addressing such problems, yet the scientific literature regarding their application to intimate partner violence is limited, primarily focusing on group interventions. This text illustrates a non-manualized contextual intervention with a 39-year-old woman who is a victim of intimate partner violence. The findings indicate that the intervention was effective in reducing problematic behaviours linked to experiential avoidance and a lack of committed action to her values, thereby enhancing the woman's satisfaction across important areas of her life. This study provides evidence on the utility of contextual interventions for psychological issues related to intimate partner violence within public healthcare settings.

Intervención Contextual Basada en ACT en un Caso de Violencia de Género

Palabras clave:
Violencia de género
Terapia contextual
Conductual
Evitación experiencial
Valores

RESUMEN

La violencia de género es un problema persistente tanto en España como en el mundo, que genera consecuencias psicológicas para las mujeres que la sufren. Entre esas consecuencias destacan los problemas relacionados con la evitación experiencial, la falta de conexión con los valores personales y la pérdida de calidad de vida. Las intervenciones contextuales se han planteado como idóneas para abordar este tipo de problemas, pero la literatura científica sobre su aplicación a la violencia de género es escasa y, principalmente, centrada en intervenciones grupales. En este texto se muestra una intervención contextual no manualizada desarrollada con una mujer de 39 años, víctima de violencia de género. Los resultados muestran que la intervención fue eficaz para reducir las conductas problema relacionadas con evitación experiencial y falta de acción comprometida con sus valores, mejorando la satisfacción de la persona respecto a áreas relevantes de su vida. El estudio aporta evidencia sobre la utilidad de las intervenciones contextuales para problemas psicológicos relacionados con la violencia de género en contextos sanitarios públicos.

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Corresponding author: Antonio Blanco Guerrero, antonio.blanco@ibsalut.es

Introduction

Intimate partner violence against women has a significant impact on various aspects of their lives, leading to both short- and long-term consequences. This phenomenon, recognized as a serious public health issue by the World Health Organization (World Health Organization [WHO], 2013; World Health Organization, 2016), produces psychological, social, and physical effects that negatively impact the quality of life and emotional well-being of the women involved. Despite the importance of addressing this issue, there is limited information on the clinical effectiveness of psychological interventions designed for women who are victims of intimate partner violence (Isaza Cantillo & Muslaco Mendoza, 2020), due to several limitations in clinical research, such as the requirement for a formal diagnosis, prior legal complaints, or small sample sizes.

Within the framework of intimate partner violence, gender-based violence stands out as encompassing various forms of abuse, including violence directed specifically against women for the fact of being women (Law 13/2007, November 26). It can be understood as a mechanism to subordinate women and maintain male dominance in the relationship, particularly within heterosexual dynamics (Fernández Velasco, 2015). The concept was first defined in the United Nations Declaration on the Elimination of Violence against Women (United Nations, 1993) as follows:

> Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. (p. 2)

Among the consequences experienced by women who are victims of gender-based violence are difficulties initiating or maintaining new romantic relationships, impacts on leisure time and social life (Fuentes et al., 2008), a higher incidence of health issues (Stubbs & Szoeke, 2020) and mental health problems (White et al., 2024), as well as consequences for their children (Ansara & Hindin, 2011), who are usually under their care. Additionally, the prevalence of these problems is high among migrant women in Spain, particularly among those from Eastern Europe and Latin America (Bentley & Riutort-Mayol, 2023).

Many published studies on interventions in cases of violence against women focus on reducing symptoms of Post-Traumatic Stress Disorder (PTSD), depression, or anxiety, with a predominant cognitive-behavioral orientation (Félix-Montes et al., 2020; Ramírez-Cruz et al., 2022; Vaca-Ferrer et al., 2020).

As an alternative to the cognitive-behavioral model, the contextual model has been proposed (Maero, 2022b) as an epistemologically appropriate option for understanding problems related to gender-based violence (Bell & Naugle, 2008). From this perspective, psychological problems —including those resulting from experiences of gender-based violence— are understood as interactive realities that depend on the social and cultural contexts in which they occur (Pérez Álvarez, 2014)

The clinical approach within the contextual model is based on the principles of functional behavioral analysis, and treatment effectiveness is evaluated more by the extent to which it promotes alignment with personal values and behavioral flexibility than by symptom reduction. The goal is to help the person take the lead in their life, acting in the direction of what truly matters to them (Pérez Álvarez, 2014).

Included within the contextual model are, among others, Functional Analytic Psychotherapy (FAP) (Kohlenberg & Tsai, 1991), Behavioral Activation (Addis et al., 2001), and Acceptance and Commitment Therapy (ACT) (Hayes et al., 1999).

Although promising results have been obtained with the application of contextual therapies to various psychological issues across different settings (A-Tjak et al., 2015; Akbari & Hayat, 2023; Eastwood & Godfrey, 2024; Marco Cramer et al., 2018; Sanabria-Mazo et al., 2023; Stiglmayr et al., 2015; Wakefield et al., 2018), studies specifically applying these approaches to problems derived from gender-based violence remain limited and have mostly focused on group interventions (Félix-Montes et al., 2020; Hernández-Chávez, 2022; Ramírez-Cruz et al., 2022; Vaca-Ferrer et al., 2020; Valizadeh & Ahmadi, 2022).

In the case of ACT, studies have explored its application to problems related to anxiety, depression, and trauma, or to individuals diagnosed with PTSD (Bean et al., 2017; Félix-Montes et al., 2020; Matud et al., 2016; Simões & Silva, 2021; Spidel et al., 2017), which are among the common consequences experienced by women victims of gender-based violence.

ACT is a therapeutic model developed by Steven C. Hayes and his collaborators since the 1980s (Hayes, 2002). It is based on Relational Frame Theory, which explains human cognition and language (Hayes et al., 2001), and it is included within the broader framework of Contextual Behavioral Science (Hayes et al., 2012).

Although ACT is a model that has evolved and continues to be refined through research contributions (Luciano, 2016), it maintains a conceptualization of psychological problems based on six processes reflecting rigid behavioral patterns, each paired with a healthier, more flexible alternative: *Fusion* (*Defusion*), *Experiential Avoidance* (*Experiential Acceptance*), *Loss of Contact with the Present* (*Contact with the Present Moment*), *Self-as-Content* (*Self-as-Context*), *Loss of Contact with Values* (*Values Contact*), and *Inaction/Impulsivity/Avoidant Persistence* (*Committed Action*) (Hayes et al., 2014).

This six-process framework is known as the *Psychological Flexibility* Model and is commonly represented by the Hexaflex —a hexagon-shaped figure in which each vertex symbolizes one process or dimension. It has led to various formulation approaches (Sandoz, 2014).

These dimensions represent different aspects of psychological flexibility and are interdependent, meaning that it is not possible to target one process without also influencing others—although emphasis can be placed on specific ones. In light of this, the model has received some criticism, particularly in the realm of research (Luciano, 2016), but it continues to be widely used due to its practical value in facilitating understanding and communication in clinical settings (Ruiz Sánchez, 2021, pp. 109–136).

Method

Participants

The individual whose case is presented gave explicit consent for its inclusion. Nevertheless, to protect confidentiality, her name has been changed and details that are not essential for understanding the case have been omitted.

H, a 39-year-old woman originally from Bulgaria, migrated to the Balearic Islands (Spain) at age 20. She speaks four languages and has worked in the hospitality sector for 16 years. She was in a 14-year relationship in which she experienced psychological and sexual violence. At the time of the clinical consultation, she was separated. She has two daughters (aged 14 and 12) from that relationship. Her nuclear family —parents and two male siblings— lives in the same town, but they were unaware of the extent of the abuse, attributing the separation to her former partner's problematic alcohol use.

The relationship began when H was 24, following an unplanned pregnancy that both partners chose to continue. Initially, the relationship was satisfactory, and two years later, they planned a second pregnancy. After the birth, financial strain led H to return to work in hospitality, which limited her involvement in strength sports —an activity she pursued with competitive aspirations— and disrupted her eating habits, resulting in weight gain.

In this context, a pattern of psychological abuse by her partner emerged, centered on criticism of her body, intelligence, and domestic performance. These behaviors reinforced feelings of body shame and social isolation in H. Meanwhile, her partner developed problematic alcohol use, associated with aggressive verbal behavior and sexual coercion. H eventually gave in to the latter, after several months, due to intense feelings of guilt for not "meeting" marital expectations. These episodes became normalized over the years, with brief interruptions when her former partner attempted to reduce his alcohol consumption at ages 31 and 35.

The violence remained hidden from her family due to her fear of failing to meet cultural expectations linked to traditional gender roles —deeply rooted in her upbringing in Bulgaria (Vassileva & Delpeuch, 2021)— and her self-perception of responsibility in the relational dynamics. At age 37, following a recurrence of sexual violence, H ended the relationship with the support of her family, although they remained unaware of the abuse she had endured. After the separation, a visitation schedule was established for the father, which functioned until, months before the referral to clinical psychology, neglect was observed—exposing the daughters to risky situations (e.g., driving after drinking). This prompted the intervention of emergency services, a criminal complaint, and H's petition for sole custody.

Clinically, at the beginning of therapy, H presented with persistent irritability, abandonment of pleasurable activities (sports, socializing), and an authoritarian maternal role, which reduced the quality of interactions with her daughters. She also reported feelings of guilt toward them and intense anger toward her ex-partner. She described herself as completely unable to cope with the ongoing legal process and expressed concern about losing her social support network.

She was treated by a male clinical psychologist at a primary care health center within the public healthcare system of the Balearic Islands. A total of 10 in-person sessions were conducted, and email exchanges took place between sessions. Each session lasted 45 minutes, with an average frequency of two to three weeks. The total duration of the intervention was approximately six months.

Instruments

The primary assessment method was the clinical interview, which was supplemented with two questionnaires completed by the client during the assessment phase and at the penultimate session, along with two self-recorded measures provided at various points during the intervention (sessions 2, 6, 7, 8, 9, and 10). The use of self-report measures is supported in the literature for ACT-based treatments (Twohig et al., 2006) and may help foster the client's active involvement in their own therapeutic process (Kanfer, 1970). The questionnaires and self-report measures used were as follows:

- A *values assessment questionnaire* created by the therapist, based on the one by Wilson and Luciano (2002) and the "*Life Snapshot Inventory*" (Ruiz García et al., 2021). It consists of 12 items referring to different life domains, in which the client rates her satisfaction in each domain on a Likert scale from 1 to 10.
- *Self-reported distress levels* regarding private events related to her experiences of gender-based violence. The client was asked to rate the level of distress these private events caused her during sessions 2, 6, 7, 8, 9, and 10.
- *Frequency of authoritarian maternal behaviors* during the previous week. The client was asked to record how many episodes of authoritarian parenting occurred in the week prior to sessions 2, 6, 7, 8, 9, and 10.
- The *Comprehensive Assessment of Acceptance and Commitment Therapy Processes* (CompACT) in its Spanish version (Giovannetti et al., 2022; Reyes-Martín et al., 2021). The CompACT was developed as a general measure of psychological flexibility and its underlying sub-processes, as conceptualized by the ACT model. It includes 23 items rated from 0 (Strongly disagree) to 6 (Strongly agree). The items are grouped into three subscales that combine the six *Hexaflex* processes into pairs: Openness to Experience (including *Experiential Acceptance* and *Defusion*), Behavioral Awareness (including *Present Moment* and *Self-as-Context*), and Valued Action (including *Values Clarity* and *Committed Action*). The subscales have maximum scores of 60, 30, and 48 respectively, with a total maximum score of 138.

Procedure

A functional behavioral assessment was conducted based on the ACT model. This assessment did not start from a psychopathological premise (Sandoz, 2014) and was not oriented toward a categorical diagnosis.

Assessment

The initial assessment was carried out during the first two sessions. The first step was to identify the problematic behaviors:

I. *Avoidance of social plans*: These had previously been an important part of her life, offering enjoyment and a sense of belonging to a mutual support network. In recent months, she had gradually reduced participation due to guilt about going out without her daughters, while taking them along was often financially unfeasible.
II. *Avoidance of physical activity*: Previously a source of personal satisfaction and goal-setting, both alone and with others. She had abandoned this practice over three years prior due to shame about her physical changes.

III. *Adoption of an authoritarian role in interactions with her daughters*: In recent months, she increasingly experienced intense irritability in response to her daughters' behaviors—reactions that had not previously triggered such strong emotions. These episodes would result in authoritarian parenting behavior, such as yelling, imposing rules, and criticism, which did not align with how she wanted to interact with her daughters.

IV. *Avoidance of memories and thoughts related to abuse*: When memories or thoughts related to the abuse or her ex-partner's neglect of their daughters surfaced, they triggered intense feelings of rage and guilt. She responded with various private and overt behaviors aimed at reducing distress, such as thought suppression, overeating outside of main meals, engaging in distracting activities, or ruminating about the neglect.

The functional analysis of these problematic behaviors is presented in Tables 1–4 at the end of the article.

Next, a case-formulation was developed based on the psychological flexibility model, highlighting the most weakened and the most strengthened processes:

- *Experiential acceptance* was one of the most weakened ACT processes. At the time of the assessment, her behavioral repertoire in response to experiences judged as negative or intolerable was largely driven by avoidance. Specifically, she tried to avoid memories and emotions related to abuse through behaviors such as thought suppression, excessive time spent on cleaning and tidying, overeating between meals, or postponing legal matters with her attorney. She also avoided physical activity due to shame about her body, and socializing due to guilt about leaving her daughters with relatives. All of these behaviors reflected a generalized pattern of experiential avoidance.
- *Committed action* was another weakened ACT process. Despite having clarity about her core values, at the time of the assessment she was not engaging in value-consistent actions; instead, her behavior was dominated by inaction, avoidant persistence, or impulsivity. She was unable to complete legal tasks with her lawyer, remained disengaged from her favorite sport, avoided social outings with friends, and maintained an authoritarian role with her daughters. This lack of committed behavior was closely linked to the high level of experiential avoidance (interconnected with the process of experiential acceptance).
- *Values contact* or *values clarity* was one of the most strengthened ACT processes. Her clearest and most stable process was values clarity. She was aware that her central values included being a good mother (providing proper care for her daughters), being a hardworking employee, maintaining a mutual support network with friends, and staying healthy through enjoyable and challenging activities—particularly strength training.

Intervention

During the intervention phase, the goal was to strengthen the most weakened processes through the most robust one. The information from the functional analysis of the problematic behaviors guided the design of the treatment plan, which was structured around experiential exposure exercises. These experiential exercises aimed to increase the capacity for acceptance, while simultaneously putting into practice committed actions aligned with her values. All exercises were framed within the objective of achieving greater psychological flexibility, thereby increasing the ability to coordinate her actions with her values.

Table 1
Social Activity Avoidance

Antecedents			Behavior	Consequences	
Context	**Public events**	**Private events**	**Responses**	**Immediate consequences**	**Long-term consequences**
Experiences of neglect of her daughters by their father	A friend proposes a social plan	Thoughts: "Even if they're with my mother, it feels like I'm leaving them alone," "What if something happens to them?"	Declines invitation to go out	(R–) Guilt reduction	Disconnection from personal values
Experiences of abuse with her ex-partner, some of which were witnessed by her daughters		"This is not being a good mother," "I should take them with me, but it's too expensive"	Does not initiate social plans with friends	(R–) Fear reduction	Loss of contact with important people and decreased support network
Financial difficulties as the main provider for herself and her daughters Cultural background that places primary responsibility for children on the mother		Intense guilt Fear		(R+) Coherence with the rule "being a good mother means always being with my daughters"	Increased deprivation of social contact

Note. R– = Negative reinforcement. R+ = Positive reinforcement. In this case, the behaviors are maintained through both negative and positive reinforcement.

Table 2
Fisical Activity Avoidance

Antecedentes			Conducta	Consecuentes	
Contexto	**Eventos públicos**	**Eventos privados**	**Respuestas**	**Consecuencias inmediatas**	**Consecuencias demoradas**
Experiences of abuse by her ex-partner, who criticized her physical appearance	Passing near the gym	Intense shame	Does not initiate physical activity	(R–) Shame reduction	Disconnection from personal values
Changes in physical appearance (less strength and more body fat)	Invitation to engage in physical activity	Thoughts: "I used to be someone, and look at me now"	Avoids walking near her gym	(R+) Coherence with the rule "I need to be like before to train with my coach"	Worsening of physical condition: less strength and more body fat
Society that privileges thin or muscular bodies over those with more fat		"If my coach saw me now…"	Avoids contact with her coach		Deprivation of experiences of personal achievement

Note. R– = Negative reinforcement. R+ = Positive reinforcement. In this case, the behaviors are maintained through both negative and positive reinforcement.

Table 3
Adoption of an Authoritarian Role in Interactions With her Daughters

Antecedents			Behavior	Consequences	
Context	**Public events**	**Private events**	**Context**	**Public events**	**Private events**
Social isolation from adult contact Ongoing legal proceedings with her ex-partner	Her daughters make noise, create disorder, delay in following a request	Anger Thoughts: "After all I do for you…"	Yells Imposes conditions	(R+) Sense of control (R+) Daughters eventually comply	Disconnection from her value "being a good mother" Feeling distant from her daughters Guilt
Deprivation of experiences of achievement and satisfaction		"I can't take it anymore"	Criticizes her daughters	(R–) The daughters stop making noise	

Note. R– = Negative reinforcement. R+ = Positive reinforcement. In this case, the behaviors are maintained through both negative and positive reinforcement.

Table 4
Avoidance of Memories and Thoughts Related to the Abuse Experience

Antecedents			Behavior	Consequences	
Context	**Public events**	**Private events**	**Context**	**Public events**	**Private events**
Experiencias de violencia Experiences of psychological violence with her ex-partner	Court requirements	Memories of violent experiences	Fails to respond to her lawyer's requests	(R–) Temporary reduction in guilt, shame, and anger	Fails to complete legal procedures necessary to obtain sole custody of her daughters
Experiences of sexual violence with her ex-partner	Contact from her lawyer	Intense shame Intense guilt	Distracts herself by eating or doing other tasks		Increase in body fat Guilt for not acting according to her value of "being a good mother"
Raised in a context with very traditional gender roles Living immersed in a heteropatriarchal culture		Intense anger	Initiates an argument with her daughters		Sensitization effect when unavoidably exposed to court requirements (brief, intense episodes), which increase emotional reactivity

Note. R– = Negative reinforcement. In this case, the behaviors are maintained through negative reinforcement.

In session 3, a detailed review of the responses to the *Values Questionnaire* was conducted, which helped identify the values that were fundamental to H. The *Bus Metaphor* (Wilson & Luciano Soriano, 2002) was introduced as a tool to illustrate the relationship she had with some of her private experiences and how that relationship was influencing her progressive disconnection from her values.

Given that the presence of a generalized pattern of avoidance was linked to the lack of committed actions, the initial emphasis was placed on the process of *experiential acceptance* using the *Pink Elephant* exercise (a variation of Wegner's *White Bear* experiment; Wegner et al., 1987), as a way of illustrating the ineffectiveness of trying to control the appearance of certain internal experiences (Hayes, 2013; Wegner et al., 1987), and the *Floating in the Ocean* metaphor (an adaptation of the *Quicksand Metaphor*; Hayes, 2013), as a way to cultivate an attitude of acceptance toward internal and external experiences she usually avoided.

The use of metaphors was approached interactively, actively involving H through questions rather than delivering them as one-way informational pieces (Ramírez et al., 2021). For this reason, the *Quicksand Metaphor* was adapted to a version more familiar to H —*Floating in the Ocean*— rather than using the original version.

A behavioral activation-style action plan (Addis et al., 2001) was agreed upon, which progressively included exposure exercises that were also committed actions aligned with her values, thereby working on the processes of *experiential acceptance* and *committed action*. This choice was based on the intention to keep H in contact with natural contingencies of her life outside the session, avoiding excessive emphasis on verbal behavior and what occurred exclusively within the session, as some recent criticisms of the ACT model have pointed out (García-Haro et al., 2024). Moreover, it allowed her to use her strengths to her advantage, since having clear values made it easier to connect them with more concrete actions aimed at those values, which helped maintain her motivation for the intervention —she understood the *"why"* of the proposed work.

Additionally, the intervention included components proposed by FAP (Kohlenberg & Tsai, 1991), insofar as *differential reinforcement* was a basic process (positive reinforcement of the functional class *acting with psychological flexibility*, and blocking or extinction of avoidance or rigidity responses), and special attention was paid to ensuring that the therapist acted as a *non-punitive audience*.

Furthermore, once it was determined that no symptoms compatible with PTSD were present, a specific exercise was introduced between sessions 5 and 9 aimed at interrupting the *sensitization process* (Domjan, 2010, pp. 31–65) that was occurring regarding internal events linked to abuse experiences (intense anger and guilt in response to memories of abuse or neglect). Prior to the intervention, H exposed herself to these events only in isolated, very intense, and brief episodes when she had no choice (e.g., in response to a court order). After narrating her experience of the relationship and the abuse during a session —which ended with a sense of relief— she was encouraged to repeat this process by reflecting on certain stages of the relationship through weekly emails, including a self-rated measure of the distress experienced while writing. This provided a behavioral trace and ensured the proper development of the expected procedure: more prolonged and frequent exposure that allowed for habituation, as recommended (Barraca Mairal, 2014, pp. 221–231), and that could help increase her tolerance of internal experiences (Table 5).

Table 5
Summary of the Intervention Phase

Principales procesos implicados	Sesiones donde ha estado presente	Técnicas y ejercicios
Values clarity	Session 3 Session 8 Session 10	Review of responses to the Values Questionnaire.
Committed action	Session 3	Bus Metaphor.
	Session 4	
	Session 7 Session 8 Session 9 Session 10	Planned actions (light-to-moderate physical activity; outings with friends without her daughters; shared activities with her daughters outside routine; resuming legal proceedings with her lawyer).
Experiential acceptance	Session 5	Floating in the ocean metaphor.
	Session 6	
	Session 7	Pink Elephant exercise.
	Session 8	
	Session 9	In-session exposure to memories and thoughts related to abuse (oral narrative).
		Out-of-session exposure to memories and thoughts related to abuse (written narrative).
		Planned actions (resuming legal proceedings with her lawyer).

No interventions were specifically aimed at directly modifying problematic behavior number III (adoption of an authoritarian role in interactions with her daughters). Instead, the decision was made to intervene directly on the remaining problematic behaviors, based on the prediction that their modification would indirectly affect behavior III by altering the contextual conditions in which it occurred.

In summary, the intervention followed the recommendations to design a specific treatment plan while also prioritizing the establishment of a positive working alliance grounded in genuine interest and an attitude of acceptance, without judgment toward the person or her experience (Romero Sabater, 2010).

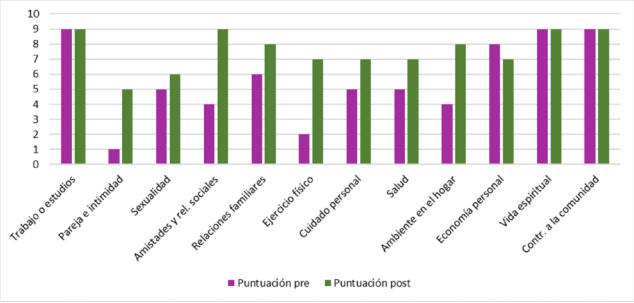
Result

CValues Questionnaire

Figure 1 shows a clinically significant increase in self-reported satisfaction across life areas that are important to H, such as romantic and intimate relationships, social connections and friendships, physical activity, and the emotional climate at home.

Qualitatively, in the final session H reported having achieved meaningful changes in these areas, particularly highlighting improvements in the emotional climate at home and social relationships. She also mentioned feeling more prepared to close the chapter on her previous relationship and to face the possibility of future relationships.

Figure 1
Values Questionnaire Scores



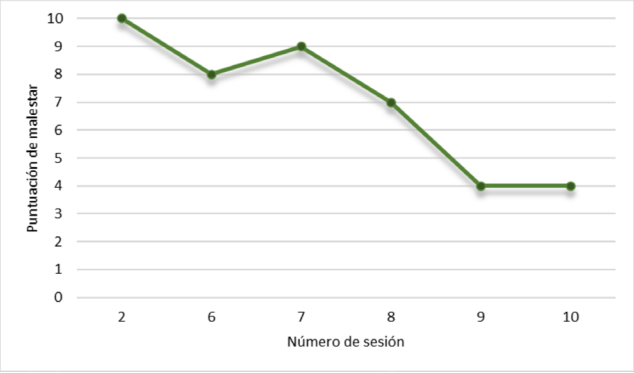
Note: Trabajo o estudios → Work or studies; Pareja e intimidad → Romantic and intimate relationships; Sexualidad → Sexuality; Amistades y rel. sociales → Friendships and social relationships; Relaciones familiares → Family relationships; Ejercicio físico → Physical exercise; Cuidado personal → Self-care; Salud → Health; Ambiente en el hogar → Home environment; Economía personal → Personal finances; Vida espiritual → Spiritual life; Contr. a la comunidad → Contribution to the community; Puntuación pre → Pre-score; Puntuación post → Post-score.

Self-Reported Distress Related to Private Events

H initially rated the distress caused by these types of private events as intolerable, assigning the highest score on a 0-to-10 scale. Figure 2 shows a progressive decrease that is clinically significant and remains stable over the final two sessions.

Qualitatively, H noted that although some distress persisted, she no longer experienced it as so limiting and therefore felt more capable of facing the ongoing legal process. Furthermore, there appeared to be a counter-conditioning, as these private events elicited fewer reactions of anger or guilt and instead triggered feelings of weariness.

Figure 2
Distress Scores Over the Course of Treatment

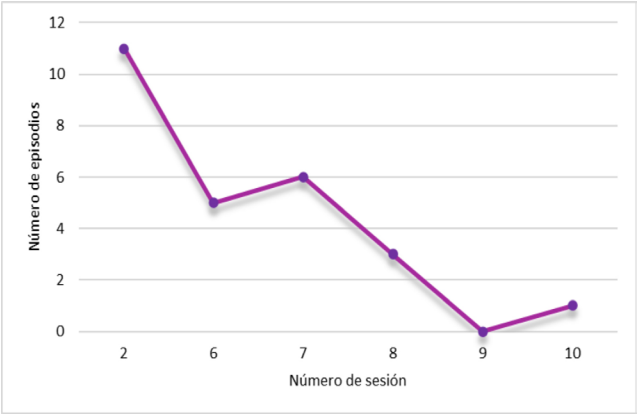


Note: Puntuación de malestar → Distress score; Número de sesión → Session number.

Frequency of Episodes in Which an Authoritarian Maternal Role Was Adopted

The recordings show a decreasing trajectory in the number of episodes in which H ended up adopting an undesired authoritarian maternal role. Figure 3 illustrates how the frequency dropped from 11 episodes in the week prior to session 2 to an average of fewer than 1 episode in the weeks leading up to the final sessions. It is worth noting that no specific intervention was implemented to directly modify the frequency of this type of behavior.

Figure 3
Number of Episodes Involving an Authoritarian Maternal Role During the Week Prior to Each Session



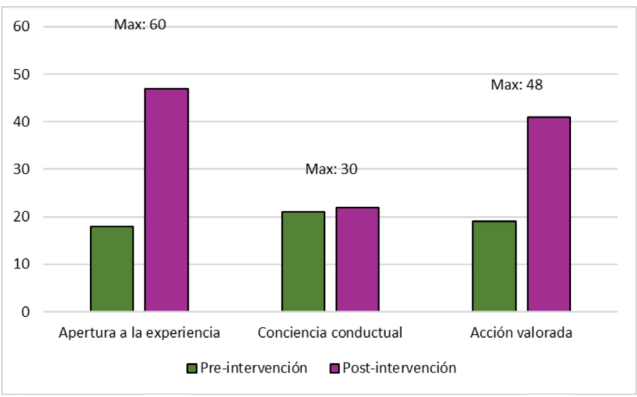
Note: Número episodios → Episodes number; Número de sesión → Session number.

CompACT Questionnaire

During the assessment phase, scores of 18, 21, and 19 were recorded on the three subscales, yielding a total of 58 points on the overall scale. These results were consistent with the qualitative clinical evaluation conducted by the clinical psychologist, which identified experiential acceptance and committed action as the most weakened processes.

After the intervention, the scores increased to 47, 22, and 41, with a total score of 110 on the complete scale. Figure 4 shows a clinically significant increase in both the global score and the subscales Openness to Experience and Valued Action. It is important to note that these subscales combine two Hexaflex processes each, as proposed by Hayes et al. (2014); in this case, the former includes experiential acceptance —one of the weakened processes— and

Figure 4
Pre-and Post-Intervention Scores on the CompACT-23 Questionnaire



defusion, while the latter includes values clarity and committed action —the other weakened process.

Post-Intervention Evaluation

No formal evaluation was conducted after the treatment; therefore, no follow-up scores are available for comparison. However, it is worth noting that, at the time this report was submitted, more than a year had passed since the end of the intervention. Given that H had the option to request a new appointment at any time and at no financial cost, the fact that she has not done so suggests that the improvement achieved may have been maintained over time.

Discussion

Based on what H reported in the first session and the information gathered during the assessment, it can be stated that she was experiencing a loss of connection with her core life values, with a behavioral repertoire marked by experiential avoidance and a lack of committed action. These kinds of difficulties have been identified as especially suitable for contextual interventions (Waltz & Hayes, 2010), such as the one described in the present case.

Although H continued to experience some degree of distress in response to certain events at the end of the intervention, this outcome was to be expected. The aim of contextual interventions —particularly ACT— is not to fight against symptoms or attempt to eliminate them, but rather to foster more flexible behavioral repertoires and support people in leading lives that are more meaningful and aligned with their values (Pérez Álvarez, 2014; Maero, 2022a, pp. 37–43). This represents a valuable alternative to the medical model, which still predominates in the public healthcare system (Ruiz Sánchez, 2021, pp. 341–372).

Post-intervention results indicate a reduction in aversive control over her behavior, resulting in a more flexible behavioral repertoire. She began engaging in more behaviors associated with acceptance (e.g., going out with friends without her daughters, while tolerating thoughts like "*what if something happens to them?*"), which made it easier for her to sustain committed actions aligned with her values (e.g., accepting invitations or initiating social plans with significant others outside the family). She also reported overall improvements in satisfaction with areas of life that were meaningful to her (e.g., romantic and intimate relationships, social life and friendships, physical activity, home climate).

These results suggest that a contextual intervention can be useful and appropriate for addressing psychological consequences stemming from experiences of gender-based violence. Moreover, the findings support the idea that applying the principles of the contextual model (Ruiz Sánchez, 2021, pp. 15–105) allows for tailored interventions that can be effective within public healthcare settings. Since most developments in contextual therapies have taken place in private or academic contexts (Ruiz Sánchez, 2021, pp. 341–372), it is important to gather evidence on how these principles can be implemented in public clinical care. Future research should aim to validate these findings through additional case studies applying contextual approaches in public settings, both for gender-based violence and other clinical issues.

The main limitation of this study is the heavy reliance on self-monitoring and self-report measures for evaluation, which may introduce subjective bias (Podsakoff et al., 2003), although this is often unavoidable in clinical settings. Furthermore, the defusion process was not directly targeted through formal exercises as typically done in ACT (Maero, 2022a, pp. 291–314), despite the fact that in two of the problematic behaviors, avoidance was partially motivated by rules such as "*I can't start training again unless my body looks like it used to*" or "*I can't leave my daughters with anyone else*". While leading authors suggest this does not necessarily constitute a limitation (Waltz & Hayes, 2010), since ACT processes are interdependent and the model is not intended to be applied as a fixed protocol, we cannot rule out the possibility that explicitly targeting defusion might have helped facilitate desired changes. Lastly, it was not possible to conduct a formal post-treatment follow-up using the same measures employed during the intervention.

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Conflict of Interest

The author declares that there is no conflict of interest.

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