EMOTION REGULATION AND EXPERIENTIAL AVOIDANCE IN INTIMATE PARTNER VIOLENCE

Amie Langer and Erika Lawrence
The University of Iowa

ABSTRACT

Despite extensive research demonstrating the prevalence and consequences of physical intimate partner violence (IPV), the literature currently lacks an evidence-based, theoretical framework within which to understand the factors that influence this behavior. Furthermore, current IPV treatments based on the Duluth and cognitive-behavioral models are limited in their efficacy. Drawing from a contextual behavioral science (CBS) approach and recent advances in research on therapeutic processes of change, the purpose of this chapter is to examine processes that may elucidate the development of novel, empirically-supported treatments that are more effective than our existing IPV interventions. Specifically, we introduce a framework to guide basic and translational research in the investigation of emotion dysregulation and experiential avoidance as functionally linked to IPV perpetration. Our rationale is outlined and supported throughout four sections. First, the psychological correlates of IPV are summarized. Second, the preliminary work on emotion regulation and experiential avoidance in IPV perpetrators is reviewed. Third, a variety of research is integrated to inform our presentation of a clinically useful framework wherein IPV is primarily maintained by negative reinforcement in the form of escape from, or avoidance of, unwanted internal experiences, and recommendations for future research is offered. Finally, we delineate the clinical implications of this framework.

Introduction

Physical aggression in romantic relationships is surprisingly common, with rates ranging from 25% to 57% in studies of dating, cohabiting, engaged, and married couples (e.g., Langer, Lawrence, & Barry, 2008; O’Leary et al., 1989; Schumacher & Leonard, 2005), and from 10% to 20% in nationally representative surveys (e.g., Straus & Gelles, 1990). Men and women are equally likely to engage in intimate partner violence (IPV) against their partners, and the most frequently employed
behaviors include grabbing, pushing, and slapping (e.g., Leonard & Roberts, 1998). The consequences of IPV are well-documented, and even mild and infrequent forms of IPV have implications for individual health (e.g., depression, anxiety, substance use; Umberson, Anderson, Glick, & Shapiro, 1998) and relationship functioning (e.g., severe, unremitting distress and instability; Rogge & Bradbury, 1999). Moreover, children who witness IPV are at increased risk for physical health difficulties and behavior problems (e.g., McNeal & Amato, 1998). Several programs have been developed for the treatment of IPV, but these programs do not produce meaningful changes in the behaviors they are designed to impact (Babcock, Green, & Robie, 2004; Healey, Smith, & O’Sullivan, 1998). To date, it is debatable whether any IPV intervention can be labeled “empirically supported,” a term denoting a clearly specified psychological treatment that has been shown to be efficacious in at least two independently conducted randomized controlled trials (RCT) in which the targeted treatment was compared with a placebo condition or control group (e.g., Chambless & Hollon, 1998).

Many existing interventions for IPV are based on feminist theory and conceptualized within the Duluth Model, employing a “knowledge-attitude-behavior” theory of change in which IPV is believed to be a function of patriarchal attitudes that condone violence, power, and control (Dobash & Dobash, 1979; Pence & Paymar, 1993). The philosophical underpinnings of the Duluth Model are that treatment is instructive rather than therapeutic; thus, psychoeducational techniques are used to promote changes in attitudes via education and re-socialization. Other treatments use a cognitive-behavioral approach (CBT), in which treatment centers around modifying faulty cognitions, developing effective communication skills, and teaching emotion control techniques to prevent future violent behavior. Most interventions are a blend of the Duluth Model and CBT approaches and, in general, focus on modifying how IPV perpetrators think and act through cognitive restructuring, skills training, and anger management techniques (e.g., Healey & Smith, 1998). Despite the lack of support for certain theoretical tenets (e.g., patriarchal attitudes; Smith, 1990; Sugarman & Frankel, 1996) and treatment components (e.g., cognitive restructuring; e.g., Feder & Forde, 2000) of these models, many states with guidelines governing the content of battering interventions mandate that the programs adhere to these models in order to be state-certified or to receive state funding (e.g., Healey, Smith, & O’Sullivan, 1998). Furthermore, the effect of these interventions on IPV recidivism is small; a meta-analysis of experimental studies revealed that, on average, a man who has been arrested, sanctioned, and has completed an IPV treatment program is only 5% less likely to perpetrate IPV again than a man who has been arrested and sanctioned but has not completed treatment (Babcock et al., 2004).

In a review of the empirical status of intervention programs for IPV, Eckhardt, Murphy, Black, and Suhr (2006) concluded that, although there has been improvement in recent years, the design, application, and study of these programs remain elusive. Despite the existence of many IPV treatments, little work has specifically examined the processes through which successful change may be promoted, and when they have, the proposed change processes have not been found to be effective mechanisms of treatment (e.g., Scott, 2004). Therefore, one of the major gaps in theories and research on IPV treatments is the identification of processes and corresponding treatment methods that may serve as important targets and facilitators of change, respectively. Similar questions have been addressed in the broader psychotherapy literature in recent years, particularly within the the
contextual behavioral science approach (e.g., Levin & Hayes, 2009). We believe that this approach may have some important implications for the study and treatment of IPV.

Put simply, the Contextual Behavioral Science (CBS) approach is an inductive and functional research paradigm that aims to integrate basic and applied psychology by developing theories of human behavior that are tied to processes of change and linked to effective treatment techniques that target those processes. The CBS approach accomplishes this goal by integrating factors related to the development and maintenance of psychological problems, and the processes through which we might influence these factors, into a unified model. In contrast to the mainstream mechanistic or syndromal approaches, which are largely atheoretical and focus on the topographical characteristics (e.g., signs and symptoms) of behavior, CBS is a theory-driven approach which focuses on the underlying processes (e.g., producing and maintaining factors) and idiographic functions of behavior. For example, depending on the context, a behavior can be considered an expression of distress (a communicative function), a way of removing an external obstacle (a problem-solving function), or a way of reducing the arousal associated with intense emotions (an avoidance function). Within the broader psychotherapy literature, the CBS approach has led to tremendous progress in theory and research on basic principles that govern therapeutic change and has been utilized in the advancement of empirically-supported treatments for psychopathology and behavioral problems. Thus, it may also prove useful for IPV treatment, in light of the evidence that IPV treatment has not been conceptualized or treated well by mechanistic or syndromal approaches.

Within CBS and across theoretical perspectives, recent advances in basic and applied research have led to the identification of a number of common functional processes underlying human pathology. Emotion regulation and experiential avoidance are two such processes complicit in the initiation and maintenance of a wide variety of psychological disorders (e.g., Mennin, Holaway, Fesco, Moore, & Heimberg, 2007) and thus have the potential to be a focus of treatment. Emotion dysregulation -- or deficits in the ability to modulate or respond to one’s emotions -- are implicated in many Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV; Psychiatric Association, 1994) Axis I disorders (e.g., depression, anxiety disorders, and eating disorders) and in the large majority of the Axis II disorders (e.g., Kring & Bachorowski, 1999). For example, it has received extensive attention as a core deficit linked to behavioral dysregulation in Borderline Personality Disorder (BPD; Linehan, 1993). Experiential avoidance, a phenomenon that occurs when a person is unwilling or unable to remain in contact with internal experiences such as emotions, thoughts, and bodily sensations, and, consequently, takes steps to alter their form or frequency (e.g., Hayes, Wilson, Gifford, Follette, & Strosahl, 1996), has also been implicated in a wide range of psychological problems and dysfunctional behaviors. For example, similar to emotion dysregulation, experiential avoidance has been linked empirically to mood and anxiety disorders, as well as numerous maladaptive behaviors, such as substance abuse and self-harm (see Chawla & Ostafin, 2007 for a review).

Across various theoretical perspectives, and within CBS specifically, innovative treatments for pathological behaviors have been developed that utilize novel applications of behavioral principles to internal experiences (e.g., emotions and thoughts), and specifically target emotion dysregulation and experiential avoidance (e.g., Hayes, Strosahl, & Wilson, 1999; Linehan, 1993; Segal, Teasdale, & Williams, 2004). More about these treatment approaches will be discussed in Section 4, but
already there have been calls to integrate components of one such treatment -- Dialectical Behavior Therapy (DBT) -- into IPV treatment programs (Fruzzetti & Levensky, 2000; Rathus, Cavauto, & Passarelli, 2006). DBT was originally developed as a treatment for parasuicidal or self-harm behaviors and utilizes emotional and behavioral skills training to reduce the ineffective action tendencies linked with emotion dysregulation (Linehan, 1993). This treatment approach has been highly successful; 7 well-controlled RCTs have determined it to be efficacious for the treatment of BPD (Lynch, Trost, Salsman, & Linehan, 2007), as well as for a wide range of treatment-resistant problems (e.g., Rosenfeld et al., 2007).

A key premise of this chapter is that basic research designed to identify the specific processes functionally important to IPV perpetration will elucidate vital processes to target in our interventions. Attempts to identify and clearly differentiate the functions of IPV (in different contexts or by different individuals) are necessary to aid our understanding of the factors that initiate and perpetuate IPV behaviors and, consequently, the development of novel, empirically-supported treatments that would likely be far more effective than existing IPV interventions. Given that IPV is theoretically and functionally similar to behaviors associated with emotion dysregulation and experiential avoidance, a thorough examination of these processes in IPV perpetrators is warranted. Although IPV likely has multiple determinants, we propose that emotion dysregulation and experiential avoidance are two constructs that may prove useful in conceptualizing the functions of this behavior. Indeed, there is a small but growing body of basic research connecting emotion dysregulation and experiential avoidance to IPV perpetration (e.g., Jakupcak, 2003), which will be reviewed in Section 2 below.

The purpose of this chapter is to introduce a conceptual framework to guide basic and translational research in the investigation of emotion dysregulation and experiential avoidance as psychological processes functionally linked to IPV. First, we summarize the existing literature on the psychological risk factors and correlates associated with IPV and outline the limitations of this research. Although much of this literature has examined IPV within categories of personality and psychopathology, it is relevant to understanding IPV in general and has informed the approach taken in this chapter. Second, we present the existing, preliminary work on emotion regulation deficits in IPV perpetrators and delineate aspects of emotion regulation that may be particularly relevant to IPV. Third, we present evidence for the role of experiential avoidance in IPV perpetration. Fourth, we offer suggestions for incorporating emotion regulation and experiential avoidance into future research on IPV perpetration. Fifth, we explicate the clinical implications of targeting functional processes in IPV perpetrators and offer specific recommendations for the development of innovative treatments.

**SECTION 1: PSYCHOLOGICAL RISK FACTORS AND CORRELATES OF IPV PERPETRATION**

Historically, most research on psychological characteristics of IPV perpetrators has focused on males and on clinical populations, although research on female IPV and in community samples has accumulated in recent years. Across samples, the personality and psychopathology correlates of IPV have received the most attention, and countless studies have established that a wide range of traits and disorders are critical risk factors for IPV...
perpetration. Additionally, more fundamental affective and cognitive factors (i.e., specific emotions and thoughts) distinguishing IPV perpetrators from non-perpetrators have also received attention, although far less attention than personality and psychopathology factors. Several components of IPV treatment programs have been based on these findings, and although the evidence is mixed, reductions in psychopathology have been linked to reductions in IPV behaviors in a few studies (e.g., Scott, 2004). The purpose of this section is to present a brief review of research on the psychological risk factors that have been identified as contributing to IPV perpetration. Given the focus of the current chapter, and that comprehensive models of general aggression have suggested the importance of both affective states and cognitive factors in understanding interpersonal aggression (e.g., Berkowitz, 1993), we chose to outline the findings based on their relations to emotion and cognition.

**Emotional Correlates of IPV Perpetration**

Numerous investigations of risk factors for IPV have demonstrated that emotion plays a key role in IPV perpetration, and most of this research has been focused on emotional symptoms present within psychopathology. Elevated rates of various DSM-IV Axis I disorders have been consistently linked to IPV perpetration for both men and women. IPV perpetrators are significantly more likely to score in the clinical range on measures of depression, anxiety, and negative emotionality in general (e.g., Capaldi & Owen, 2001; Dowd, Leisring, & Rosenbaum, 2005; Maiuro, Cahn, Vitaliano, Wagner, & Zegree, 1988; Magdol, Moffitt, Caspi, & Silva, 1998; Moffitt, Krueger, Caspi, & Fagan, 2000; Pan, Neidig, & O’Leary, 1994; Swan, Gambone, Fields, Sullivan, & Snow, 2005). In particular, posttraumatic stress disorder (PTSD) is very common among male and female IPV perpetrators, reportedly reflecting a high incidence of childhood abuse and trauma (e.g., Murrell, Christoff, & Henning, 2007; Stuart, Moore, Gordon, Ramsey, & Kahler, 2006).

IPV perpetration has also been linked to multiple Axis II disorders characterized by emotional difficulties. A large proportion of IPV perpetrators exhibit symptoms of Antisocial Personality Disorder (ASPD) and Borderline Personality Disorder (BPD), both Cluster B (“dramatic/erratic”) personality disorders impacting emotion and interpersonal functioning (e.g., Goldenson, G effner, Foster, & Clipson, 2007; Weizmann-Henelius, Viemero, & Eronen, 2004). Cluster B disorders are differentiated from other personality clusters not only by their associations with high emotional dysregulation and stress reactivity (e.g., Kraus & Reynolds, 2001), but also by their extreme “action-oriented” features (e.g., self-harm, aggression; Fossati et al., 2007). Not surprisingly, high levels of the personality facets subsumed under Cluster B -- in particular, impulsivity, manipulativeness, and aggressiveness -- have also been associated with IPV perpetration (e.g., Ehrensaft, Moffitt, & Caspi, 2004; Langer, Lawrence, & Barry, 2008; O’Leary, Malone, & Tyree, 1994). In addition, numerous studies have found significantly elevated levels of trait dependency in IPV perpetrators compared to nonviolent individuals (e.g., Goldenson, G effner, Foster, & Clipson, 2007; Murphy, Meyer, & O’Leary, 1994).

Outside of the syndromal nature of psychopathology, anger has been the most commonly studied emotion in IPV perpetrators. Compared to nonviolent individuals, there is some evidence that both male and female IPV perpetrators evidence significantly higher levels of
anger and hostility (e.g., Dutton, Saunders, Starzomski, & Bartholomew, 1994; Maiuro, Cahn, Vitaliano, Wagner, & Zegree, 1988; Sullivan, Meese, Swan, Mazure, & Snow, 2005), whereas other studies have shown that they experience anger at comparable levels of frequency and intensity (e.g., Dye & Eckhardt, 2000). Although less attention has been paid to emotions other than anger, a few studies have found that high levels of fear, jealousy, and shame are reported by IPV perpetrators, and that these emotions are related to the frequency of IPV (e.g., Babcock, Costa, Green, & Eckhardt, 2004; Foran & O’Leary, 2008). Relatedly, it has been suggested that male batterers are likely to possess a Borderline Personality Organization (BPO; Dutton, 1994), a cluster of maladaptive emotional features that become salient in intimate relationships, including an unstable sense of self, intense anger, fear of abandonment, and impulsivity. The BPO is characterized by an “angry and fearful attachment style” related to becoming both angry and afraid in response to intimacy, as well as to engaging in IPV in response to perceived threats of abandonment or relationship dissolution (Dutton, et al., 1994).

In sum, various psychological disorders and personality traits that influence the experience and expression of emotion are associated with IPV perpetration. However, we contend that studying the role of emotion in IPV perpetrators within the context of psychopathology and personality is not the best approach. The highly comorbid and heterogeneous nature of DSM diagnostic categories leads to a loss of relevant information (e.g., Widiger & Samuel, 2005), limiting the degree of knowledge gained. For example, the psychological syndromes associated with IPV perpetration are highly related to one another; depression, anxiety, PTSD, and BPD demonstrate high comorbidity (e.g., Zanarini et al., 1998). Moreover, focusing primarily on categorical constructs may be detrimental to identifying variability in factors that exist regardless of clinical diagnosis or emotional content. Finally, with the exception of anger, empirical examinations of the specific emotions that may be particularly salient among IPV perpetrators are sparse. Thus, alternate approaches to investigating the role of emotions in IPV perpetration are needed.

Cognitive Correlates of IPV Perpetrators

There is also empirical evidence to suggest that cognitive characteristics such as attributions, attitudes, and beliefs are associated with IPV perpetration. Compared to nonviolent men, IPV perpetrators express more cognitive biases and irrational beliefs (e.g., Eckhardt, Barbour, & Davison, 1998), report more aggressive thoughts in general, and report more spouse-specific aggressive thoughts in particular (e.g., Holtzworth-Munroe, Rehman, & Herron, 2000). Recent evidence suggests that female IPV perpetrators also report significantly more aggressive cognitions than non-perpetrators (Clements & Holtzworth-Munroe, 2008). Similarly, IPV perpetrators are more likely than non-perpetrators to attribute negative intent to their partners’ behaviors (e.g., Byrne & Arias, 1997) and to evaluate the use of aggression positively (e.g., as justified or appropriate to the situation; Sugarman & Frankel, 1996). Overall, evidence suggests that IPV perpetrators demonstrate general cognitive biases, generate hostile attributions in their interpretations of partner behaviors, and endorse attitudes that condone aggression.

Researchers have also examined the processes through which IPV perpetrators process information and produce cognitive content. Such processes are addressed by the social
information processing model of IPV, which posits that anger can inhibit “rational” cognitive processing and result in cognitive biases (e.g., hostile attributions) that may escalate conflict toward violence (e.g., Holtzworth-Munroe, 2000). Indeed, when compared to nonviolent samples, male IPV perpetrators demonstrate social information processing skills deficits in response to marital conflicts, particularly conflicts that involve real or perceived partner rejection or abandonment (e.g., Holtzworth-Munroe & Anglin, 1991). However, the construct of social information processing includes numerous, diverse facets of cognition (e.g., decoding, problem-solving, enactment), and it is not known which deficits are most influential in generating greater risk of IPV perpetration.

Overall, data regarding the cognitions of IPV perpetrators are qualified by issues related to assessment and research design (for a review see Eckhardt & Dye, 2000). With few exceptions, IPV researchers have investigated a surprisingly narrow range of cognitions (attitudes and attributions) and have exclusively relied upon questionnaire methodologies. Although IPV perpetrators consistently report higher levels of general and partner-specific hostile thoughts relative to non-perpetrators, the data are equivocal regarding a causal relationship between these thoughts and aggressive behavior (Norlander & Eckhardt, 2005). Moreover, the cognitive tenets included in existing theories of IPV have little empirical support. For example, there is limited evidence for the role of patriarchal attitudes (a tenet of feminist theory; Pence & Paymar, 1993) in the perpetration of male IPV (e.g., Smith, 1990; Sugarman & Frankel, 1996). Taking all this into consideration, it is not surprising that the utilization of cognitive techniques to change attitudes is ineffective at reducing IPV among perpetrators; there is no evidence that specific cognitions are causally linked to IPV, and the patriarchal attitudes often targeted do not appear to characterize most IPV perpetrators.

**Critique of This Research**

A wide range of psychopathology, personality traits, and emotional and cognitive experiences are linked to IPV perpetration. Moreover, a low threshold for experiencing negative affect – the presence of negative or unpleasant thoughts and emotions – is clearly a vulnerability factor for IPV perpetration. However, the available research converges to suggest that there is not a specific configuration of risk factors most susceptible to pathological expression. The correlational data gathered thus far do not unequivocally demonstrate that IPV perpetrators show an idiosyncratic pattern of emotional and cognitive content. More importantly, the findings do not necessarily imply a functional relationship between a given emotion or cognition and the expression of aggression during relationship conflict. In other words, we have limited knowledge regarding how these internal experiences influence IPV perpetration; the constructs previously studied may define the content and form of psychological events associated with IPV, but they do not clarify the function, maintenance, and episodic expression of pathological behavior patterns. Furthermore, effective treatment approaches have not emerged from these data. Therefore, we now turn to a discussion of processes that we believe are more clinically relevant to IPV perpetration.
SECTION 2: EMOTION REGULATION, EXPERIENTIAL AVOIDANCE, AND IPV PERPETRATION

Given the limitations of attempting to understand the links between emotions and cognitions and IPV using topographical constructs, a consideration of other factors is warranted. Only looking at the form of one’s emotions and cognitions (which we will refer to as internal experiences) associated with IPV behavior leads to a loss of information about the broader functional properties of affect and cognition that may be crucial to our ability to change the behavior. Thus, it may be more fruitful to consider one’s responses to internal experiences and the functional processes that may play a role in IPV perpetration. For example, one might investigate how IPV perpetrators, in the context of certain emotions or thoughts, manage their affective arousal or how their overt behavior may influence their distress. Specifically, emotion regulation and experiential avoidance are phenomena that comprise ways of responding to internal experiences that may be particularly useful in understanding IPV perpetration. As can be seen from the review in Section 1, there are myriad psychopathology, personality traits, emotions, and cognitions associated with IPV, and we contend that many of them may be better elucidated and treated in the context of processes such as emotion regulation and experiential avoidance. Basic and treatment outcome research targeting these processes in other clinical populations with impulsive and destructive behaviors (i.e., self-harm; Gratz, 2007), and recent work outlining the application of DBT and mindfulness-based treatment approaches to treating IPV (Fruzzetti & Levensky, 2000; Rathus et al., 2006), call for the study of emotion dysregulation and experiential avoidance processes in IPV perpetrators. In line with those calls to action, we now examine the value of investigating these processes in IPV perpetrators and summarize the preliminary research on these constructs within this population.

Emotion Regulation

The Construct of Emotion Regulation

Emotion regulation is a term used to describe the processes through which individuals influence which emotions they have, when they have them, how they experience them, and how they express them (Gross, 1998). Emotion regulation encompasses a heterogeneous set of experiential responses, including cognitive, physiological, and behavioral components. Most definitions of emotion regulation emphasize the active modification of the internal (cognitive and physiological) experiences that comprise the emotion itself. However, published definitions differ in the degree of emphasis on the external (behavioral) expression of the emotion and on the purpose of such strategies. Some conceptualizations of emotion regulation refer to one’s general capacity to control emotions; examples include (a) one’s ability to modify or maintain mood states (Lischetzke & Eid, 2003), (b) one’s conscious and active attempts to reduce negative affect (Auerbach, Abela, & Ringo, 2007), and (c) deliberate, effortful processes one employs in an attempt to override spontaneous emotional responses (Koole, 2009). Other conceptualizations of emotion regulation include emotional, cognitive, and behavioral processes, as well as a consideration of the overarching purpose of such processes; examples include (a) the internal and external factors through which emotional arousal is redirected, controlled, modulated, and modified to enable an
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individual to function adaptively in emotionally arousing situations (Cicchetti, Ganiban, & Barnett, 1991), (b) the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying one’s emotional reactions, especially their intensive and temporal features, to achieve one’s goals (Gross & Thompson, 2007), and (c) the processes one employs to manage and change if, when, and how he or she experiences emotion and emotion-related motivational and physiological states, as well as how emotions are expressed behaviorally (Eisenberg, Hofer, & Vaughan, 2007).

In general, deficits in emotion regulation abilities (i.e., emotion dysregulation) are linked to increased negative affect, decreased positive affect, and ineffective attempts to manage one’s emotions (e.g., Berking, Orth, Wupperman, Meier, & Caspar, 2008). Moreover, emotion dysregulation is also linked to discomfort with emotional experiences that, when coupled with lack of access to adaptive strategies, often leads to the use of dysfunctional or maladaptive strategies to control or restrict one’s aversive emotional state. Accordingly, research indicates that individuals who possess deficits in emotion regulation are more prone to use risky or harmful behaviors not only due to greater or more intense negative affect, but also due to a lack of effective skills for regulating negative affect. Specifically, emotion dysregulation is hypothesized to elicit and reinforce BPD-related impulsive and destructive behaviors (e.g., self-harm; Gratz, 2007) and pathological behaviors in general (e.g., problem eating, substance use, and gambling; Fox, Axelrod, Paliwal, Sleeper, & Sinha, 2007; Ricketts & Macaskill, 2003; Sim & Zeman, 2004).

Based on these findings and on the range of emotional difficulties associated with IPV perpetration reviewed above, it seems likely that IPV may result from similar deficits in emotion regulation. Given this possibility, we now summarize the limited research that has examined emotion regulation in IPV perpetrators. Then, after a critique of this research, we offer specific suggestions regarding which aspects of emotional regulation processes may be most relevant to IPV perpetration.

Emotion Regulation and IPV

The vast majority of published research on emotion and IPV has focused on the links between personality and psychopathology and IPV perpetration. However, a few studies have purportedly focused specifically on the role of emotion dysregulation. In an investigation of differences between violent and nonviolent husbands’ emotions and behaviors during marital arguments, Babcock, Jacobson, Gottman, and Yerington (2000) assessed how attachment style may be an indicator of emotion regulation in the context of relationship conflict. Their results indicated that violent husbands were characterized by problems with emotion regulation, such that they were more likely to display negative affect (i.e., stonewalling, defensiveness, domineering, belligerence, contempt, and anger) during laboratory-based dyadic interactions. In a longitudinal study of males, Dankoski et al. (2006) asserted that emotion dysregulation mediated the effects of childhood experiences and IPV, such that externalizing and internalizing symptoms in childhood predicted IPV perpetration in adulthood. In a sample of newlyweds, McNulty and Hellmuth (2008) stated that emotion dysregulation, defined as variability in negative affect over 7 days, did not exert main effects on IPV perpetration, but that husbands’ emotion dysregulation interacted with wives’ IPV perpetration to account for husbands’ IPV perpetration.

In sum, there is preliminary evidence that emotion regulation deficits are associated with IPV perpetration. However, a close look at these studies reveals that their conceptualization
of emotion dysregulation as the presence of negative affect, internalizing and externalizing symptoms, or variability in negative affect (as the three studies above have done) actually reflects possible outcomes of regulation rather than the processes or strategies of regulation. Although these outcomes may certainly arise from emotion regulation difficulties, they do not indicate how individuals regulate or manage their emotions, or the specific skills that are or are not being utilized. Emotion regulation provides little information when defined simply by the emotions that are activated or how often they are activated; it must also be defined by one’s responses associated with the activated emotions. For example, evidence that one person reports or exhibits more anger than another does not by itself demonstrate that one person does not regulate anger or regulates anger differently from the other. Both individuals may be using regulatory strategies that have effects on emotional experience or expression. Therefore, a consideration of specific strategies that may be used (or not used) by IPV perpetrators is needed.

Examining the Construct of Emotion Regulation: Skills and Strategies

Emotion regulation is a “dynamic phenomenon that is reciprocally determined in the context of an ongoing stream of emotional stimulation and behavioral responding” (Gross & Thompson, 2007), and there are an infinite number of ways in which individuals can understand, react to, and manage their emotions. As such, it is not surprising that there is a lack of consensus on the exact skills or strategies that comprise emotion regulation and, consequently, no standard methods for studying them. Indeed, the scientific literature is replete with strategies individuals use to cope with or regulate their emotional experiences, which vary in their experiential targets (i.e., cognitive, physiological, and/or behavioral), their temporal relevance (i.e., before the emotion occurs or after), and automaticity (i.e., conscious or unconscious). Moreover, the effectiveness of any given strategy can only be determined within the broader context and the individual’s goals. Therefore, for the purpose of this chapter, we impose arbitrary coherence on this process by presenting a summary of the skills and strategies commonly implicated in optimal emotion regulation, as well as the strategies that are commonly associated with impaired emotional regulation.

Research has suggested that several skills are integral to successful or adaptive emotional functioning (see Berking, et al, 2008), such as: (a) consciously attending to, identifying, discriminating, and labeling one’s current emotional state (e.g., Feldman-Barrett, Gross, Christensen, & Benvenuto, 2001; Lischetzke & Eid, 2003), (b) understanding the causes and expression of emotions (Southam-Gerow & Kendall, 2002), (c) cognitively reformulating a situation (reappraisal; e.g., Gross, 1998), and (d) accepting emotions without attempts to alter or avoid them (e.g., Eifert & Heffner, 2003). In contrast, some attempts at emotion regulation actually increase distress, undermine behavioral control, and prevent the use of more adaptive strategies (e.g., Tice & Bratslavsky, 2000). Processes or strategies that have been shown to be generally detrimental and relate to maladaptive emotional functioning include: (a) drawing attention away from a focal event (distraction; e.g., Erber & Tesser, 1992), (b) repetitively thinking about the causes, situational factors, and consequences of one’s emotional experience (rumination; e.g., Nolen-Hoeksema, 2000), (c) inhibiting the ongoing thoughts or behavioral expressions associated with emotion (suppression; e.g., Gross, 1998; Purdon, 1999), (d) altering one’s conscious connection to aversive events and accompanying internal experiences by becoming detached or independent from them (dissociation; e.g., Oathes & Ray, 2008), (e) inaction or avoiding situations that elicit emotions (disengagement; e.g., Silk,
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Steinberg, & Sheffield Morris, 2003), and (f) engaging in destructive overt behaviors (self-harm, substance use, aggression; e.g., Bornovalova, et al., 2008; Bonn-Miller, Vujanovic, & Zvolensky, 2008; Jakupcak, Lisak, & Roemer, 2002). Finally, it is important to note that any behavior under voluntary control has the potential to influence one’s emotional state or mood and can be used to regulate emotions (e.g., Parkinson & Totterdell, 1999), and therefore, it follows that IPV may also represent an emotion regulation strategy in and of itself.

Emotion Regulation Processes and IPV

A few of the aforementioned emotion regulation strategies have been systematically studied in relation to IPV. First, there is some evidence that IPV perpetrators have difficulty identifying and expressing emotions. For example, they appear to be less aware of their affective states, have difficulty recognizing emotions, and attempt to suppress their emotions, particularly in the context of relationship conflict (e.g., Umberson, Anderson, Williams, & Chen, 2003; Yelsma, 1996). Second, IPV perpetrators are likely to feel anxious or uncomfortable around others and withdraw or disengage from social interactions in order to avoid these feelings (e.g., Allen, Calsyn, Fehrenbach, & Benton, 1989; Umberson, Williams, & Anderson, 2002). Third, general and violence-specific dissociation have been shown to correlate with the frequency and severity of IPV perpetration (Conrad & Morrow, 2000; Simoneti, Scott, & Murphy, 2000). Finally, substance abuse is one of the most studied risk factors for IPV, and is highly prevalent in both male and female IPV perpetrators (e.g., Chase, O’Farrell, Murphy, Fals-Stewart, & Murphy, 2003; Chermack, Walton, Fuller, & Blow, 2001).

Although there is little empirical evidence of the link between specific emotion regulation strategies and IPV, the hypothesis that IPV perpetrators’ responses to emotions are problematic is not new. For example, Gondolf (1985) contended that IPV is associated with deficits in emotional responding, such as hiding or repressing emotions, which leads to a build-up of emotions that surface in a sudden and explosive violent act. Dutton (1995) suggested that male IPV perpetrators’ inability to “self-soothe” during distress leads to excessive rumination or the use of alcohol and drugs. These patterns of maladaptive emotional responding may, of course, be operative in IPV; however, the descriptive nature of these discussions has yet to be accompanied by experimental examinations of such processes.

Summary

In sum, the available literature on emotion regulation and IPV is sparse, and the work that has been done is impairs by insufficient conceptualizations of emotion regulation and by limited assessment of the construct (i.e., as the presence of negative affect). As such, the role of emotion regulation in IPV perpetration is largely equivocal. It is clear that future examinations must extend the outcome of emotion regulation beyond negative affect to include whether and how IPV relates to prototypical emotion regulatory processes. Based on our current understanding, IPV may result from deficits in adaptive emotion regulation skills, the use of maladaptive emotion regulation strategies, or it may represent an emotion regulation strategy itself, such that it is used directly (although not necessarily consciously) as a behavioral tactic to regulate one’s emotional experience. As mentioned earlier, the effectiveness (adaptive vs. maladaptive) of emotion regulation depends on the broader internal and external environment in which it is occurring; indeed, there is emerging evidence that a given emotion regulation strategy is likely to be ineffective or harmful when it serves
an escape or avoidance function and is used rigidly across situations (e.g., Kashdon, et al., 2006). Therefore, a complement to this approach would be to conceptualize the specific emotion regulatory strategies reviewed in this section as different forms of behavior that often can have the same function to avoid, control, or escape internal experiences. We now turn to a discussion of experiential avoidance, a phenomenon that, while related to emotion regulation, is both broader and more explicitly linked to context and function.

**Experiential Avoidance**

*The Construct of Experiential Avoidance*

Rather than defining a particular form or topography of behavior, experiential avoidance is a broad class of behaviors bound together by the common function of avoiding or escaping unwanted internal experiences. Within this conceptualization, experiential avoidance exerts detrimental effects beyond the specific features of the internal experiences themselves (e.g., intensity, frequency, negative valence) and is a core toxic diathesis underlying several forms of psychological vulnerabilities and pathological behavior. For example, experiential avoidance has been implicated in the development and maintenance of substance abuse (e.g., Forsyth, Parker, & Finlay, 2003), trichotillomania (e.g., Begotka, Woods, & Wetterneck, 2004), self-harm (e.g., Chapman, Gratz, & Brown, 2006), and high-risk sexual behaviors (e.g., Batten, Follette, & Aban, 2001).

Numerous studies have demonstrated that experiential avoidance paradoxically increases psychological distress and limits adaptive emotional and behavioral functioning for several reasons. First, evidence suggests that the malleability of internal experiences is limited, and that attempting to avoid or control these experiences inadvertently heightens their intensity and prolongs their duration (e.g., Cioffi & Holloway, 1993; Posner & Rothbart, 2000; Wenzlaff & Wegner, 2000). Second, avoidance strategies are often negatively reinforced by the short-term relief, distraction, or escape temporarily provided, and then are often used rigidly across contexts despite negative consequences. Finally, these strategies are often antagonistic to more adaptive approach-oriented responses, a barrier which ultimately results in further intrapersonal (e.g., psychopathology) and interpersonal (e.g., loss of relationships) dysfunction. Overall, the pernicious nature of experiential avoidance is ultimately due to its automaticity, inflexibility, and the accumulation of detrimental consequences.

*Experiential Avoidance and IPV*

Individuals who engage in IPV behaviors may do so in service of controlling or avoiding unwanted or unpleasant internal experiences, particularly those that occur in the context of intimate relationships (e.g., negative emotions or physiological arousal that occurs during an argument). In this way, IPV may be conceptualized as a behavior that functions – consciously or unconsciously – as a method of escape or avoidance when other strategies have failed or are unavailable. Indeed, numerous clinical observations and conceptualizations of IPV have been consistent with this hypothesis. For example, Browning and Dutton (1986) theorized that male batterers use violence both to reduce aversive physiological tension (as well as the emotions and labels attached to it) and to create emotional distance from their partner out of fear of emotional intimacy. It has been proposed that in response to troubling thoughts about
infidelity or abandonment, IPV may be a strategy to achieve closeness with a romantic partner to quell these fears (e.g., Babcock, Jacobson, Gottman, & Yerington, 2000), and that the hostile attributions of IPV perpetrators reflect an attempt to avoid identifying with more vulnerable thoughts and feelings (Schweinle & Ickes, 2007). Brown (2004) proposed that shame may be related to IPV because it is a particularly aversive affective experience related to an intense desire to escape feelings of deficiency and worthlessness. The unifying thread across these different perspectives is the assertion that emotions and other internal experiences serve an important (though maladaptive) function in IPV, such that engaging in IPV somehow helps the individual escape, manage, or regulate those internal experiences.

Although many of these explanations have gone unexamined, recent studies reveal preliminary empirical support for the role of experiential avoidance in IPV perpetration. For example, Jakupcak (2003) found that fear of emotion significantly predicted self-reported IPV perpetration. Interestingly, IPV perpetrators were just as likely to fear the ostensibly positive emotions of love and happiness as they were the negative emotions of anxiety and sadness. In a similar study, males’ greater tendency to restrict emotion was related to greater anger expression and aggression (Jakupcak, Tull, & Roemer, 2005), which is consistent with research showing that suppression as an emotion regulation strategy can be detrimental (e.g., Purdon, 1999; Wegner et al., 1987). The authors hypothesized that men may use IPV as a strategy to avoid feeling or expressing emotional vulnerability, such that the fear of emotions may be so great, or so closely associated with a loss of control, that they use aggression as a means to attenuate or terminate their affective states (Jakupcak, 2003; Jakupcak, Tull, & Roemer, 2005).

The role of experiential avoidance in IPV is also supported by evidence that persons who engage in IPV are also likely to engage in other behaviors to avoid or escape internal experiences. For example, there is extensive evidence that IPV perpetrators engage in avoidant behaviors, providing support for the presence of stronger experiential avoidance tendencies among individuals who engage in IPV. For example, as reviewed above, IPV perpetrators have difficulty noticing and identifying emotions (e.g., Umberson, Anderson, Williams, & Chen, 2003; Yelsma, 1996), tend to withdraw or disengage from interpersonal interactions (e.g., Allen, et al., 1989) and dissociate in response to distress (e.g., Conrad & Morrow, 2000; Simonetti, Scott, & Murphy, 2000). When ineffective avoidance behavior occurs pervasively, it often results in or exacerbates clinical disorders. Indeed, many forms of psychopathology common in IPV perpetrators (reviewed in Section 1) are characterized by the presence of experiential avoidance, including BPD (e.g., Chapman, Specht, & Cellucci, 2005), PTSD (e.g., Marx & Sloan, 2005), substance use (e.g., Forsyth, Parker, & Finlay, 2003), and mood disorders (e.g., Tull & Gratz, 2008). In line with recent work, we hypothesize that experiential avoidance may actually account for the relationship between IPV and psychopathology (e.g., Tull, Jakupcak, Paulson, & Gratz, 2007).

Several factors may contribute to and maintain experiential avoidance in IPV perpetrators. First, IPV perpetrators experience greater levels of emotional arousal than non-violent controls, particularly in response to interpersonal triggers. For example, studies indicate that IPV perpetrators report more intense and reactive emotional responses than non-violent controls to situations involving real or perceived abandonment, rejection, interpersonal dependency, and jealousy (Dutton, 1988; Holtzworth-Munroe & Anglin, 1991; Holtzworth-Munroe & Hutchinson, 1993; Murphy, Meyer, & O’Leary, 1994). Although limited in number, experimental studies on the biological basis of emotional responding
provide additional evidence for exaggerated emotional arousal in IPV perpetrators. For example, studies utilizing psychophysiological assessment methods have found that increases in heart rate reactivity are associated with increased male-to-female IPV (Babcock et al., 2001; Gottman et al., 1995).

Second, individuals who engage in IPV may not actually have heightened emotional arousal, but rather a lower tolerance for emotional arousal (i.e., lower distress tolerance). Distress tolerance is influenced by the degree to which individuals experience their emotional arousal as aversive or unpleasant, regardless of the actual level or intensity of the arousal. For instance, studies indicate that IPV perpetrators report that their affect is extremely unpleasant and that they experience fear of their emotions; interestingly, they are just as likely to fear the ostensibly positive emotions of love and happiness as the negative emotions of anxiety and sadness (e.g., Jakupcak, 2003). The subjective experience of greater and more aversive emotional arousal likely makes it considerably more difficult to tolerate such emotional arousal, leading to attempts to avoid it.

Third, converging findings from a variety of observational, self-report, and physiological studies provide support for the premise that IPV is associated with relief or escape from emotional experiences. Research indicates that IPV perpetrators subjectively report higher levels of aversive internal arousal before and during arguments than do non-perpetrators (e.g., Margolin, John, & Gleberman, 1988) and display more objective negative affect (i.e., stonewalling, defensiveness, domineering, belligerence, contempt, and anger) during dyadic conflict interactions (e.g., Babcock, Jacobson, Gottman, & Yerinton, 2000). In addition, the majority of perpetrators report having initiated IPV during a period of negative emotion. For example, Babcock, Costa, Green, and Eckhardt (2004) found that the most common proximal antecedents of IPV episodes are jealousy (e.g., in response to perceived infidelity) and hurt (e.g., in response to threats of dissolution). Furthermore, IPV perpetrators often report that they experience panic symptoms before engaging in aggression, and they often exhibit tremulousness and vocal changes that are accompanied by palpitations, breathlessness, flushing, and sweating when they become violent (George, Anderson, Nutt, & Linnoila, 1989). These symptoms, characteristic of autonomic nervous system arousal, are out of proportion to environmental stimuli and are perceived by the perpetrators as not under their conscious control (e.g., Bitler, Linnoila, & George, 1994). However, more research is needed to confirm that these physiological and neurological factors provide a measurable index of experiential avoidance.

**Summary**

As reviewed above, preliminary data exist that support the premise that the primary function of IPV is the avoidance of, or escape from, unwanted or aversive affective states. While limited, the results of studies linking experiential avoidance to IPV perpetration provide important directions for future research. For example, although emotions and cognitions are intricately connected, the studies done thus far have focused primarily on emotions, and we do not yet have direct evidence for the role of cognitive avoidance and IPV. Therefore, in addition to replicating existing findings, we recommend also investigating the distinct responses surrounding specific thoughts and the subsequent impact on IPV behaviors (e.g., impulsive actions when rigidly entangled with the thought “My partner must not love me”). This research would likely parallel the findings regarding emotional avoidance and
IPV; combined with using aggression to resist or avoid difficult emotions occasioned by intimacy or conflict, IPV perpetrators may also negatively evaluate the associated internal experiences or “attach” to hostile thoughts, and use aggression (along with other strategies) as a means of escaping or controlling these internal experiences. Furthermore, given the extensive data on the role of experiential avoidance in the development and maintenance of psychopathology, future work should examine its potential mediating role between psychopathology and IPV. Experiential avoidance may represent an overarching class of behaviors that holds psychopathology and IPV behaviors together. For example, if the tendency to avoid is addressed, and the use of IPV and other behaviors (e.g., substance use) as a means to escape aversive states is eliminated or reduced, the behaviors involved in psychopathology may become irrelevant as a motivator of IPV. To date, we know of no studies that have systematically addressed such issues. We expand on these recommendations for future research in Section 3.

**Integrating Emotion Regulation and Experiential Avoidance**

Before future work on emotion regulation and experiential avoidance can be implemented, IPV researchers must have a consistent, clear, working definition of these related constructs under investigation. In the study of IPV, we believe it is helpful to conceptualize emotion regulation as strategies one uses in response to emotions and associated internal experiences that, immediately or over time, affect overt behavior; more specifically, strategies that increase or decrease the likelihood of engaging in IPV, as well as increase or decrease the ability to engage in more adaptive behaviors. However, as mentioned above, although numerous emotion regulation strategies have been identified, at this point it is not clear which strategies are most detrimental or may relate most strongly to IPV, most likely because the effectiveness of regulatory strategies cannot be separated from the specific stressor being confronted or the context in which it is used. As such, the inherent reference to context and function here is one of the reasons a consideration of experiential avoidance is a needed complement to the examination of emotion regulation strategies that are measured in terms of form and frequency. Indeed, there is evidence that experiential avoidance may actually drive the very process of emotion dysregulation; for example, many of the maladaptive emotion regulation strategies reviewed above have been linked to experiential avoidance (e.g., suppression and rumination; Tull, Gratz, Salters, & Roemer, 2004). Moreover, it has been suggested that specific regulatory strategies may have minimal to no impact on emotional or behavioral functioning after accounting for experiential avoidance (e.g., Kashdon et al., 2006). Therefore, although attempting to regulate emotion is not necessarily a dysfunctional process, it can become dysfunctional when the strategies serve an avoidance or control function and are used inflexibly across contexts. In sum, experiential avoidance is a helpful framework within which to investigate maladaptive behaviors in general, and emotion regulatory strategies in particular.
SECTION 3: SUMMARY AND RECOMMENDATIONS FOR FUTURE RESEARCH

There are strong, consistent findings demonstrating that negative emotions or mood states can serve as “urgent pulls” for risky or destructive behaviors, but few studies have examined the mechanisms that may account for this link. Recent evidence from the psychopathology literature suggests that emotion regulation and experiential avoidance are two related processes that are likely pivotal to understanding pathological behaviors occurring in the context of emotions and other aversive internal experiences. As we have outlined in this chapter, we believe there is sufficient evidence to merit the examination of these processes in the context of IPV. Specifically, we propose that IPV perpetrators may have an exaggerated fear or sensitivity to certain internal experiences and, in turn, avoid these experiences via rigid overgeneralized use of overt (behavioral) and covert (physiological and cognitive) responses or strategies in a desperate effort to reduce, eliminate, or otherwise control internal experiences and achieve a sense of “safety.” From this perspective, IPV provides a convenient and rapid means to mitigate unpleasant negative affect, including the associated bodily sensations and negative thoughts, and this temporary relief or distraction ultimately serves to strengthen the behavior (see Figure 1). The powerful negatively reinforcing effects of IPV (and other experiential avoidance behaviors) dominate over actual consequences in the environment and are used even when they do not work, make things worse, or get in the way of more adaptive behavior. Within this framework, we now turn to several important questions that require empirical examination.

Figure 1. Illustration of the hypothesized relations among experiential avoidance (EA), emotion regulation (ER), and intimate partner violence (IPV). In the context of EA, maladaptive ER strategies, and/or a lack of adaptive ER strategies, intense emotional arousal is likely to lead to IPV behaviors. IPV may be negatively reinforced by the short-term reduction in, or escape from, the arousal and the accompanying thoughts and physiological sensations. With consistent use, IPV may become a conditioned response to these internal experiences.
Recommendations for IPV Research

Although preliminary studies support the premise that IPV perpetrators are likely to engage in experiential avoidance behaviors and that IPV leads to relief or escape from emotional arousal, we know of no published study that has examined the emotional and cognitive precipitants and consequences of IPV in participants’ natural environments. In addition, future research should examine whether certain internal experiences are especially likely to precede or be relieved by IPV, and whether these experiences differ depending on the presence of clinical features (e.g., BPD versus non-BPD), other individual characteristics (e.g., impulsivity), or developmental experiences (e.g., chronic early aversive environments). Furthermore, experiential avoidance and emotion regulation may have implications for broader conceptualizations of IPV that incorporate similar functional analytic principles of behavior. While the model presented in Figure 1 is a specific framework for how internal experiences may contribute to IPV, there are numerous additional distal and proximal contextual variables impacting the likelihood that IPV will occur. For example, Bell and Naugle (2008) outlined a contextual model of IPV that provides a systematic strategy for identifying and examining variables that may have a proximal relationship with IPV perpetration, such as antecedents, motivating factors, discriminative stimuli, behavioral repertoire, verbal rules, and consequences. Similar to our approach and the notion of experiential avoidance, the authors note that emotional distress, among other things, is considered a motivating state that influences the likelihood that IPV will be reinforced via a reduction in emotional distress.

Based on our current knowledge regarding emotion regulation and experiential avoidance, future research should consider three key “pathways” or scenarios that may account for the link between unwanted or negative internal experiences and IPV. First, individuals with limited access to effective response strategies are likely to rely on learned, easily executable, but detrimental strategies such as IPV in the absence of adaptive skills. Second, an individual may have the requisite adaptive skills but fail to implement them in certain situations (e.g., if the emotion is very intense), and may impulsively resort to IPV for quick relief rather than more adaptive strategies that either take longer to alleviate distress or may not alleviate distress. Third, in either of these situations, the individual may first engage in other maladaptive strategies (e.g., rumination, suppression, detachment, substance use) that increase distress or lower inhibitions and ultimately render the individual vulnerable to IPV in a more downstream manner. An important task will be to explicate these diverse but interrelated pathways in IPV perpetrators.

Bearing in mind the three potential pathways to IPV just presented, it would likely be helpful to formulate a preliminary list of strategies or skills to be included in future research. Drawing heavily from basic research on adaptive emotion regulation (e.g. Gratz & Roemer, 2004) and opponent processes of experiential avoidance (e.g., Hayes et al., 1999), we propose that adaptive emotional and behavioral functioning is bolstered by following skills: awareness, understanding, and acceptance of one’s internal experiences, the ability to engage in goal-directed behaviors and inhibit impulsive or dysfunctional behaviors in the context of unwanted or negative internal experiences, and willingness to experience unwanted or negative internal experiences to achieve one’s goals (e.g., maintaining an intimate relationship). Conversely, a lack of or deficits in adaptive skills may be manifested by
unawareness and nonacceptance of one’s internal experiences, inflexible use of avoidant strategies, and difficulty choosing one’s actions and behaving effectively when experiencing certain thoughts, emotions, physiological sensations, and urges.

The theoretical significance and clinical utility of these putative processes and skills is of ultimate importance. From a therapeutic perspective, targeting such processes would entail not only eliminating or reducing inflexible and dysfunctional response strategies, but also building adaptive skills or responses. One major advantage of the approach outlined above is that, to a large extent, emotion regulation and experiential avoidance encompass responses to internal experiences that are largely under voluntary control -- as opposed to the content, level, or sensitivity of the emotions or cognitions themselves (which are involuntary) -- and, therefore, can be a target of therapeutic change. Each will need to be linked to relevant treatment techniques or components and measured as mechanisms of change in treatment of IPV, as they are only considered valuable to the extent that changes in them bring about successful outcomes. Therefore, we now turn to a discussion of the clinical implications of this approach.

SECTION 4: CLINICAL IMPLICATIONS

The limited efficacy of existing IPV intervention programs (e.g., Babcock et al., 2004) highlights the need to refine existing treatments or to create new ones. Most existing programs utilize psychoeducational, cognitive-behavioral, and/or skills training components that often lack empirical support justifying their use, are undertaken despite evidence of contraindication, and have limited evidence of effectiveness. First, there are no data to show that clinically significant changes in patriarchal attitudes or aggressive cognitions occur due to treatment, that putative reductions in these cognitions lead to decreases in IPV behaviors, or that CBT components demonstrate added benefit over other techniques (e.g., Feder & Forde, 2000; Morrel, Elliott, Murphy, & Taft, 2003). Second, despite the consistent link between emotional experience and expression among IPV perpetrators, interventions that focus on emotion, such as trauma histories or intense anger, are often discouraged or vigorously challenged in interventions based on the Duluth Model, as these factors are viewed as rationalizations or justifications for abuse (e.g., Taft & Murphy, 2007). Moreover, CBT-based components that address emotion via anger management have limited empirical support (e.g., Murphy, Taft, & Eckhardt, 2007; Watt & Howells, 1999). Third, research has identified few behavioral strategies that relate to clinically significant change in IPV. For example, a common component of IPV treatment programs is the development of skills related to problem-solving and communication, but several studies have yielded mixed results or failed to demonstrate treatment-related differences in these skills (e.g., Gondolf, 2002).

The overarching message of most IPV treatments -- that acts of IPV do not have to be uncontrollable outbursts, but can be predictable behavioral patterns that can be stopped -- is a sound one. However, the fundamental assumption that this goal will be achieved by changing the thoughts or emotions that purportedly sustain the IPV has little empirical justification, and may even lead to iatrogenic effects. For example, the mixed findings regarding both the use and effectiveness of emotion management components of IPV treatments are not surprising given that such techniques often emphasize deliberate control of emotions, which has been shown to inadvertently heighten emotional intensity and limit flexible emotional and
behavioral responses (e.g., Posner & Rothbart, 2000; Wenzlaff, Wegner, & Klein, 1991). Similarly, extensive research shows that deliberate attempts to change or suppress thoughts can increase their occurrence and behavioral impact (Cioffi & Holloway, 1993; Wegner, Schneider, Carter, & White, 1987), and that the cognitive components of CBT do not significantly improve therapeutic outcomes (e.g., Longmore & Worrell, 2007). In sum, there is extensive evidence that the behavior regulatory function of thoughts and emotions is not necessarily mechanical or direct, and that attempting to change the content of thoughts and emotions is not an effective way to change behavior (e.g., Biglan & Hayes, 1996).

In line with the focus of this chapter, rather than focusing exclusively on changing the content of one’s emotions or cognitions (e.g., controlling anger or hostile attributions) in order to subsequently change behavior, we believe that it will be more fruitful to consider the ways in which individuals relate or respond to the content of their thoughts and emotions. As we have argued above, focusing on behaviors that are under voluntary control has the potential to directly guide therapeutic action because it is only at this level that direct manipulation and influence on IPV behaviors will occur (e.g., Hayes & Brownstein, 1986). Consistent with this perspective, recent therapies have been developed to target emotion regulation and experiential avoidance, including Dialectical Behavior Therapy (DBT; Linehan, 1993), Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) and Mindfulness-Based Cognitive Therapy (MBCT; Segal, Teasdale, & Williams, 2004). Although a full description of these approaches is beyond the scope of this article, it is important to note that rather than focusing on changing the form and content of internal experiences (via cognitive restructuring and anger management), these approaches seek to alter the behavioral impact of internal experiences by weakening reliance on avoidant responses (via acceptance and mindfulness). We now briefly discuss the general applicability of such techniques to IPV, and given the recent work outlining the application of DBT to IPV, we will elaborate on the use of this treatment specifically.

In acceptance and mindfulness-based therapies, maladaptive responses to internal experiences are targeted to facilitate adaptive emotional functioning and behavioral change. To this aim, treatment components focus on engendering an orientation toward one’s internal experiences that involves: (a) mindfully attending to and contacting one’s experiences in the present moment and nonjudgmentally, (b) relinquishing attempts to control or avoid internal experiences and accepting them as they are, and (c) actively and intentionally choosing to behave according to one’s chosen and enduring values, regardless of how consistent or inconsistent such behavior is with the more arbitrary and unstable content of one’s internal experiences (e.g., Hayes, Strosahl, & Wilson, 1999; Levitt, Brown, Orsillo, & Barlow, 2004; Twohig & Woods, 2004; Zettle, 2003). Several studies have documented support for such techniques and, more importantly, the data show that they have a mediational role in therapy outcomes (e.g., Hayes, Luoma, et al., 2006; Lundgren, Dahl, & Hayes, 2008). In other words, successful outcomes occur because of changes in acceptance and mindfulness processes. Clearly, it is an empirical question whether such techniques may be effective components of IPV treatment. However, we assert that adapting such approaches is likely to be highly effective. For example, to the extent that the experience of anger is tightly linked to engaging in aggressive behavior, the use of these techniques may eventually allow the individual to observe the thoughts, physiological sensations, and behavioral urges accompanying their anger, become aware of the automatic connection to maladaptive efforts to regulate, avoid, or act on them (such as with IPV), and then develop the ability to separate these internal
experiences from overt behavior and to choose to engage in more adaptive (non-IPV) behaviors.

Based on the clinical picture of IPV perpetrators, it seems reasonable that certain types of skills training would also be an appropriate treatment strategy. It is unclear why skills training components have received little support in the treatment of IPV, but one possibility is that the individual has the component behaviors of a skill but cannot put them together effectively in certain situations, such as in the context of relationship conflict and intense emotion. However, regardless of the basis for lack of skill usage, skill-building elements may be bolstered by an emphasis on the generation of skill use in the presence of troublesome thoughts or feelings. Recent suggestions to incorporate the skills training components of DBT in treatments for IPV seem promising in this regard (Fruzzetti & Levensky, 2000; Rathus, Cauvoto, & Passarelli, 2006). Indeed, there are several theoretical links between IPV and self-harming behaviors that are specifically targeted in DBT, in that these behaviors are often similarly reinforced by the diminished negative arousal they provide.

In contrast to inherent assumptions that IPV is an attempt to assert power (implicit in the Duluth model) or the result of angry thoughts and feelings (implicit in CBT model), an approach that considers the functions of IPV (e.g., emotional escape) would be more consistent with the approach presented in this chapter. The DBT skills of mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance specifically target deficits in one’s ability to tolerate emotional arousal and engage in adaptive behavior when experiencing intense emotions. Embedded within skills training, DBT utilizes behavioral analyses to continually assess contexts and functions of target behaviors for the individual, as well as a full range of behavioral therapy techniques (exposure, contingency management, stimulus control procedures) with a focus on negative emotional arousal (Linehan, 1993). Particular attention is paid to the reinforcing factors that maintain destructive behaviors, such as relief from emotional pain, or the factors that punish more effective behavior, such as an aversive increase in emotional intensity.

In summary, treatments for IPV have traditionally addressed emotion and cognition by utilizing methods and techniques that emphasize the control of internal states. In contrast, there is now a considerable amount of empirical support for interventions that emphasize mindfulness and acceptance, rather than direct change or control of cognitive and affective experiences, in the treatment of a wide range of behavior problems. Furthermore, recent work has linked aspects of these approaches to improving emotion regulation, empathy, communication, problem-solving skills, and overall relationship satisfaction in couples (e.g., Fruzzetti & Iverson, 2004; Kirby & Baucom, 2007; Wachs & Cordova, 2007).

**CONCLUSION**

The lack of effective treatments for IPV is partially due to the limited ability of current theory and research to guide their development or modification. Therefore, subsequent progress in treating IPV is likely to depend heavily on the ability of available models to inform both basic and applied research. While it is important to acknowledge that personality and psychopathology are strong risk factors for IPV, such constructs have provided little information with regard to why or how emotions and thoughts exert their influence on the
perpetration of IPV. Hence, it appears that other factors, in addition to psychopathology, must operate to determine whether an individual will become aggressive in an intimate relationship. We believe one way to address these gaps or weaknesses in the literature is to draw from a contextual behavioral science approach and focus attention on processes of change that have proven empirically and clinically meaningful in the treatment of behaviors theoretically and functionally similar to IPV. In this chapter, we have presented a framework to guide basic and translational research in the investigation of emotion dysregulation and experiential avoidance processes as functionally linked to IPV. Using the information presented in this chapter as a guide, it is our hope that researchers involved in this area will consider these issues and that future research will inform new approaches to IPV treatment that, when adapted and developed specifically for use with IPV perpetrators, will elaborate on and increase the effectiveness of current approaches.

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Amie Langer and Erika Lawrence


