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The dialectical psychoeducational workshop (DPEW) for males at risk for intimate partner violence: a pilot randomized controlled trial

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Abstract Data are presented from a pilot study that tested the initial effectiveness of the Dialectical Psychoeducational Workshop (DPEW) in reducing the potential risk for intimate partner violence (IPV). A randomized controlled trial (RCT) of an experimental intervention (DPEW), and a control condition, the first session of an eight-week anger management program (AMW), was employed. Differences between experimental and control groups were analyzed by chi-square and *t* tests. Self-report questionnaires were administered pre- and post-test to 55 study participants. The questionnaire was comprised of standardized measures and highly-structured questions. Quantitative analyses provided strong preliminary support for the DPEW's effectiveness in lowering a participant's desire to express anger physically, while decreasing the potential risk for physical violence. This pilot study demonstrated promising initial support for the DPEW as an alternative, preventative intervention for males at risk for intimate partner violence. Its strong preliminary results provide evidence for a larger RCT. The study's results are limited by a reliance on self-report measures, the brevity of the intervention, and a small sample size.

Keywords Intimate partner violence · Prevention · Randomized controlled trial

Intimate partner violence (IPV) is a significant personal, social, legal, and public health problem in the United States. According to the National Crime Victimization Survey (NCVS), from 1993 to 2005, the average annual domestic violence rate per 1,000 individuals (age 12 or older) for intimate partners was 5.9 for females and 2.1 for males (Catalano et al. 2007). In 2005, 1,181 females and 329 males were killed

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by their intimate partners (Klein 2009). Given the significant impact of IPV, an exploration of innovative, preventative approaches is necessary in order to combat its serious effects.

IPV research has traditionally focused on reactive, secondary intervention programs that are inconsistent as to their quality and effectiveness (Archer 2000; Babcock et al. 2004; Feder and Wilson 2005; Stith et al. 2004). Despite the gravity of the consequences of IPV, there are few, if any, targeted, primary, preventative strategies developed for individuals at potential risk for IPV. The consequences of the IPV field's continued reliance on interventions as they are currently constructed largely leaves the door open for the continuing occurrences of physical assaults to IPV victims and their children. In order to alter current trends in the prevalence and incidence of IPV, it would be advantageous for the field of IPV to begin to incorporate the extensive theory and research from related areas that has demonstrated effectiveness in preventing acts of physical violence.

Current IPV treatment programs are primarily structured for men who have already engaged in violent behavior toward their intimate partner and thus do not necessarily include those who may exhibit early signs of at-risk, violent behaviors. Incorporating a public health prevention model of treatment programs for those individuals who demonstrate early signs of potentially violent behavior may provide an alternative, pro-active approach to current reactive violence treatment programs. There is a need in the field of IPV for alternate theoretical and empirical frameworks that may assist in the development of targeted preventative programs that may deter the later onset of violence between intimate partners. The Dialectical Psychoeducational Workshop (DPEW) is an initial attempt to provide a theoretically-grounded, brief preventative intervention that may lessen the likelihood of violence between intimate partners. This paper will present the preliminary results of a pilot randomized controlled trial whose aim was to explore the initial effectiveness of the two hour DPEW, as compared to the two-hour, first session of an eight-week anger management program (AMW), in increasing anger management skills, increasing the participant's ability to feel and express empathy, increasing coping skills, and lessening the potential risk for expressions of physical violence.

A dialectical behavioral approach to IPV prevention: conceptual framework for the DPEW

Dialectical Behavior Therapy (DBT) is a theory-driven intervention that has demonstrated effectiveness in the treatment of individuals with borderline personality disorder (BPD), who share many of the characteristics inherent in males at risk for IPV (Fruzzetti and Levensky 2000; Holtzworth-Munroe 2000; Holtzworth-Munroe and Stuart 1994; Koons et al. 2001; Linehan et al. 1991, 1993; Lynch et al. 2006; Robins and Chapman 2004; Waltz 2002). Dialectical Behavior Therapy maintains that past and current invalidating environments, and as yet unknown genetic factors, cause some individuals to react dysfunctionally to intense emotional experiences (Linehan 1993; Linehan et al. 1991, 1993). The inability to regulate their emotions causes such individuals to feel out-of-control, resulting in utilizing more drastic means to cope, such as self-harm, substance abuse, and/or violent

behaviors (Fruzzetti and Levensky 2000; Linehan 1993; Linehan and Schmidt 1995; Lynch et al. 2006; Scheel 2000; Waltz 2002).

DBT employs a multimodal approach utilizing a variety of strategies, including client-centered therapy, gestalt, systems theory, as well as Eastern and Zen psychologies. The result of this conceptual amalgamation is a cognitive/behavioral-based approach that focuses on awareness of self and others, emotion regulation, validation, and empathy-building. A key difference from current approaches to individuals who exhibit violent behaviors is the validation of the client's emotions and experiences within a supportive, collaborative, therapeutic environment that offers client-centered strategies for positive change (Linehan and Kehrer 1993). Fruzzetti and Levensky (2000) affirm the effectiveness of DBT's mindfulness of the whole client, from a non-judgmental perspective, with the recognition that all elements of an individual's reality, experiences, and environment are interrelated. Linehan (1993) proposes four basic components that are essential to the process of acceptance and change in DBT: (1) mindfulness skills training—to enhance awareness of one's emotions and behaviors; (2) emotion regulation skills training—to reduce vulnerability to emotions and facilitate appropriate, adaptive responses; (3) acceptance strategies—validating the individual's emotions and behaviors as authentic, while encouraging adaptive change; and (4) exposure-based procedures—to address dysfunctional responses to intense, negative emotions. Affective instability, aroused by perceived hurts, injustices, and/or abandonment, is a key characteristic inherent within vulnerable populations who may be at risk for harmful and destructive behaviors.

Several studies suggest that potentially domestically violent males experience higher levels of anger in response to conflict than do non-violent males (Hamberger and Hastings 1991; Holtzworth-Munroe and Smutzler 1996). Holtzworth-Munroe and Anglin (1991) found that these types of men may be less able to regulate their intense, negative emotions. These emotionally volatile responses interfere with the individual's ability to seek viable, alternative solutions to conflict, which may lead to violent situations. Understanding, awareness, and acceptance of emotions are important components of Dialectical Behavior Therapy. Acquiring anger management skills is a significant step toward an individual's ability to cope with emotions that may seem uncontrollable and thus may more likely lead to potentially violent behavior.

Validation of an individual's experience and emotions provides the structure through which increased empathy may be attained. According to Linehan (1993, 1994), validation is confirming the individual's unique experience as valid and real. Validation permits individuals to trust their own feelings, and helps them to gain a better understanding of normative responses (Waltz 2002). Fruzzetti and Levensky (2000) suggest that validation skills help reduce the intra/interpersonal chaos that aggressive and potentially violent individuals often experience. Through validating their feelings and experiences, individuals who have difficulty managing their emotions begin to trust themselves and others, and can begin to form healthier relationships. Modeling empathic responses through validation provides an opportunity for individuals who may never have experienced normative emotional responses to witness the significant role of empathy in healthy relationships.

The pilot study presented here was designed to explore and test the preliminary effectiveness of the Dialectical Psychoeducational Workshop (DPEW) as an alternate

preventative approach to males at potential risk for IPV (Cavanaugh et al. 2011). The DPEW is an initial attempt to craft a brief, psychoeducational and behavioral strategy that may lessen the potential risk of intimate partner violence (IPV). Despite its apparent applicability to a subset of individuals who may potentially act violently towards their intimate partners, DBT has not been utilized as a preventative intervention strategy within the field of intimate partner violence. The pilot study tested outcomes comparing the DPEW with the initial session of an anger management program (i.e., AMW) for individuals with anger issues that may potentially lead to intimate partner violence.

The following hypotheses were tested in the pilot study: (1) individuals who participate in the DPEW will have a greater increase in their awareness of the importance of managing feelings and expressions of anger, a greater increase in their awareness of the importance of feeling and expressing empathy toward an intimate partner, and a greater increase in their awareness of adaptive coping strategies in dealing with angry feelings than participants in the AMW; and (2) individuals who participate in the DPEW will have a greater decrease in the potential risk for expressions of physical violence toward an intimate partner than participants in the AMW.

Methods

Setting, recruitment, and eligibility criteria

Subjects were recruited among attendees of a local anger management program. The men who initially presented to the program were self-referred and in search of assistance in addressing anger issues that were interfering with their personal, social, and/or occupational functioning. Anger management clients received prior notification that a research study would be taking place at the first meeting, and if they did not want to attend they could go to another meeting at a different time and location. Male participants were approached by the researcher and asked if they would like to participate in a small, exploratory research study for which they would be compensated. The purpose of the pilot study was explained carefully to the anger management attendees. If an individual expressed an interest in participating in the pilot study, he was asked to fill-out a nine-item questionnaire that assessed his eligibility for the research study.[1]

Participants were eligible for the pilot study if they met the following eligibility criteria: (1) were males 18 years of age and over, (2) reported never engaging in any prior acts of intimate partner violence, (3) had a positive response to at least one of the screening questions that asked questions such as, “If I had the opportunity, there are some people I definitely would hurt physically,” and (4) voluntarily consented to complete a self-report questionnaire and to participate in an educational workshop. If individuals met the study eligibility criteria, and agreed to sign an informed consent

[1] Requests pertaining to the complete DPEW measures and full curriculum may be made to: Mary M. Cavanaugh, PhD, at mary.cavanaugh@hunter.cuny.edu

to participate in the study, they were asked to complete the study intake form. The intake form, with identifiable information, was kept separate from the responses for study eligibility, and was linked with outcome data by a coded number. The necessary institutional human subject approvals were obtained before the initiation of the research study.

Sample size

The pilot study sample consisted of males, 18 years of age and older, of diverse race and ethnic groups. The focus was on males who were at risk for IPV. Fifty-eight men were recruited into the study. After initially agreeing to participate, three men decided (for personal reasons) to withdraw. A power analysis was conducted under the assumption that the effect size of a low-dose intervention was likely to be small to moderate. Power calculations were based on a moderate effect size, that is, 0.5 (Cohen 1992). With a final sample size of 55 (DPEW=28; AMW=27), the study had power of 50% to detect a statistically significant result. The study participants were randomly assigned to one of the two conditions (see "Randomization procedure"). As a small pilot study, with limited funding, it was not possible to develop a sample size large enough for high statistical power with a moderate effect size (see Consort flow diagram; Fig. 1).[2]

Randomization procedure

At the initial session of the original Anger Management Program, and after informed consent was obtained, study participants were randomly assigned to either the experimental (i.e., DPEW) or the control condition (i.e., the first session of the Anger Management Program). The control is referred to as the AMW. When the completed forms were returned, participants were given their intervention assignment. Randomization was blocked so that assignment to the intervention and control conditions was equalized after every fourth assignment. Assignment to condition was made by using random allocation software and then pre-set envelopes (Snow 2006). To motivate attendees of the anger management program to participate in the pilot study, they were offered compensation of a $10 gift card. Before being compensated, respondents were required to complete and return to the researcher the self-report baseline and termination questionnaires.

Data collection

Each study participant completed a self-report questionnaire at baseline and at the termination of the workshops. The questionnaire was comprised primarily of standardized measures and highly-structured questions. The completion of the questionnaire took approximately 20 minutes and occurred just prior to the beginning of the workshops and immediately at the end of the workshops.

[2] Three respondents' questionnaires ultimately could not be used as they were either missing a pre- or post-test questionnaire.

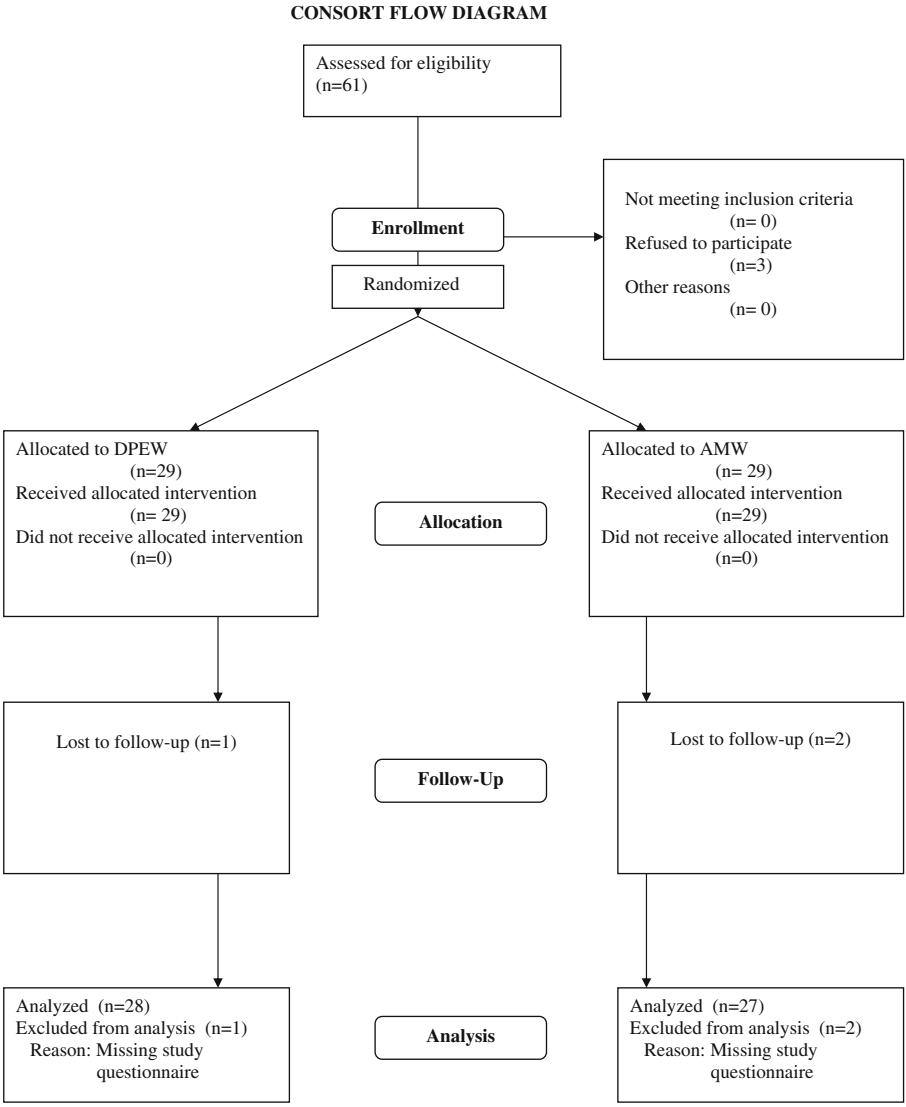

Fig. 1 Consort flow diagram

Measures

Demographic characteristics

Information was obtained regarding each participant's age, race, educational attainment, income, and marital and employment status.

Substance use/abuse

The Michigan Alcoholism Screening Test (MAST) is a widely-used measure for assessing alcohol abuse. The 25-item questionnaire was designed to provide a rapid

and effective screening for lifetime alcohol-related problems and alcoholism. Coefficient alphas vary from .83 to .95. The MAST can be reliably used as a self-report questionnaire (Selzer et al. 1975). A total score of 0–53 is possible; a score of 5 or higher is suggestive of alcoholism. The Drug Abuse Screening Test (DAST) is a 20-item questionnaire that is similarly constructed to the MAST with a "yes–no" format. It had an internal consistency coefficient of .92 among a sample of 256 drug/alcohol clients. A total score of 0–20 is possible; a score of 6 or higher indicates the presence of drug problems (Gavin et al. 1989).

Social desirability

To offset the possibility that study participants may have presented themselves in a more favorable light with regard to potentially violent behaviors, the Marlow-Crowne Social Desirability Scale (MC-2; Strahan and Gerbasi 1972) was utilized. Subjects were required to rate each item as either true or false. The MC-2 has reported reliability coefficients that range from .73 to .83 (Strahan and Gerbasi 1972). A total score of 0–10 is possible; the higher the score, the higher the likelihood for socially-desirable responding.

Anger management skills

The State-Trait Anger Expression Inventory (STAXI; Spielberger et al. 1983) is a 57-item inventory that measures state anger (the intensity of feelings of anger) and trait anger (the disposition to see a range of situations as annoying and/or frustrating and the tendency to respond with varying intensities of state anger). The STAXI measures anger expression and control, as to whether anger is directed toward self or others, and the mechanisms for controlling anger. The coefficient alpha for the STAXI ranges from .84 to .93; Trait-Temperament from .84 to .89, and Anger Expression Scales from .73 to .85 (Spielberger et al. 1983). The higher the score on the STAXI, the higher the likelihood of a respondent having difficulties with anger expression and control.

Empathy

The Balanced Emotional Empathy Scale (BEES; Mehrabian 1996) is a 30-item scale that measures the vicarious experiences of others' feelings. Items on the BEES are answered using a 9-point response format, from −4 for very strong disagreement to +4 for very strong agreement. The BEES has been factor analyzed and determined to be uni-dimensional (Mehrabian 1996). The scale has good reported reliability, alpha coefficient of .87. A higher score on the BEES indicates greater empathy in the respondent.

Coping skills

The Ways of Coping Questionnaire (WCQ) was designed to measure the thoughts and actions individuals use to handle stressful feelings and encounters (Folkman and Lazarus 1988). The WCQ is considered to be the standard in the field for coping

measurement. It consists of eight subscales each measuring a different type of coping skill. For the purposes of this pilot study, the seven item "Self-Controlling" sub-scale was utilized. It has good internal consistency with an alpha =.86. A higher score indicates greater coping skills in the respondent.

Potential for risk physical violence

The Risk of Eruptive Violence Scale (REV) was constructed to identify individuals who may appear to be non-violent but who may erupt into sudden and unexpected episodes of violent behavior (Mehrabian 1997). The alpha internal consistency of this 35-item scale is .98. The REV is reported to have high convergent validity when assessing a history of actual violence. It has good convergent validity with other measures of violence and aggression (Mehrabian 1997).[3] A higher score on the REV indicates a greater risk for sudden and unexpected violence.

Evaluative feedback

A month after the pilot study was completed, a questionnaire was administered to a group of DPEW participants to assess the initial utility and acceptability of the DPEW in achieving its desired goals. Due to high attrition in the original anger management program (from which the pilot study's participants were recruited), the questionnaire, with 12 open-ended questions, was administered to 10 DPEW participants, who were still in attendance.

Treatment conditions

Experimental intervention: the dialectical psychoeducational workshop (DPEW)

The Dialectical Psychoeducational Workshop (DPEW; Cavanaugh 2007; Cavanaugh et al. 2011) was adapted from the work of Linehan (1993, 1994). One of the primary foci of the DPEW was to provide a respectful, collaborative, supportive, interactional, experiential, and educational intervention within which to work with males at potential risk for intimate partner violence. In concert with the duration of the standard anger management program's sessions, the DPEW's length was two hours. The decision for a brief intervention was also based on empirical evidence regarding the high attrition that exists across anger and violence treatment programs nationally (Babcock et al. 2004; Gondolf 2002) and a need for abbreviated programs aimed at prevention and/or treatment of anger and/or violent behaviors for retention purposes alone.

The DPEW was both didactic and experiential. It was facilitated by a mental health practitioner, with a Master's degree in Marriage and Family Therapy, who had advanced training in both Dialectical Behavior Therapy (DBT) and in working

[3] If during the course of the study, the researchers were to become aware of a participant's threat of or use of violence, he would have been given an immediate referral for appropriate services and, where necessary, the proper legal authorities would have been notified.

within a group format. Twenty-eight men were randomly assigned to the DPEW. At the start of the DPEW, the researcher provided a brief background for the pilot study and for the purpose of the DPEW (Cavanaugh et al. 2011). Utilizing highly-interactive hand-outs[4] throughout the intervention, the primary topics targeted by the DPEW were: (1) an orientation to the rationale and principles that underlie DBT and the DPEW; (2) *Picking a Target Behavior: Chain Analysis* where participants chose one behavior they would like to change in their relationships with their partners; they were asked to consider the last time that they demonstrated that behavior and the chain of events (including external events, feelings, thoughts, and sensations) that led up to engaging in those particular behaviors toward their partners; (3) *Mindfulness Practice* where participants practiced observing and describing what they are experiencing, in the moment and without casting judgment; participants practiced gaining awareness of physical, behavioral, cognitive, and emotional cues that may lead to angry emotions and feelings; (4) *Validation Skills* were examined so that participants gained insight into what is understandable about one's own feelings *and* one's partner's feelings in response to a given situation; role play enabled participants to practice focusing on what feelings their partners may be communicating, reflecting back those feelings, and then validating their partners' feelings; (5) *Emotion Regulation Skills* were explored to assist participants in replacing anger-triggering thoughts about one's partner with thoughts to self-soothe and to empathize with one's partner; and (6) participants were given an opportunity to state the most valuable lesson(s) learned in the DPEW, skills that they recognize they most need to practice, and asked to provide one step to which they were ready to commit.

Control: the anger management workshop (AMW)

Twenty-seven men were randomly assigned to the first session of an eight-week anger management program. The decision to use the first session of this program was threefold: (1) to control for the amount of attention between treatment groups, (2) for efficiently accessing the greatest number of potential subjects, and (3) to prevent carry- over effects from having attended previous anger management sessions. The focus of the first session of the original management program was to introduce attendees to the program's purpose and structure. This was believed to be a relatively inert control condition. The AMW's primary goal was to increase the participant's awareness regarding his angry feelings and behaviors by gaining control over psychological and physical arousal to high stress experiences. The AMW's facilitator was an experienced MSW social worker, with a background in mental health and criminal justice. The AMW was two hours in length.

The AMW utilized both didactic lecture and an informal question and answer format. The facilitator applied gender role explanations as to why male participants had difficulty managing and expressing angry thoughts and feelings. Through lecture and hand-outs, information was provided on techniques to recognize and manage physical signs when feeling angry, such as rapid breathing and elevated heart and pulse rates.

[4] For copies of the DPEW hand-outs and complete curriculum, please contact: Mary M. Cavanaugh, PhD, at mary.cavanaugh@hunter.cuny.edu

Data analysis

Analysis of outcome data

Differences between experimental and control groups were analyzed by chi-square test if it was a categorical outcome variable; and by *t* test if it was a numerical outcome variable. Possible correlations among outcome variables were examined.

Descriptive statistics were computed on all variables. Distributions of continuous variables were checked with histograms, stem and leaf plots, and box plots, and the normality of the distributions was tested. When normal distribution assumptions were not met, data were transformed or non-parametric procedures used for subsequent analysis. Co-linearity among the independent variables was examined.

Bivariate analyses, using *t* tests, were utilized to evaluate the differential impact of the DPEW on all outcome variables. Each study hypothesis was assessed, controlling variables each at a time: age, race, marital status, employment status, income, education, and social desirability. The study had little missing data overall. There were no more than four percent missing data on any one scale. In handling missing items when calculating the scales, the missing item was filled in with the average of the other non-missing items (See, Cavanaugh 2007).

Results

Sample characteristics

The sample sizes for the control (AMW) and treatment group (DPEW) were 27 and 28, respectively. There were no significant differences between the two groups on socio-demographic characteristics, which provides evidence that the randomization process was successful (Table 1). In addition, histograms were used to check distributions and all were normally distributed. The DPEW participants were comprised as follow: 46.4% were White, 53.6% were non-White, 57.1% were between the ages of 18 and 35, and 42.9% were over age 36; while for the AMW: 63% were White, 37% non-White, 51.9% were between the ages of 18 and 35, and 48.1% were over age 36.

Table 2 shows no statistically significant differences between the control and treatment conditions at baseline, in all but two measures: the BEES (Balanced Emotional Empathy Scale) and a subscale of the STAXI-2 (i.e., anger management sub-scale: stxi_axi ('anger expression in,' which measures an individual's ability to suppress angry feelings).

As Table 3 demonstrates, all post-treatment scores showed a statistically significant difference between control and treatment groups and provided preliminary support for the DPEW as a more effective intervention in increasing awareness of: adaptive coping skills, anger management skills, empathy skills, and in decreasing potential risk for expressions of physical violence than the control condition (i.e., the one time, initial session, AMW). Furthermore, Cohen's "d" (Cohen 1992) was calculated to assess the magnitude of the treatment effect. The average "d" for the DPEW was 1.07, which is considered a very large effect.

Table 1 Baseline characteristics

Variable	Category	Control (n=27)		Treatment (n=28)		p value[a]
		Count	Percent	Count	Percent	
Age	18–35	14	51.9	16	57.1	0.69
	36 and over	13	48.1	12	42.9	
Race	White	17	63.0	13	46.4	0.22
	Non-White	10	37.0	15	53.6	
Marital Status	Single/Divorced	14	51.9	17	60.7	0.51
	Married	13	48.1	11	39.3	
Education	High School	14	51.9	19	67.9	0.23
	Post High School	13	48.1	9	32.1	
Employment	Employed	17	63.0	22	78.6	0.20
	Unemployed	10	37.0	6	21.4	
Income	Missing	1	3.7	2	7.1	0.57
	Less than 20,000	9	33.3	11	39.3	
	21,000 and over	17	63.0	15	53.6	
Variable	Control			Treatment		p value[a]
	n	Mean (sd)		n	Mean (sd)	
MC-2	27	5.77 (1.6)		28	5.21 (1.6)	0.1935
DAST	27	4.07 (3.5)		28	4.89 (6.3)	0.5504
MAST	27	6.33 (3.9)		28	5.89 (5.5)	0.7354

[a] p values were calculated using t test

Discussion

This pilot study provides promising preliminary support for the DPEW as an alternate intervention in increasing awareness of adaptive coping skills, anger management and empathy skills, and in decreasing potential risk for expressions of physical violence. As one DPEW respondent commented at one-month follow-up, "It (the DPEW) was very educational and it help (sic) me to recognize the (sic) anger could be stopped before it goes to (sic) far." Another man added, "I tried that validating thing with my girlfriend. Instead of being mad I told her she had a point and it seemed to help."

A key finding was the DPEW's initial effectiveness in lowering an individual's desire to express their anger physically, while at the same time decreasing their potential risk for physical violence. This is promising in that if individuals at risk for violence adopt positive, preventative strategies to manage their urges to respond angrily and choose other more adaptive and non-violent responses, they may be less likely to perpetrate acts of violence against their intimate partners.

The strength of the effect of the DPEW was unanticipated given the small sample size and a single session intervention. One possible explanation for the DPEW's initial effectiveness was provided by respondents at the follow-up meeting who

Table 2 Baseline scores on outcome measures

Variable	Control		Treatment		p value[a]
	n	Mean (SD)	n	Mean (SD)	
wcq_cc (confrontive)	27	1.3 (0.6)	28	1.3 (0.6)	0.9713
wcq_d (distancing)	27	1.3 (0.7)	28	1.2 (0.8)	0.4782
wcq_sc (self-controlling)	27	1.5 (0.6)	28	1.3 (0.8)	0.3597
wcq_sss (seeking social support)	27	1.5 (0.9)	28	1.2 (0.8)	0.1975
wcq_ar (accepting responsibility)	27	1.5 (0.8)	28	1.4 (0.8)	0.8368
wcq_ea (escape-avoidance)	27	1.2 (0.7)	28	1.1 (0.6)	0.5838
wcq_pps (problem solving)	27	1.5 (0.7)	28	1.4 (0.9)	0.6314
wcq_pr (positive reappraisal)	27	1.5 (0.9)	28	1.3 (0.8)	0.4267
bees	26	2.4(10.7)	28	3.0 (13.7)	0.0337
rev	27	−18.7 (54.7)	28	−10.9 (77.9)	0.6669
staxi_sangf (feeling angry)	26	10.1 (5.6)	27	10.5 (5.8)	0.7972
staxi_sangv (verbal)	26	9.8 (5.9)	27	10.0 (6.2)	0.9097
staxi_sangp (physical)	26	9.8 (6.3)	27	10.0 (6.4)	0.8954
staxi_tangt (temperament)	26	8.5 (4.7)	27	9.2 (5.2)	0.5985
staxi_tangr (reaction)	26	8.6 (4.6)	27	9.7 (5.1)	0.4174
staxi_axo (expression outward)	26	19.1 (5.8)	27	16.5 (6.3)	0.1312
staxi_axi (expression inward)	26	19.6 (6.4)	27	15.8 (5.1)	0.0192
staxi_aco (control outward)	26	18.3 (5.5)	27	19.4 (6.9)	0.5266
staxi_aci (control inward)	26	18.6 (5.9)	27	18.0 (7.4)	0.7386

wcq coping, *bees* empathy, *rev* potential for risk of violence, *staxi* anger management

[a] p values were calculated using t test

commented on the DPEW being "something different" and stating that "it covered things that I didn't hear about before and in a different more respectful way."

At the follow-up evaluative meeting that took place one month after the end of the pilot study, a small group (n=10) of DPEW participants were asked to complete a 12-item open-ended questionnaire. When asked if participating in the DPEW provided the necessary insights and/or skills to help manage angry feelings, all 10 respondents believed that the intervention provided useful information through which to assist them in better understanding and coping with feelings of anger. A common theme among responses was an increased awareness to pause and consider the possible consequences of their actions before acting-out angrily or violently. One participant commented,

> "Through the workshop I learned to choose my words more carefully so I don't hurt my wife's feelings and to take time-outs away from her if I need to."

Nearly all the respondents (n=9) in the follow-up commented on the utility of understanding the importance of empathy and respect for one's partner in maintaining healthy relationships. One man stated: "The best question I took to heart was who do you respect and why? Nobody ever asked me that before and

Table 3 Post-Treatment Scores

Variable	Control (n=27) Mean (sd)	Treatment (n=28) Mean (sd)	p value[a]	d
wcq_cc	1.1 (0.5)	1.5 (0.6)	0.0444	0.72
wcq_d	1.0 (0.6)	1.8 (0.8)	<.0001	1.13
wcq_sc	1.1 (0.7)	1.9 (0.8)	0.0002	1.06
wcq_sss	1.2 (0.8)	2.1(0.7)	0.0002	1.19
wcq_ar	1.1 (0.9)	2.1 (0.8)	<.0001	1.17
wcq_ea	1.0 (0.6)	1.3 (0.7)	0.0338	0.46
wcq_pps	1.1 (0.7)	2.1 (0.8)	<.0001	1.33
bees	2.6 (10.8)	3.6 (13.9)	0.0443	0.08
rev	12.5 (61.4)	−85.4 (38.5)	<.0001	1.91
staxi_sangf	11.5 (6.2)	5.4 (1.3)	<.0001	1.36
staxi_sangv	11.0 (6.2)	5.4 (1.1).	< .0001	1.25
staxi_sangp	11.0 (6.3)	5.6 (1.7)	0.0002	1.17
staxi_tangt	9.4 (4.6)	4.9 (1.5)	<.0001	1.31
staxi_tangr	9.4 (4.6)	5.1 (2.2)	<.0001	1.19
staxi_axo	18.9 (6.2)	13.1 (4.3)	0.0001	1.08
staxi_axi	18.6 (5.9)	14.2 (3.5)	0.0019	0.9
staxi_aco	17.2 (4.6)	24.0 (7.2)	0.0001	1.12
staxi_aci	17.9 (5.0)	23.9 (8.1)	0.0016	0.89

wcq coping, *bees* empathy, *rev* potential for risk of violence, *staxi* anger management

[a] p values were calculated using t test

when not one person answered my wife or my girlfriend that really opened my eyes." All 10 respondents commented on the effectiveness of the DPEW's interactive hand-outs that defined and illustrated the basic concepts regarding the dialectics of managing angry feelings and provided opportunities for respondents to practice what they had been taught. When asked if they would recommend the DPEW to others who may be at risk for acting-out physically against their intimate partner, all 10 respondents indicated that they would recommend the DPEW. The overarching theme among responses was that the DPEW was *"something new"* and *"different."* Comments included:

- "It really gave me a new perspective I didn't have before. I liked the idea of validation."
- "I've been in and out of the anger management group three times. Maybe it's time to try something new and different."

A number of the DPEW respondents stated that they had been in and out of anger management programs a number of times. They stated that their experience of those programs was that they were "all the same." This view is supported by Saunders and Hamill's (2003) review of violence intervention programs that found that nearly all are based on a cognitive-behavioral and feminist model. Smedslund

et al.'s (2009) systematic review of cognitive-behavioral therapy (CBT) for men who physically abuse their female partners concluded that the effectiveness of CBT for this population is inconclusive. The AMW, which provided the control for this pilot study, relied heavily on a behavioral and gender-based approach to explaining angry emotions. Indeed, the pilot study participants' interest in the DPEW was likely heightened by what appeared to be a 'revolving door phenomenon' among anger management program attendees. The DPEW's "novelty" was frequently commented on and regarded as a real strength by study participants. One participant stated, "It was nice not to be talked at the whole time about the same old stuff."

The theoretical, targeted, and preventative approach of the DPEW differs from that of current interventions that treat men who act-out violently in their intimate relationships (Cavanaugh et al. 2011; Cavanaugh and Gelles 2005). The DPEW's approach is encouraging for a number of reasons: (1) it applies a psychoeducational framework that has shown to be effective with alternate populations, who share many similar characteristics with individuals at risk for violent behavior; (2) contrary to current reactive IPV interventions, the DPEW takes a preventative approach to IPV targeting at-risk individuals and directing them into a specialized program; (3) although the ideal duration of the DPEW has yet to be determined, it aims to offer a brief, focused, interactive, psychoeducational workshop; and most importantly (4) the DPEW's validation of the client's experiences within a supportive and collaborative environment that offered client-centered strategies for positive change. A strength of the DPEW appears to be its attention to the mindfulness of the client as a whole being, from a non-judgmental perspective, with the recognition that all elements of an individual's reality, experiences, and environment are interrelated (Fruzzetti and Levensky 2000).

The DPEW is novel not only in its approach and content but most markedly in its duration, which is significantly shorter than current anger and violence interventions. At the one-month follow-up to gather evaluative feedback, of the 28 men who had participated in the DPEW, only 10 men had continued attending the original anger management program. This marked decline in attendance in an anger management program is not unusual and may point toward a need for abbreviated, specialized anger and violence prevention programs such as the DPEW for retention purposes alone.

The brevity of the DPEW is noteworthy for a number of reasons primarily because of the high attrition that exists across anger and violence treatment programs nationally (Babcock et al. 2004; Gondolf 2002). To reduce attrition, it may be more fruitful to construct intimate partner violence prevention and treatment programs that are shorter in length than current approaches, paying particular attention to the average amount of time individuals who attend these programs are likely to continue to attend. The two-hour duration of the DPEW may on the surface raise some concerns. Yet, given the promising preliminary results of this pilot study, as well as strong effects obtained by other low dose (1.5–2 hour) interventions with similar populations, who at ten-year follow-up reported lasting positive results, (Strang et al. 1999), it would be useful to investigate more fully the utility of shorter interventions for an at-risk population who are known to drop-out of treatment.

This pilot study found a strong effect for the DPEW. However, there are clear limitations that surround the strength of these results. The study sample is small, the novelty of the DPEW may have affected the participants' interest and motivation for change, and the intervention was brief. A larger-scale study with a bigger sample that takes place over a longer period of time, and with follow-ups at extended data points, may produce different results. Other study limitations include possible validity problems presented by a reliance on self-report measures. For example, given the brevity of a single-dose intervention, it may be that the participants' responses merely presented superficial 'change' and respondents were echoing only that which they believed to be the 'right' response from what they had heard during the intervention. This is indeed a concern. However, Huizinga and Elliott (1986) noted the utility of self-report measures and asserted that validity concerns can be addressed by also including collateral information from external sources. In future investigations of the DPEW, feedback provided by partners and ex-partners of participants as well as medical and/or criminal justice records will be gathered and examined to verify the validity of the study's self-report measures.

Conclusion

This study demonstrates preliminary support for an alternative, preventative intervention for males at risk for intimate partner violence, and it achieved its initial intent to determine whether a larger RCT was warranted. A preventative approach is novel in the field of IPV that has traditionally relied on a reactive response to men who have already committed acts of physical violence against their intimate partners. Existing treatment programs have demonstrated little effectiveness (Babcock et al. 2004; Feder and Wilson 2005). The pilot study's key finding was the strength of its effect in appearing to lower a participant's desire to express anger physically while decreasing the potential risk for physical violence. Albeit preliminary, the study's findings suggest an alternate direction for practice interventions in the field of IPV. If men identified at risk for IPV effectively adopt preventative strategies to manage their urges to respond angrily against theirs partners, they may be less likely to perpetrate acts of violence. This has important implications, across personal and social spectrums, not only for males at risk for violence, but also for victims who may be better protected from experiencing the serious and harmful effects of IPV.

The study's experimental intervention, the DPEW, was a two-hour, single-session workshop. Current anger and violence treatment programs, which vary in length nationally from 10 to 52 weeks, experience a significant decline in attendance over time. The brevity of the DPEW may provide an opportunity to explore more fully an abbreviated intervention for a population who has demonstrated high attrition rates in traditional programs (Archer 2000; Babcock et al. 2004; Feder and Wilson 2005; Stith et al. 2004). In addition, the theoretical foundation that underlies the DPEW offers an alternate conceptual framework in the design of preventative interventions for IPV. This study was an initial attempt to explore an alternative intervention program for males potentially at risk for intimate partner violence. The DPEW produced promising findings and demonstrates preliminary effectiveness that supports the utility of further study.

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