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Client Retention in Community Treatment: Completer and Noncompleter Experiences of an Individualized, Needs-Based Partner Abuse Intervention Program

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Abstract

There has been increased interest in the subjective experiences of participants of community partner abuse intervention programs (PAIPs). In the context of high attrition rates, qualitative research is needed to understand the factors associated with sustained engagement and dropout. Using a community nonmandated PAIP, the current study is a rare investigation of the experiences of both completers and noncompleters. We explored the differences between completers' and noncompleters' perceptions of the treatment process, the reasons for sustained program engagement, and the perceived outcomes of treatment. Semi-structured interviews were completed with 14 participants: nine completers and five noncompleters. The majority of participants were referred by children's social care and were unemployed at the time of interview. The interviews were conducted by research staff independent

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from the treatment-providing organization. Three themes emerged from the data: (a) Treatment as Challenging Yet Enlightening, (b) the Importance of a Well-timed and Safe Therapeutic Environment, and (c) Improved Emotional Self-Management Due to Treatment. Results highlighted how structured individualized sessions, underpinned by a strong therapeutic alliance with facilitators, helped participants increase their interpersonal problem-solving and communication skills. The study reinforced the importance of developing a therapeutic alliance and providing structured individualized treatment characterized by flexibility and accessibility. Noncompletion was perceived as related to known risk factors and treatment readiness. Therefore, it may be beneficial to employ screening measures to monitor these factors. Future research should use larger, more diverse samples to further investigate subjective experiences of PAIP completers and, particularly, noncompleters to enhance the limited literature in this area.

Keywords

batterer intervention, dropout, intimate partner violence, programs, qualitative research, treatment completion

"Why do I want to do this?" "Is it the right program for me?" "Is it worth the trouble?" "Do I feel supported?" These are some of the questions clients ask themselves at referral and beyond. Yet, not securing participants' commitment jeopardizes successful program completion, a key potential tool in reducing abuse of intimate partners. Such abuse has serious health and social ramifications for partners and families (Costa et al., 2015). In the United Kingdom, in 2017/2018, an estimated 2 million adults aged 16 to 59 years experienced some form of intimate partner abuse (Office for National Statistics [ONS], 2018). Focused surveys suggest a majority of incidents are repeat victimizations (ONS, 2016) and partner abuse intervention programs (PAIPs)[1] are a key strategy in preventing these.

However, following five meta-analyses of approximately 20 adequately controlled outcome studies, research does not offer clear support for PAIPs in preventing recidivism (Akoensi et al., 2013; Babcock et al., 2004; Feder & Wilson, 2005; Smedslund et al., 2011; Stover et al., 2009). Leaving aside issues with internal and external validity in study design, this literature suggests that reasons for negligible effects include failure to provide differentiated treatment, high rates of client drop out, low motivation to change, and problems with implementation. As a pervasive concern surrounds attrition rates, the current study was motivated by the need to identify obstacles to engagement and compliance, particularly as experienced by PAIP noncompleters.

Program Completion and Effectiveness

In response to lack of treatment effects, some primary studies have proposed evidence for a "completion effect": both in evaluations of general offender rehabilitation programs (Hollin et al., 2008; Palmer et al., 2007) and in evaluations of PAIPs (Jones et al., 2004). Completion effects are distinct from treatment effects because the intended change is only seen in program completers and not in all program participants.

If completion is essential, it implicates client engagement and retention in the program as a precursor for change. Completion rates for PAIPs are not high, however. On average, around 50% of participants fail to complete the full program, regardless of whether or not this is court mandated (Daly & Pelowski, 2000; Olver et al., 2011). Positive overall effects of treatment are inhibited by such low completion rates: Abusers who fail to complete are likely to be at greater risk to continue abusive relationship behaviors (Eckhardt, Holtzworth-Munroe, et al., 2008; Olver et al., 2011). Eckhardt et al. found that attrition was significantly related to future arrests such that more than twice as many program noncompleters (39.7%) than completers (17.9%) were rearrested during the 13-month follow-up.

The "completion effect" suggests that the predictors of dropout and recidivism may overlap. Indeed, reviews of PAIP studies have consistently shown that specific risk characteristics link to noncompletion such that, relative to completers, noncompleters are more often younger, unemployed or on low income, with substance abuse problems, and previously criminally convicted, sometimes including for domestic violence offenses (Daly & Pelowski, 2000; Jewell & Wormith, 2010). Although knowledge of salient client characteristics is important, outcome evaluations do not attend to how the program and its delivery might be altered for these clients. To investigate the psychological and treatment characteristics, evaluations must incorporate mediating factors (Bowen & Gilchrist, 2004) such as how the client characteristics interact with the program design and therapist delivery.

Reasons Given for Program Completion and Noncompletion

A small but growing body of research has recently emerged regarding PAIP clients' experiences of their therapy (Boira et al., 2013; Chovanec, 2014; Gray et al., 2014; Holdsworth et al., 2019; Holtrop et al., 2017; Morran, 2013; Morrison et al., 2018, 2019; Parra-Cardona et al., 2013; Portnoy & Murphy, 2017; Shamai & Buchbinder, 2010; Silverglied & Mankowski, 2006). Dominant themes, reviewed below, include issues regarding choice about treatment, the bond with the therapist, the benefit of skill building, and safety in the therapeutic environment.

Increased dropout rates are associated with higher degrees of coercion (Parhar et al., 2008), yet the majority of abusers entering PAIPs do so after a court order (see Cannon et al., 2016). A noted concern is that coerced compliance may reflect acquiescence rather than genuine engagement and change (Boira et al., 2013; Kelly & Westmarland, 2015). Boira et al.'s (2013) discussion groups with 27 PAIP participants found that the compulsory nature of the intervention (feeling "forced" to do it) overshadowed the entire process. Whereas some participants gradually developed an appreciation of the PAIP content, others remained ambivalent or actively disputed the need for the program. Similarly, Kelly and Westmarland (2015) found "purely instrumental" compliance by clients whose child contact was conditional on completion (p. 38). Coercing clients to complete therapy may be detrimental, yet few studies have been completed of client experiences in contexts other than legally mandated intervention.

The bond or "working alliance" (WA)[2] between the therapist and client creates the conditions for behavioral change via the intervention and may be one means to promote engagement and mitigate negative impacts of coerced treatment (Eckhardt et al., 2013). Some studies have identified the therapists as key in producing an internal change process (Boira et al., 2013; Holdsworth et al., 2019; Holtrop et al., 2017; Parra-Cardona et al., 2013; Shamai & Buchbinder, 2010). In the work by Shamai and Buchbinder (2010), participants likened their facilitator to a "teacher and father" (p. 1344). Particular therapist skills have been identified, including empathic listening and supporting the client's own problem-solving using PAIP techniques (Boira et al., 2013). Boira and colleagues found that WA ratings correlated strongly and positively with perceptions of the usefulness of therapy. Therefore, a good WA may be a mediator of successful engagement with PAIP learning.

A number of studies exploring client engagement have recommended that PAIP delivery is rebalanced to focus less on confrontation and more on the longer term support and skills needed by individuals in negotiating their desistance journey (Boira et al., 2013; Holtrop et al., 2017; Morran, 2013; Parra-Cadona et al., 2013; Shamai & Buchbinder, 2010). Most PAIPs offer psycho-education regarding patriarchal attitudes underpinning coercive control (Cannon et al., 2016). Such programs, based on the Duluth model (Pence & Paymar, 1993), assume that abuse stems from a belief system of entitlement to male privilege (Day et al., 2010). Adopting a "therapist" role is seen as contentious within this model, where to collaborate with an abuser is to collude with his excuses veiling his sexist beliefs. Although the large majority of PAIPs ascribe to the Duluth model, many are hybrid and integrate cognitive behavioral methods (Maiuro & Eberle, 2008). Notwithstanding, in an illuminating study, completers queried regarding their perceptions of the usefulness

of PAIP content rated lowest those sessions concentrating on patriarchal beliefs and rated highest those sessions on ability to control own behavior, emotional self-management, and cognitive techniques to prevent relapse (Boira et al., 2013).

Treatment occurs in group format in all PAIPs operating under the Duluth model and in the majority identifying as distinctly cognitive behavioral therapy (CBT; for a review, see Babcock et al., 2016). Compared with individual therapy, groups are favored for their opportunities for peer challenge and peer modeling of change, and for allowing therapists to observe client interactions. A number of studies note, however, that group dynamics can be negatively affected by individual client presentations, including variations in levels of past trauma (Morran, 2013; Morrison et al., 2018), degree of willingness to change (Boira et al., 2013; Gray et al., 2014; Morrison et al., 2019), and external lifestyle pressures (Gray et al., 2014). These issues can lead to individuals feeling stuck, and subsequently disengaging, which impacts negatively on group morale and belief in change. Furthermore, for some clients, making disclosures in group situations can trigger strong emotions, including guilt and shame, which may obstruct engagement or increase risk (Holdsworth et al., 2019). Therefore, it is questionable whether the group work format is optimal for all clients.

Although the above studies provide useful insights to help reduce barriers to engagement, a serious gap in the literature is that the extant research has been based on men who completed treatment. The voices of noncompleters are generally absent and research is not able to verify within-study whether these clients have different opinions of treatment compared with PAIP completers. As noted previously, program completers do not tend to represent the diversity of the wider client group who are generally younger and less educated (Jewell & Wormith, 2010). In addition, reasons given for barriers to engagement have been related to group work, generally Duluth-based, PAIPs. Such PAIPs have limited capacity for client–treatment matching as they are not needs based, that is, not differentiated by assessed client characteristics. It is therefore uncertain whether findings similar to those reviewed above would emerge from questioning noncompleters and completers of a pure CBT program with a more individualized focus. Furthermore, clients' opinions have not previously been fully explored regarding therapy that is not legally mandated.

The Current Study

The current study therefore examined participants' views of an individualized community CBT program delivered in Portsmouth,[3] a city on the south

coast of England, United Kingdom. The program is introduced in the "Method" section. Substantial efforts were made to recruit noncompleters as attention to this subpopulation is critical, given high the attrition rates for PAIPs (Olver et al., 2011). Noncompletion was defined as postcommencement client-initiated dropout (Wormith & Olver, 2002). To ensure a well-rounded insight, the study examined individuals' experiences of the treatment process as well as the perceived treatment outcomes. Therefore, the study was guided by the following questions:

Research Question 1: What are the differences between completers' and noncompleters' perceptions of the treatment process within an individualized PAIP?
Research Question 2: How do clients explain their sustained engagement of, or noncompletion of, individualized community PAIP treatment?
Research Question 3: What are the perceived outcomes following completion/termination of an individualized community PAIP?

Method

Participants and Sampling

A system was set up to recruit a purposive sample of completers and noncompleters who had been program participants. Sample size guidelines for thematic analysis studies suggest eight to 10 participants for interviews in small projects (Braun & Clarke, 2013). We hoped to recruit at least eight completers and eight noncompleters, and, to achieve this, we reached out to many of each subgroup. Clients were first contacted via text message and then, if there was no response, via telephone call or voicemail. They were subsequently sent a letter of invitation for interview. A total of 70 prospective participants were approached through four different means of contact over the course of 5 months. Ultimately, a total of 14 participants, that is, nine completers and five noncompleters, were recruited.

Our participants included 13 males and one female, and all identified as heterosexual. Most clients (11/14 [78.6%]) were referred by children's social care, with only three self-referrals. Participants' occupations ranged from student, to restaurant manager, to unemployed. Eight (57.1%) of the 14 clients were unemployed and one half of these unemployed clients came from the smaller noncompleter group. All but two clients, including all noncompleters, identified as White British. Although the mean age was 33.1 years, the completers were slightly older on average ($M = 35.88$ years, $SD = 6.85$, range = 28–50 years) than the noncompleters ($M = 27.75$ years, $SD = 1.71$, range = 27–30 years).

On average, the program duration for completers was 11.1 months (SD = 2.42, range = 7–13 months). All noncompleters had terminated their program involvement and were not currently engaged with Up2U. The average duration of the program before termination for noncompleters was 1.75 months (SD =1.08, range = 1–3 months).

Ethical Considerations

To avoid conflicting interests and to lower the probability of validity issues such as demand characteristics, all interviews were conducted by the second author (C.D.S.), a researcher independent from the current therapeutic program. Although she had previously assisted with research regarding the program, C.D.S. was university affiliated and had no relationship with the program or its participants. The study was approved on February 24, 2016, following a full university institutional review.

Materials

The program. The PAIP at the center of the current study is Up2U: Creating Healthy Relationships,[4] developed by Portsmouth City Council. Up2U is not legally enforceable and accepts self-referrals, as well as referrals from police and probation, children's services, and general medical practitioners. Whereas many custodial and community PAIPs have been criticized for using a "one size fits all" approach (Dia et al., 2009), Up2U matches participants to different intensities and modules of treatment based upon their individually assessed risk/needs and has no fixed duration (for a full program description, see Pearson & Ford, 2018). Up2U is open to abuser clients of all genders and sexual orientations provided the client is above the age of 16 years and accepts that their behaviors are unhealthy. The breadth of the program's eligibility criteria is important as a large-scale survey of bisexual women in Michigan, United States indicated that they experienced more physical and sexual abuse from their female than from their male partners (Lie & Gentlewarrier, 1991). Up2U views abuse perpetration as due to a variety of causes, not limited to male patriarchy, and therefore delivers treatment on a one-to-one basis. Although abuse perpetrators are identified not to be a homogeneous group (Dutton, 2007), most treatment models fail to reflect such individual differences (Cannon et al., 2016).

Semi-structured interview. C.D.S. conducted individual semi-structured interviews with participants. The interview schedule was adapted from previous academic research (McMurran & McCulloch, 2007; Shamai & Buchbinder, 2010) and covered a variety of discussion topics to allow the participant to

digress in detail their own personal experience of the program.[5] Discussion points included aspects such as individual reasons for either completion or noncompletion, the process of treatment, and the therapeutic alliance; for example, "How interesting did you find the program?" To maintain fluidity, the semi-structured interviews followed a nonrigid schedule that allowed freedom of movement between topics. Where necessary, prompts were used such as "Was the program suitable for people of your gender" and "How did you 'get on' with the facilitator?"

Procedure

Participants were invited to attend a one-to-one interview held at the city council offices. This location, the same setting as for the program, was chosen as the participants were familiar with the surroundings. This also facilitated on-site security measures. The interviews were conducted in a private meeting room within the council building and were audio recorded. Prior to the commencement of the interview, a spoken preamble explained the nature of the research and the participant was given a participant information sheet and an informed consent form to sign. Participants were not paid/compensated for their time. All participants were informed that their responses would be confidential, and that anonymity would also be preserved. The interviews lasted approximately 40 min or until the interviewer felt that saturation was achieved. Following the termination of the interviews, all participants were fully debriefed.

Data Transcription and Analyses

Preparing the data from the recordings for analysis required a total of 50 hr of transcription time. Thematic analysis (TA) was chosen as the most appropriate method due to its straightforward, flexible, and accessible nature (McLeod, 2011). TA is appropriate for analysis of interview data as it is underpinned by qualitative methodology, which emphasizes the use of researcher subjectivity as a resource rather than a potential issue (Clarke & Braun, 2018). Due to the nature of the research questions, TA was also suitable as it can be used in critical qualitative approaches to tell a story about the "so what" of the data as opposed to pure data description (Clarke & Braun, 2013).

Clarke and Braun (2018) have noted some confusion in defining a "theme." Therefore, this study complied with the notion that a theme occurs when there is a core concept present. However, themes are active creations of the researcher, as opposed to just passively emerging from the dataset fully formed (DeSantis & Ugarriza, 2000). Accordingly, and in line with Braun and Clarke (2006), the analysis consisted of multiple phases. The first phase involved

Table 1. Themes Relating to Specific Research Questions.

	Research Question	Associated Theme	Representation ($N_{participants}$)
1.	Completers' and noncompleters' Perceptions of the treatment process	Treatment process experienced as challenging yet enlightening	11
2.	Explanations for sustained engagement and noncompletion	Importance of a timely, safe therapeutic environment	13
3.	Perceived outcomes following program completion/exit	Improved emotional self-management	12

familiarization with the data whereby all transcripts were read 3 times and any initial thoughts were recorded before the next phase of analysis. The next phase was *initial coding*. During this phase, it was extremely important to code as many meaningful segments of data as possible to reduce the chance of losing a potential theme. Following this, all codes were allocated into various potential themes using both NVivo software and "mind map" drawings. Mind maps were used to facilitate creative thinking while integrating the concepts and emergent themes with the empirical data (Buzan & Buzan, 2010). Again, to avoid losing any potentially important data, a theme labeled "miscellaneous" was created to situate relevant codes that did not fit comfortably elsewhere. The next phase involved *reviewing themes* to evaluate their strength. This involved reviews of the extracts, as well as reviews of themes within and between interviews (Braun and Clarke, 2006). The final phase of analysis involved *defining and naming themes*. It was particularly important to capture the "essence" of each theme to underpin the core concept and how it relates to the overall "story" in conjunction with the research questions.

Due to the idiosyncratic nature of this research, no generalizations to other settings or populations are appropriate (Creswell, 1998). This critical qualitative methodology allows, however, for a much needed understanding into individual client experiences of PAIP treatment and motivations for compliance.

Results

Our findings are structured around the three research questions as the data were formulated into three related main themes overviewed in Table 1. What came through was that therapy was inherently challenging, but that the timing and the containment offered by the intervention was paramount. The

perceived consequence of this treatment was improved self-regulation. The themes percolated through both the completers' and noncompleters' accounts of their experiences of the program. However, given that previous research has rarely questioned noncompleters, these participants' responses are specifically considered in each subsection below.

Research Question 1: Completers' and Noncompleters' Perceptions of the Treatment Process

Treatment experienced as challenging yet enlightening. One idea that emerged repeatedly was that the treatment process was interactive, challenging, and enlightening. Participants reported learning a variety of skills, through simple activities and conversation, as well as developing the ability to acknowledge potentially negative characteristics about themselves:

> In a bad way sort of thing like it makes you not like yourself in the ways when you are bad . . . so I sort of know how to deal with stuff . . . it's like . . . I dunno you realise where you've gone wrong sort of thing from it . . . and when you're looking at the way it's written like on that coloured person session . . . the way the bad things you do are written you just think arh that's not me is it . . . surely that can't be me . . . it's tough 'cos you just don't see it at the time but when it's right there in black and white you sort of have to face up to it. (Leon,[6] male completer)

Although participants found some aspects of treatment difficult, they perceived the sessions as informative, a means of reframing the problem, and an opportunity for personal growth. Reflecting the challenge of treatment, Barry relayed:

> Yeah like I dunno they were proper laid-back I had a chance to say my piece like I wasn't being talked at—it was a two-way thing which is like important for me 'cos otherwise it feels a bit . . . formal you know and like when you are back in school and you have to get permission to talk . . . I would've hated that . . . no but obviously every session had a goal like and that was always explained, and me and [facilitator] always got there in the end like but like it was challenging really it was but we always got it done in a relaxed way which made me feel positive about the experience. (Barry, male noncompleter)

This interviewee, Barry, who identified as dyslexic, also mentioned "pressure" and "stressful" when describing the inherently challenging sessions. Conversely, Peter, a completer, highlighted that activities were "adjusted" to suit his learning needs ("we took the sessions at my slow pace so I didn't get

stressed out you know yeah it was good"). Noncompleter Trevor, however, repeated twice "my head just went" to explain his reaction to being put "on the spot" during the session activities. Although he described the process in positive terms ("It isn't really childish . . . it's chilled out and easy to understand"), such language suggests that some clients may need additional preparation, support, or adjustment to benefit fully from the session content.

Research Question 2: Explanations for Sustained Engagement and Noncompletion

The data pertaining to this question reflected the Importance of a Timely, Safe Therapeutic Environment, underpinned by two themes, *Completion related to safety and the therapeutic alliance* and *Noncompletion related to dynamic risk factors and treatment readiness*.

Completion related to safety and the therapeutic alliance. A frequently occurring theme throughout the narratives of the completers was the positive feeling of being in a "safe space" while undergoing the program:

> I realised that through doing this like being able to hold up a conversation in a calm environment where I am being listened to with no judgement to be like . . . to be completely honest about my past and my behaviour but know that nothing bad is gonna come from it like they are actually there to help me not try and screw me over type of thing. (Leon, male completer)

This highlights the importance of the program environment in relation to treatment engagement. In using words such as "relaxed" and "at ease," the completers reported very positive experiences. Leon alluded to negative previous experiences of interventions, but Curtis directly compared his experience with that of previous treatment:

> You know I've found his sessions really helpful and my process in and uh throughout the whole programme I just felt comfortable and safe so that made me feel able um to yeah able to talk in the environment which yeah I think I wouldn't of been able to do—I definitely didn't in my anger management. (Curtis, male completer)

The data illustrate the facilitator's role in participants' experiences, not least the consistent level of support received. It appears that this had an impact upon individuals' sustained engagement as almost all completers reported the importance of support also being available outside of sessions:

> If I didn't have a session, like my sessions . . . would be on a Wednesday, like if I needed someone to talk to . . . dya know what I mean like if I would text him or I would come in and I'd say like have you got ten minutes and he was always . . . dya know what I mean like . . . he . . . he didn't mind . . . like he would take time out. (Harry, male completer)

The accounts suggest that the program staff engage in genuine working relationships with the clients and are seen as influential motivators, positively affecting the treatment experience. The sense of connection, or attachment, is neatly conveyed by Amber:

> I can sit there and have a big conversation about something and he will come out with answers like mates do like "if you don't take my advice then that's down to you but there's my advice . . ." that's what it's like. (Amber, female completer)

Noncompletion related to dynamic risk factors and treatment readiness. While on the surface it appears that the five noncompleters left the program for different reasons, as illustrated below, all relate to risk and treatment readiness. Two participants withdrew due to other family priorities, one left due to alcohol relapse, one withdrew due to the stress of being unemployed and changing social situations, and another disengaged due to the death of a family member:

> The thing is yeah . . . I have a lot of stuff going on and had a lot of stuff going on in my life . . . my partner didn't see why the social was making me go on it, you know wasting time when I could actually be looking for a job . . . and like yeah bad stuff only really happened when I had the booze so it isn't really an issue for me like . . . I have anger issues and yeah I'm working on that but I don't need to attend a class for an hour to sort that out like I have kids to look after and I love my kids . . . I do. (Barry, male noncompleter)

Similarly, noncompleter Jay stated, "To be honest with you social services turned around and said 'right you've got to do this' and I'm thinking 'you know what I'll do it just to shut you up.'" This sense of being coerced into treatment is related to treatment unpreparedness, poor engagement, and noncompletion. Such external factors are important, given the large volume of referrals from children's social care.

For others, noncompletion was related to treatment being perceived as compounding existing high levels of anxiety. For Lawrie, there was a lack of stability and space to contemplate change:

> Normally I wouldn't come out of the house because I've got anxiety and depression . . . I wouldn't come out of the house wouldn't meet new people . . . I met [facilitator 1] and I thought I would have [facilitator 1] but then he said nope you're now with [facilitator 2] and I was like "great thanks" which just sent me a bit crazier . . . actually I was with [facilitator 3] but it was just like school kind of stuff basically and it was like I've done this like twenty years ago . . . she was straight to it you can't really sit there with [facilitator 3] and have a natter and a chat with her she's straight to the point and like oh my god I've come to relax for five minutes. (Lawrie, male noncompleter)

The interplay between external factors and internal readiness to change is also evident when listening to Frank who explained that he had to leave treatment due to going through a difficult and stressful time:

> In terms of work I was all over the place work and that erm . . . yet again my ex-partner a lot of stuff going on between us and work and I've had a couple of changes in job because I couldn't keep them since that I just had to move back in with my parents after I moved out of my place so yeah I had a really rough patch where I just wanted to be on my own really . . . I didn't want to embrace or talk to anyone at all. (Frank, male noncompleter)

Research Question 3: Perceived Outcomes Following Program Completion/Exit

Improved emotional self-management due to treatment. Nearly all participants, whether completer or noncompleter, reported positive outcomes for relationship communication due to improved self-management. Emphasis was placed upon identifying feelings of anger to prevent escalation. Completers considered these skills to be beneficial in real-life situations as a means of conflict management:

> No word of a lie I feel like I can trust now and not everyone is out to get me . . . I really don't fly off the wall at any little thing like, . . . its easy things which weren't easy for me like removing myself from a situation for five minutes like out of the firing line so that I'm not getting angrier and angrier . . . 'cos then once you have removed yourself like when you go outside and you have room to think and breathe like sometimes actually a lot of the times the row doesn't seem as important as it did back in that moment and then it's so much easier to cool it down and actually have a conversation to sort it out you know yeah like yeah I am a much better person overall like yeah. (Curtis, male completer)

Amber, the female completer, described having become a proponent of the program among her friends, being proud that she can diffuse an argument "very, very quickly." When asked what other changes she could see since finishing, she answered,

> I'm not as angry . . . I can actually talk to people now as not like building it all up and then screaming it and shouting erm it makes it easier for me to actually talk and say what I'm thinking . . . I'm a lot more calmer than what I was and I'm actually more relaxed and I'm not all tight up and don't want to run outside and go grrrr at someone . . . usually if someone even looked at me that would trigger me straight away . . . but it doesn't no more I'm just like "whatever" and carry on walking . . . I'm a good girl now. (Amber, female completer)

In general, completers frequently mentioned having learned to accept that other people have different opinions and being able to listen to them neutrally. The following is representative of what many completers seemed to suggest as an outcome of treatment:

> How it was yeah I was bad as I said like proper angry but no word of a lie like I have got some skills from this like I am so much more open to things like other people opinions and actually taking them in not such a negative instant way . . . like I have the patience to actually let someone talk before saying my bit or letting whatever is in my head fly out of my mouth. . . . (Peter, male completer)

Despite terminating the program early, among noncompleters, a theme of progress in communication nevertheless also emerged as an outcome of treatment. Barry, for example, felt that the supportive professional relationship made him feel less defensive in other relationships:

> I don't know that all of the other session givers are the same but she made me feel comfortable and like I could talk which I haven't done in ages like I wouldn't of ever spoke about stuff like that to no one from the government or council or something so she must have done something right . . . yeah I can communicate better. (Barry, male noncompleter)

Although other noncompleters described being able to communicate more effectively within their interpersonal relationships, this was not on a consistent basis. Frank reflected, "I can walk away from an argument since meeting (the facilitator) . . . but not every time—sometimes I might pick and pick just like her . . . it needs to improve." Trevor, whose experience of family bereavement led to his premature termination of the program, described an interrupted process, saying "I need to come back to address my anger."

Discussion

By integrating accounts from program noncompleters as well as completers, the current study offers a contribution to the literature on clients' experiences of community PAIPs. Program participant experiences are of particular importance in the light of PAIP attrition rates of 50% (Olver et al., 2011). The current results identify reasons for engagement, whether sustained or interrupted, and provide insight into successful treatment process. These results should be considered as intersubjective and context-bound, consistent with the qualitative paradigm (Denzin, 1984). Below, we discuss and interpret the results in the context of each research question and the relevant empirical and theoretical literature.

Regarding the first research question (What are completers' and noncompleters' perceptions of the treatment process?), a clear theme emerged suggesting that the treatment process was challenging, but enlightening. However, the appropriateness of the environment was paramount for participants. Learning of new skills was facilitated by the combination of a good working alliance (WA) and mutually agreed interactive activities. Key facets of the WA include agreeing on goals and tasks (Bordin, 1994), yet previous research has found some completers question the relevance of certain topics, and some even dispute that they need a PAIP (Boira et al., 2013; Portnoy & Murphy, 2017). The current program was individualized CBT in the context of nonmandatory referral, and so a good match between client's learning goals and those of the program might be expected.

The present results indicated that some clients found material challenging. Sometimes this related to levels of literacy and the accounts suggest that throughout the sessions there was a sensitivity to clients' individual attributes, for example, taking the session at a slower pace so that they did not feel overwhelmed. Other clients, however, felt that they just could not deal with it ("My head just went"). That some clients feel mentally exhausted and emotionally drained by their own situations has been found previously in PAIP intervention and has been related to previously unaddressed backgrounds of trauma (Boira et al., 2013; Morran, 2013; Morrison et al., 2018). In group work, some clients can be invasive and offer unwanted advice (Boira et al., 2013; Morrison et al., 2019), and some may inhibit disclosing weaknesses for fear of negative evaluation by other members (Morrison et al., 2018). Professional facilitators, in individual therapy, are likely to be better at the skills of nonjudgemental listening, avoiding criticism, and offering consistent support; qualities that group work clients appreciate from their group leaders (Boira et al., 2013).

With few exceptions, the facilitators succeeded in being able to adapt material to the learning needs of individual clients, an issue identified previously by

general offender group work noncompleters (McMurran & McCulloch, 2007). The ability of the therapist to create a learning environment is characteristic of the empirically supported principle of responsivity in general offender rehabilitation (Bourgon & Bonta, 2014). Within the two dimensions of responsivity, "general" and "specific", specific responsivity refers to how well the intervention is tailored to suit the learning style and abilities of the individual client. Although the current study did not seek to assess adherence to the principles of effective interventions, the results do suggest the importance of integrity to the responsivity principle, that is, sticking with the program without losing sight of the individual.

Considering the reasons given for sustained program engagement (Research Question 2), completers strongly attributed this to the bond or alliance with their facilitator. Consistent with studies of reasons given for client engagement in the emergent PAIP literature (Boira et al., 2013), and more widely (Sturgess et al., 2016), facilitators successfully developed a "safe environment" whereby participants felt able to respond openly to the program. Many of the participants were unemployed, and these marginal clients may have been sensitive to signs of interpersonal judgment in the working relationship. Withdrawal can be a symptom of rejection-sensitivity rupturing the therapeutic alliance (Black et al., 2013) and might be expected to occur more readily in a nonmandatory PAIP context compared with legally enforced treatment where criminal justice consequences follow noncompliance. However, participants identified that they did not feel judged thanks to the facilitators maintaining a neutral stance. This may be associated with the program's motivational needs-based approach, as opposed to one focused on holding men accountable. A recent randomized clinical trial suggests that incorporating motivational plans into CBT PAIPs increases client compliance (Lila et al., 2018).

Participants also identified the freedom to contact the facilitator outside of sessions as an important aspect of the treatment process. A developing body of research has highlighted that to maintain engagement, some offenders benefit from staff support inside and outside of treatment (Holtrop et al., 2017; Morran, 2013; Sturgess et al., 2016). Combined with structuring skills of modeling and skill building, flexible, collaborative, and responsive relationship skills are recommended practices for correctional staff (Andrews et al., 2011). They are an indication of a high-quality therapeutic WA. By offering out-of-hours support and drop-in sessions the facilitators demonstrate, and model, genuine relationships. Shamai and Buchbinder's (2010) analogy of the facilitator as a father figure seems germane (although we found no evidence of respect for the power differential). Good judgment is required in assessing when support can/should be gradually rescinded.

Noncompletion was perceived as being related to external lifestyle factors. The challenges of PAIP compliance alongside external demands have been noted previously (Chovanec, 2014; Gray et al., 2014). What was evident by considering the experiences of noncompleters, however, was that the reasons given for drop out were all associated with the "central eight" risk factors (Bonta & Andrews, 2017). Noncompleters suggested that they were unable to stay fully engaged with treatment because of "a lot of stuff going on" suggesting the strength of risk/need factors, including substance abuse, antisocial cognitions, and family/marital issues. A positive association between the central eight risk factors and dropout is not surprising, given the empirical link between dropout and recidivism risk (Olver et al., 2011), and between recidivism and heightened risk on the "central eight" factors (Bonta et al., 2014). This reinforces the likely benefit of facilitators regularly reviewing with the client the risk assessment information gathered at program commencement to understand, identify, and refocus treatment to address factors that represent risk for general recidivism and hence dropout. Previous work examining program retention of PAIP clients suggested that men whose self-identified problems matched the focus of intervention were less likely to drop out (Cadsky et al., 1996).

Noncompleters' explanations reflect treatment readiness and are consistent with the factors outlined within the multifactor offender readiness model (MORM; Ward et al., 2004). The MORM is a multifaceted model incorporating a range of individual and contextual factors which influence offenders' treatment readiness. The MORM suggests that the offender will be "ready" to engage in treatment if they possess certain cognitive, volitional, and emotional features and experience an environment where such changes are possible and supported (Day & Doyle, 2010). In the current study sample, the noncompleters reported a number of factors that are negatively related to the principles of the MORM such as a chaotic home environment, negative appraisals of treatment, and unsupportive partners. Within MORM, feeling coerced or lacking choice can negatively affect treatment readiness and engagement. Accordingly, some noncompleters discussed taking part in the program because "the social wanted me to" and "to shut them up," highlighting perceived coercion. This echoes findings by Kelly and Westmarland (2015), where like the current study, the majority of referrals were from children's social care. Research suggests that treatment effects are larger for truly voluntary programs, compared with coerced and legally mandated programs (Parhar et al., 2008). Feeling coerced into treatment can have a negative impact upon engagement (Mason & Adler, 2012; Strauss & Falkin, 2000). We return to this point below when discussing implications.

Regarding Research Question 3 (What are the perceived outcomes following completion/termination of the program?), both the completers and the noncompleters described various outcomes from treatment, the most prevalent being improved communication skills. Improved communication, underpinned by enhanced problem recognition and ownership, emerged in previous research with PAIP completers (Chovanec, 2014; Scott & Wolfe, 2000) and is a target for change within the program (see Pearson & Ford, 2018). Reassuringly, both groups of participants, completers and noncompleters, reported improvement in this area. Proposed deficits in these skills, when in high-conflict situations, have been linked to the use of violence (Curtis et al., 2004). There were reports of many auspicious applications of newfound skills in conflict management and listening; however, with noncompleters, the applications were sporadic. Some reported that the issue had not been completely resolved due to anger control issues. Previous research has established a link between emotional control deficits and increased risk of treatment dropout (Eckhardt, Samper, & Murphy, 2008). As mentioned previously, program evaluations indicate a connection between the predictors of dropout and the predictors of recidivism (Olver et al., 2011), which highlights the importance of monitoring and appraising progress on factors related to dropout such as problems in emotional regulation.

Implications for Research and Practice

At present, the current intervention program, Up2U, requires that prospective clients admit that they use unhealthy behaviors in their relationships. However, the program does not employ a treatment readiness assessment at intake. In the context of a high number of children's social care referrals, some clients may feel coerced rather than encouraged into treatment, potentially affecting attrition rates adversely (Mason & Adler, 2012). The current program, and others like it, could benefit from introducing a measure of treatment readiness to allow facilitators to identify clients who are likely to disengage from treatment and may require additional preparatory intervention (Casey et al., 2007). Available measures include the Treatment Engagement Rating (TER) scale (Drieschner & Boomsma, 2008) and the Treatment Readiness, Responsivity, and Gain: Short Version (Serin et al., 2005). The 21-item TER scale, for example, addresses nine components of engagement and shows good reliability and validity (McMurran & Ward, 2010). By using a measure of treatment readiness, facilitators may be able to identify those at-risk clients who might benefit from protective strategies, such as motivational interviewing, which has been shown to be an effective method of enhancing intimate partner abusers' treatment retention (Soleymani et al.,

2018). Future research should investigate client experiences after the implementation of a treatment readiness tool to understand the effectiveness of any preparatory intervention employed.

The timing was not right for our noncompleters to engage in therapy. These clients did not implicate program staff and many indicated a willingness to return at a more suitable time in their lives. It is reasonable to infer that individuals dropping out of treatment are at higher recidivism risk—but this is not known with the available data. One suggestion, supported by the current study, is that noncompleters and completers both experience PAIPs similarly, but that external factors prevent noncompleters from complying with treatment (Gray et al., 2014). However, given that those clients willing to return to treatment may have self-selected for the current research interviews, a positive treatment experience may have been more likely. A fruitful direction for future research would therefore be to compare the experiences of retrospectively identified completers and noncompleters. For example, interviews could be completed after 1 month of therapy (the point at which the current noncompleters began to drop out). Potentially, this could also reach those clients harboring more negative attitudes toward treatment providers, who may represent higher risk of recidivism (Hanson & Wallace-Capretta, 2004).

The present findings also indicated the value of the bond between the client and therapist as central to keeping participants engaged and enabling learning. While the current study cannot determine whether this was related to individualized treatment, it is self-evident that tailoring delivery to client individuality is more challenging in group treatment.

Research Limitations

Although this study gives insight into the subjective experiences of service users of a community PAIP, the results need to be interpreted within the context of its limitations. First, the sample was limited in size and referral method. We experienced difficulty tracking and tracing participants, with many clients having changed contact details since leaving the program. To maximize response rates, community program providers must regularly update client details so that multiple sources of up-to-date contact information are on record. Nevertheless, compared with all program referrals, the sample we ultimately obtained may have reflected greater psychological momentum for rehabilitation due to external contingencies, for example, supportive family and/or the influence of children's social care. Relatedly, the current study was a rare exploration of client experiences of individualized therapy in a non-court-mandated context. To the extent that the current

study participants were less coerced, and less affected by peer interventions, the insights the study affords cannot be applied to other PAIPs and their specific contexts.

Although only one female abuser participated in the study, we found remarkable consistency between her testimony and that of the other (male) participants regarding experience of the program and perceived outcomes. This might not be surprising, given that the research literature finds similar characteristics and motives for perpetration across males and many female abusers (Carney et al., 2007). Further research is warranted that focuses on gender similarities/differences in PAIP engagement.

A second limitation is that, due to anonymity afforded to the research participants, their criminal justice outcomes are unknown. Although past research gives a very strong indication (Olver et al., 2011), the present results would have greater significance if the division between completers and noncompleters reflected actual desistance/reoffending.

The possibility should also be noted of situational demand characteristics during the interviews encouraging participants to provide socially desirable answers. Although the interviewer was independent from the treatment-providing organization, the meetings took place in a location where the participants had received treatment and there was also a program staff member in the vicinity, albeit out of earshot. Although participants did offer criticisms of the program, this remains a potential limitation. Similarly, participants' accounts may have suffered from recall bias. Some may have overstated the positive aspects of the treatment to avoid cognitive dissonance due to the time and emotional energy that they had invested (Shamai & Buchbinder, 2010). It should be noted, however, that noncompleters also proposed positive aspects of the program.

Conclusion

There are no previously known qualitative studies that investigate the subjective experiences of both completers and noncompleters of a community PAIP. Quantitatively focused evaluations have limited scope to interrogate the "black box" of the treatment process. The current study has demonstrated the benefit of consulting program users to gain a richer understanding of both the treatment process and reasons given for engagement and noncompletion. Descriptions of the treatment process emphasized the benefit of facilitators exercising relationship skills and client responsivity consistent with adherence to the theoretically and empirically supported risk-need-responsivity (RNR) model (Bonta & Andrews, 2017). Regardless of completion or noncompletion, all participants reported treatment outcomes in relation to improved communication skills—although some noncompleters reported being unable to apply these skills consistently.

The study underlines the importance of a safe therapeutic relationship as this was proposed as a strong precipitating factor for keeping dropout-prone clients engaged. Conversely, noncompletion appeared to result from the force of the "central eight" recidivism risk factors. Frequently, these could be interpreted as treatment readiness factors. There may be benefit therefore in facilitators introducing a treatment readiness measure to identify any clients who may need intervention pretreatment or maintenance support. Future research should expand efforts to examine the subjective experiences of noncompleters to enhance client retention and help reduce the harms of intimate partner violence/abuse.

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Notes

1. We use the term "Partner Abuse Intervention Programs" throughout this article instead of "Batterer Intervention Programs" or "Domestic Violence Perpetrator Programs." We do so because "partner abuse" is a broader term better reflecting the diversity of clients and their behaviors.
2. A working alliance is said to comprise three different aspects of the therapeutic relationship: its collaborative nature, the bond between client and worker, and the two parties' ability to agree on treatment goals and tasks (Bordin, 1994).
3. The program is also delivered in other locations in England and across Scotland.
4. Hereafter referred to simply as "Up2U" for brevity.
5. The full semi-structured interview is available from the authors upon request.
6. To protect confidentiality of study participants, all names used in this article are pseudonyms.

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