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Dialogues in partner abusive clients' group treatment: Conversational tools used by counselors with differently motivated clients

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Author Comments:	

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Dialogues in partner abusive clients' group treatment: Conversational tools used by counselors with differently motivated clients

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Abstract

This qualitative study investigated talk and interaction as process factors potentially influencing outcomes in abuser group intervention. The findings showed that (a) abusers participate in group programs with considerably different degrees of motivation; (b) the interaction in abusers' various stages of change is characterized by different qualities; and (c) group counselors face a challenge in adapting their ways of working to abusers' various needs and backgrounds. The findings demonstrate the importance of attending to the interactional elements in abuser treatment programs, and show the value of matching an abuser's needs and degree of motivation with the timing of interventions. It is argued that attention to all these matters could help in making abuser programs more effective.

Keywords: group treatment, partner abuse, dialogues, domestic violence

Dialogues in partner abusive clients' group treatment: Conversational tools used by counselors with differently motivated clients

An issue of great interest in intimatrly partner abusive clients' interventions is how to understand more fully and how to intervene more effectively in client change. After decades of research, there is still only limited knowledge concerning how a change towards a cessation of abusive behavior can occur, which factors facilitate change, and what is needed to maintain change. In fact, there is no established evidence of any clear-cut best-practice treatment for this group of clients, and it has been extremely difficult to prove the effectiveness of different treatment modalities (Babcock, Green & Robie, 2004; Barner & Carney, 2011). In recent times, there have been requests for more vigorous examination of variables related not only to intervention outcomes but also to intervention processes (see e.g. Bowen, 2010; Eckhardt, Babcock & Homack, 2004; Maiuro & Eberle, 2008; Scott, 2004). These process variables are the focus of the present study.

At the present time, group-based programs are a common means of intervention in the US (Price & Rosenbaum, 2009), and also in Europe (Graham-Kevan, 2007). Here it should be noted that although female-to-male and same-sex violence in relationships is undoubtedly a serious problem, requiring specific attention and measures, recognition of the extent and severity of male-to-female violence (Tjaden & Thoennes, 2000) has meant that the majority of treatment modalities have been directed at male clients. It has been calculated that in North America alone there are several thousand abuser intervention programs (Family Violence Prevention Fund & NIJ, 2010). These vary in their curricula and operations, but each targets the cessation of violent behavior. Given the difficulty of getting valid, empirically proven evidence on the outcomes of these interventions, a current issue in abuser intervention programs concerns how far the effectiveness of such interventions can be confirmed; this is

clearly an important issue for the social welfare and criminal justice systems and other funding sources.

During the past decades, the evaluation studies of abuser intervention programs have produced disturbing findings. Although the initial examinations seemeed generally positive (e.g., Eisikovits & Edleson, 1989; Tolman & Bennett, 1990), studies using more rigorous research settings and the larger meta-analyses indicated that abuse programs produce either a small effect or no effect on recidivism, or produce desired changes on some abusers but not all in some intervention programs (e.g., Babcock et al., 2004; Davis & Taylor, 1999)., In recent years however, some studies have again indicated that abuser programs actually are effective, especially in changing some specific abuse-related psychological factors such as abusers' attitudes towards women (e.g., Buttell & Carney, 2006; Morrison & Nesius, 2003).

The challenges in demonstrating the effectiveness of abuser intervention programs are related to the high drop-out rates (Daly & Pelowski, 2000), and the lack of empirically valid research settings that would make it possible to measure effects among those who complete interventions (Eckhardt, Murphy, Black & Suhr, 2006). In addition, it has been noted that in terms of individual abuser characteristics (such as demographic features, economic and societal circumstances, cognitive, emotional and behavioral capacities, and attitudinal and motivational factors) the abusers form a very diverse group (e.g., Eckhardt, Holtzworth-Munroe, Norlander, Sibley, & Cahill, 2008). Recognition of the heterogeneity of this group of clients has led several researchers to discard any best-practice or one-size models of treatment (Levesque, Driskell, Prochaska & Prochaska, 2008; Maiuro & Eberle, 2008; Saunders, 2008); in fact, general discussion on abuser intervention programs has gradually moved from "what works?" towards a more broadly-based "what works when, where and for whom?" (McGuire, 2004, p.339). Thus, there currently seem to be more opportunities for various understandings of change as an event, and of how change can be

facilitated within interventions directed at clients who use aggression in their intimate relationships.

Several authors have recently given support to a focus which would go beyond outcome variables in abuser intervention programs, and which would look also at process variables in relation to change (see e.g. Bowen, 2010; Eckhardt et al., 2004; Scott, 2004). This has led to an increasing interest in qualitative process factors such as (the characteristics of) client motivation, program delivery, the group environment, group integrity/cohesion, the working style of group counselors, and the working alliance between clients and counselors. The aim of the present study was to participate in this broad endeavor, and to add something new by examining (a) the characteristics of the treatment processes of good and poor outcome clients, and of clients' progress towards change; (b) the qualities of the interaction between individual clients and counselors; and (c) counselors' ways of using various conversational tools with different clients. These issues were analyzed within the theoretical frames of the *Stages of Change model* (SCM), and of the method that has been referred to as *Dialogical Investigations*. These will be explained in the following sections.

Stages of Change Model

The Transtheoretical model of change (TTM) was created in the 1980s as an attempt to describe how clients proceeded towards the goal of the treatment, and to identify specific client factors that influence treatment outcome; it was intended that these aspects would be incorporated within a single comprehensive model (see Prochaska & DiClemente, 1983; Prochaska, DiClemente & Norcross, 1992; Prochaska & Velicer, 1997). The model incorporates four distinct theoretical constructs that are used to understand and measure how individuals change: (a) stages of change, (b) processes of change, (c) self-efficacy, and (d) decisional balance.

The most frequently used component of TTM is its *Stages of Change* construct. The Stages of Change model (hereafter SCM) suggests that change occurs as individuals proceed through five stages: (1) *precontemplation*, in which the person has no intention of changing the behavior; (2) *contemplation*, in which the person becomes aware that a problem exists and is interested in making a change, but has not yet made a commitment to act; (3) *preparation*, in which the person intends to take action immediately and is making decisions regarding what course of action to take; (4) *action*, in which the person is actively modifying the behavior in question; and (5) *maintenance*, in which the person has successfully changed the behavior and is working to prevent a relapse (Prochaska et al., 1992).

In SCM, each stage is seen as describing a specific constellation of attitudes and behaviors, which describes a person's level of engagement in the change process and his or her overall readiness to change. Although the speed at which individuals progress through the stages and the length of time spent in one stage may vary, the order of the stages is presumed to be invariant. Returning to an earlier stage and vacillating back and forth between adjacent stages is seen as acceptable, and furthermore, exiting from the change cycle (e.g. through relapse) is regarded as a normal phenomenon (Prochaska et al., 1992). In clinical contexts a client's stage of change is often measured through self-marked scales; these display the stage the individual is in (see e.g. SOCRATES; Miller & Tonigan, 1996; URICA-DV; Levesque, Gelles & Velicer, 2000).

The Transtheoretical Model (TTM) posits that optimal progress towards change is produced by applying different change processes and relational stances for each stage of change. TTM outlines five *experiential* processes (such as increasing awareness of the problem and of oneself), and five *behavioral* processes that include more observable behavior change (such as finding social support) (Prochaska & Velicer, 1997). TTM assumes that the change processes usually associated with experiential and cognitive treatment approaches are

most useful during the earlier stages, whereas the change processes associated with behavioral treatment approaches are expected to be most functional during the action and maintenance stages (Norcross, Krebs & Prochaska, 2011). In addition to the stages and processes of change, TTM involves two other components: *decisional balance*, which involves an assessment of the pros and cons of change, and *self-efficacy*, which reflects the degree to which an individual believes he or she has the capacity to attain a desired goal (Prochaska et al., 1992). Altogether, the aim of TTM, through the interrelating of its four core constructs, is to construct a comprehensive approach by which the client's change can be examined.

Although SCM was originally designed to describe how smokers could change their smoking behavior, the model has been used to guide interventions in a broad range of problem behaviors – interventions that include exercising (Biddle & Nigg, 2000), health education (Lach, Everard, Highstein & Brownson, 2004) and weight management (Johnson et al., 2008). During the last two decades, SCM has been applied to counseling the victims of intimate partner violence (Zink, Elder, Jacobson & Klostermann, 2004), and to abuser programs aimed at intervening and preventing IPV. Several researchers have seen SCM as offering a promising means to identify individual differences within abusers, and further, to support offenders' motivation to participate, decreasing their resistance, and improving the match between individual needs and program content (Babcock, Canady, Senior & Eckhardt, 2005; Begun, Shelley, Strodthoff & Short, 2001; Eckhardt et al., 2004; Levesque et al., 2008; Murphy & Baxter, 1997).

Despite its enormous popularity and wide use – or perhaps because of them – SCM has also faced enduring criticism. Researchers working with partner-violent clients have viewed the application of SCM as questionable in the context of abuser treatment (see Brodeur, Rondeau, Brochu, Lindsay & Phelps, 2008; Casey, Day & Howells, 2005). The critics have

seen SCM and its measuring tools as providing an overly simplified and generalizing model of change. It has also been viewed as neglecting individual variance (Whitelaw, Baldwin, Bunton & Flynn, 2000), and as failing to take account of the complex nature of many problem behaviors, such as offending or violence (Alexander, Morris, Tracy & Frye, 2010; Collins & Nee, 2010). In the present study, the aim was to examine the Stages of Change model applied to a qualitative analysis of individual clients' treatment processes; this was conducted in parallel with the application of another theoretical approach to client change, namely, Dialogical Investigations.

Dialogical Investigations

Studying talk and interaction in a multiple-actor setting necessitates a specific research setting and a method. In order to get a grasp of the on-going, constantly unfolding processes in interpersonal interaction, researchers interested in the potential of a dialogical viewpoint have developed a method called Dialogical Investigations (Seikkula, 2002; Seikkula, Laitila & Rober, 2011). Dialogical Investigations draws on the scholarly work of Mikhail Bakthin (1981) and Martin Buber (1970), a focuses on the following interactional qualities: (a) who decides the themes of the conversation and shares the turns of talking (dominances as observed at the level of conversation in this specific interaction setting); (b) whether the interlocutors in the conversation use abstract concepts and meanings which will allow different interpretations, or whether the language refers to factually existing matters and things (symbolic versus indicative uses of language); and (c) whether the interlocutors aim at listening with integrity or whether one speaker is pushing through his or her own opinions (dialogical versus monological ways of responding).

While recognizing the multiple factors that can affect the treatment outcome both within and outside the intervention, and while avoiding the assumption that particular interactional features taken in isolation will be sufficient to explain the outcome, previous studies using

Dialogical Investigations have nevertheless found that certain dialogically analyzed interactional qualities may be used to differentiate between good and poor outcomes in various interactional situations (see e.g. Guregård, 2009; Räsänen, Holma & Seikkula, 2012b; Seikkula, 2002). These studies have observed good-outcome interaction situations as situations in which shared understandings, new interpretations, and new meanings emerge. These are more frequently characterized by careful listening and adjustment of one's answers to connect with what was previously said (i.e. a dialogical manner of responding), rather than by pushing through one's own comments and opinions (a monological manner of responding). The good-outcome cases also have more talk involving abstract meanings (a symbolic language area), and less talk indicating factually existing things (belonging to the indicative language area). In addition, in our previous studies (XXXX), we found that counselors had to make intensive efforts to balance between confrontation and support, bearing in mind that the sole use of either of these approaches had been found to work less well in abuser treatment (cf., Kirsch & Becker, 2006; Silvergleid & Mankowski, 2006). The findings from these studies suggest that the quality of the treatment interaction may be influential in the treatment outcome, and that new perspectives can be opened up when one looks at the elements of the interaction on a broader, more inclusive basis; furthermore, these perspectives may be applicable to a variety of treatment settings.

In the present study, we used a multi-theoretical framework to analyze the processes of change in men attending group treatment for intimately violent clients; thus we incorporated analyses based on both the Stages of Change model and the Dialogical Investigations method. The need for an integrative rather than a competitive approach to different research paradigms and traditions has been broadly recognized (e.g., Carswell, 2002; Patton, 2002). Nevertheless, it is possible that the potential of multiple perspectives still tends to be under-used. In the present study the rationale for using two theoretical frameworks was our wish to

enhance our understandings of change in intimately abusive clients, and to see whether these two theories could bring out something new when applied in parallel. Within this framework, we conducted our processual case study; in so doing we carried out a qualitative microanalysis of four treatment processes (on individual clients), analyzed for (a) their individual progress as observed within the SCM, (b) the dialogical qualities of interaction between clients and counselors, and (c) the conversational tools used by the counselors.

The Study Setting

The detailed study setting was explained in our previous article (XXXX). The following paragraphs include only a brief description of the setting.

The Jyväskylä Model of Group Treatment

The data for the present study were obtained in Finland, within the Jyväskylä research project on the group treatment of abusers. In a framework of local multi-professional co-operation, services are offered for partner abusers, victims, and children who have experienced violence at home. The treatment is based on the voluntary (as opposed to court-mandated) participation of clients. There were no incentives for attending or completing the program. The group meetings, whether in an open-group format (with a minimum commitment to 15 attended meetings) or in a closed-group treatment program (a set of 15 meetings during one semester with the same participants) are unstructured; however, the group counselors use ideas and practices from various treatment models, including the building of awareness of control and power issues, the restructuring of cognitive processes, and sex role resocialization. Thus, following a Norwegian treatment model called ATV, the Jyväskylä model on abuser group treatment integrates ideas from both structured psycho-educational methods and supportive therapy approaches (Holma, Partanen, Wahlström, Laitila & Seikkula, 2006; cf. Raakil, 2002).

One aspect of the Jyväskylä model is regular co-operation with clients' partners. Individual interviews with partners, conducted using the Abusive and Controlling Behavior Inventory (Davies, Holmes, Lundy & Urquhart, 1995), are used in order to screen for the types and scales of violence they have experienced; these meetings also inform and support partners. Partner interviews are organized before group treatment, at the end of it, and two years after completion of the program, and thus they produce important information about the partners' experiences of abusers' behavior at home, during and after treatment. Compared with abusers' self-rated outcome evaluations, which are also in use, partner reports have been regarded as offering a more realistic (although also subjective) method of assessing the effects of treatment (Holma et al., 2006). The same inventory is used for the client men's self-evaluations of their violent acts before and after group treatment.

The Participants

For the purposes of the present study, the second author chose four different clinical cases. The choice of the cases was based on two criteria measured in the partner-reports: (i) the amount of reported violence right after the treatment, and (ii) the amount of change, measured as the difference between the partner-reported violence before and after treatment. The good-outcome cases (as they are referred to here) showed low levels of violence after treatment and a considerable decrease in violent behavior as reported by the clients' partners. Conversely, the poor-outcome cases showed a small or no decrease in the violent behavior, or even increased rates of violence after treatment, as reported by the partners.

The clients in the cases selected participated voluntarily in different group treatment programs in Jyväskylä, between the fall of 2002 and the spring of 2007. Before group intervention, all the clients had gone through a short period of individual meetings in a crisis center. The length of the group treatment period varied between 9 and 31 meetings attended. All in all, the data corpus of this study consisted of 67 video-taped group meetings (each

lasting one-and-a-half hours), comprising in total slightly more than 100 hours of recorded material. In addition, we had outcome data from two sources: the client men's own reports of their violent acts against their partners, and their female partners' reports. Both the male clients and their female partners had evaluated the amounts and types of violent acts in their relationship, as measured at the start of the treatment, immediately after the treatment, and two years after the treatment. The four clients were white Finnish males, aged from 30 to 60, with a variety of educational backgrounds and work histories ranging from a university degree to vocational schooling, and from unemployment to a managerial position. At the time, one of the clients was in the process of divorcing his wife, and three clients lived together with their wives.

Written consent for the recordings was obtained from all the participants. The recorded material is held securely by the study organizers, and the members of the research team are all committed to complete confidentiality. The chosen excerpts from the recordings were later transcribed using the model of transcription (see Appendix) developed by Jefferson (as presented in Atkinson & Heritage, 1984). In the excerpts below, pseudonyms are used throughout.

The Procedure

This study was carried out as a qualitative content analysis structured by the theoretical outlines of SCM and Dialogical Investigations. In several previous studies the procedure for identifying the stages of change of clients has incorporated a quantitative analysis of clients' self-reported measures, these being examined in relation to various client, treatment, and problem variables (see Mauiro et al., 2001, pp. 39). Because in the present study the research focus was on clients' verbalizations of change and their qualitative scaling, a different approach to the stages of change analysis was needed. For the analytical procedures in the present study, functional and useful tools were found from earlier qualitative studies (see

Scott, 2004; Zink et al., 2004) incorporating an outside-evaluator analysis of clients' stages of change. Scott's (2004, 45) work incorporated categorical, descriptive statements concerning each stage of change; these were used in our study as reference material for an outside-evaluator analysis of the clients' spoken-aloud accounts. In addition, the study by Zink and her colleagues offered ideas for the practical process of carrying out the stages of change analysis within a group of several outside evaluators. Throughout our analysis of the stages of change, the SCM frames were used, providing the theoretical background and general guidelines for our analysis.

In the first study phase, we conducted a careful analysis of the contents of each client's conversational acts within each videotaped and transcribed treatment meeting (in total 67 meetings). For all clients, each of their attended meetings was labeled according to its dominant stage of change, based on the spoken-aloud conversational turns. The labeling was based on a five-class categorization presented within SCM, consisting of the stages of precontemplation, contemplation, preparation, action, and maintenance (see Norcross et al., 2011; Scott, 2004); the labeling was first practiced among the participating researchers. In fact, the boundaries between the five classes were sometimes fuzzy, and compromises had to be made in order to find the dominant stages of change; hence – in accordance with the procedure conducted by Zink and her colleagues (2004) – the categorizing phase was repeated three times, and questions raised by unclear situations were discussed in consensus meetings within the research group.

In the second study phase, which included a detailed analysis structured by the Dialogical Investigations method (Seikkula et al., 2011), a microanalysis of the speech acts of the participants was conducted on selected parts of the treatment conversations. The detailed analysis involved conversation sequences in which clients and counselors together contributed to the construction of the discussion. In order to limit the amount of material for

the detailed analysis, six conversation sequences from each of the five classes were chosen, making altogether 30 conversation sequences. The chosen sequences were analyzed to clearly reflect the characteristics of a specific stage. In the micro-level examination, each utterance was considered in its turn-by-turn context, and dialogically examined, both as a reaction to the preceding utterances and as a condition of and context for the subsequent ones. The third study phase included an examination of the conversational tools (such as ways of responding, asking, neglecting, giving space, etc.) used by the group counselors in group conversations. The study on counselors' conversational tools was conducted within the multitheoretical frames of SCM and Dialogical Investigations.

The Dialogical Investigations method followed a four-step model: first of all, the transcribed material in the 30 conversation segments chosen was set out in the form of topical sequences, with alterations of perspective marking the sequence boundaries (Step 1). Secondly, the 30 topical sequences were each scored for semantic and interaction dominances observed at a conversation level (Step 2), symbolic and indicative uses of language (Step 3), and dialogical and monological ways of responding (Step 4). The focus of this dialogical interaction analysis was, on one hand, an examination of the elements of successful interaction, including what may be termed "change events" in the conversation excerpts, and on the other hand, examination of the elements of unsuccessful interaction, including possible obstacles to change as perceived within the treatment talk in each of the five categories of the Stages of Change model.

Initially, the first author performed the primary coding and classification of the contents of the treatment conversations in each client case. At this phase of the study a blind research setting was ensured: hence the first author was not aware of the results of the treatment. In the last phase of study, an evaluation was conducted of the changes that had occurred in the client men's violence. In this last phase, the outcomes of the clients were checked, and the

good-outcome and poor-outcome cases were compared side by side. To check for coding consistency (Richards, 2005), the authors analyzed the transcripts independently and after that, the authors' findings on the category structure and the coherence of the results were discussed together. The consensus meetings were hold twice during the coding and classification process, and organized in a form of a conversation where each client's excerpts and especially the problematic ones were examined in comprehensive comparative discussions where all raters participated. As the method and its coding manual are still under development, the coding was based on the published articles presenting the method of Dialogical Investigations (see Seikkula, 2002; Seikkula et al, 2011), and on the theoretical frames presented in the theory of SCM. As reference material, the original transcripts were used.

Results

Individual Clients' Progress as Observed from the SCM Perspective

The first case was a client, here named Mark, whose treatment process ended in drop-out after nine meetings attended. Mark did not consider himself to be violent, and saw violence primarily as a characteristic of his relationship with his partner. As viewed from the SCM perspective, Mark did not seem to proceed from the stage of pre-contemplation within the treatment period. However, Mark himself reported considerable changes in his behavior, such as complete cessation of psychological violence towards his partner. The follow-up reports provided by Mark and his partner (collected right after the treatment) were contradictory: he reported that he had not been abusive in any way, whereas the spouse reported an increase in psychological, financial, and sexual abuse towards her. They decided to move to different apartments during the treatment, and their relationship finally ended in divorce.

Another poor-outcome client, Mike, attended one closed group for 15 meetings plus five extra meetings in an open group, within approximately one year. He, too, denied that he was

violent, but said that some violent acts had occurred in the relationship a long time ago. Mike talked eagerly about violence and gender issues at an analytical or abstract level of talk; however, he seemed to avoid talk that touched him personally. In addition, Mike talked about current and former stress factors in his life, such as his harsh childhood and current hard workload, which made him feel bad, guilty, and tired. He insistently claimed that a change was needed from both partners in the relationship. Within his treatment period, Mike's process of change seemed to linger around the same questions of unfairness and tiredness. In his case too, his partner's reports showed physical, psychological, and sexual violence continuing in the relationship. Their marriage (which had lasted more than ten years) continued after the treatment.

The third client, here called Alex, attended 31 open-group meetings over sixteen months. At the beginning of the treatment Alex's spouse reported serious physical abuse, strong psychological abuse, and also sexual abuse. However, during his treatment process the client showed recognition of his problem, manifesting a wish to change from the beginning, although he also reported several relapses, i.e. violence towards his partner. In terms of SCM, Alex's process seemed to move fairly quickly from preparation to action, and after relapses, back to contemplation concerning whether he could ever change, followed by gradual preparation for a more stable change. In Alex's case, his talk about maintaining the change was often surrounded by talk about the difficulty of achieving goals, skepticism towards his ability to change, and preparation for particular situations associated with the threat of using violence. Thus, the themes from earlier stages of change were repeated during the course of Alex's treatment. Alex's spouse first reported diminished amounts of physical violence, and later in the treatment also reductions in psychological violence. Their open relationship continued after the treatment but had ended by the 2-year follow-up interview.

The fourth client case was a good-outcome treatment process, involving a client called Klaus who attended 13 open-group meetings over one year. At the beginning of the treatment, Klaus defined change as being a necessity for him; he saw the cessation of his violent behavior as being the only way to save his marriage and family. His spouse reported psychological abusiveness, but also physical and sexual abuse at the beginning of treatment. Klaus was interested in examining his own motives, feelings and reactions, and expressed a heavy load of guilt throughout the treatment. From the SCM perspective, Klaus seemed to begin the treatment at the action stage, with a serious decision to change. The difficulty of maintaining the change and learning how to refrain from violence were the most central questions in the treatment. Klaus reported a couple of relapses with violent or threatening behavior towards his spouse during the treatment. In addition, he saw himself as using more shouting and other types of psychological violence after stopping his physically violent behavior. In the follow-ups, both Klaus and his spouse reported that physical and sexual abusiveness had almost stopped during the intervention, and also that psychologically abusive behavior had diminished. Their marriage had continued up to the 2-year follow-up interview.

In our analysis of the clients' progress within various Stages of Change categories, we noted great variation between individual clients. The clients showed considerable differences in their degrees of motivation already in the initial phase, and also during their treatment processes. The clients' spoken accounts seemed to illustrate change as a fundamentally individual and non-linear phenomenon: a client's talk could reflect different stages of change even within one session, and vary back and forth between different stages during the course of treatment. Because the clients' treatment processes in this small sample varied in length and in the number of attended sessions (with the result that the differences between clients could not be measured quantitatively) the qualitative research approach that we had chosen appeared appropriate.

The Stages of Change analysis showed all five stages of the model as being identifiable in the clients' spoken accounts within the treatment conversations. It was noted that although all the clients had completed an individual pre-treatment phase in the crisis center, they seemed to start the treatment at different stages of change. Here it should be emphasized that there were no prerequisites for entering the group intervention. The results showed that in the good-outcome cases one could observe right at the beginning of the treatment several elements featuring preparation or action stages of change; these included open admission of the problem and personal commitment to change. By contrast, in the poor-outcome cases it was possible to observe during the treatment numerous elements featuring earlier stages of change. These included minimization of violent acts, or blame directed at the partners. These elements could be seen right at the beginning of treatment, and also continuously, throughout the treatment processes.

Results from Dialogical Investigations

The second analytical approach, Dialogical Investigations, focused on the qualities of interaction between the group counselors and the clients. It was noted that more dialogical elements (such as open listening, linking and responding to what was previously said, client activity in conversations, and talk at the symbolic level of meanings) occurred in the preparation, action, and maintenance stages of change. Conversely, more monological talk (involving lack of responding, counselor-dominated conversations, and talk at the indicative level of meanings) occurred at the pre-contemplation and contemplation stages of change. It was also noted that these first stages of change more frequently characterized the treatment processes of the poor-outcome clients. In contrast, the treatment processes of the good-outcome clients more frequently reflected the later stages of change. Overall, it appeared that the aspects of outcome, client motivation, and the quality of the interaction were intertwined. In the following excerpts we present results from the Stages of Change analysis, plus the

observations made via Dialogical Investigations, in relation to each stage of change. The descriptions of each stage follow the descriptions given by Prochaska et al. (1992), Prochaska and Velicer (1997), and by Norcross et al. (2011).

1. Contemplation. *The client considers change, but also rejects it.* At this stage, there is some awareness that a problem exists. This stage is characterized by ambivalence; the person wants to change, but also shows resistance to change. At this stage the client often feels "stuck."

> *Excerpt 1.*
>
> *Mike. A client within a poor-outcome treatment process. Session 1/20.*
>
> *T1: ye:es but (.) do you have any kind of (.) wishes (1) or I mean when you invest in this (.) in such a way that you take time off from work (.) then (.) mmm what could be a kind of good result that this group (.) could bring you*
> *Mike: [[well yes]] it could bring me (.) some new perspectives give (1) or that kind of for the future (2) .hhh maybe here you may notice that mmm (2) .hhh you're not so much different (.) from other people (talks quietly)*
> *T1: is it the case now that (.) this violence is currently not that kind of problem (.) I mean your own violent behavior*
> *Mike: .hhh yes that's how I feel it (2) that this (.) behavior is in a way (.) a kind of psychological controlling that can be more of a problem*
> *T2: mmm (.) what do you mean by that*
> *Mike: I mean that in a relationship u:m (…) you feel it difficult mmm (.) that kind of situation where you feel that you're losing control (.) that you can't steer the train yourself (.) the feeling of losing control (.) or feelings recognizing them it is (.) in a way you don't dare*
> *T2: .hhh you want to have all the reins in your own hands (.) all the time*
> *Mike: yes (.) it has been also in my work (.) sometimes (.) that I can take control and that if I can't (1) then I feel bad*

This excerpt describes the first session of the treatment with a client called Mike. In this early phase of the treatment, Mike articulates his motives for coming to the group. Achieving change in his personal life or in his violent behavior is not mentioned aloud; instead, Mike seems to wish to change the focus of the conversation from his physically violent behavior to other types of problems in the relationship. At this initial phase of the treatment, the client seems to have some awareness of the problem, but he does not seem ready to get to grips with the actual problem of his physically violent behavior. The fear of losing control, which

may be considered a more generally accepted and easily admitted topic, seems to serve as an easier way to bring up the client's awareness of his problems. However, if the client never comes to recognize a need to make real changes, including in his physically violent behavior, and if he continues to focus on secondary topics, the treatment process may easily become stuck.

The dialogical analysis of this excerpt shows the counselor dominating the decision concerning the theme, and structuring the turn-order of the conversation. Together, the counselor and the client construct a dialogically progressing conversation in which they build up shared understandings of the meanings given to the terms they are using, such as "the current problem" or "psychological controlling." The counselor focuses on listening and on open questions, with gentle moves towards questions that may raise some awareness of the problem.

2. Preparation. *The client wants to do something about the problem.* At this stage, clients are making a decision towards change; they may take small steps towards action, and they often have or wish to have a plan for concrete ways of implementing the change.

Excerpt 2.

Klaus. A client within a good-outcome process. Session 1/1.

Klaus: (…) I can add that in previous relationships (.) I have <u>always</u> been a kind of (.) that when I lose my cool then I shout really badly (2).hhh I have thought it tha:at (.) I have always been like that (2) and now .hhh I'd like to get that to stop (1) somehow or another
T1: u:m when Mike talked about his feelings of losing control (.) does it fit with your situation
Klaus: mmm well (.) I mean somehow (.) .hhh it's that (.) there is no threat (.) umm when I'm not nervous (1) but when it boils up then it happens so fast that (.) somehow I just boil up (.) and then it comes (.) the words
T1: your spouse (.) does not feel like that (.) .hhh you'd try to take control over her
Klaus: umm… well I've been thinking about that maybe it is that I want to put a stop (.) to the quarrelling (.) something like that it is (.) that when we both argue then (.(I say something really badly (.) and hope that it will end with that
T1: umm (1) so (.) you want to stop the quarrel and then
Klaus: ye:ah (.) something like that it is

This excerpt is derived from the first group treatment session with a client called Klaus. In this first treatment meeting, the conversation also goes into the reasons why the clients have come to the group. In explaining these reasons in his turn, Klaus talks about his wish to put an end to his shouting in situations where he loses his cool. The counselor asks whether Klaus's experience would be similar to that of another client, Mike, and this leads Klaus to describe his situation in more detail. The client seems to recognize his problem clearly, and also states his motivation for change; however, he asks for guidance for finding ways to attain his goal, and seems to be in need of realistic and achievable steps to change.

The dialogical analysis of this excerpt shows the client as taking an active part in the conversation, when he openly ponders his behavior, and his thoughts and wishes related to the unwanted behavior. The conversation is conducted using a symbolic level of meanings – the work on defining the terms "losing my cool" and "wanting to put a stop" to the situation allows for different meanings and interpretations, and in this excerpt, the defining work is done in a dialogical manner together between the interlocutors.

3. Maintenance. *The client works for consolidation of changes.* Making a change does not guarantee that the change will be maintained. The challenge during this stage is to sustain a change accomplished by previous action, and to prevent relapse. Maintaining a change may often require a different set of skills from making a change.

Excerpt 3.

Alex. A client with a good outcome. Session 8/31.

Alex: (…)well .hhh Ella said that (.) u:m those <u>hands</u> that have beaten me (2) they can't feel <u>loving</u> (.) .hhh (2) and I said (.) that (.) if you think so (1) then there's nothing to be done (2) that I can't change completely (.) that I won't cut my hands off (.) and this is what I still am (…) .hhh these were quite hard words to hear
T2: mmm I was thinking (.) that u:mm if you want to stay in that relationship (2) then in a way .hhh you give space to those words too (2) and then that euhh… (.) well I mean it is <u>true</u> what Ella has said

Alex: yeah (2).hhh it's true (.) I agree (2) and I wasn't upset by <u>that</u> but (2) but (.) when one thinks about the future of the relationship (.) that if that thing stays in one's mind <u>all the time</u> then (.) there's no reason
T1: mmm (.) yeah that if it is (.) more a kind of <u>experience</u> that needs to be said aloud (2) that if it doesn't get easier (1) then it may be difficult to be together (2) but I was listening to that (.) you talk really (.) honestly
Alex: yeah well I guess so (...)
T2: Ella has the courage to say it to you (.) .hhh these days
Alex: mmm yes (2) well yes (.) on the other hand (.) that's a good thing

In this excerpt, the client, Alex, talks about difficulties in his relationship after he has claimed to have radically reduced his violent behavior towards his partner. The Stages of Change analysis of the excerpt shows the client struggling with a problem commonly encountered during the treatment: the continuation of difficulties, even when desired changes have been achieved. The client seems to be in a maintenance stage of change, and he seems to recognize his need for support and counseling. The memories and traces which past violent acts have left, and which cannot be taken away, are central in the work with clients in this phase. In this study it was also noted that the client's talk, when it seemed to reflect the maintenance stage of change, could quickly turn in such a way as to reflect features of any of the previous stages; this illustrates both the fluctuation in the client's thoughts and feelings concerning the process of change, and the difficulty of firmly defining and measuring the client's stage of change.

The dialogical analysis of this excerpt shows a dialogically constructed conversation in which the client and the counselor listen carefully to each other. They connect their speech acts to what was previously said, but also have the possibility of expressing their different meanings and adding something new to the conversation. Speaking fairly frankly, the counselor brings up the fact that Alex has used violence against his partner; yet at the same time, the counselor shows empathy with the difficulties Alex is experiencing. He presents a positive viewpoint, describing Alex and Ella as being able to speak directly and truthfully to each other. The client seems to understand and share this viewpoint. According to Dialogical

Investigations these kinds of conversations may be important triggers for change, offering both support and a degree of challenge, especially to a motivated and actively co-operating client.

Analysis of Counselors' Tools

The previous phases of the study had shown all the five stages within the SCM to be identifiable in the material used, and thus an analysis of the counselors' conversational tools could be carried out for each stage identified. All in all, the counselors seemed to have a broad range of tools and approaches, and they used these with clients displaying different stages of change. The variety of means observed made it interesting to examine the counselors' tools and their ways of using them, in relation to clients representing different degrees of motivation and readiness to change. In conjunction with our results, we present the guidelines for treatment providers provided in the SCM framework (see Norcross et al., 2011; Prochaska & DiClemente, 1983).

SCM issues the following guidelines to treatment providers: (1) In *precontemplation*, join with a resistant client, validate the client's lack of readiness, and encourage the client's self-exploration, but do not yet support action towards change. (2) In *contemplation*, encourage clients' evaluations of the pros and cons of change, and support the emergence of new and positive outcome expectations. (3) In *preparation*, assist clients in problem solving, and encourage small steps towards change. (4) In *action*, focus on supporting clients' self-efficacy and participation in change-promoting social networks, and reaffirm the long-term benefits of change. (5) In *maintenance*, plan for follow-up support, reinforce clients' internal rewards for change, and discuss coping with relapse.

In general, SCM advises treatment providers to avoid confrontation in the first stages of change, and to use more challenging and behavioral approaches in the later stages of change. In the present study the counselors' ways of working were observed to frequently follow this

rule of thumb. Nevertheless, in the first stages of change there were also situations where more confrontational and directive ("you need to stop") approaches were adopted. In this study it was also noted that with those clients whose talk reflected features of (1) *precontemplation* and (2) *contemplation*, the counselors generally avoided confrontation or direct challenge; however, by means of small inquiring questions, the counselors seemed to try to understand the clients' ways of thinking and feeling, giving support to the clients' activity in pondering their problem situations. Nevertheless, if a client's talk reflected threatening or intimidating, behavior – minimizing the consequences of violent acts, or exhibiting other dangerously biased ways of seeing the violence – the counselors were observed to adopt a directly oppositional, educative, or confrontational stance. With clients in the (3) *preparation* stage, the counselors in this study supported the client when he seemed to be attempting to understanding his behavior. They encouraged the client to share his experiences of concrete situations, and to ponder factors underlying his problem behavior. With clients in the (4) *action* stage, the counselors were observed to depart from the SCM guidelines, as they did not directly support clients towards taking any concrete steps. Here, perhaps adopting a more therapeutic stance, the counselors considered with the clients the possible consequences of certain actions, leaving it to the clients to decide which actions to carry out, if any. With clients in the (5) *maintenance* stage, the counselors used more reflective conversations and open dialogues, and gave less direct guidance or concrete advice. In this phase, the counselors were observed to give more freedom – but also more responsibility – to the clients themselves. However, with clients who had achieved some degree of change but then relapsed, the counselors were observed to show empathy regarding the relapse, even if the clients' talk after a relapse reflected characteristics of the first stages of change. At the same time, the counselors adopted more challenging and direct approaches, questioning the reasons for the relapse. A notable feature here was that the acts of

confrontation did not appear to lead to disruptions of the conversations or to an over-dominating position on the part of the counselor. Overall, the clients, or the relationship between clients and counselors, seemed to tolerate a higher degree of confrontation in these later phases of the treatment.

Discussion

Our Stages of Change analysis indicated that the abusive clients started the group treatment at different stages of change, and that they had fairly varied conditions for starting work with the problem. Given that there were no prerequisites for entering the intervention, such a finding is not surprising, but it does emphasize the heterogeneity of this group of clients (cf. Babcock, 2009). The two good-outcome clients were observed to show considerably more characteristics of the contemplation and action stages of change, at the start of and throughout their treatment processes. In contrast, the two poor-outcome clients presented more characteristics of the pre-contemplation stage throughout their treatment processes.

In this study, the Dialogical Investigations method was used to study the interactional qualities of the treatment processes of good-outcome and poor-outcome clients displaying various stages of change. In our previous studies (XXXX), we had found the good-outcome cases to be more frequently characterized by a mutually responsive dialogue conducted at a deeper level of meanings, whereas in the poor-outcome cases the conversations more frequently turned out to be interview-type sequences, in which no new understandings were seen to emerge. Thus, it appeared that particular interactional characteristics might be associated with the treatment outcome. The findings of the present study supported this assumption. We found more dialogical responding, more client activity in the conversations, and more talk at the symbolic level of meanings in the preparation, action, and maintenance stages of change, i.e. the stages that on the whole characterized the good-outcome treatment

processes. Conversely, there were more episodes of monological responding, counselor-dominated conversations, and talk at the indicative level of meanings in the pre-contemplation and contemplation stages, i.e. the stages that characterized the poor-outcome treatment processes. Thus, we could state that the construction of a shared and productive dialogue at the symbolic level of meanings happened more often with the good-outcome clients; these were persons who were seen as being more motivated towards treatment, and also more active and more responsive conversation participants. Such interaction qualities seemed to foster the formation of reflective, insightful conversations, which could be expected to facilitate the emergence of new meanings and changes in ways of thinking, and thus the construction of changes in behavior. This is not to say, however, that the sole use of symbolic language is good: one needs to note that the use of an indicative, concrete language also plays an important role especially in abuser interventions. Incorporating the tangible world and the actual, physically occurring events (e.g., specifying what "little slapping" means) is crucial in abuser interventions where the reality of violent acts could easily be hidden and forgotten by using abstract and figurative language.

An examination of the counselors' conversational tools showed their use of a range of different approaches, applied to different clients in different phases of change. The counselors were observed to use the approaches of open listening and affirmative comments, especially in the initial phase of the treatment, and to apply more confrontational approaches in later sessions. In general, the timing of confrontation seemed to be consistent with SCM recommendations (Prochaska et al., 1992). However, in the present treatment modality the counselors were also observed to use some confrontational methods with clients in earlier stages of change, especially in situations where they used a non-accepting stance towards a client's violent acts.

In the treatment processes of the two clients who were later identified as poor-outcome cases, both clients initially denied the existence of any current problem of violence in their relationships. With these clients, the counselors were observed to use non-direct means of getting closer to sensitive topics. On some occasions the clients responded to these initiatives, but in these poor-outcome treatment processes the counselors' initiatives were often not answered, and the conversation came to a stop. These instances – at which the counselors' attempts to initiate a connection with the client got a weak or no response – were seen as truly demanding moments in the treatment conversations. In turn, in the treatment processes of those clients who were later found to be good-outcome cases, the counselors were observed to focus on encouraging the clients towards open and active discussion. However, with these clients too, the counselors were occasionally (especially in later sessions) observed to employ more direct conversational tools. These included confrontation, challenging, and presenting alternative viewpoints. It was observed that acts of this kind did not break the continuation of the dialogue (as often happened in the poor-outcome client cases).

These findings led us to consider whether there were differences in the relationship or working alliance between these clients and their counselors – i.e. whether the good-outcome processes were characterized by a more robust alliance, one that permitted presentation of a more direct confrontation without, however, leading to a perceptible break in the alliance. Conversely, in the poor-outcome client cases, the question arose of whether the case of a client's dropping out of the treatment was connected with a weak working alliance between the counselors and the client; and further whether or how the qualities of the relationship could have been improved. The ultimate question was whether characteristics of the talk and interaction could give indications of the abstract phenomena of the working alliance or therapeutic environment (see Bowen, 2010).

The finding of a possible link between interaction characteristics and the type of working alliance guided our curiosity to the elements taking place *in the space between people* (see Anderson, 2002) within abusers' group treatment. The significance of a collaborative relationship or a working alliance between counselor and client in partner-abuser treatment has been highlighted by several researchers (Brown & O'Leary, 2000; Duncan, Miller & Sparks, 2004; Taft, Murphy, Musser & Remington, 2004). As elements of the treatment relationship, acceptance, respect, and empathy have long been assumed to comprise central principles for effective treatment in psychotherapy (e.g., Rogers, 1957). However, such principles might seem to collide with a more didactic, educational, or authoritarian stance that often could be used in the treatment of clients who use aggression in their intimate relationships (Babcock, 2009; Kirsch & Becker, 2006; Silvergleid & Mankowski, 2006). In abuser interventions a collaborative relationship is a controversial concept, given that these treatment modalities are directed at unacceptable and criminal behavior, involving a variety of punitive elements (especially when a form of judicial sanction is present). These elements are likely to enter into educational and therapeutic working approaches and combine with them (Collins & Nee, 2010; Eckhardt et al., 2006). There is no doubt that finding a balance between stances will require awareness of the various contradictions embedded in the relationship between treatment providers and clients. Despite this, taking into consideration what is already known about the outcomes of partner-abuser programs, a focus on relationship qualities could be seen as a new means towards different and possibly effective work with clients of this type. Another important relational dimension of group interventions are the relationships among participant clients: besides counselors, other group members play a significant role that may influence intervention outcome, too. However, these issues were not the focus of this study and thus need to be addressed in the subsequent studies.

Evaluation of the Study

In studies on intimate partner violence, few studies have described the qualitative processes of change in abusive clients. Researchers have, however, called for a multidisciplinary approach in intervention studies in order to improve the empirical status of abuser intervention programs (Eckhardt et al., 2006; Hamel, 2008; Rolling & Brosi, 2010). In the present study, a multi-theoretical framework combining SCM and Dialogical Investigations was used to gain a better understanding of the various dimensions of abusers' processes of change. Combining the two models within a micro-analytic process research setting appeared to be a novel approach. In the event, it gave rise to important observations concerning the heterogeneity of partner abusive clients, the significance of the relationship between clients and counselors, and the characteristics of the counselor/client interaction, which emerged as vital factors in the interventions in question.

Applying the Stages of Change model to abuser-group interventions raised a number of questions. For example, the process of change was seen as a more complex and dynamically progressive phenomenon in this study than is generally presented in SCM theory (cf., Collins & Nee, 2010). It is undoubtedly true that partner violence is of a different nature from the more individually-centered problem behaviors for which SCM was originally developed (for example smoking and other addictions). Thus, in the treatment of partner violence, more attention has to be given to the environment, and to family, organization, and community level factors, which are less emphasized in SCM.

In addition, the fluctuating representations of clients' change processes observed in our outside-evaluator analysis led us to ponder criticism directed at the validity of the self-marked scales that have been used to define a client's stage of change (e.g., Carey, Purnine, Maisto & Carey, 1999). However, there seemed to be few other practical means of assessing clients' progress in change-oriented interventions, although those are reported to be under development (see Burrowes & Needs, 2009). In the present study the difficulty of absolutely

defining a particular stage of change highlighted questions of whether an exact measurement of these (seemingly) shifting and interpretative concepts was possible at all – but at the same time whether, despite their possibly simplifying effects, the scales might still offer a workable tool for examining the progress of an intervention.

The limitations of the study concern the small and selective research sample, which necessitates caution in terms of generalizations regarding abusers, counselors, or treatment modalities. Above all, the generative objectives of this micro-analytic study were to foster an interest in looking at interactions in various treatment settings. In the future, through observations from practice, it should be possible to gradually arrive at more widely-applicable knowledge. The small sample size made it possible to embark on a careful analysis of what actually happens in group conversations. An apparent limitation of the method of Dialogical Investigation is that, in its current form, it does not take into account the many non-verbal interaction events occurring at the level of gestures, movements or other bodily reactions. In the future studies this will be an essential dimension of developing the method further.

Another limitation of this study concerns the aspect of researcher subjectivity, although it should be noted that the role of the researcher is a salient characteristic in all qualitative investigations, and one that does not disappear even if – as in this study – researcher triangulation is used. All in all, we would expect the methodology and the type of data used in this study to be consonant with parallel research settings in other contexts, and we look forward to reading reports on such investigations. We would suggest that in spite of its limitations, the present study points to some new ways of developing the group treatment of partner-violent clients from an interaction point of view.

Conclusions

The present study puts a focus on some novel ideas that might help in developing interventions for partner abusive clients. These pertain to (i) the possibilities of having individual pre-treatment phases for constructing and evaluating clients' motivation, (ii) the multiple demands made on counselors' work, and (iii) what might be gained from understanding and forming an alliance with the abusive client. In previous studies, it has been suggested that beginning treatment with higher motivational characteristics predicts a good treatment outcome (Levesque et al., 2008; Murphy & Baxter, 1997). However, one can ask whether a more determined individual pre-treatment phase might help to foster clients' motivation for the group program; also whether selection criteria should be set for the clients entering the group – and if so, what these criteria should be (cf. McMurran, 2002). In several recent studies, the method of Motivational Interviewing has been proposed as offering an approach more tailored to individual needs, and also as supporting co-operation with clients in their desire to change (see e.g., Hettema, Steele & Miller, 2005). Such a method might also be applied to work with partner-violent client populations and included among the main tools used in these interventions (cf., Murphy & Maiuro, 2009; Musser, Semiatin, Taft & Murphy, 2008; Schumacher et al., 2011; Stuart, Temple & Moore, 2007).

An idea stemming from the theory of dialogical therapy (see Seikkula, 2002) is the placing of a major focus on ways of answering and listening. This may be one way to improve the experience of the client as a person to be met where he or she is. By this means the client may gain a sense of being accepted as a person despite his or her unacceptable acts. In terms of actual practice, the ideas described in this article could encourage professionals to pay more attention to the actual acts of listening, responding, and speaking to their abusive clients. Counselors may find it worthwhile to actively seek ways of constructing dialogical conversations that could lead to new understandings, more abstract conceptualizations, and perspectives offering alternatives to the problematic behavior. Furthermore, an interesting

issue for future studies would involve a larger examination of the variety of interactional and conversational tools used by different counselors in working with clients within different phases of their change processes. It would be good to get a better understanding of what should be done with clients displaying the profile of a specific stage, and what, in the practical context of treatment, should be said and done in order to improve treatment results.

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Appendix

Transcription Symbols

The transcription notation system for data segments presented here was developed by Gail Jefferson (see Atkinson & Heritage 1984, pp. ix-xvi).

Description of symbols used in the transcription:

:	Colon(s): Extended or stretched sound, syllable, or word.
(.)	Micropause: Brief pause of less than (0.2).
(1)	Timed Pause: Intervals occurring within and between same or different speaker's utterances
_	Underlining: Vocalic emphasis.
(( ))	Double Parentheses: Scenic details.
( )	Single Parentheses: Transcriptionist doubt.
=	Equal Signs: Latching of contiguous utterances, with no interval or overlap.
[ ]	Brackets: Speech overlap.
[[	Double Brackets: Simultaneous speech orientations to prior turn.
-	Hyphens: Halting, abrupt cut off of sound or word.
.hhh	Audible outbreaths
hhh	Audible inhalations

A summary of revisions

Article: *Dialogues in partner abusive clients' group treatment: Conversational tools used by counselors with differently motivated clients.*

Comment 1.
The different terms, such as ”abuser”, ”batterer”, ”perpetrator”, ”partner-abusive client”, were replaced by the general term ”abuser” or ”clients who use aggression in their intimate relationship”. In some places, however, the term ”client” was left to the text in places when it was linked with the term ”counselor” and thus framed the roles of the specific interaction setting.

Comment 2.
The reviewer aptly put a comment about updating the article of Maiuro. This piece of advice was followed, the new source of reference was included, and the spelling of the name corrected also in the list of references.

Comment 3.
We tried to formulate the sentences describing the method of Dialogical Investigation in as lay language as possible, with more concrete examples always added in parentheses. We did not wish, however, to totally impart from the terminology that guides the method and has been used in our previous articles, too. Thus, we wished to keep some of the content similar with the previous publications and hoped our readers to be able to follow the text and the interpretations based on the method of Dialogical Investigations.

Comments 4. & 5.
In this article, no quantitative approach to measure inter-rater reliability was used. In stead, we relied on regular consensus meetings and discussions that the research group hold after each rater had first independently rated all the transcribed excerpts – the more throughout explanation of the process is now included on page 13.

Comment 6.
We decided to keep the transcription notation system as it was marked in the original version of this article. The notation system should be understandable to most readers acquainted with qualitative research, and consciously chosen to not to include the more fine-grained symbols from, for example, conversation analysis techniques.

Reviewer 2.

Comment 1.
The comment of not over-generalizing the disturbing findings from studies on abuser program efficacy and effectiveness was found to be valuable. We added in a short discussion concerning the varying results from studies done during the past three decades on page 3.

Comment 2.
We added a comment of studies using SCM in victim counseling on page 6.

Comment 3.

A more complete discussion of symbolic and indicative language as conversation characteristics was included on page 25.

Comment 4.
References to the scholarly work of Mikhail Bakthin and Martin Buber were included in the literature concerning dialogical approach on page 7. The discussion on the uses of indicative and symbolic language were broadened also in discussion part, on page 25.

Comment 5.
A more precise description of the conversation dominances was added on pages 7 and 13.

Comment 6.
Some lines concerning the importance of non-verbal messages in interaction situations was added on page 29, with the lack of this dimension being recognized as a problem in the method.

Comment 7.
There were no incentives for attending or completing the program. This delineating phrase was added on page 9.

Comments 8., 9. and 10.
Although unquestionably an issue of great significance, the other group participants were not the focus of this study. Therefore, we chose not to broaden the discussion to incorporate an analysis of other members' influence on intervention outcomes. We recognize, however, that the exposure to other "good" outcome clients may differ from the exposure to other "poor" outcome clients following the theories concerning social learning and the various group processes. The idea of forming groups based on the principle of the clients' likely outcomes seems rather unethical, uncertain and perhaps unrealistic, still, it might be worth some pondering in future studies. In the present article, however, we wanted to add a mention of the effect of other group participants as an important issue worth its own discussion, and included this on page 27.

Comment 11.
The particular vignettes were chosen on the basis of their characteristics reflecting each of the five stages. The excerpts that were chosen for the detailed analysis clearly reflected characteristics of a specific stage, were easy to discern and thus were thought to provide clear examples for the readers of the study and also for other researchers willing to replicate the study process. A description of the research process was included on pages 12-13.