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 reten-

tion); (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 & 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