Dialectical Behaviour Therapy (DBT) skills for men with anger problems in Aotearoa

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Eleven men of Māori, Indian, Fijian, Samoan, South African and Pākehā descent (37% Pākehā or European) participated in a 6-month DBT skills group focused on reducing anger and emotion dysregulation. Two men withdrew early, and two additional men joined for the last 8 weeks. Adjusting for multiple comparisons, scores showed significant decreases on the Total Trait Anger domain of the Spielberger State-Trait Anger Inventory-2 between pre and post-treatment. Feedback from a post-treatment focus group indicated participants found the DBT skills group acceptable and useful, with skills from the distress tolerance and mindfulness modules used most often. Recommendations for improvement included reducing the time for homework review and increasing it for teaching. This paper offers considerations for responding to aggression in research contexts, and adds to growing evidence for DBT skills as a promising intervention for problems related to anger for men.

Key words: *Dialectical behaviour therapy, men, anger*

INTRODUCTION

Dialectical Behaviour Therapy (DBT) is an intensive outpatient treatment with multiple components. These include weekly individual therapy, weekly skills training (usually in groups of up to 8-12 participants), and telephone coaching for clients. DBT also includes weekly consultation meetings for therapists, focused on increasing practitioners' capacity and motivation to provide the treatment. Multiple research trials have demonstrated its efficacy for reducing suicidal and self-injurious behaviour in individuals with borderline personality disorder (Linehan et al., 2006; Swales, 2018). Most trials have involved 12 months of DBT, however a recent non-inferiority trial suggests that 6 months of DBT may be just as effective, and potentially offer faster improvements (McMain et al., 2022).

Initial trials of DBT involved samples comprised of North American women with borderline personality disorder (BPD), chronic suicidal behaviour and self-injury. Since then, people have applied DBT to a range of problems in which emotion dysregulation seems to be a key factor, including substance use disorders (Axelrod, 2018), eating disorders (Ben-Porath et al., 2020), and aggression (Frazier & Vela, 2014). DBT reduces anger (Ciesinski, Sorgi-Wilson et al. 2022) and has been associated with improvements in irritability and violent behaviour in females with borderline personality disorder (Linehan et al., 2008), and in men with BPD and antisocial behaviour (Wetterborg et al., 2020). DBT has also been adapted for use with suicidal and emotionally dysregulated individuals suffering from PTSD (Harned & Schmidt, 2019), particularly complex PTSD related to childhood abuse (Bohus et al., 2020). Emerging evidence suggests that DBT may have application for both victim-survivors and those who have engaged in family violence (Fruzzetti & Levensky, 2000). Evidence also shows it is effective for suicidal adolescents (McCauley et al., 2018; Mehlum et al., 2014), and is associated with improvements in aggressive behaviour for incarcerated youth offenders (Shelton et al., 2011; Trupin et al., 2002). Efforts to adapt DBT to cultures beyond WEIRD[1] populations (Clancy & Davis, 2019; Henrich et al., 2010) have included adaptations for native American youth diagnosed with substance use disorders (Beckstead et al., 2015), and Nepali women who have experienced domestic violence (Ramaiya et al., 2017).

Skills training is a major element of DBT. Component analysis and mechanisms research suggests that learning and using skills may be critical ingredients in the treatment's efficacy (Edwards et al., 2021; Linehan et al., 2015a; Neacsiu et al., 2010). Acquisition of DBT skills have been shown to mediate improvements in emotion regulation, anger control, and suicidal behaviour for adult women with BPD (Neacsiu et al., 2010). Moreover, positive changes in emotion regulation have been shown to predict improvements in symptom distress, behavioural control, and assertiveness for individuals with BPD receiving DBT. DBT skills training alone or with standard elements of usual mental health care (e.g. case management) has benefited suicidal women with BPD (Linehan et al., 2015b), adult women with eating disorders (Safer & Jo, 2010), emotionally-dysregulated adults

[1] Western, Educated, Industrialised, Rich, Democratic societies

(Neacsiu et al., 2014), adults with attention-deficit hyperactivity disorder, and adults with BPD (Soler et al., 2009). Most evaluations of DBT skills training as a stand-alone treatment have involved shorter durations, ranging between 9 and 32 weeks (Valentine et al., 2015). Accordingly, DBT skills training groups offer a treatment option that is relatively scalable and cost-effective, thereby enhancing access for those that could benefit from this approach.

The majority of DBT trials have been conducted with adult women with borderline personality disorder; men are under-represented in evaluations of this treatment. This gender difference is echoed in prevalence estimates of BPD in clinical vs non-clinical samples. Among treatment-seeking samples, estimates of the proportion of males with borderline personality have hovered around 25% (Johnson et al., 2003; Skodol & Bender, 2003). However, among community and incarcerated samples, estimates of the proportion of males meeting criteria for BPD is closer to 50% (Grant et al., 2008; Tomko et al., 2014; Trestman et al., 2007). Furthermore, males with BPD report receiving less psychotherapy and medication than their female counterparts (Goodman et al., 2010). There are a number of potential reasons for this discrepancy between the male prevalence of BPD in clinical samples versus those in the community who meet criteria for BPD. It may reflect gender biases in treatment referral and acceptance rates, gender differences in treatment engagement, or gender differences in the behavioural expression of emotion dysregulation. It may also reflect gender differences in how societies respond to men with emotion dysregulation; the pipeline from emotion dysregulation to prison may be wider for males than it is for females (Sansone & Sansone, 2011).

Because many randomised controlled trials of DBT have included female-only samples, we know less about the efficacy and the acceptability of DBT for men with problems with anger and aggression. However, a number of pre-post trials have indicated improvements in aggression for adult men in forensic inpatient settings (Tomlinson, 2018; Tomlinson & Hoaken, 2017), aggressive incarcerated male adolescents (Shelton et al., 2011), and within male-majority mixed samples of adults with intellectual disabilities and histories of aggression (Brown et al., 2013; Sakdalan & Collier, 2012; Sakdalan et al., 2010).

To our knowledge, as yet there have been no published studies specifically evaluating the acceptability of standard outpatient DBT skills training for men in Aotearoa New Zealand with problems with anger, or examining outcomes for these participants. The majority of large-scale treatment programmes for aggression in Aotearoa New Zealand are typically conducted in a group format (Arias et al., 2013; Babcock et al., 2004). Given that aggression and violent behaviour continue to be major social problems in our country, particularly within the home (Family Violence Death Review Committee, 2020; Lambie, 2018), we were interested in assessing whether this approach showed promise for treating such problems. In particular, the objective of this study was to assess the acceptability of both this intervention and the research methods to men in Aotearoa New Zealand.

Treatment acceptability is a multi-faceted concept, encompassing emotional, behavioural, and cognitive responses indicative of the extent to which a health service user likes the treatment they receive, and perceives it as appropriate (Sekhon et al., 2017). Treatment acceptability is an early focus of treatment outcome research design. In the current study we expanded this focus to consider the acceptability of the research framework designed to evaluate the treatment, particularly the outcome measures and strategies used to recruit and retain participants in the research. Our primary indices of acceptability focused on recruitment treatment engagement and non-engagement (i.e. treatment dropout), study engagement, and qualitative feedback on the treatment, and on research design. As the primary target of the intervention was problematic anger, the inclusion of a measure examining the subjective experience of anger was an important outcome variable. Because emotion regulation appears to be a key mediator of outcome in DBT (Lynch et al., 2006; Mehlum et al., 2014) and because depression in men has been implicated in aggressive behaviour in general (Krakowski & Nolan, 2017), and intimate partner violence in particular (Graham et al., 2012; Shorey et al., 2012), we also examined changes in emotion regulation, and depressive symptoms associated with DBT skills participation. Finally, we wanted to examine the acceptability of Hua Oranga, as a more holistic measure of wellbeing developed specifically for Māori tāngata whaiora, for Māori men taking part in this study. A key focus of qualitative feedback was the acceptability of DBT for cultural minority group members, given DBT's origins as a highly westernised and relatively monocultural treatment developed far from Aotearoa. As such, we were particularly keen to elicit participants' opinions on the acceptability of the intervention, including how and by whom it was delivered.

1. The aims of the research were to answer two main questions:
2. Is 6 months of weekly DBT skills acceptable to men in Aotearoa New Zealand who are experiencing anger-related problems?

Is participation in DBT skills training associated with improvements in psychological wellbeing for men experiencing anger-related problems, as measured by responses on self-report questionnaires assessing problems related to anger, emotion dysregulation and depression?

Accordingly, we recruited adult men who reported experiencing problem with anger for a DBT skills training group to be run weekly across 6 months. This duration was chosen because it allowed the opportunity to teach the full standard 26-week DBT skills curriculum, and assess without assumption which skills participants would find most relevant and useful.

METHOD

Participants

Adult men aged 18 years and over were recruited via research brochures sent to non-governmental community health and social services, governmental mental health and addiction treatment providers, and primary care services in the Auckland area. As such, individuals could

be informed of the research opportunity by health providers, or through brochures in waiting areas. Interested men or their whānau then got in touch directly with the researchers.

Prior to group sessions, potential participants met with one of the researchers for screening, orientation to the study and consent. Typically, this meeting ended with the man being provided with written information about the study, the consent form, and the assessment questionnaires, with the agreement that they would decide whether to take part, and an appointment set for 1-2 further meetings to complete the consent form and assessment, and to receive their skills workbook.

Inclusion criteria were identifying as male, proficiency in spoken English, and self-reported problems with anger and emotion dysregulation. Initial exclusion criteria were active psychosis, and intellectual impairment that precluded the individual from providing informed consent. Initially we required literacy, however relaxed this for one group member who struggled to read and write. These criteria were subsequently expanded following an incident during screening in which a potential group member touched the torso of one of the clinicians while demonstrating a stabbing. After extensive consultation, this led to the pragmatic development of a further exclusion criterion; touching a screening clinician in a threatening manner during pre-treatment assessment.

Fifteen men expressed interest in the group, 4 of whom did not take part. One did not proceed with screening because of concerns regarding the age range of the group (18 years and over), another didn't like the 6-month commitment and the third didn't think he was experiencing the problems the group intervention treated. The fourth was discontinued following the aforementioned threatening behaviour during screening.

Men were aged 23-70 years with a mean age of 44 years. Participants were of Māori, Indian, Fijian, Samoan, South African and NZ European descent. The majority (4/11) were Caucasian. Six reported a history of violence towards a family member, and 5 reported seeking help for significant physical violence.

Intervention

The intervention was comprised of 26 weeks of weekly 2-hour DBT skills training groups covering (in the following order) mindfulness, distress tolerance, emotion regulation, and interpersonal skills using an early version of the 2nd edition of the DBT skills training manual (Linehan, 2014). The first session focused on orientation to group guidelines, and identification of personal goals for the group. Group sessions took place on an evening during the week. The first hour was dedicated to a brief mindfulness practice followed by review of homework from the week prior. Following a 15-minute break, the second hour focused on skills instruction. Food was served for the 15 minutes before group and during the group break. When group members didn't show, they were text messaged and called by group leaders from the first author's phone. To aid retention in both the research study (Teague et al., 2018) and the group, group members received birthday and end of year greeting cards from the group leaders. Mindfulness skills were taught in 2-week blocks 3 times during the 6-month cycle, per the standard DBT curriculum.

Adaptations to the skills curriculum were minimal, but facilitators intentionally chose examples and stories that group members were likely to relate to. Discussions often focused on the relevance or appropriateness of a skill for the lives of men in Aotearoa. At group members' request, emotion regulation skills also included some information on chain analysis when describing the model of emotions, and content on validation and dialectics during the Interpersonal Effectiveness module.

All three authors were involved in the delivery of skills group sessions, with the 2nd and 3rd authors acting as co-leader for 3 months each, and the first author leading facilitation for the full 6 months of the skills group (i.e. group sessions were led by 2 facilitators at a time). Two of the facilitators were clinical psychologists, and one was a clinical psychology intern at the time of the study. All were trained in DBT. Two of the authors attended weekly DBT consultation team meetings with other members of a DBT adolescent and family programme. The focus of these meetings was on increasing practitioners' motivation and skills in delivering the therapy. All facilitators identified as Pākehā/NZE.

The final session involved food and a graduation ceremony followed by feedback on the group, which was gathered by the group leaders. All graduating group members ended skills training group on the same date; i.e. the intervention was established as a closed group. In the feedback session, group participants were asked what they liked and disliked about group, the skills they used most often, their recommendations for change, and their recommendations regarding matching the ethnicity of group leaders for participants.

This study received ethics approval from the Northern X Regional Health & Disability Ethics Committee (NTX/08/04/038), and was retrospectively registered with the Australia New Zealand Clinical Trial Registry (#ACTRN12621000921886). This study was unfunded.

Measures

Assessments were administered prior to and at the conclusion of group skills training, and at 6 months follow-up. Self-report questionnaires included the following:

Depression was assessed using the second edition of the Beck Depression Inventory (BDI-II: Beck, 1991). The BDI-II is a 21-question multiple-choice self-report inventory designed to examine the scope and severity of depressive symptoms, with higher scores indicating greater distress (*Cronbach's* α = .90 for the overall score; Scale min/max=0 to 63). Participants responded to each item on an escalating scale of depressive symptomatology from a 0 (e.g. "I do not feel sad") to 3 (e.g. "I am so sad or unhappy that I can't stand it").

Emotion dysregulation was assessed using the Difficulty with Emotion Regulation Scale (DERS: Gratz & Roemer, 2004) is a 36-item self-report questionnaire designed to assess clinically-relevant problems in regulating emotions, with higher scores indicating greater difficulties (*Cronbach's* α = .93 for the overall score; Scale min/max=36 to 180). Participants responded to each

item on a 1 ("almost always") to 5 ("almost always") with 11 items reverse-scored.

State/trait anger was assessed using the State-Trait Anger Expression Inventory-2 (STAXI-2: Spielberger, 1999; *Cronbach's α's* = .84-.87 for the overall trait score; total Scale min/max=57 to 228) is a 57-item self-report questionnaire designed to measure multiple dimesions of the experience of anger, with higher T-scores indicating greater problems related to angry affect. Participants responded to each item on a 1 ("almost never") to 4 ("almost always"),

Finally, we used an early version of the Hua Oranga (Kingi & Durie, 2000) - a suite of 4-item questionnaires designed to assess the 4 dimensions of wellbeing identified by the whare tapa whā model of health (Durie, 1994). Positive scores indicate improvements in wellbeing due to an intervention and negative scores indicate declines in wellbeing due to an intervention. It has 3 forms or perspectives: one is completed by the individual, another is completed by whānau, and another form is completed by a clinician working with the individual (*Cronbach's α* = .87 for the overall self-report score: Chalmers & Williams, 2018; Scale min/max=-32 to +32). Participants responded to each item on a -2 ("Much Less") to +2 ("Much More"). Group members identifying as Māori completed the Tangata Whaiora/client version of the Hua Oranga.

Table 1. *Before-to-after group Means (SD/SE) of scale variables*

	Before Group M (SD/SE)	After Group M (SD/SE)
DERS Total *	105.57 (27.76/10.49)	72.71 (16.63/5.91)
BDI *	25.71 (9.90/3.74)	11.00 (7.87/2.977)
STAXI Total Trait Anger	76.00 (8.00/3.27)	50.00 (8.00/3.266)
STAXI Anger Expression Out **	65.67 (16.42/6.70)	48.33 (8.14/3.32)
STAXI Anger Expression In +	67.00 (15.11/6.17)	57.667 (9.25/3.77)
STAXI Anger Control-Out	37.00 (10.49/4.28)	47.00 (9.86/4.03)
STAXI Anger Control-In **	33.00 (6.42/2.62)	52.50 (6.75/2.75)
Anger Expression Index *	70.67 (8.55/3.49)	51.33 (9.35/3.82)

Note: + $p < .10$; * $p < .05$; ** $p < .01$

Analysis

Paired *t*-tests were calculated for pre and post scores on the 3 outcome measures, and then corrected for multiple comparisons using the Bonferroni method. We have also presented the unadjusted comparisons to allow readers to interpret the results dependent on their view of the need for adjustment, as for this stage of study (i.e. an uncontrolled pre-post study, with a small sample size) it may be more effective and in keeping with the exploratory nature of the research not to adjust for multiple comparisons.

RESULTS

Two participants dropped out within the first 4 weeks citing work commitments, and a clash with another course that had already been paid for. In the last module (i.e. 2 months before the conclusion of skills training), we received a request from another man to join the group. Subsequently, he and another male relative participated in the remaining 8 sessions.

Table 1 shows scores on the outcome measures before and after skills training. Using *t*-tests, comparisons of scores on outcome measures before and after group showed significant decreases in scores on the DERS (p = 0.047), BDI (p = 0.018), STAXI Total Trait Anger (p = .001), and STAXI Anger Expression Index p = .028), and a significant increase in STAXI Anger Control-In scores (p = .009).

The adjusted threshold for statistical significance from the Bonferroni correction is 0.05 / 8 = 0.00625. Following Bonferroni corrections for multiple comparisons, the decrease in STAXI Total Trait Anger remained significant.

Themes from qualitative feedback from group members included liking mindfulness activities, the use of text messaging and phone calls to 'chase [them] up', the provision of food, and the orientation to group guidelines. They disliked discussions going off on tangents, especially during homework review, and 'being counselled' by other group members. The skills they reported using most often were from the crisis-survival section of the distress tolerance module (TIP, Pros & Cons, ACCEPTS, and Self-soothe), and from the mindfulness module (Observe, Describe, Participate and Wise Mind). Their recommendations for improvement included the provision of skills instruction recordings for self-review, having weekly mini-reviews of mindfulness and crisis-survival skills, including more space for taking notes in the workbooks, reducing the time for homework review and increasing the time for skills instruction (i.e. 40 and 80 minutes rather than apportioning an hour to each). Two group members wanted to make group longer (i.e. 3 hours) however others didn't agree with this. Most group members reported that the ethnicity of facilitators didn't matter. The group members who disagreed reported that they didn't think they would attend if the facilitators' ethnicity matched their own, owing to concerns about confidentiality as their communities were small and close-knit.

DISCUSSION

The current study found that participation in a 6-month DBT skills group was associated with significant improvements in anger, emotion regulation and depressive symptomatology for a small group of men in Aotearoa New Zealand. Completers were uniformly positive about the impact of learning and using DBT skills on their lives and relationships, reporting that they found both the skills and the method of delivery acceptable and useful for them. The men provided robust feedback

regarding their likes, dislikes and areas for improvement. Accordingly, the two primary aims of the study were met. Six months of DBT skills training appears to be acceptable to men in Aotearoa who endorse problems with anger, and participation in this intervention was associated with positive change in self-reported difficulties in emotion regulation, anger, and depressive symptoms.

The strengths of the study include the focus on providing DBT skills training to fidelity, the inclusion of NZ men, the focus on engagement, and the relatively low dropout rate (Dixon & Linardon, 2020). The duration of sessions mirrored those provided within the treatment developer's clinic where the first author was trained. Two of the three facilitators attended a DBT consultation team, and the entire standard adult skills core curriculum was included, allowing the participants to comment on the acceptability of all core skills. Although the group sessions weren't coded for adherence, the lead facilitator has extensive experience with this modality, having provided adherent DBT group sessions on two trials (Cooney et al., 2010; Linehan et al., 2006).

The authors engaged in a range of strategies both to retain participants in group, and also to retain them in the study. Unfortunately we were not able to obtain 6-month data for the two participants who dropped out of group skills training. However, based on the low drop-out rate and feedback from participants, group members may have felt cared for, attached, and more likely to remain in group as a result. The strategies (termed 'attachment strategies' in DBT, and particularly used to engage individuals with addictive disorders in DBT for substance use) included the provision of food, the inclusion of goal-setting at the outset of group, calling group members during group sessions and breaks if they no-showed, sending cards and other messages inviting them to return if they had missed 3 sessions in a row, obtaining detailed information at the outset from group members about ways of getting in contact with them, and getting permission to contact other people in their lives to track them down if we were having trouble reaching them (Dimeff & Linehan, 2008; Salsman, 2022).

This study has a number of limitations which signal important considerations for the design of a full-scale trial evaluating DBT for violent behaviour. The criterion excluding individuals who engaged in highly intimidating behaviour during the screening and pre-treatment assessment process significantly limits the validity of our findings. This criterion was driven by pragmatic concerns, as working with the individual whose behaviour led to this criterion crossed the limits of some research staff after the screening interaction, owing to potential risks to the safety of the leaders and the other group members. Given the timeframe and an absence of alternative providers, we opted to exclude this individual from the trial. For future research, it will be important to have processes and contingency plans to protect the safety of assessors, therapy staff and participants during the trial, that are acceptable to all members of the research team.

The pre-post study design makes it impossible to determine whether the improvements in participants' scores on research measures were due to the intervention, or other unmeasured factors, such as additional unassessed problems experienced by participants. The absence of a control group, and random assignment to either intervention or control means it's entirely possible that improvements in outcome measure scores were due to the passage of time, or other uncontrolled and unmeasured variables. Furthermore, the researchers included additional participants in the second half of the intervention, in a way that was unplanned, in response to requests. This limits the generalisability of the acceptability findings, in particular. These participants received a smaller dose of the intervention and therefore had less time to tire or become dysregulated by the process and withdraw prematurely. It's also possible there may have been material in the first half that they disliked and may have led to dropout if they were present for it.

The sample itself was very small, and then made smaller by the dropout by two members, who didn't complete outcome measures at 6 months. These pose further threats to the validity of the quantitative findings. Finally, the fact that the focus group was run by the group leaders limits the validity of the qualitative feedback. In other treatment feasibility research conducted by our team, post-intervention focus groups have been facilitated by interviewers who are independent from the therapy team. The interviews are typically individuals with lived experience of mental distress, and the feedback is anonymous to the group leaders. We are strong proponents of service user-led research, and independence of intervention provision and evaluation, and are committed to this going forward.

Despite these limitations, this study garnered useful information for the provision of DBT skills groups for adult men in Aotearoa New Zealand, in that it provided quantified data on changes in symptoms, recruitment, and dropout rate, as well as rich qualitative information gathered both from the participants' feedback, and also their behaviour. In addition to the findings reported above, we noted a phenomenon that we have repeatedly experienced in Aotearoa, in comparison with our experiences delivering DBT skills training in the US and the UK. There were three instances during the course of this intervention when individuals brought members of their family along to group. This pattern occurred for a number of ethnic identities. One instance involved a request to do so ahead of time, which led to the standard informed consent and orientation process before the family member joined. The other two instances involved family members unexpectedly showing up despite a careful informed consent and orientation process that preceded group members' joining group. Anecdotally, the authors have experienced this previously with other Aotearoa New Zealand DBT groups comprised of both adolescents and their families, as well as adults, with multiple settings and ethnicities. Group members have brought partners, siblings, in laws, and adult children along to group sessions whom they believed could benefit from learning DBT skills. Often, this has occurred with no notice, and with the expectation that the person could join group on the day. Personal communication with DBT providers and researchers in other countries suggests that this pattern is specific to Aotearoa New Zealand. During this study, on the occasions that this occurred without warning, group leaders were highly conflicted about turning guests away, feeling that it violated important

values of hospitality and manaakitanga. We believe that this transaction (both the expectation that the uninvited guests would be included as a matter of course, and the strong urge to include them experienced by group leaders) may reflect something about a collective social tenet in Aotearoa New Zealand of welcoming people, especially those seeking support. It may also indicate a lean towards a collective rather than individual identity in NZ society. Accordingly, we recommend routinely including in the DBT group guidelines for NZ tāngata whaiora an explicit statement of the DBT team's position on the inclusion of friends and family members in group, and consideration of how whānau may be involved in learning skills.

The other significant lessons in this research related to the event that prompted the additional exclusion criterion. This underscored two things. First, there is a need for all individuals involved in skills training with this population to be very clear from the outset with themselves and with participants about personal and organisational limits regarding threats or acts of violence. One of the principles of DBT is not to exclude people from treatment for engaging in behaviour that the intervention is designed to treat. At the same time, DBT's original focus was on the treatment of borderline personality disorder, with suicide attempts and non-suicidal injury targeted as behavioural markers of BPD, rather than aggression towards others. This creates challenges when the target behaviour involves harm towards treatment providers or other group members. The act by the individual being screened was highly threatening to both assessors, and involved direct physical contact. Broad consultation with multiple forensic, ministry of justice, and DBT specialists occurred regarding how to respond. All non-DBT specialists were based in Aotearoa New Zealand. They unanimously surmised that the individual appeared to be highly dangerous, and strongly advised that the individual be declined for the skills group, and referred elsewhere. In contrast, one forensic DBT specialist based in North America voiced mixed feelings about having this individual in group, noting that the combination of aggression and emotion dysregulation was common in forensic settings (McCann, personal communication, October 2008). She also noted that there was far more control over the environment in secure units, where aggressive behaviour can be more contained and therefore safety is easier to establish and maintain. Furthermore, the specialist observed that more homogeneity in the risk profiles of group members in such settings meant that group members were able to 'keep each other in line'. In many respects this individual's profile was highly consistent with the problems the skills group sought to treat. However the severity of these problems far exceeded those of the majority of group members, none of whom engaged in such behaviour during assessment or group sessions. The research team had a clear safety protocol relating to skills group delivery, however screening and assessment safety measures involved simply ensuring that individuals were either seen within a service during working hours, or if outside of working hours, were not seen individually. This was insufficient. Furthermore, the team's limits regarding threatening behaviour were not clear. We learned from this that it is important that all parties involved in violence prevention research are in clear agreement about exclusion criteria, and the research team's policy regarding response to threats by group members. Similarly, the research team needs to have a clear policy regarding assault by group members and to communicate this to everyone involved. In addition, the setting, timing, and environment of the group needs to be set up in a way that minimises the risk for all parties.

Second, in addition to having an agreement about exclusion criteria, and refining details of the safety protocol for researchers, further concerns related to participant safety and informed consent. Over and above retaining a valued member of the research team, the self-report and behaviour of this individual indicated a level of violence that was more pervasive and extreme than that of other participants. This underscores the need for participant information to be clear about the personal risk of assault related to taking part in group interventions for violence, and the reality that if group leaders witness or are victims of violence by group members, they will report it to police. In addition, group guidelines need to specify expectations regarding how group members interact with each other, in terms of communication, unwanted touch and non-verbal intimidation.

Several weeks after the decision to exclude the individual from the study, the first author was able to consult with the treatment developer of DBT. Linehan was strongly against the exclusion, stating (1) researchers on interventions for violent behaviour needed to be willing and able to work with individuals at risk of engaging in violence, (2) that simply being afraid of someone was not a reason not to work with them, and (3) that there was no evidence that taking part in DBT skills training had made people's behaviour worse (Linehan, personal communication, January 2009). Integrating her position with that of forensic practitioners who hold extensive knowledge and experience in working with violent offenders may pose a dialectical opportunity for future thought and research. There is a difference between declining to work with an individual simply because their presentation is frightening, as opposed to a situation where the treatment setting and context offers insufficient protection given a violent history coupled with a presentation that includes physical threats.

This study indicates that DBT skills may be a promising intervention for men struggling with problems related to anger in Aotearoa New Zealand. However it is a leap to conclude that the next step would be a randomised controlled trial for dysregulated men engaging in violent behaviour, particularly if the focus was on family violence. Future research on DBT skills as an intervention for family violence needs to examine in more detail issues related to trial design, and to explore in more depth the cultural acceptability of DBT skills training as an intervention for Indigenous men who have engaged in family violence. Issues relating to design include how to engage and retain men and their families in research of this nature, the feasibility of gathering collateral information on primary outcomes (i.e. violence to family members) without jeopardising the safety of informants, and how to raise the chances of accurate self-report from participants while also meeting duties of care regarding harm to minors if participants disclose family violence to

research assessors. Most countries mandate reporting of child abuse, regardless of whether the information is obtained via research activity. Certificates of confidentiality for research in the US, for example, do not exempt researchers from their obligation to report child protection concerns. Research on family violence in other countries has circumvented this by ensuring anonymity of research assessments. Assessments occur online or via anonymous phone lines, and participants only disclose which treatment they're receiving and broad demographic details rather than their identity. However, an ethics submission by our team for a study interviewing individuals with lived experience of family violence and offering participant anonymity was declined on the basis that the researchers had "an ethical and legal obligation to contact relevant authorities if they discover a person in the community who is at risk of violence or harm from another, and not recording identities goes against this" (March, 2021). Clearly this is an issue that is fraught with important and conflicting principles. Further research, including consultation with whānau most affected by such safety concerns, is sorely needed.

The current study provided support for the acceptability of DBT skills for men experiencing anger-related problems in Aotearoa New Zealand, and the feasibility of conducting pre-post outcome evaluation with this population. Results indicated that this intervention is acceptable and holds promise of benefit for men with anger problems in Aotearoa New Zealand. Further research is needed on these issues, in order to evaluate the efficacy of this treatment for a significant and tragic problem affecting Aotearoa New Zealand.

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The authors have no conflict of interest to declare.

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