

Predictors of Discontinuation From Individual Treatment in Men Perpetrators of Intimate Partner Violence

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Practitioners working with male perpetrators of intimate partner violence (IPV) observe high rates of treatment dropout in their clientele, which can undermine their ability to reduce the occurrence of IPV. Studies have also mostly documented predictors of dropout from group-format IPV treatment programs, but not from individual-format treatment modalities. This study aimed to identify the predictors and key moments of dropout in 206 French-Canadian men seeking individual treatment for IPV. Results of Cox regression survival analyses indicate that age, education, employment, court-ordered treatment, adult attachment, and the number of perpetrated acts of psychological violence were significant predictors of dropout. Findings highlight the need to assess and

target those predictors early in treatment to help men remain in therapy and prevent further use of IPV.

KEYWORDS: intimate partner violence; survival analysis; Cox regression; individual therapy; men; treatment dropout

Despite important breakthroughs in awareness campaigns and research initiatives over the past decades, intimate partner violence (IPV) remains a major public health issue worldwide (World Health Organization, 2017). In response to IPV's deleterious repercussions, various treatment programs have been developed to help male perpetrators discontinue their use of violence (Richards et al., 2019). Studies assessing the effectiveness of these programs have revealed that treatment completers are less likely to re-offend afterward than noncompleters (see Karakurt et al., 2019, for a meta-analysis). Yet, these studies reveal moderate to high levels of dropout in men entering treatment for IPV, with as much as 36%–52% of them abandoning treatment before its completion (Mach et al., 2020; Richards et al., 2019). These high rates highlight the necessity to better understand treatment dropout in men with IPV-related difficulties, especially as it is associated with a higher risk of resorting to IPV once again (Lila et al., 2019). Yet, despite increasing research efforts in the past decades, the study of treatment dropout (or attrition) in violent men is still in its early stages. Indeed, considering that group therapy (i.e., often with a predetermined duration and specific goals) is the most common modality of intervention for violent men (Cannon et al., 2016), very few studies have documented treatment attrition in individual therapy for IPV (i.e., one-on-one counseling with variable durations and personalized therapeutic goals). Also, to date, very few researchers have differentiated participants who dropped out of treatment according to their level of completion of therapy, such as before beginning therapy, during or after the intake assessment sessions, or even just before the end of the treatment. Considering the number of therapy sessions completed is associated with IPV perpetration posttreatment (Taft et al., 2001) and since determining the precise moment at which men are at higher risk of dropping out of therapy might help prevent attrition (Butters et al., 2020), an understanding of treatment dropout in men seeking individual treatment for IPV-related difficulties while accounting for the specific timing of attrition is needed.

TREATMENT FOR PERPETRATORS OF IPV

Although most treatment programs designed for male perpetrators of IPV in Canada and in the United States are offered in group format, individual therapy is also a common therapeutic method that helps men reduce their IPV-related behaviors (Cannon et al., 2016). Individualized therapy for IPV includes interventions aimed at increasing motivation to change, safety and life stability, at challenging thoughts and behaviors that promote violence, while increasing relationship skills and addressing

issues related to past trauma (Murphy & Eckhardt, 2005; Murphy et al., 2020). Individual treatment is a useful approach to the treatment of IPV, as it offers the flexibility and the time needed to address men's specific difficulties, including the psychological issues that give rise to the use of violent behaviors, such as psychological distress, mental health disorders, attachment issues, trauma, substance abuse, or low self-esteem and shame (Ferraro, 2017; Murphy & Meis, 2008). Researchers have indeed suggested that individualized approaches to the treatment of IPV perpetrators could allow the therapist to adapt therapeutic efforts and target individual factors, such as readiness-to-change, comorbid mental health issues (e.g., substance abuse) and lack of attendance to sessions, that are known to hinder treatment progress in terms of reducing the occurrence of IPV (Arias et al., 2013; Butters et al., 2020; Murphy et al., 2020). Yet, to date, few studies have documented the factors that might reduce men's attendance to individual-based treatment for IPV.

Attrition in Men Consulting for IPV Perpetration

To date, close to 50 studies have examined the factors that predict men's attrition from IPV treatment programs. In these studies, treatment attrition or dropout (e.g., leaving treatment before completing the prescribed number of sessions) is usually treated as a binary variable: completion or discontinuation of treatment (e.g., Lila et al., 2019, see Richards et al., 2019, for an exception). Yet, this conceptualization of treatment dropout in violent men has limitations: this dichotomization of attrition does not allow researchers to consider the specific moment at which dropout takes place, and the percentage of sessions required to consider a treatment completed vary from one study, as well as from one program, to another. As raised by Jewell and Wormith (2010), attrition can occur between the referral and the assessment (i.e., post referral attrition), between the assessment and the beginning of treatment (i.e., post assessment attrition) and during treatment (i.e., in-treatment attrition). Considering that the average duration of IPV treatment programs is 18 group sessions (Jewell & Wormith, 2010), the percentage of completed sessions, even for in-treatment attrition, should also be considered. By dichotomizing treatment attrition without considering the number of completed sessions, participants who drop out before the assessment process would be categorized similarly to those who dropped out near the end of group therapy, which is a strong bias in assessing this concept. Indeed, dropping out before treatment has begun, compared to after having completed 10 sessions, might reflect very different realities, and be associated with treatment outcome differentially. Attrition in group treatment for IPV is also difficult to compare to attrition in individual treatment for IPV since in a group format, there is often a predetermined number of sessions, whereas in individual treatment, its duration varies depending on the needs of the client. It thus appears necessary to identify key moments of attrition in men who are seeking individual treatment for IPV. The examination of the number of sessions completed by men in individual treatment for

IPV represents a promising avenue as it makes up for the limitations of a dichotomous attrition variable.

Predictors of Attrition in IPV Treatment

Studies on attrition from individual treatment in men who seek help for IPV-related difficulties are scarce and most studies have examined the predictors of attrition in group-format IPV treatment programs. In their meta-analysis, Jewell and Wormith (2010) divided predictors of attrition in men engaged in group-format treatment for IPV into three categories: (a) demographic variables, (b) violence-related variables, and (c) intrapersonal variables.

Demographic Predictors of Attrition. Five demographic factors stand out as consistent predictors of the discontinuation of group treatment for IPV (Jewell & Wormith, 2010; Mathieu et al., 2006). Four of them—younger age, lower income, lesser education, and unemployment—have been suggested to reflect more unstable lifestyles in men who dropout from therapy (Cadsky et al., 1996). More precisely, men who are younger, less educated and who have a lower income are more likely to drop out of IPV treatment post referral and during treatment (Richards et al., 2019). Marital status has also been suggested as a predictor of treatment attrition since being unmarried is associated with a higher dropout rate (e.g., Bowen & Gilchrist, 2006). Yet, other studies have shown that marital status does not differentiate men who dropout from therapy from those who complete it (e.g., Scott, 2004).

IPV-Related Predictors of Attrition. Although IPV-related factors were less consistent predictors of treatment dropout (Jewell & Wormith, 2010), studies have highlighted the importance of considering the source of referral (court-ordered or not) and the severity of the violent behaviors perpetrated to better understand attrition. For instance, American studies showed that a first offense and court-ordered treatment were linked to the completion of treatment (e.g., Buttell & Carney, 2002) whereas, the Canadian study of Cadsky et al. (1996) revealed that a court-order referral was related to the discontinuation of treatment. Other conflicting results were found regarding the severity of violence perpetrated. Indeed, whereas North American studies report that men who discontinue treatment generally inflict more severe psychological, physical, and sexual violence than those who complete it (Carney et al., 2006; Rooney & Hanson, 2001), British research has found that a greater number of perpetrated acts of physical and psychological IPV was related to treatment completion (Bowen & Gilchrist, 2006). It is important to note, however, that the definition of completion differed between these studies.

Intrapersonal Predictors of Attrition. In addition to being known risk markers of the perpetration of IPV in adult men (e.g., Lila et al., 2018; Norlander & Eckhardt, 2005), anger and alcohol use are positively related to attrition from IPV treatment (Eckhardt et al., 2008; Lila et al., 2020). However, in their meta-analysis, Jewell and Wormith (2010) noted contradictory results and concluded that anger cannot be considered a stable predictor of IPV treatment dropout. Concerning alcohol use, Chang

and Saunders (2002) argued that alcohol abuse is related to attrition, but not weekly alcohol consumption.

Another predictor of IPV perpetration and attrition in men who consult for IPV-related difficulties that has been proposed, but remains understudied, is attachment insecurity (e.g., Brassard et al., 2014). Attachment theory posits that attachment models developed in childhood through repeated interactions with primary attachment figures remain relatively stable over time and through adulthood, during which they are reexperienced with the romantic partner. As such, when the attachment figures fail to meet the security needs of children, attachment insecurities develop into attachment anxiety and/or attachment avoidance (Mikulincer & Shaver, 2016). Attachment anxiety describes a hypersensitivity to signs of rejection, abandonment, or partner unavailability, and manifests itself in obsessive behaviors, an excessive desire for proximity, greater emotional reactivity, and jealousy. Attachment avoidance describes the fear of emotional closeness, mistrust, and discomfort with intimacy. It manifests as a strong desire for self-reliance and a tendency to minimize one's needs and feelings of vulnerability (Mikulincer & Shaver, 2016). Results on the links between attachment insecurity, IPV perpetration, and treatment attrition are surprising. Although some studies have revealed that attachment insecurity (anxiety and avoidance) was related to the use of violence (e.g., Brassard et al., 2014), others have found that men with a secure attachment (i.e., low anxiety and avoidance) are more likely to drop out of group-format treatment for IPV (Medoff, 2006). Such results emphasize the need to better document how attachment insecurity is related to attrition from treatment in violent men as it may help clinicians and researchers better understand how men's relational schemas affect their ability to remain in therapy.

The Current Study

Most studies that have examined attrition in men consulting for IPV-related difficulties have highlighted predictors of attrition in group-format treatment programs and, as a result, studies on attrition from individual treatment in men are scarce. Yet, the benefits of individualized treatment are important because such treatment modality allow us to address the ways in which men's internal or psychological issues are related to their use of violence (Ferraro, 2017). Moreover, treatment dropout is almost always operationalized as a dichotomous variable (e.g., Mathieu et al., 2006) and, although some authors (e.g., Taft et al., 2001) have recommended accounting for the number of completed sessions, very few studies have done so. The use of survival analyses makes it possible to statistically determine the moment at which cessation of therapy is more likely while identifying the factors associated with these cessation times. Furthermore, although men who perpetrate IPV are prone to social desirability when answering self-report questionnaires (e.g., Freeman et al., 2015), few studies have controlled for this bias (Bowen & Gilchrist, 2006).

OBJECTIVES AND HYPOTHESES

The present study aimed (a) to identify the key moments of cessation in individual treatment for IPV as well as (b) the factors associated with these moments of cessation in a sample of men seeking therapy for IPV, while controlling for social desirability. Although no a priori hypotheses were put forward for the first objective, three hypotheses were formulated for the second objective. The first hypothesis proposed that older participants, with more education, a higher income, a stable occupation, and those married or living with their partner will complete more treatment sessions. The second hypothesis postulated that men who are referred by a judiciary authority (court or Youth tribunal) will complete fewer sessions, as the study was conducted using a Canadian sample. The third hypothesis suggested that men who report higher levels of angry personality traits and who report higher alcohol use will complete fewer treatment sessions, while those with higher attachment insecurities will complete more treatment sessions. Given the absence of sufficient data, the number of acts of psychological and physical violence toward the partner were examined as potential predictors in an exploratory way.

METHOD

Participants and Procedure

This study was part of a larger research program conducted in collaboration with a community organization offering individual therapy to men with IPV-related problems. The sample consisted of 206 men aged 18–69 years ($M = 35.05$, standard deviation [SD] = 10.77) who entered treatment between June 2007 and July 2012. They were predominantly French-Canadian (93.2%) or English-Canadian (1.5%), and 5.3% were born in a different country (e.g., Belgium, Columbia, Maghreb). Although all participants reported having been in a relationship in the past year, they were either single (21.8%), dating (16.5%), cohabiting (37.4%), married (16.0%), or separated/divorced (8.3%) when they started treatment. Most of them were employed (64.1%), mostly full-time (50.5%), but some were unemployed (26.8%), retired (1.8%), or full-time students (7.3%). Men had completed an elementary (15.5%), high school (61.2%), preuniversity (12.6%), or university (10.7%) education. Their average annual income was CAN\$ 23,278 ($SD = 17,252$). The main self-reported reasons for seeking treatment were the use of psychological or physical IPV (42.2%), anger management issues (16.5%), impulsivity (8.3%), and jealousy (3.4%). They reported a weekly average of 5.52 alcohol drinks ($SD = 11.17$) and 46 participants (22.3%) reported drug use at least once a week. Of the participants, 19.4% were self-referred, 18.9% were referred by a relative, 35.4% by another professional, 6.3% by another resource, and 19.9% were referred by a judicial authority (8.7% from a Youth Center, 11.2% court-ordered). A number of participants had sought psychological help in the past (61.3%) and 27.3% were taking medication for a mental health issue (e.g., depression, anxiety, insomnia, attention deficit disorder).

Before their first session with their therapist, participants completed questionnaires of an average duration of 45 minutes, in a private office inside the community organization. The treatment offered in this community organization draws from different theoretical approaches, but it is largely rooted in cognitive-behavioral models (e.g., education, cognitive restructuring, communication skills training), and is based on the principle that violence is unacceptable and a learned behavior that must be eliminated from the repertoire of behaviors. In collaboration with the men, common goals are developed around reducing acts of violence and can include, for instance, managing anger and learning communication skills. In July 2012, the secretary provided the research team with the number of sessions completed by each participant, while also indicating which participants were still in treatment at this time. This project received the approbation of the ethics research committee of the researchers' institution.

Measures

A sociodemographic questionnaire gathered information on participants' gender, age, occupation, marital status, education, income, weekly use of alcohol and drugs, and source of referral. All measures were in French and selected based on their strong psychometric qualities.

Social Desirability. A short version of the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1991; BIDR-18; Frenette et al., 2000) assessed the participant's tendency to respond in a socially acceptable manner. The 18 items are rated on a 7-point Likert-type scale and measure the tendency to lie to oneself (self-deception) and to present oneself in a favorable light to others (impression management). Only the items assessing impression management were retained to control this bias. Total scores are created by averaging the scores for each item of the subscale, a high score reflecting a higher presence of social desirability. The alpha coefficient within the sample ($\alpha = .69$) is acceptable and is similar to the one found by Frenette et al. (2000).

Perpetrated IPV. The Revised Conflict Tactics Scales (CTS2, Straus et al., 1996) measured the number of violent acts perpetrated in the past 12 months. Of the original measure, only two scales were used for this study: perpetrated physical and psychological violence. For each of the 18 items, the participant indicates the frequency of violent acts perpetrated in the last year. The sum of the middle points of each item (e.g., three to five times becomes four) is calculated. In this sample, the reliability is adequate for the scales of perpetrated physical ($\alpha = .84$) and psychological ($\alpha = .81$) violence.

Anger. The State-Trait Anger Expression Inventory (STAXI; Spielberger, 1988) assessed anger proneness as a personality trait. The score on this scale is obtained by averaging the 10 items, a high score indicating a higher presence of this personality trait. In this sample, the Cronbach's alpha coefficient of the angry personality trait scale is satisfactory ($\alpha = .89$).

Attachment. The abridged 12-item version of the Experiences in Close Relationships scale (ECR-12; Lafontaine et al., 2016) measures attachment-related avoidance and anxiety. The score for each dimension is computed by averaging its six respective items, rated on a 7-point Likert scale, with a higher score indicating higher attachment insecurity. In this sample, Cronbach's alpha coefficients are .83 for avoidance and .89 for anxiety.

Analytic Strategy

In this prospective study, the data collected at the beginning of the treatment were examined as related to the number of sessions completed at the end of either the treatment or the study. A Cox survival regression analysis was used to determine (a) the different key moments at which attrition is more likely and (b) the factors associated with these key moments. This analysis evaluates, according to the number of sessions, who has continued and who has dropped out of treatment. For each session, a life table illustrates participants who are still in treatment at the beginning of the interval (session n) and at the end of the interval (session $n + 1$), the dropout rate, as well as the probability of still being in treatment. This first step of the analysis determines the moments when treatment is more likely to be discontinued. The second step assesses which covariates are related to these key moments (of greater risk) of attrition and represents their predictive effect by a coefficient B and a Wald χ^2 . Covariates with a significant Chi-square are significant predictors of the moment of cessation. The statistical assumptions of multiple linear regression (i.e., minimum sample size, multivariate normality, linearity, homoscedasticity, lack of multicollinearity and extreme values) apply in a Cox regression. According to Tabachnick and Fidell (2019), the assumptions of homoscedasticity, multivariate normality, and linearity are not necessary, but they allow for greater statistical power. The effect that covariates have on the continuation of treatment must also be the same throughout the study.

RESULTS

Preliminary Analyses

Table 1 presents the descriptive statistics for the study variables. The number of completed sessions ranged from 1 to 30, with an average of almost eight sessions. Most variables were normally distributed, based on skewness and kurtosis indices (within ± 1.00). A nonlinear transformation (square root or logarithmic) corrected the skewness of skewed variables (annual income, number of acts of psychological IPV, weekly alcohol use). The number of acts of physical IPV perpetrated in the past year was dichotomized (0 = no act, 1 = at least one act) due to its highly skewed distribution. Preliminary Pearson correlations (or biserial point correlation for dichotomous variables) between the number of sessions completed by the participants and the

TABLE 1. Descriptive Statistics of Quantitative Variables

Variables	Mean	SD	Skewness	Kurtosis
Number of completed sessions	7.83	6.92	1.61	2.99
Age	35.05	10.77	0.81	0.50
Annual income (CAN\$)	23,588	17,599	1.04	1.30
Weekly alcohol use	5.52	11.17	6.09	54.93
Social desirability	4.11	1.18	-0.12	-0.06
Acts of perpetrated psychological violence	39.75	36.53	1.43	1.66
Trait anger	2.24	0.67	0.15	-0.61
Attachment avoidance	2.68	1.01	0.57	-0.13
Attachment anxiety	4.18	1.35	-0.04	-0.74

Note. SD = standard deviation.

eight factors being studied were performed. The results revealed that none of the variables retained were linearly related to the number of sessions completed in therapy ($p > .05$), which supported the relevance of adopting a nonlinear analysis strategy such as survival regression.

Main Analysis

Identifying Key Moments of Treatment Discontinuation. Results of the survival analysis presented in Table 2 suggest that participants primarily dropped out of therapy after one (22 cases), two or three (25 cases), or five sessions (22 cases). These sessions were also associated with the highest probability density values (i.e., the *probability* of not surviving to the midpoint of an interval, given survival at the start of the interval) and the hazard (or failure rates, i.e., the *rate* of not surviving at the midpoint of an interval, given survival at the start of the interval) were particularly high at these moments. The highest failure rates were after the 24th (.29) and the 29th session (.50), although the standard error associated with these rates was high. Such a high standard error may indicate bias, as these high values do not necessarily represent moments when cessation of treatment is more likely. Based on the analysis of the life table, the survival curve, the hazard (or failure rates), and relying on the work of Monras and Gual (2000), three key moments of cessation of treatment were identified: (a) early cessations (after 2 or 3 sessions); (b) short-term cessations (after 5 sessions); and (c) medium-term cessations (after 11 sessions).

Identifying Factors Related to Dropout. Cox's regression analysis also identified which factors are associated with the moments when attrition probabilities are high. Tabachnick and Fidell (2019) Cox's regression assumptions were met, except for the absence of interaction between time and factors (7 factors interacted with time). In this analysis, the temporal variable was the number of completed sessions and the treatment status (still being in treatment) was the criterion variable. Factors

TABLE 2. Life Table Survival Estimates

Number of Sessions	Participants Still in Treatment	Number Censored Cases	Participants at Risk	Number of Terminations	Proportion Dropped	Proportion Surviving	Cumulative Proportion Surviving (SE)	Probability Density (SE)	Hazard (SE)
0	206	0	206	0	0.00	1.00	1.00 (0.00)	0.00 (0.00)	0.00 (0.00)
1	206	0	206	22	0.11	0.89	0.89 (0.02)	0.11 (0.02)	0.11 (0.02)
2	184	0	184	25	0.14	0.86	0.77 (0.03)	0.12 (0.02)	0.15 (0.03)
3	159	1	158.5	25	0.16	0.84	0.65 (0.03)	0.12 (0.02)	0.17 (0.03)
4	133	0	133	7	0.05	0.95	0.62 (0.03)	0.03 (0.01)	0.05 (0.02)
5	126	1	125.5	22	0.18	0.82	0.51 (0.03)	0.11 (0.02)	0.19 (0.04)
6	103	2	102	12	0.12	0.88	0.45 (0.03)	0.06 (0.02)	0.13 (0.04)
7	89	0	89	8	0.09	0.91	0.41 (0.03)	0.04 (0.01)	0.09 (0.03)
8	81	0	81	10	0.12	0.88	0.36 (0.03)	0.05 (0.02)	0.13 (0.04)
9	71	0	71	6	0.08	0.92	0.33 (0.03)	0.03 (0.01)	0.09 (0.04)
10	65	0	65	8	0.12	0.88	0.29 (0.03)	0.04 (0.01)	0.13 (0.05)
11	57	0	57	9	0.16	0.84	0.24 (0.03)	0.05 (0.02)	0.17 (0.06)
12	48	1	47.5	7	0.15	0.85	0.21 (0.03)	0.04 (0.01)	0.16 (0.06)
13	40	1	39.5	2	0.05	0.95	0.20 (0.03)	0.01 (0.01)	0.05 (0.04)
14	37	1	36.5	5	0.14	0.86	0.17 (0.03)	0.03 (0.01)	0.15 (0.07)
15	31	1	30.5	4	0.13	0.87	0.15 (0.03)	0.02 (0.01)	0.14 (0.07)
16	26	1	25.5	3	0.12	0.88	0.13 (0.02)	0.02 (0.01)	0.13 (0.07)
17	22	0	22	3	0.14	0.86	0.11 (0.02)	0.02 (0.01)	0.15 (0.08)
18	19	0	19	3	0.16	0.84	0.09 (0.02)	0.02 (0.01)	0.17 (0.10)
19	16	1	15.5	1	0.06	0.94	0.09 (0.02)	0.01 (0.01)	0.07 (0.07)
21	12	0	12	1	0.08	0.92	0.07 (0.02)	0.01 (0.01)	0.09 (0.09)
22	11	1	10.5	1	0.10	0.90	0.06 (0.02)	0.01 (0.01)	0.10 (0.10)
23	9	1	8.5	0	0.00	1.00	0.06 (0.02)	0.00 (0.00)	0.00 (0.00)

TABLE 2. Life Table Survival Estimates

Number of Sessions	Participants Still in Treatment	Number Censored Cases	Participants at Risk	Number of Terminations	Proportion Dropped	Proportion Surviving	Cumulative Proportion Surviving (SE)	Probability Density (SE)	Hazard (SE)
24	8	0	8	2	0.25	0.75	0.05 (0.02)	0.02 (0.01)	0.29 (0.20)
25	6	0	6	0	0.00	1.00	0.05 (0.02)	0.00 (0.00)	0.00 (0.00)
26	6	0	6	0	0.00	1.00	0.05 (0.02)	0.00 (0.00)	0.00 (0.00)
27	6	0	6	0	0.00	1.00	0.05 (0.02)	0.00 (0.00)	0.00 (0.00)
28	6	0	6	1	0.17	0.83	0.04 (0.02)	0.01 (0.01)	0.18 (0.18)
29	5	0	5	2	0.40	0.60	0.02 (0.01)	0.02 (0.01)	0.50 (0.34)
30	3	1	2.5	2	0.80	0.20	0.00 (0.01)	0.00 (0.00)	0.00 (0.00)

Note. SE = standard error.

were introduced in three blocks: (a) social desirability was entered in the first block as a covariate, (b) the seven interaction terms (factor X time) for the factors that interacted with time, and (c) the 12 factors under study. The final model included a total of 20 variables and significantly predicted the cessation of treatment in men seeking help for IPV, $\chi^2(20, N = 206) = 348.52, p < .001$.

Table 3 presents the regression coefficient (B), standard error, hazard ratio (e^B), and Wald's statistic to assess the significance of each predictor. The hazard ratio allows us to assess how a factor changes the risk of dropping out of treatment when the values of all other factors remain stable. For example, the hazard ratio (e^B) is 1.60 for attachment avoidance, which means that an increase of one point in an attachment avoidance score is associated with a .60 increase in the hazard rate. Results revealed that seven factors are significant predictors of discontinuation of treatment: age, completion of postsecondary studies, stable employment (full-time), judicial referral, number of psychologically violent acts perpetrated, and attachment-related anxiety and avoidance.

Associations Between Factors and Key Moments of Dropout. To clarify how each predictor related to key moments of treatment dropout, a separate survival curve was constructed for each factor by comparing participants who scored below average with those who scored above average. Results revealed that age relates to the probability of dropping out of individual therapy for IPV at the 10th session, which corresponds to medium-term cessation. From this point on, younger participants were the more

TABLE 3. Results of the Main Survival Analysis

Variables	B	SE	χ^2_{Wald}	p	e^B
Age	0.06	0.01	18.44	<.001	1.06
Stable occupation (1 = yes)	1.35	0.39	12.39	<.001	3.87
Postsecondary studies (1 = yes)	-1.14	0.39	8.63	.003	0.32
Gross annual income ^a	0.00	0.00	0.19	.66	1.00
Married/Common-law (1 = yes)	-0.02	0.17	0.01	.923	0.98
Order of the Court/Youth protection (1 = yes)	-1.68	0.38	19.92	<.001	0.19
Perpetrated psychological violence ^a	0.07	0.03	4.54	.033	1.07
Perpetrated physical violence (1 = yes)	-0.27	0.35	0.57	.451	0.77
Trait anger	-0.09	0.15	0.34	.560	0.92
Alcohol use ^b	0.01	0.15	0.00	.972	1.01
Attachment avoidance	0.47	0.19	6.15	.013	1.60
Attachment anxiety	0.57	0.12	24.30	<.001	1.77

Note. Factors with a Wald χ^2 statistic with a $p < .05$ are bolded. Statistical indices related to the interaction terms are not presented but are included in the analysis.

^aA square-root transformation was performed on this variable. ^bA logarithmic transformation was performed on this variable.

likely to drop out. The results also showed that participants with a stable occupation (full-time worker or student) were less likely to drop out of therapy after the first session than those with no stable occupation, but this trend disappeared after the sixth session. These results for education require some caution when interpreting because the interaction between the number of sessions and education was not eliminated by the inclusion of the interaction term (number of sessions X education). Participants who did not complete postsecondary studies appear to drop out of therapy more than others, starting from the second session, yet, this trend was reversed at the fifth session. The magnitude of this trend also seemed to vary with the number of sessions completed, as it became almost nonexistent at the 7th session and became important again around the 9th session. Thus, the education level of men seems to be related to early dropout, as well as short- and medium-term dropouts.

Results revealed that court-ordered participants were more likely to drop out as early as the first session. This effect seemed to fade around the 9th session, indicating that this factor is related to early attrition. Participants who reported having perpetrated more acts of psychological IPV were less likely to discontinue treatment from the 13th session, indicating that the number of psychologically violent acts in the past year is associated with medium-term treatment dropout.

Participants with a lower attachment avoidance score were also more likely to drop out of therapy after the 1st session. Results revealed that this trend faded around the 2nd session and came back around the 6th session, with an increase of dropout in less avoidant men, indicating an effect of low attachment avoidance on early and short-term attrition. Participants with lower attachment anxiety were also more likely to drop out of therapy after the third session, suggesting that this factor is related to attrition early in the treatment process.

DISCUSSION

This prospective study, conducted with a large sample of men undergoing individual therapy for IPV, allowed us to identify three key moments of attrition from treatment and their associated predictors. The results suggest that four factors are related to dropout in the first three sessions (early dropout): lower education, lack of a full-time occupation, a judicial referral, and lower levels of attachment avoidance. Four factors are related to dropout after 4–6 sessions (short-term dropout): higher education, a court-order referral, and lower degrees of attachment anxiety and avoidance. Three factors are related to dropout after 8–13 sessions (medium-term dropout): younger age, a higher level of education, and fewer acts of psychological IPV perpetrated in the previous year. Results partly supported our hypotheses as they emphasize the roles of age, education, occupation, source of referral, frequency of IPV, and attachment insecurity as significant predictors of men's attrition from individual treatment for IPV. Contrary to our hypotheses, income, relationship status, alcohol use, and anger were not significant predictors of treatment dropout.

Key Moments of Treatment Discontinuation

Results revealed three key moments where the risk of dropout is higher in men seeking individual therapy for IPV: early (1–3 sessions), short-term (4–6 sessions) and medium-term dropout (8–13 sessions). These key moments are comparable to those reported by Delgadillo et al. (2014), who conducted a similar study in a population receiving an individual treatment of “low intensity” (e.g., psychosocial help, psycho-education) for anxiety problems and depressive symptoms. Another study targeting group-format psychotherapy for alcoholism, however, identified later moments of cessation (Monras & Gual, 2000). It should be noted that these authors’ treatment was held over 2 years and that their life table was based on 4-week intervals, limiting the precision of their analysis and comparison with the present study.

Many reasons may explain early attrition. We could suppose that some of the men who sought individual therapy were uncomfortable with the individual process or with the therapist, which might explain why they dropped out early in the process. Some participants may have started therapy with unrealistic expectations and were disappointed with the process, or others could have been asked by a relative or an expert to start a therapeutic process but realized it did not suit them. Indeed, some studies have shown that the underestimation of the need to engage in therapy is associated with poorer outcomes, including a poorer therapeutic alliance (Patterson et al., 2008), which could increase therapy dropout after a few sessions.

Dropping out of therapy after 4, 5, or 6 sessions could have happened to participants who realized they had low motivation to change their behaviors, or, who realized, after the assessment process, that what was offered to them did not suit their needs. Studies with borderline patients (e.g., Gamache et al., 2018; Soler et al., 2008) have also shown that impulsivity, low motivation, the absence of compromise toward therapy, and the impression of a poor therapeutic alliance were associated with short-term dropout from therapy, which could also be the case with our participants as violent men tend to show similar traits (Ross & Babcock, 2009).

Medium-term therapy dropout in participants could be explained by the perception that some men might have had of having completed therapy, or of having achieved certain goals. It should be noted that attrition from individual therapy differs from discontinuation in predetermined group therapy. The cessation of individual therapy is a decision that can be taken by the client, the therapist, or by mutual agreement. Thus, the full or partial attainment of some therapeutic goals may lead to a medium-term dropout of individual treatment, unlike in group therapy with a predetermined number of sessions.

Factors Related to Key Moments of Dropout

Our findings reveal that 7 (out of 12) factors that were assessed are significant predictors of attrition of individual therapy for men seeking help for IPV. Younger men who received less education, had no stable occupation, were constrained to attend

treatment as per a court order, and who reported fewer acts of perpetrated psychological IPV and lower levels of attachment-related anxiety and avoidance tended to cease their treatment earlier, but not necessarily at the same key moments.

Demographic Variables. Results suggest that younger clients are more likely to cease therapy, as reported by Jewell and Wormith (2010) in their meta-analysis. However, our study highlighted that age was a significant factor in predicting medium-term dropout only (from the 10th session), which contrasts with other studies that have highlighted younger age as a determinant of early dropout (e.g., Askeland & Heir, 2013; Richard et al., 2019). Perhaps, younger participants had little experience with therapy resulting in lower expectations toward the process. As such, they may have found early sessions useful but, considering that younger participants in group therapy are recognized as experiencing less negative consequences of their negative behaviors compared to older participants (McKellar et al., 2006), they might have gotten the impression, after 10 sessions, that treatment was no longer needed.

Results also revealed that participants who had less education (high school diploma or less) are more likely to discontinue their treatment early, while those who had more education (preuniversity degree or more) are more likely to drop out of treatment in the short- and medium-term. This nuance was not found in previous studies, as Jewell and Wormith (2010) only identified a low level of education as a direct risk factor for dropping out of group therapy. According to Kennedy's (2000) review on correctional facility inmates, earlier cessation of treatment by participants with lower levels of education could reflect a difficulty to understand what is expected of them in treatment. For short- and medium-term dropouts, it is possible that men who are more educated progress faster in therapy and achieve their personal goals sooner than less educated participants. This result must however be interpreted with caution since a statistical assumption of the analysis (absence of education x sessions interaction) was not met.

The absence of a stable occupation—either as a worker or as a student—was linked to an early cessation of treatment, which is similar to the results of Askeland and Heir (2013). Indeed, unemployed, part-time workers, or retired men are more likely to discontinue treatment early than men who have a full-time occupation (work or study). As an explanation, Cadsky et al. (1996) suggested that men with a significant lack of stability in life tend to find it more difficult to engage in therapy. As individual therapy requires one to participate in regular appointments, a lack of stability in one's schedule might prevent from engaging fully in a therapeutic process.

Violence Related Variables. Results supported our second hypothesis and revealed that court-ordered men are more likely to drop out early and in the short-term. These results are in line with those of the Canadian study of Cadsky et al. (1996), although they contradict most research conducted in the United States (Jewell & Wormith, 2010). This could partly be explained by differences between the Canadian and American justice systems. According to Cadsky et al. (1996), the penalties for ceasing IPV treatment are lower and less enforced in Canada, which might

limit retention in therapy. Studies also show that intrinsic motivation observed in voluntary participation is related to better retention in treatment for IPV (e.g., Donkin & Glozier, 2012). As an individual therapy for IPV may require more intrinsic motivation and personal investment than group-format therapy, court-ordered men may want to end treatment as soon as possible, especially if they are not willing to take responsibility for their violent acts.

Results also suggest that men who reported perpetrating more acts of psychological IPV in the year preceding therapy were less likely to discontinue treatment from the 13th session onward, which is consistent with the results of three other studies (Bowen & Gilchrist 2006, Carney et al., 2006, Rooney & Hanson 2001). Indeed, a higher frequency of psychological IPV is associated with a greater need for therapeutic help, requiring longer treatment. Thus, participants who perpetrated fewer psychologically violent acts might have achieved their personal goals earlier in the process. Being willing to report more acts of such abuse may also indicate a greater awareness of the problem (Bowen & Gilchrist, 2006). Thus, continuing treatment in the medium-term could reflect greater responsibility-taking by men (Donkin & Glozier, 2012).

Intrapersonal Variables. Contrary to our hypothesis, attrition was not significantly associated with trait anger or the weekly use of alcohol, when controlling for social desirability and all 12 factors. Perhaps this can be explained by the fact that therapy dropout could result from substance abuse that interferes with therapy, rather than the actual weekly consumption of alcohol (Chang & Saunders, 2002). As for anger, inconsistent results have been found in past studies, as noted in the meta-analysis by Jewell and Wormith (2010), suggesting that trait anger might not exert a direct influence on dropout from IPV treatment. In contrast, trait anger has been associated with lower completion of group therapy for male perpetrators of IPV as men with high trait anger are more likely to present a clinical profile of resistance toward therapy (Eckhardt et al., 2008). Yet, since our study examined attrition from individual therapy for IPV, perhaps this predictor was addressed more easily in individual therapy, compared to what is possible in group therapy, thus preventing its negative effect on treatment resistance and dropout.

Regarding attachment insecurities, results support our hypothesis and conclusions from Medoff's (2006) study, as they reveal that men with low attachment-related anxiety or avoidance drop out earlier than those who present higher levels of attachment insecurity. Regarding attachment anxiety, results could be explained by the fact that men who fear rejection by others might try to please and obtain approval from their therapist, in addition to a fear of losing their partner if they do not remain in therapy and solve their IPV-related issues (Goodall, 2015). The empathy showed by the therapist toward them and the possibility of learning new ways of regulating their emotions could also encourage anxious men to remain in therapy. Those with high attachment avoidance, who are normally uncomfortable with closeness and intimacy, might feel increasingly comfortable talking with a therapist who shows empathy and tries to understand their perspective while helping them reduce their use of

IPV. The unidirectional nature of a therapeutic relationship, in which the client only has to focus on their own experience, and does not have to deal with protecting the other from what they are expressing, might also be more comfortable for avoidant men and may explain why those who normally avoid vulnerability remain engaged in therapy for a longer period (Darish, 2009). Those with high attachment avoidance could also remain in therapy longer as their tendency to use minimization and denial strategies (Mikulincer & Shaver, 2016) initially prevents them from taking responsibility for their use of violence, thus increasing the time they need to reach their therapeutic goals.

IMPLICATIONS

This study is the first to document the risk factors for attrition from individual-format treatment in men with IPV-related difficulties. Using an innovative statistical approach, survival regression analysis, this study identified three key moments of treatment dropout as well as their associated risk factors. The present study adds to previous research by documenting the role of attachment insecurities, in addition to previously known factors, as predictors of individual treatment dropout for IPV, justifying the inclusion of attachment insecurities in future prediction models of therapy attrition. For therapists working with this particular clientele, the present study can inform their expectations, lead them to adjust their assessment protocols or customize their intervention plans to promote the retention of clients in therapy in light of the identified predictors.

For instance, the identification of three key moments within a therapeutic process during which the risk of attrition is higher, as well as their related risk factors, can be of great help for therapists as it offers them precise time frames and variables to consider when attempting to establish a strong working alliance with men consulting for IPV-related difficulties. In line with recent treatment recommendations for IPV perpetrators (Butters et al., 2020), the current study highlights the importance of individualized assessment and intervention planning that includes the consideration of demographic factors and co-occurring concerns affecting treatment completion. Therapists might thus profit from implementing the completion of short self-report questionnaires after the initial referral and before the first intake session, which would allow them to assess risk factors for therapy attrition before men would even start treatment. By gathering such information, therapists might be better equipped to prevent dropout, thus improving their treatment's effectiveness in reducing the occurrence of IPV (Helfritz et al., 2006). Our findings also suggest that indicators of a more unstable life situation (i.e., low employment rate, low education) are especially salient in men who drop out early in the therapeutic process. In conjunction with previous research that has highlighted the association between limited resources (e.g., financial stress, housing issues) and higher levels of perpetrated IPV in men (e.g., Schwab-Reese et al., 2016), such results emphasize the need for IPV services offered to men to account for these psychological characteristics. As suggested by

Butters et al. (2020), interventions that, in addition to addressing the use of violent behaviors, also coordinate community responses to support men's resources and accessibility to education, employment, and housing opportunities might help reduce both IPV and treatment attrition. Finally, considering the role of court-order referral on attrition, we might consider the implementation of motivation-based treatment approaches in interventions aimed at perpetrators of IPV. The inclusion of motivational strategies that target specific risk factors early in the therapeutic process might indeed help retain those who are at higher risk of dropping out of therapy by increasing their readiness to change and their compliance toward therapy (Lila et al., 2018).

LIMITATIONS AND FUTURE DIRECTIONS FOR RESEARCH

Although the clinical and nonincarcerated sample of men in this study is larger than those in the majority of previous studies, the generalization of our results is limited to French-Canadian men who are seeking help. Recruiting men from a single community organization also limits the generalization of results. Our sample is possibly unrepresentative in terms of ethnicity, a variable that was not accounted for in this study, but that has proven to be a stable predictor of attrition from therapy for IPV (Jewell & Wormith, 2010). Replication of this study is thus needed in larger samples of men from various community organizations, ethnicities, and languages.

This study allowed us to identify predictors of dropout from individual treatment based on the data collected at the onset of therapy. As such, it is not possible to account for changes in these variables during the course of therapy. Survival regression analysis, a statistical approach that has rarely been used in IPV research (see Lila et al., 2019, for an exception), considered 12 factors simultaneously while controlling for social desirability and reducing type I error. However, some interaction effects (with education, occupation, court-order referral, attachment anxiety) have not been eliminated, which invites readers to use caution when interpreting results. Also, some variables identified as stable predictors of dropout of group treatment for IPV (e.g., ethnicity; Jewell & Wormith, 2010) or that are relevant in the study of IPV (e.g., child sexual abuse, Brassard et al., 2014) could be considered in future research.

The questionnaires used have good psychometric qualities, in addition to being combined with an objective measure of dropout from therapy (the number of sessions completed). However, the inability to determine the reasons for discontinuation is an important limitation of the study. Indeed, having completed a high number of sessions does not always indicate therapeutic success; some shorter therapies can also be successful, especially in individual therapy. Examining men's motivation, therapeutic alliance, and therapeutic gains would also be of great interest to predict and explain treatment dropout in future studies. However, this research was conducted in a natural clinical setting without intervention by the researchers, a strength that promotes the external validity of the results.

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