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programs and practice

An Acceptance and Commitment Therapy Approach for Partner Aggression

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Partner aggression is a major public health concern. Batterers' intervention programs (BIPs) are commonly used as an alternative to incarceration for offenders who have been arrested for domestic assault. Historically, BIPs have shown little effectiveness in reducing partner aggression. This article presents a new BIP based on acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999). ACT is a third-wave therapy that builds on the cognitive-behavioral tradition, focusing on increasing psychological flexibility by promoting acceptance and mindfulness processes. Several lines of evidence support the use of ACT in the treatment of partner aggression. Achieving Change Through Values-Based Behavior (ACTV; Lawrence, Langer Zarling, & Orengo-Aguayo, 2014) was developed based on ACT principles with a specific focus on feasibility and transferability to the community correctional setting and court-adjudicated treatment. ACTV incorporates experiential skills training and uses innovative methods to engage participants and teach the ACT processes. This article details the components of ACTV, including a case study to illustrate one participant's journey through the program. We also present preliminary pilot data, which look promising with respect to reductions in domestic assault and violent recidivism.

KEYWORDS: violence; abuse; intervention; corrections; mindfulness; acceptance

Intimate partner violence (IPV) against women is a major public health concern in the United States and worldwide. It has been identified as a significant human rights issue (Joachim, 2000). IPV, also called *domestic violence*, *partner abuse*, or *partner*

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aggression, is often described as a specific type of family or domestic violence, in which the perpetrator is a current or former intimate partner of the victim. IPV has been defined as "physical violence, sexual violence, threats of physical/sexual violence, and psychological/emotional abuse perpetrated by a current or former spouse, common-law spouse, non-marital dating partners, or boyfriends/girlfriends of the same or opposite sex" (Breiding, Basile, Smith, Black, & Mahendra, 2015).

Data from the 2011 National Intimate Partner and Sexual Violence Survey indicate that more than 10 million women and men in the United States experience physical violence each year by a current or former intimate partner. More than 1 in 5 women (22.3%) and nearly 1 in 7 men (14.0%) have experienced severe IPV at some point in their lifetime, translating to nearly 29 million U.S. women and nearly 16 million U.S. men. Finally, almost half of men and women have experienced at least one psychologically aggressive behavior by an intimate partner during their lifetime (Breiding, Smith, et al., 2014). Even mild and infrequent forms of IPV have negative consequences for victims, relationships, and children raised in these homes (e.g., Coker et al., 2002; Umberson, Anderson, Glick, & Shapiro, 1998).

The purpose of this article is to introduce a new intervention for IPV based on acceptance and commitment therapy (ACT). In this article, we will describe ACT, outline the evidence for its use in the treatment of partner aggression, introduce a new batterers' intervention program (BIP) based on ACT (called Achieving Change Through Values-Based Behavior [ACTV]), and present preliminary data on its effectiveness.

OVERVIEW OF TREATMENTS FOR INTIMATE PARTNER VIOLENCE

Because of the incidence and impact of IPV, much research and clinical work has been focused on the causes of domestic violence and how to treat it. The most popular type of BIP for men is a program based on the Duluth model. This program uses a psychoeducational group format to educate men about their attitudes concerning their perceived right to use power and control to subjugate women. A second approach, the cognitive-behavioral treatment (CBT) model, considers IPV as a learned behavior and focuses on changing faulty cognitions and intense emotions while also incorporating skills training related to communication skills and emotion control techniques. Duluth model–based programs are typically didactic and psychoeducational groups that focus on issues relating to gender egalitarianism and patriarchal ideology (see Murphy and Eckhardt, for additional discussion of these approaches). In practice, most programs use a combination of Duluth and CBT methods. Aside from Duluth model and CBT approaches, there are very few alternative BIP formats.

The treatment outcome literature suggests that Duluth and CBT interventions are similarly efficacious (e.g., Morrel, Elliott, Murphy, & Taft, 2003; O'Leary, Heyman, & Neidig, 1999). However, both types of intervention are only modestly efficacious. Treatment outcome studies based on these programs demonstrate very small effects on aggressive behavior beyond the effects of mandatory arrest alone. Completing an intervention program is related to a reduction in legal involvement (i.e., arrests for

domestic violence; Babcock & Steiner, 1999), but physical aggression rates after treatment remain high (up to 47%) and psychological aggression (e.g., threats of violence) often remains elevated as well (e.g., Grusznski, Brink, & Edleson, 1988). A meta-analysis of experimental studies revealed that, on average, a man who has been arrested, sanctioned, and completed an intervention program (Duluth, CBT, or a combination of both) is only 5% less likely to perpetrate physical aggression toward a female partner than a man who has only been arrested and sanctioned (Babcock, Green, & Robie, 2004). Moreover, these treatments are less effective at reducing physical aggression than mental health treatments are at reducing problems such as depression, anxiety, and marital distress (e.g., Johnson, Hunsley, Greenberg, & Schindler, 1999). In sum, treatment outcome studies have failed to identify superior treatments or intervention modalities, although these data are necessarily qualified by methodological limitations inherent in many of the outcome studies (e.g., high dropout rates; see Eckhardt, Murphy, Black, & Suhr, 2006).

Studies focusing on specific treatment components (e.g., duration, educational, or therapeutic), instead of general treatment packages, have found evidence that motivational techniques, used primarily within CBT approaches, are associated with positive treatment outcomes (Kistenmacher & Weiss, 2008; Taft, Murphy, Elliott, & Morrel, 2001). Such techniques, originally developed for substance abuse treatment, emphasize therapist expressions of empathic support, the development of a collaborative working alliance, and helping clients progress through stages of behavior change (Miller & Rollnick, 1991). For example, Taft et al. (2001) found that motivational techniques were associated with greater session attendance, which in turn predicted lower partner reports of physical assault and injuries at posttreatment. Moreover, participants' reports of greater group cohesion and a strong working alliance with the facilitator were associated with program compliance and lower levels of physical and psychological aggression at follow-up (e.g., Taft, Murphy, King, Musser, & DeDeyn, 2003). Therefore, even though evidence does not suggest a superior treatment package, these findings support the promotion of a collaborative therapeutic environment to bring about successful behavior change in this population.

ACCEPTANCE AND COMMITMENT THERAPY

Clinicians and researchers have shown increasing interest in mindfulness and acceptance-based treatments. One such treatment, ACT (Hayes, Strosahl, & Wilson, 1999), is a cognitive-behavior therapy that is rooted in a functional contextual approach to human language and cognition called *relational frame theory* (RFT; Hayes, Barnes-Holmes, & Roche, 2001). The details of RFT go beyond the scope of this article, but virtually every component of ACT is connected conceptually to RFT.

ACT builds on traditional cognitive behavioral therapy but emphasizes different processes in behavior change. One of those core processes is *psychological inflexibility*, which refers to behavior that is rigidly guided by internal experiences (i.e., thoughts, feelings, and urges) rather than personal values (Bond et al., 2011).

In other words, psychological inflexibility is acting based on how one thinks or feels rather than what would be most effective or workable. In contrast to psychological inflexibility, ACT aims to increase *psychological flexibility*, which is the ability to engage in valued patterns of activity independent of the internal experiences that may arise. In other words, to be able to do what is important, even if psychological barriers (e.g., anger, fear, lack of confidence, shame) are present.

ACT views *experiential avoidance* and *cognitive fusion* as common sources of psychological inflexibility. Experiential avoidance is a phenomenon that occurs when a person is unwilling or unable to remain in contact with particular internal experiences (e.g., emotions, thoughts, physical sensations, memories, or urges) and engages in behaviors to alter the form or frequency of those experiences even when doing so does not work or causes harm (e.g., Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). For example, when people find their feelings and thoughts aversive, they often try to change or to get rid of them. They seek out ways to provide relief for this negative or unpleasant state. These efforts to control are often ineffective and paradoxically lead to the intensification of emotions and thoughts that the person was trying to avoid in the first place (Hayes, Orsillo, & Roemer, 2010). Cognitive fusion is when verbal processes dominate behavior (e.g., Blackledge, 2007). For example, thoughts or beliefs, such as "I shouldn't be treated this way," have excessive control over one's behavior, such that the person is unable to make flexible behavior choices when experiencing that thought.

To target experiential avoidance and cognitive defusion, ACT uses both traditional behavioral and cognitive behavioral therapy techniques (e.g., exposure) as well as others that are more recent or that have been developed outside the behavior tradition, such as cognitive defusion, acceptance, present moment awareness, values, and commitment methods (Hayes et al, 1999). The goal of these techniques is not to directly change the content or reduce the frequency of aversive experiences; rather, the aim is to foster willingness to experience potentially aversive internal experiences while also promoting behavior that is consistent with desired goals and values. Thus, the therapy facilitates the identification and clarification of such goals and values and attempts to make the individual's moment-by-moment behavior choices based on one's ultimate values versus a more immediate wish to change an aversive state. Put simply, such techniques are designed to create a psychological context in which thoughts and feelings do not have to affect behavior, and freedom to choose values-consistent action is more possible.

Acceptance and cognitive defusion are thought of as antagonistic processes to experiential avoidance and cognitive fusion. Acceptance involves the active and aware embrace of one's internal experiences without unnecessary attempts to change their frequency or form. Cognitive defusion involves strategies that help participants notice and experience their thoughts with openness, curiosity, and some psychological distance. This enables a helpful disconnection between experience and action and reduces impulsive behavior (i.e., one can have a thought, feeling, or urge without acting in accordance with it). These processes are fostered in ACT by exercises, metaphors, and experiential practice. All of these processes are in the service of adaptive

behavior change, which is guided by the participants' identification and connection with their own personal values.

EVIDENCE FOR ACCEPTANCE AND COMMITMENT THERAPY AS A TREATMENT FOR PARTNER AGGRESSION

There are several lines of empirical evidence demonstrating the link between experiential avoidance and aggressive behavior.

In the general aggression literature, there is evidence for the tension-reducing and reinforcing effects of aggression. For example, Bushman and colleagues (Bushman, 2002; Bushman, Baumeister, & Philips, 2001) have found that aggression serves an affect regulatory function, such that individuals are significantly more likely to engage in aggressive behavior when told it will provide emotional relief or improve an aversive mood. Similarly, Verona and Sullivan (2008) found that physiological reductions following aggression reinforced subsequent aggressive acts and that heart rate reductions following aggressive responding were associated with the probability of increased aggression. The aforementioned findings suggest that experiential avoidance (i.e., distress relief) is a power reinforcer of aggression and can be learned quickly.

The partner aggression literature provides evidence that experiential avoidance is an important risk factor for violence. First, experiential avoidance is positively related to relationship violence (Bell & Higgins, 2015; Reddy, Meis, Erbes, Polusny & Compton, 2011; Shorey et al., 2014). Second, many forms of psychopathology commonly associated with partner aggression are characterized by the presence of experiential avoidance, including borderline personality disorder (e.g., Chapman, Specht, & Cellucci, 2005), posttraumatic stress disorder (PTSD; e.g., Marx & Sloan, 2002), substance use (e.g., Forsyth, Parker, & Finlay, 2003), and mood disorders (e.g., Tull & Gratz, 2008). It has been hypothesized that experiential avoidance may actually account for the relationship between psychopathology and partner aggression (e.g., Tull, Jakupcak, Paulson, & Gratz, 2007). Third, there is evidence that partner aggression is driven by lack of acceptance and an inability to tolerate emotional experiences (e.g., Cohn, Jakupcak, Seibert, Hildebrandt, & Zeichner, 2010).

The aforementioned evidence indicates that experiential avoidance is a known risk factor for violence and suggests that targeting experiential avoidance is a potentially useful strategy to reduce partner aggression. Other data provide support for using ACT to treat partner aggression.

First, partner-aggressive individuals are less apt to notice or identify their emotions than nonviolent controls. For example, they are less aware of their internal states and have greater difficulty recognizing emotions (e.g., Umberson, Anderson, Williams, & Chen, 2003; Yelsma, 1996). This provides support for using mindfulness skills to encourage awareness of internal experiences and to reduce acting on "autopilot."

Second, partner aggression is associated with a lower tolerance for emotional distress. For instance, studies indicate that individuals who engage in partner aggression

report that their affect is extremely unpleasant and negatively evaluate the expression of emotions (e.g., Jakupcak, Salters, Gratz, & Roemer, 2003). Moreover, partner aggression is associated with the suppression or restriction of emotions, such as withholding emotional expression, particularly emotions that display vulnerability (e.g., Tull et al., 2007; Umberson, Williams, & Anderson, 2002). This provides support for the ACT skills that promote acceptance or ongoing and nonjudgmental openness to internal experiences.

Third, individuals who engage in partner aggression exhibit poor empathic accuracy regarding their partners' thoughts and feelings as well as a general lack of understanding of others and/or an inability to tolerate the negative emotions of others (Clements, Holtzworth-Munroe, Schweinle, & Ickes, 2007; Marshall & Holtzworth-Munroe, 2010). This provides support for several ACT processes that foster acceptance and increased perspective taking.

Fourth, previous studies have found that partner-violent men are often considered to be resistant to treatment and lacking in motivation for change (Pence & Paymar, 1993) and intervention programs that use motivational techniques are associated with positive treatment outcomes (Kistenmacher & Weiss, 2008; Taft et al., 2001). As described earlier, ACT includes a central focus on values identification and then using those values as motivation to make adaptive behavior change. ACT has also shown success with other treatment-resistant populations (e.g., Clarke, Kingston, James, Bolderston, & Remington, 2014) and court-adjudicated populations (e.g., Hayes, Bissett, et al., 2004; Luoma, Kohlenberg, Hayes, & Fletcher, 2012).

Finally, a positive working alliance with the facilitator has been positively associated with decreased aggression after treatment for partner-violent men (e.g., Taft et al., 2003). ACT places a heavy emphasis on the therapist/facilitator maintaining a collaborative and nonjudgmental stance. Moreover, a successful ACT therapeutic alliance is supported by the therapist/facilitator's ability to be psychologically flexible; the same processes that apply to the clients apply to them as well. In fact, in one recent randomized study, ACT was shown to reduce therapists' entanglement with negative thoughts about their most difficult clients, and that in turn considerably reduced their sense of job burnout (Hayes, Wilson, et al., 2004).

Taken together, the research literature converges on the potential utility of ACT interventions for reducing perpetration of IPV. Partner aggression has multiple determinants, and the ACT model is not intended as the "final word" on partner aggression. However, the model can be flexibly applied to different forms of aggression (e.g., psychological and physical aggression) and to aggression perpetrated by people with various gender and sexual identities.

THE DEVELOPMENT OF ACHIEVING CHANGE THROUGH VALUES-BASED BEHAVIOR

Using the aforementioned research as a guide, as well as a pilot efficacy study (Zarling, Lawrence, & Marchman, 2015), a new ACT-based program for court-mandated

domestic violence offenders was developed in collaboration with the Iowa Department of Corrections called ACTV (Lawrence et al., 2014). ACTV is based heavily on ACT principles with a specific focus on feasibility and transferability to the community correctional setting. For example, ACTV can be facilitated by correctional staff and can be used with open or closed groups. ACTV was developed to fit the structure of court-adjudicated treatment, and it retains the coordinated community response (CCR) component from the Duluth model. Although the form of CCR varies across communities, the premise is that domestic violence is reduced via the close cooperation of individuals, groups, and agencies that are involved with issues surrounding domestic violence, such as the criminal justice system, law enforcement, probation officers, victim advocates, the medical community, family and children services, and so forth (see Shepard, Falk, & Elliot, 2002, for more information).

ACTV comprises 24 sessions that are intended to be held once a week for 90 minutes to 2 hours. Ideal group size is between 8 and 12 participants, but up to 15 can work. At the current time, there is not a specific assessment that needs to be completed prior to a participant beginning the ACTV program. Ideally, one male facilitator and one female facilitator will lead ACTV groups. Before being trained in ACTV, facilitators need to have education/training in domestic violence dynamics and laws. We have developed a training protocol specifically for the ACTV curriculum, which involves an initial 4-day training (led by a doctoral-level professional and experienced ACTV facilitators) and then 6 months of supervision and coaching while the trainee leads their first 24 sessions. New group facilitators are encouraged to adopt a supportive and nonjudgmental stance that promotes openness and trust within the group, and a large part of training is spent on helping the ACTV facilitator develop their own psychological flexibility. For example, several activities during the training focus on the difficult thoughts and emotions that come up when working with domestic assault offenders (e.g., “They will never change”) and practice experiencing these private reactions without believing or disbelieving them and without avoiding them. Relatedly, trainees are encouraged to connect with their own values and what is important to them about working with offenders.

THE ACHIEVING CHANGE THROUGH VALUES-BASED BEHAVIOR CURRICULUM

Overall, the ACTV program focuses on experiential learning of the ACT processes, building patterns of valued behavior, and addressing barriers to behavior change. The ACT processes are framed as skills that one can practice and learn, and these skills are practiced during group sessions. The overall goal is learning new ways to respond to cognitive and emotional experiences in a way that promotes effective, value-based living. More specifically, ACTV sessions divided into five skills-based modules (Table 1). We will describe each module in detail in the following text.

The Big Picture/Core Skills sessions are interwoven throughout the 24 weeks to provide anchoring points for new members and review for others. These sessions introduce the main concepts of the curriculum, such as values identification, being

TABLE 1. Description of Achieving Change Through Values-Based Behavior Sessions

Modules	Description
Big Picture/Core Skills (seven sessions interspersed throughout the 24 weeks)	The goal of these sessions is for participants to develop an intrinsic motivation to change by connecting with their own values. Mindfulness skills are introduced to help participants notice their own behaviors within their relationships, the multiple contributors to these behaviors, and to distinguish between behavior that is values-driven and behavior that is in service of experiential avoidance. Participants identify healthy and unhealthy relationship behaviors and evaluate their own behavior and relationships in terms of their values.
Emotion Regulation Skills (four sessions)	These sessions explore the function of emotions and invites participants to notice how they have tried to control or avoid unwanted emotions in their life and how workable or unworkable these strategies have been in terms of their values. Acceptance or willingness is introduced as a skill which involves noticing emotions as they arise and allowing them to be there without trying to alter their form or frequency.
Cognitive Skills (four sessions)	Participants learn how the mind produces many thoughts, and although we cannot control all of them, we can notice them and step back from them. The goal is to create a useful distance from problematic thoughts (i.e., defusion) to allow more mindful choices and increased behavior in service of one's values. A key principle in these sessions is that we are in control of our behavior no matter what thoughts we may have.
Behavioral Skills (five sessions)	Participants learn and practice basic communication skills such as reflective and active listening and how to communicate in an assertive and respectful way. They also learn and practice appropriate conflict resolution skills and how to set and respect boundaries. All the skills from the previous sessions (e.g., mindfulness, acceptance, defusion, values) are incorporated into role-playing and practice.
Barriers to Change (four sessions)	These sessions help participants identify potential barriers to engaging in values-based behavior (e.g., substance abuse, mood and anxiety difficulties, parenting difficulties) and offer strategies and outside resources to help overcome these barriers.

in the present moment, increasing awareness of one's behaviors, and learning how one's history and personality may influence their behavior. Values are placed front and center of the curriculum. Values work is particularly useful for this population because the participants often do not have a sense of what would make their life meaningful. Discussions and exercises centered around the question "What is most important to you?" often break new psychological ground for participants and provide lightbulb moments. A distinction is made between one's most deeply held values and "pleasantness." In other words, the focus is on what is meaningful, not what feels good.

Importantly, values identification is uncoerced. The facilitators are there to guide the participant as they choose their own values, not to tell the participants what to value. When the participants connect with their values and have expressed commitment to those values, it affords a sense of control and provides the "why" for the hard work of behavior change. For example, for participants who have been court mandated, they often state that freedom is an important value. Therefore, behavior in service of that value means actions to reduce or eliminate criminal behavior and contact with the judicial system.

Another concept introduced in the Big Picture/Core Skills sessions is the Matrix, which is a tool used to help participants identify and discriminate their experiences as sensory experiences or mental experiences, and their behavior as either in service of values (toward moves) or away from unwanted mental experiences (away moves; see Polk, Schoendorff, Webster, & Olaz, 2016, for more information about the Matrix). The Matrix is an engaging and collaborative approach used to deliver the ACT concepts simply and effectively, even when clients are resistant or unmotivated to participate. ACTV uses the Matrix as the primary method to increase the participants' engagement with the material, attention to the present moment, and awareness of the antecedents and consequences of their behavior. For example, a lot of time is spent noticing the difference between a feeling (e.g., anger) and a behavior (e.g., aggression). A key idea throughout all sessions is that we can behave independently of our thoughts and emotions.

Finally, the Big Picture/Core Skills sessions also include some educational pieces related to learning about the contributors to one's behavior and identifying healthy relationship behaviors versus abusive behaviors. One session is spent identifying the participants' beliefs about how people should behave (including gender roles), childhood experiences, personality, and stress/coping styles. This session provides the foundation for becoming aware of certain thoughts and emotions that may be problematic or troublesome as well as situations that may be particularly stressful. For example, if participants can recognize that they were reinforced for cleanliness as a child, it is often enlightening to link that to why they may feel overwhelmed or frustrated when the house is not clean. These situations can then be used as fodder for future skills-based sessions and the applications of new ways of responding.

The Emotion Regulation Skills and Cognitive Skills sessions introduce and encourage practice of the ACT processes, specifically acceptance and cognitive defusion.

Values work and the Matrix are also incorporated in these sessions to provide a thread throughout the curriculum and link everything together. Homework is offered/encouraged but not required.

The Emotion Regulation Skills sessions focus on emotional intelligence and learning new ways to respond to emotions; for example, helping the participants recognize the effects of trying to avoid or control their emotions and how those control efforts have impacted their values, especially their relationships. Participants are given opportunities to practice letting go of the struggle with their emotions and learn how to be open and accepting of their emotional experiences. Facilitators take the stance that it is helpful to think of emotions as sources of information, not right or wrong, and that one's *behavior* when feeling an emotion is either workable (consistent with their values) or unworkable (inconsistent with their values).

The Cognitive Skills sessions focus on psychoeducation about thoughts (e.g., the mind works by addition not subtraction), identification of thoughts that are troublesome or problematic for participants, and then learning to step back and gain some distance from those thoughts. For example, exercises in these sessions are aimed at decreasing the behavioral impact of thoughts by interacting with them in different ways (e.g., writing thoughts down, saying thoughts over and over, making pictures of them, writing them on balloons, etc.). Finally, these sessions also encourage the participants to put behavioral change in action, both in and out of session, and focus on working with internal obstacles as they come up when making those changes. Exercises during session are specifically designed to evoke difficult thoughts or feelings so they can be worked with in the moment and the participants can apply their new skills.

The Behavioral Skills sessions focus on practicing behaviors related to interpersonal relationships, such as speaking and listening effectively, resolving conflict, and interpersonal boundaries. These sessions are part education (e.g., the differences among assertive vs. passive vs. aggressive communication) and part practice. Each session has dedicated time to put the skill into action with other group members. Of note, the ACT processes learned during previous sessions (e.g., present moment awareness, acceptance, defusion, and values) are incorporated into the Behavioral Skills, and content is related back to those processes. For example, when engaging in role plays and practicing communication skills, the focus is also on being able to effectively manage emotional responses during those conversations. We have found that interpersonal conflict for participants is often a result of dysregulated emotions, just as much as from communication skill deficits.

Finally, the Barriers to Change sessions address environmental or life circumstances that can hinder successful behavior change like substance abuse, parenting difficulties, and unemployment. For example, during the parenting sessions, the participants connect with their parenting values and identify the thoughts and feelings that often serve as barriers to effective parenting. A focus is then on using acceptance and mindfulness skills to support behavior change in service of their parenting values. Similarly, during the communication skills sessions, effective speaking and listening skills are practiced, with a particular eye toward what serves as barriers to

implementing those skills when needed with their partners. Oftentimes, this leads right back to using mindfulness or acceptance skills. In other words, these sessions can be thought of as providing particular content areas in which to apply the ACT skills.

HOW DOES ACHIEVING CHANGE THROUGH VALUES-BASED BEHAVIOR DIFFER FROM OTHER TREATMENT MODELS OR PROGRAMS?

ACTV is an evidence-based program that builds on the foundation set by previous BIPs like the Duluth model and CBT programming. Rather than a completely new program, ACTV is an extension of previous BIPs in that it retains components that have shown success, while adding other components in an attempt to address some of the limitations of previous programs. ACTV represents an intellectual and practical evolution of the BIP, and we anticipate that it will change and evolve based on continued implementation and research. We attempt to outline in the following text how the ACTV program is unique in theory, philosophy, and implementation; however, empirical data are needed to conduct rigorous comparisons of ACTV and other programming to investigate if any of these programmatic differences account for different outcomes. It is hoped that this will be an ongoing task in the field in the years ahead.

First, ACTV differs from other programs in the conceptualization of the causes of partner-aggressive behavior. In contrast to assumptions that aggression is an attempt to assert power over women (implicit in the Duluth model) or the result of angry thoughts and feelings (implicit in the CBT model), the ACT model of aggression is based on the premise that aggression has many possible causes and can only be fully understood “in context.” By design, ACTV facilitators do not make a priori assumptions about the causes of any one person’s violent behavior but rather encourage the offenders notice and identify the antecedents and consequences of their own behavior while using their experiences as fodder for group discussion and skills training. This is consistent with the substantial evidence showing that men who engage in partner aggression represent a heterogeneous group, and, in turn, there is very little evidence to justify the practice of mandating all perpetrators to interventions assuming power and control issues are the cause of violence (e.g., Cantos & O’Leary, 2014).

The ACTV skills not only focus on decreasing experiential avoidance and cognitive fusion to enact behavior change but also recognize other contributors to one’s behavior such as childhood trauma and stress. Importantly, ACTV does so in a way that does not condone violent behavior or minimize responsibility for it; rather, the ACTV philosophy is that by increasing awareness of what contributes to one’s behavior, one has greater ability to notice and change it. The ACT model has a core contention that people need not cede control of their behavior to their thoughts and feelings. Thus, ACTV takes the stance that people always have the ability to control one’s behavior regardless of past experiences, beliefs, thoughts, or emotions one may have. However, ACTV acknowledges it may be difficult to change one’s behavior when experiencing difficult thoughts and feelings and therefore includes skills training

related to acceptance and defusion. Thus, ACTV takes a different perspective on accountability than other programs.

Second, as mentioned earlier, ACTV focuses on changing participants' *relationship* with and *responses* to their thoughts and emotions, rather than their form or frequency. Other CBT programs and ACTV are similar in focusing on awareness of thoughts and "self-talk," but ACTV is different in that it does not teach or encourage challenging them or replacing them with messages that are more objective and calming. ACTV provides a series of innovative techniques for facilitating change that do not involve challenging thoughts or correcting cognitive distortions. For example, instead of changing maladaptive thoughts and emotional patterns through cognitive reappraisal or self-talk methods, ACTV aims to alter their function, how they are experienced, or how they influence other behavior. As described earlier, ACTV does this primarily through teaching present moment awareness, acceptance, and defusion.

Third, ACTV is an experiential program. The focus is more on the participants practicing and learning the skills "in vivo" and less on lecture or advice giving. ACTV facilitators do not tell participants what to think or engage in active problem solving related to changing difficult thoughts and feelings or discerning the absolute truth of what is right or wrong. For example, the ACTV facilitator encourages noticing and "sitting with" one's emotional and cognitive experiences, particularly when those thoughts or emotions show up in the moment during group sessions. This is tied explicitly to values and what works for that individual person. Actively working through skills and information, rather than merely receiving teaching, allows participants to find salience with their own lives and experiences.

Fourth, ACTV places the identification of participants' personal values front and center. All ACTV sessions incorporate values, and any skills training is done with one's personal values as the motivator for behavior change. Other CBT programs may seek to effect changes similar to the ACT conceptualization of values, but interventions do not typically conceptualize such changes as linked to personal values and do not target such changes as mediators of change or as outcomes (Plumb, Stewart, Dahl, & Lundgren, 2009). ACT overlaps with some principles of motivational interviewing (MI; Miller & Rollnick, 2012), and both approaches share a focus on values. However, the two approaches differ in their definition of values. ACTV also departs philosophically from MI in that ACTV does not view attitude change as a fundamental driver of behavior change (for additional comparison of ACT and MI, see Bricker & Tollison, 2011).

Finally, the posture of the ACTV facilitator is collaborative and nonjudgmental. Although it is not unique to ACT to focus on a strong therapeutic relationship, ACT is different in that the facilitators are not only supportive and empathetic; they strive to be psychologically present, open, and effective. In fact, ACTV facilitators are encouraged to embody and model the ACT processes and to demonstrate psychologically flexible behavior. The ACTV facilitator is "in the same boat" as the participants and

does not make assumptions about what is right or wrong for a particular person, instead focusing on what works in terms of their values.

OUTCOME DATA

As mentioned earlier, a recent study examined an ACT-based group program in a clinical sample of adults who had recently engaged in aggression (Zarling et al., 2015). In this study, 101 participants were randomly assigned to either a 12-week ACT treatment group or a 12-week control group. The control group used a support and discussion format with no direct instruction or practice of behavioral change. Results showed that the participants in the ACT group had significantly greater declines in both physical and psychological aggression 6 months posttreatment. Moreover, the treatment improvements were mediated by reductions in both experiential avoidance and emotion regulation (Zarling et al., 2015). However, this experimental examination of the ACT protocol was done in a relatively controlled environment with individuals not involved in the criminal justice system. ACTV represents the translation of this protocol to the correctional setting and the offender population.

One study has examined the effectiveness of ACTV in the community corrections setting (Zarling, Bannon, & Berta, 2016). The purpose of this quasi-experimental study was to examine the impact of ACTV on reducing new criminal charges 1 year postintervention compared to the traditional program, which was a combination of the Duluth model and CBT. Administrative data were collected from a sample of 3,474 men who were arrested for domestic assault and court mandated to treatment (either ACTV or Duluth/CBT) from 2011 to 2013. Data included any new charges incurred in the 1-year postintervention period. Comparing recidivism rates between ACTV and Duluth/CBT for the entire sample (including men who dropped out), ACTV participants had *one-third* the rate of domestic assault and violent charges during the 1-year postintervention. When examining only treatment completers (i.e., men who completed all 24 sessions and requirements of both programs), ACTV participants had *one-half* the rate of domestic assault and violent charges. Although this study is preliminary, the results are surprisingly positive given the general marginal impact of BIPs in reducing domestic assault recidivism (e.g., Babcock et al., 2004).

FUTURE DIRECTIONS

ACTV needs to be evaluated in rigorous studies. Larger, randomized trials with longer follow-up intervals will be essential to expand on our preliminary results. Studies that include potential mediating (e.g., experiential avoidance) and moderating (e.g., race) variables are also needed. Finally, evaluation of ACTV must also consider the influence of system components on outcomes. For example, we do not know the effectiveness of ACTV alone compared to ACTV with supervision/probation and additional referrals to services needed.

Another area of future study is the training needed to facilitate ACTV. It will be important to systematically examine different training methods and to continually adjust to the context of the correctional setting. Although ACTV was specifically developed so that facilitators without a mental health background could facilitate it effectively, one particular question will be if different or additional training could be provided for facilitators who do not have a mental health background and see if that improves outcomes.

In the state of Iowa, ACTV is currently being used with both male and female domestic violence offenders in community corrections. It is also being used with male domestic violence offenders in the jails and prisons. Data collection is ongoing, and results will be available in 1–2 years. Finally, ACTV is currently being adapted to use with general high-risk offenders as well as sex offenders.

ACHIEVING CHANGE THROUGH VALUES-BASED BEHAVIOR CASE STUDY

History and Presenting Issues

Ed is in his late 30s and lives in a suburb of a Midwestern city. He currently lives in an apartment with his girlfriend, Sue. He works outdoors as a manual laborer and has one biological son by a past girlfriend. Ed's son is a teenager, and Ed has custody of him half-time. Sue's two young children from a previous relationship also live with them half-time. Ed and Sue have been together for several years. Ed reported that the only other significant romantic relationship he has had was with his son's mother and that he currently has a relatively peaceful co-parenting relationship with her.

Ed was raised primarily by his mother. His father left the family when Ed was 2 years old. Ed's father was in the military, and he moved around frequently. After his parents separated, his father was largely absent from his life. He reported a lot of inconsistency and instability in his childhood and a lack of parental support and love. Ed was hesitant to discuss his parents and reported that his childhood is a source of pain for him.

Ed's relationship with his girlfriend was turbulent at the start of treatment. Ed and Sue fought frequently, and he often resorted to yelling and throwing things. He described that their relationship lacked intimacy and they lived more like roommates. His son inquired about his emotional state during this time and had suggested that Ed might be depressed. Ed often drank alcohol to numb his feelings.

Ed indicated that money is a hot-button topic for him and Sue. Ed works 40+ hours per week, and Sue is unemployed. However, Sue was in charge of their finances, and she often objected to Ed's financial decisions. For example, Ed reported that Sue criticizes him for purchases that he believes they should be able to afford, such as pizza and beer. Ed has difficulty understanding her perspective because he has a well-paying job and he would like more freedom with how to spend his money. Last year, during an argument over money, they both became very upset. Sue did not agree with Ed purchasing a meal for him and his son, and they began to argue. According to Ed, Sue

bit him and then he pushed her. Ed was the one to call the police, not expecting that they would arrest him. Ed was charged with domestic assault. Subsequently, Ed was court ordered to complete ACTV.

Course of Treatment

Ed joined a group of 10 other men who were at various stages of the ACTV program. Ed described himself as nervous when he first attended group, and one of the ACTV facilitators described him as resistant, appearing shut down with his arms crossed over his chest. Ed eventually started to look forward to the open and respectful atmosphere. He felt a connection with the other members of group, realizing that he was not alone in his struggles. Ed found the facilitators engaging and indicated that the male facilitator was funny and personable and the female facilitator was a great teacher. “They work perfect together,” he said. Observing their healthy and respectful co-facilitator relationship helped him to recognize the problems in his own relationship. Ed started to open up after a few weeks when he began to realize that ACTV was improving his life.

Ed’s first session was one of the Big Picture sessions. The session is designed to encourage offenders to think about the influences on their behavior, including beliefs about gender roles, impactful childhood experiences, personality, and coping skills. Ed learned from the discussion and exercises in this session that he is an emotional person. This surprised him and primed him to notice his emotional reactions to certain situations in his relationship with Sue. The first few sessions also helped Ed to clarify his values. Ed cares deeply about his son, who is successful academically and a source of support and love in Ed’s life. Ed also noted that his work is important to him because it provides stability and purpose in his life. Ed struggled with his values as they relate to other relationships in his life. He recognized that his childhood experiences have made it difficult for him to identify what is workable for him in family relationships as well as his romantic relationships. However, he was able to connect with *qualities* of behavior that are important to him, such as being honest and respectful. He noted that ACTV taught him that he can always behave according to his values, even if others are not behaving how he would like. Ed resonated with this idea and found it helpful to identify what he can control versus things outside his control.

In the next sessions, the facilitators presented the Matrix, and Ed reported that this tool helped him notice the thoughts and emotions that were difficult for him. He said that he became aware of when his anger starts to get intense as well as the thoughts that tended to make it worse (“I shouldn’t be treated this way”). Applying the Matrix to his behaviors helped him recognize that he often moves away from his sadness and anger by “stewing” and going over and over things in his mind. He identified drinking alcohol as another way that he moves away from uncomfortable emotions. Finally, he recognized that verbal and physical aggression was another common way that he attempted to avoid the unwanted feeling of being out of control

or perceiving he was being disrespected. Upon examination of how these strategies play out in his life, he was able to recognize that these behaviors were not helpful and usually make things worse. Practicing with the Matrix has helped Ed to take a moment just to notice and be mindful of his emotions, which allows him some space to make more purposeful behavior choices (instead of automatically moving away from his experiences).

In the Healthy Relationships session, Ed learned that although every relationship looks different, there are certain behaviors that occur in healthy relationships (e.g., support, trust, respect) versus behaviors that do not (e.g., control, manipulation, violence). He had a chance to evaluate the health of his own relationship. He realized that he and Sue were actually very much alike, which often led to mutually escalating cycles of tension and aggression. At this point, Ed began to question if the way his current relationship was going was workable for him (or Sue). Ed volunteered to explain his situation during this session, with the facilitators using the Matrix. Ed learned through this exercise that most of his behaviors with Sue were away moves (behaviors in the service of avoiding unwanted feelings) and that he engaged in very few toward moves (behaviors in the service of his values). This session gave him ideas about specific toward moves he could engage in, such as helping Sue make dinner or listening to her talk about her day.

In the Emotion Skills sessions, Ed learned that his emotions could provide him with information but that they do not have to control his actions. Learning about the distinction between feelings and actions was helpful for him (i.e., *feeling* angry is different from *acting* out of anger). He said it was almost relieving to know that his anger and sadness were not signs of weakness or "right or wrong," they were just what he was feeling. Metaphors and experiential exercises were used to facilitate the concept of being accepting toward one's emotions and being willing to experience them in service of values-consistent behavior. Ed reported that he has slowly developed a more accepting perspective toward his emotions and has even begun to appreciate his emotions. For example, he now sees more meaning to his sadness, in that he realizes that it is stemming from a lack of love and intimacy in his life. He also noticed that when attempting to make toward moves in his relationship with Sue, he felt vulnerable, which made him uncomfortable. When Ed explained this during group, the facilitator posed the question, "Are you willing to feel vulnerable, if it means building a loving relationship with Sue?" This was something that Ed had to think about for a while.

In the Cognitive Skills sessions, Ed recognized certain thoughts that seemed to pop up frequently when he feels sad and angry. He noted that "I am a failure" and "I can't stand feeling this way" were thoughts that hooked him. When he got hooked by them, he would often try to push those thoughts away and/or behave impulsively. ACTV helped him see how these thoughts were automatic "chatter" from his mind and not statements of fact. He also learned through experiential exercises that attempting to avoid or change his thoughts actually made them more prominent. Through work during group sessions, Ed began to gain some distance

from these thoughts by interacting with them in different ways (e.g., writing them on cards and creating art with them) and practicing engaging in other behaviors when those thoughts came up (e.g., mindfully noticing the thoughts). He also repeated his most troubling thought "I am a failure" over and over again in a funny voice. Ed reported that he felt silly when doing this, but afterward, he noticed that the thought had so much less power over him. Then, when he was at home, he practiced translating those skills by taking a time-out or talking to his son when he had those thoughts.

The Behavioral Skills sessions helped Ed practice being assertive. Ed often let his anger and sadness build up to the point that he would then explode and then he was unable to use effective communication. Now that he had learned ways to more effectively respond to his emotions and thoughts, the communication practice focused on how he can effectively talk and problem solve with Sue. For example, Ed often feels sad because they do not spend time together and have lost their connection. Assertiveness practice involved Ed putting this into words in a constructive way. Then, conflict resolution practice involved how to reach an agreement to solve the problem. In Ed and Sue's case, it was a matter of reaching a compromise that they were both happy with (i.e., watching a movie together on Saturday evenings after the kids went to bed). Ed also had an epiphany during the Interpersonal Boundaries session when he realized that his behavior of allowing Sue to have unfettered access to his bank account was not working because it was a trigger for most of their arguments. This session allowed him to brainstorm possible solutions to setting new boundaries in this area (e.g., changing it so she does not receive e-mail notifications when he makes a purchase) and how to communicate those new financial boundaries with Sue effectively.

The Barriers to Change sessions that had the most impact on Ed were the parenting sessions. He noted that he has more insight into how arguments, including physical aggression, impact children in the home. Ed has noticed that Sue's children are often disrespectful to her, and he realized that they are likely modelling Ed's behavior toward their mother. This insight contributed to Ed's motivation to give Sue positive attention and treat her respectfully. For example, he has been making an effort to ask her about her day and provide support when she's had a difficult day. He also has learned ideas to parent more effectively and improve his relationship with his son. For example, Ed noticed that he was treating his son almost more like his friend than his child. Although Ed's son is a teenager, he still needs structure and guidance from his father, such as having a curfew and helping with household chores. Finally, the session on mood and stress helped Ed recognize that a lot of the emotions he experiences have been a lifelong struggle with anxiety and depression. Before ACTV, Ed tended to think only his anger was a problem and to connect it only with arguments with Sue. However, he is now more aware of the bigger picture of his emotional health, which impacts his functioning in all areas of his life. The facilitators provided Ed with local resources and references so he could continue to address these issues with a mental health professional.

Outcome

Ed reported that the most important thing he learned from ACTV was the ability to act in a way consistent with his values even when experiencing difficult thoughts and emotions. For example, when he does disagree with Sue, instead of responding to his anger by yelling and throwing things, he now takes a moment to notice and step back from the immediate urges to respond. He is able to "surf the wave," as he puts it, and either take a time-out or engage in effective communication in the moment. These new strategies have been very effective for Ed, and he noted that arguments with Sue are much less frequent. He also reported that he drinks less alcohol because he does not turn to drinking as a coping mechanism anymore. It seemed the key for Ed was the combination of noticing his feelings and thoughts and accepting them for what they are (instead of avoiding them) combined with identifying values-consistent alternative behaviors. Overall, Ed has significantly decreased the amount of time and effort he spends on avoiding or controlling uncomfortable experiences (e.g., sadness and anger) and instead now spends more time and effort on behaviors that are important and meaningful.

At the end of his treatment, Ed was enthusiastic about ACTV's influence in his life. He had more insight into his own emotional state and had more effective and healthy ways of managing his emotions. Ed is now able to devote more of his time and energy to parenting, which he has realized gives him great satisfaction. Although Ed's relationship with Sue still has problems, his experience in group helped him recognize what behaviors characterize a respectful, caring relationship and clarified his values regarding the kind of partner he wants to be and the relationships he wants to be in. He also noted that the facilitators provided an accepting environment that allowed him to be himself and motivated him to change, which he felt was a big part of his success. Ed even recommended that ACTV be a requirement before getting married. One of the facilitators who led Ed's group said that he thought Ed was leaving group with more direction and a better idea of what he wanted.

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