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A feasibility test of a brief motivational interview intervention to reduce dating abuse perpetration in a hospital setting

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Abstract

Objective—To describe the intervention development process and feasibility testing of a hospital-based brief intervention to reduce the perpetration of adolescent dating abuse (ADA). To our knowledge, this intervention is the first to focus exclusively on ADA perpetration reduction via a motivational interview-type intervention in this setting.

Method—The rationale for and the six Intervention Mapping steps used to generate the intervention are described. Feasibility is conceptualized as intervention acceptability, demand, implementation, practicality, integration, and limited-efficacy.

Results—The Real Talk intervention was integrated smoothly into the emergency department setting. Participants did not experience any negative impact, and the vast majority (86%) reported that they felt helped. Quantitative assessments suggest that the intervention reduced the number of participants in the pre-contemplation stage of change regarding their use of relationship violence, and may have moved them forward into the action stage. Real Talk participants were more likely than those in the control group to tell friends to help them stay calm around their partner after drinking alcohol, and to talk with their doctor to get help for their problems.

Conclusions—Real Talk was developed to meet an unmet need for tertiary ADA interventions in non-school settings. It was developed in accordance with a recommended framework, informed by theory, and subsequently tested for feasibility. Feasibility assessment results suggest that Real Talk can be implemented in health care settings and may influence attitudinal and behavioral outcomes in the desired directions.

INTRODUCTION

Adolescent dating abuse (ADA) perpetration is a serious public health problem. As many as 20% of high school-attending girls, and 10% of boys, are physically or sexually assaulted by a dating or sexual partner each year (Vagi, O'Malley Oben, Basile, & Vivolo-Kantor, 2015), and recent data suggest that 12% of U.S. high school-attending youth have ever perpetrated physical or sexual abuse against a dating partner (Mumford & Taylor, 2014). Consequences of ADA can be long-lasting and severe, and may include mental health problems, poor academic achievement, sexual and reproductive health problems, injury and death (Ackard, Eisenberg, & Neumark-Sztainer, 2007; Campbell et al., 2002; Exner-Cortens, Eckenrode, & Rothman, 2013; Foshee, 1996). The purpose of this paper is to describe the development

process and feasibility assessment of an ADA perpetration intervention that was designed to take place in a healthcare setting.

There are now several theory-based, evidence-based programs for the *primary prevention* of ADA for high school and middle school students (Foshee et al., 1998; Miller, Heisterkamp, & Moideen, 2008; Taylor, Stein, Mumford, & Woods, 2013; Wolfe et al., 2009). The majority of these are classroom-based educational programs that teach youth to recognize what counts as healthy and unhealthy relationship behaviors, and encourages them to reexamine attitudes about gender roles. *Secondary prevention* programs--those that target youth at high risk for ADA perpetration (e.g., youth who have witnessed interparental partner violence or experienced maltreatment) are uncommon (Cohen, Glaser, Calhoun, Bradshaw, & Petrocelli, 2005), with some exceptions (Ball et al., 2012). *Tertiary prevention* strategies are strategies that target those who have already started perpetrating ADA and need to be stopped, and they are virtually nonexistent. Some adult batterer intervention programs have offered specialized tertiary prevention groups for younger male perpetrators, but these have not been tested for effectiveness and their acceptability among participants has not been described in the scientific literature (Peacock & Rothman, 2001).

There are a few problems with the existing array of dating abuse prevention strategies. First, as many of their originators acknowledge, effects may be relatively small, may be short-term if not supplemented by booster sessions, and may not be effective at changing all of the intended behavioral outcomes (*i.e.*, may reduce victimization but not perpetration, or may reduce bystander behavior but not self-report ADA perpetration) (Ball et al., 2012; Cornelius & Resseguie, 2007; Foshee et al., 1998; Miller et al., 2012; Rothman, Decker, & Silverman, 2006; Taylor et al., 2013; Teten Tharp, Burton, & Freire, 2011; Wolfe et al., 2009).

Moreover, assessments of school-based interventions on ADA and other issues have found that their impact may depend almost entirely upon factors such as (a) the fidelity and quality of the program delivery; (b) the local culture and whether the curriculum is a fit, both for the students' values, language, and developmental stage, and the time and place (*i.e.*, may reference outmoded ADA, such as "calls your cell phone 100 times a day" although texting has replaced phone calling), (c) the support or lack thereof of the classroom teacher(s) hosting the external interventionists who are presenting the program; (d) the literacy level of the students; (e) the likability of the staff person delivering the intervention; (f) the presence of competing anti-violence programs with similar or dissimilar messages at the same school or in the community; and (g) local or national events, such as a rape case in the community or celebrity ADA event. For a rich discussion of these and other factors that tend to impact the effectiveness of prevention programming, please see Nation et al. (2003) on "Principles of Effective Prevention Programs" (Nation et al., 2003).

A second problem with existing ADA prevention programs is that almost all of them are school-based and relatively expensive to implement. It's unsurprising that the majority of prevention strategies are implemented in schools because large numbers of youth can be reached at once, but prevention scientists have discovered that school-based intervention programs often have limited and short-term impacts (Alford & Derzon, 2012; Durant, Baskin, Thomas, & Allison, 2008; Glantz & Mandel, 2005; Powers & Thompson, 2013). It may be particularly difficult to change youth dating-related attitudes and behavior in

classroom settings where their potential partners are also present. Another problem with school-based ADA interventions is that the students at highest risk for adolescent problem behavior, including perpetrating aggression, may also be more likely to be truant or to drop out--meaning that they aren't in school to receive the programming when it's offered (Ball et al., 2015). A final problem is that purchasing an evidence-based curriculum or hiring trained facilitators can cost thousands of dollars. Taking classroom time away from other subjects for the ADA intervention also deters some principals.

The rationale and inspiration for developing a hospital-based dating abuse perpetration intervention

Effective secondary and tertiary ADA prevention interventions that take place in non-school settings are needed because it is important to reach non-school-attending youth, and the field needs a range of prevention programming options that can be used in diverse settings. It has been demonstrated that hospital-based brief interventions for youth can be effective for topics other than ADA, including alcohol use, illicit drug use, and risky driving (Bernstein et al., 2010; Sommers et al., 2013; Spirito et al., 2004; Tanner-Smith, Steinka-Fry, Hennessy, Lipsey, & Winters, 2015). The term "brief intervention" refers to a specific type of patient-healthcare provider interaction that typically lasts 15–30 minutes during a clinical visit, though can be as brief as a five-minute advice session (Colorado Clinical Guidelines Collaborative, 2008; SAMHSA, 2015). Brief interventions use a variety of educational techniques, including motivational interviewing. Motivational interviewing is a style of interacting that involves active listening on the part of the interventionist, eliciting "change talk" from the participant, and permitting the participant to express ambivalence about pros and cons of giving up their unhealthy behavior (Hettema, Steele, & Miller, 2005; Rollnick & Miler, 1995; Shorey, Martino, Lamb, LaRowe, & Ana, 2015). One of the advantages of motivational interviewing is that it can be taught to lay interventionists relatively quickly and inexpensively, making it cost effective (Tanner-Smith & Lipsey, 2015; Winters, Botzet, Dittel, Fahnhorst, & Nicholson, 2015).

In 2004, a brief motivational-interview style intervention to address youth alcohol and marijuana use had already been tested and established as effective at a large, urban, Safety Net hospital where members of the research team worked (Bernstein et al., 2009; Bernstein et al., 2010). The patient population of the hospital is disproportionately Black and/or Hispanic, living in poverty (14% in U.S. vs. 80% at hospital), and experiences higher-than-average levels of adverse childhood experiences (ACEs) such as the incarceration of a parent, witnessing interparental violence, or experiencing childhood sexual abuse (DeNavas-Walt & Proctor, 2015; Rothman, Bernstein, & Strunin, 2010). Many youth utilize the emergency department services of the hospital for what would be considered routine medical issues, such as pregnancy tests, the treatment of urinary tract infections, or flu symptoms. Because patients can spend two or more hours waiting for care, and because many of the patients are not experiencing acute medical problems, it makes an ideal setting for brief interventions.

The lead author had prior experience working for and with batterer intervention programs as a curriculum expert, including cooperatively developing state guidelines and standards for

intervention groups for adolescent perpetrators of dating abuse (Massachusetts Executive Office of Health and Human Services, 1999). Therefore, the team decided to capitalize on the success of the brief motivational interview-style intervention model, combine it with dating abuse-related content, and determine if a new, ADA tertiary prevention intervention might work in the hospital setting. In 2004, when members of the research team undertook this project, no other researchers had yet completed a test of a brief interventions for ADA impact, but there was one brief intervention for emergency department-based youth that was designed to address sibling, peer, and dating abuse perpetration simultaneously under way (Cunningham et al., 2013). In addition, there was a group of researchers who had used brief intervention to address partner abuse victimization with adult women (Schumacher, Coffey, Stasiewicz, Leonard, & Fals-Stewart, 2007). Using these two brief interventions as models, in addition to the aforementioned tested drug and alcohol brief intervention, the research team began the process of developing and pilot-testing the “Real Talk” brief motivational interview-style intervention for ADA perpetration.

The process of developing the Real Talk brief intervention

The Real Talk intervention development process used the Intervention Mapping protocol method, which entails six steps: (1) Needs assessment, including establishing a participatory planning group; (2) Identifying behavior change goals; (3) Selecting a behavior change theory to guide the development of the intervention; (4) Creating the program and preparing materials; (5) Implementing the intervention; and (6) Evaluating and refining the intervention based on results (Bartholomew, Parcel, & Kok, 1998). In addition to these steps, the intervention developer gathered background information on brief intervention and motivational interviewing by reading about them and participating in training delivered by national experts (BNI ART Institute, 2015), interviewing staff of an existing alcohol brief intervention, using a Delphi process to vet the ADA intervention script with a panel of experts, role-playing the intervention for a focus group of youth from the target population, and revising the intervention based on youth and expert feedback before pilot-testing it for “limited-efficacy” (see Table 1)(Bowen et al., 2009).

This paper describes the development and feasibility test of the Real Talk intervention.

The hypotheses of the feasibility test were:

(Hypothesis 1) It will be feasible to create a brief motivational interview-style intervention to address ADA perpetration for a hospital setting.

(Hypothesis 2) The intervention will be acceptable to the participants and hospital staff.

(Hypothesis 3) Binary limited efficacy results will suggest the intervention has improved individuals’ use of ADA perpetration prevention strategies.

Development Step 1: Needs assessment—Determining that there was a need for an ADA perpetration-focused brief intervention was straightforward. The research team met and discussed ADA with the Chief and Clinical Chief of the Department of Pediatrics, the Chief of the Division of Pediatric Emergency Medicine, social workers affiliated with the hospital’s counseling program for children who are exposed to interparental partner abuse,

hospital child abuse protection experts, the hospital domestic violence program coordinator, and a clinical psychologist with expertise in treating adult domestic violence offenders. State-level and community-based experts were also consulted. There was consensus that ADA was an important public health issue and that no ADA perpetration interventions were already in place at the hospital. Other types of intervention-related concerns were raised, however, and had to be incorporated into the design. For example, physicians wanted to ensure that the delivery of the Real Talk intervention would not interfere with the flow of clinical care in the emergency department, and domestic violence advocates wanted to ensure that victims of adolescent intimate terrorism would not be engaged in the intervention. Child protection experts wanted assurance that hospital protocols would be followed when cases of child abuse or neglect were reported to the interventionist. Each of these were addressed as the Real Talk intervention content and procedures were developed.

Development Step 2: Identifying behavior change goals—Logical and achievable behavior change goals related to ADA became apparent by reading the manualized script of the pre-existing alcohol brief intervention. The primary goal of the Real Talk intervention was to reduce participants' self-reported perpetration of ADA. Secondary behavior change goals included developing behavioral techniques that could reduce the likelihood of alcohol-related ADA perpetration (such as avoiding one's partner when drinking, or asking friends to help them remain non-violent in advance of attending a party together), and seeking help for problems including substance use and mental health symptoms from healthcare providers. Goals related to knowledge, attitudes, and readiness to change were also created, but because it is now understood that knowledge and attitude change are not strongly predictive of behavior change (Eagly & Chaiken, 1993), the behavior change goals were prioritized.

Development Step 3: Theoretical basis—Basing the Real Talk intervention on a successful prototype meant inheriting the theory that informed that prior intervention, which utilized three theories; The Stages of Change model, the Theory of Planned Behavior, and the theory of motivational interviewing (Ajzen, 2012; Miller & Rose, 2009; Prochaska & Diclemente, 1983). Not all brief interventions use a motivational interviewing style for patient interaction. However, all brief interventions are constructed on the premise that individuals with a behavioral problem can be categorized in one of five "Stages of Change," which include precontemplation, contemplation, action, maintenance, and relapse (Cohen et al., 2005; Prochaska & Diclemente, 1983). Brief interventions recognize that participants are in one of these five stages and seek to move them one step forward on the continuum. Brief interventions also draw on the concepts of the Theory of Planned Behavior (Ajzen, 1991). This theory suggests that in order for an individual to change a behavior, he or she must first develop an intention to change, and that intention is created when the individual believes there is a good reason for making the change, that he or she is capable of making it, and that other people will think well of them if they make the change. Brief interventions incorporate these ideas by structuring the interaction in order to persuade the participant that a change would be beneficial, that he or she has the skills and can find the necessary support to sustain a change, and that social norms support the type of change being considered. Finally, brief interventions that use a motivational interviewing interaction style are based on the theory that there are two key elements of successful behavior change counseling sessions—

relating with empathy, and evoking “change talk” from the participant (Miller & Rose, 2009). The Real Talk brief intervention was therefore scripted to include moments of reflecting back the participant’s feelings and opinions, asking open-ended questions, and negotiating objections the participant might raise about ending the use of dating aggression.

Another theoretical consideration was how Real Talk should be tailored by gender. Feminist theory suggests that the meaning, impact and consequences of experiencing partner aggression vary based on the gender of the perpetrator and/or victim (Reed, Raj, Miller, & Silverman, 2010). Therefore, interventionists were trained to stop the intervention if they sensed that participants might be ADA victims who were blaming themselves, particularly when intervening with female participants. The eligibility screening instrument specified that violence used in self-defense did not count, so all enrolled participants had perpetrated at least one act of physical or sexual violence that was not in self-defense. Nevertheless, interventionists were trained to listen for descriptions of violence that sounded more like self defense than aggression, and to stop the intervention if they sensed the patient needed victim services. In addition, interventionists were trained to take cues from the participants’ conversational style and to relate to them accordingly, which often meant using a different manner with females and males. For example, many female participants were eager to talk about their relationships as they might with a friend, so the interventionist would use a befriending style. Some of the male participants were more reticent and had a “down to business” tone, so the interventionist would match that interaction style.

Development Step 4: Creating Real Talk intervention materials—The Real Talk intervention materials were created iteratively over a year-long period. A first draft copy of the intervention manual, intervention handouts and props, and a resource book containing referral options were put together collaboratively by the PI, a brief intervention expert, research assistants, and a project advisor from a nationally-funded, local youth dating violence prevention program (i.e., Start Strong). Drafts were shared with youth peer-leaders affiliated with the Start Strong program, field tested with several patients, and then materials were refined.

Development Step 5: Implementing the intervention—The intervention was pilot-tested by a single, trained, White, female, social work student interventionist with ten participants in 2012. The procedure was that the interventionist would scan the computer system to note when age-appropriate patients with non-severe conditions were put in treatment rooms. She would then knock on their doors and ask if they were interested in participating in a research study about relationships. If they were interested, and confirmed that they were English-speaking, between 16–21 years old, had a dating partner in the past year, and at least one drink of alcohol in the last month, they completed a one-page eligibility survey that comprised 18 abusive acts items. The items were adapted from the Safe Dates Perpetration Acts Scale (Foshee et al., 1998), prefaced by the statements “do not count times that you did these things in self-defense,” and response options were “never,” “1 to 3 times,” “4 to 9 times,” and “10 or more times.” Those who endorsed one or more items were eligible. The pilot-testing took place in the context of a small-scale randomized controlled trial (RCT) (described below).

There were many lessons learned through the process of “going live” with the intervention with these ten participants. First, it took practice to get used to stopping and starting the intervention to make way for physicians and nurses who needed to tend to patients. Second, the interventionist learned to ask the patient if his or her dating partner was going to visit at the hospital in order to avoid unexpected interruptions that could have jeopardized patient safety. Although the participants had perpetrated ADA, many had also experienced bidirectional ADA, so the interventionist had to ensure that patients were not endangered by any aspect of their participation. Third, we learned that friends who accompanied patients to the hospital were often eligible for the intervention and wanted to participate as well. We received IRB approval to recruit and screen these non-patients for intervention participation in a private space in the hospital setting, as well. Fourth, we learned the importance of outreach and coordination with nursing staff; nurses who recognized the interventionist and knew about the intervention goals were quick to facilitate access to patients and offer help such as the use of their computer stations. Fifth, we learned that enrolling males was much more difficult than enrolling females for several reasons, including that males were less likely to come to the hospital so there were fewer of them to approach, that males who did come to the hospital were more likely to be too sick-feeling to want to participate in a conversation, and that males were on the whole less likely to want to engage in research when approached. The hypothesis that Black, male patients would be more likely to enroll if they were approached by a Black male interventionist as opposed to a White female was tested in a separate trial in 2014, and results indicated that the interventionist race and gender did not influence the engagement rate. Finally, we learned that patients experienced fatigue if the process of completing the RCT eligibility form, consent or assent form, baseline survey, and contact information form took too long—so we developed techniques for making these procedures as efficient as possible.

Development Step 6: Feasibility assessment—As described in Table 1, the term “feasibility” can be used to describe a number of different aspects of how easy, challenging, or worthwhile it is to implement an intervention. We conceptualized feasibility as comprising acceptability, demand, implementation, practicality, integration, and limited-efficacy. The demand, implementation, practicality and integration assessment results have already been described above, as assessment of these elements is also recommended as part of the Intervention Mapping development process. In this section, we describe our assessment of the intervention acceptability and limited-efficacy.

The acceptability of the intervention with the participants in the pilot was assessed via close and open-ended questions on the follow-up survey, and the acceptability with emergency department and other hospital staff was assessed via non-standardized one-on-one conversations with key informants. The closed-ended questions on the follow-up survey revealed that the overwhelming majority (93%) of participants would recommend the intervention to a friend in a similar situation, and 86% reported that the intervention helped them (Table 2). None reported that the intervention endangered them, and none reported that the intervention had a negative impact on them. The 12 participants who reported that the Real Talk intervention did help them were asked a follow-up open-ended question about how. Responses included:

It made me think about my actions.

After talking to you felt that I could do better for myself and stuff that isn't good for me. I liked that you helped me see they weren't doing me any good...I looked back at actions and wasn't happy with them.

The [action plan] list was helpful when I got angry. I actually looked at it and practiced it. It was helpful.

Participants were also asked what techniques they used to reduce violence perpetration as a result of the intervention, and replies included:

Taking a walk, praying, speaking to someone for advice on the situation that has been through it.

Breathing, talking to her about our problems, walking away.

Limited-efficacy is a test of an intervention during a feasibility study conducted with a convenience sample, with intermediate rather than final outcomes, shorter follow-up period, or limited statistical power (Bowen et al., 2009). The Real Talk limited-efficacy assessment used an RCT sample, and assessed both intermediate and final outcomes using valid and reliable measures, used a one month follow-up period, and had limited statistical power as only 36 individuals were enrolled. A copy of the instrument used and more detail about the measures is available from the first author. The Institutional Review Board (IRB) reviewed and approved the research protocol. Participants were between 15–19 years old, 26% male, 44% Black, 22% Hispanic, 15% White, and 19% Multiracial. At the one-month follow-up, 59% of the intervention group and 89% of the control group contributed T2 data, for a final analytic sample of N=27. Of these 27 participants, 10 were in the intervention group, and three subjects in the intervention group were male. Four of the 17 control group members were male. The control group received standard of care, which was a handout about ADA. Potential baseline differences between the intervention and control group participants on demographic variables (*i.e.*, sex, race, age) were assessed using a combination of chi-square and t-tests. The raw scores on measures of interest at post-test as outcome variables were analyzed via analysis of covariance (ANCOVA), where the exposure variable was the study condition (intervention vs. control) and the baseline values of outcome variable were included. Given that there were no differences in baseline characteristics between the intervention and control group participants, no variables were entered into regression models as statistical controls. In cases where the outcome of interest had binary response options (yes vs. no), logistic regression analysis was performed. Means, standard deviations and the range of scores on outcomes of interest pre- and post-intervention are presented in Supplementary Table 1. Table 2 presents the results of the limited-efficacy analysis which found that the intervention had an impact on reducing the number of participants in the pre-contemplation stage of change regarding their use of violence in intimate relationships, and may have moved them forward into the action stage. In addition, those in the intervention group were more likely than those in the control group to tell friends to help them stay calm around their partner after drinking alcohol, and to talk with their doctor to get help for their problems.

DISCUSSION

The Real Talk intervention was planned and developed using a standard, evidence-based approach (Bartholomew et al., 1998) (Hypothesis 1). First, it was determined that there was a need for this type of intervention in the hospital environment, and that from a practical standpoint the intervention could take place without interrupting patient care. Next, prior interventions with similar aims that addressed other issues such as adolescent substance use, peer violence, or adult partner violence victimization were reviewed in order to create a template for the intervention steps or script. The theories that informed these previously tested interventions, therefore, also underlies Real Talk—including the Stages of Change, Theory of Planned Behavior, and motivational-interviewing theory. Real Talk intervention materials, content, and ADA-specific scripting was created in collaboration with youth who were demographically similar to the intervention target population, experts in brief intervention, and experts in adult and adolescent relationship abuse. The final stage of development was to pilot-test the intervention to determine its acceptability and limited-efficacy.

The Real Talk intervention proved to be acceptable and non-harmful to participants during the pilot trial (Hypothesis 2). Participants reported that they would recommend the intervention to a friend in a similar situation and that they felt it had helped them. They reported specific ways in which the intervention helped them reconsider their use of aggressive tactics in relationship conflicts, and these included walking away from conflict, using breathing techniques to calm down, avoiding alcohol when they knew they might see their partner, and relying on friends for help with relationship conflict. Importantly, no adverse events were reported during the trial and no participant reported that they had been harmed or that their safety was jeopardized as a result of participating in the intervention or related research. The intervention was also acceptable to the emergency department staff, physicians, and social workers whose work was impacted by the presence of the interventionist in the emergency department.

The small-scale RCT was not powered to detect statistically significant differences in outcomes between the Real Talk intervention and control group participants, but rather to identify possible positive impacts of the intervention in order to inform decisions about whether it merited further testing. There were several encouraging results of the RCT, including that the intervention participants appeared to advance from the pre-contemplation and contemplation stages of the Stages of Change model to action related to desisting from ADA behavior. In addition, intervention group participants appeared more likely than control participants to use techniques to reduce their risk for ADA perpetration in high-risk situations, such as parties when they were consuming alcohol (Hypothesis 3). The RCT did not demonstrate substantial differences in self-reported ADA perpetration at the one month follow-up. This may have been partially attributable to the brevity of the follow-up period.

Collectively, these results encourage optimism about the potential for the Real Talk intervention to demonstrate impact on ADA perpetration via the larger-scale and longer-term trial it is being subjected to from 2014–2016. Nevertheless, there are reasons to be skeptical that Real Talk will prove efficacious: four prior partner violence perpetration brief

interventions were largely unsuccessful in achieving the desired impact. These four studies found, respectively, that: a brief intervention did not impact court-ordered batterers' recidivism after completing batterer intervention programs (Crane & Eckhardt, 2013), did not substantially improve knowledge, attitude or behavior change for adult hospital patients who were also partner abuse victims or perpetrators and were exposed an educational video (Ernst et al., 2011), did not reduce men's use of physical aggression against female partners (Woodin & O'Leary, 2010), and did not reduce urban-residing adolescents' perpetration of ADA (Cunningham et al., 2013). On the other hand, there were some positive findings in these studies, as well—Crane & Eckhardt's one session brief intervention did improve batterer intervention program attendance, even if it didn't result in better perpetration outcomes (Crane & Eckhardt, 2013). Ernest et al. found that they were able to change the knowledge, attitudes and practices of non-abusive and non-abused male and female patients to be less accepting of partner abuse, even if it didn't impact abusive and abused patients (Ernst et al., 2011), and Woodin & O'Leary found that their couples counseling brief intervention resulted in reductions of women's use of physical aggression and acceptance of emotional abuse, even if it didn't impact men (Woodin & O'Leary, 2010). Cunningham and colleagues, who conducted a brief intervention similar to Real Talk in that it was for primarily Black and Hispanic adolescents living in poverty in an urban area and took place in an emergency department, found that their intervention reduced self-reported moderate and severe dating violence *victimization* for up to one year following the intervention, even if it didn't impact perpetration (Cunningham et al., 2013). Cunningham et al.'s results are particularly notable given that a large-scale RCT conducted by a research team in Philadelphia recently concluded that there was no effect of a similar brief intervention for adult, alcohol-using, female victims of partner abuse in an emergency department setting (Rhodes et al., 2015). In short, the literature about the impact of brief intervention on either adult or adolescent partner abuse perpetration or victimization is too sparse, too disparate in terms of inclusion criteria, measures, and methods, and too divergent in results to be able to draw any conclusion about the potential for this form of tertiary prevention to be worthy of investment. Hopefully the forthcoming results of the larger-scale Real Talk RCT will help illuminate some aspects of the questions about this form of intervention and its utility for addressing ADA.

Limitations

This study was subject to several limitations. First, much of the feasibility assessment data was qualitative and relied on subjective reports from hospital staff, the interventionist, and patients. Qualitative reports were supplemented with quantitative survey questions for intervention participants, but social desirability may have influenced their results. Attempts were made to reassure patients of survey response confidentiality, but the self-report nature of the quantitative outcomes assessment may have under-detected negative outcomes and resulted in over-inflation of positive changes. In addition, the small sample size and short follow-up period meant that statistically significant changes may not have been apparent in our data. The larger-scale RCT underway should address this limitation.

Research implications

Forthcoming efficacy results from a larger-scale RCT will clarify the impact of Real Talk, and contribute to the emerging literature about the effectiveness of hospital-based interventions for ADA and adult partner abuse more generally. Additional formative, process and evaluation research that contributes to the knowledge-base about perpetrator-oriented interventions will be useful. The results of this feasibility assessment will hopefully encourage others to try novel approaches to ADA prevention. Innovation in the field is urgently needed.

Policy and clinical implications

It would be premature to make definitive policy or clinical recommendations based on the findings of a feasibility assessment. However, the results of this assessment nevertheless may be useful for stakeholders who are planning ADA prevention efforts; policies that address the perpetration of ADA, as well as the victimization, are needed. Clinical expertise in ADA perpetration, specifically, is also important for progress in this field.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Feasibility concepts and how they were assessed

Table 1

Feasibility concept	Definition	How it was assessed for Real Talk
Acceptability	How the intervention recipients and the interventionists feel about the intervention	<ul style="list-style-type: none"> • Open- and closed-ended questions answered by participants on follow-up survey • Report from interventionist
Demand	The extent to which there is need for the intervention with the population or in the setting	<ul style="list-style-type: none"> • Communication with ED staff about the fit of the intervention within organizational culture • Perceived demand as per pediatric healthcare staff and social workers
Implementation	The extent, likelihood and manner that an intervention can be fully implemented as planned in a non-research situation	<ul style="list-style-type: none"> • Quality of implementation assessed through standardized fidelity assessment
Practicality	The extent to which an intervention can be delivered when resources, time, or other factors make it challenging	<ul style="list-style-type: none"> • Documented factors affecting implementation ease or difficulty
Integration	The level of system change needed to integrate the intervention into the existing infrastructure	<ul style="list-style-type: none"> • Perceived fit with infrastructure according to ED staff
Limited efficacy-testing	Test of the intervention on outcomes in a limited way; using a small sample, convenience sample, or non-experimental design.	<ul style="list-style-type: none"> • Pre- and post-intervention surveys were implemented with a small sample of intervention participants; results are presented in Table 2.

Table 2

Limited-efficacy of intervention on select outcomes (N=27)

	β	SE	p-value
<u>Readiness to change relationship problem behaviors (Stages of Change)^a</u>			
Precontemplation	-0.57	0.27	0.04*
Contemplation	-0.39	0.27	0.17
Action	0.23	0.20	0.26
Maintenance	-0.14	0.35	0.68
<u>Relationship behavior in past month</u>			
Physical or sexual dating violence perpetration ^b	-0.05	0.32	0.89
Avoided seeing partner when knew would be drinking alcohol ^c	-0.08	0.12	0.50
Got away or stayed away from partner when drunk to avoid fight ^c	0.41	0.24	0.10
Tell my friends to help me stay calm around my partner after drinking alcohol ^c	0.75	0.29	0.02*
Something else that would stop me from harming or being unfair to my partner ^c	1.32	0.64	0.10
<u>Use of helping services^d</u>			
Talked to a counselor about drug or alcohol use	3.21	(0.43–23.8)	0.25
Talked to a counselor about relationship	0.90	(0.08–10.7)	0.94
Called a hotline for help with drugs, alcohol, mental health, or relationship	0.94	(0.07–12.0)	0.96
Talked to my doctor about getting help for problems	7.50	(1.09–51.5)	0.04*

^a Assessed via an adapted version of the Readiness to Change Scale, comprising 10 items with five Likert-type scale response options including “strongly disagree,” “disagree,” “undecided,” “agree,” and “strongly agree.” A sample item from the precontemplation subscale is: “As far as I’m concerned, I don’t have any relationship problems that need changing.” A decrease in the score indicates participants agreed less with the subscale statements in that category. Reliability coefficient $\alpha=0.70$. For means, SD, and range please see online Supplementary Table 1.

^b Physical or sexual dating violence perpetration in the past three months was assessed via an 18-item version of the Safe Dates Perpetration Acts Scale (see Foshee, 1998) which used four response options: “never,” “1 to 3 times,” “4 to 9 times,” and “10 or more times.” A continuous score was calculated; higher scores represented more acts had taken place and/or taken place more frequently. Reliability coefficient: $\alpha=0.79$.

^c Assessed via an original item with response options: “No times,” “1 to 3 times,” “4 to 6 times,” and “7 or more times.”

^d Assessed via an original item with question stem: “In the past month, have you done any of the following?” with response options “yes,” “no,” and “don’t know.”

**
p 0.05