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Client Retention in Community Treatment: Completer and Non-completer Experiences of an Individualised Needs-based Partner Abuse Intervention Programme

Dominic Pearson[1]

Chloe Steward[1]

Amy Ford[2]

Accepted for publication in *Journal of Interpersonal Violence* 19th January 2020.

[1] The University of Portsmouth, UK
[2] Portsmouth City Council, UK

Corresponding author:
Dominic Pearson, Department of Psychology, The University of Portsmouth, King Henry Building, King Henry 1st Street, Portsmouth, Hampshire, UK, PO1 2DY.
Email: dominic.pearson@port.ac.uk

Abstract

There has been increased interest in the subjective experiences of participants of community Partner Abuse Intervention Programmes (PAIPs). In the context of high attrition rates, qualitative research is needed to understand the factors associated with sustained engagement and drop-out. Using a community non-mandated PAIP, the current study is a rare investigation of the experiences of both completers and non-completers. We explored i) the differences between completers' and non-completers' perceptions of the treatment process, ii) the reasons for sustained programme engagement, and iii) the perceived outcomes of treatment. Semi-structured interviews were completed with 14 participants, nine completers and five non-completers. 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 from the treatment-providing organisation. Three themes emerged from the data, these were: (i.) Treatment as Challenging Yet Enlightening; (ii.) the Importance of a Well-timed and Safe Therapeutic Environment; and (iii.) Improved Emotional Self-management Due to Treatment. Results highlighted how structured individualised 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 individualised treatment characterised by flexibility and accessibility. Non-completion 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, non-completers to enhance the limited literature in this area.

Keywords: batterer intervention, drop-out, intimate partner violence, programmes, qualitative research, treatment completion

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'Why do I want to do this?' 'Is it the right programme 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 jeopardises successful programme 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; Soleymani, Britt, & Wallace-Bell, 2018). In the UK in 2017/18, an estimated 2 million adults aged 16 to 59 experienced some form of intimate partner abuse (Office for National Statistics, [ONS] 2018). Focussed surveys suggest a majority of incidents are repeat victimisations (ONS, 2016), and partner abuse intervention programmes (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, Koehler, Lösel, & Humphreys, 2013; Babcock, Green, & Robie, 2004; Feder & Wilson, 2005; Stover, Meadows & Kaufman, 2009; Smedslund et al., 2011). 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. Since 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 non-completers.

Programme 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 programmes

(Palmer et al., 2007; Hollin et al., 2008), and in evaluations of PAIPs (Jones, D'Agostino, Gondolf, & Heckert, 2004). Completion effects are distinct from treatment effects because the intended change is only seen in programme completers, not all programme participants.

If completion is essential it implicates client engagement and retention in the programme as a precursor for change. Completion rates for PAIPs are not high, however. On average, around 50% of participants fail to complete the full programme, regardless of whether or not this is court-mandated (Daly & Pelowski, 2000; Olver, Stockdale & Wormith, 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 behaviours (Eckhardt, Holtzworth-Munroe, Norlander, Sibley, & Cahill, 2008; Olver et al., 2011). Eckhardt et al. found that attrition was significantly related to future arrests such that more than twice as many programme non-completers (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 non-completion, such that relative to completers, non-completers are more often: younger; unemployed or on low income; with substance abuse problems; and, previously criminally convicted, sometimes including domestic violence offences (Daly & Pelowski, 2000; Jewell & Wormith, 2010). Although knowledge of salient client characteristics is important, outcome evaluations do not attend to how the programme 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 programme design and therapist delivery.

Reasons Given for Programme Completion and Non-Completion

A small but growing body of research has recently emerged regarding PAIP clients' experiences of their therapy (Boira, del Castillo, Carbajosa, & Marcuello, 2013; Chovanec, 2014; Gray, Lewis, Mokany & O'Neill, 2014; Holdsworth, Bowen, Brown, & Howat, 2019; Holtrup et al., 2017; Morrison et al., 2018, 2019; Morran, 2013; Parra-Cardona et al., 2013; Portnoy & Murphy, 2017; Silverglied & Mankowski, 2006; Shamai & Buchbinder, 2010). 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, Wormith, Derkzen & Beauregard, 2008), yet the majority of abusers entering PAIPs do so after a court-order (see Cannon, Hamel, Buttell, & Ferreira, 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) over-shadowed the entire process. While some participants gradually developed an appreciation of the PAIP content, others remained ambivalent or actively disputed the need for the programme. Similarly, Kelly and Westmarland (2015, p. 38) found "purely instrumental" compliance by clients whose child contact was conditional on completion. 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 behavioural 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 Shamai and Buchbinder (2010, p. 1344) participants likened their facilitator to a 'teacher and father'. 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 re-balanced 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 programmes, 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-behavioural 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 behaviour, 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-behavioural therapy (CBT) (for a review see Babcock et al., 2016). Compared to individual therapy, groups are favoured for their opportunities for peer challenge and peer modelling of change, and for allowing therapists to

observe client interactions. A number of studies note however that group dynamics can be negatively impacted 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 that 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 non-completers are generally absent, and research is not able to verify within-study whether these clients have different opinions of treatment compared to PAIP completers. As noted previously, programme 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 related to group-work, generally Duluth-based, PAIPs. Such PAIPs have limited capacity for client-treatment matching as they are not needs-based i.e., not differentiated by assessed client characteristics. It is therefore uncertain whether findings similar to those reviewed above would emerge from questioning non-completers and completers of a pure CBT programme with a more individualised 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 individualised community CBT programme delivered in Portsmouth,[3] a city on the south coast of England,

UK. The programme is introduced in the Method section below. Substantial efforts were made to recruit non-completers as attention to this sub-population is critical given high the attrition rates for PAIPs (Olver et al., 2011). Non-completion was defined as post-commencement 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 non-completers' perceptions of the treatment process within an individualised PAIP?
- Research question 2: How do clients explain their sustained engagement of, or non-completion of, individualised community PAIP treatment?
- Research question 3: What are the perceived outcomes following completion/termination of an individualised community PAIP?

Method

Participants and Sampling

A system was set up to recruit a purposive sample of completers and non-completers who had been programme participants. Sample size guidelines for thematic analysis studies suggest eight to ten participants for interviews in small projects (Braun & Clarke, 2013). We hoped to recruit at least eight completers and eight non-completers, and to achieve this we reached out to many of each sub-group. Clients were first contacted via text message, and then, if 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 five months. Ultimately, a total of 14 participants, nine completers and five non-completers, 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 non-completer group. All but two clients, including all non-completers, 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 non-completers (*M* = 27.75 years, *SD* = 1.71, *Range* = 27-30 years).

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

Ethical Considerations

To avoid conflicting interests and lower the probability of validity issues such as demand characteristics all interviews were conducted by [author initials], a researcher independent from the current therapeutic programme. Although she had previously assisted with research regarding the programme, [author initials] was University affiliated and had no relationship with the programme or its participants. The study was approved on 24th February 2016 following a full University institutional review.

Materials

The programme. The PAIP at the centre 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. While many custodial and community PAIPs have been criticised for using a 'one size fits all' approach (Dia, Simmons, Oliver, & Cooper, 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

programme description see Pearson & Ford, 2018). Up2U is open to abuser clients of all genders and sexual orientations provided the client is over the age of 16 and accepts that their behaviours are unhealthy. The breadth of the programme's eligibility criteria is important as a large-scale survey of bisexual women in Michigan, USA indicated 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 homogenous group (Dutton, 2007), most treatment models fail to reflect such individual differences (Cannon et al., 2016).

Semi-structured interview. [Author initials] 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 programme.[5] Discussion points included aspects such as individual reasons for either completion or non-completion, the process of treatment, and the therapeutic alliance. For example, "how interesting did you find the programme?" To maintain fluidity, the semi-structured interviews followed a non-rigid schedule which allowed freedom of movement between topics. Where necessary, prompts were used such as "was the programme 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 programme, 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 informed consent form to sign. Participants were not paid/compensated for their time. All participants were informed that their responses would be confidential, and anonymity would also be preserved. The interviews lasted approximately 40 minutes 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 hours 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 emphasises 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 *familiarisation with the data* whereby all transcripts were read three 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 labelled 'miscellaneous' was created to situate relevant codes which 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 & Clarke, 2006). The final phase of analysis involved *defining and naming themes.* It was particularly important to capture the 'essence' of each theme in order 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 generalisations 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 non-completers' accounts of their experiences of the programme. However, given that previous research has rarely questioned non-completers, these participants' responses are specifically considered in each sub-section below.

[Table 1 about here]

Research Question 1: Completers' and Non-completers' 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 re-framing 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 non-completer)

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"). Non-completer 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 Non-completion

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, *Non-completion 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' whilst undergoing the programme:

> 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 programme 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 to 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 programme 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)

Non-completion related to dynamic risk factors and treatment readiness. Whilst on the surface it appears that the five non-completers left the programme 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 non-completer)

Similarly, non-completer 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 non-completion. Such external factors are important given the large volume of referrals from children's social care.

For others, non-completion 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 non-completer)

The interplay between external factors and internal readiness to change is also evident when listening to Frank who explained 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 non-completer)

Research Question 3: Perceived Outcomes Following Programme Completion/Exit

Improved emotional self-management due to treatment. Nearly all participants whether completer or non-completer, 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 programme 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 programme early, among non-completers 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 non-completer)

While other non-completers 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 programme, described an interrupted process, saying "I need to come back to address my anger".

Discussion

By integrating accounts from programme non-completers as well as completers the current study offers a contribution to the literature on clients' experiences of community Partner Abuse Intervention Programmes (PAIPs). Programme participant experiences are of

particular importance in 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 non-completers' 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 and mutually agreed interactive activities. Key facets of the working alliance 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 programme was individualised CBT in the context of non-mandatory referral, and so a good match between client's learning goals and those of the programme 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 non-judgemental 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 non-completers (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, i.e., sticking with the programme without losing sight of the individual.

Considering the reasons given for sustained programme 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, Woodhams, & Tonkin, 2016), facilitators successfully developed a ‘safe environment’ whereby participants felt able to respond openly to the programme. Many of the participants were unemployed, and these marginal clients may have been sensitive to signs of interpersonal judgement in the working relationship. Withdrawal can be a symptom of rejection-sensitivity rupturing the therapeutic alliance (Black, Curran, & Dyer, 2013), and might be expected to occur more readily in a non-mandatory PAIP context compared to legally enforced treatment where criminal justice consequences follow non-compliance. However, participants identified that they did not feel

judged thanks to the facilitators maintaining a neutral stance. This may be associated with the programme's motivational needs-based approach, as opposed to one focussed on holding men accountable. A recent randomised clinical trial suggests that incorporating motivational plans into CBT PAIPs increases client compliance (Lila, Gracia, & Catalá-Miñana, 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 modelling 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 working alliance. 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 judgement is required in assessing when support can/should be gradually rescinded.

Non-completion was perceived as being related to external lifestyle factors. The challenges of PAIP compliance alongside external demands has been noted previously (Chovanec, 2014; Gray et al., 2014). What was evident by considering the experiences of non-completers however, was that the reasons given for drop-out were all associated with the 'central eight' risk factors (Bonta & Andrews, 2017). Non-completers 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 drop-out is not surprising, given the empirical link between drop-out and recidivism risk (Olver et al., 2011), and between recidivism and heightened risk on the 'central eight' factors

(Bonta, Blais, & Wilson, 2014). This reinforces the likely benefit of facilitators regularly reviewing with the client the risk assessment information gathered at programme commencement to understand, identify, and refocus treatment to address factors that represent risk for general recidivism and hence drop-out. Previous work examining programme 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).

Non-completers' explanations reflect treatment readiness, and are consistent with the factors outlined within the Multifactor Offender Readiness Model (MORM) (Ward, Day, Howells & Birgden, 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 non-completers reported a number of factors which 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 non-completers discussed taking part in the programme 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 programmes, compared to coerced and legally mandated programmes (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 programme?’), both the completers and the non-completers 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 programme (see Pearson & Ford, 2018). Reassuringly, both groups of participants, completers and non-completers, reported improvement in this area. Proposed deficits in these skills, when in high conflict situations, have been linked to the use of violence (Curtis, Ronan & Borduin, 2004). There were reports of many auspicious applications of newfound skills in conflict management and listening; however, with non-completers 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 drop-out (Eckhardt, Samper & Murphy, 2008). As mentioned previously, programme evaluations indicate a connection between the predictors of drop-out and the predictors of recidivism (Olver et al., 2011), which highlights the importance of monitoring and appraising progress on factors related to drop-out such as problems in emotional regulation.

Implications for Research and Practice

At present, the current intervention programme, Up2U, requires that prospective clients admit that they use unhealthy behaviours in their relationships. However, the programme 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 programme, 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, Day, Howells, & Ward, 2007). Available measures include the Treatment Engagement Rating (TER) scale (Drieschner & Boomsma, 2008) and the Treatment Readiness, Responsivity, and Gain: Short Version (Serin, Kennedy & Mailloux, 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 interventions employed.

The timing was not right for our non-completers to engage in therapy. These clients did not implicate programme 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 non-completers and completers both experience PAIPs similarly, but external factors prevent non-completers 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 non-completers. For example interviews could be completed after one month of therapy (the point at which the current non-completers began to drop-out). Potentially this could also reach those clients harbouring more negative attitudes towards 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 individualised 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 programme. To maximise response rates, community programme providers must regularly update client details so that multiple sources of up-to-date contact information are on record. Nevertheless, compared to all programme referrals, the sample we ultimately obtained may have reflected greater psychological momentum for rehabilitation due to external contingencies, e.g., supportive family, and/or, the influence of children's social care. Relatedly, the current study was a rare exploration of client experiences of individualised 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.

While 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 programme 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, Buttell, & Dutton, 2007). Further research is warranted that focusses 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/non-completers reflected actual desistance/re-offending.

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 organisation, the meetings took place in a location where the participants had received treatment and there was also a programme staff member in the vicinity, albeit out of earshot. Although participants did offer criticisms of the programme this remains a potential limitation. Similarly, participants' accounts may have suffered from recall bias. Some may have over-stated 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 non-completers also proposed positive aspects of the programme.

Conclusion

There are no previously known qualitative studies which investigate the subjective experiences of both completers and non-completers of a community PAIP. Quantitatively focussed evaluations have limited scope to interrogate the 'black box' of the treatment process. The current study has demonstrated the benefit of consulting programme users to gain a richer understanding of both the treatment process and reasons given for engagement and non-completion. Descriptions of the treatment process emphasised the benefit of facilitators exercising relationship skills and client responsivity, consistent with adherence to the theoretically and empirically supported RNR model (Bonta & Andrews, 2017). Regardless of completion or non-completion, all participants reported treatment outcomes in

relation to improved communication skills - although some non-completers 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 drop-out prone clients engaged. Conversely, non-completion 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 pre-treatment, or, maintenance support. Future research should expand efforts to examine the subjective experiences of non-completers to enhance client retention and help reduce the harms of intimate partner violence/abuse.

Notes

1. We use the term ‘Partner Abuse Intervention Programmes’ throughout this manuscript, instead of ‘Batterer Intervention Programmes’ or ‘Domestic Violence Perpetrator Programmes’. We do so because ‘partner abuse’ is a broader term, better reflecting the diversity of clients and their behaviours.
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 programme 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 manuscript are pseudonyms.

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Tables

Table 1

Themes Relating to Specific Research Questions

	Research Question	Associated Theme	Representation ($N_{participants}$)
1.	Completers' and Non-completers' Perceptions of the Treatment Process	Treatment Process Experienced as Challenging Yet Enlightening	11
2.	Explanations for Sustained Engagement and Non-Completion	Importance of a Timely, Safe Therapeutic Environment	13
3.	Perceived Outcomes Following Programme Completion/Exit	Improved Emotional Self-Management	12