INTERVENTION PROGRAMS FOR DOMESTIC ABUSER
PROGRAME DE INTERVENȚIE PENTRU ABUZATORUL DOMESTIC

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Abstract

The study is dedicated to describing the intervention program for the domestic aggressor, both from the perspective of theories that explain the phenomenology of violence, and from the perspective of intervention practices. The program contains the theoretical analysis of the intervention models: the cognitive-behavioral model, the dynamic approach, the systemic approach, the clinical and non-clinical models. The program was based on an integrative model that includes didactic presentations, dialogic exchanges, videos, role-playing games. The psychological intervention program presents the eclectic integrative model, developed and implemented by the author in a penitentiary environment. The effectiveness of the program was done, in accordance with the specialized literature, in terms of the size of the retest effect, significant values of the effectiveness of the program (ηp2 > 0.5) were recorded, as well as significant differences for all variables of interest associated with the domestic aggressor.

Keywords: **aggressor domestic, violence family, intervention program, therapeutic models.**

Rezumat

Studiul este dedicat descrierii programei de intervenție pentru agresorul domestic, atât din perspectiva teoriilor care explică fenomenologia violenței, cât și din perspectiva practicilor de intervenție. Programul conține analiza teoretică a modelelor de intervenție: modelul cognitiv-comportamental, abordarea dinamică, abordarea sistemică, modelele clinice și non-clinice. Programul s-a bazat pe un model integrativ care include prezentări didactice, schimburi dialogice, videoclipuri, jocuri de rol. Programul de intervenție psihologică prezintă modelul eclectic integrator, elaborat și implementat de autor într-un mediu penitenciar. Eficacitatea programului s-a făcut, în acord cu literatura de specialitate, în ceea ce privește mărimea efectului de la retest, au fost înregistrate valori semnificative ale eficacității programei (ηp2 > 0,5), precum și diferențe semnificative pentru toate variabilele de interes asociate cu agresorul domestic.

Cuvinte-cheie: **abuzator domestic, modele terapeutice, program de intervenție, violență domestică.**

Introduction. Domestic abusers (DV) leaves its victims deeply traumatized, both physically and emotionally. In many cases, unfortunately, it results in their death, which has made the question "what should be done about men who beat their partners?" [17, p. 606]. Thus, DV and IPV interventions have gained considerable momentum in countries around the world with the aim of preventing or at least reducing the prevalence of this form of violence. L. K. Hamberger and J. E. Hastings (1993), as cited by R. C. Davis and colleagues (2008),

group the types of interventions for DV perpetrators into five categories, according to their orientation [10].

In this context, the first intervention model is framed within the feminist orientation. The feminist approach is "a political approach" [11, p. 4], which asserts that violence between men and women has its roots in a patriarchal society that empowers men and oppresses women [apud 10]. DV is seen as a means of establishing and maintaining male dominance and is seen as a by-product of male and female sex roles. Economic subordination has made women dependent on men and unable to leave abusive situations. Feminist-based intervention programs are mainly based on "re-educating" abusers about male and female roles and appropriate behavior in intimate relationships.

Based on the realization that providing services to victims of domestic abuse for a moment or for a period of time and then returning them to the same environment did little to solve the problems. This was aided by voices, particularly those of men's counselors, who advocated for the rehabilitation of men who stated that they wanted a change in behavior [17]. In this way, the first group intervention programs were developed, with group intervention being considered more appropriate than individual counseling or marital therapy because it expands the social networks of batterers by including support persons. Groups were also found to be less costly compared to individual counseling sessions [10].

Aligning with the feminist mainstream, the traditional paradigm of intervention programs has centered on analyzing power from a gender perspective. Traditionally, DV in intimate and couple relationships reflected the patriarchal organization of society, in which men had the dominant role. Violence, in all its forms, was the means of maintaining male supremacy when men felt their power and dominance threatened. Physical strength gave them an advantage, while economic inferiority made women dependent and unable to escape abusive relationships. Thus, most of the pioneers in the field created intervention programs for male abusers based on the feminist educational model, the Duluth model being one of them and the most widely known and used [19].

The Duluth model (*Domestic Abuse Intervention Project of Duluth*, Minnesota) posits that the root cause of DV is the patriarchal mindset of male supremacy and dominance, emphasizing the importance of the community sanctioning male power and control in a coordinated response [23]. According to the Duluth model, the abuser maintains control over his partner, constantly exercising acts of coercion, intimidation, and isolation marked by violence. The model is implemented in a variety of protocols, lasting from 8 to 36 weeks, and is the gold standard treatment in most communities, with some US states mandating it.

Cognitive-behavioral therapy (CBT) group therapy is another approach to treating bullies. CBT theory for bullies is based on the premise that behaviors are influenced by the way people construct and interpret their environment and experiences, i.e. how they think about themselves, other people and established relationships, and that behaviors are learned as a result of experiences reinforced positively and negatively through the reward and punishment system. Cognitive-behavioral theory posits that men batter because: 1) they imitate examples of abuse they have witnessed in childhood or in the media; ii) abuse is rewarded; 2) it enables the abuser to get what he wants; and 3) abuse is reinforced through the compliance and submission of the victim. The cognitive-behavioral model, based on social learning theory, considers that domestic violence is a behavior learned by perpetrators through direct ob-

servation of role models, indirect observation (e.g., through the media), and learning experiences through "trial and error" [apud 10, p.199].

The dynamic family approach sees partner violence as symptomatic of repressed anger that needs to be expressed in other ways. The family approach sees both partners as responsible for the violence. As a working technique, batterers, and often their partners, are assigned to groups that work on developing better communication within the dyadic relationship and venting anger.

The *insight-oriented* approach interprets DV as a symptom of underlying issues from the perpetrator's past (e.g., "residual fear or anger from past parental abuse") that unconsciously drive current violent behavior [10, p. 5; p. 197]. Intervention involves examining inner experiences, past experiences, and current interactions with others.

The systemic approach is based on the premise that DV is generated by competition for control in dyadic relationships, with each partner trying to dominate and control the other. According to this approach, DV initially manifests itself in verbal and emotional abuse, and as both partners strive to win, one partner may resort to violence. For this reason, it is recommended that partners attend therapeutic groups together, so that they work together in dyad so that each partner identifies and recognizes his or her role in the violence and improves communication skills [apud 10].

Clinically, interventions for partner abusers often include emotion management as a technique to promote change in aggressive behaviors [6], and the results of several meta-analyses demonstrate that psychotherapeutic approaches to anger have significant effects on reducing related clinical symptoms [12]. In this context, there is a wealth of empirically supported reasons to hypothesize that DV is significantly associated with anger, hostility and internalizing negative affect [6]. Last but not least, while not so long ago psychological violence and aggression was considered to be a secondary form of DV, less severe compared to physical violence, there are studies showing that its impact on the mental health of the victim is at least comparable to that of physical violence, which is why it should be given sustained attention.

In view of the above, DV researchers have opined that there is a need for valid instruments with real psychometric qualities to assess aggression, anger and hostility of aggressors. In the literature, the Aggression Questionnaire (AQ) developed by A. H. Buss and M. Perry (1992) measures the discussed variables and is one of the most widely used self-report instruments.

Speaking of intervention programs for domestic abusers, it should be noted that the terminology uses the term "intervention" for abusers, with the intervention being provided by "facilitators" or "teachers" following a didactic format described as educational or psychoeducational "courses". "Feminist-oriented programs in particular object to the word treatment and may not consider rehabilitation as the primary goal of the program" because "we do not consider our work to be therapy. Beating is a natural consequence of patriarchal values" [19, p.17]. The therapy is provided by counselors or therapists who provide counseling to "clients", being couples therapy or the systemic family approach that specifically addresses the needs of victims.

Compared to the US, in Europe, the rehabilitation of DV abusers is largely based on behavior change programs, founded on the principle that men must take responsibility for their abusive behavior and that such behavior can be learned.

H. Geldschläger and colleagues (2014), in a study on the effectiveness of

treatment programs for domestic abusers conducted in European countries based on a questionnaire translated into fifteen languages (Bulgarian, Croatian, Czech, Croatian, Dutch, English, Estonian, French, German, Hungarian, Italian, Latvian, Lithuanian, Polish, Portuguese, Spanish, Czech, English, Romanian, Bulgarian, Croatian, Estonian, French, German, Italian, Latvian, Lithuanian, Polish, Portuguese, Romanian, Slovenian, Slovenian, and Spanish), identified the following approaches, presented in percentages in the table below:

Table 1.
Approaches to working with domestic abusers [apud 12, p.15]

Approaches	Percentage (%)
Cognitive-behavioral	46
Psychoeducational	32
The Duluth Model	8
Constructivist and narrative	6
Systemic/family	5
Psychodynamics	5
Other	32

In the category "Other" therapists included various combinations of the mentioned approaches used in practice or combinations of humanistic approaches and Gestalt therapy, such as alternative to violence (ATV), phenomenological approach, ecological model, eclectic models based on psychodynamic approach and EMDR, motivational interviewing, mindfulness or somatic psychotherapy [12, p.15].

Despite the limitations, therapeutic approaches have proven to be challenging, as perpetrators have been shown to have complicated psychosocial and psychiatric histories. Many have witnessed domestic violence or were victims of childhood abuse. In addition, borderline, narcissistic, and antisocial personality disorders are common among IPV perpetrators [22], and the co-occurrence of substance abuse and related problems is high, with rates ranging from 40 to 92% [23]. Although important or of high severity, these problems are not the focus of family perpetrator intervention.

In practice, modern intervention programs tend to combine different theoretical approaches to the treatment of batterers, although most programs for batterers are based on the Duluth model, which assumes that physical violence is part of a patriarchal spectrum characterized by men's need to control women. Regardless of the program and its underlying theory, the goals focus primarily on skill development and promotion, anger reduction and control, stress management, reducing abusive and aggressive behavior, DV education, and holding batterers accountable for their use of violence and improving communication skills. In general, these goals are consistent with the main intervention standards for batterers, demonstrating their relevance [8].

A small number of studies, however, have evaluated the impact of DV programs on convicted offenders. In this regard, studies show that they are more likely to work with perpetrators who voluntarily participate in therapy programs or have been referred by the courts, and much less likely to work with those who have been convicted of DV or have been prosecuted. For example, S. J. Walker, M. Hester, and W. Turner (2018) identified only two studies out of the sixty-seven articles reviewed dedicated to inmates convicted of DV, one conducted in a prison and one conducted in a detoxification (substance abuse) clinic [24]. D. G. Dutton (1995), cited by J. C. Babcock et al. (2004), found strong effects of interventions for convicted offenders and found that only 4% of offenders who participated in a counseling program recidivated, compared with 16% of offenders who did not participate, with effects maintained for 2 years after the in-

tervention. J. C. Babcock and R. Steiner (1999) showed that offenders convicted and incarcerated for DV offenses who completed a DV-reduction intervention group program were less likely to subsequently commit DV and non-DV offenses compared to those who dropped out of the program [3]. However, effect sizes were generally small. L. Angene (2000), cited by T. P. George (2020) showed that forensic monitoring of offenders' participation in intervention programs dedicated to reducing DV increased their attendance in counseling sessions and decreased the risk of recidivism [16]. On the other hand, a review of the literature by S. Moore (2009) found that of the ten court rulings on DV programs studied, three demonstrated reductions in recidivism, five resulted in no difference, and two of the rulings provided mixed results [22].

Other studies have demonstrated the effectiveness of intervention programs despite less significant effect [1, 2, 15]. For example, R. C. Davis, B. G. Taylor and C. D. Maxwell (2000) found lower recidivism rates among program participants, but, examining the effect of program duration, concluded that the intervention may have reduced violence only during the period when offenders were still under court control, rather than actually changing their behavior [86]. Other evaluations also show lower recidivism rates among those who complete treatment than among those who drop out [5]. In addition, intervention programs may also have a positive effect on other risk factors for DV, such as behavior control and reduction in alcohol and drug use [21]. One of the most comprehensive studies demonstrating the effectiveness of intervention programs for DV perpetrators is by E. W. Gondolf (2004). His study was conducted in four cities over a four-year period with a large sample of 618 violent men [17].

Traditionally, the effectiveness of intervention has been seen in terms of increased safety for the victim, but in reality it can encompass many aspects that are not easily captured or measured as a unit, in terms of perpetrators' acceptance of responsibility, respect for the victim and preconceptions about women, and social attitudes towards violence.

The recidivism rate, on the other hand, is a measure of the effectiveness of an intervention program for offenders. In this regard, some research has shown that between 15% and 53% of offenders drop out of the program [7, 8, 9], which has caused concern among specialists about stopping or at least reducing DV. It has been shown that dropout or withdrawal from family offender intervention programs is a good predictor of recidivism [5], which has shifted researchers' attention to identifying offender characteristics so that individuals likely to drop out of the program can be more easily recognized [9, 20]. These mixed results may be due, researchers say, to an inconsistency in defining the success or effectiveness of the program, either from the perspective of program completion or from the perspective of relapse prevention.

Taking all this into account, experts in the field are of the opinion that the effectiveness of DV control programs remains an open question, and more systematic reviews are needed to capture key elements to stop DV.

The aim of the study was to empirically demonstrate the effectiveness of implementing an integrative intervention program in the prison environment in order to reduce aggression in inmates convicted of DV.

Methodology To this end, we conceptualized the program taking into account the factors that facilitate the commission of DV acts, in accordance with the literature in the field, which materialized in the specific objectives of the program. To assess the effectiveness of the intervention program, we decided to measure the

responses of program participants at three points in time: pre-test, at the beginning of the program, mid-test, at the mid-point of the proposed program interval, and at the end of the program, the post-test evaluation stage. The assessment at the three testing moments was self-report so that the facilitator did not influence the subjects' responses to the scales of the selected instruments.

The instruments used Thus, the refocusing on planning scale tracked the subjects' desire to change, the blaming others scale tracked the acceptance of responsibility for the DV acts committed, and the rumination scale was selected to assess the subjects' cognitive restructuring. In addition, all these scales represent a measure of emotional self-regulation. We also used representative scales to assess DV with the help of the interview grid C1. The grid allows the identification of the factors generality of violence (AG), namely domestic violence and violence against intimate partner (VIP). The physical aggression scale (AF) of the AQ questionnaire was used to assess subjects' acquisitions regarding the harmfulness of using instrumental aggression, and the anger scale (F) measured impulsivity and lack of control. Last but not least, we mention emotional distress as a facilitator of DV.

Results and discussion Regardless of the orientation and approach of the different types of programs for domestic abusers, their intention is to bring about change, to take ownership of the acts committed and to prevent recidivism [14]. In this regard, the outcome variables selected to assess change at the three points of testing were represented by questionnaire scales correlated with the specific objectives of program implementation.

In this respect, taking into account the above and the recommendations of studies in the literature, the results on the effectiveness of the intervention program in the present study, as well as the comparisons between the types of aggressors identified in the preliminary analysis of the program implementation are interpreted in terms of the effect size (low, moderate, high).

For the first set of variables related to willingness to change, taking responsibility and cognitive restructuring, the statistical processing of the data revealed the expected effect of the program for the variable *refocusing on planning*, between the three moments of the test a significant effect ($\eta p^2 = .669$) and a high power of the test ($1\text{-}\beta = 1.000$), $p = 0.000$. Significant differences were also found in the DB (M1 = 7.45; M2 = 8.54; M3 = 14.72), ASS (M1 = 11.28; M2 = 10.42; M3 = 13.57) and NP (M1 = 9.66; M2 = 10.00; M3 = 15.33) experimental groups between the three testing times ($p < 0.001$). The effect size and test power were significant $\eta^2 = .294$, $1\text{-}\beta = .728$. In terms of *blaming others*, the results show that the intervention program had the expected effect [$F(2,18)= 30.06$, $p=0.000$, $\eta p2 = .669$, $1\text{-}\beta = .99$], but there was no significant effect between the intermediate and final test moments [$F(2,18)= .13$, $p > 0.05$], with between-group differences being insignificant [DB (M2 = 8.90, M3 = 8.18), ASS (M2 = 7.85, M3 = 8.00) and NP (M2 = 9.33, M3 = 8.00)]. The effect size is statistically small $\eta^2 = .015$, the power of the test being small $1\text{-}\beta = .068$. Also, for the variable *rumination*, the statistical results demonstrated the effectiveness of the intervention program [$F(2,18)= 17.20$, $p=0.000$, $\eta p2 = .489$, $1\text{-}\beta =1.000$], but there were no significant effects between the intermediate and final time of testing, and between groups the differences were insignificant [DB (M2=7.63; M3=5.54), ASS (M2=10.42; M3=13.57) and NP (M2=7.33; M3=6.33)]. Although the effect size is statistically significant $\eta^2 = .040$, which could allow extrapolation of the results to the general population, the power of the test is low ($1\text{-}\beta = .127$).

The self-reported responses of the subjects demonstrated improvement in

the mean scores of the dimensions under analysis from one point in time to the next. The NP subtype, in this respect, obtained significant averages compared to the DB and ASS types

In the literature, the duration of intervention programs for family aggressors (PIA) varies from 12 weeks to 36 weeks, but a minimum of 100 hours is required [17, 22]. In this sense, the program was structured in 12 sessions, with a frequency of 1 session per week, depending on the complexity of the activities and the specificity of the group of participants, the duration of which varied between 60 and 90 minutes. The 12-week duration of the program was aimed at preventing attrition, attrition and boredom, which can lead to drop-out and exit (or exclusion) from the program. The sessions were delivered by the study author, the program facilitator, a clinical psychologist in the national penitentiary system, with training in cognitive-behavioral and integrative psychotherapy, presenting as follows.

Tabel 2

Content of the psychological intervention program

Session 1. Introduction to the program: Nonviolence	Activities: completion of the participation contract, setting group rules, presentation of objectives, presentation of objectives, running of meetings, homework, participation; recounting the crime; self-awareness exercises.
Session 2. Domestic violence	Activities: Definition of DV; Myths related to DV; Presentation of the cycle of violence syndrome; consequences of abuse; explanation, discussion.
Session 3. Power and control	Activities: Abuse; Understanding power and control tactics; Explanation, discussion.
Session 4. Emotions	Activities: Defining anger; myths about anger; awareness of situations that produce anger in relationships and in general; relaxation breathing techniques.
Session 5. Anger management	Activities: Anger situations; Anger cues; Building an anger management plan; Relaxation techniques.
Session 6. Mid-term evaluation	Activities: Discussion; Feedback; Application of questionnaires.
Session 7. Circle of aggression	Activities: Aggression cycle; Aggression indicators; Muscle relaxation techniques.
Session 8. Family of origin	Activities: family; discussing how families influence behavior; genogram.
Session 9. Cognitive-emotional coping	Activities: Cognitive-emotional coping; A-B-C-C-D-E model; Explanation, discussion.
Session 10. The most violent behaviors	Activities: each member discusses examples of his/her violent behavior, addresses any denial; discusses personal plan to prevent aggressive and violent behavior.
Session 11. Assertiveness	Activities: Distinguishing between assertive, passive, passive-aggressive and aggressive behavior styles; Conflict resolution model; examples; practical exercises
Session 12. Closure	Activities: Evaluation of program components; Evaluation of the usefulness of the program; Feedback; Application of questionnaires.

The program was based on an integrative model , with trained facilitators leading groups of ten to twelve men through a 26- or 52-week curriculum that includes didactic presentations, dialogic exchanges, videos, role-plays, and homework such as journaling [14].

The intervention was based on a progressive learning and change strategy structured in:

1) acquisition of knowledge about aggression and its forms of manifestation, acquisition of knowledge of the difference between instrumental, manipulative and spontaneous, anger-based aggression (assessment using the AQ instrument, Physical Aggression and Anger scales);

2) to identify and discuss the situations in which the participants have adopted aggressive behaviors and their consequences in personal, social, legal, etc. (evaluation with the help of the C1 grid, scales generality of aggressiveness/violence, aggressiveness/violence against the partner);

3) development of adaptive cognitive-emotional coping strategies (assessment using the CERQ instrument, the Rumination, Blame others, Refocus on planning scales);

4) reducing emotional distress (assessment using the PDE instrument);

Conclusions

The aim of the formative research was to examine the effectiveness of an integrative intervention program to reduce aggression in men convicted of DV. In this regard:

1. The objectives of the study, as well as the stages of the study, have been established in such a way that they are feasible;

2. The integrative intervention program for perpetrators has been developed based on the international standards that govern them in general as well as taking into account the needs of the participants;

3. The quasi-experimental design of the research was considered acceptable, taking into account both the number of subjects participating in the program and the difficulties of randomization of subjects in the prison environment;

4. The evaluation of the proposed variables was done in three stages of the research, namely pre-test, intermediate and post-test;

5. The analysis of the effectiveness of the program was done, in agreement with the literature in the field, in terms of effect size and test power. In this regard, significant effect size values ($\eta p^2 > 0.5$) were recorded, as well as high test power for all variables of interest associated with DV. The obtained results demonstrate the subjects' willingness to change and to take responsibility for their actions. Considering the results obtained, we can state that the development of an empirically validated intervention program for perpetrators has been successful.

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