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Therapeutic Alliance with Perpetrators of Intimate Partner Violence: The Roles of Childhood Interpersonal Trauma and Attachment Insecurity

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ABSTRACT

Intimate partner violence (IPV) represents a major global health concern with devastating consequences. Many perpetrators seek treatment to stop their violent behaviors, where a strong therapeutic alliance (TA) could support their progress. This study's first aim was to examine how individual or cumulative childhood interpersonal trauma (e.g. sexual abuse, neglect) and attachment insecurity (anxiety, avoidance) reported by IPV perpetrators predict the quality of TA reported by their therapist. The second aim was to assess whether childhood interpersonal trauma interacts with attachment insecurity in predicting TA. The third aim was to explore whether the number of therapy sessions moderates these associations. A sample of 349 men entering treatment for IPV completed admission questionnaires and their therapists assessed the quality of TA at the end of treatment. Results revealed that childhood interpersonal trauma and attachment insecurity did not predict TA directly, but that TA was worse when men reported childhood physical neglect with high attachment anxiety. The number of sessions moderated the links between TA and physical abuse, exposure to parental psychological IPV, and attachment (anxiety and avoidance). By documenting predictors of TA among IPV perpetrators, this study highlights the importance of trauma history, attachment insecurity, and of promoting longer treatment duration.

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From 2014 to 2019, 3.5% of Canadians have experienced intimate partner violence (IPV), which can lead to multiple short- and long-term physical and psychological consequences (Conroy et al., 2019). Engaging in therapy can be a relatively effective way to reduce the risk of IPV reoccurrence among perpetrators (Babcock et al., 2024). However, recent meta-analyses showed that 9 to 67% of men perpetrators of IPV who engage in therapy do not

complete it (Cunha et al., 2024), and that non-completion of treatment was associated with a higher risk of IPV reoccurrence (Travers et al., 2021). The quality of the therapeutic alliance (TA) between the therapist and the IPV perpetrator constitutes a crucial process to investigate, as it has been associated with a greater probability of completing treatment and a lower frequency of perpetrated physical and psychological violence following treatment (Rondeau et al., 2001; Taft et al., 2003). TA includes three dimensions: goals (i.e., agreement between the therapist and the client on treatment objectives), tasks (i.e., agreement on the tasks to achieve established goals), and bond (i.e., mutual sense of trust, respect, and collaboration between the two parties; Bordin, 1979). The later dimension warrants special attention as it may be particularly challenging to establish with clients who do not seek therapy voluntarily (Taft et al., 2003). Many IPV perpetrators experience mistrust toward others, which can interfere with therapeutic work and outcomes (Horvath, 2001; Pilkington et al., 2021). Therefore, examining predictive factors of a positive TA bond – beyond court-ordered referral – could help organizations who treat IPV perpetrators identify and target key factors to foster a stronger TA with their clientele. Exploring specific individual predictors of TA – in this case, childhood interpersonal trauma (CIT) and attachment – could help identify which perpetrators are more likely to struggle with trust or may need additional help to form an alliance (Hepp et al., 2021; Wallin, 2007). Leveraging the therapist's perspective on TA quality can aid in addressing the limitations of high treatment dropout. Moreover, therapists have a broader view of the therapeutic process, can assess TA for clients who are no longer reachable, can compare TA across clients, and are less prone to social desirability biases. Additionally, therapists can account for the number of sessions each participant completed, a fundamental factor in TA formation (Horvath, 2001).

Childhood interpersonal trauma and therapeutic alliance

CIT refers to traumatic experiences that occur before the age of 18 with a parent or someone in the victim's surroundings. It includes physical, psychological, or sexual abuse; physical neglect (e.g., lack of food); psychological neglect (e.g., lack of emotional support); exposure to parental physical or psychological IPV; and peer bullying (Godbout et al., 2017). There is also extensive literature linking adverse childhood experiences (ACE) to IPV (Zhu et al., 2024). Meta-analyses (Godbout et al., 2019; Li et al., 2020; Zhu et al., 2024) found significant, but small, associations between CIT (or ACE) and IPV perpetration (physical, psychological, sexual). CIT can result in complex symptoms in adulthood, including post-traumatic symptoms and deficits in self-regulation (e.g., difficulties in anger management, aggressive behaviors, social avoidance). The strength of these associations increases when multiple

forms of trauma have co-occurred, which is referred to as cumulative CIT (Cloitre et al., 2009). Therefore, this study will consider both cumulative CIT and distinct forms of trauma among adult men in IPV treatment.

According to Bowlby (1988), CIT may foster mistrust in relationships, as these traumas frequently occur within relationships with significant attachment figures expected to provide care. Early breaches of trust and security are imprinted in memory, possibly causing individuals to view themselves as bad or weak, and others as dangerous and deceitful. These representations can persist over time, shaping individuals' behaviors and expectations in subsequent close relationships (Bowlby, 1988). A therapeutic relationship is a context in which these dynamics can unfold. It is therefore possible that mistrust issues related to early life events must be overcome to establish a good TA (Hepp et al., 2021). A qualitative study on couples in therapy, where one partner has a history of CIT, highlighted mistrust among CIT survivors (Whittaker et al., 2023): for example, a participant who experienced sexual abuse struggled to bond with their therapist due to feeling intimidated.

Findings from two other studies suggest that the association between CIT and the quality of TA might depend on other variables, such as the number of attended therapy sessions and the person's attachment. In a study by Paivio and Patterson (1999), the severity of four forms of CIT (physical and psychological abuse; physical and psychological neglect) was negatively related to the quality of TA at the beginning of therapy, but these associations diminished by the end of treatment. This study's findings suggest that the number of therapy sessions could attenuate the negative link between CIT and the quality of TA. In a study by Lafrenaye-Dugas et al. (2018), an interaction was found between cumulative CIT and attachment in their link with TA among a sample of adults seeking sexual therapy. Results revealed that cumulative CIT was associated with a lower TA (tasks dimension), but only when the level of attachment avoidance was high. These results support the relevance of exploring whether the number of completed sessions and attachment might interact with cumulative CIT to predict TA in IPV perpetrators.

Attachment insecurities and therapeutic alliance

According to attachment theory, attachment is an innate system that ensures the child's survival through seeking proximity with the attachment figures when feeling threatened (Bowlby, 1988; Mikulincer & Shaver, 2016). If attachment figures are available and comforting, the child will experience attachment security, whereas if the figures have uncertain availability or are unable to protect or reassure, attachment insecurity can arise (Mikulincer & Shaver, 2016). Longitudinal studies suggest that attachment patterns in childhood are relatively stable over time and may shape romantic relationships in adulthood (see Fraley & Dugan, 2021, for a review). However, significant events, both

negative (e.g., traumatic events; Mikulincer et al., 2011) and positive (e.g., psychotherapy; Taylor et al., 2015), can modify these patterns.

Brennan et al. (1998) have identified two continuous insecurities: attachment anxiety and attachment avoidance. Attachment anxiety refers to a negative self-representation, leading to excessive doubt, fear of rejection or abandonment, and hypervigilance about the availability of attachment figures. When individuals with high attachment anxiety are faced with a real or perceived threat of abandonment, their attachment system becomes hyperactivated, leading them to seek their attachment figure's attention for reassurance. Attachment avoidance refers to a discomfort with emotional intimacy based on a negative representation of others as unreliable, leading to an excessive need for independence. In individuals with high attachment avoidance, perceived threat to autonomy would lead to deactivation of the attachment system, prompting them to minimize the need for comfort and distance themselves from emotions or cognitions that could trigger the attachment system (Mikulincer & Shaver, 2016). Attachment-related anxiety and avoidance have been consistently related to IPV perpetration as a dysfunctional way to either seek reassurance or to keep the partner at a distance (Velotti et al., 2022). In contrast, secure attachment is characterized by low levels of both anxiety and avoidance (Brennan et al., 1998) and is related to a lower perpetration of IPV (Spencer et al., 2021).

A positive TA could result from perceiving the therapist as a safe attachment figure, thereby facilitating the development of an emotional bond (Bowlby, 1988). Yet, it might be challenging for individuals with attachment insecurities to feel secure in the therapeutic relationship. People with attachment anxiety can quickly adopt the therapist's treatment suggestions, which do not necessarily indicate a high level of collaboration but rather reflects their desire to please the therapist (Mikulincer & Shaver, 2016). TA ruptures may also be more frequent and intense due to strong angry reactions, excessive need for validation and hypersensitivity to signs of rejection (Mikulincer & Shaver, 2016). People with attachment avoidance tend to be more mistrustful and reluctant to show vulnerability (Wallin, 2007). They may appear non-collaborative by rejecting the tasks suggested by the therapist, and their defensive reactions stemming from their strong desire for autonomy could complicate TA rupture resolution (Mikulincer & Shaver, 2016).

In the specific context of IPV-related treatment, no studies have examined the links between perpetrators' attachment insecurity and TA. Yet, a meta-analysis by Diener and Monroe (2011) found that higher levels of attachment insecurity were weakly related to lower TA in individual therapy ($r = .17$), based on reports from both clients and therapists in university-based outpatient centers. The timing of the TA measurement was not specified. A meta-analysis by Bernecker et al. (2014) with adults from outpatient centers obtained similar results indicating that higher levels of attachment anxiety

($r = -.14$) and avoidance ($r = -.12$) were related to a lower TA reported by the client. However, most studies measured TA during the first three sessions. According to Safran et al. (2006), while a strong TA at the onset of treatment is an effective predictor of success, TA must remain strong throughout. Thus, assessing TA at the end of treatment could prove relevant, especially with IPV perpetrators that may enter treatment with mistrust. A systematic review by Smith et al. (2010) consisting mainly of clients in individual therapy in university counseling centers revealed a moderate positive link between attachment *security* and TA, but no significant links with attachment *insecurity*. These mixed results may not apply to IPV perpetrators and suggest that other factors or moderators are needed to understand attachment's role in TA.

The current study

There are several limitations in the literature regarding the roles of CIT and attachment in predicting a positive TA. First, no studies have considered court-ordered referral or examined the roles of (or potential interaction between) cumulative or individual forms of CIT and attachment insecurities on the quality of TA in IPV perpetrators, despite their higher prevalence in this population (e.g., Li et al., 2020; Velotti et al., 2022). Second, few studies measured TA at the end of treatment, most assessing it during the first three sessions (e.g., Bernecker et al., 2014; Smith et al., 2010). Third, many studies (e.g., Bernecker et al., 2014; Smith et al., 2010) focused solely on the client's TA assessment, neglecting the therapist's perspective. Finally, some studies (e.g., Paivio & Patterson, 1999; Smith et al., 2010) excluded participants who dropped out of treatment, despite dropout potentially indicating poor TA. To address these gaps, we measured TA quality as perceived by therapists at the end of treatment, and we considered the number of completed sessions as a potential moderator of the studied associations. Since clients can more reliably report their CIT and attachment insecurities, while therapists provide a more systematic TA assessment – especially when clients dropped out of therapy –, we combined both perspectives to explore TA predictors beyond court-ordered referrals.

The first aim of this study was to examine the predictive role of CIT (cumulative and eight forms), and attachment insecurity (anxiety, avoidance) measured in men at the beginning of their treatment for IPV-related issues on the quality of TA as reported by their therapist at the end of treatment. Based on the literature reviewed, the first hypothesis suggests that participants with either a history of cumulative CIT (H1a) or a single form of CIT (H1b) would present a lower TA as perceived by their therapist. The second hypothesis suggests that participants with higher levels of attachment-related anxiety (H2a) or avoidance (H2b) will present a lower TA as perceived by their therapist. The second aim of this study was to examine whether childhood

interpersonal trauma interacted with attachment insecurity in predicting TA (Q1). The third aim was to study, in an exploratory way, whether the number of therapy sessions moderated these associations (Q2). Court-ordered referral was retained as a control variable for all the research hypotheses and questions, given its well-known association with mistrust and resistance.

Method

Procedure

This study was part of a larger research partnership program in collaboration with 10 nonprofit organizations that are part of a national association specializing in IPV services in Canada. The types of treatment varied from one organization to another, but followed a common framework consisting of a combination of cognitive-behavioral strategies and psychoeducation aimed at fostering accountability and acquiring new skills (Roy et al., 2024). The study's variables were collected during two distinct phases of the research program.

In the first phase, men answered a battery of online questionnaires via the secure *Qualtrics* platform upon their admission to a community resource specializing in IPV. Completing questionnaires was required as part of the organizations protocols for new clients, but agreeing to use their data for research purposes was optional and did not impact the services they received. Once the admission questionnaires were completed, the research team transmitted a summary of the responses to the organization, as detailed in the consent form. In the first phase, IPV and its risk factors were assessed through 11 questionnaires; only data from the sociodemographic, cumulative CIT, and attachment questionnaires were used in the current study.

The second phase of the research program began when a participant dropped out or completed treatment. The therapists who provided treatment and agreed to take part in this phase were invited to complete a brief online termination questionnaire on the *Qualtrics* platform assessing their perception of TA for each participant. When two therapists co-led a group, they jointly completed the questionnaire. Data from the termination questionnaire were then matched with responses from the first phase's database, using a personalized alphanumerical code. The two phases of the project received the approbation of the ethics research committee of the researchers' institution. Data were collected from April 2020 to September 2023.

Participants

The sample consisted of 349 participants entering treatment for IPV-related issues, including 348 individuals who identified as male (gender identity) and one non-binary individual whose sex assigned at birth was male. Participants

were aged between 18 and 90 years ($M = 37.55$, $SD = 11.56$). They were mostly born in Canada (89.3%), while 10.7% were born abroad. Their primary language was either French (96.5%), English (1.4%), Spanish (0.9%), Arabic (0.5%), Creole (0.5%), or Portuguese (0.2%). They reported a median annual income ranging between CAN\$40,000 and \$44,999. Of the participants, 69.3% were employed, 26.3% were unemployed (e.g., receiving social assistance), 2.9% were students, and 1.4% were retired. In terms of their highest level of education, 18.8% completed elementary school, over half of the participants (54.6%) completed high school, and 26.6% completed post-high school studies. About half of the participants (52.7%) were in a romantic relationship when entering treatment, while 47.3% were not. One-third (31.8%) sought treatment under a court order, and 35.7% had received a restraining order preventing them from contacting their (ex-) partner.

In addition, most participants (58.9%) received group therapy, 32.8% received individual open-ended therapy, and 8.3% received another format of treatment (e.g., couple therapy). The therapy lasted an average of 5.7 months (up to 26 months, $SD = 4.41$), with an average of 11 sessions (up to 63, $SD = 10.63$). According to therapists, 32.2% of participants completed treatment.

Measures

A sociodemographic questionnaire collected self-reported information on participants, such as age (in years), gender (e.g., male, non-binary), occupation (e.g., employed, student, retired), education (e.g., elementary, secondary, post-secondary), income (ranges, e.g., \$30,000 to 34,999), and court-ordered referral (yes/no). All measures were available in French, English, and Spanish.

Childhood interpersonal trauma

CIT was assessed using the Childhood Cumulative Trauma Questionnaire (CCTQ; Godbout et al., 2017). This 12-item questionnaire includes eight forms of CIT: physical abuse (3 items), psychological abuse (1 item), physical neglect (1 item), psychological neglect (1 item), exposure to parental physical (1 item) and psychological (1 item) IPV, peer bullying (1 item), and sexual abuse (3 items). For each item, respondents had to specify the frequency with which each event occurred in a typical year before age 18, on a scale of 0 (*never*) to 6 (*every day*), except for the three sexual abuse items, which assessed whether the event ever occurred (yes/no) before age 18. Each form of CIT was coded as either not experienced (0) or experienced (1). The total score is the sum of the eight forms of CIT (ranging from 0 to 8), with a higher score indicating a greater number of CIT types. The Cronbach's alpha coefficient in this sample is adequate ($\alpha = .85$).

Attachment insecurity

The abbreviated 12-item version of the Experiences in Close Relationships scale (ECR-12; Lafontaine et al., 2016) measured romantic attachment-related anxiety (e.g., “*I worry about being abandoned*”) and avoidance (e.g., “*I don’t feel comfortable opening up to romantic partners*”). Each dimension was assessed using six items, rated on a seven-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The total score for each dimension is obtained by averaging the six items, with a higher score indicating a higher level of attachment insecurity. In the present study, the reliability was adequate for anxiety ($\alpha = .88$) and avoidance ($\alpha = .83$).

Therapeutic alliance

The therapist’s perception of TA for each participant was assessed using a brief termination questionnaire developed by the steering committee of the collaborative research project. This brief form gathered treatment-related information (e.g., duration of treatment, number of completed sessions, waiting period before treatment, treatment format). Perceived TA was assessed using a single item that asked the therapist to evaluate their appreciation of TA with the participant on a scale ranging from 1 (*very low*) to 5 (*very high*), with a higher score indicating a stronger TA. To ensure a systematic evaluation of TA, a definition of the bond (Bordin, 1979) was provided with the question: “*What is your assessment of the user in terms of the therapeutic alliance (i.e., the formation of a mutual sense of trust, respect, and collaboration between the therapist and the user).*” The reliability and validity of this item have not been studied.

Analytic strategy

Statistical analyses were conducted using SPSS 28 software. Descriptive analyses were performed on all variables to examine frequencies, means, and extreme and missing values. Pearson’s correlations between sociodemographic or treatment-related variables and TA examined the relevance of including covariates in the main analyses. The two research hypotheses were tested using three hierarchical multiple regression analyses. For each analysis, court-ordered referral and number of sessions were entered in the first step, followed in the second step respectively by (1) cumulative CIT, (2) the eight forms of CIT, or (3), attachment-related anxiety and avoidance. In the third step, interaction terms between two predictors (e.g. anxiety x number of sessions) were entered using a stepwise approach to reduce the number of analyses and maintain high statistical power. Consequently, test-wise error rates were not adjusted. Interactions were probed using Process macro version 4 when the interaction term was below .10, as suggested by Hayes (2022). The statistical assumptions of multiple

linear regression (e.g., lack of multicollinearity, normality, linearity, and homoscedasticity of the residual values) were verified and met beforehand (Tabachnick & Fidell, 2019). The percentage of unique variance explained by each predictor (sr^2) was estimated for significant effect sizes.

Results

Preliminary analyses

Table 1 presents the descriptive statistics for the main study variables. On average, TA reported by therapists corresponded to a moderate level. Participants experienced, on average, three different forms of CIT, with over half of the participants reporting either physical abuse, exposure to parental psychological IPV, and/or peer bullying. The average scores for attachment anxiety and attachment avoidance suggested a relatively high presence of attachment insecurity in the sample, similar to other clinical samples (e.g., Brassard et al., 2021). The variables were normally distributed, based on skewness and kurtosis indices, allowing for the use of parametric analyses. Little's MCAR test ($p = .245$) showed a completely random pattern of missing values. Pearson's correlations between the predictors and TA revealed that TA was not associated with cumulative CIT, the eight individual forms of CIT, nor the two dimensions of attachment ($ps > 0.05$). We also examined whether other variables (i.e., age, education, income, drug use, number of children, treatment format) were correlated with TA. Besides number of sessions and court-ordered referral (see Table 1), no other variables were associated with TA with a correlation higher than .20. Notably, there was no significant difference in TA between participants who took part in individual-format treatment and those partaking in group-format treatment.

Main analyses

Childhood interpersonal trauma and therapeutic alliance

A first multiple hierarchical regression analysis was conducted, which predicted the quality of TA, with the number of sessions and court-ordered referral in step 1, cumulative CIT in step 2, and the three interactions with attachment and number of sessions in step 3. The regression model was significant at step 2 ($F(3, 261) = 34.93, p < .001, R^2 = .28$) and no interactions were significant. Beyond the number of sessions ($\beta = .48, p < .001, sr^2 = .24$) and court-ordered referral ($\beta = -.19, p < .001, sr^2 = .05$), cumulative CIT was not significantly associated with the quality of TA reported by the therapist ($\beta = -.04, p = .495$). This suggests that the number of different CIT experiences were not associated with TA. A higher number of sessions and non-

Table 1. Correlation matrix and descriptive statistics for the main variables.

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Therapeutic alliance	1													
2. Cumulative CIT		1												
3. Physical abuse			1											
4. Psychological abuse				1										
5. Physical neglect					1									
6. Psychological neglect						1								
7. Exposure to parental physical IPV							1							
8. Exposure to parental psychological IPV								1						
9. Peer bullying									1					
10. Sexual abuse										1				
11. Attachment anxiety											1			
12. Attachment avoidance												1		
13. Number of sessions													1	
14. Court-ordered (1=yes)														1
<i>M</i>	3.47	3.10												
<i>SD</i>	1.12	2.35												
Skewness	-0.28	0.25												
Kurtosis	-0.83	-1.15												
% yes			52.2	44.5	15.7	38.3	24.3	56.2	59.5	23.6				31.2

CIT = Childhood interpersonal trauma. IPV = Intimate partner violence. * $p < .05$. ** $p < .01$.

court-ordered therapy were associated with a better TA as reported by the therapist.

A second multiple hierarchical regression analysis was conducted, which predicted TA quality, with number of sessions and court-ordered referral in step 1, the eight CIT forms entered together in step 2, and the 24 interactions with attachment and number of sessions in step 3. The regression model was significant ($F(10, 253) = 10.45, p < .001, R^2 = .26$). Beyond court-referral and number of sessions, none of the eight forms of CIT were significantly associated with the quality of TA (see Appendix). However, three interactions were added in the model ($ps < .10$).

First, the interaction between physical neglect and attachment anxiety significantly predicted the quality of TA reported by the therapist ($\beta = -.17, SE = .08, p = .046, 95\% \text{ CI} [-.334, -.003]$), which added 1.1% of the explained variance in TA. As shown in Figure 1, results from the simple slopes analyses revealed that when attachment anxiety was low (1 SD below the mean), physical neglect was not significantly related to TA ($b = .15, SE = .21, p = .464, 95\% \text{ CI} [-.259, .567]$), whereas when attachment anxiety was high (1 SD above the mean), physical neglect was negatively related to TA ($b = -.43, SE = .21, p = .044, 95\% \text{ CI} [-.856, -.013]$).

Second, the interaction between physical abuse and number of sessions significantly predicted the quality of TA ($\beta = .03, SE = .01, p = .023, 95\% \text{ CI} [.004, .048]$), which added 1.4% of the explained variance in TA. As shown in Figure 2a, when the number of sessions was low (1 SD below the mean), physical abuse was not significantly related to TA ($b = -.16, SE = .16, p = .318, 95\% \text{ CI} [-.486, .158]$), whereas when the number of sessions was high (1 SD above the mean), physical abuse was positively related to TA ($b = .37, SE = .16, p = .026, 95\% \text{ CI} [.044, .689]$).

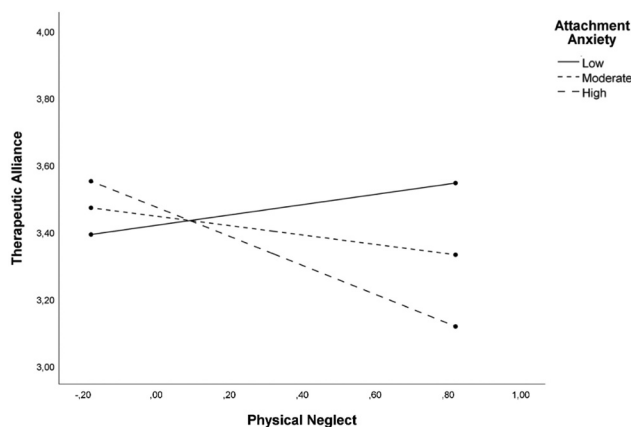


Figure 1. The interaction between physical neglect and attachment anxiety in the association with the therapeutic alliance reported by the therapist in men seeking help for intimate partner violence.

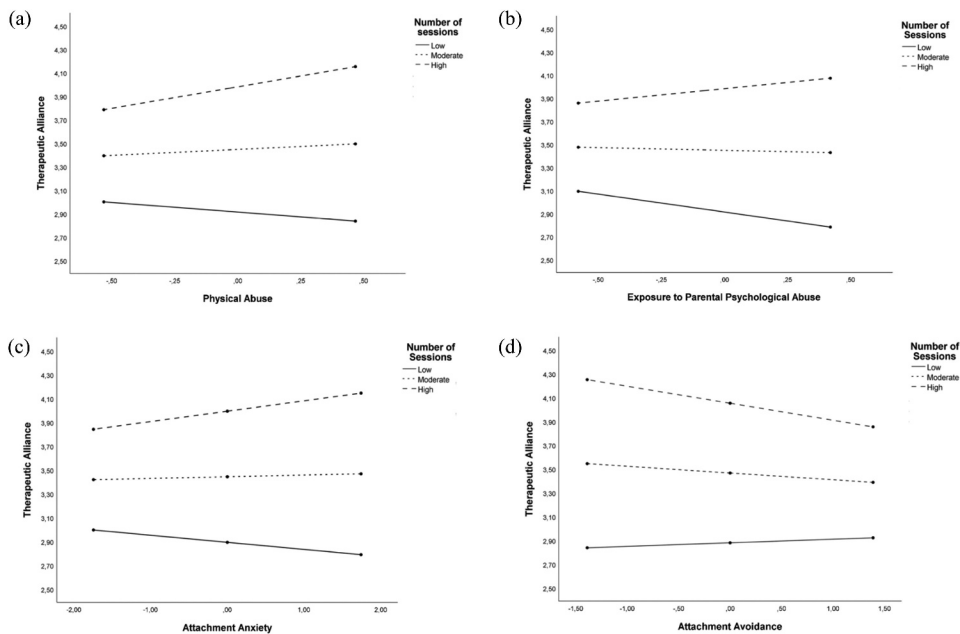


Figure 2. The moderating role of the number of sessions in the association between the therapeutic alliance reported by the therapist and (a) physical abuse, (b) exposure to parental psychological intimate partner violence, (c) attachment anxiety, and (d) attachment avoidance in men seeking help for intimate partner violence.

Third, the interaction between exposure to parental psychological IPV and number of sessions significantly predicted the quality of TA ($\beta = .03$, $SE = .01$, $p = .025$, 95% CI [.003, .048]), which added 1.4% of the explained variance in TA. As shown in Figure 2b, when the number of sessions was low (1 SD below the mean), exposure to parental psychological IPV was marginally and negatively related to TA ($b = -.31$, $SE = .17$, $p = .064$, 95% CI [-.637, .018]), whereas when the number of sessions was *very high* (3 SD above the mean), exposure to parental psychological IPV was positively related to TA ($b = .78$, $SE = .38$, $p = .045$, 95% CI [.019, 1.533]).

Attachment insecurity and therapeutic alliance

A third multiple hierarchical regression analysis was conducted, which predicted the quality of TA, with number of sessions and court-ordered referral in step 1, attachment-related anxiety and avoidance in step 2, and the two interactions with number of sessions in step 3. The regression model was significant ($F(4, 260) = 26.44$, $p < .001$, $R^2 = .28$). Beyond court-referral and number of sessions, attachment anxiety was not significantly associated with the quality of TA reported by the therapist ($\beta = .03$, $p = .545$), nor was attachment avoidance ($\beta = -.06$, $p = .162$). The two interactions with number of sessions were significant ($ps < .05$).

First, number of sessions moderated the link between attachment anxiety and the quality of TA ($\beta = .01$, $SE = .00$, $p = .033$, 95% CI [.001, .014]), which added 1.3% of the explained variance in TA. As shown in [Figure 2c](#), when the number of sessions was low (1 *SD* below the mean), attachment anxiety was not significantly related to TA ($b = -.06$, $SE = .05$, $p = .200$, 95% CI [-.151, .032]), but when the number of sessions was *very high* (2 *SD* above the mean), attachment anxiety was positively related to TA ($b = .15$, $SE = .08$, $p = .043$, 95% CI [.004, .300]).

Second, number of sessions moderated the link between attachment avoidance and the quality of TA ($\beta = -.01$, $SE = 0.004$, $p = .024$, 95% CI [-.016, -.001]), which added 1.4% of the explained variance in TA. As shown in [Figure 2d](#), when the number of sessions was low (1 *SD* below the mean), attachment avoidance was not related to TA ($b = .03$, $SE = .06$, $p = .615$, 95% CI [-.088, .148]), whereas when the number of sessions was high (1 *SD* above the mean), attachment avoidance was negatively related to TA ($b = -.14$, $SE = .05$, $p = .009$, 95% CI [-.249, -.037]).

Discussion

This study is the first to investigate the role of CIT and attachment insecurity as well as their interaction on the quality of TA in a relatively large sample of male perpetrators of IPV. The results revealed that CIT (H1a and H1b) as well as attachment insecurity (H2a and H2b) were not significantly related to TA reported by the therapist beyond number of sessions and court-ordered referral. However, a significant interaction revealed that childhood physical neglect was related to poorer TA when attachment anxiety was also high (Q1). Additionally, the number of sessions acted as a moderator in the associations between TA and physical abuse, exposure to parental psychological IPV, and attachment-related anxiety and avoidance, respectively (Q2). These original findings enhance our knowledge of the factors associated with TA in male perpetrators of IPV, using a prospective and multi-observer design.

Childhood interpersonal trauma

In contrast to our first hypothesis, neither cumulative CIT nor the eight individual forms of CIT were associated with TA reported by the therapist. However, we found significant interactions between CIT and attachment anxiety as well as the number of sessions. First, physical neglect was associated with a poorer TA when there was a higher level of attachment anxiety, but not when there was a lower level of attachment anxiety. As mentioned previously, CIT can lead to a representation of others as untrustworthy or dangerous and a representation of oneself as weak or bad (Bowlby, 1988). The strong need for reassurance and approval in individuals with high levels of attachment anxiety,

mixed with feelings of distrust toward others, could make their behavior appear disorganized, defensive, or explosive to the therapists, which could negatively color their assessment of TA (Mikulincer & Shaver, 2016). Conversely, a greater sense of self-value (lower attachment anxiety) could protect TA from the potentially negative aspects of physical neglect. Indeed, the security and sense of self-worth acquired through positive interpersonal experiences (e.g., past therapy) could facilitate the formation of a good TA by lowering the hypervigilance and reactivity to challenging feedback or perceived lack of validation from the therapist (Mikulincer & Shaver, 2016).

Second, our results revealed that physical abuse and exposure to parental psychological IPV were associated with a *stronger* TA when there was a high or very high number of sessions, but not (or only marginally) when there was a lower number of sessions. These results may be explained by the progressive establishment of a sense of security and trust toward the therapist as the participant realizes over the course of the treatment that abusive relational dynamics experienced in childhood will not be reproduced in the therapeutic relationship. According to Hepp et al. (2021), trauma survivors often experience a sense of distrust toward others. Overcoming trust issues may be essential to establish a positive TA. However, it may take longer for trauma survivors to develop a sense of trust within the therapeutic relationship and for this trust to become noticeable to the therapist (Bowlby, 1988).

Attachment insecurity

Contrary to our second hypothesis, attachment-related anxiety and avoidance were not directly associated with the quality of TA reported by the therapist. However, the number of therapy sessions moderated the associations between TA and both attachment anxiety and avoidance. Attachment anxiety was associated with a stronger TA when there was a higher number of sessions, but not when there was a lower number of sessions. According to Mikulincer and Shaver (2016), while clients with attachment anxiety may readily agree with the therapist's treatment suggestions out of a desire for validation, their relational ambivalence may hinder the formation of a strong TA at the start of treatment. As previously mentioned, clients with high attachment anxiety tend to focus on gaining attention, affection, and support from others, yet they may harbor profound fear of rejection and doubts about their ability to be accepted by others. These insecurities may cause them to refrain from expressing their needs, especially when anticipating disapproval or rejection. They may also react strongly when they are confronted or disapproved by the therapist regarding their violent behavior, potentially resulting in a weaker TA reported by the therapist during the initial stage of therapy. As treatment progresses and the therapist provides a stable and supportive presence, a greater sense of security may develop within the therapeutic bond, reducing their ambivalence,

thereby strengthening the TA perceived by the therapist (Mikulincer & Shaver, 2016).

In contrast, attachment-related avoidance was associated with a *poorer* TA when there was a higher number of sessions, but not when there was a lower number of sessions. Due to their negative representation of others, individuals with high attachment avoidance tend to be more mistrustful and may maintain emotional distance in their interactions with the therapist by refusing to show vulnerability (Wallin, 2007). Yet, these avoidant tendencies may not be visible at the beginning of treatment to an external observer, especially if the treatment's focus is more educational in the first sessions. As the treatment progresses and a greater degree of disclosure and vulnerability is required (Bernecker et al., 2014), they may start to experience more discomfort toward the therapeutic process, which can become noticeable to the therapist and negatively color their assessment of TA. Furthermore, as the end of the treatment and separation from the therapist approach, painful memories associated with attachment can be reactivated, leading to a deactivation of the attachment system, which can result in increased defensive reactions and TA ruptures (Mikulincer & Shaver, 2016). According to Wallin (2007), resolving ruptures with avoidant clients can be challenging, because they tend to struggle to express their internal states and minimize the importance of their experiences in the therapeutic bond.

Number of sessions and court-ordered referral

Although number of therapy sessions and court-ordered referral were not the focus of this study, their strong effect sizes warrant discussion. Our findings revealed that a higher number of therapy sessions is related to the development of a stronger TA, as reported by the therapist. Higher TA may be linked to more sessions due to client characteristics. In a study of IPV perpetrators (Rondeau et al., 2001), those who completed treatment showed the highest levels of commitment, agreement with the therapist, and working abilities. Alternatively, higher TA could result from more time to build an alliance. In the current study, two-thirds of participants did not complete therapy, which could be due to lower-quality TA (Sharf et al., 2010). However, client dropout could also have negatively influenced the therapist's evaluation of TA.

To a lesser extent, court-ordered therapy was associated with a lower perceived TA by the therapist. In this sample, one-third of participants had a court-ordered referral. A previous study showed that, compared to self-referred participants, court-ordered participants had lower average contemplation scores (i.e., thinking about changing but without specific plans; Begun et al., 2003). Among court-ordered men, the motivation and commitment in the therapeutic process could thus be reduced. A study on the predictors of discontinuation from individual treatment of IPV

revealed that court-ordered participants were indeed more likely to drop out earlier than self-referred participants (Brassard et al., 2021). According to Wilkowski and Robinson (2008), there is a higher level of hostile attribution in men with court-ordered referrals than in men without such referrals, which means they can more easily attribute hostile intentions to others in ambiguous situations (Nasby et al., 1980). This could lead to increased mistrust in social interactions and possibly to a lower TA reported by the therapist. These results all support the importance of fostering TA in court-ordered men entering treatment for their IPV behaviors.

Limitations

Although this study provides additional insights into the quality of TA among IPV perpetrators, it has limitations. First, the sample lacked diversity in terms of sexual orientation, gender identity, and country of origin, limiting the generalization of results to mostly heterosexual cisgender French-Canadian men. Greater diversity in future studies could help examine TA among varied individual profiles. Additionally, only 31% of the participants were court-ordered to treatment, a significantly lower proportion compared to other studies (e.g., Begun et al., 2003). Moreover, 33% of the participants received individual treatment, which exceeds the norm reported in US surveys (Hamel et al., 2020). These factors must be considered when generalizing our findings. Second, TA was reported solely by the therapist, which may be limited by recall bias and individual differences in how therapists connect with certain clients, based notably on the therapist's personal factors (e.g., years of experience, field of training, attachment style; Ackerman & Hilsenroth, 2003). We did not collect data on therapists' experience and qualifications, although these factors could affect TA. Future research could assess TA from both therapist and client perspectives to minimize biases stemming from therapists' subjective evaluations and explore how therapist characteristics may impact TA, despite challenges like social desirability and attrition. Third, TA was assessed by a single item from a non-validated questionnaire that focused solely on the bond between the participant and the therapist, while TA comprises two other dimensions – goals and tasks. Future studies could use the validated Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), as it assesses all three TA dimensions with multiple items and includes both client and therapist versions. Finally, we focused on treatment-related and individual factors to predict TA. However, the percentages of unique variance explained by them were notably low. Future studies could explore additional individual factors associated with mistrust, such as psychological distress or negative personality traits, to deepen our understanding of TA.

Clinical implications

Despite these limitations, our findings offer several clinical implications. First, individuals referred to treatment by court order are more likely to report low TA and drop out early (Brassard et al., 2021). Using motivational strategies, like motivational interviewing, in initial sessions could improve retention by boosting engagement and willingness to change, especially in IPV perpetrators with low motivation (Lila et al., 2018). A meta-analysis (Santirso et al., 2020) found dropout rates were 1.73 times higher in IPV treatments without motivational strategies. These strategies may extend treatment duration and enhance TA, or vice versa. Second, since the link between CIT and TA seems to fluctuate depending on the level of attachment anxiety, therapists should investigate both past CIT experiences and attachment representations to guide therapeutic interventions and foster the quality of TA. For instance, emotionally focused individual therapy (EFIT: Johnson, 2019) could be useful as it is a therapeutic approach that centers on attachment and is sensitive to trauma survivors. Third, therapists could concentrate on the resolution of TA ruptures, which are more frequent among clients with attachment insecurities (Mikulincer & Shaver, 2016). Resolving TA ruptures could provide clients with reparative emotional experiences, enable the exploration of negative feelings, and lead to a better TA (Safran et al., 2006). Therapists could also receive training on potential challenges of working with people higher in attachment insecurity. This could help them better identify and acknowledge their countertransference, which can be a window to a client's unconscious needs and used as a tool for therapeutic change (Mikulincer & Shaver, 2016). Lastly, as more avoidant individuals encounter more difficulties in forming a strong TA with their therapist, Daly and Mallinckrodt (2009) suggested tailored interventions, with therapists initially maintaining a more distant stance at the beginning of treatment. Over the course of sessions, therapists can attempt to narrow the gap by introducing higher levels of intimacy and encouraging avoidant individuals to explore the sources of their discomfort with closeness.

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Ethical standards and informed consent

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation [Comité d'éthique de la recherche des lettres et sciences humaines de l'Université de Sherbrooke] and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all participants for being included in the study.

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