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Dropout From Trauma-Focused Treatment for Intimate Partner Violence Against Women

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ABSTRACT

The current study aimed to analyze the characteristics, and the factors associated with dropout from a trauma-focused (TF) cognitive-behavioural therapy (CBT) tailored for intimate partner violence against women (IPVAW) that has been shown to be effective. Ninety-one female survivors of IPVAW entered a randomized controlled trial comparing two versions of the TF-CBT, both delivered in eight weekly sessions and group format. A total of 37.4% of women who entered treatment dropped out during treatment; an additional 7.1% dropped out after randomization and before starting treatment. There were no significant differences in dropout rate between conditions. Most of the dropouts occurred before session 4 (68.3%) and were related to practical/external difficulties (63.4%). Regarding sociodemographic features, dropping out significantly related to younger age, being migrant and being unemployed or active working. For characteristics of violence, dropouts significantly differed from completers in time elapsed since the last violence episode (lower in dropouts). Finally, regarding their clinical state, women that dropped out scored significantly higher in posttraumatic cognitions and anxiety. Comparisons between dropouts due to practical/external difficulties and due to treatment-related issues showed significant differences in origin (more dropouts related to practical difficulties in migrant women) and time since last episode of violence (lower in dropouts due to treatment-related issues). Data highlight the need for personalized retention strategies for younger and migrant women and measures to facilitate the attendance to sessions prior to entering a TF-therapy. This is an analysis of data collected as part of a clinical trial preregistered as ISRCTN73702156.

1 | Introduction

Dropout is a widespread concern that affects the effectiveness and reduces the therapeutic gains of psychological treatments and can be seen as an indicator of their acceptability and tolerability (Hoppen et al. 2023; Imel et al. 2013). There is no consensus on the definition and operationalization of dropout; some of the proposed definitions include participants who do not complete the specified treatment protocol (Imel et al. 2013), participants who do not complete the post-treatment assessment (Lewis et al. 2020), or participants who discontinue treatment

prematurely before recovery (Simmonds-Buckley et al. 2022; Swift and Greenberg 2012).

This problem is clearly evident in the treatment of post-traumatic stress disorder (PTSD), for which several treatments have been shown to be effective with moderate to large effect sizes (American Psychological Association 2019; Bisson et al. 2013; International Society of Traumatic Stress Studies – ISTSS 2018; National Institute of Health and Care Excellence – NICE 2018). Yet, clinicians report high dropout rates, albeit with high variability across trials, depending on the specific

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Summary

- Dropouts mostly occur in the first sessions and are not related to the exposure components of the treatment.
- Migrant women might find it difficult to stay in group treatment because of more unstable working conditions (rotating shifts or frequent job changes).
- Women with more recent violence episodes are probably more interfered by symptom severity and a sense of unsafeness.
- The key to reducing dropouts likely lies not in improving the program itself, but in addressing the needs of women who are most likely to face difficulties staying in treatment due to other priorities, such as achieving work stability and regaining a sense of safety. Supporting them in resolving these issues first may better prepare them to participate in trauma-focused group treatment.

treatments considered and the definition of dropout. Dropout rates range from 16% or 18% for psychological therapies for PTSD (Imel et al. 2013; Lewis et al. 2020), to 20.9% for guideline-recommended therapies (Varker et al. 2021). The highest rate (41.5%) has been reported for trauma-focused (TF) therapies (Mitchell et al. 2022), which, conversely, have the strongest evidence. In fact, increased dropout rates have been reported for TF-therapies (namely cognitive processing therapy -CPT- or prolonged exposure -PE-) when compared to non-TF-therapies for PTSD (Hoppen et al. 2023; Imel et al. 2013; Lewis et al. 2020; Varker et al. 2021). This may be related to the confrontation with traumatic images, which can be anxiety-provoking and pose additional challenges and demands for patients (Gjerstad et al. 2024).

These reviews and meta-analyses also found that higher dropout rates were associated with a higher number of sessions (Imel et al. 2013; Varker et al. 2021); military trauma (vs. civil trauma; Varker et al. 2021; Wright et al. 2024); younger age (Wright et al. 2024); more severe clinician-rated PTSD symptom (but not self-reported; Mitchell et al. 2022); and comorbidity with depression (Wright et al. 2024). There is also some evidence of increased dropouts in group delivery format (e.g., Imel et al. 2013, estimate that the group format conveys a 12% increase in the dropout rates), although some authors report no effect of the group format (Lewis et al. 2020). When considered, the reasons for dropout more frequently reported included issues related to the treatment itself and competing demands with work and family care (Varker et al. 2021).

Dropout from therapies for PTSD may be even more noticeable in female survivors of intimate partner violence (IPV), since this population faces situational challenges such as the presence of an ongoing stressor, housing and financial instability, concerns for their safety and limited resources, among others (Galovski et al. 2022). TF-therapies have proven to be effective in improving emotional state and even reducing revictimization in this population, but clinical trials only occasionally provide information about dropouts. The pioneering work by Kubany et al. (2004) applying a cognitive-behavioural therapy (CBT) for

IPV reported a dropout rate of 19.6% among women who started treatment, rising to 35.2% when those who dropped out before starting treatment were also included. Compared with completers, women who dropped out were significantly younger, less educated, more depressed, more shame prone and had lower self-esteem at the initial assessment. Focusing on IPV exposure, Iverson et al. (2011) examined it as a predictor of treatment engagement (i.e., starting and completing therapy) in CPT. Results indicated that women with recent IPV (i.e., past year) were less likely to begin treatment relative to women who reported past IPV only or no history of IPV. However, for women who began treatment, IPV exposure was not predictive of dropping out from treatment. In a later study Crespo et al. (2021) compared individual and group versions of a TF-CBT with higher dropout rates in the group format (35.7% vs. 20%), though the difference was not statistically significant, and with most of the dropouts occurring in the first sessions. Applying narrative exposure therapy (NET) Orang et al. (2018) found dropout rates of 33.3%, with significant differences in educational level (lower for dropouts). When informed, the most common reasons for dropout were work-related issues, family responsibilities and treatment-evoked distress (Crespo et al. 2021; Orang et al. 2018).

Beyond clinical trials, data from clinical settings have shown dropout rates of 28% for TF-therapies for interpersonal violence, rising to 59.6% when including those who do not start treatment (Ghafoori et al. 2022). In this study, being unemployed and lower scores in quality of life were predictive of pretreatment dropout, while being female and Latinx and scoring higher on social relationships were predictive of post-initiation dropout. Regarding domestic violence, Gonçalves et al. (2024) reported a 33.5% overall dropout rate, with highest rates for cognitive therapy -CT- (40.5%) and PE (38.8%) and lowest ones for NET (25.5%).

All these data point to high dropout rates in TF-therapies for IPV, acknowledging some of the reasons for dropout as well as some of the predictor variables, albeit with low consistency across studies. As dropout is an important setback in intimate partner violence against women (IPVAW) treatment, with potential harms such as reduced effectiveness of the intervention or repeated requests for help for the same problem, further research on this topic would be needed to implement more effective strategies aimed at reducing dropout.

In this line, the present study focuses on analyzing the characteristics of dropouts and identifying factors associated with them based on data from a randomized clinical trial (RCT) testing the effectiveness of a group TF-CBT tailored for IPVAW. Specifically, it aimed to (1) explore the time and reasons for dropping out from treatment; (2) explore whether dropouts were associated with sociodemographic variables, characteristics of the violence (i.e., type, duration, severity, frequency and consequences) and clinical variables (i.e., posttraumatic symptoms, meaning of IPV, affect, emotional regulation, depression, anxiety, self-concept and overall functioning); and (3) analyze differences in factors associated to dropouts due to treatment-related issues vs. to practical/external difficulties.

Based on previous research it was hypothesized that: (1) Dropouts will occur mostly in the initial sessions and will be related to practical/external difficulties; (2) there will be

significant differences between completers and dropouts in sociodemographic variables (dropouts will be younger, less educated and more frequently unemployed) and clinical variables (dropouts will score higher in depression and PTSD symptoms and lower in self-esteem at baseline). No hypotheses are stated regarding the relationship between characteristics of violence (i.e., type, duration and severity of the abuse) and attrition since there is not enough evidence. Similarly, there is no prior evidence regarding the specific factors related to dropout due to treatment-related issues vs. practical/external difficulties, so no hypotheses in this respect are put forward either.

2 | Methods

2.1 | Participants

The present study was a secondary data analysis of a RCT aimed to test the effectiveness of a group TF-CBT for IPVAW (cf. Crespo et al. 2024a). Participants were recruited in community settings, through several women's services around Madrid (Spain). Eligibility criteria were: being a woman 18 years of age or older; reporting recent or past experiences of any form of IPVAW (i.e., physical, sexual or psychological abuse by an intimate partner or ex-partner); having experienced IPVAW at least 1 month before the start of the trial; presenting significant posttraumatic symptoms according to DSM-5 criteria as determined by the Global Assessment of Posttraumatic Stress Scale 5 (EGEP-5; in Spanish: Evaluación Global de Estrés Postraumático 5; Crespo et al. 2017); being proficient in Spanish; and having voluntarily agreed to take part in the study. Exclusion criteria included: suicide risk as assessed by Item 9 (scores > 1) of the Spanish version of the Beck Depression Inventory II-BDI-II (Beck et al. 1996); presenting conditions that could prevent compliance with the treatment (namely, abuse of alcohol or drugs, cognitive impairment or illiteracy in Spanish); having been diagnosed or suffering from psychotic disorders; and having received therapy for trauma within the past 6 months.

A total of 148 women were initially screened for eligibility; 33 were excluded for different reasons and 24 (16.2%) declined to participate. Consequently, 91 entered the treatment (12 of them entered the treatment after two-months in the waiting-list -WL-control group).

2.2 | Intervention

The CBT applied here is a brief multicomponent program based on Labrador et al. (2009) and Crespo and Arinero (2010) that incorporates an extended application of the exposure technique and, as a main innovation, the evocation of positive autobiographical memories (CBT-M+).

This CBT-M+ was applied in face-to-face group format (6–8 women per group) in eight weekly sessions of 100–145 min and included the following components and timing: (1) psychoeducation (Session 1); (2) exercises of diaphragmatic breathing (Sessions 1–7); (3) activity scheduling (Session 2); (4) techniques to improve self-esteem and cognitive re-evaluation of biased cognitions (Sessions 2–3); (5) imaginal exposure focused on

the memory of IPV situations (including hot-spot exposure) (Sessions 3–7); (6) positive memories evocation (Sessions 4–7); and (7) relapse prevention (Session 8).

The CBT-M+ was compared to a version without the positive memories evocation (CBT). To ensure equivalence between both conditions, the CBT incorporated a placebo task consisting of the evocation of neutral images (i.e., several geometric figures) in Sessions 4–7 for the same length of time as the positive memory evocation task in the CBT-M+ group.

The intervention protocol was manualized to ensure the homogeneity and replicability and can be accessed in Crespo et al. (2024b).

2.3 | Variables and Measures

2.3.1 | Dropout

The therapist recorded each participant's attendance/absence at the end of each session, along with the reason for absences, which was collected via telephone afterwards. Women were considered dropout if: (1) They abandon after randomization and before beginning treatment (pretreatment dropout); or (2) they failed to complete treatment protocol by missing at least three sessions. Consequently, to be considered a completer women had to attend at least five sessions (i.e., at least 62.5% of the treatment).

2.3.2 | Demographic Variables and History and Features of Violence

An *ad hoc* structured interview assessed sociodemographic characteristics (e.g., age, nationality, job status, marital status, educational level ...), the history and features of the abuse (e.g., type of violence, duration, frequency, severity ...) and its consequences (e.g., required medical attention, was reported ...). It also included information about social and psychological support, and substance use.

2.3.3 | Clinical Variables

Posttraumatic symptoms were assessed using the *Global Assessment of Posttraumatic Stress Scale 5* (EGEP-5; Crespo et al. 2017), which measures the severity of PTSD symptoms (score range 0–80; higher scores indicate more severe symptoms) and PTSD diagnosis (in this study $\alpha = 0.91$).

The meanings of the IPV were measured with the *Centrality of Event Scale* (CES 7-item version, Berntsen and Rubin 2006), which assesses the extent to which a traumatic event forms a central component of an individual's personal identity and a reference point for the attribution of meaning to other experiences (scores range 7–35; higher scores meaning more centrality of the event; in this study $\alpha = 0.74$); and with the *Brief Version of the Posttraumatic Cognitions Inventory* (PTCI-9, Wells et al. 2019), which measures negative posttraumatic cognitions about the self, the world, and self-blame, (scores range 1–7; higher scores

showing more negative posttraumatic cognitions; in this study $\alpha = 0.77$).

To assess associated symptoms, we administered the *Beck Anxiety Inventory* (BAI, Beck and Steer 1990), which measures the presence and severity of anxiety symptoms (scores range 0–63; higher scores showing more severe symptoms; in this study $\alpha = 0.88$); and the *Beck Depression Inventory II* (BDI-II; Beck et al. 1996), which identifies the global level of depression. The scores range 0–63 (higher scores showing more severe symptoms; in this study $\alpha = 0.89$).

The *Positive and Negative Affect Schedule* (PANAS, Watson et al. 1988) was applied to assess positive (PA) and negative affect (NA). Scores in each scale range 10–50 (higher scores showing more intense positive/negative affect; in this study PA $\alpha = 0.92$; NA $\alpha = 0.89$).

To measure emotional regulation, we used the *Difficulties in Emotion Regulation Scale—Short Form* (DERS -SF, Kaufman et al. 2016), which evaluates the difficulties that people may experience in regulating their emotions (scores ranging 18–90; higher scores showing more difficulties; in this study $\alpha = 0.87$); and the *Difficulties in Emotion Regulation Scale—Positive* (DERS-P, Weiss et al. 2015), which focuses on clinically relevant difficulties in regulating positive emotions (scores range 13–65; higher scores indicating greater positive emotion regulation difficulties; in this study $\alpha = 0.88$).

Women's self-concept was measured with the *Rosenberg's Self-Esteem Scale* (RSS, Rosenberg 1965), which assesses feelings of self-respect and self-acceptance. The scores range 10–40 (higher scores meaning higher self-esteem; in this study $\alpha = 0.60$). Moreover, the *Self-Concept and Identity Measure* (SCIM, Kaufman et al. 2015) was administered to assess identity disturbances (scores 27–189; higher scores showing more identity disturbance; in this study $\alpha = 0.81$).

The *12-Item Short Form Health Survey, Version 2* (SF-12 v2, Ware Jr et al. 2002) was used to assess overall mental and physical health (scores range 0–100; higher scores meaning better overall health). Moreover, the impairment scale of the *EGEP-5* provided information about women's difficulties in daily functioning (scores ranging 0–7; higher scores meaning higher difficulties). According to the normative data, scores > 1 are indicative of functional problems.

2.4 | Procedure

Participants were assigned to a therapeutic group based on their availability; for each therapeutic group, the treatment modality (i.e., CBT or CBT-M+) was randomly assigned using the *Salinas software* (s.f.). Thus, 41 women were assigned to CBT and 50 to CBT-M+. All in all, 13 therapeutic groups were held (6 for the CBT and 7 for the CBT-M+), all carried out by the same therapist (a female psychologist with training in TF-therapies and in IPVAW). The study was approved by the Ethics Committee of the Faculty of Psychology of the Complutense University of Madrid (ref: 2020/21_025) and it was conducted following CONSORT recommendations (Boutron et al. 2017). The trial

protocol was preregistered (ISRCTN73702156) and published (Crespo et al. 2022).

2.5 | Data Analysis

Chi-square and t-tests were used to compare dropouts and completers on socio-demographic variables, history of IPV and symptomatology. In chi-square tests, Cramer's V was calculated to estimate the strength of the association between categorical variables as well as risk ratios. When significant effects were found in variables with three or more levels, stratified Chi-square tests were performed. For the t-tests, the Levene's test was previously applied to check the assumption of equality of variances and the effect size (Hedges's g) was computed for significant differences.

To compare dropouts due to treatment-related issues and to practical/external difficulties chi-square statistical and Mann-Whitney U tests (*r* effect size) were performed. In this case, non-parametric tests were chosen because of the small sample size and the unequal size of the groups.

Statistical analyses were conducted with SPSS 29 (IBM Corp. 2023).

3 | Results

3.1 | Participants Characteristics

Participants' characteristics are shown in Table 1. The average age of participants was about 40 years, with a wide range (20–73 years). Most of them were Spanish, had children, had completed secondary studies and were active workers, although approximately one-third were unemployed. About one-half of the women were separated or undergoing separation procedures, although 10 women (11%) still lived with the aggressor at the time of the assessment and six women (6%) maintained a romantic relationship with him.

As regards characteristics of IPV, its average length was 14.5 years. All the women had experienced psychological abuse; physical abuse was also very common (82.4%). Over one-half of the participants had experienced all three types of abuse (i.e., psychological, physical and sexual) throughout their lives (52.7%). Most of the women rated the severity of the violence as high or extreme and around a quarter had have suffered violence by some former partner.

Regarding their emotional state, 94.5% of the women met the diagnostic criteria for PTSD (73.6% for PTSD with dissociative symptoms). Posttraumatic symptoms generated significant functional impairment in most of the women (95.6%). According to the cut-off points of the scales, the mean depression score can be considered moderate, the mean anxiety scores severe, and the mean level of self-esteem low. Their negative affect was at the average level of the scale while positive affect was below it. They did not show difficulties in emotional regulation (either for negative or positive emotions) or identity disturbances. They showed a moderate-low mental

TABLE 1 | Characteristics of the participants, IPV history and emotional status ($n = 91$).

Characteristic	Total $n = 91$
Sociodemographic	
Origin—Spanish n (%)	69 (75.8)
Age (years) M (SD)	42.80 (13.45)
Marital status n (%)	
Single	30 (33.0)
Married/living with partner	16 (17.6)
Separated/divorced	44 (48.4)
Job status n (%)	
Active worker	45 (49.5)
Unemployed	28 (30.8)
Others	17 (19.8)
Level of education completed n (%)	
None/primary	12 (13.2)
Secondary	68 (74.7)
University	11 (12.1)
Have children n (%)	77 (84.6)
Psychiatric/psychological attention n (%)	61 (67.0)
Psychoactive drug use in the last year n (%)	41 (45.10)
Alcohol use in the last year n (%)	33 (36.3)
Violence and abuse	
Keep contact with abuser n (%)	28 (30.8)
Duration (months) of IPV M (SD)	174.40 (144.04)
Month since last IPV episode M (SD)	14.54 (21.89)
Psychological violence n (%)	91 (100)
Physical violence n (%)	75 (82.4)
Sexual violence n (%)	52 (57.1)
Economic violence n (%)	78 (85.7)
Control n (%)	87 (95.6)
Frequency of IPV n (%)	
Monthly/weekly	10 (11.0)
Daily or almost daily	81 (89.0)
Severity of IPV n (%)	
Mild/moderate	13 (14.3)
High	51 (56.0)
Extreme	27 (29.7)
Reported the abuse n (%)	50 (54.9)

(Continues)

TABLE 1 | (Continued)

Characteristic	Total $n = 91$
Had to leave home due to IPV n (%)	27 (29.7)
Medical attention for IPV n (%)	34 (37.4)
Social support for IPV n (%)	
Bad	52 (57.1)
Regular	33 (36.3)
Good	6 (6.6)
Clinical, emotional and functional	
Posttraumatic symptoms (EGEP-5) (0–80) M (SD)	43.65 (16.02)
Centrality of IPV (CES) (7–35) M (SD)	30.89 (4.08)
Posttraumatic cognitions (PTCI-9) (1–7) M (SD)	3.80 (1.15)
Anxiety (BAI) (0–63) M (SD)	32.04 (11.36)
Depression (BDI-II) (0–63) M (SD)	26.24 (11.00)
Positive affect (PANAS) (10–50) M (SD)	25.63 (7.67)
Negative affect (PANAS) (10–50) M (SD)	29.56 (8.58)
Difficulties emotions regulation (DERS) (18–90) M (SD)	46.60 (11.91)
Difficulties in positive emotions regulation (DERS-P) (13–65) M (SD)	16.73 (5.81)
Self-esteem (RSS) (10–40) M (SD)	23.99 (4.05)
Identity disturbances (SCIM) (27–189) M (SD)	92.43 (20.04)
Mental health (SF-12) (0–100) M (SD)	33.74 (9.71)
Physical health (SF-12) (0–100) M (SD)	45.57 (10.31)
Impairment (EGEP-5) (0–7) M (SD)	4.81 (1.50)

health level and a moderate physical health level. Finally, the level of functional impairment was average according to the cut-off points of the instrument.

3.2 | Dropout Details

As shown in Table 2, a total of 34 women (37.4%) who entered (treatment) dropped out by missing three consecutive or alternating sessions. When also considering the seven women that dropped out after being assigned to treatment and before starting it (pretreatment dropout), the total dropout rate increased to 45.1%. Although dropouts were higher in the CBT than in the CBT-M+ (41.5% vs. 34.0% for women that entered treatment and 48.8% vs. 42% for total dropout), these differences did not reach statistical significance. Total dropout rate was also higher among women who had previously been in the WL control group (66.7% vs. 41.8%), but the difference was not statistically significant ($\chi^2_{(1)} = 2.61$, $p = 0.106$).

TABLE 2 | Dropouts detail and differences in dropout from CBT vs. CBT-M+.

Characteristic	Total <i>n</i> = 91	CBT <i>n</i> = 41	CBT-M+ <i>n</i> = 50	χ^2	<i>p</i>
Dropout (missing at least 3 sessions) <i>n</i> (%)	34 (37.4)	17 (41.5)	17 (34.0)	0.523	0.470
Total dropout (including pretreatment dropout) <i>n</i> (%)	41 (45.1)	20 (48.8)	21 (42.0)	0.418	0.518
Dropout session <i>n</i> (%)				0.053	0.819
Pretreatment to Session 3	28 (68.3)	14 (70.0)	14 (66.7)		
Sessions 4–7	13 (31.7)	6 (30.0)	7 (33.3)		
Reason for dropping out <i>n</i> (%)				1.410	0.494
Practical/external difficulties	26 (63.4)	11 (55.0)	15 (71.4)		
Treatment-related issues	11 (26.8)	7 (35.0)	4 (19.0)		
Other reasons	4 (9.8)	2 (10.0)	2 (9.5)		

On average women that dropped out attended 22% of the sessions ($M = 1.76$; $SD = 1.22$; range 0–4 sessions), and women that did not drop out attended 85.8% of the sessions ($M = 6.86$; $SD = 1.05$; range 5–8 sessions). A total of 28 women (68.3%) dropped out of treatment before the fourth session. Only four women (9.7%) dropped out after session five, with no women dropping out in the final session (i.e., Session 8). There were no significant differences between treatments in the dropout session ($\chi^2_{(7)} = 6.61$, $p = 0.471$). As the two treatments began to differ after session four, we specifically analysed whether there were differences between the percentage of dropouts for each treatment before (i.e., from no start treatment to Session 3) and after this session (i.e., from Session 4–7). There were no significant differences.

The reasons for dropping out were related to practical/external difficulties for most women (63.4%); these circumstances included work-related issues (36.6%), family care (17.1%) and, less frequently, health issues (9.8%). A total of 11 women (26.8%) dropped out due to treatment-related issues, including inappropriate timing of treatment in their lives (14.6%) and treatment-evoked distress (12.2%). Both treatments did not differ significantly in reasons for dropout ($\chi^2_{(5)} = 5.66$, $p = 0.341$). Moreover, there were no significant associations between the reasons (i.e., practical/external difficulties vs. treatment-related issues) and the moment of dropout (i.e., from no start to Session 3 vs. Sessions 4–7) ($\chi^2_{(2)} = 1.65$, $p = 0.438$).

As there were no significant differences in dropout from the two treatments (i.e., CBT and CBT-M+), they were considered together in the subsequent analyses.

3.3 | Differences Between Dropouts and Non-Dropouts

Comparison of the sociodemographic characteristics of women who discontinued treatment versus completers (see Table 3) showed that women who dropped out were significantly younger (39.44 vs. 45.56 years; $t_{(89)} = 2.20$; $p = 0.015$; $g = 0.46$, 95% CI [0.04–0.87]).

In addition, there were significantly more dropouts among migrant than among Spanish women ($\chi^2_{(1)} = 12.17$; $p < 0.001$; Cramer's

$V = 0.37$) (RR = 6.38; 95% CI [2.09–19.41]). Given that the percentage of dropouts was higher among migrant women, the effect of mother tongue was analysed. Among the seven women who were not native Spanish speakers, 6 (85.7%) dropped out of treatment, which was significantly higher than the 41.7% dropout rate found among women who were Spanish native speakers ($\chi^2_{(1)} = 5.06$; $p = 0.043$; Cramer's $V = 0.24$) (RR = 8.40; 95% CI [0.97–72.91]).

Job status showed also significant effect ($\chi^2_{(2)} = 9.01$; $p = 0.011$; Cramer's $V = 0.32$). The stratified Chi-square analyses showed significant effects only for migrant women ($\chi^2_{(2)} = 11.81$; $p = 0.003$; Cramer's $V = 0.73$), indicating that among migrant women who were active workers or unemployed, the majority dropped out of treatment (88.9% and 90%, respectively), which clearly exceed the percentages found among Spanish women (25% and 55.6%, respectively). Conversely, analyses of the origin for each job status showed significant effects only for active working ($\chi^2_{(1)} = 12.50$; $p < 0.001$; Cramer's $V = 0.53$), indicating that dropouts among active workers were significantly higher in migrant than in Spanish women (88.9% vs. 25%).

Regarding the characteristics of the violence suffered by the women, there were significant differences in the time elapsed since the last episode of violence, which was significantly ($p = 0.021$) more recent among women who dropped out of treatment (9.68 vs. 18.52 months; $t_{(75.55)} = 2.06$; $p = 0.021$; $g = 0.41$, 95% CI [−0.01–0.82]).

Finally, in terms of clinical symptomatology, women who dropped out of treatment showed significantly higher levels of posttraumatic cognitions (4.04 vs. 3.60; $t_{(75.20)} = -1.77$; $p = 0.04$; $g = -0.38$, 95% CI [−0.79–0.04]), and anxiety (34.24 vs. 30.24; $t_{(89)} = -1.69$; $p = 0.047$; $g = -0.35$, 95% CI [−0.76–0.06]).

Differences between dropouts and completers did not reach statistical significance for the rest of variables.

3.4 | Reasons for Dropping Out of the Treatment

Comparisons were made between women who dropped out due to practical/external difficulties ($n = 26$) and those who dropped

TABLE 3 | Differences in baseline measures between women completing and dropout.

Characteristic	Treatment completion <i>n</i> = 50	Dropout <i>n</i> = 41	Statistics	<i>p</i>
Sociodemographic				
Origin <i>n</i> (%)			$\chi^2_{(1)} = 12.17$	< 0.001
Spanish	45 (65.2)	24 (34.8)		
Other (migrant)	5 (22.7)	17 (77.3)		
Age (years) M (SD)	45.56 (13.73)	39.44 (12.46)	$t_{(89)} = 2.20$	0.015
Marital status <i>n</i> (%)			$\chi^2_{(3)} = 4.21$	0.240
Single	13 (43.3)	17 (56.7)		
Married/living with partner	9 (56.3)	7 (43.8)		
Separated/divorced	28 (63.6)	16 (36.4)		
Job status <i>n</i> (%)			$\chi^2_{(2)} = 9.01$	0.011
Active worker	28 (62.2)	17 (37.8)		
Unemployed	9 (32.1)	19 (67.9)		
Others (student, retirement, housewife)	13 (72.2)	5 (27.8)		
Level of education completed <i>n</i> (%)			$\chi^2_{(2)} = 0.68$	0.712
None/primary	6 (50.0)	6 (50.0)		
Secondary	39 (57.4)	29 (46.2)		
University	5 (45.5)	6 (54.5)		
Have children <i>n</i> (%)			$\chi^2_{(1)} = 1.82$	0.178
No	10 (71.4)	4 (28.6)		
Yes	40 (51.9)	37 (48.1)		
Violence and abuse				
Contact with abuser <i>n</i> (%)			$\chi^2_{(2)} = 0.54$	0.461
No	33 (52.4)	30 (47.6)		
Yes	17 (60.7)	11 (39.3)		
Duration (months) of IPV M (SD)	194.04 (142.09)	150.44 (144.50)	$t_{(89)} = 1.44$	0.076
Month since last IPV episode M (SD)	18.52 (26.41)	9.68 (13.42)	$t_{(75.55)} = 2.06$	0.021
Psychological violence <i>n</i> (%)			—	—
No	—	—		
Yes	50 (54.9)	41 (45.1)		
Physical violence <i>n</i> (%)			$\chi^2_{(1)} = 0.01$	0.908
No	9 (56.3)	7 (43.8)		
Yes	41 (54.7)	34 (45.3)		
Sexual violence <i>n</i> (%)			$\chi^2_{(1)} = 3.56$	0.059
No	17 (43.6)	22 (56.4)		
Yes	33 (63.5)	19 (36.5)		
Economic violence <i>n</i> (%)			$\chi^2_{(1)} = 3.58$	0.058

(Continues)

TABLE 3 | (Continued)

Characteristic	Treatment completion	Dropout	Statistics	<i>p</i>
	<i>n</i> = 50	<i>n</i> = 41		
No	4 (30.8)	9 (69.2)	$\chi^2_{(1)} = 0.04$	1.000 ^a
Yes	46 (59.0)	32 (41.0)		
Control <i>n</i> (%)				
No	2 (50.0)	2 (50.0)	$\chi^2_{(1)} = 1.03$	0.505 ^a
Yes	48 (55.2)	39 (44.8)		
Frequency of IPV <i>n</i> (%)				
Monthly/weekly	7 (70.0)	3 (30.0)	$\chi^2_{(2)} = 1.99$	0.385
Daily or almost daily	43 (53.1)	38 (46.9)		
Severity of IPV <i>n</i> (%)				
Mild/moderate	7 (53.8)	6 (46.2)	$\chi^2_{(2)} = 0.26$	0.607
High	31 (60.8)	20 (39.2)		
Extreme	12 (44.4)	15 (55.6)		
Violence by former partners <i>n</i> (%)				
No	38 (53.5)	33 (46.5)	$\chi^2_{(1)} = 2.16$	0.141
Yes	12 (60.0)	8 (40.0)		
Reported the abuse <i>n</i> (%)				
No	26 (63.4)	15 (36.6)	$\chi^2_{(1)} = 0.029$	0.591
Yes	24 (48.0)	26 (52.0)		
Had to leave home <i>n</i> (%)				
No	34 (53.1)	30 (46.9)	$\chi^2_{(1)} = 2.57$	0.109
Yes	16 (59.3)	11 (40.7)		
Medical attention <i>n</i> (%)				
No	35 (61.4)	22 (38.6)	$\chi^2_{(1)} = 2.44$	0.118
Yes	15 (44.1)	19 (55.9)		
Psychiatric/psychological attention <i>n</i> (%)				
No	13 (43.3)	17 (56.7)	$\chi^2_{(1)} = 0.04$	0.841
Yes	37 (60.7)	24 (39.3)		
Psychoactive drug use in the last year <i>n</i> (%)				
No	27 (54.0)	23 (46.0)	$\chi^2_{(1)} = 0.003$	0.954
Yes	23 (56.1)	18 (43.9)		
Alcohol use in the last year <i>n</i> (%)				
No	32 (55.2)	26 (44.8)	$\chi^2_{(2)} = 0.62$	0.735
Yes	18 (54.5)	15 (45.5)		
Social support for IPV <i>n</i> (%)				
Bad	27 (51.9)	25 (48.1)		
Regular	19 (57.6)	14 (42.2)		
Good	4 (66.7)	2 (33.3)		

(Continues)

TABLE 3 | (Continued)

	Treatment completion	Dropout		
Characteristic	<i>n</i> = 50	<i>n</i> = 41	Statistics	<i>p</i>
Clinical, emotional and functional				
Posttraumatic symptoms (EGEP-5) (0–80) M (SD)	43.96 (15.37)	43.24 (17.28)	$t_{(89)}=0.20$	0.419
Centrality of IPV (CES) (7–35) M (SD)	30.65 (4.68)	31.20 (3.29)	$t_{(84.05)}=-0.65$	0.265
Posttraumatic cognitions (PTCI-9) (1–7) M (SD)	3.60 (1.01)	4.04 (1.28)	$t_{(75.20)}=-1.77$	0.040
Anxiety (BAI) (0–63) M (SD)	30.24 (11.04)	34.24 (11.48)	$t_{(89)}=-1.69$	0.047
Depression (BDI-II) (0–63) M (SD)	25.06 (11.26)	27.68 (10.64)	$t_{(89)}=-1.13$	0.130
Positive affect (PANAS) (10–50) M (SD)	25.58 (7.61)	25.68 (7.84)	$t_{(89)}=-0.06$	0.475
Negative affect (PANAS) (10–50) M (SD)	28.30 (8.89)	31.10 (8.03)	$t_{(89)}=-1.56$	0.061
Difficulties emotions regulation (DERS) (18–90) M (SD)	47.68 (11.74)	45.30 (12.12)	$t_{(89)}=0.95$	0.172
Difficulties in positive emotions regulation (DERS-P) (13–65) M (SD)	16.60 (5.75)	16.80 (5.96)	$t_{(89)}=-0.12$	0.453
Self-esteem (RSS) (10–40) M (SD)	23.94 (4.29)	24.05 (3.78)	$t_{(88)}=-0.13$	0.450
Identity disturbances (SCIM) (27–189) M (SD)	90.18 (19.81)	95.12 (20.22)	$t_{(88)}=-1.17$	0.123
Mental health (SF-12) (0–100) M (SD)	32.58 (10.54)	35.22 (8.42)	$t_{(87)}=-1.28$	0.102
Physical health (SF-12) (0–100) M (SD)	45.73 (10.68)	45.36 (9.93)	$t_{(87)}=0.17$	0.433
Impairment (EGEP-5) (0–7) M (SD)	4.90 (1.39)	4.68 (1.65)	$t_{(89)}=0.67$	0.253

Note: Bold type indicates a significant *p* value.

^aFisher's exact test.

out due to treatment-related problems ($n = 11$) for sociodemographic variables, violence characteristics and clinical symptoms. Significant differences were only found for origin and time since last episode of IPV. Specifically, there were significantly more dropouts related to practical/external difficulties among migrant women (100% vs. 50%; $\chi^2_{(1)} = 10.67$; $p < 0.001$; Cramer's $V = 0.54$); and months since the last episode of IPV were lower among those who dropped out due to treatment-related issues ($M = 2.00$; $SD = 2.10$) than among those who dropped out due to practical/external difficulties ($M = 14.15$; $SD = 15.15$) ($U = 55.50$; $p = 0.003$; $r = 0.48$). There were no significant differences for the rest of variables.

4 | Discussion

This study provides an in-depth analysis of the dropouts from TF-therapy for IPVAV showing that dropouts mostly occur in the first sessions of the treatment and are related to practical difficulties to attend the sessions, to younger age, to being migrant and to have suffered more recent episodes of violence.

Overall, this study analyses attrition from a group format of TF-CBT delivered to women with high levels of violence and emotional sequelae, which has been shown to be effective (see Crespo et al. 2024a). Data show that approximately 37% of women who

enter treatment drop out by not completing at least 62.5% of sessions; the total rate increases to 45% when also the pretreatment dropouts are considered. Although comparison with dropout rates from other studies is difficult, due to differences in treatment contents and formats and in the definition of dropout, our results are close to the upper range reported for TF-therapies in different populations (cf. 41.5% in Mitchell et al. 2022), in which dropout rates tend to be somewhat higher compared to other psychological interventions for PTSD (cf. Bisson and Olff 2021; Hoppen et al. 2023; Lewis et al. 2020; Varker et al. 2021).

Furthermore, our results are in line with those found by Gonçalves et al. (2024) for TF-therapies for domestic violence, and particularly with those reported specifically for PE (39%) and CT (40.5%), which the treatment delivered here is based on. This similarity of results is noteworthy even when they define dropout more restrictively than in the present study (cf. failing to attend at least nine sessions). This could be related to the group format used here which is less flexible than individual therapy in terms of schedule and, thus, requires of the women an extra effort of adjustment, which make it less appealing.

Consistently with other studies (e.g., Crespo et al. 2021; Ghafoori et al. 2022; Imel et al. 2013; Varker et al. 2021) most dropouts occur early at treatment (i.e., before starting or in the first three sessions), before the exposure module. This is particularly

noteworthy because of the concerns about the implementation of exposure-based interventions in the context of IPVAW (e.g., Warshaw et al. 2013). These are not supported here; in fact, the data show no significant association between the reasons and the moment of dropout. This pattern of early treatment attrition could be related to the mismatch between treatment and women's expectations, to the difficulties for the integration in the group and to the lack of motivational and therapeutic commitment. Moreover, due to the key role of group cohesion for the effectiveness of group interventions (Burlingame et al. 2001), early dropouts may negatively affect the remaining participants' motivation and implication (see Sánchez-Ferrer et al. 2025). In contrast, in this study those women who remained in the treatment showed good adherence and high satisfaction and achieved significant overall improvement (Crespo et al. 2024a). Consequently, motivational elements could be incorporated in the first sessions (e.g., motivational interviewing as proposed by Ragucci et al. 2024), as well as a screening of the stage of motivation for change that could guide the decisions about the inclusion of each woman in a therapeutic group.

The reasons for dropping out are mostly related to practical/external difficulties, especially work-related issues, which would be linked to their changing and insecure living conditions. However, this finding might be subject to social desirability bias. Some IPV survivors, especially when they are still experiencing high traumatic stress, tend to avoid having negative conversations that express critique to others, so they would perhaps be uncomfortable admitting that they were not pleased with the treatment, and could thus prefer to cite practical reasons for their dropout.

Although reasons for dropout are seldom reported in literature, practical/external difficulties have been proposed as crucial factors for dropout in IPVAW (e.g., Crespo et al. 2021; Orang et al. 2018). Indeed, the data show differences between dropouts and completers in terms of their employment situation, with a higher incidence of unemployment among women who drop out (also found for interpersonal violence by Ghafoori et al. 2022). This may be related to the prioritization of basic needs over mental health needs (Ghafoori et al. 2022). Or maybe that during the course of treatment these women find a job that is incompatible with the therapeutic groups, leading them to drop out. In these cases, individual therapies could be enforced in order to better adapt to their schedules.

The present results corroborate the association between dropouts and younger age that has been repeatedly found both in clinical trials (Kubany et al. 2004; Wright et al. 2024) and in naturalistic settings (Ghafoori et al. 2022; Semmlinger et al. 2025). In fact, this association is the most consistent in literature on dropouts and could point to the need of adapting interventions to younger people. Nonetheless, it should be noted that the average age in this study is above 40 years; moreover, age shows a wide dispersion, which could indicate a large disparity in the age of the women in each therapeutic group and may point to the fact that younger women have greater difficulties to integrate with older women than vice versa. It would be very useful to better understand this age effect in order to optimize the group applications of TF-therapies by fostering group cohesion. Moreover, clinicians should explore age-specific engagement

strategies to address the particular life challenges that younger adults face (e.g., work, education and childcare responsibilities) (Wright et al. 2024).

Contrary to expectations no significant effect of educational level was found. However the data show a higher dropout rate among migrant women, which seems to be related, on the one hand, to not being native Spanish speakers, which can make it difficult for them to follow this type of treatment; and, on the other hand, with particularly complicated and unstable working conditions that can be demanding in terms of working hours and availability, making continuity in the therapeutic groups unfeasible. Data indicating an 89% dropout rate among working migrant women and the higher incidence of dropouts related to practical/external difficulties (of which work issues are central) among migrant women would support this explanation. All these data highlight the need to translate and adapt interventions for migrant women, who seem to have greater difficulties in seeking help from IPV services (Cuesta-García et al. 2024), but also in staying in treatment once they seek help (Alonso and Labrador 2010).

The analysis of the relationship between characteristics of violence and dropouts show that dropouts are related to more recent episodes of violence (less than 1 year). This would point to the need of getting out the violent situation before entering this type of treatment (cf. Kubany et al. 2004). The fact that women who drop out for treatment-related reasons report a recent episode of IPV (2 months) aligns with this conclusion. However, keeping in contact with the aggressor showed no significant effect, which would not support this interpretation. Furthermore, there is no relationship with severity, types and frequency of violence, perhaps because women in this study have suffered severe and long-lasting IPV with low variability in these variables. All in all, these results are in line with Iverson et al. (2011) and are a suggesting starting point for further research on the effect of history and features of violence on dropouts.

In terms of symptoms, women who dropout show significantly higher levels of: posttraumatic cognitions, which may be related to this aspect being under-addressed in treatment; and anxiety, which would indicate the requirement of prior work on anxiety management. However, the hypothesized relationship with PTSD, depression and self-esteem was not found. It is worth noting that in this study the assessment of PTSD symptomatology was based on self-reports, so it remains open whether the relationship with dropouts could appear in measures based on clinician assessment, as found by Mitchell et al. (2022). Further research to gain understanding of the complex association between clinical variables, measures and treatment dropout would be enlightening.

The study has several limitations that must be noted. First, the small sample size could have implications for the statistical power, especially considering the high number variables. This has made it impossible to perform some analyses (e.g., differences between refusals and dropouts or between dropouts at different times) and has limited the power of analyses of differences between treatment-related dropouts and those related to practical/external difficulties. Second, since all treatments were applied by the same therapist, in order to increase

internal validity, the generalization of the results could be potentially limited, even though the manualized protocol and the supervisions could have mitigated any potential biases. Nevertheless, the results found here may depend on the therapist's ability to motivate participants and establish a strong therapeutic alliance. Finally, it is worth mentioning the lack of consensus on the definition and operationalization of dropouts, which makes comparison with other studies difficult. In this line, future research should focus on analyzing the specific requirements of each dropout definition (i.e., after randomization and before treatment begins, during treatment, in the post-treatment evaluation ...). Knowing the rates and characteristics of dropouts for each of these concepts will allow for a better adaptation of treatments and interventions to each moment, profile and situation. Furthermore, future research on dropout through process evaluation with qualitative methods would be highly enlightening.

In summary, the results of this study contribute to a better understanding of attrition from TF-therapies among survivors of IPVAW, which is essential to improving their retention and outcomes. It is intended to be a first step in designing interventions that are increasingly tailored to women's unique characteristics, needs and circumstances. In this regard, the data highlight the need for: the implementation of specific motivational strategies and measures to enhance the therapeutic alliance in the first sessions; personalized retention strategies for younger and migrant women (e.g., idiomatic and cultural adaptations and attention to basic needs); specific measures to facilitate the reconciliation of therapy with work; and specific interventions to stabilize and reassure women with recent violence or high levels of anxiety or posttraumatic cognitions prior to entering a TF-therapy. In this way, the present study is in line with the concept of personalizing mental health, which has been gaining ground in recent years in an attempt to progressively increase the effectiveness of psychological interventions and to provide better care for people who need and seek help (Moggia et al. 2024).

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The datasets generated and/or analyzed during the current study are not publicly available due to ethical approval and confidentiality agreements made with participants but are available from the corresponding author on reasonable request.

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