Dialectical Behavior Therapy in the Treatment of Abusive Behavior

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In Dutton, Don and Sonkin, Daniel (eds) (2003). Intimate Violence: Contemporary Treatment Innovations. New York: Haworth Trauma and Maltreatment Press.

Introduction

Although a variety of advances have been made in interventions for individuals who batter their domestic partners, many who participate in such treatments continue to be abusive (Babcock, under review, Dunford, 2000). Given the severity and prevalence of this problem, exploration of new treatment approaches is warranted, in particular for men who do not improve in available treatments. Dialectical Behavior therapy (DBT; Linehan, 1993a) offers one promising option. DBT, developed in the 1980's, has been designed to treat patients who are chronically suicidal and engage in self-harming behaviors. The first efficacy study of DBT included such patients, and additionally required a diagnosis of borderline personality disorder (BPD; Linehan, Armstrong, Suarez, Allmon & Heard, 1991). DBT has subsequently been primarily associated with treatment of BPD, although it is now being applied to a range of other populations (Linehan, 2000).

Linehan and colleagues (Linehan et.al, 1991; Linehan, Comtois, Koerner, Brown, Dimeff, Tutek, Schmidt, Kanter, Recknor, Cochran & Mar, 1998) have reported on two randomized clinical trials of standard DBT. Subjects in these studies were women meeting criteria for BPD who also had engaged in recent self-harm behavior. In each case, the treatment lasted one year. The first study used a treatment-as-usual (TAU) in the community control condition, and the replication/extension trial used a treatment-by-experts control condition. The initial trial comparing DBT to TAU found better results for DBT at post-test on retention in treatment, frequency of self-harm behavior, and number of days of psychiatric hospitalization. Data from a preliminary report on the second trial, using data at 4-months into treatment, suggested that the results of the initial RCT appeared to be replicating (Linehan, etal, 1998).

DBT has also been studied at other sites with similarly promising findings (Koons, Robins, Tweed, Lynch, Gonzalez, Morse, Bishop, Butterfield & Bastian, 2001). Koons et.al.,

(2001) compared standard DBT to treatment as usual (primarily cognitive-behavioral) in a Veterans Administration clinic. Subjects were 20 female veterans who met criteria for BPD. At the end of the 6-month treatment period, subjects receiving DBT showed greater decreases in depression, hopelessness, suicidal ideation and expression of anger relative to subjects in the TAU condition. This study extends findings on DBT to a less suicidal, less frequently self-harming population with BPD, and also confirms that DBT can be conducted successfully outside the site at which it was developed. It is also relevant for the treatment of PA men, as it demonstrates that DBT can assist patients with anger problems in reducing their expression of anger.

DBT has begun to be applied to a broader range of clinical problems, with a number of themes common across these populations (Linehan, 2000). First, DBT is typically applied with clinical populations that are difficult to treat, or for whom traditional treatments have shown limited success. Second, because DBT focuses on problems associated with emotion dysregulation, populations it has been adapted to typically include people experiencing problems associated with emotion dysregulation. In addition, these populations tend to have multiple diagnoses and/or life problems and have high treatment drop-out rates (Linehan, 2000). Adaptations of DBT have been developed for a variety of mental health problems, including substance abuse (Dimeff, Rizvi, Brown & Linehan, 2000), bulimia (Safer, Telch & Agras, 2001), suicidal adolescents (Miller, Rathus, Linehan, Wetzler & Leigh, 1997), post-traumatic stress disorder (Becker & Zayfert, 2001) and depressed elderly patients (Lynch, 2000). There are data supporting the efficacy of DBT with most of these populations, although it does not always include RCT's (Koerner & Dimeff, 2000, Koerner & Linehan, 2000).

A number of clinicians and researchers working in the area of domestic violence have begun to think about how to apply DBT with people who are violent, with some promising work being done in this area. (Fruzzetti & Levensky, 2000, McCann, Ball & Ivanoff, 2000). Fruzzetti & Levensky (2000) describe an adaptation of DBT for batterers, and McCann et al (2000) describe their use of DBT with forensic populations. To date no clinical trials have tested the efficacy of DBT to reduce violent or abusive behavior, so it is important to remain cautious about the use of DBT with this group (Scheel, 2000). Nevertheless, there are a variety of reasons to believe that DBT may be a useful treatment for partner abuse.

The purpose of this chapter is to provide a general description of DBT principles and interventions, and to discuss how these might be applied to address partner abuse. This chapter focuses on how standard DBT (the model tested in the original RCT) might be adapted to individuals who abuse their partners, and does not directly address treatment needs of victims, children or families. This chapter draws on the existing literature on characteristics and treatment of individuals who are abusive to their partners. The vast majority of this literature focuses on males who are abusive to female partners, which is what this chapter will primarily focus on as well. There is a continuing need for further research on partner abuse in same-sex couples. This chapter also draws on the existing literature on DBT and its applications.

Why DBT for partner abuse?

There are a number of reasons that DBT is attractive as a potential treatment model for partner abusive (PA) men. There is overlap in the populations that DBT was developed for (BPD) and the population of PA men. In addition, many of the difficulties faced by those working with PA men are issues that DBT attempts to address. Following are some of the characteristics of PA men, and treatment of PA men, that are consistent with the strengths of DBT as a treatment approach.

Borderline personality disorder in partner abusive men. A number of studies have found that borderline characteristics differentiate batterers from non-violent men (Hamberger & Hastings, 1991, Hastings & Hamberger, 1988), and these characteristics seem to be prominent in at least a subgroup of men who are violent to their partners (Dutton, 1995a, Dutton, 1995b, Dutton & Starzomski, 1993, Gondolf & White, 2001, Waltz, Babcock, Jacobson & Gottman, 2000). Although these studies have not typically involved diagnosis via clinical interview, they are suggestive that at least a subgroup of men who engage in partner violence have characteristics associated with the disorder. A number of typologies of male batterers propose that one subgroup is made up of men who have borderline characteristics (i.e. "dysphoric/borderline"). Given that DBT was designed in part to treat individuals with borderline personality disorder, it may be appropriate for at least this subgroup of PA men. It is important to note that most research on DBT has included female subjects exclusively, so it remains to be seen if this approach works as well with men, or what, if any, modifications may be necessary for male clients.

*Anger/emotion dysregulation.*Consistent with meeting criteria for BPD, batterers tend to experience high levels of anger (see Schumacher, Feldbau-Kohn, Slep & Heyman, 2001 for review), one of the symptoms of BPD. One of the primary goals of DBT is to help clients increase their ability to modulate intense negative affect, including anger. DBT targets emotion dysregulation very directly and provides a broad set of skills that help clients respond to difficult emotions more adaptively.

Multiproblem/multidiagnostic/complex treatment picture. Individuals meeting criteria for borderline personality disorder very often also meet criteria for one or more Axis I disorder ( ). Similarly, at least a sizable subgroup of men seeking treatment for partner abuse experience depression (Feldbau-Kohn, Heyman, & O'Leary, 1998, Maiuro, Cahn & Vitaliano, 1988), substance abuse (Hotaling & Sugarman, 1998), and a variety of Axis-II related characteristics and problems (e.g. Gondolf & White, 2001, Hamberger & Hastings, 1986, Tweed & Dutton, 1998). DBT was specifically designed to treat such multiproblem/multidiagnostic individuals, and provides a set of treatment stages and targets to assist with case conceptualization, treatment planning and implementation.

Efficacy of traditional treatments limited. Both individuals meeting criteria for BPD, and people with a history of abusive behavior toward spouses are notoriously difficult to treat. BPD tends to be a persistent disorder (Barasch, Frances & Hurt, 1985), and progress in treatment is generally slow. Men who batter their partners tend to have high recidivism rates, and treatments with broad efficacy have been elusive (Dunford, 2001). Although traditional treatments for PA men work well for some, many men continue to be violent or to engage in other abusive behaviors. DBT was specifically designed to address behaviors that are difficult to change, and to address motivational factors that interfere with change. DBT is likely to be most appropriate for those men who do not seem to benefit from traditional batterer treatment programs.

Life-threatening behavior. Many clients in both of these populations engage in behaviors that are life-threatening, either to themselves, someone else or both. DBT targets life-threatening behavior as the top treatment priority, and support is provided to the therapist to relentlessly pursue change in this area. Factors that maintain life-threatening behavior are carefully identified and targeted.

Therapy-interfering behavior/poor compliance. One reason standard cognitive-behavioral approaches may be less than optimally effective with both batterers and people with

BPD is that compliance with treatment tends to be poor in both cases. Therapy attendance, completion of homework and collaborative behavior during sessions are often problems for both of these populations. DBT seeks to address this problem by directly targeting therapy-interfering behavior as a top priority, and by utilizing interventions to increase level of commitment to change.

High drop-out rate. Both batterers (Daly & Pelowski, 2000) and people with BPD (Kelly, Soloff, Cornelius, George, Lis & Ulrich, 1992) have relatively high rates of drop-out from treatment. Research with batterers suggests that the multi-problem, multidiagnostic men who are less committed to change and have poorer relationships with their therapists are more likely to drop out (Rondeau, Brodeur, Brochu & Lemire, 2001). DBT puts heavy emphasis on maintaining clients in treatment and addressing problems in the therapeutic relationship, and has been shown to have better rates of retention than treatment as usual in the community (Linehan et.al., 1991). In addition to standard DBT approaches to client retention, Dimeff, Rizvi, Brown & Linehan, (2000) have recently developed as set of "attachment strategies" for drug dependent clients with BPD who are at high risk for drop-out. These strategies may also be applicable to batterers as they specifically focus on increasing the client's connection with the therapist.

Therapist burn-out. Mental health professionals working with both people with BPD and those working with PA men tend to experience frustration, anxiety and burn-out. The life-threatening behaviors that are present create a situation in which there is a strong urgency for the therapist to produce change in the client's behavior; however, given that available treatments are often of limited effectiveness, and change is generally slow, it makes sense that therapists are stressed by work with these populations (Linehan, 1993a). DBT addresses these problems in several ways, including requiring an on-going consultation team for the therapist, providing non-pejorative ways of conceptualizing client problems, and a set of assumptions about patients, therapists and therapy that are designed to reduce therapist burn-out.

To what extent DBT may be appropriate for men who batter but do not have borderline characteristics is less clear. In general, DBT has primarily been used to address the issues of multi-problem individuals with complicated diagnostic pictures (i.e. co-morbid Axis I and Axis II pathology). This intensive level of treatment may not be needed for PA men who fit the profile of a "family only" type, who typically do not engage in severe or frequent violence, and

tend to have minimal psychopathology (Holtzworth-Munroe & Stuart, 1994, Waltz et. al., 2000, for whom more traditional forms of treatment may be more appropriate.

Biosocial theory

DBT is informed by a biosocial theory of borderline personality disorder formulated by Linehan (1993a). Given the complexity of the problems associated with this disorder, it is not surprising that no single etiological factor has been identified that can adequately explain its development. Linehan's biosocial theory proposes that BPD results from a particular combination of biologically-based emotion dysregulation, and a particular type of interpersonal context, referred to as the "invalidating environment". The theory proposes that these two factors each influence the other in an on-going, transactional process, such that emotionally dysregulated individuals are more likely to be invalidated, and invalidation tends to increase emotion dysregulation, with the symptoms associated with BPD being the result of this process.

Emotion dysregulation, according to this model, involves four basic components. First, the person is more *sensitive* or reactive to events and experiences that may cause emotional responses. For example, a partner being mildly distracted may have little impact on a well-regulated person, but may set off a strong emotional response in an emotionally dysregulated individual. Second, the emotionally dysregulated person also tends to have very *intense* emotional responses. Experiencing the partner being mildly distracted not only triggers a response, it triggers a strong emotional response. The dysregulated person feels not just annoyed or impatient, but may experience intense fear, anger or rage. This intense emotional response includes the subjective experience of the emotion, the physiological arousal associated with it and other components of emotions (Linehan, 1993a). Third, once the emotionally dysregulated person is having an emotional response, it is *difficult for him to regulate* or reduce that response, including having more difficulty controlling behaviors that will decrease the emotion. For example, the person may lack the skills to self-soothe or calm himself, to attend to things that are less upsetting, or to organize himself to problem-solve or pursue obligations such as work, childcare, etc. Finally, the dysregulated person's emotions tend to last longer than they do for others, and it takes longer for the person to return to a more neutral or calm affective state. Abusive individuals sometimes report that they became violent after a number of difficult events happened and their anger "built up" to an uncontrollable level. A DBT perspective would likely

conceptualize this experience as reflecting an inability to return to baseline after an emotion has been triggered, leading to increased vulnerability when the next negative event occurs.

There is evidence from a variety of sources that can be interpreted as support for the notion that men who batter their partners experience higher levels of emotion dysregulation than non-violent men. Several studies, for example, have found that men who have engaged in partner abuse respond with higher levels of anger to certain types of relationship conflict scenarios than do non-violent men (Dutton & Browning, 1988; Holtzworth-Munroe & Smutzler, 1996). Dutton and Browning (1988) showed videotapes of conflictual couple interactions to batterers and a control group of non-violent men. PA men responded to scenarios involving a wife telling her husband she was going to spend a weekend away with a friend with greater anger than did non-violent men. Holtzworth-Munroe & Smutzler (1996) similarly found that men who abused their partners responded with greater levels of anger to scenarios involving relationship conflict relative to non-violent men. Interestingly, the PA men did not report higher levels of other negative emotional responses such as sadness or fear. These studies can be interpreted as support for the notion that PA men respond to emotional stimuli with more intense responses, at least in the case of anger.

Recent psychophysiological research lends support to the notion that partner-violent individuals react more strongly to the physiological arousal associated with emotions than non-violent people (George, Hibbeln, Ragan, Umhau, Phillips, Doty, Hommer & Rawlings, 2000). George et al (2000) compared PA individuals (27 male and 7 female) to subjects meeting criteria for a substance abuse disorder who were non-violent, to a control group of non-violent, non-substance abusing individuals. Subjects were infused with sodium lactate at one time and a placebo at another in a double-blind design. This substance induces physiological symptoms associated with anxiety or panic in subjects who have panic attacks, but not in others. PA subjects reported higher levels of fear, sense of losing control and feelings of unreality than the other two groups of subjects. PA subjects also had significantly greater behavioral signs of agitation, fear, panic and rage during the lactate infusion, as rated by observers; however, PA individuals did not show significantly greater increases in physiological measures of arousal. These results suggest that PA individuals may respond to physiological cues of arousal with increased levels of anxiety and agitation, possibly because they are more sensitive to these cues,

or because they fear that they will be unable to control their emotional or behavioral responses (George et al, 2000).

Research also supports the notion that PA men may lack emotion regulation skills, and thus may be less able than non-violent men to regulate their negative emotions. Holtzworth-Munroe and Anglin (1991) found that batterers generated less competent responses to scenarios depicting hypothetical relationship conflicts than did non-violent men, when asked how they might respond to such a situation. Although this difference could be interpreted as a lack of social or problem-solving skills, it may also reflect an inability to regulate negative affect in order to organize one's self to produce a skillful response. If PA men in this study were feeling angry in response to the hypothetical conflict situation, and were unable to modulate that anger, they would be likely to have more difficulty coming up with a reasonable solution to the situation. Taken together, these results are consistent with the notion that PA men experience emotion dysregulation, especially with regard to anger.

Linehan's theory posits that to develop BPD, one must have not only a biological predisposition toward emotion dysregulation, but also be exposed to a certain type of environment, which she calls the invalidating environment (Linehan, 1993a). In these families, invalidation occurs persistently and frequently. Invalidation can take many forms, but the essence of invalidation is that the child is not treated as worthy, respected, and reasonable; instead, the family communicates that the child is unimportant, unworthy, flawed, or "crazy." (Although the "invalidating environment" is discussed here in terms of families, note that invalidation can happen at many levels within systems, i.e. societal level, school level, etc.).

Invalidating families do not acknowledge or accept the child's feelings or perspectives, but communicate that the way the child is responding is unacceptable or otherwise wrong or inaccurate. The child's internal states, emotions and wants may be ignored, or he may be told that he is not really feeling that way. Invalidating families generally do not provide helpful or appropriate assistance or input on how to regulate and cope with emotions. These families may emphasize just having a "stiff upper lip" and "getting over it," or "acting like a man," thinking positively or ignoring feelings. These approaches may work for some people or in some circumstances, but for the child who is very sensitive to emotional stimuli and whose emotional responses are difficult to modulate, these approaches generally do not work well.

A large number of studies have investigated various aspects of the families of origin of

PA men. Although none have directly assessed invalidation per se, a number of studies have assessed experiences that are likely to be related to invalidation, such as abuse in the family of origin. Schumacher, Feldbau-Kohn, Slep & Heyman (2001) in a recent review, conclude that exposure to interparental verbal and physical abuse, and being the target of verbal or physical abuse in childhood are consistently found to predict being violent in an adult partner relationship. Two additional family of origin variables, being rejected by one's parents and child sexual abuse, were also found to increase risk for partner violence in men, but somewhat less consistently so than exposure to verbal and physical aggression. The studies reviewed relied on retrospective self-reports of family of origin experiences. Although studies of exposure to family-of-origin abuse, such as those reviewed by Schumacher et al (2001) do not directly assess the experience of invalidation, on-going verbal, physical and/or sexual aggression are occurring are inherently invalidating, as these experiences ignore the child's need for safety and respect. It also seems likely that other forms of invalidation likely occur in families experiencing abuse.

The combination of emotion dysregulation and the invalidating environment are hypothesized to interact in an on-going way, with each factor affecting the other, resulting in the problems associated with BPD (Linehan, 1993a). The dysregulated child frequently experiences intense negative emotions, sometimes in response to perhaps stimuli; however, the invalidating family responds to the child's negative affect by minimizing, ignoring, shaming or cirticizing the child. The child therefore does not learn how to cope with her emotions. She does not learn to trust or rely on her internal cues, because they do not match with the external environment; other people are not getting as upset, other people say there is nothing wrong or that the child should not be feeling that way. Instead of learning how to self-soothe or modulate her emotions in some other way, the child has no good means of coping with the intense emotions. Over time, the child in this situation may resort to more and more drastic means to cope with her emotions, such as self-harm or substance abuse, while simultaneously becoming more and more out of control of both her emotions and her behavior in response to those emotions. The increase in out of control behavior likely prompts further invalidation, and so on.

It is important to note that the biosocial theory informing DBT may or may not be relevant to any given man who engages in partner abuse. Although there are reasons to believe it may apply to at least a subgroup of these men, this theory was not created to explain abusive behavior in partner relationships. Some models of battering focus on the function of violence as a means of

gaining power and control in relationships. Proponents of this view may argue that battering has nothing to do with poor emotion regulation capacity, but is instead used to control others. As is often the case with complex behaviors such as partner abuse, it seems likely that there are multiple factors influencing the behavior, across a variety of levels of analysis, and that these factors operate differently for different people, and across different episodes of abusive behavior. This biosocial theory may help explain some battering behavior, and be relevant for some batterers, but is not being proposed as a comprehensive theory of domestic violence.

Theoretical underpinnings of DBT: Behavioral theory, dialectics and zen

Although primarily based on a behavioral orientation, DBT diverges from a straight behavioral approach in that it incorporates two other systems of thought: dialectical philosophy and zen. Each of these rich traditions inform DBT in a variety of ways. Although too complex to address in full here, both of these systems will be discussed, with emphasis on how each influences the treatment.

A dialectical philosophy holds the assumption that given a particular stance or position, truth can also be found in the opposite position (Linehan & Schmidt, 1995). It also assumes that change comes about through achieving a synthesis of these opposite positions. Rather than searching for a "right" position and a "wrong" position, a dialectical approach advocates looking for the truth that is present in each position, with change and growth emerging through that process as a synthesis arises. A dialectical approach is ideally suited to respond to the many polarities that arise in work with individuals with BPD, both in terms of their black-or-white world views, and in terms of mental health professionals' sometimes black-or-white responses to these difficult clients. The emphasis is placed on holistic, both-and thinking thinking.

Linehan (1993a) argues that the central dialectic in therapy with borderline clients is that of acceptance versus change. Therapeutic interventions are organized around this underlying principle, and stalemates or stuck points in therapy are evaluated in terms of how they may reflect being off-balance in the direction of acceptance, or in the direction of change. Change refers to interventions and therapeutic stances focused on getting the client to do things differently. Traditional behavioral and cognitive-behavioral therapies focus almost exclusively on helping clients change. They provide a set of techniques designed to help people change their behavior, emotions and/or thinking. Acceptance, in DBT, refers to therapeutic interventions

focused on validating the valid aspects of the client's thoughts and reactions, understanding things from his perspective and accepting and acknowledging his reality. People with BPD are often frantic to change or eradicate parts of their own experience, in particular painful emotions. Another aspect of acceptance in DBT is working on allowing one's self to experience reality, to simply experience one's emotions as they occur, without attempting to avoid. DBT therapists strategically knit both change-oriented and acceptance-oriented interventions throughout treatment.

Applying a dialectical philosophy to working with batterers, several dialectical polarities emerge. One crucial dilemma is the dialectic around, on the one hand, holding the person accountable for his abusive behavior, and clearly communicating the unacceptability of the behavior as well as the need for change, while on the other hand seeing and understanding the client's perspective, his limitations and the factors that have influenced him to be abusive. From a DBT perspective, both of these positions are valid and necessary parts of the picture. It is the case that abusive behavior must stop, that the person must be held responsible for it and that he must change it. It is also the case that the abusive person's history and context have shaped him and influenced his behavior. From a DBT perspective, therapy is unlikely to be effective if the therapist neglects or ignores either side of this dialectic. Of course, these two positions can be very difficult to maintain simultaneously. The therapist may need to work on developing his/her capacity for holding onto two seemingly contradictory realities at the same time. Having a theoretical basis for understanding why batterers behave as they do that promotes a compassionate view of the problem may be helpful. Working within a consultation team that is actively involved in holding onto both of these realities may also be helpful in preventing the therapist from getting stuck in one or the other position.

DBT also utilizes concepts from a zen philosophical tradition, which influence the flavor of the treatment in a broad way. All the specifics of how this philosophy are incorporated cannot be described here, but a general feeling will be provided. A mindfulness tradition emphasizes the developing an ability to directly experience one's reality without avoidance, as well as developing a stance from which to observe one's self. Many people with BPD, like all of us, struggle to escape the reality of the suffering that is present in life, which is of course understandable; however, the struggle to escape leads to many maladaptive behaviors. In DBT, the skills of tolerating affect and other aspects of experience, being willing rather than willful,

and learning to experience rather than avoid are woven in throughout the treatment. Clients practice skills that help them to develop an ability to notice what they are experiencing, for example, to notice their own emotional states, the thoughts going through their minds, their urges. Many come to treatment without much ability to observe these things, and that greatly interferes with making changes.

A mindfulness tradition informs a number of important concepts that are part of the treatment, including the notion of being "non-judgmental." A non-judgmental stance is one that is free of a moralistic assessment of "good" versus "bad". This is a very relevant issue for working with abusive people. Therapists teach clients to work on being non-judgmental, but also work on being non-judgmental themselves. A non-judgmental stance means avoiding being superior or patronizing toward the client, or assuming that the client is somehow less of a person. Maintaining a non-judgmental stance toward the violent person means shifting one's focus from the "badness" of the behavior to instead focus on the consequences of violence: that it is harmful to others, prevents the development of healthy relationships, and creates many problems in the abusive person's life, therefore is worth changing. It is important to be clear that being non-judgmental does not mean that the behavior is viewed as "acceptable" or "OK". The point is to focus on abusive behavior as a problem to be solved, rather than focusing on a more moralistic view. Although this shift can be a difficult one, if a clinician chooses to take this stance, it can prevent getting caught up in extreme anger at the client, which is usually not likely to be helpful.

OVERVIEW OF TREATMENT

Standard DBT is a multimodal outpatient psychotherapy that provides intensive services (i.e. individual psychotherapy, group skills training, phone consultation for the client); however, this model is based on a set of principles that can be applied in a variety of treatment settings. In addition to being principle-driven, DBT is also a stage model of treatment. Each stage has a set of hierarchically arranged treatment targets representing the client problems that are addressed at that stage. Some of the basic DBT principles that guide the structure of DBT programs will be described here.

From a DBT perspective (Linehan, 1993a), there are five basic components that are essential to the change process for individuals meeting criteria for BPD, and for DBT programs to be successful. First, clients must learn new, more adaptive skills to deal with painful emotions

and other difficult life problems. There is an assumption in DBT that people in this population lack the skills they need to behave more adaptively, so instruction in new skills is an essential aspect of treatment. New skills are most often taught in a group skills training format. Second, there is also an assumption that there are generally many obstacles to utilizing these new skills, and these obstacles must be addressed in therapy. Factors such as lack of motivation, intense emotions that make using skills difficult, or relationships or other life circumstances that interfere with change must be addressed. In DBT, these types of obstacles are usually addressed in individual psychotherapy. Third, generalization of new skills to a variety of contexts is essential, but often requires specific support. Clients need access to help with generalizing new skills to their day-to-day lives, which is often addressed through phone consultation with a therapist or skills coach. Fourth, DBT is a team approach and makes the assumption that this type of work is impossible to do well in isolation, so team consultation is also an essential function. Finally, DBT provides for a "structuring the environment" function; this function involves a team member or administrator having sufficient control over the treatment setting to allow for DBT to happen.

DBT can be structured in a number of ways, depending on the resources available and client needs. In standard DBT (ie. the model that has been tested) the five functions are primarily addressed in individual psychotherapy (addressing obstacles to change), group skills training (for development of new skills), phone consultation to the client (for generalization of skills), consultation team for the therapist and optional ancillary treatments (i.e. pharmacotherapy, support groups, etc.; Linehan, 1993a).

DBT is a stage model of treatment, including pre-treatment and stages one through four. Pretreatment and Stage 1 have been more elaborately developed and tested than Stages 2 through 4, and are the primary focus of this chapter. Stage is determined by the problems the client is experiencing that need to be addressed in treatment, and each stage includes a set of hierarchically organized treatment targets, or problems that are the focus for change at that stage. The purpose of the treatment target hierarchy is, at the broadest level, to assist the clinician in developing a conceptualization of the client, and at the more concrete level, in deciding what to focus on in a given session or interaction with the client. Clients with borderline characteristics often have numerous difficult problems happening at once, as well as frequent crises. These diffuse issues can make it difficult to stay on track and make progress on any one issue. DBT

provides guidelines regarding when addressing certain targets should be adhered to strictly (i.e. when life-threatening behavior has occurred) versus when flexibility is expected. The targets help insure that issues that are difficult to address (such as abusive behavior) do get focused on in the session, but the guidelines are not to be used rigidly in a "cook book" fashion.

The pre-treatment stage is for clients who have yet to commit to changing targeted behaviors (e.g. self-harm, violence), have yet to commit to therapy, and/or have committed at some point but are no longer committed. At this stage, the therapist orients the client to what treatment is about by explaining how DBT is conducted and what she can expect if she decides to participate. The therapy also focuses on increasing the client's level of commitment.

Commitment to change is often a major problem for people with violent behavior. Many abusive clients enter therapy under court referral, and are likely to be working at a pre-treatment level, in which they are not committed to therapy or to changing abusive behaviors. The DBT therapist in this situation focuses on the pre-treatment target of increasing level of commitment, before trying to achieve other goals. DBT includes a variety of strategies used for increasing the client's level of commitment, which would be used at this point in the therapy process. For example, the therapist may have the client explore the pros and cons of stopping abusive behavior versus continuing to be abusive. The therapist may explore any areas of the client's life that he *does* want to change and then link those goals to reducing abusive behavior (i.e. stopping violence in the service of having a more satisfying relationship with one's partner). The therapist is likely to try to build on any commitment the client is willing to make, and to reinforce him for small commitments, while attempting to shape him into larger commitments. On the other hand, the therapist may use the "devil's advocate" strategy and argue in favor of continuing with maladaptive behavior, given that most often people respond to this by identifying the reasons *for* changing maladaptive behaviors.

When to move from pretreatment to Stage 1 can be a difficult decision that involves an important dialectic. On the one hand, Stage 1 work is impossible if the client has absolutely no commitment to change. It is not reasonable to attempt Stage 1 treatment if the client expresses no interest in changing him behavior. On the other hand, blaming others, minimizing and denying are hallmarks of batterer behavior; it does not make sense to expect the batterer to stop having his problem in order to be in therapy. Consequently, the DBT therapist must make a decision about what level of commitment is sufficient to proceed from pretreatment into Stage 1

balancing both sides of this dialectic. Work on commitment level is likely to continue intermittently during Stage 1, as the client's level of commitment waxes and wanes.

It is important to note that DBT is a voluntary treatment; for individuals who are mandated into treatment, it is important that they still have the opportunity to opt into or out of DBT. This is sometimes accomplished by having two programs available– a DBT approach and some other treatment approach.

Once at Stage 1, the primary goals become establishing a strong therapeutic relationship, developing safety in the person's life and learning important skills to deal with intense emotions and relationship difficulties. The specific treatment targets are, in order, 1) suicidal and other life-threatening or violent behaviors, 2) therapy-interfering behaviors, 3) quality-of-life interfering behaviors (e.g. homelessness, lack of employment, substance use, etc.), and 4) increasing skills.

The therapy is structured around these treatment targets such that, if a top treatment target behavior has occurred since the previous session (i.e. the person has been violent or engaged in parasuicide), it is automatically a focus of the session. If no life-threatening behavior has occurred, the therapist turns the focus to any behaviors on the part of the client that are interfering with the process of therapy (therapy-interfering behavior). The third highest priority is then quality-of-life interfering behaviors, which include any problems that significantly interfere with the client's quality of life such as substance abuse, lack of employment or adequate housing, unaddressed medical problems, etc.. Finally, the therapist includes teaching and coaching on DBT skills throughout. Although these targets are arranged hierarchically, in practice a given session often includes some focus on all of the top targets.

Therapy-interfering behavior of the client refers to anything the client does that interferes with the process of therapy or has a significant negative impact on the therapist's desire to work with the client (Linehan, 1993a). Since BPD clients tend to have significant relationship problems, it is not surprising they also have problems in their relationships with therapists. It is crucial that the therapist and client work on their relationship, and the client's behavior that affects the relationship, so that the therapist-client team is able to maintain a good connection and be motivated to work together. For example, BPD clients may demand more time or attention than the therapist wants to give, get angry at the therapist and act on that, withdraw and be unresponsive, not complete homework assignments, etc.. DBT addresses these

problems very directly, with the therapist both calling attention to the behaviors in a non-judgmental fashion, and then working with the client on how to change the behavior. Therapy interfering behaviors of the therapist are also considered to be inevitable and important, and addressed directly. Most often this happens within the context of the consultation team.

Stage 1 also addresses significant quality of life interfering behaviors, such as substance abuse and other Axis I disorders, homelessness, unemployment, dysfunctional health-related behaviors, and so on. These are organized hierarchically in terms of their relationship to the higher level targets, such that any quality of life interfering behavior that contributes to the client engaging in suicidal or violent behavior would likely be a high target. DBT uses a variety of standard cognitive-behavioral and problem-solving approaches to address quality of life targets.

In developing new forms of DBT to address the needs of other treatment populations, DBT therapists and researchers often develop a more detailed set of targets relevant to that behavior (Linehan, 2000). For example, in a version of DBT developed for substance abusers, substance abuse is the top quality-of-life interfering behavior. In addition, a more detailed set of targets relevant to substance abuse is also used (Dimeff, Rizvi, Brown & Linehan, 2000), including behaviors such as "keeping options to use drugs open" (such as by staying in contact with your dealer), etc. Having such a list of violence-relevant target behaviors may also be helpful, and would likely include such behaviors as destroying property, verbal abuse, out-of-control anger, urges to be violent, and so on. Self-monitoring of violent and abusive behaviors, as well as these violence-relevant targets may be useful in determining the focus of sessions. Clients may be reluctant, embarrassed or unwilling to self-monitor and report abusive behavior. If so, this would be addressed as a therapy-interfering behavior.

Once Stage 1 issues have been addressed, the person advances to Stage 2, in which they focus on post-traumatic stress issues. This is not to say that these issues are ignored at Stage 1; however, they are not a primary focus until safety and skills are well-established. Finally the person moves into the more advanced stages of therapy that focus on individual goals (i.e. for career, education, relationships, etc.), building of self-respect (Stage 3) and a capacity for true joy and connection (Stage 4).

INTERVENTIONS

DBT interventions embody the central dialectic of the treatment: acceptance versus change

(Linehan, 1993a). Change-oriented interventions focus on eliciting, teaching and developing new behaviors. Acceptance-oriented strategies focus on acceptance of reality as it is, acknowledgment of what is, and validation of the client. Although it is not possible to describe all of the therapeutic interventions that are a part of DBT here, some primary ones will be discussed. The implications of applying these interventions to aggressive and abusive behavior will be explored.

Orienting & Commitment

DBT begins with orientation to the treatment and the establishment of a commitment by the client. Orienting involves describing and explaining what the treatment is about and how it works. The client is told what she can expect from the therapist, and what will be expected of her if therapy is pursued. Orienting strategies are used throughout treatment, in particular when a new intervention or goal is being introduced. Orienting is used because clients can more actively participate in their therapy if they understand what is going to happen, and what is expected of them. Orienting with abusive clients would include explanation of the fact that one purpose of the therapy is to stop abusive behavior. They would be given information about what is meant by abusive behavior, and given an explanation of how abusive behavior develops and is maintained. From a DBT perspective, this explanation would include some emphasis on dysregulation and the effects of the invalidating environment. It may also incorporate other research findings on the development and maintenance of abusive behavior.

Therapy also begins with the client being asked to make a commitment to whatever goals are being established, such as stopping abusive behavior and participating in therapy. Continuing with DBT would not be viewed as appropriate if the client has absolutely no interest in changing abusive behavior, although this lack of commitment could be the focus of "pretreatment" intervention. Commitment strategies are used in the eliciting and strengthening of commitment, with the goals being that the client be realistic about what he is agreeing to, making as firm a commitment as possible, and committing in a way that is most likely to promote keeping the commitment.

Validation

At the most fundamental level, validation in DBT is the therapist communicating to the client

"that her responses make sense and are understandable" (Linehan, 1993, p.222). As described earlier, many people with BPD have extensive histories of *invalidation*, having been told that their reactions are unreasonable, that they are just "too sensitive," or that the way they are reacting to events makes no sense. Validation in therapy helps the client come to trust his own responses more, to feel understood and connected, and to gain a better understanding of what normative responses are.

An important component of validation is that it involves "confirming" a person's experience, as opposed to being complimentary (Linehan, 2001). For example, telling someone they have done a good job when they firmly believe they have not is actually invalidating. In addition, the DBT therapist strives to only validate that which is valid, rather than to be universally validating. Valid responses include those that are normative, make sense given the circumstances, or make sense given the person's goals (Linehan, 2001). For example, getting angry when your partner criticizes you harshly may be valid in the sense that most people would react that way; however, then hitting your partner is not valid if your goal is to improve the relationship.

The DBT therapist searches for client responses that can be validated. Validating various experiences and emotions that lead up to violence is often important (Fruzzetti & Levensky, 2000). For example, the therapist would likely communicate that it makes sense that the client feels fear and sadness when his partner threatens to leave, since most people feel those emotions when the loss of an important relationship seems likely. Finding things to validate can be particularly difficult with abusive clients. Much of their experience of the violence may be outside the realm of what should reasonably be validated. For example, the client may think that the victim "deserved" to be hit or that his violent behavior was "her fault." The therapist needs to consider a variety of factors in choosing what to validate, including in what sense the behavior is "valid" (i.e. in terms of past learning, being a normative response that most people would experience, or moving one in the direction of one's goals) (Linehan, 1997). Some behaviors may make sense (be valid) in terms of the client's history, but not in terms of the client's goals. For example, it may make sense that a client is violent if he was physically abused and emotionally neglected in childhood, witnessed violence between his parents, never learned skills to cope with anger, and is now in a conflictual relationship (Fruzzetti & Levensky, 2000). On the other hand, violence is not valid in terms of reaching one's goals, if those goals include having a good

relationship with a partner, staying out of jail, etc. The therapist should also carefully consider whether the validation is likely to reinforce that particular behavior in a problematic way.

Behavioral and solution analysis

One of the most central strategies of DBT is behavioral analysis (BA) (Linehan, 1993a). It is crucial that therapists doing DBT have a thorough understanding of basic behavioral principles and interventions, including behavioral analysis. A brief description will be provided here.

Behavioral analysis is a method of assessment in which a problematic behavior (which could include thinking, feeling, or overt behavior, or some combination) is analyzed in terms of the precipitants leading up to it and the events that follow. The first step is identifying what the problematic behavior is, being as behaviorally specific as possible. The therapist and client then do a "chain analysis" of the events, thoughts, feelings and behaviors that led up to the problematic behavior, and follow this through to include an analysis of the events that followed, with particular attention to the consequences of the problematic behavior. The behavioral analysis needs to be detailed; a primary mistake made in carrying out behavioral analyses is to make assumptions about how one event led to another. In addition, as noted by Fruzzetti & Levensky (2000), behavioral analyses in DBT tend to emphasize the occurrence of emotions and emotion dysregulation, as these tend to be a primary target for intervention.

The therapist uses his/her knowledge of the client and the client's history to develop hypotheses about what factors might be influencing the client. This includes the use of "insight strategies" (Linehan, 1993a). Insight strategies involve noting connections and patterns. For example, the therapist may focus on how certain events or emotions often lead to the client responding in a particular way. The therapist may also focus on in-session behavior, for example, commenting on how the client responds to the therapist. The goal is to develop an understanding of what events, thoughts and emotions trigger problem behaviors, and what consequences are present that may be maintaining these behaviors, in order to identify places to intervene.

Applying DBT to the problem of eliminating violent and abusive behavior would likely include heavy use of behavioral analysis. A therapist working with a PA man would conduct behavioral analyses of past instances of violent and/or abusive behavior, in order to formulate an

understanding of what variables are influencing the behavior. The first step would be to identify the specific violent/abusive behaviors being targeted. This is particularly important because the client's conception of what constitutes violent and abusive behavior may be different than the therapist's. For example, threatening one's partner with a raised fist, without actually hitting her, may be considered abusive by the therapist, but not by the client. Self-monitoring of the behaviors of interest is likely to be useful. In the case of low baserate behaviors, for example, a batterer who is only infrequently violent, it may be particularly useful to monitor related behaviors such as level of anger, thoughts about being abusive, urges to be abusive, and so on. Behavioral analyses can then be done on these target-relevant behaviors.

As described earlier, the behavioral analysis should be a very detailed, step-by-step description of the events leading up to the violence/abuse, the actual violent/abusive behaviors and the consequences. Fruzzetti, Saedi, Wilson, Rubio & Levensky, (1999) have developed a semi-structured interview, the Domestic Violence Interview (DVI), which guides the interviewer through a behavioral analysis of violent or aggressive behavior (Fruzzetti & Levensky, 2001). The analysis should begin as early in the chain of events as necessary, for example, when the batterer first noticed himself becoming angry, agitated or upset, when stressful things first started affecting him, etc. Although each person is unique, some common factors that may be identified through behavioral analysis of abusive behavior will be described. These factors are then targeted for intervention through a solution analysis.

One factor that can contribute to problematic behavior is that alternative, more adaptive behaviors may never have been learned; the person is lacking the skills needed to do something different. For example, the abusive person may lack self-observation skills crucial to noticing that he is becoming angry; he may lack assertiveness skills with his partner (Dutton & Strachan, 1987, O'Leary & Curley, 1986); he may lack skills to soothe or calm himself; he may lack skills to express emotions other than anger. Any of these behavioral deficits may increase the risk for violence, and would direct the therapist to working on increasing skills in these areas. In DBT, if a skills deficit appears to be contributing to the problem, the intervention of choice is skills training. The therapist works with the client to learn the needed new behaviors, and to apply those in the relevant contexts. Since BPD clients generally show skills deficits, they also participate in structured skills training, usually in a group. Individual therapy is used, in part, to focus on application and generalization of skills to particular situations.

Violent and abusive behavior can also be maintained by reinforcing consequences. The violence or abuse may be reinforced by the batterer getting his way in an argument, by the partner stopping some aversive behavior or by the reduction of a state of negative affect or arousal following violent behavior. All of these scenarios are familiar to professionals who work with PA men. It may be difficult to think of a case where violent or abusive behavior did not seem to be reinforced in some way, at least in the short term. One reason these consequences of violent behavior are powerful is that they are usually very immediate.

If violent or abusive behavior is being reinforced, one approach is to attempt to change the contingencies so they no longer support this behavior. This type of intervention is referred to as "contingency management." Obviously this is a difficult task since the therapist does not have control over all the contingencies. The use of arrest is an example of using punishment to decrease violent behavior. Although mixed, there is some evidence that arrest, which is clearly punishing for many people, is somewhat effective in reducing the likelihood of future violence (Sherman & Berk, 1984). In the absence of direct control over contingencies, the therapist may help the client get more in touch with the broader range of consequences of both his abusive and more adaptive behavior. Highlighting the longer-term negative consequences of violence may be useful. Self-monitoring of times when the client had the urge to be abusive but was not can provide opportunities for the therapist to give or highlight reinforcing consequences. The difficulties with controlling consequences also suggest the importance of concentrated work earlier in the chain of events leading up to violence, to prevent its occurrence (Fruzzetti & Levensky, 2000).

Sometimes maladaptive behaviors occur because the individual's engagement in more adaptive behavior is blocked by strong emotions, such as fear, guilt or anxiety. They may know what to do, and could actually do the behavior if they were not fearful or guilty, but are blocked by those emotions. For example, an abusive person may want to ask for something from his partner, but feel afraid and avoid doing it. Their fear and frustration about not being able to make a request may lead to them becoming angry and abusive. In DBT, the intervention of choice in situations where emotions like fear, guilt or shame are blocking adaptive behavior is the behavioral technique of exposure. Exposure has been demonstrated to be a highly effective means of reducing emotions like fear. The word "exposure" refers to the person being exposed to, or in the presence of, the feared stimulus. This can be done through imagery, or in vivo.

Exposure-based techniques are widely used in the treatment of PTSD and a variety of other anxiety-related disorders. By way of example, if a batterer who is a war combat survivor has an intense fear reaction to some stimulus, he may then have a secondary emotional response of anger, and become violent. In addition to other interventions, exposure to the combat-related traumatic cues may reduce the fear response, and decrease the likelihood of violence.

Finally, problematic behavior may be influenced or maintained by clients' beliefs or cognitions. If the behavioral analysis suggests that the client's beliefs or thoughts play a role in maintaining the behavior, cognitive-based interventions may be useful. This could include a range of interventions used in cognitive-behavioral therapies, such as self-monitoring of cognitions, examining evidence for the cognitions, and developing challenges for maladaptive cognitions, etc.

Irreverent and reciprocal communication styles

DBT therapists utilize stylistic strategies to guide some specific aspects of how they interact with clients. These stylistic strategies must be adapted to fit with a given therapist's style; however, they can be very useful in responding to some of the more difficult elements of treating individuals with BPD. These two styles, irreverent and reciprocal communication, provide two sides of a dialectic, one end representing warmth and responsiveness, the other end representing confrontation and desynchrony (Linehan, 1993a).

The reciprocal style involves expressing warmth, connection and caring. It also includes use of self-disclosure. Two types of self-disclosure are used in DBT; disclosures about the therapist's reactions to the client, and disclosures about the therapist's use of skills, approach to problems, or other forms of modeling. Self-disclosure is carefully used for the client's benefit, not to inappropriately meet the therapist's own needs. DBT therapists use self-disclosure to give the client feedback about how the client is affecting the therapist or about how he is coming across, particularly when the client engages in therapy-interfering behaviors. Although other approaches avoid self-disclosure with borderline clients, DBT takes the stance that the therapist's reactions and feelings can provide essential feedback to the client, allow him to learn about his impact on others and provide opportunity for crucial processing of the therapeutic relationship.

The irreverent communication style is, as the name implies, a style that involves taking an outrageous position, being deadpan or off-beat, or taking things to an extreme. It is not

disrespectful or cynical, but is often humorous. This style is used to help the client see when she is being extreme, to lighten things up or to get things moving beyond a stuck point. It is used to get the client's attention, or shakes things up when they are bogged down or stuck, in particular when the client is stuck in some rigid or extreme way of thinking.

DBT Skills Training

The teaching of skills is an integral part of DBT. The particular skills taught are divided into four types: core skills, emotion regulation skills, distress tolerance skills and interpersonal effectiveness skills (Linehan, 1993b). These skills are based on the assumption that difficulty tolerating and modulating painful affect often leads to the other behavioral problems experienced by emotionally dysregulated clients. The skills are also organized around the central acceptance-change dialectic. Clients practice both learning to change their emotional states, and learning to tolerate and be in the presence of painful emotions, without engaging in maladaptive behaviors in response to those emotions (i.e. drug use, self-harm, violence, etc.)

The core skills of DBT are based on eastern philosophy and meditative practices. They include learning to observe and describe one's thoughts and emotions, and practicing "mindfulness". Many of us spend a great deal of our time doing one thing, while thinking about several others, barely aware of what we are doing in the moment. Mindfulness involves remaining focused on "one thing at a time". It is the practice of taking control of where one focuses one's attention. Emotion regulation skills involve learning about what emotions are and how they operate, how to be less vulnerable to negative emotions and how to change negative emotional states. For example, clients learn that behaving consistent with an emotion (e.g. being passive when depressed, aggressing when angry) tends to increase or prolong that emotion, whereas acting opposite to an emotional state (e.g. being active when depressed, gentle or calm when angry) tends to decrease the emotion.

Distress tolerance skills involve learning to tolerate negative emotions in order to get through difficult situations, without doing something destructive. For example, clients learn skills such as how to distract, to self-soothe, to think through the pros and cons of sticking with whatever they are working on, and so on. These strategies are not designed to change or resolve the situation, but simply to help the client get through difficult or emotionally painful moments.

Finally, interpersonal skills, focused primarily on appropriate assertiveness, are taught. Interpersonal situations are broken down into a number of different components, such as determining what your goals are in the situation: maintaining a positive relationship, getting what you want, and/or maintaining a sense of self-respect. Clients use homework practice and worksheets to work through various interpersonal situations, and are coached in group on ways to apply better interpersonal skills, including how to ask for things effectively, how to be direct and persuasive without alienating others, how to validate others, and so on.

Recent attempts to adapt DBT skills training to the treatment of batterers (Fruzzetti & Levensky, 2000, McCann, Ball & Ivanoff, 2000, Rathus, J., personal communication) have included several additions and changes to the standard DBT skills package. First, a psychoeducational component on violence and abuse is likely to be helpful. Standard DBT skills groups begin with an orientation that includes a description of BPD and a description of the biosocial theory underlying DBT. A group for partner abusive men might include a psychoeducational component describing what violence and abuse are, and, from a DBT perspective, might also describe the roles of emotion dysregulation and other BPD-related problems in violent and abusive behavior. Fruzzetti & Levensky (2000) describe the addition of a new skills module in their batterer treatment program, which focuses on teaching validation skills. This module instructs clients in how to validate both themselves and others, including instruction designed to help increase empathy. Other possible modifications proposed by Rathus (personal communication) include a direct focus on jealousy in the emotion regulation module.

Consultation group

The consultation team is designed to help members stay on track with the dialectics of treatment. The consultation team provides a place for team members to express their feelings about the work they are doing and to get validation and support; however, the team must provide more than just support to be effective. DBT teams also provide constructive input and feedback about the therapist's work, help team members maintain a non-pejorative stance toward clients, and stay on track with doing the best possible treatment.

Team dynamics and the maintenance of a strong team are crucial to the success of a DBT program. In the service of helping teams function well, the DBT model provides a set of assumptions about patients, therapists and therapy, and a set of agreements for consultation team

members (Linehan, 1993a). For example, team members agree to do their best to be non-defensive, and to recognize that mistakes are expected. Team members agree to attempt to find the least pejorative, least blaming explanation for clients' behavior. The team is charged with helping each therapist recognize when a client's behavior is pushing the therapist beyond his/her limits, and to problem-solve ways to address such therapy-interfering behavior. In addition, the team points out therapy-interfering behavior of the therapist, and helps the therapist find ways to deal with it.

The consultation team component of DBT has clear and direct application to the treatment of abusive people. The need for support and consultation for therapists in working with this population is clear. In addition, the role of the consultation team in maintaining a dialectical stance, and avoiding getting polarized in a destructive way, is also essential when treating abusive individuals. Maintaining a dialectical stance and avoiding black or white thinking while working with abusive individuals is probably one of the most difficult therapeutic tasks clinicians face. A strong team can be very helpful in that arena.

Conclusion

It is clear from the description provided here that a standard form of DBT adapted directly for batterer treatment is likely to be more resource intensive than a typical batterer group treatment approach, since it provides both individual psychotherapy, group skills training and phone consultation to the client. Currently available resources in many programs may make providing this form of DBT impossible. One solution is to develop criteria that can be used for selecting a subgroup of clients to be eligible for DBT. These might include high levels of emotion dysregulation, borderline characteristics, or high risk for continued violence and/or treatment drop-out. Alternatively, the standard form of DBT might be modified to meet all five functions, but do so in a less resource-intensive manner, such as addressing obstacles to change in a group that utilizes behavioral analyses, rather than doing this in individual therapy.

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