Dialectical Behavior Therapy for Domestic Violence: Rationale and Procedures

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Domestic violence is a significant social problem with significant psychological and medical consequences for its victims and their children. In part because treatments for domestic violence are often not effective, and in part because of the hypothesized similarities between the problems of chronically aggressive men and chronically suicidal women (e.g., emotion dysregulation), a rationale for applying Dialectical Behavior Therapy (DBT) to domestic violence is provided. This new application of DBT, designed to treat aggression and violence in families, is described. Aggression assessment procedures and conceptualization issues are presented, along with a case to illustrate treatment principles and intervention strategies. Typically targeting men who batter their partners, this new application includes the four essential functions of DBT, including attending to client motivation, skill acquisition, skill generalization, and team/therapist consultation. In addition, a number of new treatment developments are presented to target reducing and eliminating aggression: validation and empathy skill training; a focus on reconditioning anger responses to be more normative (including identifying alternative emotions and their associated effective coping responses); skills training on accurate interpersonal emotional expression; and understanding the functions of aggression and teaching skills in how formerly aggressive partners can get relationship and self-management needs met skillfully. A brief overview of the other strategies and components of DBT, and how they are applied to treating domestic violence, is also provided. Particular attention is devoted to therapists maintaining a nonjudgmental stance by utilizing mindfulness practice and team consultation.

Domestic violence (also referred to as partner abuse, battering, aggressive or violent behavior, etc.) is a significant social problem in the United States. Data from a national survey indicate that 1 out of 8 husbands engaged in at least one violent act toward his wife during the year of study, and 1.8 million wives are assaulted by their spouses or partners each year (Straus & Gelles, 1990). The National Institute of Justice (1994) estimates that partner abuse occurs in between 2.5 million and 4 million homes each year in the United States, with the vast majority of violence perpetrated by men against their female partners. Moreover, once battering has begun, it is likely to continue to occur, and will often escalate in frequency, intensity, and severity (Feld & Straus, 1989).

Domestic violence has enormous negative consequences for its female victims, who show both increased psychological problems (e.g., depression, substance abuse, posttraumatic stress disorder, and higher suicide risk) and increased physical health problems (e.g., over 1 million women seek medical care for injuries related to battering, and 20% of all women's emergency room visits are the result of battering; Houskamp & Foy, 1991; Stark & Flitcraft, 1982). In addition, significant problems have been identified in children, both as a direct result of observing aggression and violence between parents and indirectly as a function of the other consequences (e.g., depression, health problems, jail) of their parent victims and perpetrators.

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Continuing Education Quiz located on p. 526.

Applying Dialectical Behavior Therapy to Domestic Violence: Rationale

Developing or implementing a new treatment for any problem is justified under the following circumstances: (a) data show that existing treatments do not work well; (b) data demonstrate better outcomes with a new treatment; (c) a new treatment is more resource efficient than an old one (without diminishing outcomes); or (d) treatment providers prefer a new treatment (e.g., reduced burnout), as long as outcomes are not diminished and costs do not increase.

The rationale for applying Dialectical Behavior Therapy (DBT) to problems of aggression and violence in families generally follows this logic: (1) Outcomes for existing treatments for battering (both recidivism and drop out rates) are generally poor; (2a) there are several theoretical links between parasuicidal and borderline behaviors successfully treated by DBT and aggressive and violent behaviors of batterers; (2b) empirical findings suggest that aggressive behaviors in batterers may be reinforced by *both* instrumental gains and diminished negative emotional arousal, paralleling reinforcers for parasuicidal behaviors of borderline clients; (2c) empirical outcomes of DBT are strong with respect to relevant overlapping treatment targets (outcome and treatment retention); (3)

DBT costs much less than prison (and any successful treatment likely would measure up well against the social and individual costs of battering), and (4) stress and burnout among treatment providers is believed to be high, and DBT targets reducing stress and burnout among providers.

Problems With Existing Treatments

Domestic violence treatment programs typically treat male batterers using a weekly group format for periods ranging from 8 to 36 weeks. Most batterer treatment programs use cognitive-behavioral interventions, with a curriculum that includes core instruction in anger management (e.g., anger recognition, time-out, self-talk strategies, and relaxation training) and violence cessation (e.g., time-outs, self-talk, relaxation). The curriculum may also include interventions from a feminist perspective, including sex-role education, resocialization, and discussions of patriarchal, male power issues, and may include training in skills to improve relationship functioning, such as communication and conflict resolution skills, social skills, and assertion skills (Holtzworth-Munroe, Beatty, & Anglin, 1995).

Given the difficulties with dropout rates in treating batterers, the emphasis in DBT that is placed on orienting, committing, and collaboration may be effective for this population of clients.

Poor outcomes. Most published studies have found limited if any reductions in rates of recidivism. For example, Rosenfeld (1992) reviewed 25 outcome studies of batterers' treatment programs and found that across the studies, the average recidivism rate (defined as at least one act of violence by the time of the follow-up assessment) was 27%. Rosenfeld concluded that batterers who completed treatment had only slightly lower rates of recidivism than batterers who refused treatment, dropped out of treatment, or were arrested and not referred to treatment. Gondolf (1997) evaluated the outcomes of 840 batterers receiving treatment at four "well-established" cognitive-behavioral batterer treatment programs, finding that 39% reassaulted at least once during the 15-month follow-up, 70% engaged in verbal abuse, and 43% percent committed threats of violence during that time.

High dropout rates. The dropout rate between initial contact with batterer treatment programs and program completion is often greater than 90% (Gondolf & Foster, 1991). Additionally, even among batterers who are court-ordered to treatment, 40% to 60% or more do not complete the prescribed number of sessions. For example, Babcock and Steiner (1999) evaluated 339 male batterers who had been court-ordered for batterer group treatment: Only 106 (31%) completed the treatment.

Support for an Emotion-Dysregulation Model

Most treatments for domestic violence (e.g., anger management, general cognitive-behavioral interventions, role resocialization) are pragmatic. That is, they have been developed in response to behaviors of batterers that are proximal to their aggression (anger, attitudes and attributions, beliefs about roles). However, researchers studying batterer typology have found that batterers are a heterogeneous population with respect to these variables. Moreover, most studies that have measured appropriate variables have identified a subtype of batterers who exhibit borderline personality disorder behavior traits or emotion regulation problems (e.g., Hamberger and Hastings, 1986), and most batterers fit profiles in *DSM-IV* Cluster B.

Tweed and Dutton (1998) conducted a cluster analysis of 79 batterers, and found that 38 (48%) of the batterers fell into an "impulsive" cluster, 32 (41%) fell into an "instrumental" cluster, and 9 (11%) did not fit into either cluster. These authors found that the "instrumental" group was more narcissistic, antisocial, and aggressive, and reported more severe physical violence, whereas the "impulsive" group was more passive-aggressive, borderline, and avoidant, and had higher chronic anger and fearful attachment. They suggest that instrumental batterers use violence to maintain control of their partners (for instrumental gain), whereas impulsive batterers engage in violence to reduce their own aversive arousal and negative affect.

Rubio and Fruzzetti (2000) argue further that many men who have antisocial personality disorder or a significant subset of antisocial behaviors (partner abuse) may have disorders that overlap with borderline personality disorder. They suggest that many aggressive and violent men have the same psychological difficulties with emotion regulation (and related problems of "self" such as being unable to identify emotions, wants, etc.) as do chronically suicidal and parasuicidal borderline women. Furthermore, they argue that in addition to the frequent instrumental gains accrued by the use or threat of aggression, such behaviors may also be negatively reinforced by diminished negative arousal following threats or use of aggression.

Effectiveness of DBT

DBT is a treatment for emotion dysregulation and the various behavioral difficulties associated with severe and chronic emotion dysregulation. DBT is the only treatment to date to have garnered significant empirical support for treating multi-problem, parasuicidal borderline

women (e.g., Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). Moreover, the established efficacy of DBT in treating concomitant problems (e.g., substance use, affective disorders, other quality-of-life problems) is important in considering treating batterers, who also are likely to have problems with substance use as well as other significant behavioral problems.

DBT has demonstrated an ability to keep suicidal and self-harming borderline individuals in treatment to its completion (16% dropout over 1 year; Linehan et al., 1991), despite the fact that this population (borderline women) has a very high dropout rate in other treatments. Given the difficulties with dropout rates in treating batterers, the emphasis in DBT that is placed on orienting, committing, and collaboration may be effective for this population of clients.

Finally, working with batterers is challenging and demanding for treatment providers: Dropout rates are high, outcomes are poor (recidivism rates are high), crises are common, and successes and reinforcers are relatively infrequent. This parallels the difficulties of therapists in treating multiproblem, chronically suicidal and borderline clients. “Treating the therapist” is a tenet of DBT (Linehan, 1993a), recognizing that motivating skillful therapists is essential both for their well being and for improved outcomes in their clients. This approach seems particularly appropriate with providers of batterer treatment as well.

Describing DBT for Domestic Violence

DBT has been comprehensively described elsewhere (e.g., Linehan, 1993a). Applying DBT to aggressive and violent behaviors has been accomplished primarily through a systematic utilization of existing DBT principles, structures, and strategies, with a few modifications. The modifications to established DBT have been developed specifically for the treatment targets and problems of this client population. In this section we will describe each of the essential components of DBT and their relevant application to aggressive partner behaviors.

Assessment

Assessment in DBT for domestic violence serves three primary purposes: to determine appropriateness for the treatment, to identify treatment targets, and to measure the effectiveness of the treatment:

Assessment to determine appropriateness for inclusion in the treatment. This assessment simply identifies factors relevant to inclusion and exclusion criteria: Does the client have the kinds of problems for which the treatment (and the specific treatment program) is intended? Does the client meet any exclusion criteria of the treatment program? These might include imminent suicidal behaviors, current threats toward others (e.g., with Tarasoff implications), current severe psychosis that makes participation in treatment difficult or impossible, current prison inmate status (unless the treatment program is operated within the facility or the facility allows brief furloughs for treatment), and so on.

Assessing inclusion and exclusion criteria requires clear program guidelines from the treatment team regarding how it is applying DBT: For whom/what behaviors is this treatment being offered? Are there any empirically derived exclusions? Similarly, inclusion and exclusion policies of the clinic, agency, or other setting in which the treatment is being offered must be determined and assessed. The more specific these criteria are, the easier they are to assess efficiently with questionnaires, phone screening, or a face-to-face interview. Moreover, inclusion and exclusion criteria can be highlighted in brochures or advertisements to those making referrals so that a minimum amount of time (for both staff and those who would be excluded) can be devoted to this phase of assessment.

Assessment to identify treatment targets to aid the delivery of services. Identifying primary treatment targets is especially important in DBT in general as well as in DBT for batterers. Because the problems of domestic violence are within the set of priority targets within DBT, these “first stage” targets must be assessed continuously (see Table 1). Because DBT is a behavioral treatment, the antecedents and consequences of these target behaviors must be

Table 1
Stage 1 Treatment Targets

Decrease:
- Life-threatening behavior: suicidal and parasuicidal behaviors, thoughts, urges, actions; aggressive and violent thoughts, urges, and actions; child neglect
- Therapy-interfering behaviors
- Quality-of-life interfering behaviors (that threaten stability, individually or in the family)
  - Criminal behaviors that may lead to jail
  - Problematic sexual behavior (outside relationship, high risk/unprotected)
  - Seriously dysfunctional interpersonal behaviors
  - Significant employment or school related dysfunctional behaviors
  - Illness-related dysfunctional behaviors
  - Housing-related dysfunctional behaviors
  - Mental health–related dysfunctional behaviors (e.g., severe *DSM* Axis I–IV Disorders)

Increase: Individual Behavioral Skills and Self-Management
- Mindfulness
- Distress tolerance
- Emotion regulation
- Interpersonal effectiveness
- Validation and empathy

identified as intermediate or secondary targets for change in order to influence primary targets.

There are, of course, a number of ways to assess these secondary targets (antecedents and consequences of aggression). We have developed a semistructured interview, the Domestic Violence Interview (DVI; Fruzzetti, Saedi, Wilson, Rubio, & Levensky, 1999), that provides a functional analysis of aggressive and violent behaviors vis-à-vis emotion dysregulation, couple intimacy and relationship factors, and instrumental gains. In the DVI, the assessor (usually the therapist in the first or second appointment) guides the client through a behavioral analysis of the vulnerability factors, emotions, thoughts, actions, events, etc., along the chain of behaviors toward a specific aggressive episode. The target of the therapist is to be nonjudgmental and noncritical, eliciting as much descriptive data as possible from the client, utilizing cues (such as establishing context—date, day, time, place, room, temperature, events of the day) to enhance reporting. This is, of course, typical of behavioral or functional analysis in general. This strategy allows the therapist to listen to the client's whole story without responding except to communicate acknowledgement and understanding of the events (including thoughts and feelings) of the client. No attempts are made to suggest alternative behaviors at this time, nor to engage in any therapeutic strategies other than assessment per se. This affords the therapist with early targets for intervention once a commitment to treatment is established. Of course, use of formal assessment protocol is only one option and may not be necessary. However, careful, comprehensive, and detailed behavioral analysis (including a focus on identifying emotions along the chain of behaviors) must be completed in some manner.

The assessor . . . guides the client through a behavioral analysis of the vulnerability factors, emotions, thoughts, actions, events, etc., along the chain of behaviors toward a specific aggressive episode.

Assessment of outcomes to determine the effectiveness of the treatment. There are at least four consumers of outcome data that should be satisfied when considering which outcomes to measure: (a) the client; (b) the therapist (and other members of the treatment team); (c) whomever is paying for the treatment (this may be the client exclusively, but often also includes third-party payers, the public, etc.); and (d) administrators responsible for resource allocation, at all levels of care and administration (i.e., from direct supervisors to agency heads, legislators). If the program has a research component, human subject review boards and scientific peers must also be considered.

In general, there are two types of relevant "data" (this word is used loosely here to represent any kind of information used to determine effectiveness) that should be considered: primary outcomes and intermediate outcomes. Most obvious is outcome on the primary target: Has aggression and violence ceased? The longer the follow-up period, of course, the more confidence we may have in the effectiveness of the program. Thus, knowing that the client has not battered during the 6-month period of treatment would not be as useful as knowing about recidivism over a 1- or 2-year (or longer) follow-up period. The other kind of data relevant to understanding outcomes involves measuring putative mediators of outcome; these are often the secondary targets of treatment needed to achieve success on primary targets. For example, skill acquisition and generalization, client collaboration, attendance, substance use, and other secondary targets of treatment are believed to predict long-term outcome (e.g., primary target of decreasing aggressive behaviors). By measuring these variables, treatment providers can tell whether or not the immediate targets are affected, thereby increasing the likelihood that longer term (primary) targets will be achieved in an enduring way. Of course, measuring intermediate variables is only useful when data support the model on which they are predicated and the variables in question actually do predict outcomes empirically.

Measures of mediators and direct indices of outcome can be collected during time intervals or continually (daily or weekly) throughout the treatment. Long-term outcomes are collected at termination and at subsequent posttermination intervals. We typically utilize quarterly assessments (every 3 months), daily self-monitoring cards, and therapist reports and ratings. During the initial and quarterly assessments, data that can likely be collected reliably with interval sampling are assembled. This might include questionnaire data (social support, alcohol and drug use, skill acquisition, depression severity, attitudes toward treatment, etc.) or interview data (covering similar topic areas). Daily self-monitoring cards include daily recording of aggressive thoughts, urges, and action (and suicidal thoughts, urges, and action if present in past year), drug and alcohol use, sleep and other relevant vulnerability factors, skill practice, emotions, social contacts made that day, and so on. As secondary targets are identified they are included on the diary card; as targets are achieved they are removed.

In order to have high confidence in treatment effectiveness, it may be important to have collateral sources of data. For example, police and court records, and either interview or questionnaire data from a current partner

concerning client conflict and other potentially aggressive behaviors may aid in understanding the true impact of the interventions provided (there are significant demand characteristics on the client's self-report in many cases). If partners are asked to provide any information, it is essential that clients do not have access to it for obvious safety reasons. One easy way to do this is to collect follow-up data anonymously from partners. Although it may be impossible to identify individual treatment successes and failures, this method maximizes safety for partners and allows the overall impact of the treatment program to be evaluated in a more valid manner.

Let us use a case example to illustrate how treatment targets would be assessed and organized initially with the DVI. This case is a composite of typical behaviors of multiple client presentations, and will be employed throughout the rest of this paper to illustrate other components of DBT for aggressive and violent behavior.

Case example. Mr. A. is court-referred for treatment while waiting for adjudication subsequent to battering his partner. In the most recent episode of battering, neighbors called the police late at night in response to loud noises and screaming. Both partners were found with bruises and facial lacerations, and the female partner's eyes were swollen almost shut. She was treated in the emergency room and released. He was treated in the forensic unit and released on bail the next day, and went to live, temporarily, with his brother across town. He told police that "she started the fight, I was only protecting myself" while she told police that he escalated over the course of the evening, finally beating her with his hands when she attempted to leave to go stay with a friend.

The domestic violence interview (see above) was conducted around this specific episode and determined the following chain of behaviors:

1. He had been late to work on that day, in part because he had driven his wife to work after her car would not start;
2. He was anxious arriving for work late (reported that his lateness is a frequent problem);
3. He tried to sneak in but his supervisor saw him;
4. He felt "angry" and in the interview also identified fear of losing his job and embarrassment over getting caught trying to hide his lateness;
5. He felt angry at his wife all day (ruminated) for "making him late" to work;
6. He further ruminated about the effect of his lateness on his employee evaluation, which would be completed later that month;
7. He was angry and upset upon returning home for the evening;
8. He drank "a couple of beers" while waiting for dinner;
9. He argued verbally with his wife during dinner; he was critical of her in many ways which continued for several hours through the evening (she watched television and generally ignored his criticisms);
10. Around 10:45 p.m. she yelled at him, called him "irresponsible" regarding work, pointing out that he had been late many times previously because he had not set the alarm, not remembered his work schedule, and so on;
11. He verbally threatened her, telling her to "shut up or I'll shut you up";
12. He identified intense anger, which he called a "white out";
13. He grabbed her;
14. She pulled her arm loose and yelled at him that she had told him she would leave him if he threatened her again;
15. She went to get her coat and keys;
16. He grabbed her by the arm again, they struggled, pushing and scratching each other;
17. She again tried to get to the door;
18. He knocked her down, knelt down on the floor and slapped and punched her repeatedly in the face;
19. She went into the bathroom;
20. He sat down on the sofa;
21. The police arrived and he was arrested.

Let us turn our attention now to the treatment structure and hierarchy of treatment targets, to understand which behaviors are addressed, in what order, in DBT for domestic violence.

Treatment Hierarchy, or Structure of Treatment

One of the essential structures of DBT is its detailed attention to a hierarchy of treatment targets. Table 1 highlights the essence of the treatment hierarchy, which is described below.

Orienting and committing to treatment. After one or more assessment sessions, but prior to treatment per se, one to two sessions are devoted to describing in detail what a client can expect if she or he participates in this treatment (orienting) and evaluating the pros and cons of participation, culminating in an active decision whether or not to participate (commitment). Clients begin identifying intermediate targets for treatment, complete a diary card daily to track relevant behaviors as they are identified, and complete out-of-session assignments designed to clarify and enhance commitment.

This phase may be complicated by the fact that clients may be court-ordered to treatment. It is essential for these clients that the therapist highlight their freedom to choose (or not) DBT, even given the apparent absence of alternatives (they must attend *some* treatment or be remanded to court or jail). This has at least a couple of im-

plications: First, therapists must be knowledgeable concerning alternative treatments available in order to compare and contrast them accurately with DBT. Especially relevant are any outcome data available, the structure and expectations of other programs, and so on. The target here is not to dissuade someone from participating in another treatment or to convince someone to participate in DBT per se, but rather to facilitate an active commitment to treatment (DBT or other) or an active commitment to no treatment. The target is active commitment to a course of action that will likely help the person achieve the kind of life he or she desires, from a "wise mind" perspective.

It is essential to highlight how DBT is likely different from most other treatments for domestic violence (such as anger management or more standard CBT, in one or both of which many clients will already have participated): In DBT:

- there is an emotion regulation focus, and not just on anger as the precipitant for aggression;
- active skills are taught as the solutions to problems (aggressive and violent behavior, of course, but other problems that are in any way connected to aggression also);
- mindfulness is a core skill in DBT (with emphasis on both the attention-focus and wise-mind aspects of mindfulness);
- although there is a psychoeducational component to DBT skills, the treatment involves a collaborative and integrative application of these skills (including attention to generalization);
- idiographic behavioral assessment (behavioral or functional analysis, self-monitoring) and behavioral interventions/behavior therapy are the primary change strategies (not insight or understanding, per se);
- there is an assumption about the value of the client as a human being, and that she or he has a repertoire that includes valuing the integrity of others and valuing nonviolent action with partners (the client also may have a repertoire that values the use of aggressive and violent behaviors; the former repertoire then would be the target for enhancement, consistency, and reinforcement, the latter for reduction or elimination);
- it is assumed that treating aggressive and violent clients is demanding of therapists' treatment skills and sometimes challenging emotionally, and that therefore therapists need a team for support in order to be effective.

Pros to be considered with a client trying to decide whether to commit to DBT may include the following: previous treatments may not have been effective (i.e., entering repeatedly into a treatment that has not worked may diminish motivation; DBT may not only be a new treatment for batterers, but also directly addresses motivation and commitment in treatment); other parts of the treatment hierarchy may be relevant to the client (e.g., depression, substance use, poor relationships, etc.; see below); DBT is a demanding and comprehensive treatment (involves skill training, behavioral analysis, generalization of skills, homework/practice) that operates within a treatment hierarchy, so clients may be motivated by treatment targets in addition to reducing aggression; treatment is very focused on specified targets, so clients are well-oriented participants in their therapy; treatment is a collaborative enterprise; and so on. Of course, as a dialectical treatment, every one of these potential pros to DBT may also be a reason *not* to participate in DBT: It is a complicated and demanding treatment, is very focused, requires active commitment, participation, and collaboration. After clients commit to DBT in principle, commitment to specific aspects of treatment are continually monitored and addressed as needed throughout treatment.

Also with respect to commitment, it is important to clarify what role, if any, the therapist or treatment program will take vis-à-vis court-related matters. For example, states or counties have different limits to confidentiality with court-mandated clients than for purely voluntary clients. Also, DBT is an empirically minded approach to treatment, and, as such, we are loath to make predictions about a client's future behavior unless an index or instrument or assessment methodology has demonstrated predictive incremental validity in making such predictions. Thus far, we are aware of no such indices for domestic violence and consequently we will agree to report *only* what we observe directly. Thus, clients (even apparently highly motivated or successful ones) should not expect us to make predictions about the likelihood of their recidivism. Rather, they should expect us to report only the specifics of their participation in treatment and any group aggregate outcome or follow-up data collected in a particular agency.

Case example. Mr. A. and the therapist identified several pros to treatment for him: He had been through other treatments (at least three); he desired a more stable, nonviolent life; he wanted to have children and did not think raising them in a violent environment was healthy for them; and he expected his wife would leave him again (he had moved back in with her about 3 weeks after the most recent episode), possibly permanently, if he battered again. The identified cons to treatment were that it involved a lot of time and effort (minimum 6 months, daily monitoring practice) and he "did not like" the idea of focusing on emotions other than anger. However, he did commit to 6 months of treatment as a package (i.e., all components), and began treatment after

these three sessions focusing on assessment, orienting, and committing.

Stage 1. This is the stage in which aggressive and violent behaviors are targeted (see Table 1). In this first stage of treatment, the highest-order targets are those on the continuum of life-threatening behaviors: suicidal/parasuicidal behaviors, aggression toward others, and child neglect. Thus, assessing these behaviors in every session via daily diary card and targeting these problem behaviors in session are the first order of business for the therapist. Although not explicitly part of the original set of targets in DBT for borderline women (Linehan, 1993a), aggressive and violent behaviors against partners are clearly on the continuum of life-threatening behaviors in DBT.

Even if a client has not been aggressive or violent in a given week, this may be targeted in session. The first goal in this stage of treatment is sufficient *self-management* that the person no longer engages in life-threatening behaviors (toward self or others, including threats and other verbal behaviors that may have the same function as actual aggression). Thus, until enough of the pieces or links of the chain of behavior have been addressed that the client has sufficient skills for comprehensive self-management (no aggressive or suicidal actions, etc.), prior episodes of aggression (as well as current thoughts or urges) continue to be examined and treated.

Self-management is approached behaviorally to establish intermediate targets (toward enhanced safety, reduced—and ultimately no—aggression) in Stage 1: Is the person able consistently to engage in reasonably safe behaviors (not harming self or others: having a reasonable life expectancy him- or herself, and predictable behavior such that others' behavior does not function to avoid harm from the person)? Does the person participate actively in treatment (come to sessions, come on time, collaborate in treatment, complete practice exercises and daily self-monitoring) and not engage in other behaviors that interfere with treatment? Does the person exhibit behavioral control to a degree sufficient to maintain a reasonable and stable quality of life (stable housing, stable and sufficient income for minimal standard of living, not in jail, substance use modest or less)?

Case example. With repeated behavioral analyses (and after learning emotion identification skills), Mr. A. identified hurt and shame in response to his wife's statements (that he was "irresponsible") during the episode described earlier. Later he also described shame regarding his own "completely pathetic" behavior, overwhelming fear that she would leave him, shame that he was harming her in order to force her to stay, and "overwhelming" feelings of worthlessness prior to beating her. As prior violent and current near-violent episodes were analyzed using the DVI format of behavioral analysis, a pattern of aggression was identified, in proximal response to fears of his wife leaving, shame about his own behavior, and hurt resulting from verbal, invalidating statements from his wife (or others). Anger was identified as a generally secondary emotion, primarily functioning as an escape from fear, shame, and hurt. Vulnerability factors (earlier in the chain of behaviors) such as poor work performance, social rejection, poor sleep, and alcohol use were identified. The primary reinforcers for aggression seemed to be: (a) It successfully inhibited his wife from leaving, at least temporarily; (b) it did result in reduced arousal from or awareness (albeit temporarily) of fear, shame, or hurt.

In this stage of treatment, assessment, skill training, behavioral analysis and behavior therapy, and multiple therapeutic strategies (validation, problem solving, reconditioning emotional responses to stimuli to make them more normative, shaping, etc.) are used to identify links in the chain toward aggressive behaviors (antecedents) that can be changed. In addition, reinforcing consequences that can be altered are identified and targeted, and the reinforcement of alternative, nonaggressive behaviors is emphasized. These processes will be described later regarding Mr. A.

In the first stage of treatment, the highest-order targets are those on the continuum of life-threatening behaviors: suicidal/parasuicidal behaviors, aggression toward others, and child neglect. Thus, assessing these behaviors in every session . . . and targeting these problem behaviors in every session are the first order of business.

Stage 2 and beyond. Just as with DBT for suicidal behaviors, once stability and self-control are established, the targets may shift. Once a client is stable, treatment moves to Stage 2 and may target other emotional and life problems in continuing individual treatment (e.g., Linehan, 1993a) or may turn to focus more on improving couple and family relationships in couples or family therapy (Fruzzetti et al., in press). Because DBT as it is applied to treat aggressive and violent behaviors is the focus of this paper (and by definition are Stage 1 targets), please see these other sources for information about subsequent stages of treatment.

In DBT, self-management (Stage 1 target) is achieved by the comprehensive acquisition, application, and generalization of skills. In the following section, a brief description of these skills is provided.

Mindfulness skills are essential to help reduce confusion about self, decrease (or inhibit increasing) cognitive and emotion dysregulation, increase attention-focus, increase contact with wise-mind values (core values), and enhance awareness of one's own behavior. Mindfulness aids assessment in general and enhances client ability to recognize when they are on problematic chains of behavior (the earlier on the change they become aware, the better), which makes successful changes (e.g., nonaggressive outcomes) more likely. In DBT mindfulness skills, clients are taught how to observe, describe, and participate in experiences in a nonjudgmental, effective way, focusing attention on one thing at a time. The focus here is both on observing, describing, and participating in one's own experience and on being able to observe and describe the actions, feelings, and so on of significant others in a nonjudgmental way. We have augmented the standard DBT mindfulness handouts (Linehan, 1993b) with skill focus on "relational mindfulness," or the ability to observe and describe, nonjudgmentally (and empathically), another person. Mindfulness is the foundation on which the other skills rest. Thus, we teach mindfulness first, before going on to other skills, and then again prior to teaching additional skill modules.

Distress tolerance skills are integral to increasing safety and self-control, and are employed to forestall aggressive behaviors. Given research that has identified a subtype of batterers as particularly impulsive, these skills may be especially important. Furthermore, they are used to reduce impulsive behaviors that likely lead to further dysregulation, even if not aggressive per se (rumination, substance use, etc.), and to provide a "window" (a break from escalation) in which a client can utilize mindfulness (of current status and where the current "chain" of behavior is likely to lead). This window, in which the client briefly tolerates distress, allows him or her to orient to using skills to alter the trajectory of current behaviors, ultimately reducing distress via more functional means (not through dysfunctional escape behaviors, aggression, etc.). These skills include many strategies for surviving crises, accepting reality, controlling arousing stimuli (inhibiting escalation or fostering deescalation; e.g., time-out) and tolerating distress to allow natural change. To the extent that aggressive behaviors are negatively reinforced by subsequent reductions in negative emotional arousal, finding nonaggressive means to reduce painful arousal, such as distress tolerance, emotion regulation and interpersonal skills (below), may be particularly important.

> Self-management in Stage 1 is achieved by the comprehensive acquisition, application, and generalization of skills: mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness, and validation/empathy.

Emotion regulation skills help stabilize and manage labile emotions and decrease painful negative emotional arousal. Clients are taught new ways to think about and understand emotions and new strategies for managing them, including decreasing emotional vulnerability, reducing unnecessary emotional suffering, and strategies for changing painful emotions over time. In particular with batterers, we emphasize accurate identification of emotions (DBT Handout 4), reducing vulnerability to painful negative emotional arousal (DBT Handout 6), and reducing emotional suffering (DBT Handouts 9 and 10; Linehan, 1993b). We have augmented existing skills with additional focus on the following: (a) possible functions of anger as a secondary emotion (i.e., a secondary emotion is hypothesized to function as to escape from or block primary emotions such as fear/jealousy, sadness and guilt/shame; it is assumed that stimuli that normatively elicit these other emotions have been conditioned to elicit anger instead, so reconditioning these stimuli to elicit their normative emotional response is an important part of this treatment); (b) how to disclose emotions effectively (combined with interpersonal effectiveness skills); and (c) understanding the links between emotion and aggressive behaviors, including the reinforcing functions of aggressive behaviors both privately (i.e., to reduce negative arousal) and publicly vis-à-vis an intimate partner (e.g., to titrate intimacy; cf. Saedi & Fruzzetti, 2000).

Interpersonal effectiveness skills help reduce interpersonal chaos and increase interpersonal effectiveness. Included are skills designed to help balance (a) objectives or goals in a specific situation, with (b) maintaining the relationship, and (c) maintaining (or enhancing) self-respect. Somewhat paradoxically, we use self-respect effectiveness (utilizing mindfulness) to reduce aggression (increased respect of others) by targeting increased awareness of wise-mind values of nonaggression, noncoercion, and fairness.

Validation skills are used to reduce one's own dysregulation (self-validation), to improve relationships (validating others), and to enhance empathic understanding as a means of reducing aggressive behaviors (thoughts, urges, and actions). These skills include (a) understanding the forms and functions of validation (including empathy) and invalidation, (b) specific skills to identify targets (e.g., emotions, opinions, effective behaviors) for understanding and validation, (c) empathy and validation practice, and (d) the verbal and communication skills to validate others effectively. Part of validation necessarily

includes understanding the impact of aggression and violence on others. This is a kind of "empathy" training that involves integrating mindfulness of others (relational mindfulness) with mindfulness of core values (wise mind). The result is more empathic understanding of the impact of aggression, and this may function (via contingency clarification) to decrease avoidance of emotion and increase motivation not to use aggression. Thus, we practice understanding and validating the impact of aggression (empathy) not as a kind of aversive counterconditioning, but more as a means of mindfulness practice and recommitment to nonaggressive behavior.

The first four modules mentioned (mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness) are adapted directly from Linehan's *Skills Training Manual* (1993b). The last module (validation) is adapted both from Linehan (1997) and Fruzzetti (1995, 1996), and is elaborated elsewhere (Fruzzetti, Hoffman, & Linehan, in press; Hoffman, Fruzzetti, & Swenson, 1999).

Modes and Functions of Treatment

Linehan (1993a) has argued that DBT must include the following four functions: skill acquisition; skill generalization; enhancing client motivation to change (behaviorally defined); and enhancing therapist motivation and skills. At times, a fifth function, structuring the environment, is also important in DBT. As a direct application of DBT, these four (and sometimes five) functions of treatment are considered essential in treating domestic violence as well. However, the modes with which these functions are achieved may vary from program to program. Some of the options for delivering these services are described below.

Skill acquisition. Skills may of course be taught in traditional groups (cf. Linehan, 1993b), and this is perhaps the most common mode in which this function is achieved (it is resource efficient). However, individual skill training, self-study, email or internet augmentation, video or CD-ROM formats, and so on, could be employed, consistent with other skill training approaches in behavior therapy.

Skill generalization. DBT with batterers similarly employs the full behavioral array of strategies to bring skills into clients' daily lives: telephone skill coaching, generalization programming, between-session practice exercises, in-vivo shaping, etc. It is essential to structure generalization in small, achievable steps with considerable (albeit temporary) therapist reinforcement to enhance practice and skills until the use of new skills is naturally reinforced in the client's life (i.e., under the control of natural reinforcers). This is especially important to convey to clients: Because they have used aversive and aggressive control strategies in the past, others may require repeated and consistent alternative (nonaggressive, nonaversive) behaviors of the client before they respond in trusting, reinforcing, appreciative, reciprocal (all likely reinforcing) ways. Until that time, the therapist must provide social reinforcement and help the client finds ways to be reinforced by the intermediate success of behaving skillfully, even if others do not yet respond in naturally reinforcing ways.

Client motivation. The essence of motivation from a behavioral viewpoint is, What are the controlling variables for target behaviors? That is, what antecedent conditions (discriminative stimuli, or sometimes conditioned stimuli) are necessary to elicit the target behavior (e.g., aggressive behavior) and what consequent stimuli reinforce it (or punish or extinguish alternative, less problematic, behaviors)? Client motivation (i.e., acting more skillfully and with self-control) is enhanced via behavioral analysis, solution analysis, and the application of skills (behavior therapy).

> Battering, like parasuicidal behavior, may be difficult to change because it may be extremely difficult to remove its reinforcers: aggressive behaviors may be negatively reinforced by subsequent diminished negative emotional arousal, as well as by intermittent instrumental gains.

Battering, like parasuicidal behavior, may be difficult to change because it may be extremely difficult to remove its reinforcers. As noted above, these behaviors may be negatively reinforced by diminished negative emotional arousal, as well as positively reinforced by intermittent instrumental gains. Thus, DBT strategies often must focus on changing antecedent steps on the chain of behaviors toward aggression by identifying and reinforcing alternative, nonaversive means of reducing painful negative emotional arousal. These antecedent steps include: (a) mindfulness of present state, including identifying what "chain" (or pattern) of behavior the client is currently participating; (b) awareness of the wise mind commitment to getting off chains that could lead to aggression; (c) using skills to decrease negative emotional arousal, especially early in the chain; (d) using skills to achieve goals, in ways that are consistent with the client's wise-mind values (e.g., nonaggressive means; fairness); and (e) using skills to accept what is not possible, those immediate goals that can not be achieved skillfully (at least not at that moment), within wise-mind values of one's own behavior.

The function of enhancing client motivation for skillful behavior may be addressed in individual treatment (typical in DBT) or in a group format. Either way, the focus is on using the treatment hierarchy to establish targets, use various assessment tools (especially diary cards) to monitor targets, to conduct behavioral analyses, solution analyses (employing skills as solutions to problems), and to plan generalization strategies in this part of the treatment (cf. Linehan, 1993a).

Motivation and skill enhancement of the therapist. Treating batterers can be a demanding set of tasks. Not only are clients themselves suffering, their behavior has often had a very harmful impact on one or more people. Dropout rates are high and success rates low in this client group, and can easily result in therapists becoming demoralized. Clients often do not immediately reinforce "good therapy," and may in fact be quite critical of the therapy or the therapist. By definition, batterer clients have violent histories, few skills for self-management in difficult emotional situations (like those that therapy may elicit), the therapist him- or herself could legitimately feel threatened, and progress is often slow. This parallels treatment for chronically suicidal women in DBT. For many of these reasons, "treatment of the therapist" is an essential part of DBT, both as a means of enhancing therapist skills and as a means of providing therapists support to do difficult work (Fruzzetti, Waltz, & Linehan, 1997).

Typically, these functions are met through weekly team meetings that consist of two or more therapist providing peer supervision and support. Most therapists treating batterers already work with at least a cotherapist, so many of the support functions of the team naturally are met. However, targeting effective and adhering treatment sometimes requires more effort: Giving feedback to peers may be difficult, especially when the work is already demanding. Nevertheless, improving treatment delivery *and* providing support are essential in DBT, regardless of client group or target problems.

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Treatment Strategies

DBT with batterers employs the usual set of DBT treatment approaches and strategies: a focus on both *acceptance* of the client and her or his current problems and difficulties, and a focus on *change.* The way DBT instantiates this dialectic of acceptance and change is with the comprehensive application of behavioral principles and behavior therapy in the context of a validating therapeutic environment. Full discussion of these strategies is beyond the scope of this paper (cf. Linehan, 1993a). Nevertheless, a couple of important points in applying DBT with batterers are emphasized below.

Behavior therapy. One of the most important developments of the "new wave" of behavior therapies in recent years has been the focus on the role of emotion in behavioral analysis and therapy, from both an operant and a respondent perspective. This is especially true of DBT, and with batterers this focus on emotions is just as important. Moreover, additional focus is placed on the theoretical (and practical) difference between primary and secondary emotions. For example, many batterers are able to identify only anger in the chain of behaviors leading to aggressive action. Further analysis may reveal instead that anger is a secondary emotion whose function is to block a different (primary) emotion such as shame, fear, sadness, or hurt.

Thus, the behavior therapy techniques employed with batterers include the full array of intervention strategies (exposure/response prevention, skill acquisition and generalization, contingency management and clarification, stimulus control procedures, cognitive modification, etc.) with a focus on negative emotional arousal involving a variety of emotions, not just anger. We do not assume that aggression is necessarily a "natural" response to anger (an implied respondent model). Rather, we assess its function, not only regarding external reinforcers but especially vis-à-vis negative emotions. And, as noted above, we target reconditioning stimuli to elicit a broader, more normative range of emotions than simply anger, teach how to identify and label these other emotions, and how to manage them effectively. Again, this is not different from DBT with other client populations per se, but does represent a departure from many other treatments for domestic violence.

Validation. Similarly, validation in DBT for domestic violence is no different from DBT for other target behaviors. What may be particularly difficult for therapists is the activity of finding the validity in aggressive and violent behaviors. That is, we may be so against aggression that suggesting it has validity may be, particularly at first, difficult. But how is it valid? First, it may be valid in the sense that it "works," or is effective in some immediate sense (either instrumentally or to diminish or escape aversive emotional arousal, or both). In addition, aggressive behaviors may be valid responses given a person's life history (that may have included modeling condoning of aggression). Moreover, other behaviors of the client may be valid, and it is essential (from a shaping standpoint) to

identify even small valid behaviors along the chain toward aggression in the service of reducing and eliminating violence.

Case example. After his initial commitment to treatment, Mr. A. then attended only four of the next eight skill groups and missed several appointments with his individual therapist. When he did come in for treatment, he often had not completed his daily assessments or his practice. Behavioral analysis of these therapy-interfering behaviors (e.g., missed sessions, noncompliance) showed that Mr. A. had been quite ashamed of his behavior following earlier behavior analyses, and had felt "horrible, miserable" for several days following earlier sessions. The therapist validated how difficult this must have been and targeted ending the assessment and change phase of the session 20 minutes early, with the last part of the session devoted to using skills to manage difficult emotion that Mr. A. was feeling at that moment. In addition, a brief skill-coaching telephone call was scheduled for the day after sessions to assist with in-vivo assessment and subsequent skill generalization. Mr. A. subsequently missed fewer sessions and regularly completed his diary card, at least several days per week.

In addition to doing repeated comprehensive behavior analyses and solution analysis (with practice and rehearsal of new skills) of prior aggressive behavior, therapy devoted increased time to current nonaggressive but emotionally volatile conflict episodes between Mr. A. and his wife. Mr. A. learned to be mindful of her and the larger context of their relationship and, whenever possible, his own hopes and goals for the relationship prior to conflict situations—and to take a minute off from conflict to achieve this constructive orientation. Using interpersonal skills, he was able to highlight what he was doing and why for his wife, who was quite supportive of his efforts.

Significant therapeutic time was expended in exposure and response prevention/learning alternative responses to stimuli that formerly elicited anger. For example, imaginal (and later, in vivo) exposure to criticism targeted identifying hurt and defensive feelings, in addition to angry ones, and Mr. A. practiced appropriate coping responses (distress tolerance, emotion regulation, and interpersonal skills). In addition, imaginal exposure to situations in which Mr. A. could not get what he wanted, even with interpersonal skills, was targeted. Instead of only responding with frustration and disappointment, Mr. A. practiced identifying disappointment or sadness and their appropriate coping responses. Similar procedures were practiced with fear, shame, guilt, and other stimuli that typically had elicited only anger (and concomitant aggressive urges) in the past.

There were several times over 6 months that Mr. A. reported urges to use violence, and twice "got in the face" of his wife. Because of the risk of harm, Mr. A. did agree to move out of the house for at least 1 week following any subsequent physically threatening or actual physically aggressive behavior (contingency management).

After 5 months in treatment, Mr. A.'s wife shoved him into the refrigerator during a conflict episode. He got up and left the house (he yelled at her that he was angry and that her behavior was "unfair" because of all the work he put in to being nonviolent). Despite being angry and emotionally hurt, he was also pleased with his self-control. After the full 6 months of individual treatment, Mr. A. graduated from Stage 1 and he and his wife entered couples therapy to work on reducing their aversive conflict styles, increasing their constructive conflict skills, and enhancing support and intimacy in their relationship. Both partners reported no further violence at the end of 6 months of couples therapy.

While we do not hesitate to highlight their aggressive behaviors, analyze them behaviorally, and include a frank look at their consequences (including natural consequences such as jail, separation or divorce), we are committed to using positive change strategies as much as possible.

Dialectics

Dialectics is both a method of argumentation and an approach to ontological questions. In DBT, therefore, it is the comportment of the therapist (approach to argumentation and discourse with clients and on the team) and an assumption about the nature of reality. Therefore, at least with respect to behavior, causation can be understood from multiple, even apparently opposite, perspectives, and change is most likely to occur in the context of appreciating multiple perspectives and synthesizing them. Thus, a dialectical worldview in DBT balances and synthesizes not only acceptance (validation) and change (behavior therapy), but also other therapeutic strategies (consulting to clients versus environmental intervention; reciprocal versus irreverent communication, etc.), multiple team member perspectives, and so on. DBT with batterers fully embraces this dialectical perspective, without modification to standard DBT (Linehan, 1993a).

Therapist Mindful Practice

Again, DBT with batterers involves the standard target of therapists taking a nonjudgmental stance. Although this may at times be difficult in treating clients who have

harmed (and may continue to harm) others, this remains the ongoing target. Of course this perspective is informed by dialectics: It is essential to be completely committed to change (elimination of aggression) while simultaneously committed to being nonjudgmental about aggressive behaviors and about the person.

Many batterer clients have had experiences in treatment of being judged, chided, criticized, and so on regarding their violent behaviors. While we do not hesitate to highlight their aggressive behaviors, analyze them behaviorally, and include a frank look at their consequences (including natural consequences such as jail, separation, or divorce), we are committed to using positive change strategies as much as possible, not using arbitrary aversive control to effect change (it is also not a very effective means), and to remaining mindful of the whole client from a nonjudgmental perspective. Team support is essential to maintain this position, especially in cases of recidivism, client verbal abuse toward the therapist, repeated slips toward noncommitment to change, and so on.

Case example. The early phase of Mr. A.'s treatment, as noted above, included repeated missed sessions and other treatment-interfering behavior (no diary cards, little practice between sessions). Moreover, despite his clear commitment early on to living a life that had no room for aggression, he discounted this desire later on ("Hey, everybody has to watch out for himself, including me. If I need to be a little rough around the edges to take care of myself, so be it") and was frequently critical of the therapy ("these skills are worthless") and the therapist ("What do you know about this? You don't give a shit about me. You're just doing your job [sarcastically] and don't give a damn how it fucks me over"). The ability of the team to support the therapist in observing limits (reducing verbal aggression in session was important to this therapist) while simultaneously fostering a humane attitude of acceptance that the client was doing the best he could (and needed to do better) helped the therapist maintain balance. Thus, the therapist could recognize that the treatment was very demanding for Mr. A.: Diary cards and behavior analysis elicited a lot of shame for which he initially had few skills with which to cope effectively. Similarly, there were many factors in Mr. A.'s life that could easily be understood to contribute to his use of aggression. It was also true that his behavior had a very negative impact on his wife and was in many ways ruining his life. By maintaining a nonjudgmental stance, the therapist was able to balance these factors, validate his efforts and potential to change, noticing even very small improvements in behavior (shaping) that might easily not have been recognized without team support in the context of his considerable therapy-interfering behaviors. Consequently, the therapeutic relationship was strengthened and the client expressed less and less hostility in sessions over time, along with more consistent skill practice both in and out of session.

. . . "treatment of the therapist" is an essential part of DBT, both as a means of enhancing therapist skills and as a means of providing therapists support to do difficult work.

Summary and Conclusions

Developing and evaluating new treatments for domestic violence are justified in general due to the high dropout rates and moderate to poor outcomes reported for existing treatments. DBT is promising because of its theoretical links to, and empirical support for, treating related targets in other client populations. Nevertheless, only pilot cases have been evaluated so far, but outcomes have been promising. Dropout rates have been low (15%) and recidivism rates, at least at termination, have also been low (less than 10%). However, client samples have been quite limited. For example, few clients have been court-ordered (most have been voluntary), so the promising results may not endure with more court-ordered clients. Similarly, the majority of our clients so far have begun treatment in the context of wanting couple or family treatment, and battering treatment has been required (Stage 1) prior to couple or family interventions (Stage 2 and beyond). Thus, pretreatment motivation may be particularly high in our samples. Finally, no randomly controlled study has been completed, so direct comparisons with other treatments are not yet possible.

Nevertheless, DBT with batterers may be an appropriate choice for clients who have failed in other treatments, and is appropriate for further study. More systematic study is needed specifically to test further the applicability of the underlying model of emotion dysregulation, to determine the overall effectiveness of DBT for domestic violence, and to try to identify client factors that make this treatment likely to be effective for some clients and not others. For example, data may demonstrate that for "instrumental" batterers (those for whom emotion regulation does not seem to be a factor in aggression) DBT is not effective.

The problems of domestic violence are big enough such that no one treatment is likely to be effective universally. However, DBT does address factors that may have contributed to poor outcomes in other treatments: The DBT focus on commitment to treatment may help reduce dropout and enhance compliance and practice; the nonjudgmental comportment and focus on validation by

the therapist may enhance the therapeutic alliance and help reduce dropout; and the focus on emotions other than anger may allow other skills to be learned (e.g., emotion identification and regulation) to treat skill deficits likely to contribute to aggressive and violent behavior.

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DBT With an Inpatient Forensic Population: The CMHIP Forensic Model

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Implementation of Dialectical Behavior Therapy (DBT) in a forensic or criminal justice setting differs dramatically from standard outpatient DBT. Forensic patients are multiproblem patients with violent histories and multiple diagnoses including borderline personality disorder (BPD), antisocial personality disorder (ASPD), and concomitant Axis I psychotic or mood disorders. DBT was selected for this population because of its emphasis on treating life-threatening behaviors of patients and therapy-interfering behaviors of both patients and staff. The forensic inpatient DBT model described here includes modification of agreements, targets, skills training groups, and dialectical dilemmas. An additional skills module, the Crime Review, was developed to supplement standard DBT. Conclusions and recommendations for applying DBT in a forensic setting are presented.

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Continuing Education Quiz located on p. 527.

FORENSIC INPATIENT SETTINGS, including criminal justice and forensic hospitals, differ significantly from standard DBT outpatient settings. The patient/inmate population is incarcerated, male, and characterized by antisocial behaviors. In one study, 97% of correctional in-