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Changes in aggression and stress in perpetrators and victims of domestic violence due to the "Blue Cards" procedure

Zmiany w agresji i stresie u sprawców i ofiar przemocy domowej pod wpływem procedury „Niebieskie Karty"

Abstract

The research aimed to examine changes in stress and aggression syndrome among victims and perpetrators of domestic violence while participating in the "Blue Cards" procedure. The study participants were 30 female domestic violence victims, ranged in age between 27 and 58 years (M = 4,33; SD = 9,19), and 30 male perpetrators of domestic violence aged between 22 and 56 years old (M = 36,97; SD = 10,06). Aggression syndrome was measured using the Inventory of Psychological Aggression Syndrome (IPSA II), and the stress level was assessed by the Perceived Stress Scale (PSS-10). The prospective study used a test-retest procedure. Both aggression and stress were examined in the whole sample of 60 individuals twice: at baseline and six months after the "Blue Cards" procedure was introduced.

Participants have rated self-report aggression syndrome and stress, and also they have assessed the aggression syndrome of his/her partner. Nonparametric Wilcoxon signed-rank tests have been used for test-retest comparisons. The results show that active participation in assistant activities decreased the level of stress in domestic violence victims and their perception of perpetrators' aggression syndrome. The "Blue Cards" procedure may be considered an effective method of supporting victims and preventing domestic violence among perpetrators.

Keywords: aggression syndrome; domestic violence; stress; female victims, male perpetrators.

1. Introduction

1.1. Domestic violence

Domestic violence is a widespread phenomenon often treated as "normal" behavior in many countries. Domestic violence is defined as "intentional acts or gross negligence carried out by one of the family members against others, using the existing or created by force or power advantage and causing the victims harm or suffering, violating their rights and personal rights, in particular their lives or health, both physical and mental" (Mellibruda, 2000, p. 755). Such behaviors demonstrate the occurrence of domestic violence as the intentionality of the action, violation of the rights and personal rights of the other person, violation of the rights and goods of the individual that prevent him or her from self-defense, causing various types of damage, and uneven distribution of forces (Rode, 2010a). According to Lewoc (2014), it is challenging to estimate the scale of domestic violence due to the closed environment of the family.

Since the World Conference on Human Rights in Vienna in 1993 and the Declaration on the elimination of violence against women adopted in the same year, society and governments have recognized that violence against women is a matter of public order and human rights and appropriate legal regulations have been introduced. However, it proved to be extremely difficult to document the scale of domestic violence in individual countries and monitor this phenomenon to implement appropriate assistance and prevention procedures. International studies of the World Health Organization (WHO) on women's health and domestic violence indicate that home is often not a safe space for women, as it is in intimate relationships that they are exposed to violence the most often.

What makes this situation even more complicated is that many people believe it is "normal." Experiencing domestic violence has far deeper and more serious consequences than the direct harm suffered by the victims. The psychological costs of experiencing trauma, both by women and often by children who are witnesses of such situations, are severe (García-Moreno et al., 2000).

Domestic violence is a broad concept that covers a wide range of behaviors – from a single incident of pushing during an argument to constant and ubiquitous beating or coercion (Riggs et al., 2000). It occurs both in families where members have a university degree and an excellent financial situation and among the poor, who have no education. Intra-family violence occurs between family members or people in close interpersonal relationships (Widera-Wysoczańska, 2010). The broader approach to domestic violence consists of two types among adults: towards the spouse/partner and children, and also two types in children: towards parents and siblings (Herbert and Browne, 1997).

A few empirical studies on domestic violence were aimed at finding risk factors for its occurrence, which would allow identifying a specific feature or set of features that could be used to determine the profile of a potential perpetrator and the victim. The alarmingly high frequency of domestic violence and its serious consequences, especially psychological ones, for both victims and perpetrators seem to be a sufficient justification for deepening knowledge about this phenomenon (Riggs et al., 2000).

Relationships between family members form a specific system of mutual dependencies. Becoming a victim of domestic violence is a process that is easy to succumb to and difficult to oppose. It is often accompanied by the belief that the current life situation is the only possibility. Similarly, becoming a perpetrator has a long and complicated course, which involves creating mechanisms to deny and deform sensitivity. The perpetrators of violence have a distorted picture of reality (Dyjakon, 2014). In scientific publications, domestic violence sources are seen as the interaction of various psychological factors, among others such as stress and aggression (Farrington, 1986; Jakupcak et al., 2002; Kane et al., 2000; Malik and Lindahl, 2006).

1.2. Stress

Stress is a ubiquitous phenomenon in human life, which is not necessarily harmful in all cases. Thanks to its existence, it is possible to mobilize the body to take on various tasks and challenges. Its harmful consequences occur if too high-stress levels and a too-long duration of its influence exist. Lazarus and Folkman (1984) define stress as a kind of interaction between the individual and the

environment. The assessment of the degree of threat or harmfulness of a stressor affects the strength of its impact. It takes place in two stages: the primary assessment relates to the stressor classification as a threat, challenge, or already existing loss, while the second stage refers to its capabilities, resources, enabling it to meet the requirements arising in a stressful situation. According to this approach, stress appears in a situation assessed as a threat accompanied by the belief that there are no sufficient resources to cope with it.

In defining stress, one usually speaks of an imbalance between the individual's abilities, resources, and requirements. Hobfoll (1989, 2002) defines resources as values, objects, conditions, and personal properties that are either valuable to humans themselves or serve as the means to achieve objects having that value (e.g., money, marriage, sense of control, social support). According to the researcher, stress occurs when there is a threat of losing resources, their real loss or lack of profits after investing resources. However, the loss of resources is the key to experiencing stress. The strength of the negative sensations after losing them is greater than the positive ones after multiplying them. Also, it often leads to further losses, which have increased strength and frequency. In domestic violence, individuals may believe that there are no possibilities to cope with this situation, leading to the loss of resources.

1.3. Aggression

Aggression – the second variable analyzed in the presented research concerning the phenomenon of domestic violence – is defined as any behavior intentionally taken to cause harm, cause pain, suffering, and loss of values (Anderson and Bushman, 2002; Baron and Richardson; 1994; Tedeschi and Felson, 1994). In the General Model of Aggression (Anderson and Bushman, 2002), whose authors have attempted to comprehensively explain the occurrence of aggressive behaviors, the roots of these behaviors seem to occur caused by two factors: human and situational. The first applies to all individual properties of a person (personality, attitudes, beliefs, and temperament), while the second one relates to elements of the environment that can affect the increase or decrease in aggressive behavior (Anderson and Bushman, 2002). The concepts of aggression and violence seem to be synonymous. However, it should be emphasized that these are not identical phenomena. What distinguishes violence from aggression is, above all, the advantage that always lies in the dominance of the perpetrator. It can relate to physical strength, but it can also be a psychological and emotional advantage, which takes as a primary goal to control and subordinate the victim (Helios and Jedlecka, 2017).

The other studies (Franczyk-Glita et al., 2018) investigated various types of aggression expression occurring in a group of 30 women experiencing various forms of violence in intimate relationships. The results show that these women more often directed their aggression at themselves or expressed it in a hidden form (hostility), while less often they expressed aggression in an indirect form, compared to women who did not experience violence in an intimate relationship. Dyjakon (2019) has analyzed in the case study the changes occurring in the perpetrator of violence under the influence of individual therapy in terms of identity and interpretation of life history and current events in family relationships. The results indicate that the client's individual experience has internalized the changes, leading to changes in identity structure.

1.4. The "Blue Cards" procedure to limit domestic violence

The "Blue Cards" procedure has been used in Poland since 1998 to identify cases of domestic violence and to take intervention measures in providing support, psychological, social, and legal assistance as well as conducting systemic work with the family aimed at stopping violence (Kozłowska, 2015; Sasal, 2005). According to the act, as part of the "Blue Cards" procedure, an Interdisciplinary Team[1] and Working Groups which solve individual problems related to domestic violence, provide support to victims of violence, take action against the perpetrator of violence (e.g. motivate him to take therapy) and develop an individual assistance plan for individual family members. Both corrective-educational and psychotherapeutic programs of psychological assistance to perpetrators of violence in intimate relationships are focused on changing violent behavior and increasing the safety of victims of violence (Dyjakon, 2019).

1.5. The current study

Although the "Blue Cards" procedure has been around for a long time, there is a lack of research that would refer to the legitimacy of the methods used to reduce domestic violence. Stress and aggression may significantly impact the appearance of violent situations in the family and maybe the result of experienced and implicated violence. Both factors correlate with each other, creating a cause-and-effect sequence. In this study, stress levels and aggression syndrome

[1] The Interdisciplinary Team is appointed on the basis of art. 9a paragraph 1, 2 and 15 of the Act of 29 July 2005 on the prevention of domestic violence (Journal of Laws of 2015 No. 1390, from 2019, item 730) by the head of the commune, mayor or city president, while the commune council by way of resolution, it defines the procedure and manner of appointing and dismissing members of the interdisciplinary team as well as the detailed conditions of its functioning.

were analyzed in both perpetrators and victims of domestic violence covered by the "Blue Cards" program. This study examines changes in aggression and stress in perpetrators and domestic violence victims due to psychotherapeutic activities undertaken as part of the "Blue Cards" procedure. Additionally, an analysis of differences between the perpetrator's self-report of aggression syndrome and the victim's assessment of his aggression was also examined. These results of studies can help evaluate and improve future psychotherapeutic work with families experiencing domestic violence.

The following research questions were formulated: (1.) Will active or passive participation in the "Blue Cards" procedure reduce the level of stress and aggression in victims of domestic violence? (2.) Will active or passive engagement in the "Blue Cards" procedure decrease the level of stress and aggression in perpetrators of domestic violence? (3.) Are there differences in assessing the perpetrator's aggression before and after participation in the "Blue Cards" procedure between the perpetrator's self-report and the victim's perception? (4.) Among female victims of domestic violence, do those who actively participated in the therapy differ significantly in assessing the perpetrator's aggression from those who were passively engaged in the "Blue Cards" procedure? To our best knowledge, the present study, for the first time, explores changes in stress and aggression in perpetrators and victims of domestic violence due to participation in the "Blue Cards" procedure. Thus we cannot formulate specific hypotheses.

2. Methods

2.1. Participants

The test group consisted of 60 people: 30 women and 30 men, assisted by the "Blue Cards" procedure. Women constituted a group of victims experiencing domestic violence, while men constituted a group of domestic violence perpetrators. The average age of the group of women was about 40 years of age (M = 4,.33; SD = 9,19; Range 27 – 58 years) while in the group of men about 37 years of age (M = 36,97; SD = 10,06; Range 22 – 56 years old).

People participating in the study had higher education: n = 10 people (16,67%), secondary: n = 24 people (40%) and vocational education: n = 26 people (43,33%). Among 30 victims of domestic violence, all were women. The passive group included 19 (63,33%) women, participating solely in the working group's meetings

organized under the "Blue Cards" procedure. In contrast, the Active sample included 11 (36,67%) females engaged in therapy for people experiencing violence at the Specialist Support Center for Victims of Family Violence in Opole (36,67%). All perpetrators of domestic violence were men. The Passive group comprised 18 (60%) males, who participated solely in working group meetings. The Active sample consisted of 12 (40%) men engaged in therapy (i.e., in the corrective and educational program for perpetrators of domestic violence).

2.2. Measures

Two dependent variables were measured: perceived stress and aggression syndrome. The independent variables were: gender (women, men), a role in domestic violence (perpetrator, victim), and the level of participation in the "Blue Cards" procedure (active, passive).

The Psychological Inventory of the Aggression Syndrome (IPSA II) was developed by Gaś (1987) to examine the general level of aggression syndrome and its qualitative characteristic. The questionnaire consists of 56 items grouped into 11 factors: 1) propensity to retaliate, 2) self-destructive tendencies, 3) aggression control disorders, 4) displaced aggression, 5) unaware aggressive tendencies, 6) indirect aggression, 7) instrumental aggression, 8) hostility towards each other, 9) physical aggression towards the environment, 10) hostility towards the environment, 11) reactive aggression. Respondents evaluate each statement on a three-point scale (*True, False, I do not know*). The questionnaire has high reliability; the index of absolute stability estimation obtained in the test-retest of the overall result, checked by double-checking the same group of people, is: for women 0,86, and men 0,84 (Gaś, 1987). In the present study, the IPSA II overall score reliability, measured using Cronbach's α, was 0.92, and for individual subscales in the range between 0.63 to 0.83.

The Perceived Stress Scale (PSS-10) by Cohen et al. (1983) in the Polish adaptation was developed by Juczyński and Ogińska-Bulik (2009), and it was used to measure the level of stress. It contains ten questions regarding stress intensity assessment over the last month. The respondents answer a five-point scale from 0 to 4 (0 = *Never*, 1= *Almost never*, 2 = *Sometimes*, 3 = *Quite often*, 4 = *Very often*). The reliability of the Polish adaptation of the scale is satisfactory, with Cronbach's α coefficient ranged from 0,72 to 0,90 (Juczyński and Ogińska-Bulik, 2009). In this study, Cronbach's α coefficient was 0,82 for the PSS-10.

2.3. Procedure

The first part of the study was conducted during the initial contact with the client to identify the family situation. Then, the study was repeated after six months. Each participant was tested twice with the same set of tools. In between the research activities, there were means undertaken to stop the use of domestic violence (working group meetings, therapy for people experiencing violence, a corrective and educational program for perpetrators of violence). The research ethics committee at the local university expressed a positive opinion on the research design. The study included those individuals who voluntarily gave informed consent to participate in the study.

The Kolmogorov-Smirnov test result with the Lilliefors correction for PSA-10 and all IPSA II scales and subscales showed that scores differ significantly from the normal distribution. A nonparametric Wilcoxon signed-rank test was performed separately in the groups of victims and perpetrators of domestic violence, and also separately in active and passive participants of therapeutic activities. This test was performed to compare the scores in stress and aggression syndrome before and after six months of participation in the "Blue Card" procedure. Statistical analyses were performed with the use of the *Statistica 12*.5 program.

3. Results

3.1. Changes in stress and aggression in victims of domestic violence

Table 1 presents the comparison of the stress and aggression before and six months after taking actions related to the "Blue Cards" procedure in the group of victims of domestic violence, distinguishing between those who participated in the therapy (Active participants) and those who did not participate in the proposed therapeutic activities (Passive participants). The stress level decreased significantly under the influence of active participation in the "Blue Cards" procedure, whereas the differences were not statistically significant in the passive group. Furthermore, participation in the "Blue Cards" procedure decreased the levels of aggression in female victims. Statistically significant differences were found in displayed, indirect, and instrumental aggression in the group of female victims actively participating in therapy, after six months from the time the family was included in the "Blue Cards"

procedure. However, in the group of women not taking part in therapy, significant differences can be noted in total aggression syndrome, propensity for retaliation, displaced and indirect aggression, hostility towards others and the environment.

Table 1. Comparison of the self-report stress and aggression syndrome scales between active and passive victims of domestic violence before and six months after taking actions under the "Blue Cards" procedure

		Victims of domestic violence					
		Active (n = 11)			Passive (n = 19)		
Variables		n	T	p	n	T	p
Stress (PSS-10)		11	6,00	0,01	18	45,00	0,05
Total Aggression Syndrome (IPSA II)		8	5,00	0,05	14	13,00	0,01
	Propensity for retaliation	4	00,00	0,06	11	50,00	0,01
	Self-destructive tendencies	5	50,00	0,50	7	110,50	0,67
	Aggression control disorders	5	70,00	0,89	10	90,50	0,06
	Displaced aggression	6	100,50	0,00	9	50,00	0,03
	Unconscious aggressive tendencies	3	20,00	0,59	9	150,00	0,37
	Indirect aggression	7	00,00	0,01	11	100,50	0,04
	Instrumental aggression	2	10,50	0,00	11	170,50	0,16
	Hostility towards each other	6	50,00	0,24	1	00,00	0,01
	Physical aggression towards the environment	2	10,00	0,65	7	40,50	0,10
	Hostility towards the environment	5	70,00	0,89	9	20,50	0,01
	Reactive aggression	5	20,50	0,17	10	100,00	0,07

3.2. Changes in stress and aggression in perpetrators of domestic violence

Table 2 shows differences in an active and passive group of domestic violence perpetrators before and six months after participation in the "Blue Cards" procedure. Stress level did not change significantly due to the "Blue Cards" procedure, neither in the Active nor in the Passive samples of male perpetrators of domestic violence. In the group of active participants in the "Blue Cards" procedure, aggression syndrome decreased in the total scores, a propensity for retaliation, aggression control disorders, unconscious aggressive tendencies, and indirect aggression. In contrast, in the group of perpetrators who passively take

part in the therapy, the only aggression towards the environment changed significantly after six months.

Table 2. Comparison of the self-report stress and aggression syndrome between active and passive perpetrators of domestic violence before and six months after taking actions under the "Blue Cards" procedure

		Perpetrators of domestic violence					
		Active (n = 12)			Passive (n = 18)		
Variables		n	T	p	n	T	p
Stres (PSS-10)		12	38,00	0,93	16	52,00	0,40
Total Aggression Syndrome (IPSA II)		12	1,50	0,00	14	41,00	0,47
	Propensity for retaliation	10	40,50	0,01	12	220,00	0,18
	Self-destructive tendencies	9	200,50	0,81	10	180,00	0,33
	Aggression control disorders	7	00,00	0,01	13	420,00	0,80
	Displaced aggression	11	210,50	0,30	8	140,00	0,57
	Unconscious aggressive tendencies	12	130,50	0,04	12	270,50	0,36
	Indirect aggression	8	00,00	0,01	11	200,00	0,24
	Instrumental aggression	8	70,00	0,12	6	90,00	0,75
	Hostility towards each other	6	100,00	0,91	12	350,00	0,75
	Physical aggression towards the environment	11	220,00	0,32	9	30,00	0,02
	Hostility towards the environment	6	60,00	0,34	9	180,50	0,63
	Reactive aggression	7	60,00	0,17	11	290,00	0,72

3.3. Changes in the aggression of perpetrators of domestic violence: A comparison of perpetrator's self-reports with the victim's perception

Participation in the "Blue Cards" procedure did not change perpetrators' aggression in their self-report assessment. However, when domestic violence victims rated the aggression of perpetrators after six months of participation in the program, the differences were statistically significant (see Table 3).

Table 3. Differences between test (at baseline) and retest (after six months of participation in the procedure of the "Blue Cards") in self-report aggression of perpetrators and in the perception of victims of domestic violence

		Assessing of aggression of domestic violence perpetrators						
		Perpetrator's self-report				Victim's perception		
Variables		n	T	p		n	T	p
Total Aggression Syndrome (IPSA II)		26	116,50	0,13		29	4,45	0,00
	Propensity to retaliation	22	31,82	0,14		23	30,16	0,00
	Self-destructive tendencies	19	80,50	0,56		18	20,52	0,01
	Aggression control disorders	20	61,00	0,10		23	30,74	0,00
	Displaced aggression	19	86,00	0,72		23	30,98	0,00
	Unconscious aggressive tendencies	24	29,17	0,07		25	20,94	0,00
	Indirect aggression	19	74,00	0,40		19	30,7	0,00
	Instrumental aggression	14	30,00	0,16		21	30,75	0,00
	Hostility towards each other	20	63,50	0,12		24	20,62	0,01
	Physical aggression towards the environment	20	73,50	0,24		18	20,74	0,01
	Hostility towards the environment	15	43,50	0,35		19	10,21	0,22
	Reactive aggression	18	60,00	0,27		24	20,98	0,00

3.4. Changes in the aggression of perpetrators of domestic violence in victim's perception: A comparison of active and passive female participants

Domestic violence perpetrators' aggression before and after six months of participation in the Blue Card" procedure was also examined in domestic violence victims' perception, comparing active and passive groups (Table 4). In the perception of domestic violence victims, the perpetrator's aggression decreased during participation in the "Blue Cards" procedure. Among active female victims of domestic violence, statistically significant differences were found in the total aggression syndrome, propensity for retaliation, aggression control disorders, displaced, indirect, and instrumental aggression. Also, in the group of domestic violence victims not taking an active part in therapy, statistically, significant differences occurred in the overall result of the aggression syndrome and all subscales, except for the factor regarding retaliation.

Table 4. The aggression of perpetrators of domestic violence in the perception of victims (comparison groups of active and passive participants); analysis of differences in rating before and six months after taking actions under the "Blue Cards" procedure

		Perpetrator's aggression in the perception of victims of violence					
		Active (n = 11)			Passive (n = 19)		
Variables		n	T	p	n	T	p
Total Aggression Syndrome (IPSA II)		11	1,00	0,00	18	5,00	0,00
	Propensity forretaliation	11	2,50	0,00	12	160,50	0,07
	Self-destructive tendencies	7	13,50	0,93	11	20,00	0,01
	Aggression control disorders	8	2,00	0,02	15	70,00	0,00
	Displaced aggression	9	1,50	0,01	14	20,50	0,00
	Unconscious aggressive tendencies	11	15,50	0,11	14	100,50	0,01
	Indirect aggression	8	1,00	0,01	11	00,00	0,00
	Instrumental aggression	7	1,00	0,02	14	40,00	0,00
	Hostility towards each other	9	10,00	0,13	15	210,50	0,02
	Physical aggression towards the environment	10	11,00	0,09	8	20,00	0,02
	Hostility towards the environment	7	6,50	0,20	12	110,50	0,03
	Reactive aggression	10	17,00	0,28	14	50,00*	0,00

4. Discussion

4.1. The stress level in perpetrators and victims of domestic violence

After six months from the time when the family was covered by support in the form of the "Blue Cards" procedure, the stress level in the group of victims of domestic violence who started therapy decreased. In the group of victims who did not participate in therapy, the stress level did not change statistically. The obtained research results confirm Elklit, Eriksen, and Hansen's (2014) studies, which also showed that negative psychological symptoms, including stress, were reduced during the therapeutic program among women experiencing violence.

The lack of statistically significant differences in the group of perpetrators of domestic violence on the level of perceived stress may be associated with the disclosure of the situation regarding the use of violence, which has only con-

cerned the intra-family system. The publicity of situations related to violence may have caused stress reactions among the perpetrators. The obtained result can be considered in reference to the COR Theory of Conservation of Resources (Hobfoll, 1989). As a result of informing the relevant services about the violence used in the family, the perpetrator of domestic violence loses resources such as a sense of stability and impunity of his actions, which may cause his further stress reactions.

When working with victims and perpetrators of domestic violence, it is crucial to eliminate stress adverse effects. The literature on the subject suggests that stress can be an effect and a cause of domestic violence (Rode, 2010a). Considering stress in cause and effect categories, concerning the phenomenon of intra-family violence, it would be worth focusing on eliminating the stress of perpetrators of domestic violence, since the stress related to disclosure of their acts may ultimately cause other violent reactions among them, and covering the family with help in the form of a procedure. In this case, the "Blue Cards" may be counterproductive.

4.2. Aggression in victims of domestic violence

In the group of women who took part in therapy, the total aggression syndrome and its subscales (i.e., indirect aggression) decreased. However, in the group of victims who passively participated in the Blue Cards procedure, the overall result of the aggression syndrome and factors such as a propensity for retaliation, displaced aggression, indirect aggression, self-hostility, and hostility towards the environment changed significantly. The results suggest that the aggression syndrome decreased in the group of victims who did not participate in therapy, while in the group of women who participated in therapy, the aggression syndrome remained relatively unchanged. Differences in the change in aggression levels between groups of active and passive women in therapy may suggest that women who do not take part in therapy can cope more effectively with controlling aggressive reactions. However, this conclusion may be misleading and involve a feeling of relief that victims may experience by informing the institution of violence that is taking place in their family and their abandonment of aggressive defensive forms to stop their partner's behavior.

Since the launch of the "Blue Cards" procedure, victims may be required to defend their rights to assistance services. Perhaps the women participating in therapy, in comparison with those who do not participate in it, gain greater confidence and a desire to defend their rights, leading to more aggressive solutions. The lack of changes in most dimensions of aggression syndrome in women par-

ticipating in therapy may also be evidence of their reaction in problem situations by choosing aggressive strategies for solutions, which Rode mentioned (2010b). Besides, according to Januszek et al.'s (2015) research, female motives of aggressive behavior most often take on a defensive character, confirming the results obtained. This construct is also consistent with the assumption of the stability of aggression syndrome and its resistance to change.

4.3. The self-report aggression syndrome of perpetrators of domestic violence

The results indicate that among men participating in the corrective and educational program, the overall result of the self-report aggression syndrome and individual factors: the propensity for retaliation, aggression control disorders, unaware aggressive tendencies, and indirect aggression, were reduced. The men taking part in therapy have acquired the skills of refraining from harming someone, taking revenge, and retaliating for the harm they have suffered. Also, they learned to control their aggression and avoid direct aggressive reactions, which Gaś (1987) wrote about describing individual factors of the aggression syndrome. These results find confirmation in the presented studies of Chamberland et al. (2007), which also showed that participating in therapy increases the perpetrators' awareness of aggression and causes them to choose non-aggressive forms of solutions.

In the group of men who did not actively participate in therapy, the aggression syndrome appears as a permanent construct because only one of its factors, which is physical aggression towards the environment, has changed significantly. The results indicate that physical aggression towards the environment among men who did not participate in therapy increased over six months from when the "Blue Cards" procedure was introduced in the family. For perpetrators who do not take therapeutic actions, the "Blue Cards" procedure itself does not constitute any limit in continuing aggressive behavior. It may even strengthen their reaction in physical aggression towards their intimate partners in the relationship.

4.4. The aggression of perpetrators of domestic violence in the perception of victims

Regarding the perpetrators of domestic violence in the perception of victims, it was found that after six months from the time of initiating the "Blue Cards" procedure in the family, victims of domestic violence rated their part-

ners as less aggressive as a result of the general aggression syndrome and for all other factors except for the factor about hostility towards the environment. It can be assumed that the "Blue Cards" procedure meets its main assumptions and makes the perpetrators of domestic violence appear less aggressive in the perception of the victims.

Thanks to institutional support, people experiencing violence can feel the effects of actions that have been taken and observe real changes in the behavior of their partners. Also, providing family assistance in the form of the "Blue Cards" procedure may give victims of domestic violence a sense of greater security, which may directly translate into assessments of perpetrators' aggression. Even if the aggression syndrome of perpetrators of violence has not changed, women may perceive their partners as less aggressive.

It is also worth noting that the factor of "hostility towards the environment" has not changed statistically significantly in perpetrators of domestic violence in victims' perception. This factor in Gaś's (1987) description concerns the hostile attitude towards the environment and hostile desires. Victims of domestic violence may still perceive their partners as aggressive individuals. Nevertheless, this aggression may not be directed towards them but may affect the outside family environment.

Sasal (2005) reports that the primary goal of the "Blue Cards" procedure is to stop the phenomenon of violence, which, given the obtained results, seems to confirm the effectiveness of the "Blue Cards" procedure, assuming that aggression is a factor contributing to domestic violence. According to Rode (2010a), it should be noted that aggression can be only one of many factors that can contribute to domestic violence and is not a separate construct that causes violent reactions in isolation. Therefore, it seems necessary to continue research considering various factors that may contribute to the phenomenon of domestic violence.

The victim's perception of domestic violence perpetrators was also examined, distinguishing between a group of domestic violence victims who actively and passively participated in the therapy. The active female group of victims, after six months, rated their partners as less aggressive in the total aggression syndrome and its five subscales: a propensity for retaliation, aggression control disorder, displaced aggression, indirect aggression, and instrumental aggression. In contrast, women who did not participate in the therapy assessed the partners as less aggressive in general aggression syndrome and for most of the factors. These differences may suggest that in the perception of women taking part in therapy, perpetrators' aggression has changed less than in women not taking part in therapy. It may be related to increasing awareness of aggression in

the group of women participating in the therapy. Victims participating in relief activities gain knowledge about aggression and can assess their partners more harshly. Besides, victims who participate in therapy can improve their self-esteem and change their value system, which can lead to more stringent assessments compared to victims who do not participate in therapy.

The presented results allow us to put forward the thesis that initiating the "Blue Cards" procedure in the family brings the intended effects in the victims' perception. It is worth noting that the mere implementation of the "Blue Cards" procedure can provide victims of violence with an impulse to change their lives, translating into perpetrators' behavior and their response strategies. The presented results may be a hint for future work with the victims and the perpetrators of domestic violence. Strengthening women's beliefs about reducing their partners' aggressiveness may be the foundation for further work under the "Blue Cards" procedure and allow considering the activities under the procedure mentioned above to be effective. However, it is necessary to carry out research considering pairs of the victim-perpetrator of domestic violence, as the results presented relate to unrelated groups of perpetrators and victims of domestic violence. Therefore there are no grounds to relate them to specific intra-family relationships. It is important to note that the six-month period is a short time and does not allow a full overview of the situation related to domestic violence.

5. Conclusions

Based on the study results, it can be concluded that therapy for victims of violence has given the intended effects and that people who have been participating in it deal with stress better. Thus, it seems necessary to motivate domestic violence victims to participate in the Blue Cards procedure and in therapeutic programs intended for them, which will allow them to improve their mental condition and contribute to reducing their stress.

For the group of men taking part in therapy, the results indicating changes in the aggression syndrome were obtained thanks to the support of the family in the form of the "Blue Cards" procedure, which does not confirm the assumption that the aggression syndrome, as a durable and shaped construct based on early childhood experience, does not undergo significant changes. The obtained results may indicate that the therapeutic program proposed for the perpetrators in the form of corrective and educational interactions brings the intended effect and allows those participating in it to acquire knowledge on coping with aggres-

sion and choosing non-aggressive forms of behavior in inter-family interactions. An essential element of working with people using violence should make them aware of their own aggressive reactions, and consequently the violence they use, and to sensitize them to the inadmissibility and punishment ability of such behavior. It also seems like one of the elements of sentences for abuse of a family member must be the obligation of perpetrators of violence to participate in corrective and educational programs.

The research results indicate that an essential element of working with families where violence occurs is motivating particular family members to participate in therapy and strengthening their motivation when taking therapeutic actions. It can be assumed that the therapeutic program offered for victims and perpetrators of violence implements its assumptions and leads to the inhibition of the phenomenon of aggression, which may determine domestic violence. This study found that greater engagement in therapy reduces stress in victims and perception of aggression in perpetrators of domestic violence. Thus, the "Blue Cards" procedure may be considered an effective intervention and prevention program for domestic violence victims and perpetrators.

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