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Psychological Treatment of Men Convicted of Gender Violence

A Pilot Study in Spanish Prisons

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In this article, the effectiveness of a psychological treatment program for men who are in prison for committing a serious offence of gender violence is tested. The sample consisted of 52 men who were imprisoned in eight Spanish prisons. The psychological treatment was a cognitive-behavioral program, in a group format, with 20 weekly sessions that lasted for 8 months. The results showed a significant improvement of irrational beliefs, about both women and violence, as a strategy to cope with everyday difficulties and a significant decrease of psychopathological symptomatology, anger, and hostility. On the other hand, results indicated that the only difference between the patients who dropped out of treatment and those who completed it was the level of initial motivation for treatment. Implications of this study for clinical practice and future research in this field are discussed.

Keywords: *gender violence; prison; psychological treatment*

Gender-based violence is a problem that is on the increase and is currently reaching very high proportions. A study of domestic violence carried out in 2000 by the Ministry of Social Affairs involving a sample of more than 20,000 Spanish women, for instance, revealed that at least 4% of those over 18 (about 640,000) are abused in the home. There is also a further 12% (about 1,865,000) who, although not regarding themselves as abused, suffer degrading behaviors that are inconsistent with a healthy couple relationship such as insults, forced sexual relationships, or humilia-

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Table 1
Results in Batterers' Treatment Programs

Author and Year	Follow-Up	Results
Deschner, McNeil, and Moore (1986)	1 year	Significative improvement
Harris (1986)	Posttreatment	Improvement in 73% of cases
Hamberger and Hastings (1988)	Posttreatment	Significative improvement; 51% of dropouts
Edleson and Syers (1990)	6 months	Significative improvement; 68% of dropouts
Faulkner, Stoltemberg, Cogen, Nolder, and Shooter (1992)	Posttreatment	Significative improvement
Palmer, Brown, and Barrera (1992)	1 year	Significative improvement related to nontreated batterers
Rynerson and Fishel (1993)	Posttreatment	Significative improvement
Echeburúa and Fernández-Montalvo (1997)	3 months	48% of therapeutic rejections at the beginning of the program; 69% therapeutic success with treated cases
Taylor, Davis, and Maxwell (2001)	1 year	Significative improvement

tions (Echeburúa, Fernández-Montalvo, & De la Cuesta, 2001). Studies carried out in the United States indicate that between 15% and 30% of women undergo some type of aggression in their relationship as a couple (Goldman, Horan, Warshaw, Kaplan, & Hendricks-Matthews, 1995; O'Leary & Arias, 1988; Stith, Williams, & Rosen, 1990; Straus & Gelles, 1990).

These disturbing figures have led to a greater interest in the psychological treatment of perpetrators, particularly within a community environment. The fact that many batterers continue to harass their victims after the end of the relationship raises questions about the efficacy of providing support services for victims in the absence of intervention for perpetrators (Hart, 1996). The first program for intimate partner violence offenders was established in the United States in 1977. The outcome has been a number of specific intervention programs for this type of aggressors, and the results in some cases are decidedly hopeful, especially with men who have completed the full program (Echeburúa & Fernández-Montalvo, 1997). Psychological treatment, then, is currently seen as the most appropriate option, although one of the difficulties that exists is that of aggressors denying or at least minimizing the problem and putting blame for the cause and perpetuation of the conflict onto their partners. The studies carried out in the past years (Deschner, McNeil, & Moore, 1986; Echeburúa & Fernández-Montalvo, 1997; Edleson & Tolman, 1992; Faulkner, Stoltemberg, Cogen, Nolder, & Shooter, 1992; Gondolf, 1997; Hamberger & Hastings, 1988, 1989; Harris, 1986; Rynerson & Fishel, 1993) show the utility of the psychological treatments—especially the cognitive-behavioral techniques—to reduce and eliminate aggressions from men against women (Babcock & La Taillade, 2000; see Table 1).

In spite of the empirically supported effectiveness of this kind of intervention, however, the heterogeneity of the programs and the variety of the techniques used preclude

one from drawing definite conclusions (Anguera, 1997; Gondolf, 1997). Also, it should not be forgotten that a common characteristic of all of these programs is the high rate of refusals and dropouts from treatment (especially in the first 3 months of the intervention). In Echeburúa and Fernández-Montalvo's (1997) study, for example, with a sample of 31 batterers, 48% rejected the treatment because they denied the existence of the problem, minimized it, or attributed it to their victim's behavior. This rate of refusal is similar, even sometimes lower, than those obtained in other studies (Edleson & Syers, 1990; Faulkner et al., 1992; Hamberger & Hastings, 1988).

The encouraging results refer largely to male abusers who have received no punishment for their violent behaviors. It may be assumed that the profile of perpetrators imprisoned for acts of gender violence (bodily harm, homicide, sexual assault, etc.) is quite different. These types of cases, although more serious, have in general terms received less attention as prisoners serving sentences for violence against women represent a relatively small proportion of the total prison population, and they usually adapt well to prison rules (Echeburúa, Fernández-Montalvo, & Amor, 2003). In these cases, the more or less prolonged stay in prison (depending on the kind of crime) does not guarantee the future elimination of the abusive behaviors. Family violence in the perpetrator is an overlearned behavior that is hidden in prison but arises in an automatic way as soon as the batterer is involved in a couple relationship. The causes and maintenance of this kind of violent behavior are very complex and require a specialized intervention. Otherwise, the probability that the abuse will reappear after prison is high (Fernández-Montalvo, Echeburúa, & Amor, in press).

Therapeutic work with offenders has to deal with a lot of resistance, particularly under the specific circumstances of a prison environment. There have been several studies involved in the development of therapy motivation for the situation in prisons. There is some empirical evidence for that point of view, although the existing studies are not completely consistent (Dahle, 1997).

The aim of this pilot study is to test a specific program of psychological intervention for prisoners condemned for violent behaviors against women. This program is intended to examine the effects of the treatment on a series of measures thought to assess cognitive change hopefully related to a reduced risk of violence. The purpose of this program is to teach perpetrators the required skills to control violent impulses, to reestablish a partner relationship based on harmony and equality, and to improve empathy and self-esteem. The therapy is intended to provide them with adequate coping strategies to deal with high-risk situations for violent behaviors, to modify negative attitudes of hostility, and to restructure the frequent cognitive distortions related to women's inferiority and the use of violence as a valid way of solving conflicts.

Method

Participants

At the beginning of the study, there were 70 participants lodged in eight Spanish prisons who were in jail for a serious offence of violence against their intimate partner.

After studying all participants in these eight prisons, a sample of 52 men was selected according to the following criteria: (a) being an adult males (18-65 years old), (b) serving a sentence for a serious offence in relation to gender violence, (c) not suffering from any serious mental disorder (e.g., psychosis, major depression, or bipolar disorder) or disabling physical disease, and (d) being literate and taking part in the program voluntarily, having been properly informed of its characteristics and having signed the informed consent. A total of 18 participants were excluded because they did not want to participate in the study ($n = 12$) or suffered a serious mental disorder ($n = 6$).

The mean age of the sample was 40 (range = 27-58). The level of education of most participants was rather low, with a clear predominance of participants who left school at the minimum leaving age (81%) and with only 4% with university education. This means that the socioeconomic level of the cases studied varied between the lower and middle classes.

Moreover, a previous history of psychiatric problems was observed in 22% of the sample, a percentage that is slightly higher than that of the general population (15-20%; Klerman, 1986; Vallejo, 2002). The main disorders related to psychiatric history were depression (54%), addictive behaviors (33%), and personality disorders (13%).

From a penal point of view, the participants had spent an average of 2.5 years in prison, the great majority serving the sentence for a crime committed under level-two imprisonment conditions (without permission for leaving prison). One significant aspect of this section was that almost half (46%) of the sample had killed their partner (or attempted to do so). Furthermore, 31% had a previous prison record, chiefly for bodily harm or threats (47%), theft (41%), and to a lesser degree, breach of the peace (6%) and illegal possession of arms (6%).

Assessment Measures

Measures of Empathy and Abusive Cognition

The Inventory of Distorted Thoughts About Women (Echeburúa & Fernández-Montalvo, 1998) comprises a checklist of 13 binary items aimed at detecting irrational thoughts in the aggressor that are related to sexual roles and the inferiority of women. These thoughts are of great interest insofar as they are conducive to the display of violent behaviors. The participant has to state which ideas in the inventory correspond to his normal way of thinking. Each affirmative response scores one point, so that the inventory score ranges from 0 to 13. The higher the score, the greater the number of women-related cognitive distortions. Test-retest reliability is .92, and the internal consistency alpha coefficient is .87.

The Inventory of Distorted Thoughts on the Use of Violence (Echeburúa & Fernández-Montalvo, 1998) comprises a checklist of 16 binary items aimed at detecting irrational thoughts in the aggressor that are related to the use of violence as an acceptable way of resolving conflicts. These thoughts are extremely relevant to the extent that they are conducive to the display of violent behaviors. The participant has to state which ideas in the inventory correspond to his normal way of thinking. Each

affirmative response scores one point, so that the inventory score ranges from 0 to 16. The higher the score, the greater the number of cognitive distortions connected with the use of violence as an acceptable way of resolving conflicts. Test-retest reliability is .89, and the internal consistency alpha coefficient is .94.

The Interpersonal Reactivity Index (Davis, 1980) consists of 28 items that assess four components of empathy: fantasy (capacity for imagination and identification with fictional characters), awareness of perspective (capacity to appreciate the point of view of others), empathic interest (capacity for showing concern for persons who have negative experiences), and personal distress (capacity to feel the negative emotions of others as one's own). Each of the 28 items is marked on a Likert-type scale that ranges from 0 (*absolute disagreement*) to 4 (*absolute agreement*). The full range of the scale is, therefore, 0 to 112. The higher the score, the greater the empathic capacity. In this study, the Spanish version of Garrido and Beneyto (1995) was used. In our study, test-retest reliability is .82, and the internal consistency alpha coefficient is .84.

Measures of Psychopathology and Personality

The SCL-90-R (Derogatis, 1992; González de Rivera, 2002) is a self-administered general psychopathological assessment questionnaire. It comprises 90 items with 5 alternatives for each on a Likert-type scale ranging from 0 (*none*) to 4 (*very much*). The aim of the questionnaire is to reflect a participant's symptoms of psychological disturbance. As it has been shown to be sensitive to therapeutic change, it may be used for either single or repeated assessments. The SCL-90-R consists of nine areas of primary symptoms (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism). It also provides three overall indices that reflect the participant's overall level of severity. The cut-off point of the global symptoms index (GSI) is 63.

The State-Trait Anger Expression Inventory (STAXI, Miguel-Tobal, Casado, & Cano-Vindel, 2001; Spielberger, 1988) consists of 10 items related to state-anger (the intensity of the emotion of anger in a specific situation) and a further 10 related to trait-anger (the individual disposition to experience anger habitually). The range of scores is from 10 to 40 on each scale. The STAXI also has a third subscale of 24 items connected to the form of expressing anger (anger expression-out, anger expression-in, and anger control).

The Barratt Impulsiveness Scale (version 10; Barratt, 1985) consists of 33 items aimed at assessing how impulsive participants are. Scores from 0 to 4 on a Likert-type scale provide a total scale range of 0 to 132. This instrument has 3 subscales of 11 items each, giving a range of 0 to 44. The first subscale assesses motor impulsivity, the second cognitive impulsivity, and the third improvisation and failure to plan ahead. The higher the score, the stronger the presence of each trait measured on each subscale. The sum of all the subscales gives the total score. In this study, the Spanish version of Luengo, Carrillo de la Peña, and Otero (1991) was used.

The aim of the Self-Esteem Scale (Rosenberg, 1965) is to assess the feeling of satisfaction that a person has about himself or herself. There are 10 general items, each

carrying a score between 1 and 4 on a Likert-type scale, giving a questionnaire range of 10 to 40. The higher the score, the greater the level of self-esteem. The cut-off point for the adult population is 29. The Spanish version used in this study can be found in Fernández-Montalvo and Echeburúa (1997). Test-retest reliability is .85, and the internal consistency alpha coefficient is .92.

Measures of Maladjustment

The Inadaptation Scale (Echeburúa & Corral, 1987a) reflects the extent to which the participant's current problems affect different areas of daily life: work, social life, free time, relationship with partner, and family life. This instrument also has a subscale that takes account of the overall level of maladjustment in everyday life. The self-report comprises a total of 6 items, each carrying a score of between 0 and 5 in accordance with a Likert-type scale. The full range of the instrument is therefore 0 to 30, with 12 points representing the overall cut-off point. The higher the score, the greater the level of inadaptation. The psychometric properties of this scale can be found in Echeburúa, Corral, and Fernández-Montalvo (2000). Test-retest reliability is .86, and the internal consistency alpha coefficient is .94.

Treatment Variables

The Scale of Expectation of Change (Echeburúa & Corral, 1987b) reflects the patient's motivation for treatment. The patients are required to point out in a scale that ranges from 1 (*nothing*) to 6 (*very much*) the degree of expected improvement.

The Questionnaire of Satisfaction With Treatment (Larsen, Attkinson, Hargreaves, & Nguyen, 1979) consists of 8 items related to quality of therapeutic assistance, to degree of help received, and to satisfaction with treatment. Each item ranges from 1 to 4 points; the total questionnaire scores range from 8 to 32.

Treatment Program

The intervention is a wide program of treatment based on a cognitive-behavioral model and is comprised of 20 two-hour group sessions. The program includes the modification of cognitive and behavioral deficits related to gender violence. This program is tailored to the specific features of each patient.

In the first part of the intervention (sessions 1-3), motivational aspects such as acceptance of responsibility for the crime and motivation for therapy, are taken into account. The second part (sessions 4-15) includes the treatment of the psychopathological symptoms usually associated with violent men and focuses on empathy, skills training, anger management, and modification of cognitive distortions related to the crime. Finally, the program includes a specific intervention in relapse prevention (sessions 16-20) by identifying high-risk situations for violent behavior and teaching inmates adequate coping strategies alternative to violence.

A summary of the specific components of the treatment program is described in Table 2. A more detailed description of the program can be found in Echeburúa and Fernández-Montalvo (1998).

Table 2
Summary of Intervention Program

Motivational Aspects	Techniques
Acceptance of the own responsibility; motivation for the therapy; advantages of the group treatment; acceptance of the basic principles of the therapy	Motivational interview
Psychopathological Aspects	**Therapeutic Techniques**
Empathy deficit and emotional illiteracy	Exercises to develop the empathy (videotapes, autobiographical stories, testimonies, etc.) and techniques for emotional expression
Cognitive distortions related to women's inferiority and to the use of violence as an acceptable way of solving the conflicts	Education about gender equality; cognitive restructuring
Uncontrolled anger	Explanation of the cycle of the violence and the process of escalade of the anger; time out; cognitive distraction; self-instruction training
Anxiety or stress	Relaxation
Depressive symptoms	Cognitive restructuring; development of hobbies
Pathological jealousy	Cognitive restructuring; satiation
Assertiveness and communication deficit	Assertiveness and communication skills training
Solving problems deficit	Problems solving training
Dissatisfaction with sexual relationship	Education about sexuality
Relapse Prevention	**Techniques**
Self-esteem deficit	Cognitive restructuring; establishment of positive goals
Alcohol and drugs abuse	Program of controlled consumption
Relapse	Identification of high-risk situations for relapse; teaching of coping strategies; development of a positive lifestyle

Source: Echeburúa and Fernández-Montalvo (1998).

Procedure

The participants of this study are part of a program of psychological intervention with prisoners convicted of violence against women that is currently running in eight Spanish penal institutions.

The initial assessment was carried out during September and October 2001 by forensic psychologists under the direction of the authors of this study. All the participants completed the questionnaires individually in the psychologist's presence during pretreatment assessment before the intervention program. Once the therapeutic intervention was over, a posttreatment assessment was carried out to determine the therapeutic results.

The therapeutic intervention, also developed by psychologists of prisons specifically prepared for it, lasted for 8 months (from November 2001 to June 2002) and was carried out in prison. Each group, with five to eight people, was directed by two therapists of different sex.

Results

The paragraphs below show the results of treatment for cognitive and psychopathological variables and the degree of acceptance of the program. Moreover, an analysis of predictive variables for the dropouts and for prognosis of therapeutic results was made.

Program Acceptance

In general, the therapy was considered encouraging by the participants involved. In fact, 92% of the perpetrators completed the program, so dropping out was limited to 4 participants (8%). This figure was even more remarkable given that no direct penitentiary benefits were derived from the participation in the therapy. The reasons for abandoning the program included the lack of motivation for the treatment (4 individuals). In the case of participants who dropped out of the treatment, it took place during the first stages of the therapy (3 individuals before the first 3 sessions and 1 after the initial appraisal).

Changes in Cognitive Distortions and in the Variables of Personality and Adaptation

In the posttreatment assessment, the individuals experienced a significant modification in previous cognitions in terms of attitudes toward women and toward the use of violence as a valid way of solving conflict and in terms of improvement of anger control (see Table 3).

These changes were significant insofar as the cognitive distortions modulate subsequent behavior, and anger is an emotional state that leads to violent behavior.

Changes in Psychopathological Symptoms

The level of psychopathological symptomatology prior to the treatment was not very high, and therefore the changes in this area were not especially significant. On completion of the program, however, more than specific changes in a particular area, an overall decrease in psychological symptomatology as a trend was observed. The individuals tended to show a greater level of emotional stability (see Table 4), which was especially encouraging from an impulse control viewpoint.

Table 3
Results in Cognitive Distortions and Personality and Adjustment Variables

	Pretreatment		Posttreatment		
	M	*SD*	*M*	*SD*	*t*
Cognitive bias about women	4.5	2.3	3.3	2.1	2.82**
Cognitive bias about use of violence	6.5	2.2	5.2	2.3	2.67**
Empathy	62.1	13.8	64.8	12.2	1.01
State-anger	13.5	4.6	11.8	2.4	2.26*
Impulsivity	45.5	17.3	43.8	13.8	0.53
Self-esteem	30.1	4.5	30.4	4.2	0.52
Inadaptation	17.7	7.7	15.1	8.7	1.55

Note: $N = 48$.
*$p < .05$. **$p < .01$.

Table 4
Results in the SCL-90-R

	Pretreatment		Posttreatment		
	M	SD	M	SD	t
Global Severity Index	46.5	10.6	40.9	8.8	2.01*
Positive Symptoms Distress Index	45.1	10.5	42.1	7.6	1.72
Positive Symptoms Total	45.4	14.6	44.2	9.9	0.47
Somatization	50.4	13.1	47.8	13.7	0.96
Obsessive-compulsive	44.1	11.1	42.1	8.4	0.92
Interpersonal sensitivity	40.6	15.7	41.6	10.3	0.37
Depression	46.3	9.3	44.1	7.7	1.34
Anxiety	42.8	13.1	41.1	8.4	0.75
Hostility	40.2	18.1	31.8	18.8	2.05*
Phobic anxiety	39.1	20.4	37.1	20.1	0.48
Paranoid ideation	46.3	15.5	48.4	7.2	0.83
Psychoticism	41.6	19.2	41.2	13.2	0.17

Source: Derogatis (1992).
*$p < .05$.

Prediction of Therapeutic Results

When comparing the people who had completed the program with those who dropped out, it was seen that the expectations for change played a very important role. In particular, the worse the expectations for change, the more likely the participants were to abandon the treatment (Wilks' Lambda = .94; $p < .05$). This variable allowed for the correct classification of 54% of the individuals in terms of completion of the treatment (see Table 5).

Table 5
Discriminant Analysis of Dropouts

Means and Standard Deviations According to Discriminant Function

Variable	Dropouts[a] *M*	Dropouts[a] *SD*	Completers[b] *M*	Completers[b] *SD*	*t*
Expectation of change	3.5	1.7	4.5	0.9	2.02*
Dropouts centroid = 0.97					
Completers centroid = 0.08					

Prediction of Results

	Number	%	Real Group Dropouts Number	Real Group Dropouts %	Predicted Group Completers Number	Predicted Group Completers %
Dropouts	4	7.7	3	75.0	1	25.0
Completers	48	92.3	23	47.9	25	52.1
% cases correctly classified = 53.8						

a. $n = 4$.
b. $n = 48$.
*$p < .05$.

Table 6
Multiple Regression Analysis Between Pretreatment Variables and Severity of Symptoms in the Posttreatment

	R	R^2	R^2 adjusted	*F*
	.88	.78	.77	53.3**
Variable	**B**	**β**	***t***	**Range**
Severity of symptoms in pretreatment (global symptoms index)	0.77	0.92	8.75**	1°
Previous psychiatric history	3.52	0.16	2.16*	3°
Hostility	0.10	0.20	2.16*	2°

*$p < .05$. **$p < .001$.

Regarding the therapeutic failure, the severity of the symptoms (according to the GSI) immediately prior to the treatment, the hostility attitudes, and the previous psychiatric history accounted for 77% of the variance and as a result led to poorer therapeutic results being predicted (see Table 6).

Discussion

Batterer intervention programs are at least moderately successful at preventing further abuse by batterers (Palmer, Brown, & Barrera, 1992; Taylor, Davis, & Maxwell, 2001). These evaluations must be viewed with caution because of methodological limitations of their own (Gondolf, 2001). In addition, attrition rates continue to be a major problem (Gerlock, 2001).

Psychologically treating men in prison who have a history of violence against women is a necessary measure to prepare them for their future life in freedom and to protect society from further recidivism (Austin & Dankwort, 1999; Echeburúa et al., 2001). The therapy is especially suitable during the last stage of their prison sentence, when access to freedom is pending.

From a therapeutic point of view, the program of treatment offered has been attractive and has had only a few dropouts, these being related to participants' lower expectations of improvement. All of the dropouts took place during the first three therapeutic sessions, when group cohesion and the relationship with the therapist were still weak and when no clear therapeutic achievements had yet been reached (cf. Dalton, 2001; Daly & Pelowski, 2000; Hamberger, Lohr, & Gottlieb, 2000).

The results obtained, even though modest, have clearly been encouraging, most of all when the participants were imprisoned for severe crimes and when an additional difficulty with this type of participant is denial—or, at least, minimization of the problem—by the perpetrator, as well as the attribution to the partner of the beginning or maintaining of the conflict (Corsi, 1995; Echeburúa et al., 2003; Fernández-Montalvo & Echeburúa, 1997; Howes, 1980).

The most significant changes were produced in the areas of cognitive distortions, hostility attitudes, and uncontrolled anger. These changes, together with an overall decrease in psychological symptomatology, have a good prognosis in terms of greater control of impulses and a perception of the world (especially in perception toward women and the use of violence) that is more adequate and closely adjusted to social reality (Gondolf, 1997).

The poorest results of the treatment were related to a previous psychiatric history (in spite of not currently having mental disorders), to the severity of the symptoms at the beginning of the program, and to very remarkable hostility attitudes.

This therapeutic program is still preliminary, and therefore the results remain inconclusive. It is important to assess, using long-term follow-up, whether these changes (above all, those experienced at the cognitive and impulse-control levels) are upheld over time.

This is a pilot study. Therefore, there are some limitations associated with the research. The first is the small sample size and the lack of a control group. We do not know, for example, to what extent the benefit derived from the treatment might be because of the breaking of the monotony of prison life. And the second is that it focuses on the change of attitudes and behaviors of perpetrators in jail. It is not possible to find out how these participants will treat women when they return to their communities. It is therefore important to analyze the behavior of these people when

accessing parole or when they have finally completed their sentence. The aim is to determine whether the recidivism rate of these participants is lower than that of prisoners sentenced for similar offences who have not received the therapeutic program, which implies the need for a study some years from now (Babcock & Steiner, 1999). This is a line of research in which the authors of this study are currently involved.

Another line of interest not covered in this study may be, as suggested recently by White and Gondolf (2000), to establish a typology of perpetrators according to personality disorders and to design specific therapeutic programs according to these. Also, inputs from victims, either through personal contact or trial documentation, might shed more light on the personality of the offenders. The final purpose is to propose tailored therapies according to the type of personality disorder experienced.

And last, the therapeutic group treatment could be followed in further research by a similar period of individual therapy because each case may be unique. In this way, the results could be better.

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