


Artículos

**A COGNITIVE-BEHAVIOURAL INTERVENTION  
AND ITS IMPACT ON BURNOUT, DEPRESSION,  
AND ANXIETY: A CASE STUDY OF WOMEN  
WORKING WITH VICTIMS OF VIOLENCE**


**INTERVENCIÓN COGNITIVO-CONDUCTUAL Y SU IMPACTO EN EL BURNOUT,  
DEPRESIÓN Y ANSIEDAD: ESTUDIO DE CASO CON MUJERES QUE TRABAJAN  
CON VÍCTIMAS DE VIOLENCIA**

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**Abstract:** This study aimed to evaluate the impact of an intervention on burnout, anxiety, and depression among female professionals working with victims of violence. The intervention used a quasi-experimental pretest-post-test design. The CESQT was used to assess burnout, and the Beck Depression Inventory was used to assess anxiety and depression. The study population comprised 41 women (psychologists, lawyers, and social workers). Of these, 61% (25 women) participated in the intervention, which consisted of individual cognitive behavioural therapy sessions conducted in 2024 at a public organisation. Pre- and post-intervention changes in anxiety ( $p = .001$ ) and depression ( $p = .058$ ) were assessed using paired-samples t-tests. Cohen's  $d$  for anxiety was 0.718, indicating a moderate to large effect size; for depression, Cohen's  $d$  was 0.399, corresponding to a small to moderate effect size. The main results included a significant reduction in anxiety levels and a slight change in depression levels.

**Keywords:** Cognitive-behavioural intervention, mental health, anxiety, depression, women working with victims of violence.

**Resumen:** El objetivo de esta investigación es evaluar el impacto de una intervención en el burnout, la ansiedad y la depresión en mujeres profesionistas que atienden a víctimas de violencia. La intervención fue de tipo cuasiexperimental con un diseño pretest-postest. Para la evaluación del burnout se utilizó el CESQT, y para la ansiedad y la depresión, los cuestionarios de Beck. La población estuvo conformada por 41 trabajadoras (psicólogas, abogadas y trabajadoras sociales). De ellas, el 61% (25 mujeres) participó en la intervención, consistente en sesiones individuales cognitivo-conductuales realizadas en 2024 en una organización pública. Mediante la prueba *t* para muestras relacionadas, se evaluaron los cambios pre y post intervención en ansiedad ( $p = .001$ ) y depresión ( $p = .058$ ). El valor *d* de Cohen para la ansiedad fue de 0.718, lo que indica un tamaño del efecto moderado a grande; para la depresión, la *d* de Cohen fue de 0.399, correspondiente a un efecto pequeño a moderado. Entre los principales resultados se destaca una reducción significativa en los niveles de ansiedad y un cambio leve en los niveles de depresión.

**Palabras clave:** Intervención cognitivo-conductual, salud mental, depresión, mujeres que trabajan con víctimas de violencia, burnout.

## Introduction

Those who attend to people who have been victims of any type of violence encounter narratives of traumatic experiences daily. Constant exposure to these experiences in the course of their work in emotional, psychological, or legal care can pose a psychosocial risk that negatively impacts their health. At the 39th World Health Assembly, organised by the World Health Organisation (WHO, 1986), attendees stated that work is a key component of health and well-being. However, in adverse circumstances, it can produce both physical and mental distress and decrease personal resources. Arranz and Freducci (2023) noted that despite their severity, people have minimised and overlooked the risks associated with psychosocial work.

Extensive theory and research support the link between health and productivity. According to Marín and Pico (2004), accidents and illnesses, exacerbation of work-related illnesses, risky conditions at work, decrease in life expectancy, hypertension, alcoholism, and mental health disorders reflect this phenomenon. The concept of occupational health encompasses a comprehensive view of the relationship between human beings, productive processes, and the deterioration or improvement of their well-being.

The WHO International Commission on Occupational Health (2010) recognises that occupational health should extend beyond the protection of employees' health. It should also cover health promotion, including activities that enhance organisational well-being. The aim is to address occupational risks or diseases by preventing, analysing, and controlling them while promoting safe and healthy environments. Therefore, it is important to highlight actions designed to improve organisational well-being. This study aimed to evaluate the impact of a cognitive-behavioural intervention on burnout, anxiety, and depression among female professionals who care for victims of violence.

### Risk Factors and Their Effects on Healthcare Activities

Caring for people requires skills, attitudes, and qualities that are deeply tied to emotions. Maslach and Jackson (1981) found that those who engage in care activities need a high level of involvement to care for people experiencing adverse situations. This emotional burden can lead to what we refer to as emotional fatigue, where professionals experience a reduced ability to feel or express emotions, which may result in apathy or a lack of emotional responsiveness.

According to Figley (1995), this type of emotional behaviour occurs in individuals who treat those who have experienced trauma. They experience physical, mental, and emotional exhaustion, along

with intense empathy and a desire to help alleviate the pain of the people they care for. We refer to this phenomenon as empathy or compassion fatigue. He pointed out that security professionals, psychologists, social workers, phone support staff, law enforcement, and those working with survivors of violence often suffer from empathy burnout. This is because their jobs require a great deal of empathy on their part.

Canet and García (2006) noted that people exhibit behavioural symptoms. These include arriving late, being absent, lacking enthusiasm, feeling frustrated, and experiencing boredom. Psychological symptoms include feelings of irritation, lack of motivation, guilt, and low self-esteem. Cognitive-affective symptoms may involve distancing themselves from the people they serve, rushing through tasks, and being cynical. Physical symptoms include headaches, sleep disorders, and muscle or gastrointestinal discomfort.

According to Morales et al. (2003), people whose work involves alleviating suffering “increase their vulnerability and risk due to constant exposure to the trauma of their patients” (Morales et al., 2003, p. 11). These authors add that psychosocial risk manifests as “physical and psychological exhaustion, a distant and isolated attitude in relationships with others and a feeling of inadequacy in the tasks performed” (Morales et al., 2003, p. 23).

Stressors in jobs involving human services and social work include workload, budget cuts, staff shortages, high emotional demands of the role (Van Heugten, 2011), and inadequate resources to meet needs and demands. Workers in these roles may feel undervalued. They often take on too many responsibilities and feel compelled to meet the needs of those they serve, despite feeling emotionally depleted (Lander & Nahon, 1995). There may be a discrepancy between professions with a humanistic philosophy that are in a dehumanised system and a mismatch between the reality of violence, expectations of what they can do, and their achievements (Castillo, 2001). The lack of resources, users' dependence on those who assist them, difficulties in reconciling work and family, conflicts of professional ethics, and feelings of responsibility for the future of those they serve compound this issue. Other problems include excessive demands, poor physical work environments, noncompliance with the need for continuing education, case supervision, service evaluation, little recognition of achievements, and despair at not being able to end the violence (Canet & García, 2006).

Given these labour conditions, individuals working in this field are at risk of suffering from health problems (Cañar & Vinueza, 2019). These authors explored the levels of burnout and resilience indicators in individuals whose job is to care for victims of violence. The results suggest that within this population, there are “high levels of resilience and a medium/average level of burnout” (Cañar & Vinueza, 2019, p. 5).

Burnout syndrome primarily affects individuals who work closely with others. Experts understand it as the effect of chronic stress experienced in the context of work interactions. According to Gil-Monte (2003), it is characterised by a negative evaluation of the job and the capabilities available to perform the job. It is compounded by “the feeling of exhaustion, due to the development of negative feelings, and cynical attitudes and behaviours towards the people who do the work, who are seen in a dehumanised way” (Gil-Monte, 2003, p. 183). The term carries psychosocial connotations, as it links adverse health effects to organisational dynamics and structures rather than to individual responsibility. It frames causality as arising from psychosocial risks in the work environment, positioning the job itself as the source of the disorder.

According to Gil-Monte (2005), this syndrome comprises four dimensions. The first includes low enthusiasm for work, implying cognitive decline and decreased expectations of professional achievement. The second is psychological exhaustion, which refers to the physical and emotional fatigue caused by interpersonal problems at work, especially if the interactions are unpleasant. The third includes feelings of inertia and indifference, which may manifest as cynicism. The fourth includes feelings of guilt, which arise from developing negative and indulgent behaviours and attitudes. Focusing on work rather than the employee avoids singling out individuals and prevents feelings of shame, guilt, or discriminatory attitudes that label employees as unhealthy. If unaddressed, this dynamic may worsen the problem, as those experiencing stigma often withdraw, become distrustful, depressed, hostile, anxious, or disoriented, and develop feelings of insecurity and uncertainty towards others (Gil-Monte, 2003).

Those with burnout can experience physical and mental impairments that affect their tasks and self-perception. They may feel “worn out, exhausted and tired on a professional and emotional level” (Gil-Monte, 2003, p. 188). When they sense their control over situations slipping, they often give up or stop trying to manage work challenges. Studies such as those by Duarte-Arias and Valencia-Basto (2024) have noted a significant relationship between anxiety, depression, and burnout. The authors highlighted that higher anxiety and depression levels are associated with psychological exhaustion and low enthusiasm for work.

Burnout can easily be confused with other illnesses, such as anxiety or depression, because they share similar clinical symptoms and behavioural traits. Differentiating between these requires consideration of the concepts outlined by Beck (1964) in cognitive theory. Beck's (1964) primary thesis was that emotional disorders encompass systematic biases in information processing. In anxiety, bias presents as an overestimation of the degree of danger in certain situations, along with an underestimation of one's ability to cope. In

depression, individuals express it as an error in judgment when they process negative experiences (of loss or deprivation), which they overestimate and consider to be global, frequent, and irreversible.

According to Clark and Beck (2012), non-pathological anxiety is a complex system of behavioural, physiological, affective and cognitive responses inherent to the human condition. It enables individuals to assess relevant information in each context, evaluate available resources, and anticipate possible outcomes, allowing them to act effectively and cope with adverse or challenging situations. This type of anxiety may indicate burnout, whereas pathological anxiety manifests as an actual clinical disorder.

Pathological anxiety is considered a disproportionate emotional response that exaggerates the relationship between the objective value of a threat posed by a situation and the emotional response to it. It interferes with effective and adaptive socio-emotional management in adverse circumstances and impairs daily functioning. Those who suffer from it may experience an “increased sense of subjective apprehension at the mere thought of an imminent potential threat, regardless of whether it actually materialises” (Clark & Beck, 2012, p. 26).

The above analysis highlights the importance of supporting the mental health of workers in high-stress environments. Arón and Llanos (2004) emphasise the need to prevent emotional exhaustion and propose protective actions, such as maintaining clean personal spaces. Other recommended strategies include engaging in activities unrelated to violence, seeking technical and emotional support, and drawing on institutional resources to help professionals manage their emotional responses.

### **Interventions With Healthcare Workers**

The International Labour Organisation (ILO) proposed reference frameworks for studying psychosocial factors at work 40 years ago. However, it was not until 2011 that Juárez-García and Camacho reviewed the theoretical and methodological perspectives of this concept in depth. They highlighted the significance of designing workforce interventions tailored to the specific complexities of each environment, particularly for employees involved in caregiving.

There is evidence of the risks faced by this population. However, few studies have examined the results of interventions aimed at reducing negative effects and improving workplace well-being. Flores (2012) explains that “the exercise of containment between peers and that carried out by experts allows professionals working with women who have been abused not to compromise their professional practice” (p. 169). These practices ensure adequate work well-being, underscoring the positive effects of these interventions. In Chiapas, Mexico, the Secretariat of Gender Equality (2019) started an

Emotional Containment and Self-Care Tools Program. It aims to support employees who assist women who have survived violence. It consisted of eight group sessions and 100 individual sessions based on the Gestalt psychology approach. This resulted in “group integration and consolidation, (...) transparency in internal communication within work centres, in work groups by area speciality and in the group as a whole” (p.28).

Other proposals use methods similar to those of Quevedo (2019). They reported that social workers, psychologists, and lawyers used music therapy in counselling, treatment, and prevention of gender-based violence (GBV). These activities had a positive effect on aspects such as “emotional management, relational health and agency” (Quevedo, 2019, p. 5).

Emotional support programs and individual interventions have also proven effective in improving health outcomes. According to Serrano-Blanco et al. (2017), containment refers to the regulation of behaviour by the individual or through the intervention of an external agent when individuals display behavioural disorders. The latter results from failures in self-regulation mechanisms and the immediate environment's inability to provide effective containment. Emotional containment involves offering support to individuals who feel unsettled or are outside their normal circumstances. Professionals support a person's emotions through accompaniment and provide appropriate spaces for expressing feelings.

The study by Andreo et al. (2020), conducted with both clinical (CP) and non-clinical populations (NCP) with and without anxiety disorder diagnoses, found that CP used fewer adaptive coping strategies than NCP. Gutierrez and Márquez (2020) examined individuals with emotional disorders seeking psychological help and observed that those who employed adaptive cognitive coping strategies were less likely to experience anxiety or depression. These strategies involve managing anxiety and depression through active and adaptive coping methods that effectively address these issues (Pozzi et al., 2015). They include activities such as problem-solving, which applies cognitive and behavioural techniques to modify stress-inducing situations, and cognitive restructuring, which changes the perception of stressful events. Other strategies include seeking social support (emotional support from others) and expressing the emotions that arise during stressful situations.

Given the above, this study aimed to reduce anxiety, depression, and burnout among the participants. An emotional support program was implemented within a cognitive-behavioural framework, grounded in the theoretical and empirical background reviewed.

## Method

### Research Design and Hypothesis

This quasi-experimental study used a pre- and post-test design with two groups. This study aimed to evaluate the impact of a cognitive-behavioural intervention on burnout, anxiety, and depression among female professionals who treat victims of violence. The following general and specific hypotheses were formulated.

General hypothesis (Gh): The cognitive-behavioural intervention will significantly decrease burnout, anxiety, and depression levels among the participants.

Specific Hypothesis 1 (H1): The intervention significantly reduced the participants' anxiety levels.

Null Hypothesis 1 (H01): There will be no significant difference in anxiety levels before and after the intervention.

Specific Hypothesis 2 (H2): The intervention significantly reduced the participants' anxiety levels.

Null hypothesis 2 (H02): There was no significant difference in anxiety levels before and after the intervention.

Specific Hypothesis 3 (H3): The intervention will significantly reduce mental exhaustion, guilt, and indolence among participants.

Null Hypothesis 3 (H03): No significant differences will be observed in the levels of psychological exhaustion, guilt, and indolence among the participants before and after the intervention.

## Participants

The total sample consisted of 41 professionals working with survivors of violence in a public institution in the state of Morelos, Mexico. The inclusion criteria were current employment during the intervention, completion of pre- and post-intervention assessments, and informed consent. The intervention was conducted from October to December 2024 and did not involve financial compensation for the participants.

Sixty-one per cent of all employees participated, corresponding to 25 professional women working with victims of violence. Within this group, 48% held degrees in psychology, 28% in law, and 24% in social work. The mean age of the patients was 38.8 years (range, 25–55 years). Participants were also asked about their time in their professional roles: 20% had worked for fewer than six months, 24% for six months to one year, 32% for one to three years, 20% for three to five years, and 4% for more than five years.

## Instruments

The following instruments were used: the Burnout Test (Spanish acronym CESQT), the Beck Depression Questionnaire, and the Beck Anxiety Inventory. Each is described below, along with its validity and reliability.

The CESQT is a 20-item self-report questionnaire with five response options ranging from Never to Very Often: Every Day. The CESQT measures burnout using four subscales: One subscale is guilt, which relates to feelings of negative and indulgent behaviours and attitudes. Mental exhaustion is the physical and emotional fatigue that arises from dealing with people who cause setbacks. Indolence is the emergence of behaviours and attitudes of cynicism and indifference on the part of professionals who provide services to an organisation's clients. Work enthusiasm indicates a person's desire to achieve professional goals and is a source of personal satisfaction. The CESQT has statistical criteria for use in the Mexican population. The results of studies on this instrument (see Gil-Monte & Noyola, 2011; Gil-Monte & Zúñiga-Caballero, 2010; Gil-Monte et al., 2009) show that the fit of the hypothesised four-factor model was adequate and confirmed the formulated hypothesis. Cronbach's alpha coefficient showed good values for all four scales of the questionnaire. Most of the subscales had acceptable asymmetry values. However, enthusiasm for work slightly exceeded the  $\pm 1$  criterion.

The Beck Depression Inventory (BDI) is a self-report measure that assesses depressive symptoms through 21 items, each with four response options rated from 0 to 3, indicating the severity of symptoms. The total score, ranging from 0 to 63, reflects the individual's level of depression: 1–10 points indicate no depression; 11–16, minor mood disturbances; 17–20, mild depression; 21–30, moderate depression; 31–40, severe depression; and 41 or more, extreme depression. Jurado et al. (1998) confirmed that the instrument meets psychometric standards of reliability and validity for the Mexican population, with internal consistency (Cronbach's  $\alpha = .87$ ,  $p < .000$ ) and significant correlations with the Zung Scale ( $r = .70$ ,  $p < .000$ ;  $r = .65$ ,  $p < .000$ ) across different samples. Likewise, Contreras-Valdez et al. (2015) found that the two-factor model best represented the data, with no significant differences between men and women.

The Beck Anxiety Inventory (BAI), a self-report instrument, evaluates anxiety symptoms and distinguishes them from depression symptoms. It consists of 21 items rated on a scale of 0–3, yielding total scores between 0 and 63. Researchers interpreted anxiety levels as follows: 0–7, low anxiety; 8–15, mild anxiety; 16–25, moderate anxiety; and 26–63, severe anxiety. Robles et al. (2001) and Díaz-Barriga and Rangel (2019) reported strong validity and reliability for the Mexican population, with internal consistency coefficients of .83 and .89, respectively.

### Ethical Considerations

The intervention process relied on international ethical guidelines for research involving human subjects to respect their dignity, well-

being, integrity, and responsibility. The intervention process followed international ethical guidelines for research involving human subjects, including those drawn up by the WHO and the International Organisation for Medical Sciences, the Declaration of Helsinki, and the Universal Declaration of Ethical Principles for Psychologists. The board of the institution that conducted the intervention reviewed and approved the protocol.

Individuals wishing to participate in the study read and signed an informed consent form explaining the objectives of the assessment and intervention, the sections comprising the battery of tests, and the theoretical model underlying the interventions. The researchers explained how they would handle the results of the questionnaires, noting that they would report this information anonymously and in a group format, making it impossible to identify the respondents individually. Permission was also requested to display group results in technical and academic reports. The organisers informed the participants that they could withdraw from the intervention at any time without penalty.

## Procedure

The emotional support program, that is, the intervention, lasted for three months. The team scheduled individual support sessions lasting one hour each week for each participant, with a maximum of 12 sessions per participant. Three psychology professionals who had previously trained in the program conducted the sessions online and provided follow-up and supervision during the intervention.

The first stage of the intervention was an introduction to the program, which was designed to explain the objectives of the intervention to the participants, inform them of the risks and benefits of participating, and emphasise that participation was voluntary. The employees confirmed their acceptance of the intervention program by signing informed consent forms. During this meeting, the goal was to establish rapport between the psychologist assigned to the process and the participant. The dynamics, frequency, and duration of each session were determined. The cognitive-behavioural model used to conduct the sessions is also explained.

The researchers used Google Forms to distribute the questionnaire. These included sociodemographic questions and other study-related items. The facilitator shared the link to the form during the session and remained online during the video call to answer participants' questions.

The third stage of the intervention involved providing diagnostic feedback to participants. In the second session, the researchers shared and explained the questionnaire results with each participant individually. We also conducted a detailed interview to examine their

health issues, symptoms of anxiety or depression, and conflicts at work, home, and in their social life.

Goal setting was the fourth stage of the intervention. Based on the questionnaire results and observations from the interview, the participant and I established work objectives within the framework of the cognitive-behavioural model. These objectives aimed to help participants acquire psychoeducational and self-care tools for managing their condition.

The fifth stage of the intervention involved conducting sessions and assessing progress. The sessions incorporated cognitive-behavioural techniques, such as relaxation training and the identification of cognitive distortions, to reduce anxiety and stress, as well as the examination of intrusive thoughts. Tasks and activities, including journaling and thought recording, were assigned to the participants using active listening and continuous validation of their emotions, thoughts, and experiences. Each participant's progress, achievements, and challenges in relation to their goals were assessed weekly, along with their application of the techniques provided or independently developed during the process, with an emphasis on critical reflection.

The final stage of the intervention was the closing of the program. During this stage, the participants were asked to complete a battery of instruments using the Google Forms application. The questionnaire results were returned individually, and the participants' experiences and perspectives regarding the intervention, sense of improvement, and achievements were discussed with them. Table 1 shows the time periods and sessions associated with the program.

**Table 1**

*Stages in the Emotional Containment Program*

Month	Session number	Activity/topic
October	1	Diagnostic evaluation (administration of instruments)
	2 and 3	Diagnostic feedback, in-depth interview, and goal setting.
November	R24_F3_04	Actions for self-care, sleep hygiene and coping with anxiety.
	7 and 8	Coping with stress resulting from workload, working conditions, and personal conflicts among co-workers.
	9	Containment of emotions derived from the recognition of and coping with physical and emotional distress.
December	10	Review and feedback on recommendations made during previous sessions on topics related to self-care, sleep hygiene, and coping with anxiety and stress.
	11 and 12	Ending the intervention, administering the instruments, returning individual results, and analysing the changes observed.

**Data Analysis**

The evaluations were processed and analysed using SPSS (version 21). Cronbach's alpha reliability analysis and Pearson's correlation were conducted to assess the reliability and validity of the instruments used. Descriptive statistical analyses were performed to obtain the means, standard deviations, frequencies, and percentages of the variables evaluated before and after the intervention. Pre- and post-intervention measurements were analysed to test the hypotheses. The Wilcoxon test was applied to the CESQT dimensions because they were all ordinal variables. A paired-samples t-test was conducted for the ordinal variables of anxiety and depression, with the effect size calculated using Cohen's *d*.

## Results

Cronbach's alpha reliability analysis was used to assess the internal consistency of the scales. The CESQT scale obtained an alpha of .812, the anxiety scale an alpha of .800, and the depression scale an alpha of .803. These values indicate the high reliability and internal consistency of the instruments used.

Correlations between theoretically related constructs (convergent validity) and unrelated constructs (discriminant validity) confirmed the validity of the instruments. Anxiety was positively correlated with psychological exhaustion ( $r = .443$ ,  $p = .030$ ) and indolence ( $r = .554$ ,  $p = .005$ ). Depression was significantly associated with the same dimensions ( $r = .574$ ,  $p = .003$ ;  $r = .497$ ,  $p = .013$ , respectively). Anxiety and depression demonstrated a strong positive correlation ( $r = .635$ ,  $p = .001$ ), further supporting convergent validity.

In contrast, enthusiasm for work was not significantly correlated with anxiety ( $r = -.180$ ,  $p = .400$ ) or depression ( $r = -.129$ ,  $p = .549$ ), supporting the discriminant validity of the construct. These indicators confirm the psychometric adequacy of the scales used in this study.

### Burnout, Anxiety, and Depression Assessment

Table 2 presents the means and standard deviations for each dimension evaluated before and after the intervention. Although no significant differences were observed in the four dimensions comprising the CESQT, there were notable reductions in Anxiety and Depression indicators, suggesting a possible positive effect of the intervention on these dimensions.

**Table 2**  
*Average Results of the Dimensions Evaluated*

Indicator	Pretest evaluation		Post-test evaluation	
	Average	Typ. Dev.	Average	Typ. Dev.
CESQT – Enthusiasm for work	3.2	.88	3.3	.73
CESQT – Mental exhaustion	1.3	.94	1.6	1.07
CESQT – Indolence	0.2	.25	0.2	.26
CESQT – Guilt	0.4	.53	0.3	.58
Anxiety	7.6	5.1	4.5	4
Depression	5.0	5.3	3.1	3.4

At both evaluation points, there were high levels of enthusiasm for work and low levels in the other dimensions, indicating the absence of burnout.

Table 3 shows the anxiety data categorised by anxiety level. A decrease was observed in cases at the moderate level (from 0% to 16%), along with an increase at the low level (from 52% to 76%), confirming the effectiveness of the intervention.

**Table 3**  
*Participants by Anxiety Range and Pretest-Post-test Evaluation*

Anxiety range	Pre-test		Post-test	
	N	%	N	%
Low	13	52	19	76
Mild	8	32	6	24
Moderate	4	16	0	0
Severe	0	0	0	0
Total	25	100	25	100

A decrease in the average depression score was observed. Table 4 presents the categorisation by levels of depression, showing a decrease in cases at the level of “minor mood disturbances” (from 24% to 8%) and an increase at the level of “no signs of depression” (from 76% to 92%).

**Table 4**  
*Participants by Depression Level and Pretest-Post-test Evaluation*

Depression Level	Pre-test		Post-test	
	N	%	N	%
No signs of depression	19	76	23	92
Minor mood disturbances	6	24	2	8
Mild depression	0	0	0	0
Severe depression	0	0	0	0
Extreme depression	0	0	0	0
Total	25	100	25	100

*Pre-and Post-Intervention Comparison*

The impact of the intervention on the participants was assessed based on information obtained from the pre- and post-intervention evaluations. As shown in Table 5, the Wilcoxon signed-rank test Z-scores for the four dimensions of the CESQT showed no significant differences between pre- and post-intervention.

**Table 5**  
*Pre- and Post-Intervention Comparison*

**Table 5** *Pre- and Post-Intervention Comparison*

CESQT Dimension	Pre-intervention mean	Post-intervention mean	Z	next. (bilateral)
Mental exhaustion	1	1.5	-1.239	0.215
Indolence	0	0	-0.63	0.529
Guilt	0	0	-1.527	0.127
Enthusiasm for work	3.6	3.6	-0.751	0.453

Table 6 shows the pre- and post-intervention comparisons of anxiety and depression scores. A significant reduction in anxiety

scores was observed between the pre- and post-test assessments, with a significant difference according to the paired-sample t-test ( $t = 3.589$ ,  $p = .001$ ). The calculated effect size (Cohen, 2013) was  $d = 0.718$ , indicating a moderate to large impact. A decrease in the mean scores for depression indicators was observed. The paired-samples t-test indicated a marginally significant difference ( $t = 1.993$ ,  $p = .058$ ), with a small-to-moderate effect size ( $d = 0.399$ ). Although statistically inconclusive, this result suggests a significant improvement.

**Table 6**  
*Pre- and Post-Intervention Comparison of Anxiety and Depression*

		Paired Samples t-test					Cohen's test
		Average	Typ. Dev.	Typical error	T	next. (bilateral)	Cohen's d
Par 1	Pre_int. Anxiety - Post_int. Anxiety	3.08	4.2907	0.8581	3.589	0.001	0.718
Par 2	Pre_int. Depression - Post_int. Depression	1.84	4.6159	0.9231	3.745	0.058	0.399

The data analyses partially support the general hypothesis, as the intervention showed a significant effect on anxiety indicators and an improvement in depression, although it did not modify the burnout levels. HE1 was also accepted because the intervention significantly reduced participants' anxiety levels.

## Discussion

In Mexico, occupational health research has focused on describing psycho-emotional distress and its relationship with sociodemographic variables. The work of Arón and Llanos (2004) and Canet and García (2006) contributes to the identification of levels of emotional exhaustion and risk factors among those attending to survivors of violence. They proposed self-care and mitigation strategies for psychological distress. However, this study provides empirical evidence of the effectiveness of the intervention. This not only makes it possible to describe and identify risk factors and distress but also to advance concrete proposals for care in the Mexican context of the study.

The findings of the present study highlight the importance of cognitive-behavioural interventions implemented to improve workers' well-being by reducing anxiety and depression levels. The results partially support the study hypotheses. A significant decrease in participants' anxiety levels was observed, along with a sizable (albeit only marginally significant) improvement in depression indicators and no significant changes in burnout indicators assessed using the CESQT. These indicators suggest that the intervention successfully addressed immediate emotional symptoms but failed to significantly modify the perceptions associated with burnout.

The HE1 indicators were conclusive, indicating that the hypothesis was accepted. Statistical tests showed that the intervention substantially reduced anxiety symptoms among the participants. This is consistent with empirical evidence supporting the efficacy of cognitive-behavioural interventions, such as the evidence reported in the meta-analysis conducted by Hofmann et al. (2012). These authors referenced the effectiveness of the interventions implemented in this framework in contexts with high emotional demands.

Regarding HE2, the results showed a marginally significant difference with a small to moderate effect size. This hypothesis is statistically inadmissible, although the evidence suggests that it could be considered effective in future studies with greater statistical power. This statistical trend may be attributable to the short duration of the intervention or to a greater resistance of depressive symptoms to short-term changes (Beck, 1964).

As the results corresponding to HE3 did not show significant differences in any of the dimensions evaluated by the CESQT, the null hypothesis was accepted. A possible explanation, supported by the studies of both Gil-Monte (2005) and Maslach and Leiter (2016), is that burnout (as a psycho-social process) requires intervention processes incorporating group and organisational levels to achieve sustained transformations.

Although the intervention had positive effects on anxiety and depression, it did not improve the burnout indicators. This may be consistent with the analyses of Arón and Llanos (2004) and Canet and García (2006). These authors stress the importance of intervening in various aspects with professionals working on gender violence issues, since the latter are prone to experiencing emotional exhaustion due to their work. They also proposed an intervention and emphasised the significance of preventive actions, distinguishing between individual levels of intervention with self-care and group levels with team strengthening, protection, and social support. Therefore, burnout is posited as a dynamic process, the prevention and treatment of which requires changes in organisational dynamics designed to enhance the quality of life from a holistic perspective.

The findings suggest that while emotional symptoms can be improved through individual interventions, these actions are ineffective in addressing burnout. The latter is affected by structural, organisational, and cultural factors such as job insecurity, work overload, limited autonomy, and unstable employment. In this respect, regulatory frameworks such as NOM-035-STPS should promote mandatory preventive actions in organisations that guarantee healthy working conditions and workplaces.

Finally, the small sample size and lack of a control group limit the generalisability of the results but raise new questions for future research. These include which organisational interventions reduce burnout in contexts with high emotional demand and the impact of systematic access to emotional support and self-care spaces on this population.

## Conclusions

The results of this study, which evaluated the impact of a cognitive-behavioural intervention on the mental health of professional women treating victims of violence, suggest that the intervention had a significant effect on reducing participants' anxiety levels. In the case of depression levels, the decrease was large but only marginally significant, and no significant changes were found in the burnout dimensions. These results support the planning and implementation of actions focused on psychosocial care to improve the occupational health of workers facing high emotional burdens while performing their work. They point to the need for comprehensive strategies, including an analysis of organisational processes and risks, to prevent burnout syndrome.

Given the above, institutions employing professionals who treat survivors of violence should design psychoeducational programs to support emotional containment, management, and self-care among their employees. It is also necessary to develop institutional policies to address the effects of burnout on employees and promote healthy working environments.

For future research, we suggest using experimental designs with larger groups, including a control group, and follow-up assessments to ensure the sustainability of these effects. It would be useful to consider variables such as empathy overload, structural violence, and vicarious stress among similar groups of health professionals in future studies. The findings of this study suggest that emotional support, psychoeducational, and/or self-care programs can be incorporated into workplace initiatives to prevent employee burnout and improve the quality of services. From a public policy perspective, it is important to strengthen the NOM-035-STPS-2018 to implement mandatory actions that will create healthy work environments. Finally, it is essential to acknowledge that burnout is also a result of

Mexico's structural conditions, underlining the urgent need to strengthen labour legislation, formalise and stabilise jobs, and create quality employment.

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