



**ORIGINAL RESEARCH: EMPIRICAL
RESEARCH - QUANTITATIVE**

Development of nurse-led videoconference-delivered cognitive behavioural therapy for domestic violence: Feasibility and acceptability

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Abstract

Aims: Because of the COVID-19 lockdown, an internet-based adaption of a nurse-led cognitive behavioural group therapy (CGBT) was provided for perpetrators of domestic violence. The aim of this study was to describe the development of the therapy, examine the initial feasibility and impact on patient satisfaction of the programme and evaluate the associated patient-reported experiences.

Design: Programme development as well as testing its feasibility and acceptability using cross-sectional survey data.

Methods: Anonymous data were collected at a university hospital in Norway between October and December 2021. Feasibility was examined by comparing the numbers of patients who agreed to participate, chose not to participate or dropped out during the intervention. There was a self-reporting scale that evaluated patient satisfaction, and the participants were invited to make suggestions for improvement of the intervention. The results of the study are reported in accordance with the STROBE checklist.

Results: The videoconference-delivered CGBT was feasible. Two of the 67 patients refused to attend therapy delivered in a remote manner (3.0%), and four patients (6.0%) were classified as non-completers. Overall, patients were satisfied with the therapy.

Conclusions: This study described a promising nurse-led internet-based intervention for individuals who were domestically violent and had voluntarily sought healthcare help. The participants' satisfaction with the intervention indicates its acceptability and feasibility. However, research on internet-based cognitive behaviour therapy is still in its infancy. These results may guide the future development of internet-based cognitive behavioural therapy (CBT) for individuals who perpetrate domestic violence. Further research is needed on the pros and cons of this mode of service delivery.

Impact: This study addressed the challenges of providing treatment for domestic violence during the COVID-19 pandemic by examining videoconference-delivered CBT for individuals who perpetrate domestic violence.

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KEYWORDS

cognitive behavioural therapy, COVID-19, domestic violence, experiences, nursing, outcomes, patient satisfaction, videoconferencing

1 | INTRODUCTION

The COVID-19 pandemic has profoundly affected life in the general population (Piquero et al., 2021). Restrictions on social contact, unpredictable work conditions, school closures and restrictions on regular activities have all imposed changes on family life. Many people have suffered economically. Rising unemployment has created stress and conflict due to income loss, and a significant increase in domestic violence has been reported in many countries around the world (World Health Organization, 2019). Although the scientific evidence showing exactly how the ongoing COVID-19 pandemic has affected rates of domestic violence remains limited, existing knowledge suggests that the impact has been negative (Nesset, Gudde, et al., 2021; Piquero et al., 2021; Usher et al., 2020). A recent study in Norway reported a 54% increase in intimate partner violence being reported to the police between March and December 2020 (Nesset, Gudde, et al., 2021). Similar descriptions were reported in a narrative review on challenges and risks to children and adolescents mental health, and social distancing during the pandemic was found to have increased children's exposure to parental violence (Fegert et al., 2020).

As a consequence of the pandemic prevention measures, interruptions of regular medical services forced mental healthcare services to reorganize, and internet-based psychiatric therapy was developed to meet patients' need for help. Nurses at an anger management outpatient clinic at St. Olav's University Hospital developed a manualized cognitive behavioural group therapy (CBGT) for perpetrators of domestic violence. Cognitive theory, on which the anger management therapy is based, is concerned with negative automatic thoughts and feelings about oneself and others that occur in certain situations and which affect a person's reactions (Jarwson et al., 2015). CBGT is a well-known therapeutic approach to domestic violence (Jarwson et al., 2015; Nesset et al., 2020). While the effectiveness of group-based approaches has been established for individuals who voluntarily seek treatment for domestic violence, research on group-based cognitive behavioural therapy (CBT) delivered by videoconference is sparse (Barnett et al., 2021).

2 | BACKGROUND

Domestic violence is defined as a form of interpersonal violence against an intimate partner, a child, an elderly person or other family members (World Health Organization, 2019). The violence can be physical, psychological or sexual, and it is often a mix of the three. Physical violence may include slapping or shoving, hitting with a fist, choking, beating or using some form of weapon (World Health Organization, 2019). Psychological violence encompasses a wide

range of non-physical violent behaviours, such as name-calling, isolation from friends and family, financial control, threats to commit suicide and death threats (World Health Organization, 2019). The World Health Organization defines sexual violence as any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting (World Health Organization, 2019).

CBGT is among the most common treatment approaches offered to perpetrators of domestic violence (Nesset et al., 2019). However, systematic reviews and meta-analyses evaluating its effectiveness for domestic violence have concluded that knowledge remains sparse (Karakurt et al., 2019; Nesset et al., 2019). In addition, primary studies often lack detailed descriptions of the content of the different therapies included under the heading of 'cognitive therapy'. As a result, it is difficult to reach conclusions about their effectiveness (Nesset et al., 2019).

Recent randomized controlled trials on the effectiveness of CBGT for individuals perpetrating domestic violence have reported a reduction in violence after therapy (Murphy et al., 2017; Nesset et al., 2020; Palmstierna et al., 2012; Taft et al., 2016). However, most studies evaluate the effect of treatment on convicted perpetrators, with Palmstierna et al. (2012) and Nesset et al. (2020) being two of very few exceptions in this regard. One randomized controlled trial of men self-referring for treatment for domestically violent behaviour reported a substantial decrease in violence after therapy (Nesset et al., 2020). In a meta-analysis investigating the relationship between domestic violence perpetration and victimization and mental health outcomes, the researchers suggest that interventions targeting perpetrators' coping strategies, emotion regulation, rumination and past trauma may be valuable for ending violent behaviour (Spencer et al., 2019). Another study of men self-referring to therapy for intimate partner violence found enhanced emotion regulation and a decrease in symptoms of anxiety and depression after CBGT (Nesset, Bjorngaard, et al., 2021). Most studies of CBGT typically seek outcomes such as a reduction of violent behaviours, improved self-esteem, reduced substance abuse and improved anger management (Nesset et al., 2019). However, group participants often present with co-existing challenges in their lives, including poor mental health, and it is important to address these to reduce the risk of recurrent domestic violence (Spencer et al., 2019).

Digitally delivered responses to domestic violence provide a valuable opportunity to respond to the growing demand for evidence-based practice in mental health settings (Hesser et al., 2017; Kourti et al., 2021; Matsumoto et al., 2021). Videoconference-delivered CBGT may enable patients in remote areas to attend real-time interactive sessions with therapists (Matsumoto et al., 2021).

Existing scientific knowledge suggests that violence prevention programmes could be delivered via digital technologies (Hesser

et al., 2017), although systematic reviews of videoconference-delivered CBGT for perpetrators of domestic violence are lacking (Barnett et al., 2021). An umbrella review of systematic reviews suggests that videoconferencing has the potential to become a viable form of treatment delivery for a host of psychiatric syndromes (Barnett et al., 2021). However, there is little evidence about the feasibility and acceptability of videoconference-delivered CBGT for individuals who voluntarily seek treatment for domestic violent behaviour. Furthermore, little is known about the patients' perceptions of digitally delivered CBGT.

Moreover, there is limited knowledge about patients' satisfaction with nurse-led CBGT delivered by videoconference in clinical settings. Although patients' experiences and satisfaction with new programmes are essential to improve service quality for individuals who perpetrate domestic violence, there are no published studies describing and evaluating the impact of such nurse-led programmes in relation to this outcome. Previous research on internet-based psychological interventions for different psychiatric syndromes has raised concerns about whether a working alliance can be created between patient and therapist in this kind of setting (Farver-Vestergaard et al., 2019). Furthermore, some have asked whether it is possible for patients to engage in the therapy to an extent sufficient for positive change in mental health symptoms (Farver-Vestergaard et al., 2019).

Finally, no studies have specifically explored patients' experiences of CBGT delivered by videoconference in clinical settings during the COVID-19 pandemic. Responding to these gaps in the literature, we developed an internet-based version of an evidence-based CBGT intervention and conducted a cross-sectional study to assess whether the intervention was feasible and acceptable in a clinical setting.

3 | THE STUDY

3.1 | Aims

As there are substantial gaps in the available literature about videoconference-delivered CBGT for individuals who are domestically violent, this initial study posed the following research questions:

- Is a group-based CBT intervention delivered by videoconference feasible to implement in a clinical setting?
- Were the participants satisfied with the intervention?
- Did gender affect levels of satisfaction?

In addition, we aimed to describe the technical and practical challenges of ensuring the safe delivery of videoconference-delivered CBGT.

3.2 | Design

This study involved a cross-sectional questionnaire survey. It was undertaken at an outpatient clinic at St. Olav's University Hospital,

Centre for Research and Education in Security, Prisons, and Forensic Psychiatry and nurses delivered the group treatment.

3.3 | Sample/participants

The study participants were recruited from patients who had attended therapy for aggressive and violent behaviour against their partners and/or children at the outpatient clinic between March 2020 and October 2021 ($N = 67$; see Figure 1). To be deemed eligible for the CBGT, individuals had to be at least 18 years of age and able to understand and speak Norwegian. Informed consent to participate in the study was electronically obtained from the participants prior to study inclusion. Of the 67 eligible participants, 28 returned the questionnaire.

3.4 | Data collection

The online survey was conducted between October and December 2021 and consisted of four sections: an orientation section, a section including the CSQ-8 satisfaction scale, a section comprised of two open-ended questions that invited the respondents to give feedback on their experiences with the CBGT and a section on their personal characteristics and use of the service. Completion of the survey took approximately 10 min. Submission of the survey constituted a statement of informed consent.

The data were collected electronically via eFORSK. This system is used for the electronic invitation and collection of clinical data and supports secure storage of self-reported research data. The survey was distributed using a link. The respondents confirmed their ID electronically on helsenorge.no, before the form was made available for consent and responses. After the participants consented to participate, they completed the scale via secure digital mail or via the personal register *Helsenorge* (the Norwegian quality indicator system).

3.5 | Variables and outcome measures

Sociodemographic information on gender and age and use of services was self-reported by the participants after they had completed the interventions (post-intervention data collection only). The respondents' ages were reported in groups: 18–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years and over 65 years (Table 1).

The primary outcomes concerned initial feasibility, defined as the percentage of eligible patients choosing not to participate in the intervention, and acceptability, defined as the percentage of participants choosing to drop out from the intervention (non-completers). Reasons for intervention discontinuation were collected.

Patient satisfaction with the intervention was assessed using the client satisfaction questionnaire 8-items (CSQ-8) tool. The CSQ-8 contained questions about how satisfied the client was with the

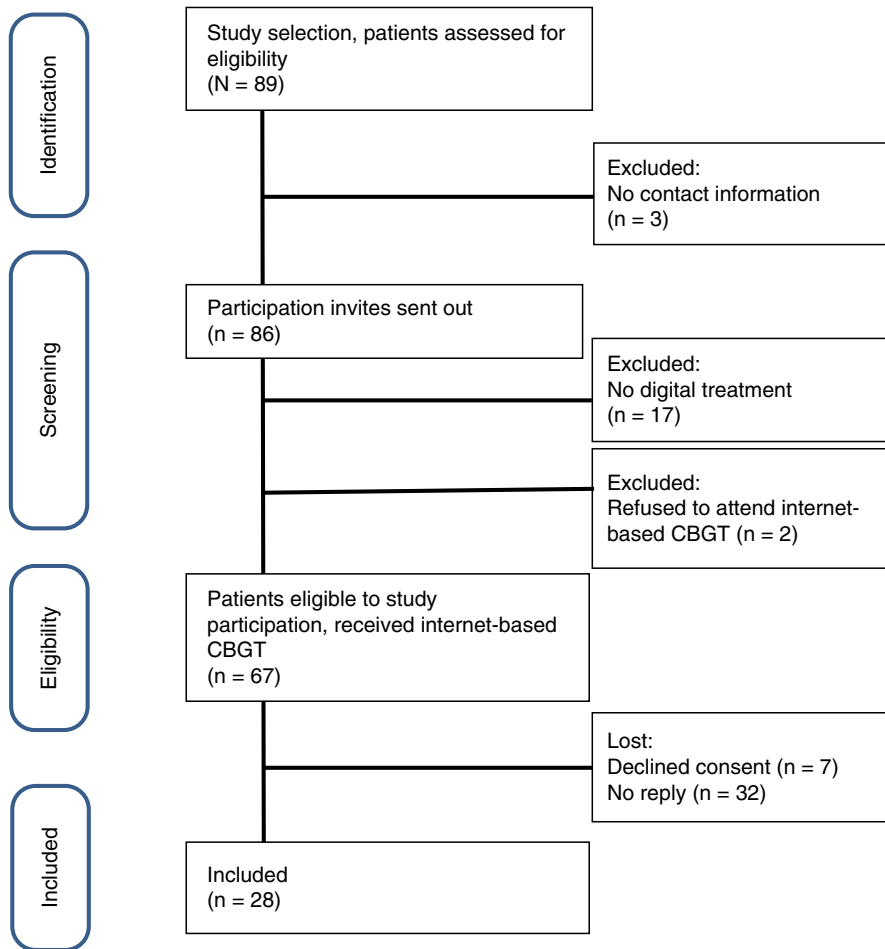


FIGURE 1 Participant flow

TABLE 1 Demographic characteristics of participants (N = 28)

Variable	n (%)
Gender	
Female	7 (25)
Male	21 (75)
Age group (years)	
18–24	2 (7.1)
25–34	8 (28.6)
35–44	12 (42.9)
45–54	4 (14.3)
55–64	2 (7.1)

health services that they had received. The items were answered using a 4-point Likert scale (1 = low satisfaction and 4 = high satisfaction), where scores ranged from 8 to 32 and a higher score indicated greater satisfaction. In addition, there was an open field into which the client could enter comments, tips and suggestions for improvement (Attkisson & Greenfield, 2004). The CSQ-8 is under validation in a Norwegian population and has been used in a research study in Norwegian mental health settings (Lara-Cabrera et al., 2016). The Cronbach's alpha for our sample was .87, indicating a very good internal consistency (Gagnier et al., 2021).

3.6 | The videoconference-delivered cognitive CBGT

The videoconference-delivered CBGT was delivered once a week over 15 weeks by the third and fourth authors.

The original CBGT from which the digital version was derived was developed and manualized by psychiatric nurses (Jarwson et al., 2015). The main goal of the intervention was to reduce and ultimately prevent future intimate partner violence (psychological, physical, material and sexual). Each group consisted of approximately six patients and received two or three individual sessions and 15 CBGT sessions. A group session lasted approximately 2h. The intervention had a family focus, with partners and children invited to attend one of the individual sessions. The main purpose of meeting with the victim partner was to explain the therapeutic process that the perpetrator would be undergoing. If the couple had children, they were encouraged to bring them to an individual session. To minimize the child's feelings of guilt and shame, the nurses explained in an age-appropriate manner what type of behaviours were regarded as violence (i.e. acts of physical and psychological aggression and controlling behaviours) and that the violent parent was responsible for their own behaviour. Furthermore, the nurses explained that the violent parent and partner would be undergoing therapy, which might give the family hope that positive change was possible. Finally,

by meeting the victims of the violence, the nurses were able to assess the risk of ongoing violence and take necessary measures to protect the victims, if necessary (e.g. contacting child welfare services or the police).

The important aspects of the CBGT in this study were to teach the patients that their ways of perceiving stressful situations affected how they emotionally reacted to them as well as to explain to the patients that exposing children to recurrent domestic violence would negatively affect their development. Identifying and exploring the typical situations in which violence has occurred is an essential part of therapy to learn how to avoid violent reactions in the future (Jarwson et al., 2015). The patients were encouraged to face challenging violence-inducing situations at home and to practise alternative reaction strategies, such as time-out and positive self-talk (Jarwson et al., 2015). Finally, it was important for the patients to learn how to accept negative emotions, without acting them out.

3.7 | Development process of the videoconference-delivered CBGT

To facilitate the development of the content and design of the programme, a three-step implementation process was applied as follows: (a) choosing course content and the digital platform, (b) changing the procedures to share homework and (c) changing the procedures to offer patients individual sessions to improve collaboration with family members.

When the lockdown was imposed in March 2020, the nurses began to assess how the intervention could be delivered in a safe manner. Skype for Business was chosen as the digital platform, as recommended by the hospital's IT security department. Informed consent to participate in a videoconference-delivered therapy was obtained from the patients by telephone along with permission to contact them digitally.

The therapists modified the written material used for psychoeducation purposes (i.e. PowerPoint files), making it suitable for a digital solution. The 'silence clause' was important to review with the patients in the digital groups to ensure that no unauthorized people could see or hear what went on during the therapy sessions. Workbooks and the other written material to be used during the therapy process were sent by email to the patients in advance of the sessions. The patients connected to the videoconferences via PC, iPad or smartphone.

The content of the treatment programmes was the same. Only the mode of delivery was different. For instance, a video about domestic violence normally shown during in-person therapy groups was now given as homework and discussed afterwards in the videoconference sessions.

Violent episodes were discussed in the same manner as in the in-person group therapy, namely by identifying the negative automatic thoughts and beliefs that were active in the anger-induced situation. The patients received interactive feedback from the other group members during the sessions. If the individual patient agreed to it, the therapists shared their homework on the screen for the other

group members to discuss and give feedback on—for instance, suggesting alternative ways of interpreting a situation.

3.8 | Ethical considerations

Prior to study commencement, the study was assessed by the regional ethics committee and defined as a quality assurance project (Quality assurance project no. 285208). In Norway, quality control studies fall outside the regional ethics committee's remit. The data protection officer at St. Olav's University Hospital approved the study. To guide the development of the survey, we used the checklist for reporting results of internet e-surveys (CHERRIES; Eysenbach, 2004).

3.9 | Data analysis

The data were entered into an Excel spreadsheet and then imported into IBM SPSS Statistics Version 28.0 (IBM Corp. Released, 2021). IBM SPSS Statistics for Windows, Version 28.0. (IBM Corp). Descriptive statistics were produced to summarize the sociodemographic variables. Frequencies, percentages, means and standard deviations were calculated to describe the patients' satisfaction with the interventions.

Feasibility was measured by calculating the percentage of patients who had refused to participate in the intervention and the percentage classified as non-completers. The open question was not mandatory, therefore the qualitative data gathered from the responses were presented as comments in the results section.

3.10 | Validity and reliability/rigour

To ensure the validity and reliability of the study, an appropriate scale for measuring patient satisfaction was included (Miglietta et al., 2018). In our sample, Cronbach's alpha value for the scale was very good. The statistical analyses were carried out by a blinded evaluator. For the qualitative component, the context and coding and generated themes were categorized manually by the first author. The reporting of the results was guided by the tool for 'strengthening the reporting of observational studies in epidemiology' (STROBE; von Elm et al., 2007).

4 | RESULTS/FINDINGS

4.1 | Participants

The videoconference-delivered CBGT programme was offered to 67 patients between March 2020 and October 2021. All patients were then invited to participate in the study, and 28 completed the survey (42% response rate).

4.2 | Feasibility and acceptability

Two of the 67 patients (3.0%) refused to attend therapy delivered by videoconferencing. Four patients (6.0%) were classified as non-completers (one patient left the intervention due to other health issues, two due to changes in a work situation and one because of difficulties with therapy in a group setting). Knowledge of acceptability was obtained by asking the participants to comment on the usefulness of the videoconference-delivered CBGT. Seven participants shared their reflections on how the therapy had worked for them. Overall, the participants were content with the therapy and with the nurses who had led the sessions. They reported feeling safe in the group setting and said that they had learned a lot about themselves (e.g., about difficult feelings and the vulnerabilities that lead to anger and violence), even though it was only a digital group. The female participants were more content with the length of the therapy, as measured by item 5 in the CSQ-8 (see Table 2), whereas the male participants stated that they would have liked the intervention to have lasted longer. One participant said that they would recommend the videoconference-delivered CBGT to others who were struggling with anger and domestically violent behaviour. Others commented that they would have liked to have had both in-person group therapy and online sessions.

Some participants reported challenges with the therapy. These included problems with internet bandwidth, unstable internet connection, lack of software and hardware (e.g. webcams) and problems with noise during the sessions. Some participants had to use their smartphones, which meant that they were only able to see one co-participant at a time, rather than the whole group. Some participants had only older mobile phones that did not have in-built cameras, hence they were unable to see the other group members at all. Moreover, those following the group therapy by mobile phone were not able to read the PowerPoints presented by the nurses during the psychoeducation sessions, as their screens were too small. The nurses noted that Skype for Business could only display up to five participants on the PC screen at the same time, which made it difficult to run larger groups. Some participants had no private space in the home and were anxious about being disrupted by family members or colleagues. Finally, the nurses found it challenging to monitor the risk of ongoing domestic violence during the videoconference-delivered therapy (e.g. because it was difficult to observe bodily signs of anger arousal).

5 | DISCUSSION

5.1 | Feasibility and acceptability

This study investigated the development of nurse-led videoconference-delivered CBGT. The feasibility of this intervention was measured by calculating (1) the percentage of patients who refused to participate in the intervention and (2) the percentage of patients classified as non-completers. A high rate of patients (97%)

chose to participate. This finding is in accordance with previous literature on group-based teletherapy (Puspitasari et al., 2021). Four patients dropped out of the intervention. The reasons for declining to participate were not collected, but the reasons for leaving the intervention were. Only one participant dropped out due to difficulties with therapy in a group setting. The low rates of people refusing to participate or being classified as non-completers, while preliminary, suggest that the intervention was feasible and well accepted. As suggested by Payne et al., videoconferencing groups can be a viable alternative to in-person groups, although further research is needed to obtain a better understanding of how to improve retention rates (Payne et al., 2020).

5.2 | Patient satisfaction

The mean satisfaction scores in our study are comparable to those in previous studies on patient satisfaction with psychotherapy for male inmates (Morgan et al., 1999) and group teletherapy for individuals with psychosis (Wood et al., 2020). Satisfaction with the intervention was indicated by quantitative and qualitative data, and the majority of the participants said that they would recommend the services to a friend (CSQ-8, item 8). About the pre-defined hypothesis that gender would affect satisfaction with the therapy, we found that female participants scored higher than male participants on the CSQ-8 satisfaction scale. However, our sample was limited by its small size and the absence of a control group, which might have biased the results. The observed trends may have been secondary to the benefits of the group setting, rather than the video-based solution. However, in line with this study, previous research has suggested that internet-delivered CBT may be a feasible alternative or supplement to existing treatments of individuals who perpetrate domestic violence (Hesser et al., 2017). Nevertheless, given the lack of studies measuring patient satisfaction in mental health settings during the COVID-19-pandemic, a larger trial assessing patient satisfaction is needed (Hawrysz et al., 2021).

5.3 | Service delivery and technical challenges

The use of technology posed some problems. Several technical challenges were reported, including problems related to audio and video during the video chat-based therapy sessions. For instance, those with internet problems could be logged off during the sessions and fragments of conversation audio could be lost. These issues caused interruptions to the flow of the group interactions, a problem highlighted in previous research (Appleton et al., 2021). The therapists reported that this was very disturbing to the patients, especially during the first few sessions. However, as patients become accustomed to the digital platform, the patients or therapists would simply repeat what they had been saying once the interruption had been resolved.

About homework, and the sharing of that with the group, all patients who digitally participated worked with their specific anger

TABLE 2 Participants' satisfaction with the internet-based cognitive therapy

Items	ICBT (N = 28)			ICBT male (n = 21)			ICBT female (n = 7)			
	M	SD	95% CI	M	SD	95% CI	M	SD	95% CI	p
1	3.32	0.670	3.06–3.58	3.24	0.7	2.92–3.56	3.57	0.535	3.08–4.07	.348
2	3.32	0.612	3.08–3.56	3.25	0.625	2.95–3.52	3.57	0.535	3.08–4.07	.296
3	3.11	0.685	2.85–3.37	3.24	0.74	2.71–3.38	3.29	0.488	2.83–3.74	.568
4	3.75	0.441	3.58–3.92	3.67	0.483	3.45–3.89	4	0	4.0–4.0	.208
5	3.14	1.01	2.75–3.53	2.90	1.01	2.43–3.38	3.86	0.378	3.51–4.21	.027
6	3.46	0.637	3.22–3.71	3.38	0.669	3.08–3.69	3.71	0.488	3.26–4.17	.321
7	3.64	0.559	3.43–3.86	3.52	0.602	3.25–3.80	4	0	4.0–4.0	.101
8	3.43	0.634	3.18–3.67	3.38	0.59	3.11–3.65	3.57	0.794	2.85–4.30	.405
CSQ-8, total score	27.2	3.87	25.7–28.7							

Note: CSQ-8 scores ranged from 8 to 32, a higher score indicates greater satisfaction (1 = low satisfaction; 4 = high satisfaction).

Abbreviations: CSQ-8, Client Satisfaction Questionnaire 8-item version; ICBT, Internet-based Cognitive Behavioural Therapy; M, mean; SD, standard deviation.

*Significant level at $p < .05$ is bold.

situation on templates that they filled out between group meetings. However, this demanded some preparation in advance of the sessions. For the therapists, to share with everyone in the group what each patient had worked with, patients had to send their homework to the therapist in advance by email. In the first videoconference group, extra time was required to establish this new routine. Later difficulties were avoided through appropriate planning and clear instructions. The patients presenting their homework could then receive feedback from the other group participants and the therapist, without affecting the group dynamics. In addition, it took some time before the therapists were accustomed to observing the non-verbal body language via video. On the other hand, the therapists reported that it was easier for some patients to actively participate in digital discussions with other patients because, for example, they were more easily able to interrupt each other in video-based discussions.

There was also positive feedback associated with the digital solutions. By offering videoconference-delivered CBGT, patients living in remote areas could be included, and those in employment could take time away from work for the specific period of the session, which reduced time constraints. In addition, patients could participate in the groups even if they were in COVID-19 quarantine, had family members in quarantine or had symptoms of COVID-19. In this way, many barriers to attendance were removed. Digital meetings were also held with the local health, children and family services. When the COVID-19 restrictions were imposed, these digital solutions became critically important for ensuring that service delivery could continue.

The patients appreciated the opportunity to engage in shared learning and overcome the social problems created by the COVID restrictions. The group participants were able to share their emotions and knowledge in an interactive way. In the context of widespread difficulties with accessing mental health services during the pandemic, this finding is promising, with the potential to help patients overcome severe challenges. The use of videoconference-based group therapy provides many new possibilities for nurses looking to support their patients. However, to better document these benefits, more research is needed.

5.4 | Limitations

This was a feasibility study with certain limitations. Since no randomization or allocation concealment procedures were performed, conclusions about the effects of the videoconference-delivered CBGT on violence would be inappropriate. Second, the patients could not be blinded to the therapy, and since they never attended the in-person version of the CBGT, the two methods of treatment delivery could not be compared. Third, the validity of the questionnaire warrants further consideration, as a validation of the CSQ-8 in a Norwegian population is yet to be published. In addition, only 28 of 67 eligible participants returned the questionnaire, which is a risk, as the study relies on self-reported outcomes. Furthermore, the sample had a majority of male perpetrators, which limits the external validity with regard to other populations. Finally, the results come from

a small sample of patients, all of whom reported their experiences after the intervention. Therefore, the results should be interpreted as a summary of perceptions from several individual participants.

Nevertheless, the sample group appreciated this simple intervention delivery method. As few patients dropped out of the intervention and most reported that they were satisfied with the programme, this demonstrates the potential of the intervention to improve engagement with treatment and maintain access to mental health services. That being said, no previous research has reported on patient satisfaction with videoconference-delivered CBGT. More research is thus needed to replicate our findings. Future studies should explore how to optimize videoconference-delivered interventions and better understand the impact on larger samples, applying measurements before and after the interventions.

6 | CONCLUSIONS

Our findings provide preliminary evidence that patients are satisfied with nurse-led CBGT. This evaluation adds to the literature on the value of videoconference-delivered therapy for individuals who perpetrate domestic violence. The findings should also help nurses and researchers recognize the potential of videoconference-delivered therapy as an alternative to in-person therapy during crises such as the COVID-19 pandemic.

AUTHOR CONTRIBUTIONS

MBN, CL, MCL-L and TP made substantial contributions to conception and design. MBN, MCL-L and CL drafted the original manuscript. AM and EN collected data, described the therapeutic intervention and were involved in revising the manuscript. CL made substantial contributions to the conception and acquisition of data and performed the statistical analysis. CL, MBN and MCL-L interpreted the data. TP critically reviewed the manuscript for important intellectual content. MBN, CL, MCL-L, AM, EN and TP agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. All the authors gave final approval of the version of the manuscript.

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CONFLICT OF INTEREST

The authors declare that they have no conflict of interest to disclose.

PEER REVIEW

The peer review history for this article is available at <https://publons.com/publon/10.1111/jan.15347>.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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