Alliance formation and change in psychotherapy with men perpetrating violence against their female partners

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Contents

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Summary

Three qualitative studies were conducted to investigate alliance formation and change in individual psychotherapy with men who had perpetrated intimate partner violence (IPV). The rationale behind these studies was the need to learn more about how therapists can succeed in engaging clients undergoing IPV therapy so that they can benefit from the therapeutic collaboration. Premature dropout is common in IPV therapy, and those clients who drop out of treatment are more likely to re-assault their partner than those who complete therapy. The three studies draw on data from a naturalistic process and outcome study of therapies with male clients conducted at five outpatient clinics that specialize in IPV therapy. The audio recordings of therapy sessions in 20 therapy cases—10 in which the client dropped out prematurely and 10 in which the client completed therapy with a good outcome—were analyzed qualitatively. The therapists were experienced in conducting IPV therapy.

In the first analysis, we aimed to conceptualize the clients' contributions to establish an initial working alliance. The transcripts of the first therapy session were analyzed by the use of constructivist grounded theory.

In the second analysis, we aimed to investigate how the therapists responded to the clients' different ways of inviting an alliance and how the therapists' strategies for establishing an alliance related to the outcome of the case. The transcripts of the first two sessions and the final session of the therapies were analyzed by the use of constructivist grounded theory.

In the third analysis, the aim was to gain knowledge of how in-session client change unfolded through the course of good-outcome therapies and how in-session change could illuminate the changes reported by clients and their partners from their everyday lives. From the 10 completed cases, we selected the three clients who had most convincingly changed their violent behavior and ways of relating to their partners. Interpretive phenomenological analysis was used to analyze the transcripts of approximately 40% of the sessions for each case.

The results of the two analyses concerning early alliance formation resulted in two conceptual models. By analyzing client contributions to an alliance, we developed a conceptual model of client-offered gateways and invitations to an alliance. The three gateways—clients' reflections on seeking therapy, notions of change, and disclosures of violent acts—were built of invitations that gradually ascended from weak to strong. The generic aspects of the movement from weak to strong invitations to an alliance were the

clients' awareness of how they created their own aggression and violent acts and their sense of agency in relation to their partner.

The analysis of the therapists' responsiveness to the clients' invitations conceptualized three modes of interaction patterns (co-creative, pull-avoid, and tiptoeing softly) characterized by specific therapist strategies. In both the co-creative and the pull-avoid interaction patterns, therapists attended to the same aspects of the client's perpetration of violence. However, the therapists in the co-creative pattern explored the client's personal experience of his abuse, while the therapists in the pull-avoid pattern attended to the descriptions of violent acts. The tiptoeing softly interactions were characterized by therapists trying to establish an alliance by exploring aspects of the client's life other than his perpetration of violence. The comparison between interaction patterns and outcome showed that the clients who completed therapy and disclosed more self-awareness and agency in relation to the violent events in the final session than in the first session had participated in the co-creative pattern.

The case-by-case analysis of in-session change conceptualized a model of five important turns (interaction patterns) with which these therapists and clients engaged to allow the client to become a safe husband and father. The five turns evolved around a key topic—stories about "the annoying other"—that the clients repeatedly brought up in most therapy sessions. As the therapists encountered these repetitions by exploring the clients' subjectivity and agency, the clients developed awareness of their personal problematic patterns of being an intimate partner and father and a cohesive self-narrative that addressed actual events from being a boy to being a man. Furthermore, the clients developed a capacity to recognize the state of mind of the other when feeling attacked. As a result of these processes, the clients exhibited a capacity to bring new interpersonal skills into the real world and relate more empathetically to the partner and children.

The three conceptual models have the potential to sensitize therapists to what they may encounter as invitations from the clients in the first session, how their interventions may create facilitative or hindering therapeutic interaction patterns, and the important role of the repetitions regarding "the annoying other" in IPV therapy. Such therapist sensitivity is especially important in the context of IPV treatment, where alliance formation and change are difficult but crucial. Furthermore, the model of client change in therapy illuminates how change evolved circularly around the key topic and not linearly through stages. The results suggest that change in psychotherapy for men perpetrating IPV is not only about ending violent behavior. Significant change was observed as a growth of the male client's awareness of both his own state of mind and that of his partner and children. Furthermore, the results

suggest the importance for therapists to engage the client in self-exploration and not solely in problem-solving interventions, such as anger management.

List of papers

I. Lømo, B., Haavind, H., & Tjersland, O. A. (2016). From resistance to invitations: How Men Voluntarily in Therapy for Intimate Partner Violence may Contribute to the Development of a Working Alliance. *Journal of Interpersonal Violence*, 1-23. doi: 10.1177/0886260516628290

II. Lømo, B., Haavind, H., & Tjersland, O. A. Finding a Common Ground: Therapist Responsiveness to Male Clients Who Have Acted Violently Against Their Female Partner. (manuscript submitted for publication)

III. Lømo, B., Haavind, H., & Tjersland, O. A. Five important turns in becoming a safe husband and father: A Case-by-case Study of In-session Change in Psychotherapy with Men Acting Violently Against Their Female Partner. (manuscript submitted for publication)

Alliance Formation and Change in IPV Psychotherapy

The benefits of using psychotherapy across a range of therapy approaches for a variety of psychological disorders are well-documented (Lambert, 2013). The success of "the talking cure" has inspired clinicians and policy makers to apply the principles of psychotherapy to client populations that are not the typical psychotherapy clients. Men perpetrating violence against their female partners represent an example of such a population.

Historically, husbands have had a legal right to punish their spouses. In the USA, the State of Alabama rescinded the "husbandly" right to physically punish his wife in 1871 (Barner & Carney, 2011), and in Norway, this legislation was withdrawn in 1687 (Johnsen, 1985). Subsequently, intimate partner violence (IPV) has become criminalized in Norway; however, for a long period, IPV has been ignored and considered a private matter. In the 1970-80s, the Women's Movement directed attention to the violence experienced by women in their homes and the development of educational and therapeutic interventions for men perpetrating IPV to stop violence against women. The application of the principles of psychotherapy to a behavioral problem defined as a crime is challenging and associated with certain dilemmas.

For example, in the US, most men are court mandated to treatment programs. Coercion might provide the client with an opportunity to receive a treatment that he most likely would not have sought himself, but it might also reduce his motivation to undergo therapy. Therefore, one could expect voluntary therapy to be more helpful. Furthermore, numerous qualitative studies investigating how men relate to and explain their use of violence have revealed that they often deny or minimize the severity of their violent acts. These men externalize the responsibility for these acts and blame the victim (Adams, Towns, & Gavey, 1995; Cavanagh, Dobash, Dobash, & Lewis, 2001; Henning, Jones, & Holdford, 2005; Flinck & Paavilainen, 2008; Goodrum, Umberson, & Anderson, 2001). In the context of therapy, these ways of relating to the perpetration of violence portray clients who have relatively insufficient insight into the self and the consequences of their violent actions for their partners. In addition, such client behavior could easily be understood as weak motivation for change (Alexander & Morris, 2008), and clients who undergo IPV counselling have been found to often express low motivation for change (Levesque, Gelles, & Velicer, 2000). These client characteristics are often general exclusion criteria for psychotherapy. Moreover, the harm to the victims – both women and children – caused by the violence might activate the therapist to take responsibility for ending the violence. However, changing a client's behavior is an impossible task for a therapist. The moral aspects of acting violently in intimate relationships

might also evoke negative feelings in the therapist toward the client (see Kozar & Day, 2012). These particular conditions highlight the difficulties faced by therapists in establishing a therapeutic alliance with clients in IPV therapy.

In Norway, psychotherapy began to be offered to men who acted violently in their intimate relationships in 1987. During this time, an outpatient clinic named Alternative to Violence (ATV) was established. ATV was the first IPV treatment program in Europe. This ambition to apply psychotherapy to men perpetrating IPV emphasized that because psychological change could not be forced upon a person, therapy must be voluntary. The core concept underlying the ATV clinic was to develop an approach in which the clients' use of violence was confronted in a supportive manner. This approach was based on the hypothesis that addressing the client's use of violence instead of ignoring the abuse (which was the tendency in society at that time) could help the men find alternatives to violent behaviors and create safer homes for women and children. Furthermore, confronting the men about their violent acts without support and empathy could challenge the development of a working alliance and enhance the risk of the client to dropping out from therapy (Räsänen, Holma, & Seikula, 2012a; Taft & Murphy, 2007). Both clinical experiences and empirical results have shown that male clients often drop out of IPV therapy (e.g., Daly & Pelowski, 2000; Jewell & Wormith, 2010), underlining the importance of finding efficacious ways to overcome the aforementioned challenges in engaging clients in therapy.

ATV's endeavor to develop a psychotherapy program specialized in ending violent acts has raised several questions over the past 30 years, including "what types of psychological needs do clients presenting for therapy have?" "How can therapy be adjusted to the specific needs of the client?" "How can therapists be more successful in engaging clients to undergo therapy?" and "what characterizes good and poor outcome therapy processes?" Because IPV therapy is a relatively new enterprise, studies in this field are not as extensive as general psychotherapy studies. For example, many more studies have focused on client characteristics than the process of IPV therapy. The outcome studies conducted have provided inconsistent results regarding whether clients benefit from the treatment. Moreover, while a few process and outcome studies have been conducted, very few studies have investigated individual therapy.

Consequently, ATV began to investigate their therapy for male clients to answer these questions. In response to this initiative, the Norwegian Centre of Violence and Traumatic Stress Studies (NKVTS), in collaboration with ATV, conducted a naturalistic process and outcome study named the ATV Therapy study. This study provided the opportunity to analyze

the associations among the client characteristics and different process and outcome variables. Furthermore, the data gathered allowed for an investigation of the events that occurred during the therapy sessions from the start to the end of therapy. Observations of therapist and client in-session interactions are suitable for identifying patterns in successful and unsuccessful alliance formations. In addition, such inquiry could clarify the ways in which a good alliance between the client and the therapist facilitate change throughout the course of therapy. The studies comprising this thesis are based on data from the naturalistic process and outcome study.

There is a need to unpack the process by which a working alliance is established at the beginning of IPV therapy. Furthermore, the process of change during therapy and how these processes eventually lead to a good treatment outcome must be investigated. To generate knowledge regarding how therapists can help men who perpetrate intimate partner violence engage in therapy and become safe husbands and fathers, I conducted a qualitative process study of *individual IPV therapy*. The individual therapy format is assumed to represent a rational and focused context for investigating alliance formation and change processes in client-therapist interactions.

Intimate Partner Violence: From a Social to a Clinical Phenomenon

As previously mentioned, the understanding of IPV has changed dramatically throughout history. Women's enduring fight for equal rights in different areas in society highlighted that violence against women represented a serious violation of the basic principles of human rights. Documentation of the prevalence of violence perpetrated in intimate relationships and the severe consequences of this violence to the victims clarified that IPV is a serious social and health problem, particularly for women and children. Furthermore, by moving the phenomenon to the clinical context, attention was drawn toward the man who acted violently, leading to more detailed descriptions and explanations of his psychology and therapeutic needs. To better understand men who perpetrate violence, another significant social change in contemporary Norway must be mentioned. Compared with earlier times, more men are currently actively involved in childrearing. Men are commonly expected to emotionally and practically engage in their children's lives (Haavind, 2006). Because both of these social changes are expected of men, these trends are relevant in developing theories about men perpetrating IPV and exerting effort to change these acts (Haavind, 2001; 2011).

Prevalence and Consequences of IPV

Studies have shown that violence against women is extensive. In a World Health Organization (WHO) multi-country study investigating women's health and experiences of domestic violence, women from 10 Asian, European, African, and South-American countries were interviewed. The prevalence of the victim experiences of physical partner violence throughout their lifetime varied considerably. Such abuse was reported by nearly 13% of women living in cities in Japan and 61% of the women living in the province areas of Peru (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). The researchers conclude the following: "The variation in prevalence within and between settings highlights that this violence is not inevitable, and must be addressed" (p. 1260, ibid.).

IPV is most often, but not exclusively, perpetrated by men and causes harm to women. In a cross-sectional study investigating Norwegian men and women aged between 18 and 75 years, a comparable number of men and women (15.3%) reported having experienced 'less severe' physical violence (pinching, scratching, hair pulling or slapping) from a romantic partner/ex-partner during their lifetime. However, significantly more women (8.2%) than men (1.9%) have been exposed to severe physical violence (kicked, strangled, or beaten up) from a romantic partner/ex-partner (Thoresen & Hjemdal, 2014). In a similar survey conducted in the United States in 1995/96, 20.4% of the women and 7.0% of the men reported physical assault by a current or former opposite-sex partner during their lifetime (Tjalden & Thoennes, 2000).

Both physical and psychological IPV are associated with significant physical and mental health consequences in both male and female victims (Campbell, 2002; Coker et al., 2002). Physical IPV victimization has been associated with an increased risk of depressive symptoms, substance abuse, and the development of a chronic disease, chronic mental illness, and injury (ibid.). Because women appear to be more exposed to severe physical IPV than men, women have a higher risk of poor health. For example, Tjalden and Thoennes (2000) found that women reported more fear of bodily injury, time lost from work, physical injuries, and use of medical, mental health, and justice system services than men.

Furthermore, witnessing domestic violence in childhood enhances the risk of boys perpetrating IPV and girls becoming exposed to IPV as adults by approximately two-fold (Whitfield, Anda, Dube, & Felitti, 2003; Smith-Marek et al., 2015). Studies investigating the intergenerational transmission of IPV (Ehrensaft et al., 2003), the high prevalence of intimate partner violence, and the severe consequences of IPV emphasize the need to help both the victims and perpetrators of IPV. Thus, psychotherapy for men acting violently against their

female partners is an important intervention to end current and future violence against both women and children.

Intimate Partner Violence

Different terms, such as domestic violence, family violence, battering, interpersonal violence and spousal abuse, are often used in the field of IPV (Devaney & Lazenbatt, 2016). The different concepts are employed interchangeably even though they stem from different theoretical orientations (ibid.). I use the term intimate partner violence because this term most closely captures the topic of interest, i.e., male clients perpetrating violence against their female partners. However, although this term is used, it is not my intention to ignore the fact that most male clients at ATV are fathers, indicating that their children either witness or are directly exposed to the violence.

The types of actions captured by the concept of IPV are typical acts of *physical violence,* such as hitting, kicking, and choking (severe) as well as slapping, pushing, and pinching (moderate). Furthermore, IPV refers to *psychological/emotional violence*, such as threats, harassment, humiliation, and controlling the partner's activities, and *property violence*, such as hitting the wall/door and destroying objects. *Sexual violence*, such as rape and sexual harassment, is another type of IPV. All of these acts are included in the definition of domestic violence by the Council of Europe's Convention on preventing and combating violence against women and domestic violence as follows:

All acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses for partners, whether or not the perpetrator shares or has shared the same residence with the victim. (Council of Europe, 2011)

The emotional dependency that exists between the perpetrator and the victim is a specific and vulnerable aspect of IPV. The clinical cases treated by therapists at the ATV clinics include male romantic partners who perpetrate different types of violence against their female romantic partners, often in the context of raising children. Thus, violence is perpetrated in a heterosexual relationship in which the man and woman stay together due to love and shared parenting. Furthermore, their common goals are to show each other understanding and affection and build a durable relationship (Haavind, 2000a).

Violence perpetrated in an intimate relationship will always, even if it occurs only once, be perceived as a violation of the basic principles of a love relationship (Hydén, 1994; Skjørten, 1994). Furthermore, this violence is a violation of the standards of a good father. This type of masculine dominance no longer has any legitimacy in contemporary Norway for

either her or him. Following the first occurrence of a violent act, the man can process the event by taking full responsibility for his actions and ensuring that the act will never occur again. The couple can dismiss a one-time violent event under very specific conditions (e.g., stress or use of alcohol) as an exception to their typical expression and resolution of their differences. Under such circumstances, the woman can forgive her partner's behavior, and thus, the balance of their relationship can be reestablished.

However, repeated violent acts and the breaking of the promise that 'it will never happen again' are clear violations of positive masculinity. The man becomes a manifestation of negative masculinity both to himself and others. This phenomenon calls for broader explanations than special circumstances and an exception. To understand the phenomenon of the repeated use of IPV, researchers have studied the characteristics that distinguish these men from men who do not perpetrate IPV (Chase, O'Leary, & Heyman 2001; Gottman et al., 1995; Hamberger, Lohr, Bonge, & Tolin, 1996; Holthzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000; Holthzworth-Munroe & Meehan, 2004; Holthzworth-Munroe & Stuart, 1994; Langinrichsen-Rohling, Huss, & Ramsey, 2000; Tweed & Dutton, 1998; Waltz, Babcock, Jacobson, & Gottman, 2000; White & Gondolf, 2000). Furthermore, the interaction and dynamics of a violent intimate relationship, accounting for violent acts perpetrated by both parties, have been examined (Johnson, 2006; Johnson & Leone, 2005).

Generally, these typologies/categories highlight that IPV ranges in comprehensiveness and severity. These typologies have been used to explain the occurrence of intimate partner violence and determine the types of treatments that could be suitable for specific clinical cases (e.g., Stith, McCollum, Amanor-Boadu, & Smith, 2012; Antunes-Alves & Stefano, 2014).

Theoretical Models of IPV

Scholars have proposed a variety of theoretical models explaining the occurrence of IPV and the best methods to respond and stop the use of violence. These models are often categorized as sociocultural, interpersonal or systemic, and intrapersonal models (Finkel & Eckhardt, 2011; Murphy & Eckhardt, 2005). As illustrated by the names of the models, structural, relational, and individual or biological aspects are emphasized to explain the development and maintenance of IPV (Devaney & Lazenbatt, 2016). Furthermore, these models advocate treatment approaches that are closely related to their explanations of IPV.

The sociocultural model emphasizes that certain cultural norms increase the likelihood of IPV. Thus, this model constructs IPV as a social phenomenon (Dobash, Dobash, Wilson, & Daly, 1992; Pence & Paymar, 1993; Walker, 1984). Proponents of this model assert that men, in particular, learn dominant tactics (patriarchal norms) both from their family of origin and

society and that men's violence is a way of controlling the behavior of their partners (Pence & Paymar, 1993).

According to the systemic models of IPV, the context for understanding assault is the intimate relationship rather than society and its cultural norms. IPV is considered an interactional phenomenon that results from dysfunctional interactions (negative emotions and communication) within the family or couple (Stith et al., 2012).

Finally, the individual models consider IPV a result of certain specific characteristics of the individual. Empirical knowledge regarding the risk factors, such as childhood exposure to violence (Murrell, Christoff, & Henning, 2007; Whitfield et al., 2003; Smith-Marek et al., 2015), attachment styles (Babcock, Jacobson, Gottman, & Yerington, 2000; Dutton, 2006), alcohol/drug abuse (Leonard & Quigley, 1999; White & Chen, 2002), and psychological disorders, such as depression (Feldbau-Kohn, Heyman, & O'Leary, 1998; Kessler, Molnar, Feuer, & Appelaum, 2001), PTSD (Dutton, 1995; Taft, Kaloupek, Schumm, Marshall, Panuzio, & Keane, 2007; Taft, Watkins, Stafford, Street, & Monson, 2011) and personality disorders (Birkley & Eckhardt, 2015; Dutton & Starzomski, 1994; Hamberger & Hastings, 1986; Saunders, 1992), are used to explain why certain men are at a higher risk than others of acting violently. Acting violently is defined as a tendency that is situated inside the individual, and the context of the violence is ignored. The individual model clearly constructs IPV as a clinical phenomenon.

The debate related to considering IPV a social phenomenon as opposed to a clinical/psychological phenomenon is controversial. The sociocultural model warns against theories that ignore the client's intent and instead focus on violence as a result of stress or anger, an inability to express feelings, or childhood traumas. This focus hinders the male client from taking responsibility for his actions and, thus, changing them (Pence & Paymar, 1993). In contrast, the proponents of the individual model assert that constructing IPV as an attitudinal problem reduces the complexity of the problem and ignores the psychology of abusiveness (Dutton & Corvo, 2006). The therapist must attend to the client's psychological needs to help him relate differently in intimate relationships.

Even though a single model of IPV cannot capture the whole complexity of the phenomenon, all models contribute significantly. When tasked with developing therapeutic approaches that successfully engage these men in therapy, drawing upon all three models is useful. We need to explore/understand the way in which the male client with his difficulties and recourses tries to construct himself as a man in relation to his female partner. What is the man trying to accomplish? What is at stake in his relationship with his female partner?

Therapeutic Interventions

The different theoretical models of IPV have inspired the development of various treatment approaches. However, most IPV treatments are based on two major models (Eckhardt, Murphy, Black, & Suhr, 2006). The most frequently offered intervention in the USA is based on the sociocultural explanation of IPV (Duluth model). This treatment program educates men about patriarchal attitudes and becoming more egalitarian toward their female partner (Pence & Paymare, 1993). The other major intervention is based on cognitive behavioral therapy (Murphy & Eckhardt, 2005). This model considers IPV to be learned behavior and attempts to change the men's faulty cognitions and emotions and help them develop more appropriate social and relational skills (Eckhardt et al., 2006). Because both approaches seek to clarify and change the clients biased attitudes, beliefs or information processing styles and help the client take responsibility for and change his violent actions, these approaches have several common features, and distinguishing these approaches could be challenging (Babcock, Green, & Robie, 2004; Healey, Smith, & O'Sullivan, 1998). However, the Duluth approach is considered more didactic with a lesser focus on emotion regulation, relational skill building, long-term effects of childhood traumas and other individual psychological problems than the cognitive-behavioral model (Eckhardt et al., 2006; Murphy & Eckhardt, 2005). Thus, these models have become representatives for both educational and therapeutic approaches.

These two approaches are inconsistent in terms of whether to apply or avoid confrontational interventions. The educational approach claims that therapists must confront their clients' denial of violence and tendency to blame the victim to help them become aware of their attributional errors (Pence & Paymar, 1993), while the therapeutic approach argues that these confrontations could prevent alliance formation (Dutton & Corvo, 2006; Mankowski, Haaken, & Silvergleid, 2002; Murphy & Baxter, 1997; Räsänen et al., 2012a; Taft & Murphy, 2007). However, all IPV treatment programs are confrontational because they consider IPV to be wrong, and the main goal of the program is to end violence. This is in clear contrast to therapies that are more supportive in encouraging the client to discover his needs and goals for therapy (Gondolf, 2007). If confrontation is defined as addressing violent behavior, whether IPV treatment should be confrontational is not a valid question. The question becomes "how should violence be addressed to engage clients to undergo therapy?"

The finding that the therapeutic relationship is important for a good outcome (Horvath, Del Re, Flückiger, & Symonds, 2011) emphasizes that violence must be addressed in a way that enhances the client's experience of being treated respectfully in an understanding manner.

Therefore, the above-mentioned questions may be addressed by studying how male clients and their therapists approach violence to find a way to end it.

Conducting psychotherapy at ATV. The outpatient clinic ATV has had the goal of combining gender political[1] and psychotherapeutic principles to help male clients end their violence. Thus, the therapeutic method emphasizes that violent behavior must be exposed. However, this exposure must be performed supportively to develop a good alliance. The model emphasizes four therapeutic principles that are important to address during the course of therapy. First, the clients must be helped to disclose and acknowledge their violent behavior. This principle is anchored in the understanding that the client's experience of responsibility for and ownership of his violent actions is a necessity to change this behavior. Second, practice behavioral, cognitive, and emotional assignments are performed to help the clients regulate their anger and violent acts and develop and expand their relational and social skills. Third, investigating, clarifying, and elaborating on the clients' life experiences that relate to their violent behavior are performed. This principle is rooted in the understanding of the importance of creating a cohesive self-narrative. The finale principle is the exploration of the clients' understanding of the implications of their violent acts for themselves and particularly for those who are exposed to the violence (for a more detailed description of the treatment, see Råkil, 2002).

Because clients who perpetrate violence constitute a heterogeneous group, each therapy process is individually adjusted and has no time limit. To meet the diversity of the clients' psychological needs, the ATV model has integrated techniques and ideas from therapeutic approaches, including cognitive behavioral therapy, emotion focus therapy, and trauma work. This model is a form of assimilative integration (Stricker & Gold, 2003) that allows the therapist to use the approaches that appear useful but always in the framework of addressing the topic of the perpetration of violence.

The State of Knowledge in Therapy for Men Perpetrating IPV

Most published studies investigating IPV interventions are conducted based on group programs (Babcock et al., 2004). In a recent review of the current state of knowledge regarding IPV interventions, only 3 of 30 studies included individual interventions (Eckhardt et al., 2013). All interventions were short-term motivational interventions (1-2 sessions) employed at the beginning of therapy (Kistenmacher & Weiss, 2008; Mbilinyi et al., 2011;

[1] IPV was defined as a problem "belonging" to men that caused severe health problems for women. To emphasize the gender political position and confirm that men rather than women should be responsible for ending men's violence against women, only male psychologists were employed.

Musser, Semiatin, Taft, & Murphy, 2008; Taft, Murphy, Elliott, & Morrel, 2001). In contrast, general psychotherapy studies investigating behavioral problems are mostly based on individual therapy approaches.

The lack of studies exploring individual therapy is likely best explained by the fact that in several states in the USA, the group format is the required treatment, and individual therapy is recommended only under specific circumstances (Austin & Dankworth, 1999). These formatting specifications are likely due to practical issues, such as reaching more men than would be reached in individual therapy. In addition, the group format is considered particularly suited for taboo and shameful problems. Meeting other men struggling in similar ways may prevent the feeling of being alone and facilitate connectedness and courage to change (Yalom & Leszcz, 2005). Group therapy conducted as a "one-size-fits-all" intervention may not be as flexible as individual treatment in meeting the clients' great variation in expectations and readiness to change (Alexander & Morris, 2008; Kistenmacher & Weiss, 2008; Levesque, Gelles, & Velicer, 2000) and their psychological difficulties (Askeland & Heir, 2014; Dutton, Bodnarchuk, Kropp, Hart, & Ogloff, 1997; Gondolf, 2002; Murphy, Morrel, Elliott, & Neavins, 2003).

Murphy and Meis (2008) assert that the development of interventions for men acting violently against their female partners has bypassed the development of individual treatment that is usually needed to support the adaption of a group format. Furthermore, the development of group programs "has been hampered by the simultaneous need to address social and political concerns in the field, complex group processes, and technical implementation of interventions methods" (p. 175). Consequently, studying the process and outcomes of individual therapy provides an opportunity to gain important knowledge regarding the mechanisms of change in IPV therapy.

Outcomes of IPV group therapy. The outcome of IPV group therapy is usually measured by either client or partner reports regarding the occurrence and frequency of different types of violent acts. Partner reports are included due to the knowledge that clients might underreport their violent acts both because they are court-ordered to treatment and because of the shame associated with perpetrating violence (Armstrong, Wernke, Medina, & Schafer, 2002; Strandmoen, Askeland, Tjersland, Wentzel-Larsen, & Heir, 2016). In addition, police reports of new violent acts have been used to measure the outcome of treatment. These measures are obviously imprecise and most likely invalid in measuring the reduction in violent acts in intimate relationships.

A few randomized controlled trails (RCTs) investigating the effectiveness of IPV group treatment have been conducted. Smedslund and colleagues (2011) conducted a meta-analysis of the effectiveness of CBT group programs (both Duluth and CBT groups) in reducing male-to-female violence. These authors included four studies comparing treatment conditions with a control group (Taylor, Davis, & Maxwell, 200; Dunford, 2000; Feder & Dugan, 2002; Labriola, Rempel, & Davis, 2008) and two studies comparing CBT group programs with other therapy programs (Easton, 2007; Saunders, 1996). All studies were conducted in the U.S. Only one RCT study showed a significant positive effect of the treatment condition (Taylor, Davis, & Maxwell, 2001). The effect of treatment was positive when the outcome was measured by police reports of new violence at the 6- and 12-month follow-ups after treatment. However, when the outcome was measured by partner reports of the reoccurrence of violence, the difference between the treatment and control conditions was not significant. Due to these findings and the limited number of studies included in the meta-analysis, the researchers concluded that evidence regarding the effect of IPV treatment programs is lacking; in addition, whether these interventions are helpful, have no effects or are harmful is unknown (Smedslund, Clench-Aas, Dalsbo, Steiro, & Winsvold, 2011). These findings are consistent with the results of other meta-analyses of outcome studies of IPV therapy (Babcock et al., 2004; Eckhardt et al., 2013; Feder & Wilson, 2005).

Several reasons could explain the lack of evidence of a good outcome, including some related to methodological issues (e.g., design of the study or measurement of violence) and the specific conditions under which the IPV group therapy is conducted (court-ordered treatment or training of counselors) (see Babcock et al., 2004). However, these reviews of the effectiveness studies provide limited insight into how IPV therapy leads to change. Therefore, to develop effective IPV treatments, investigating how the different processes of therapy relate to the treatment outcome is important.

The working alliance and IPV therapy. The working alliance is among the most frequently scrutinized phenomena in psychotherapy studies. This interest can be traced to scholars' efforts to understand how and why psychotherapy is effective and findings that different psychotherapy approaches yield similar beneficial effects on the clients (Horvath, Del Re, Flückiger, & Symonds, 2011; Wampold & Budge, 2012). Bordin's trans-theoretical working alliance construct is the most commonly used description of alliance (Bordin, 1979, 1983, 1994).[2] Bordin suggested that the working alliance consists of the following three

[2] The concepts of working alliance and therapeutic alliance appear to be used interchangeably in studies investigating alliance. If I could purpose a distinction between these two concepts, it would be that the working

interdependent components: agreement on the treatment goal, agreement on the task for therapy, and the emotional bond (trust and respect) between the client and the therapist. Bordin emphasized the collaborative and consensual components of the relationship. The concept "alliance describes the degree to which the therapy dyad is engaged in collaborative, purposive work" (Hatcher & Barends, 2006).

Meta-analyses have repeatedly found a positive relationship between the quality of the alliance and diverse outcomes in different types of psychological therapies and that effective alliances are established relatively early in treatment (Horvath et al., 2011, Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Orlinsky, Rønnestad, & Willutzki, 2004). In contrast to general studies conducted in the field of psychotherapy, few studies investigating the relationship between the alliance and different outcomes of IPV therapy have been conducted, and these studies have several limitations.

All available studies focused on group therapy. The formation of a working alliance in group therapy likely develops differently than the alliance formed between a therapist and a client (Horvath & Symonds, 1991). For example, in the group format, the therapists intervene to enhance the relationship among the group members (group cohesion) to ensure that the group setting is a safe therapeutic arena rather than to form a strong alliance with each individual (Kozar & Day, 2012). The findings of one study underline the following differences: the clients' ratings of the group cohesion, but not of the alliance with the therapist, predicted the outcome of therapy (Taft, Murphy, King, Musser, & DeDeyn, 2003). Another limitation of alliance studies in the field of IPV therapy is that several studies rely on a third party's (the partner) perception of change (outcome) rather than on the client's report. Due to the "halo effect", the client's rating of the alliance is expected to be less correlated with the partner's outcome reports than with his own reports of change (Wampold & Imel, 2015). A final limitation is that these studies mostly involve clients who are court-mandated to therapy, which might influence the way the clients rate the alliance. Despite these shortcomings, these studies have provided evidence that the client's perception of the alliance is important for the outcome of therapy.

In one study, the researchers found that an observer's ratings of the male clients' working alliance during the first session predicted the reduction in the use of psychological and

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alliance emphasizes the process of the initial alliance formation and that the concept of therapeutic alliance highlights how this early consensual and collaborative relationship unfolds throughout the course of therapy in a way that involves client change. However, the formation of a working alliance is not necessarily therapeutic, but it is a necessary aspect of the therapeutic process (Horvath et al., 2011).

physical violence at the end of treatment (Brown and O'Leary, 2000). In addition, in interviews with male clients who dropped out of therapy, the most frequently presented reason is that their goals for treatment were not being met by the therapists (Brown, O'Leary, & Feldbau, 1997). In another study, the clients' ratings of the alliance after the fourth group session positively predicted the completion of the treatment program (Rondeau, Brodeur, Brochu, & Lemir, 2001).

Furthermore, a study involving 107 mostly court-mandated men found that the therapist's, but not the client's, early ratings of the alliance predicted certain types of post-treatment abuse as reported by the female partners (Taft et al., 2003). This finding is contradictory to findings in general psychotherapy in which the clients' ratings of the alliance predict the outcome better than the therapist's ratings (Horvath & Symonds, 1991). These court-ordered clients likely evaluated the therapist relationship as positive due to fears of negative reports to their probation officers. Hence, these early ratings disrupted a possible relationship between the clients' evaluation of the alliance and the outcome (Taft et al., 2003)[3]. In fact, a further analysis of the same sample demonstrated that the clients' alliance ratings reliably increased across sessions and that the growth in the alliance ratings predicted the treatment outcome at the six-month follow-up (Walling, Suvak, Howard, Taft, & Murphy, 2012).

Researchers have also investigated the influence of the client characteristics on alliance formation. For example, Walling and colleagues (2012) found that Caucasian clients reported a significant increase in the alliance ratings over time, whereas clients of minority backgrounds did not report significant changes in the alliance over time. Their interpretation of this finding was that the treatment studied was more adjusted to fit clients with majority than minority backgrounds. Additionally, due to cultural meanings of psychological treatments or stressful lives, male clients with a minority background likely struggle more than Caucasian clients in finding the collaboration with the therapists meaningful.

In addition, the clients' readiness to change has been found to be a strong predictor of the clients' early working alliance ratings (Taft, Murphy, Musser, & Remington, 2004), which emphasizes the importance of the clients' initial expectations of therapy. In fact, motivation-enhancing interventions early in therapy have positive effects on the clients' treatment completion, decrease the dropout rates, and improve in-session engagement (Crane & Eckhardt, 2013; Crane, Eckhardt, & Schlauch, 2015; Kistenmacher & Weiss, 2008; Musser &

[3] In fact, the clients' early ratings of the group cohesion predicted the reduction in physical abuse at follow-up, which might be explained by the possible difference in the alliance development between individual and group therapy mentioned above.

Murphy, 2009; Musser, Semiatin, Taft, & Murphy, 2008; Scott, King, McGinn, & Hosseini, 2011; Taft, Murphy, Elliott, and Morrel, 2001).

Collectively, these findings emphasize that the client's experience of the collaboration with the therapist is important for whether he will benefit from therapy. Furthermore, clients' self-reports of the alliance early in therapy might not be the best measurement of how useful he finds the collaboration with the therapist, at least not in mandatory treatments. Therefore, therapists should rely on a broader set of observations to assess the initial alliance. Finally, the findings clarify that several therapist characteristics and interventions might hinder an alliance with groups of clients (e.g., white majority therapists meeting minority clients), which highlights the importance of adjusting the treatment approach based on the client's needs and readiness for change.

Dropouts in IPV therapy. Dropping out of therapy might be an indication that the client did not find the alliance with the therapist beneficial. In IPV therapy, many male clients drop out (Rondeau et al., 2001). In a meta-analysis, the dropout rates from IPV treatments ranged from 22% to 78% (Jewell & Wormith, 2010). The large range in the dropout rates is partly due to the way the dropout rates are measured. For example, the definition of dropout might include pre-assessment, pretreatment, or in-treatment attrition. Dropouts during the therapy might include both early dropouts (during the 5 first sessions) or dropouts at any time during the treatment. Furthermore, comparing the dropout rate in a voluntary sample with that in a mandatory sample is difficult. Due to the consequences of dropping out from a mandatory program, court-ordered men can be expected to complete the treatment more often than self-referred men. Several studies support this hypothesis (Rosenbaum, Gearan, & Ondovic, 2001; Jewell & Wormith, 2010). Notably, completing a treatment intervention does not automatically assure a good outcome.

However, an increased risk of recidivism has been observed among clients who drop out of therapy (Daly & Pelowski, 2000; Gondolf, 1997). To obtain more knowledge regarding the risk factors of dropping out, client characteristics, such as demographic variables, and violence-related and intrapersonal factors have been studied (Daly & Pelowski, 2000). For example, men who are employed and older appear to complete treatment more often than men who are unemployed and younger (see, e.g., Jewell & Wormith, 2010). In a previous study of voluntary men clients at ATV, nearly one in four men dropped out before the forth session. Young men, men with an ethnic minority background, men without prior therapy experiences, and men who were seen by a psychology student therapist were particularly vulnerable to dropping out of therapy (Askeland & Heir, 2013).

These findings can help therapists identify clients who might be at a risk of dropping out. However, these studies do not provide insight into the ways by which therapists can engage different clients to undergo treatment. As previously mentioned, motivation-enhancing interventions that are tailored to the client's readiness to change have been shown to increase client engagement in therapy. Hence, scrutinizing what the clients might offer as invitations to a working alliance during the initial phase of therapy and how therapists can be responsive to such invitations appear warranted. One way to reduce the dropout rate in IPV therapy could be to obtain knowledge regarding the ways in which therapists and clients overcome the challenges to establishing a collaborative alliance for changing violent behavior.

Understanding How IPV Individual Therapy Leads to Change

As outlined above, outcome studies investigating IPV therapy do not appear to offer much information regarding the effect of therapy. Additionally, outcome studies are not designed to obtain information regarding how the activity in therapy can shed light on the changes that occur in the real world (Levitt, Butler, & Hill, 2006). Significant questions that are not answered by such studies include the following: how do clients and therapists interact to form a viable alliance? What types of skills or perspectives are developed during therapy that might help the client relate non-violently in intimate relationships?

Client's experiences of change. To investigate how IPV therapy works, researchers have interviewed clients about the way they changed their violent behavior and how therapy facilitated this change. Collectively, several studies exploring male client's experiences of change have highlighted increased responsibility for prior abusive behavior, the development of empathy toward their partners' victimization, reduced dependency on the partner, and increased self–awareness and communication skills. (Gondolf & Hanneken, 1987; Holtrop et al., 2015; Scott & Wolfe, 2000; Silvergleid & Mankowski, 2006; review see Sheehan, Thakor, & Stewart, 2012; Wangsgaard, 2001). Concerning facilitating processes in IPV group therapy, the clients emphasized the therapists' engagement and competence in running the group and the balance between support and confrontation among the group members. These patterns in the clients' accounts of their change processes in therapy can guide therapists regarding the topics that should be addressed and the processes that should receive attention. However, obtaining more information regarding how responsibility or empathy is developed throughout the course of therapy and the way in which the therapist and the client achieve a good balance between support and confrontation is needed.

Studying in-session processes. Performing observations of the ongoing interaction between the client and therapist is a suitable approach for answering the above-mentioned

questions. At the University of Jyväskylä in Finland, a group of researchers conducted a considerable number of qualitative studies investigating in-session interactions in group therapy. Even though the dialogs studied were obtained in the context of group therapy, the results highlight several specific challenges that must be addressed by the therapists in IPV therapy and aspects that appear to be healing and hindering. Räsänen and colleagues conducted a series of studies that are particularly interesting for the framework of the present qualitative process study (Räsänen, Holma, & Seikkula, 2012a; 2012b; 2014). Concerning confrontational and supportive therapist interventions, the researchers found that therapists used confrontational and challenging talk in conversations addressing violent incidents. However, the therapists used softer, more supportive and relationship-focused interventions in addressing the client's traumatic experiences and stressors (Räsänen et al., 2012a). In another study, the authors found that the dialogs in the good outcome cases were characterized by a greater exchange and an exploration of the participants' meanings and equality in listening and responding between interlocutors than those in the poor outcome cases (Räsänen et al., 2012b). Moreover, the poor outcome clients showed more difficulties than the good outcome clients in the transition from descriptions of a concrete situation to a more abstract reflection of the client's feelings and thoughts. These findings suggest that particular interactional characteristics might be associated with the therapy outcome. A study comparing good and poor outcome cases supported this assumption. This study indicated that clients participated in group therapy with considerable different levels of motivation, and the interaction within the clients' various stages of change was characterized by different qualities (Räsänen et al., 2014). During the stages of change that characterized the good outcome cases, more dialogical responding, client activity in the conversations, and talk at the symbolic level of meanings were observed. In contrast, the stages most often detected in the poor outcome cases were characterized by monological responding, therapist dominated conversations, and talk at the indicative level of meanings (ibid.).

Collectively, this study illuminated that the strategies used by therapists to approach the topic of violence differ from those used to approach other topics, such as trauma experiences. Furthermore, even though therapists respond differently to clients who express more or less motivation for change, the therapists did not succeed in enhancing the clients' motivation. These findings emphasize the importance of further studying the interactions between the client and therapist to illuminate the patterns in the therapist strategies that facilitate or hinder the formation of an early alliance.

How the alliance can create change in IPV therapy. Even though a strong early alliance predicts client change, more knowledge regarding how the alliance creates client change is needed. Wampold and Budge (2012) developed a tripartite model illustrating how the alliance creates change in psychotherapy. This model serves as a framework for an understanding of the different challenges and possibilities faced by the male client and therapist in individual IPV therapy in establishing a working alliance and developing personal change.

The model starts with the *initial therapeutic bond,* which creates a certain level of basic trust between the client and the therapist. This bond is proposed to be a prerequisite for the client to stay in therapy and engage in therapeutic work. The male client is expected to enter IPV therapy with a negative image of his masculine identity. He may be influenced by emotions of shame and may rationalize his violent actions to defend his dignity and protect against the therapist's rejection. Additionally, even clients who present voluntarily to therapy might have been pressured by their partner or child protection services to seek help. Such coercion most likely negatively affects the client's expectations of the therapist. These are the first challenges faced by therapists in forming basic trust with the client. The therapist must look beyond the client's strategies of defense and search for the client's needs that can identify a common ground to change their violent behavior.

After the initial bond is formed, the alliance can follow three pathways to create change. The first pathway is the *real relationship* (Gelso, 2002, 2009, 2014; Gelso & Carter, 1994). A personal connection to another person who invests in ones' well-being is assumed to be health promoting. Many clients struggle with being honest and authentic in disclosing violent acts and events. This struggle might create a distance from the therapist and prevent the feeling of connectedness. The model circle of empathy (Barrett- Lennard, 1981) proposes that the client must let himself be known (disclose relevant material) for the therapist to develop a certain level of empathy (McLeod, 1999). Some clients perpetrating violence have difficulties in letting themselves be known not only in the beginning of therapy but also when they act violently between therapy sessions. The therapist must find ways to convey the pain caused both to the victims and the client by the violent act to appear genuine. The therapist must not blame the client or minimalize the violence. If both parties are honest and authentic, belongingness and social connection can develop, and the reparation of ruptures in the relationship might be perceived as corrective experiences and further strengthen the relationship (Wampold & Budge, 2012).

The second pathway of the alliance focuses on the client's *expectations* of being able to cope with and solve the problems that brought him to therapy. These expectations are developed through the therapist's adaptive explanations of the problem and its possible solutions and might become healing if the explanations make sense to the client. The challenge in the second pathway is that clients typically present with an understanding of their problem that does not allow for therapeutic solutions. For example, male clients may explain that their violent acts are due to the partner's provocative behavior and that they need to defend themselves. The partner who is not in therapy cannot be changed. The more adaptive explanations of the violent acts might be the client's way of perceiving and understanding their partner's and their own contributions to their interaction, childhood feelings that are triggered, or difficulties in asserting his needs appropriately. The therapist must portray the violence as the client's personal problem without being perceived as a person who does not understand the client or who sides with the partner. This pathway covers the process of agreement on the goals and tasks for therapy.

The third pathway involves specific *health-promoting activities* that are offered in all types of therapeutic approaches, and via this pathway, the alliance fosters change. A variety of health activities across different psychological difficulties are found to be therapeutic (Wampold, 2007), and therapeutic tasks that target specific symptoms appear to create change in the targeted symptoms (Wampold & Budges, 2012). However, whether the specific tasks function as change mechanisms for specific problems or whether a myriad of healthy activities can function as change mechanisms for numerous mental disorders remains unclear. The most commonly offered health-promoting tasks in IPV therapy include regulating affect (emotional awareness, tolerance, and time-out), replacing maladaptive attributions with adaptive attributions, developing social and relational skills (listening skills and appropriate assertiveness) and enhancing the mentalization of the self and the other. However, knowledge regarding how these tasks are delivered through the course of therapy and how they facilitate changes in violent behavior is lacking.

Studies investigating the significance of an early alliance and the high dropout rate in IPV therapy suggest that exploring the events that occur between the client and the therapist during the first few sessions is warranted. In particular, by studying the micro-processes that occur during the early sessions of therapy, we may be able to identify patterns of successful and unsuccessful alliance formation. Furthermore, because the outcomes of IPV therapy are equivocal, studying client change and facilitative interactions as they unfold within sessions and across sessions throughout the course of therapy in good outcome cases might be helpful.

These patterns of alliance interaction and client change may add to our knowledge regarding how to engage men perpetrating violence in therapy and enhance the possibility of obtaining good outcomes because the observed patterns are situated in the moment-to-moment process of therapy and, thus, can guide therapists in their ongoing dialog with their clients (Levitt, Neimeyer, & Williams, 2005).

Design of the ATV Therapy Study

After developing and conducting a psychotherapeutic approach to IPV over a nearly 25-year period, ATV took the initiative to evaluate its approach. NKVTS designed and conducted a naturalistic process and outcome study to obtain knowledge regarding the relationships among client characteristics, therapeutic processes, and the ways in which clients benefitted from undergoing this treatment. In the naturalistic process and outcome study, the data regarding the client characteristics were collected at the intake assessment, and the outcome and process variables were measured throughout the course of therapy and at follow-up. Between January 2010 and July 2011, all male clients who presented for therapy were asked to participate in the study. Those clients who agreed to participate were asked for permission to allow the researchers to contact their intimate partners.

The present qualitative inquiry is based on data collected during the treatment process in the context of both poor and good outcome cases.

Population of the ATV Therapy Study

During the inclusion period, 222 men contacted the clinics and were assigned to an intake assessment. Twenty-two men did not show up for the assessment, and 11 men were referred to other outpatient treatments after the assessment due to severe psychological disorders or substance addiction. Of the 189 men scheduled to undergo treatment, 141 men provided consent to participate in the process and outcome study. Forty-two men allowed the researchers to study their intake data but did not approve to participate in the process and outcome study. Five men did not consent to participate in either the assessment or the process and outcome study. Finally, one man was excluded from the study due to a deficiency in Norwegian language skills (see app., figure 1). Of the 141 men who participated in the process and outcome study, 26 men did not enter the first therapy session, resulting in 115 men who participated in at least one session of either group (31 men) or individual (84 men) therapy. Because the focus of the qualitative process study is on individual therapy, the population of 84 men participating in this therapy format will be further discussed.

The therapy processes were defined by the therapist as complete when the client and therapist had agreed that the client had benefited from therapy and could stop treatment. A case was defined as a dropout by the therapist when the client ended the treatment prematurely, and the therapist did not assess the process of ending violence as complete. This definition of dropout is very wide because it includes all clients who dropped out at any time during the treatment. According to this definition, of the 84 men undergoing individual therapy, 53 men dropped out, and 31 completed the therapy. The clients who dropped out attended on average 7.6 sessions (range = 1-34; Sd= 7.2 sessions). Because the aim of this study was to explore early alliance formation, dropout was defined as the ending of therapy by the client before or during the 5th session. According to this definition, 29 (34.5%) clients dropped out of individual therapy.

Fifteen therapists participated in the process and outcome study. All therapists were clinical psychologists who were trained and skilled in IPV therapy. The therapists had on average 7.4 years (range 1-23) of experience in IPV therapy and 9.4 years (range 3-23) of experience as a clinical psychologist.

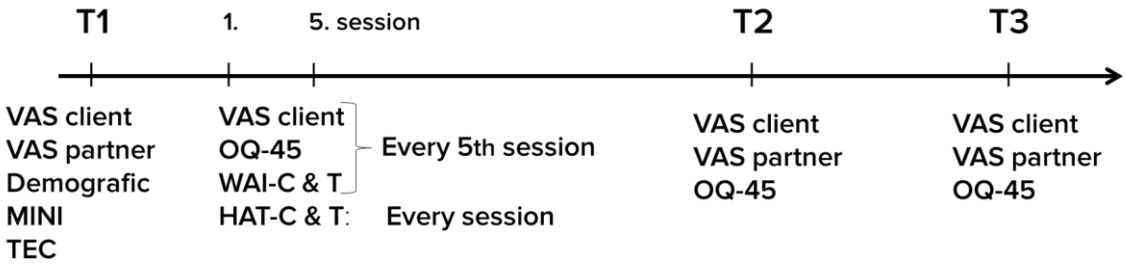
Measurements

At *intake,* the participants' demographics, perpetration of violence (Shortened version of the Violence Questionnaire [VQ], (Askeland, Evang & Heir, 2011) called Violence Alcohol & Substance abuse Questionnaire [VAS], (Strandmoen et al., 2016), trauma experience (Traumatic Experiences Checklist [TEC]; Nijenhuis, Van der Hart, & Kruger, 2002), and psychological disorders (Mini International Neuropsychiatric Interview [MINI], Lecrubier et al., 1997) were assessed by two clinical psychologists experienced in IPV therapy.

For the 84 men undergoing individual therapy, the *outcome* of therapy, i.e., perpetration of violence and mental health distress, was measured at the intake assessment (T1), after the first session of therapy, after every fifth session, at the end of therapy (T2), and, finally, at the 18-month follow-up (T3). The perpetration of violence was measured using the VAS-client and VAS-partner Questionnaire (Strandmoen et al., 2016). Mental health distress was measured using the OQ-45 (Lambert et al., 1996). Both client measurements were self-reports. The partners' reports of violence were attained by phone interviews at T1, T2, and T3. During the post-treatment assessment of the outcome, both the client (at T3) and the partner (at T2 and T3) were asked to shortly describe the client changes or lack of changes after participating in therapy.

The *therapy process* was captured by audio recordings of all therapy sessions. In addition, the therapeutic alliance was measured using the working alliance inventory (WAI-SR,

Hatcher & Gillaspy, 2006), which was completed by both the client and the therapist during the first therapy session and then every fifth session. Furthermore, both parties evaluated each session using a modified version of the Helpful Aspects of Therapy form (HAT; Llewelyn, Elliott, Shapiro, Firth, & Hardy, 1988). The client evaluated whether the session had been beneficial to him on a scale from 0 (low) to 5 (high) and described what might have been/not have been helpful during the session. The therapists answered questions regarding the significant themes during the session and whether anything had changed for the client or in the therapist's relationship with the client.



Findings from the Assessment Data

The findings of two international papers (Askeland & Heir, 2014; Strandmoen et al., 2016) and one Norwegian report (Askeland, Lømo, Strandmoen, Heir, & Tjersland, 2012) based on data from intake assessments (N= 184) have been published. These studies describe the different aspects of the male clients. The men's age ranged from 18 to 72 years (mean = 35.9 years), 86.5% of the men had a Norwegian ethnic background, 76.5% of the men were married or cohabitants, 77.6% of the men were fathers, and 70.8% of the men were employed or students. All men had performed at least one type of violent act (physical, psychological, property, or sexual violence) against their partners. Most men reported having perpetrated physical violence against their partners. In addition, nearly 18% of the men had used physical violence against their children (Askeland et al., 2012). According to a comparison of the clients' and their partners' reports of the occurrence of violence, a disagreement was observed in which the men reported less violence than their partners, but only psychological violence was consistently reported differently (Strandmoen et al., 2016).

Furthermore, approximately 50% of the men reported that they had experienced emotional neglect or abuse in their family of origin, and nearly 62% of the men reported experiencing physical abuse from their parents (Lømo, Askeland, Strandmoen, Tjersland, & Heir, 2013). Moreover, 70% of the men qualified for one or more psychiatric diagnoses as measured by

the MINI, and the main diagnoses included anxiety, depression, and alcohol/substance abuse (Askeland & Heir, 2014).

The Qualitative Process Study of Individual IPV Therapy

In the process and outcome study, 84 men participated in one or more individual therapy sessions. Of this sample, we chose a smaller number of cases to investigate the aims of the qualitative process study. Data regarding the dropout status, completion of therapy, number of attended sessions, outcome of therapy, and intake assessment were used to select cases for the qualitative process study. Furthermore, these data were used to describe and contextualize the cases. The modified HAT form was used to select the sessions. The audio recordings and verbatim transcriptions of these sessions were the primary data for the three qualitative analyses. The selection procedures are further described in the method section.

Aims of the study. The overall aim of the qualitative process study was to scrutinize the processes of initial alliance formation and client change as these phenomena unfold in voluntary individual psychotherapy for men perpetrating violence against their intimate partners. This aim was achieved through the following research questions, which guided the three analyses: 1) How do male clients contribute to the alliance formation during the first therapy session? 2) How do therapists respond to their clients' different invitations to establish a common ground for personal change? 3) How can in-session client change be observed throughout the course of therapy and how can these changes explain a good outcome?

The first aim of the study was to scrutinize the phenomenon of working alliance formation as it unfolds during the early therapy sessions in voluntary individual IPV therapy. The process of initial alliance formation was studied from the positions of both the client and the therapist. First, the ways in which the male clients contributed to the establishment of a working alliance were investigated. In this analysis, I started with a critical view of the dominant narrative by men perpetrating violence in which they denied and rationalized their violent acts. I was not critical of the existence of the behaviors related to these concepts, but I assumed that this narrative could not enhance the therapists' skills in forming an alliance with these male clients. Therefore, the focus was on what the men might ask for or respond to during their first meeting with the therapist that could be indicative of personal change. Second, the analysis of the alliance formation particularly focused on the therapists' strategies and initiatives in response to the offering by the client and how these strategies appeared to inform the outcome of therapy.

The second aim was to investigate how the activity in therapy could shed light on the reduction in violence reported by the clients and their partners at the end of therapy and the follow up assessment. The focus was on how the client change developed within sessions and across sessions throughout the courses of treatment with good outcomes. By investigating how the clients changed with therapy and how the therapeutic dialog appeared to facilitate this change, I hoped to improve explanatory theories regarding how psychotherapy for men perpetrating IPV works and develop therapeutic principles that can guide therapists in their interaction with clients.

The final aim was to integrate the findings regarding the early alliance formation and in-session client change during the course of therapy to determine whether a model of personal change can be developed to facilitate interventions in IPV therapy and guide clinicians in their in-session decision making in this specific field (Levitt, Butler, & Hill, 2006; McLeod, 2013). The conceptualization of the aspects of the therapeutic process should be relevant in terms of how helpful these aspects might be to prevent dropout, enhance engagement in therapy and improve the treatments offered to men who act violently against their partners.

Methods

The selected data and analytical methods were chosen to ensure that this study collected trustworthy data and methods that could deepen our understanding of the process of early alliance formation and change in IPV therapy. To evaluate the trustworthiness of the results of the qualitative process study, we must consider how well the results capture the studied sample. *Internal validity* refers to an appraisal of the data material, the research methods and procedures, and the results (Andenæs, 2001). Levitt and colleagues propose the concept of methodological integrity as the methodological foundation of trustworthiness (Levitt, Motulsky, Wertz, Morrow, & Ponterotto, 2017). In addition to the trustworthiness of the results, the generalizability of the results must be considered. *External validity* refers to how well the results can be transferred to contexts other than the particular context in which the study was conducted. The present study's generalizability is further discussed in the discussion section. The steps performed and choices made to enhance rigor and trustworthiness are described below.

Data Selection for the Qualitative Process Study

The data explored in the in-session inquiry included both quantitative and qualitative data of therapy cases collected in the ATV Therapy study. Because each case is a case of

"something" (McLeod, 2010), the therapy cases used in the three analyses should be cases that illuminate the process of early alliance formation and therapeutic change in the context of voluntary therapy for men perpetrating intimate violence against their female partners. The sampling of both the cases and the sessions in each case was theoretically driven (McLeod, 2010; Smith, Flowers, & Larkin, 2009; Ponterotte, 2005) because these selections were assumed to expand theory regarding the topics of interest.

The clients and therapists participating in the inquiry have been described in detail in three papers, including the clients' demographic variables, use of violence, trauma experiences, and number of sessions attended as well as the therapist's gender, training, and theoretical orientation. Therefore, in this overview, the rationale underlying the strategies used to sample the cases and sessions for the three analyses is discussed.

Selection of cases. The selection of relevant cases was performed in two steps. First, I selected cases that represented two contrasting groups, i.e., those who succeeded in forming an alliance and those who failed to form an alliance. This sample was selected using a purposive sampling strategy (Flick, 2009) to obtain contrasting cases and ensure that the sample was rich in variance and the nuances of alliance interactions. Second, to study therapeutic change, I sampled from cases of successful alliance formations that have been previously studied to identify the cases with the most convincing good outcomes.

Cases for studying alliance formation. By the time I started including cases for the inquiry of the alliance formation, 48 of the 84 clients who underwent individual therapy had ended their treatment. Among these accessible cases, the therapist had categorized 16 cases as complete and 32 cases as dropouts.

I started selecting among the completed cases. To ensure that the initial alliance formed in these cases was viable in terms of a good outcome, I selected cases in which the clients at the end of therapy (T2) reported either no perpetration of violence or a considerable reduction in the types and frequency of violent acts in addition to a reliable change on the OQ-45. Furthermore, cases in which the client had attended the highest number of sessions were selected. This selection criterion was adopted to create a contrast to the dropout group and ensure that the two parties in therapy had worked for a considerable time on the client's relational and behavioral problems. Finally, I included cases that were similar to the population of the ATV therapy study in terms of the perpetration of violence (VAS), mental health (OQ-45), and traumatic experiences (TEC) at T1. This final criterion is considered more abstract and statistical than theoretical because it was applied to include the typical rather than relevant cases (Flick, 2009). However, the selection of typical cases might

strengthen the generalizability of the findings to similar populations (McLeod, 2010). The selection procedure of the completed cases with a good outcome resulted in the inclusion of 10 cases.

Second, I selected dropout cases to allow for comparisons of the early alliance formation between two contrasting groups. To ensure a clear contrast between the groups, dropout cases in which the clients attended the fewest sessions were selected. I assumed that these cases best represented interactions that were perceived as not helpful by the clients. In addition, cases were selected to ensure that the two groups were as similar as possible at the beginning of therapy in terms of the clients' reports of violence (VAS-client), mental health (OQ-45), and life trauma (TEC). In total, 10 dropout cases were selected, and only negligible differences were observed between the two groups, except for the number of sessions attended and the way in which the therapy ended. The 20 selected cases constituted the sample for the first and second analysis.

In addition to these sampling criteria to ensure a contrasting case study, I sought to include as many therapists and ATV clinics as possible. Even though all therapists were trained in the ATV model, I assumed that including different therapists and clinical sites could enhance the diversity in the therapists' approaches to building an alliance. Furthermore, if a therapist was represented in both a dropout and a completed case, I selected one of each to illuminate how the same therapist formed different alliance interactions.

The process of maximizing wanted variation and minimizing unwanted variation is useful for achieving analytical control (Andersen, 2005) and may improve our ability to explain what occurs during alliance formation in IPV therapy. Strauss and Corbin (1998) named these processes explanatory power. Similarly, Kvale (1996) proposed the concept of analytic generalization as an evaluation of the extent to which the results of a study can be used as a guide for what could occur in another situation. In qualitative research studies, the adequacy of the dataset is not determined by the number of cases; in contrast, the diversity among the cases is critical. I expected that this sample would allow for observations of therapist-client dyads who, to varying degrees, struggled to identify a common ground for working together and either succeeded or failed to form a viable alliance. Furthermore, I assumed that the cases would generate insightful findings that could answer the research questions regarding the clients' contributions to early alliance formation and the therapists' responsiveness to the clients' invitations (Levitt et al., 2017).

Cases for studying therapeutic change. The second step of the sampling procedure was to select cases that would be relevant for an inquiry of the change processes in the good

outcome cases. These cases were drawn from the 10 completed cases previously studied. The results of the analysis of the therapists' responsiveness to the clients' invitations served as a starting point for the selection of cases. This analysis revealed that even in clients who completed therapy and reported a good outcome in terms of violence at the end of treatment, the way that the clients spoke about their violent acts during the final session did not necessarily support the impression of a good outcome. Furthermore, after combining partner reports and client reports regarding the occurrence and frequency of violence at the end of therapy and at the 18-month follow-up, the types of changes achieved by the client became uncertain.

To enhance the possibility of studying in-session changes that resulted in a good outcome, I used the following selection criteria. The client strongly invited the therapist to collaborate to change his violent behavior, and the therapist responded in a manner that helped the client and therapist co-create a viable alliance to achieve personal change. Furthermore, the client and partner expressed similar descriptions of how the client had changed his violent behavior and his way of relating to the partner, both reported no occurrence or a considerable reduction in the frequency and severity of violence, and the client reported a reliable change on the OQ-45. Moreover, the clients' reflections during the final session regarding the therapy process and changes obtained supported the impression of a good outcome. The final criterion used to select the cases was the number of sessions attended. Based on studies indicating that approximately 50% of clients who participate in less than 20 sessions do not substantial improve from therapy, I selected cases who attended more than 20 sessions. Following this sampling procedure, I was able to include three cases.

Compared with the remaining seven completed cases and the population of the ATV therapy study, these three cases could be considered exceptional in terms of being long-term therapies with a good outcome as defined by both qualitative and quantitative data from the clients and their partners. I assumed that this narrow selection could provide an opportunity to study cases that were rich in in-session interactions to shed light on the changes reported in the client's real world.

Selection of sessions. To study the way in which the clients invited the therapists to a working alliance, I inferred that the first therapy session could provide rich data regarding the invitations to an alliance presented to the therapist during the therapist's first encounter with the client. Therefore, the first session of the 20 cases was selected for analysis.

In the inquiry regarding how the therapists related to the clients' invitations to an alliance and intervened to engage the clients in therapy, I assumed that including both the first

and second sessions was necessary. This allowed for an examination of how the therapist followed up on the challenges or possibilities to form an alliance created during the first session. In addition, the final session was included for all cases. I hypothesize that the final therapy session in both the dropout and completed cases could shed light on the beginning process of forming an alliance regarding both why therapy ended prematurely and how the collaboration in the completed cases had been helpful (Råbu, Binder, & Haavind, 2013). The final therapy session provided both observational data and reflexive data. The therapist and the client might refer back to their initial interaction to make sense of the client's past, present and future in relation to the problem that brought him to therapy. Altogether, 52 sessions were selected for the second inquiry.

In the third study, the process of in-session client change throughout the course of therapy was analyzed. Therefore, sessions that represented the beginning, middle, and ending phases of therapy were selected. Furthermore, sessions were included based on the clients' and therapists' short evaluation (HAT) of each session. I chose sessions that were rated by the clients as helpful (4 or 5 on a scale from 0-5) or those during which the client or therapist described obtaining changes. Additionally, I included sessions during which the client and therapist worked on the client's recent use of violence because changing this behavior is the main goal of therapy. In certain cases, the analysis of a certain session revealed information about other sessions found helpful by the client. Nine additional sessions were included in the empirical material in this manner. This gradual sampling strategy was applied because I expected that this method could add information regarding the specific change process during therapy (Glaser & Straus, 1967). Altogether, 32 sessions from the three cases, including approximately 40% of the sessions of each case, were included in the final analysis.

Collectively, the three qualitative in-session studies comprised analyses of 75 therapy sessions, representing therapy processes in 20 male clients.

Audio recordings of sessions. The audio recordings of the therapy sessions were conducted using a small digital recorder, which provided an opportunity to examine what actually occurred between the therapist and the client. Because the researchers were not present as observers in real time, the act of observing had a very limited influence on the interaction between the two parties in therapy. However, both the therapist and the client could have been conscious of the recording, which may have influenced their participation. However, the more familiar the technology is to the actors and the more time the actors spend with this technology, the less attention the actors devote to the small device, and the

interaction is expected to become the focus of the actors' attention. Thus, the audio recordings can be considered adequate and robust data informing the aim of the analyses.

Most sessions, except for nine sessions that were gradually included during the data analysis of the in-session change, were transcribed verbatim by psychology students (I transcribed one case consisting of three sessions). I listened to the gradually sampled sessions and wrote detailed summaries of these therapist-client interactions. The audio recordings and transcriptions of the sessions captured the lived complexity of the therapy encounter (McLeod, 2010) and allowed for a thorough exploration of the dialog between the two parties in therapy. These data allowed for the empirical material to be revisited both by listening to and reading the transcribed dialog, which deepened my first impression of the in-session interaction. Moreover, these data allowed all researchers to observe the same data material.

Data Analysis

The three data analyses were conducted in collaboration with Professor Hanne Haavind and Professor Odd Arne Tjersland. The second author, Hanne Haavind, is a psychotherapist and researcher with a special interest in development in children and young people, and the relationship between men and women as co-parents and love-partners. The third author, Odd Arne Tjersland, is a clinical psychologist who specializes in family and couple therapy. He has conducted studies investigating child sexual abuse and the mediation process in separating parents. As the first author, I took the lead in the analytical work and met with each of the two other authors separately and jointly for comparisons and discussions of the interpretations.[4]

Inquiry of initial alliance formation. To obtain insight into the ways in which the clients and therapist attempted to form an early alliance, the sessions comprising these two inquiries were analyzed according to the steps and categorizations described by Grounded Theory (Strauss & Corbin, 1998). The approach was explorative because the aim was to gather rich, nuanced, and contextualized information about the phenomenon of early alliance formation. Furthermore, these analyses were consistent with constructivist grounded theory (Charmaz, 2003) because the final categories were the result of the researcher's interpretation of the data.

To scrutinize the initial alliance formation in IPV therapy, Bordin's conceptualization of the alliance was used as a sensitizing device for a broad search of the ongoing interactions for relevant content (Hsieh & Shannon, 2005; Kohlbacher, 2006). The concept of alliance was

[4] Throughout the manuscript, "I" is used to refer to the first author, while "we" is used to refer to the first author, Professor Hanne Haavind, and Professor Odd Arne Tjersland.

not operationalized in terms of goal, task or bond. In contrast, the concept was used as a perspective to approach the therapeutic dialog. We approached the data by asking the following questions: How do clients invite the therapists to collaborate regarding personal change in connection to his perpetration of violence? How do therapists behave to engage the clients and identify a common ground for this collaboration?

The coding of the therapeutic dialogue was performed following a series of analytic steps. In Step 1, we paid careful attention to each occurrence in which both parties indirectly or directly touched upon possible or improbable ways of working together to realize change. In Step 2, we coded the therapist initiatives, client responses to these initiatives and how the therapist followed up on the client's responses to the therapist's initiative. In Step 3, we used the previously identified interaction sequences as grounded theory meaning units and assigned these units category labels. In Step 4, we performed a sequential analysis. During this stage, we placed meaning units for each case in a chronological sequence (from the beginning to the end of each session and from the beginning to the end of each therapeutic case). We treated these sequences as meaning units and assigned these units category labels.

We first conducted an intensive analysis of certain cases, including both dropout and completed cases. The sessions of each case were coded separately one case at a time. The analysis was performed independently by all three authors. The first author took the lead in the analytical work and met with each of the two other authors separately and jointly for comparisons and discussions of the interpretations. In the analysis of the client contributions, the third author was blinded to the outcomes of the cases to determine whether knowledge regarding the outcome influenced the interpretation of the client's contributions to a working alliance. Such an influence was not observed. Following this intensive investigation of certain cases, we analyzed the remaining cases using the same analytical procedures. The trustworthiness of the coding was ensured through regular auditing meetings with the co-authors.

Inquiry of in-session change. To study the in-session change, I approached the data from a different perspective than that used in the previous two analyses. The cases were selected based on more detailed knowledge than the 10 completed and 10 dropout cases. We knew that a viable alliance was established during the two first sessions and that the client had changed in the direction of becoming a safe husband and father. Furthermore, I selected the sessions described by the clients as helpful. Based on this selection procedure, we expected to observe several sequences of helpful interactions. Because we sought to understand how the in-session interaction could make sense of the changes reported by the clients and their

partners in their everyday lives, the data were analyzed by performing an interpretative phenomenological analysis (IPA) (Smith, Flowers, & Larkin, 2009).

IPA is concerned with how participants make sense of experiences and is theoretically rooted in phenomenology, hermeneutics and idiography (Smith, 2010, 2011). I attempted to stay close to the phenomenon of 'in-session interaction and change' by analyzing each case from an inductive position, seeking to comprehend the interactions between the client and therapist and the personal relevance to each specific client. I assumed that the individual and each therapy dyad were a unique and complex entity (Ponterotto, 2005; Smith, 2011). I read the transcripts with an understanding that everything that occurred during the session could be relevant for making sense of the change process in the case. Furthermore, I included the hermeneutic perspective by interpreting the client's and therapist's attempts to make sense of the client's experiences in a way that could create change. The interpretation was informed by knowledge of psychotherapy, personal change, and the phenomenon of IPV, but I did not approach the data with a specific therapeutic method or theory. In contrast to testing the data according to an already conceptualized theory, I expected that conceptualizations of theory would derive from our engagement with the data (Rennie, 2000). The analysis was idiographic because each session of each case was analyzed in detail and configured in a course of time. This narrative approach to each case helped the construction of the content of change and how the interaction between the two parties made sense to the observed changes in each session and throughout the course of the therapy process.

I first became familiar with the cases by simultaneously reading the transcripts and listening to the audio recordings of the selected sessions. I analyzed all sessions of a single case before proceeding to the next case. During the reading and re-reading of the transcripts, I coded the themes that were introduced and discussed, therapist interventions, and new perspectives that developed during the sessions. These coded meaning units were then systematically combined to condense the descriptions of the content and process of each therapy session (Malterud, 2001).

In the following phase, the two co-authors were involved in the analysis. These authors independently studied the transcribed sessions and the summaries of the sessions for one case using the aforementioned inductive analytical questions as a basis. To ensure trustworthiness, I held separate and joint meetings with the two co-authors to compare the similarities and differences in the understanding of the therapeutic process. The coded segments of the text of each session were compared with each other with a focus on change and progression. Through this analytical work, we arrived at a concurrent way of interpreting

the therapeutic dialogue during the sessions and the progression of the case. This process resulted in a coherent narrative regarding the content, interaction and change from the beginning to the end of the case. Then, the two remaining therapy processes were analyzed following the same procedure described above. The coherent narratives of the courses of therapy were then evaluated against the initial coding of each therapy session to ensure that our construction of the therapy process was consistent with the content and process of each session.

The final step of the analysis was to compare the three therapy processes from beginning to end. We searched for similarities and differences among the cases. Through this analytical process, we identified pathways of client changes and interaction patterns that appeared to facilitate these changes.

To demonstrate the quality of the findings reported in all three papers, extensive examples (excerpts, dialogs, and narratives) from the cases were used to support and illustrate the findings. These dense descriptions allow the reader to appraise the coherence between the developed conceptual models and the state images from the data material.

Reflexivity

A common characteristic of all interpretive methods is that the researcher brings her/his conscious and unconscious preconceptions into the process of analyzing the data. During the interpretation of the data, the researcher's preconceptions can be clarified as certain pre-existing expectations are reinforced while others are extended or even challenged (McLeod, 2010). This process allows the qualitative researcher to grasp the complexity of the material and significant patterns in the interactions between the clients and therapists. However, the researcher's emotional involvement with the topic of interest or presuppositions evolved from reading the literature may interfere with the fair collection and interpretation of data (Morrow, 2005). Reflecting on how one's preconceptions are reinforced, extended or challenged in the process of data analysis and explaining one's horizon of understanding to the audience (Rennie, 2000) may limit any biased effect of the researcher's positions.

In this qualitative study, some aspects of the relationship between me as the principal investigator and the observed data invite further reflection. As an observer, I was not present in real time but observed the therapeutic interactions (by listening to audio recordings and reading the transcripts) several times in retrospect, together with the two coauthors (see description of coauthors on page 28).

In examining my own process of engaging with the data, my experiences of having been in the same position as the therapists I observed led to reflections. I have conducted

psychotherapy sessions with male clients who had perpetrated IPV and have knowledge of the dilemmas that therapists might face in collaborating with these men. In addition, all the therapists who participated in the study were my colleagues[5]. Thus, the therapists knew who the researcher was, and the therapists were not anonymous to the researcher. I had selected the cases and could recognize the therapists' voices when listening to the audio recordings. The therapists knew that their interventions in the sessions would be scrutinized and compared to the approaches and interventions of the other participating therapists in ways that they could not control. My relationship with the therapists challenged the analysis of their contributions to the therapies. It was important to me that the analysis not resulted in descriptions of high- and low-achieving therapists. At the same time, it was crucial to describe examples of interactions that appeared to result in both strong and weak alliances. To ensure the completion of this task, I met several times with the therapists to focus on how to learn from both the completed and dropout cases. In addition, the choice to select therapists who had both dropout and completed therapies prevented a focus on high- and low-achieving therapists and enhanced the importance of understanding the therapist's acts in the context of the clients' contributions to therapy and the clients' acts in light of the therapist's responsiveness (Stiles, 2013)

Furthermore, the process of analysis initiated reflections on my theoretical training as a clinical psychologist specializing in psychotherapy with adults. I was trained in the social constructivist approach to therapy. This position assumes that reality is socially constructed and that language has an important role in making meaning (Anderson & Goolishian, 1992; Bruner, 1985, Haavind, 2000b; 2007; McNamee & Gergen, 1992; Ponterotto. 2005). The language used in therapeutic models often differs from the language used by the therapist and client to create an understanding of the client's problems. Therefore, my ambition is to develop a therapeutic language that is close to the language used by clients to describe themselves so that they might find it relevant in their effort to change.

On the basis of this position, I assumed that the dominating language used to describe how male clients deny, minimalize, and rationalize their violent acts could negatively affect the alliance formation process. Furthermore, I hypothesized that the clients most likely would not describe themselves using these concepts. Our first approach to the material, i.e., searching for the male clients' *invitations* to an alliance, must be considered a direct

[5] I held part-time employment at ATV while I completed my doctoral thesis at NKVTS and the University of Oslo, Department of Psychology.

derivation of my theoretical preference and created the possibility of conceptualizing invitations to an alliance in a sample that is described as mostly resistant.

In the following two analyses, my attention was drawn to how the therapist and client, with a special focus on the therapist, interacted to create meaning that could lead to a working alliance and to client change. The findings that therapist responsiveness and the focus on clients' subjectivity and agency were important both in forming an alliance and in developing change reinforced my preconceived assumptions. In contrast, the clients' repetitions of stories about "the annoying other" in most sessions of their therapeutic process challenged my understanding of change in therapy as gradual. The thorough analysis of these repetitions in therapy emphasized how the therapists' approach created dialogs in which new meanings ensued and the difference between facilitative and hindering interactive patterns in these therapies.

Through such reflective processes in collaboration with the coauthors, my theoretical and clinical training did not interfere with the data in a way that prevented the findings from being grounded in the material. In contrast, my theoretical preference guided me in finding categories that initially were not easily observable.

Ethical Considerations

The overall process and outcome study was approved by the Regional Committee for Medical and Health Research Ethics (Region South-East) and the Norwegian Social Science Data Services. All men who sought treatment at the ATV outpatient clinic during a period of a year and a half were asked to participate in the study. The participants were informed about the study both verbally and in written form and that their decision to participate did not affect the possibility of receiving treatment. The clients provided written consent.

After the clients agreed to the therapeutic process being observed, they provided access to perhaps the most vulnerable aspects of their own and their family members' lives. Both the contrasting case studies and the case-by-case study of the clients' disclosures, struggles and successes in their dialog with the therapist emphasize several distinct ethical issues (McLeod, 2010). Confidentiality is particularly important in these inquiries. Details in the excerpts from the therapy sessions can be changed to disguise the clients' identities. However, the client might recognize that the extracts used to describe the categories or the case are examples from his own therapy and life. In addition to changing the clients' names, ages, occupations, and characteristics of their family members, I altered parts (phrases typically used by the clients) of the dialogs to render these excerpts less recognizable to the client. I discussed these adjustments with the co-authors to ensure that important meaning in

each case is not lost or distorted. Furthermore, I used different cases to document the findings. Thus, only a limited amount of information is disclosed from each case.

Several specific ethical obligations are connected to the enterprise of IPV therapy that must be described. These requirements are a part of the Norwegian Law of Health Professionals. During a session, if a client either discloses an intention to perpetrate violence (to cause harm either to others or himself) or acts in a way that enhances the possibility of such acts, the therapist is required to intervene to prevent further violence. Furthermore, the therapist is also required to include child protection services if he/she becomes concerned about the client's ability to care for his children. During the sessions that I analyzed, all therapists raised these issues on a general basis. However, no examples of therapists expressing the need to involve the police or acute mental health care were observed in any of the analyzed sessions. One therapist mentioned during the first session that he found it necessary to involve child protection services. This dialog was challenging, and the client expressed fear of losing custody of his children or being considered a poor parent. Thus, this issue appeared to threaten alliance building.

Results

Paper I: From Resistance to Invitations: How Men Voluntarily in Therapy for Intimate Partner Violence May Contribute to the Development of a Working Alliance.

The analysis of the clients' contributions to an alliance during the first session resulted in a conceptual model of gateways and invitations to a working alliance. Gateways are themes that have the potential to provide a path toward collaboration on personal change. Across all clients, each gateway was opened through invitations that ranged from strong to gradually weaker invitations to an alliance. The first gateway was the clients' presentations of their reasons for seeking treatment. This gateway included three invitations, i.e., as one's own choice to seek treatment, seeking treatment to avoid a negative consequence, or presenting treatment as a mistake. The second gateway was the client's notions of change. This gateway involved invitations emphasizing the need to change their violent behavior, that violence was unacceptable but inevitable or understandable, or the need to change their partners. The third gateway was the clients' ways of disclosing and describing the violent events. Four invitations constituted the final gateway to an alliance, i.e., the violence was disclosed as a personal narrative, a scene, or a fragment of one's life or described as something else.

Overall, the clients who completed therapy presented with stronger invitations than the clients who dropped out of therapy. In particular, the gateway 'notion of change' divided the

two groups. However, an overlap was observed between the two groups concerning the strengths of the invitations (see app., table 1). The strongest invitations were suggestive of the clients' approach motivation goals, whereas the weaker invitations were suggestive of avoidant motivation goals. This conceptual model has the potential to increase the therapists' awareness of the types of invitations they can expect from clients during the first session and that weak invitations can be transformed into stronger invitations to an alliance.

Paper II: Finding a Common Ground: Therapist Responsiveness to Male Clients Who Have Acted Violently Against Their Female Partner.

The analysis of the therapists' strategies and initiatives in response to the offering by the client generated the following core category: Finding Common Ground. The following three main categories represented the interaction sequences: Co-creative, Pull-avoid, and Tip-toeing softly interactions. A set of constituent sub-categories represented the specific therapist strategies. The core category, i.e., Finding Common Ground, refers to the key underlying task faced by clients and therapists to build a shared space within which they could work together. The main and sub-categories identified in the analysis can be understood as representing ways in which the therapy dyads approached this task.

The specific therapist strategies observed in the co-creative interactions included a contextualization of the violent acts, exploration of the client's subjectivity (feelings, thoughts, and intentions) around the violent event and his perspective of those affected by the abuse, collaborative formulation of client goals and values, and connecting the client resources to the treatment tasks. In the pull-avoid interaction, the therapists engaged the client in describing the violence, provided a voice for those affected by the abuse, noted the clients' resources and persuaded a correct goal and task for therapy. Finally, in the Tiptoeing softly interaction, the therapist avoided exposing the clients' use of violence. Instead, the therapists explored other issues that appeared to be important to the client to establish an initial bond with the client.

The core category of 'finding common ground' also captures the following essential aspect of the case comparison design of the study: the extent to which the client was able to remain within ground or decided to leave. The clients who participated in the co-creative pattern appeared to experience the most successful treatment. Furthermore, therapists who employed strategies characterizing the pull-avoid interaction appeared to prevent a good outcome even in cases in which the client strongly invited the therapist to an alliance and completed therapy (see app., table 2). These findings highlight the value of a model of therapist responses to client invitations as a means of conceptualizing the therapeutic alliance during the early sessions of IPV psychotherapy.

Paper III: Five Important Turns in Becoming a Safe Husband and Father: A Case-by-case Analysis of In-session Change in Psychotherapy with Men Acting Violently Against their Female Partners.

The case-by-case analysis of the in-session changes resulted in the identification of five important turns with which the therapists and clients engaged to allow the client to become a safe husband and father. These three therapy dyads found a common ground for changing the client's violent behavior during their first session. The men invited the therapists to work with them in addressing violence as a personal problem, and the therapists responded by exploring the violent acts as subjective experiences. This was the *first turn* in which the therapist and the client engaged. The *second turn* was a recurring interactional pattern. During most sessions, the clients disclosed stories from their daily lives about "the annoying other" and his efforts to suppress and control his anger and aggression. The therapists' strategies involved exploring the client's subjective experience of the events with "the annoying other". As the therapist encountered these client repetitions, gradual client change was observed within three different but intertwined turns. In the *3th turn*, the clients and therapists clarified and expanded upon the client's personal patterns of being an intimate partner and father. In the *4th turn*, a cohesive self-narrative was developed that addressed the significant events that occurred during the transition boyhood to manhood. Finally, in the *5th turn*, an effort was made to involve the state of mind of the other in getting to know and challenging oneself when feeling attacked (see app., figure 2).

As a result of these processes, the clients exhibited a capacity to apply new interpersonal skills in the real world. Acquiring new ways of relating to a partner or child was a difficult task. This process combined the exploration of the client's own and other's needs and how they mutually influenced each other. This process also involved concrete efforts to experiment with new ways of engaging with the other.

Discussion

To discuss the findings of the three qualitative analyses, drawing upon Goldfried's (1980) conceptualization of the therapeutic enterprise as involving various levels of abstractions is helpful. Goldfried placed the theoretical framework explaining how and why change occurs at the highest level. In the field of IPV therapy, the theoretical models and connecting therapeutic approaches described earlier in the introduction represent this level. The therapeutic techniques used in therapeutic interactions (e.g., role play, open-ended questions, and exploring emotions) are placed at the bottom level. Goldfried places the level

of clinical strategies between these two levels. When these strategies are empirically founded, they could be called principles of change.

Using a contrasting and purposive sample (completed, dropout cases and good outcome cases), I observed the performance of therapy at the lowest level of abstraction to conceptualize clinical strategies in IPV therapy. The concept of clinical strategy includes the therapists' intentions (Hill, 2009), which can be identified by observing the in-session interactions. Because these strategies are grounded in empirical data, these strategies can be considered principles of change in IPV therapy.

Notably, the analysis of the clients' contributions to the alliance might not appear to be a direct study of clinical strategies because this analysis focused on the clients' rather than the therapists' contributions. However, client actions are related to the therapist in the therapeutic context. The conceptual model of gateways and invitations notes clinically relevant themes for therapists to be aware of in the endeavor to establish an alliance. Therefore, the result of this analysis is formulated at the level of clinical strategy.

The design of the ATVT study does not allow for assumptions about causal relationships between the in-session processes and the outcome. For example, I cannot state that a client dropped out of therapy because the client and therapist formed a pull-avoid interactional pattern and constructed violence as unwanted behavior. The outcome of dropping out or completing therapy is driven by complex reasons, and a better understanding of the characteristics of both facilitating and hindering interactions in therapy is a tool for improving IPV treatment. The conceptual models developed here can be used to argue for improvements in clinical strategies to establish a working alliance and change in IPV therapy. I propose that the suggested principles of change are suitable to guide therapists in similar treatment contexts in their moment-to-moment interactions with clients.

In the following sections, I first elaborate on how the conceptual model of gateways and invitations and the model of therapist responsiveness to finding common ground shed light on the theoretical concepts of expectations of therapy, problem formulations, and agreement on goals and tasks. Second, I discuss how the model of five important turns to becoming a safe husband and father can illuminate the principles of change in IPV therapy and client changes in their everyday lives. My aim is to use these findings to expand general theories of alliance and change in a direction that will capture the specific challenges in IPV therapy but also to introduce knowledge from general psychotherapy to the field of therapeutic work with men perpetrating IPV.

I propose that this aim could empower therapists to relate to the phenomenon of IPV more as a clinical phenomenon in the context of intimate relationships and less as a social phenomenon. In working with intimate partner violence, the therapist must prevent re-abuse to enhance the safety of the partner and their children. Safety issues must never be neglected because the consequences of IPV for the victims are considerable in terms of both physical and psychological health. Simultaneously, the safety issue must not dominate the work in a manner that prevents the therapist from creating a therapeutic collaboration within which the client can change.

Untangling the Phenomenon of Alliance Formation in IPV Therapy

According to the contextual model of how the alliance works to create change in psychotherapy, the first step in forming an alliance is the establishment of the *initial therapeutic bond* (Wampold and Budge, 2012; Wampold & Imel, 2015). The observation of the clients' contributions and therapists' responsiveness at the beginning of therapy allowed for an analysis of this process. The client's first impression of the therapist, his general expectations of therapy and his motivation for change all affect the formation of the initial bond (ibid.). For example, men seeking therapy voluntarily could be expected to be more internally motivated and have more initial positive expectations of therapy than court-ordered or -mandated men (Begun et al., 2003).

The observed variations in the client's invitations to an alliance were based on a sample of men who entered therapy voluntarily. Nonetheless, the findings illustrated that several men chose to enter treatment even though they felt pressured to participate (a few men even considered therapy a mistake). Clients who felt forced to enter therapy did often not recognize their violent behavior as a personal problem. Their purpose of contacting the therapist appeared to be anchored in a desire to avoid the loss of a relationship with their partners or children and being defined as a violent man. These desires emphasize that the client is an active agent who is engaged in constructing his life and relationships (Bohart & Tallman, 1999). Thus, the concept of voluntary is nuanced in a manner that includes feeling coerced to enter therapy and simultaneously being an agent attempting to maintain a desirable position and self-image. In IPV therapy, voluntary therapy does not automatically indicate that the client is motivated to work on personal issues. One might hypothesize that such combinations also exist in a mandatory sample. These findings show that observing the differences in mandated and voluntary therapy might not be the most beneficial exercise in investigations that seek to highlight how therapists can increase clients' engagement in

therapy. In both mandated and voluntary therapies, the therapists must be attentive to how the client recognizes his violent acts and what he aims to achieve from the therapy.

Regarding the client's initial motivation, the strength of the clients' invitations to an alliance could be considered an expression of his motivation or readiness to change (Prochaska & DiClemente, 1983; Prochaska & Norcross, 2002). A dualistic comprehension is embedded in the concept of motivation as follows: the client is either motivated or not motivated to change his problem. Moreover, the client's motivational state is often interpreted as his ability or capacity to utilize therapy. This understanding of client motivation is enhanced by findings from both IPV therapy and general psychotherapy in which the clients' motivation predicts the process and outcome of therapy (Crane, Eckhardt, & Schlauch, 2015; Delay & Pelowsky, 2000; Kistenmacher & Weiss, 2008; Norcross, Krebs, & Prochaska, 2011; Olver, Stockdale, & Wormith, 2011; Orlinsky et al., 2004; Scott, 2004; Scott et al., 2011; Scott & Wolfe, 2003). In contrast, the conceptual model of client offered invitations to an alliance contributes with nuances concerning *what* the client is inviting to and the *way in which* he is inviting. For instance, all men expressed that violence was wrong and unwanted, but they differed in how they assimilated acting violently as a personal problem, unwanted behavior, or something that belongs to the other. The concept of invitation is resource- and client-focused because it describes the clients' wants and needs in therapy. Furthermore, the variability in the model suggests that further steps can be taken toward a viable alliance in terms of moving from a weak to a stronger invitation.

Therefore, it is important to emphasize that the model of gateways and invitations is not an attempt to deny the clients' denial or externalization of violence. In contrast, this model is rooted in the hypothesis that concepts related to resistance are not useful in overcoming the challenges observed in establishing a working alliance. I purpose that the model of gateways and invitations creates a new view of these clients, which in turn, can broaden the therapist's space of actions. Thus, this model is a result of a social constructionist approach (Levitt et al., 2017; Morrow, 2005; Ponterotto, 2005)

Furthermore, the model of the therapists' responsiveness to the clients' invitations highlights the interactive aspects of finding a common ground. For example, when the client presented with strong invitations to an alliance, the therapist appeared to respond more easily by exploring the client's subjective experiences. However, from the opposite perspective, i.e., when the therapist employed explorative interventions, the client responded more easily by offering strong invitations. Even though the client and therapist influence each other mutually, the therapist's responsibility is to act in a way that can help the client solve his psychological

problems that is consistent with her/his therapeutic approaches (Kramer & Stiles, 2015; Stiles, 2013).

Our findings highlight the importance of the therapist's responsiveness. Based on the analysis of the clients' contributions only, the way in which the client invited to an alliance certainly appeared to influence the progress of the therapy. Clients who dropped out of therapy presented with weaker invitations than clients who completed therapy. However, after adding the analysis of the therapist's responsiveness to the client's invitations, the findings illustrate that the therapist's strategy affected the process of alliance formation in certain cases independently of the strength of the client's invitations. This finding illustrates how the client's contribution (motivation) at the beginning of therapy unfolds as a relational phenomenon in the dialog with the therapist.

Proponents of the contextual model suggest that the initial therapeutic bond must be created before the client and the therapist can engage in the three pathways of the alliance (Bordin, 1979; Wampold and Budge, 2012; Wampold & Imel, 2015). However, how the client and therapist together managed to clarify the client's personal problematic patterns that needed to be changed to end violence appeared to be more important in forming an initial alliance than whether the client entered therapy voluntarily (initial expectancy) and presented with strong invitations (motivation). Thus, this clarification is a way to enhance the client's expectations that the therapy will be helpful, which is the second pathway in the contextual model. To find a common ground, considering the client's violent behavior as his personal problem rather than violence as unwanted behavior to get rid of or something else became a crucial endeavor from the very beginning of the therapeutic interaction. Based on this analysis, I do not argue that the initial bond is not important; however, therapists in the IPV field should be particularly attentive to the challenges and possibilities connected to developing the client's expectation of therapy.

Expectations of therapy. The conceptual model of gateways and invitations illustrates how clients' explanations of their violent acts in various degrees match the therapeutic endeavor of personal change work. Wampold and Budge (2012) explain that a challenge to the second pathway of the alliance is that clients typically present with an understanding of their problem that does not allow for therapeutic solutions. Our findings illuminated that therapists never succeeded in engaging clients who expressed that their partners were the problem in therapy regardless of which interactional pattern they adopted with the client. In addition, when the client expressed an emerging sense of violence as a personal problem, the client most often dropped out of therapy. This finding indicates that

clients who explain their violent acts by holding someone else responsible or are vague regarding who is responsible represent specific challenges for establishing a viable expectation of therapy (see app., table 1).

The therapists who addressed the vague or weak invitations to an alliance often employed a strategy that pulled the client toward the therapist's perceived desirable goal or task for therapy, and these clients responded by being compliant to the therapist's suggestions. The clients agreed that acting violently was a wrong and unwanted behavior. The pull-avoid interactional pattern appeared to obscure that the clients were not being helped to see how they could overcome the problem. The client could be arguably in a position of wanting to eliminate violence without knowledge of helpful solutions, which might have influenced their commitment to the therapist-introduced goals (Tryon & Winograd, 2011). The same description can explain the outcome of the tiptoeing softly interactions. By tiptoeing around the topic of how to understand and work on violent behavior in therapy, the clients' need to participate in IPV therapy became unclear. The therapists who negotiated explicitly with clients offering weak invitations were unable to achieve an agreement regarding violence as a personal problem and did not succeed in forming an alliance. All three types of interactions ended with the client dropping out of therapy or the client completing therapy by expressing how the therapy had defined him as a violent man, which is a definition he considered unjust or unfavorable (see app., table 2). In the unsuccessful cases, the therapists and clients did not formulate an understanding of the clients' problems that clarified or, at least during the early stage of therapy, suggested tasks that included the clients' active engagement in ending violence.

Wampold and colleagues note that clients' expectation of therapy are enhanced when they accept the therapist's explanation of their problem and the therapist acts accordingly to the explanation (Wampold, 2007; Wampold & Budge, 2012). Our findings show that during the early stage of IPV therapy, the therapists' explicit negotiation and verbal persuasion that violence must be understood as a personal problem might hinder alliance formation. However, the findings indicate that therapists enhance their clients' expectations when they explore the clients' subjective experiences of acting violently. This clinical strategy can be interpreted as an example of therapists acting according to their therapeutic understanding that violence is a personal problem.

In this manner, the clients' understanding that their aggression is triggered by someone else is not challenged or overlooked but instead is explored and made a topic of interest. I argue that this is an example of a therapist approach that combines confronting (addressing

violence) and supportive (addressing and acknowledging client subjectivity) interventions, which is emphasized by clients as important contributions in their change processes (Levitt, Butler, & Hill, 2006; Levitt, Pomerville, & Surace, 2016; Sheehan et al., 2012). These explorations clarified the client's vulnerability and resources in relating to his partner and might have facilitated client trust in that therapy could help him solve his problem. The client might have also felt met and understood in an authentic way by the therapist, which converges upon Gelso's (2002, 2009) concept of a real relationship in therapy. Clients have described these therapeutic strategies as helpful in setting aside their defenses and to do the work of self-exploration (Levitt et al., 2016).

Problem formulations. To increase the clients' expectation of therapy, it appears important for therapists to construct the client's problem in a way that he can recognize and find relevant (Kjøs & Oddli, 2013). In addition, the problem formulation must enhance the therapist's trust that the client is able to change.

The conceptual model of gateways and invitations shows that regardless of the strength of the invitations, all clients expressed that someone else wanted them to enter therapy and that the partner triggered their violent acts. The invitations establishing the gateways formed a continuum in which the client's awareness of the violence as a personal problem and self-agency in relationships with others gradually transcended from weak to strong. Furthermore, even clients who invited strongly on all gateways at the beginning of therapy and who attained a good outcome disclosed stories about the way in which 'the annoying other' triggered his aggression and acts of violence throughout the entire course of therapy. These stories of the annoying other were similar to those provided by the clients who offered weaker invitations in the gateway notions of change observed at the beginning of therapy. Even though they expressed responsibility for their own acts of violence, the feeling of being unjust and unreasonably treated was repeatedly present throughout therapy. Moreover, the strategy of 'not letting the other get to him' to prevent acting violently also prevented an awareness and reflection of their own state of mind and their partners' state of mind.

Collectively, these findings underscore that the comprehension that one's violent behavior is caused by someone or something else rather than the self might be the core dynamic in perpetrating IPV. Additionally, these findings strengthen the view that these clients' main struggle was not that they externalized the responsibility for their own actions but rather that they were unaware of how they themselves created their own aggression. The clients presented to therapy with a lack of awareness regarding both their and their partners'

state of mind. The focus in IPV therapy appears not to be whether the client wants to change his violent behavior or address conflicts with his partner differently but how to enhance the clients' awareness of his problematic patterns and how these patterns lead to violent behaviors. I assume that this problem formulation might help therapists become sensitive to their clients' wants and needs rather than to a disavowal of responsibility.

One might state that the client in IPV therapy primarily needs help to get to know himself better. If the problem is increasing awareness of personal problematic patterns, we need models that clarify how this awareness develops. The assimilation model describes the process through which clients' problematic experiences (memories, feelings, attitudes or behaviors that are threatening or painful) are assimilated through therapy (Stiles et al., 1990; Stiles, 2002). This topic is discussed further in the section Principles of Change in IPV Therapy.

Agreement on the goals and tasks of therapy. Even therapists skilled and trained in IPV therapy attempted to persuade their clients to agree to therapeutic goals and tasks or tiptoed carefully around the topic of violence to establish an initial alliance—actions that reveal the challenge of identifying and agreeing on client-specific goals in this field. These therapist strategies appeared to limit explorations of the clients' wants from therapy. The explicit purpose of IPV therapy might shed light on why these therapists did not explore or negotiate more often all sides of the client's wants from therapy.

Gondolf (2007) argues that all IPV treatment programs are confrontational in the sense that they understand IPV as wrong and that the main goal of the program is to end violence. This is in clear contrast to therapies that are supportive in encouraging the client to discover his needs and goals for therapy. When the goal of therapy is predetermined, the possible discrepancy between what the client and the therapist perceive as appropriate goals for therapy is removed. Hence, the therapists might be more attuned to establishing an agreement on ending violence, clarifying the severity of violence, and preventing the externalization of violent actions rather than to getting to know the client. Clients complying with the therapists' suggestions without engaging in self-exploration in a pull-avoid pattern can be explained by Rennie's (1994a) study of clients' deference in psychotherapy. Deference is defined as the client's submission to the expert position of the therapist. One property of clients' deference in Rennie's study was 'meeting the therapist's perceived expectations'. Arguing against or nuance the therapist's formulation of the goals and tasks is likely highly difficult for these clients. The goals suggested (find alternatives to violence) were consistent with the client's perception of violence as a wrong and unwanted behavior. However, when trauma work was

recommended as a task for ending violence before a consensus of violence as a personal problem was reached, the clients were less likely to understand the goal of the task, rendering the therapist in the expert position and the client in the position of a passive recipient.

The telling therapeutic strategies observed in the pull-avoid pattern clearly differ from the therapeutic interventions used to explore the client's thoughts, feelings and intentions around his violent behavior observed in the co-creative interactions. Previous studies have shown similar findings. Räsänen and colleagues (2014) found more counselor-dominated conversations in interactions with male IPV clients who were judged to be low on the readiness to change scale than with clients who were judged to be high on the same scale. Furthermore, interviews with prominent therapists about how they facilitate client agency in general psychotherapy revealed that the therapists promoted introspection when they perceived that the clients had the necessary skills to change, but they taught skills and conveyed information when they sensed that the client lacked these skills (Williams & Levitt, 2007; Levitt & Williams, 2010). These findings imply that therapists who employed pull-avoid strategies might have interpreted the clients as not having the skills necessary to arrive at a viable goal through exploration. When the client failed to convey a therapeutic goal, as perceived by the therapist, the therapist assumed what the client was lacking instead of helping the client achieve or expand his self-understanding. In contrast, the therapists who perceived the clients as having strong invitations found more room to explore the client's subjectivity.

During the process of identifying the treatment goal, Mackrill (2011) argues that it might be helpful to differentiate between the client's life goals and their goals for therapy. For example, exploring the types of changes that the client wants to achieve in his real life and how the therapy can be a tool to achieving these changes is important. A client's life goal could be a goal at a higher level of generality than a therapeutic goal. One way to identify a client's wants and goals for therapy is for the therapist to explore with the client the structure (level of generality) of his goals (Cooper & McLeod, 2007). The conceptual model of gateways and invitations offers a set of concepts suitable for clarifying different explicit and implicit goals for therapy. In addition, Mackrill highlights that therapists develop treatment goals and, in certain instances, life goals on behalf of the client. Awareness of how goals and tasks can differ across the client's and the therapist's contexts can help the therapist navigate in achieving potential consensus on the goals.

Furthermore, instead of attending to the process of identifying a therapy goal as a once and for all task, therapists should expect that new and different goals might emerge

throughout the course of therapy (Cooper and McLeod, 2007, 2011). This approach might help the therapist expand her/his space of action in the process of goal consensus. By investigating the client's intentionality (his reasons for entering therapy and what is at stake when he acts violently), the two parties in therapy can clarify and explore different layers of goals and how these goals can be achieved in therapy (Cooper & McLeod, 2011).

Moreover, the general goal of 'stop using violence' is a negation of the client's problem and can be described as an avoidance motivational goal (Grosse Holtforth, 2008; Grosse Holtforth & Castonguay, 2005; Grosse Holtforth, Grawe, & Castonguay, 2006). Elliot & Friedman (2004, as cited in Mackrill, 2011) reported that clients who were involved in more personal avoidance than approach goals were less satisfied with their therapists and experience less enhancement in well-being than clients with fewer personal avoidance goals. Furthermore, the activation of clients' avoidant goals early in treatment can lead to ruptures, while the activation of clients' approach motivational goals fosters a working alliance and enhances positive outcomes in therapy (Caspar, Grossman, Unmussig, Schramm, 2005; Flückiger & Grosse Holtforth, 2008; Gassmann & Grawe, 2006). Recognizing that the goal of 'ending violence' does not offer any direction for more specific goals or tasks for therapy is important.

Our findings illustrate that the therapists were able to formulate more nuanced goals or specific problems to overcome, such as "change my way of thinking about the other", "being more positive", or "being able to solve conflicts with the partner without using violence", only when the therapist explored the client's thoughts, feelings, and perceptions around the violent incident. These goal formulations are also conceptualizations of the tasks for therapy (Cooper & McLeod, 2007, 2011) and therapeutic collaboration (Tryon & Winograd, 2011). The verbalizations of the goals highlight what the client specifically needs to work on and how to collaborate to change his violent behavior. Moreover, these interactions formulated more specific goals and tasks that could be expanded upon throughout the course of therapy.

Based on the co-creative interaction pattern, we learned that strategies, such as contextualizing violent events, exploring the client's subjectivity of the violent events, investigating the client's perspective of those affected by the abuse, and connecting the client's resources and general tasks in therapy, were strategies that engaged the clients in a dialog that constructed violence as a personal problem, and the client completed therapy with a good outcome. The connection between the therapist strategies that fostered proactive client agency and a good treatment outcome and the connection between the strategies that

discouraged proactive agency and a poor outcome are supported by other studies (Räsänen et al., 2012b; 2014; von der Lippe, Oddli, & Halvorsen, 2017).

In summary, to find a common ground for changing perpetration of violence, it appears pivotal for the therapist to not overlook any vague comprehensions of violence as a personal problem. The clients' explanations of their violent acts should be understood as an expression of the client's struggle to be aware of how his problematic patterns are connected to his acts of violence. Violent events that are explored to understand the clients' subjective experiences appear to help clients perceive their aggression as a personal problem and engage in therapy. In particular, it is crucial for therapists to be aware of their interventions and how the clients respond to these interventions. Directive or cautious interventions that ensue compliant client responses without any self-exploration appear to prevent client engagement in therapy and a good outcome of therapy.

Principles of Change in IPV Therapy

Theoretical models of why IPV occurs are often, but not always, supported by empirical evidence (Devaney & Lazenbatt, 2016). For example, studies investigating the characteristics of men perpetrating violence (in contrast to those who do not perpetrate violence) have formed the basis of both explanations of IPV and principles for how to change IPV. For instance, if IPV is explained by men's problems with regulating anger, the principle of change is "anger management"; if IPV is caused by patriarchal attitudes, the principle launched is "develop gender equal attitudes" or "challenge biased beliefs". These clinical strategies are examples of health-promoting activities, which constitute the third pathway of the alliance (Wampold and Budge, 2015). In these examples, the middle level is derived from the highest level of abstraction in Goldfried's model. In contrast, the analysis of the in-session change in the good outcome cases identified principles of change and clinical strategies from the lowest level of abstractions.

The observation of the in-session changes clarified that the work required by the client and therapist between the successful beginning and ending of therapy was not easy. The therapeutic interactions that resulted in a good outcome were summarized in the model of five important turns (patterns of interactions) engaged in by the therapist and client to help the client to become a safe husband and father (see app., figure 2). This model highlights the aspects of change in IPV psychotherapy that are suitable for informing theoretical models of changes in psychotherapy and launching principles of change in IPV therapy. This topic is discussed in further detail.

Change as repetitions and circularity. The clients' repetitions of the stories about 'the annoying other' were a surprising finding because I expected to observe a gradual change in the clients' perceptions of their partners throughout the course of therapy. My pre-assumption was most likely embedded in how change processes in psychotherapy are typically conceptualized. The therapeutic change process is often outlined as stages or phases the client goes through.

In general, clients are expected to undergo the following stages for therapy to work: unconscious incompetence, conscious incompetence, conscious competence, and finally, unconscious competence (Goldfried, 2009). The trans-theoretical model (TTM) describes the process of changing problematic behavior (e.g., smoking and violent acts) by the following six stages: pre-contemplation, contemplation, preparation, action, maintenance, and termination (Prochaska & diClemente, 1982; Prochaska & Norcross, 2002). Furthermore, the assimilation of problematic experiences scale (APES) refers to the following eight levels through which problematic experiences are assimilated: warded off/dissociated, unwanted thoughts/active avoidance, vague awareness, problem statement/clarification, insight and understanding, work through, resourcefulness/problem solution, integration and mastery (Stiles et al., 1990; Stiles, 2002). The levels of the APES could be considered a continuum, with the intermediate stages occurring between the main stages (Stiles, 2002).

These conceptual models of client change are grounded in the specific fields from which the different models were developed[6]. However, these models also provide general descriptions of client change, which could capture all therapeutic change processes. For example, the client change processes observed in the three good outcome cases can be described by the regular developmental sequence illustrated in the assimilation model (Stiles, 2002). First, the clients recognized violence as a personal problem (vague awareness). Then, the clients reformulated the problem from 'not being good enough to tolerate provocations' to more personal issues, such as a struggle to express one's feelings and needs (problem statements/clarification), followed by an understanding of the personal patterns more deeply through the development of a cohesive self-narrative (insight/understanding). Finally, the clients resolved the problem by developing new perspectives regarding both themselves and others and rehearsals of alternative responses to acting violently (work through,

[6] The TTM model was developed based on studies investigating how to quit smoking and therefore launches a model of readiness to change problematic behavior. In contrast, studies investigating time-limited psychotherapy of depression have shaped the assimilation model that is a description of the sequence of psychological change (Stiles, 2002).

resourcefulness/problem solution, and integration/mastery). This way of describing change depicts change as a linear process.

Even though client change could be described as a gradual and linear process, the analysis of the in-session change process revealed that repetitions of the same perspective were more prominent than a smooth and gradual evolvement. The stories about 'the annoying other' were repeatedly introduced to therapy even though new perspectives were developed in the previous session, which could be interpreted as a relapse from a more integrated to a less integrated stage. Prochaska & Norcross (2002) state that relapses (start smoking or act violently again) are the rule rather than the exception. Because clients relapse and therefore progress through the stages several times, the change process is likely spiral rather than linear. However, when the process of relapses is described using clinical examples (Prochaska & Norcross, 2002), I find the movement described to be more consistent with moving back to the start or starting over again and, therefore, somewhat linear.

Based on the observation of the in-session interaction, I propose a circular model of change. Rather than understanding the repetitions about 'the annoying other' and the reoccurrence of violent acts as relapses or starting over again, these repetitions should be interpreted as the client's way of bringing his personal problem of acting violently to the scene of therapy. The therapeutic strategy of exploring the client's inner experiences of the situations with the annoying other moved these accounts from deadlocked repetitions to salient change work. The therapists approach the key issue of 'the annoying other' both similarly (focusing on subjectivity) and differently (range of interventions, adding new perspectives). This work creates possibilities for the client to transcend toward being more aware of his inner disturbances and resources and being able to include the partner's state of mind in situations where he felt attacked.

Each of the turns in which the therapist and client engaged was intertwined and interdependent. Hence, the process of change unfolded as circular movements around the key topic of 'the annoying other' rather than as a linear movement from one stage to the next. Client change was observed as a radial expansion from the midpoint and included the repeated occurrence of all turns (see app., figure 2). Thus, the 'annoying other' did not vanish because most intimate partners can be expected to be annoying occasionally; instead, the clients were able to relate behaviorally, cognitively, and emotionally to their partners' contributions in non-violent ways. This finding is supported by a meta-analysis of clients' therapy experiences. The clients experienced the change as holistic, including patterns of thinking, behaving, feeling, and relating (Levitt et al., 2016).

Stiles (2002) discusses the difference between transcending gradually and back and forth along stages by referring to two contrasting assimilation studies. In one study, the therapist followed the client's stage, and the client took the initiative to advance to higher levels (Glick, Stiles, & Greenberg, 2000). In the other study, the therapist challenged and pulled the client along the stages (Osatuke, Stiles, Shipiro, & Barkham, 2000). Graphically, the first study showed a smooth but gradual progression along the stage continuum, whereas in the latter study, progression was described as a saw-tooth pattern, which might resemble the pattern of repetitions in the analysis of the in-session changes. In the Osatuke et al. (2000) study, this pattern was explained by the therapist's strategy of focusing on the issues individually. In response to each new topic introduced by the therapist, the client started at a lower level than that reached in response to a different topic in a previous session. In our sample, the client introduced the pattern of repetitions (saw tooth), and the therapist maintained the focus on change by not approaching the story about 'the annoying other' as a return to the need to recognize violence as a personal problem. Instead, the therapists attended to these stories as an opportunity to expand the clients' understanding of themselves and the others. This therapist strategy could be considered an example of therapists following the client's stage as described by Glick et al. (2000). However, I claim that a model in which the clients' and therapists' repetitious engagement in 'the annoying other' is described solely as a gradual and linear change would not be embedded well in the data and could facilitate misinterpretations of the clients' contributions and therapists' expectations in the field of voluntary IPV therapy.

IPV therapy models also organize their content by phases. The ATV model followed by the therapists participating in this qualitative inquiry emphasizes the following four phases: focus on violence, focus on responsibility, focus on connection between personal history and present use of violence, and focus on consequences of acting violent (Råkil, 2002). In a recent book on trauma-informed treatment and prevention in intimate partner violence, the authors propose an individual therapeutic approach that includes the following phases: establishing a therapeutic alliance, focusing on safety and stabilization, enhancing relationship functioning, and finally, recovering from trauma and preventing relapse (Taft, Murphy, & Creech, 2016). These models convey that clients need different amounts of time to pass through the phases; however, the successful completion of one stage is necessary before moving to the next (Råkil, 2002).

The main domains of the phases outlined in the ATV model can be recognized in the turns taken in the three good outcome cases. This should not be surprising because the data

included observations based on the ATV model. The new knowledge added by our analysis is that the therapist did not approach these phases successively. Instead, the different phases of therapy were addressed and worked on in an intertwined and repeated fashion. Hence, I use the concept of *turns* rather than *phases* to describe the facilitative work. I claim that the model of the five important turns is more closely linked to the actual practice of therapy and, therefore, might offer more useful guidelines for therapists than models that describe change by phases or stages. Models that depict the process of client change as linear and facilitative change work as one step after the other may mislead the therapist to interpret that repetitious work is an indication of stagnation rather than salient change work.

The role of bringing everyday life experiences into therapy. The stories the clients told about 'the annoying other' represented actual events from their everyday lives and were not accounts of what usually occurs between the clients and their partners. This distinction between 'personal' and 'habitual' narratives (Polanyi, 1982 referred in McLeod, 1999) appears to be important. Telling stories about their actual daily life experiences might have served as a means to evoke feelings and thoughts that were present in the actual and relevant event (Rennie, 1994b). Thus, the therapist's explorative questions elicited relevant personal material that could be clarified and expanded upon.

Furthermore, storytelling might be considered a way in which humans make sense of their lives (Bruner, 1990; Polkinghorne, 1988) and has been shown to be a way of coping with inner disturbance (Rennie, 1994b). Therefore, we can understand the reoccurring story of 'the annoying other' as the clients' effort to make sense of what was actually occurring with their partners. In these interactions, the client did not experience the partner as the woman he would like her to be and simultaneously he experienced that he was not able to act as the male partner he would like to be. The exploration of the client's subjective experiences of 'the annoying other' led by the therapist, but certainly followed up by the client, directed the attention toward the fact that *he* was the observer and that what he *observed* helped them both get to know more deeply how his self-respect was threatened and how his sensitivity toward his partner's state of mind could be enhanced. Thus, the stories of everyday life served as an arena in which his masculinity could be worked out in the tension between self-respect and sensitivity to the female partner (Haavind, 2000a). Thus, gender was not addressed as the cause of IPV but as the result of IPV.

The therapist's active listening and explorations could be considered acts of acknowledgment. In this setting, acknowledgment is intended, on the one hand, to validate the client's experiences and, on the other, to recognize his way of experiencing the world, i.e., the

way in which he constructs reality (Moi, 2017). A therapist can only respond appropriately in a way that can facilitate new insight and behavior if he or she clearly and genuinely understands the client. Such therapeutic interaction demands attentive presence or awareness on the part of the therapist. If the therapist followed prior or more generalized knowledge, such as 'clients need to manage anger' or the stories of 'the annoying other' are examples of patriarchal attitudes or disavowing responsibility, the therapist could have easily mobilized interventions to help the client act differently or understand women's rights differently. Hence, the therapist would have risked missing what was at stake for the particular man and positioned him as a recipient of therapy.

When the therapists approached the clients' storytelling of 'the annoying other' as an opportunity to clarify the clients' inner experiences of both themselves and the others, the stories became particularly relevant starting points for change. The client allowed himself to be known, and the therapist entered the client's subjective world (McLeod, 1999). What started out as an effort to make sense of everyday events was transformed into an act of making sense of oneself. One might argue that engagement in such empathic interactions is particularly important for men who struggle with being sensitive to their partners' needs without experiencing this process as a threat to their dignity.

Client agency in therapy and real life. One significant question is how the observed in-session process of change can shed light on the changes the client describes in his real life after ending therapy. To elaborate upon this connection, it is beneficial to underline how both the clients and their partners emphasized the importance of change in violent behavior. However, the client's openness about his feelings, his capacity to be less negatively affected by others' contributions, and his more empathic involvement with his partner and children were perceived as equally important changes. These descriptions of change highlight the client's active involvement in his relationships with his partner and children.

Agency is concerned with the way people affect things, others, themselves, or their lives (Mackrill, 2009). One might state that male clients entering IPV therapy experience a lack of agency both regarding their own feelings and behavior and in their relationship with their partners. Although the encouragement of clients' agency appeared salient in both the analyses of early alliance formation and change in the good outcome cases, the design of the analyses does not allow for a causal connection between these in-session processes and the outcome of therapy. However, the way agency was developed and addressed in the therapy sessions might shed light on how the clients brought experiences and changes obtained in the therapy room to their real world.

Client agency consists of his actions and reflections and is a condition of human existence and relatedness (see Mackrill, 2009; Rennie, 2004). Thus, clients are agents everywhere both in the therapy room and outside in the real world. For example, the client acted agentic when he disclosed disturbing events from everyday life. These interaction sequences between him and his partner were often told without much reflection. Hence, these accounts represented the client's none-reflexive agency. The therapist's strategies facilitated reflections and awareness. Reflecting upon our interactions with reality through language representations evolves meaning (Bruner, 1985; Haavind, 2000b; 2007) and is the foundation of intentionality (Rennie, 1994b, 2004). Thus, to engage in reflexivity clarifies one's intention and opens the search for new ways to cope with conflict. Client reflections concerning helpful events in therapy emphasize this point. Curiosity about themselves was developed by the therapists' encouraging sustained exploration of how the clients interacted with their significant others (Fitzpatrick, Janzen, Chamodraka, & Prak, 2006; Fitzpatrick, Janzon, Chamodraka, Gamberg, & Blake, 2009; Levitt et al., 2016). Moreover, the clients did not want to be persuaded; instead, they wanted to arrive at a solution that was based on a thorough understanding of their challenges (Levitt et al., 2016).

Client agency as acting was also introduced to therapy using role-play. In these tasks, acting and reflecting occurred almost simultaneously. For example, in a role-playing activity, the client acted what he wanted to say to apologize to his son for being aggressive and violent. The therapist involved herself in the role-play by validating and also mildly correcting ("maybe you should not say that") the client's way of phrasing the excuse. Almost immediately after the therapist's feedback, the client discovers that he is being accusatory. The client is self-aware when he forms the intention to apologize; however, when he acts, he appears to lose awareness until his initial intention is disturbed, and then, he becomes aware again. In this manner, the two parties together create an interaction and a dialog that help the client consider his likely actions in everyday life by stepping away from the activity and reflecting upon and becoming aware of his intentions and the process through which he loses this awareness.

These rehearsals appeared to help the clients transcend the distinction between intentions and intentions-in-actions (Searl, 1983 as referred in Rennie, 2004). This work might have helped the clients become more reflective and aware when they acted in the real world. According to Giorgi, Giorgi, and Boudreau (2011), clients conveyed that concrete actions that challenged old assumptions were necessary for developing new insight and future patterns. These therapeutic interactions are also examples of the way in which therapy allows

for new and corrective experience (Castonguay & Beutler, 2006). Furthermore, the concept of procedural learning might illuminate the value of this repetitive work. Complex activities (such as trusting the other, interpreting the other's mind and regulating one's own feelings) must be repeated until all of the relevant neural systems work together to automatically reproduce the activity (Grigsby & Stevens, 2000).

Limitations and Future Research

The present study analyzed interactions between men entering IPV therapy voluntarily and therapists who were trained and experienced in IPV therapy. Furthermore, the context of these therapeutic interactions was an outpatient clinic that specialized in IPV treatment in a country where gender equality is the norm rather than the exception. These aspects of the context of the study may limit the potential significance of the findings for mandatory treatment and therapists who are less experienced in IPV therapy, work in clinical settings not specified for IPV or in more patriarchal cultures. However, the aim of this qualitative analysis was not to draw a universal conclusion about a randomly sampled population as in statistical generalizations (Kvale, 1996). Instead of transcending context by eliminating individual variation, we purposively selected variation and similarities to enhance the possibility of producing results that are dense and nuance descriptions of alliance formation and change processes in IPV therapy. The level of generalization is the meaning that we attributed to the observed patterns of client contributions to an early alliance, therapist responsiveness, and the process of change (Oddli, 2012).

Furthermore, it is important to note that the recipients in this study are practitioners, and the selection of cases was assumed to be highly relevant for therapists. I aspired to generate knowledge that can help therapists facilitate change in a client population that often drop out of therapy and struggle to end their violent behavior. The models include concepts that are suitable to guide therapists in their current efforts to establish an alliance and the cumbersome trajectory towards a good outcome. Hopefully, the conceptual models of alliance and change will inform and inspire clinicians in a wider set of contexts in the field of IPV treatment than the particular population we studied.

Two lines of future studies appear particularly interesting and useful. Three cases were analyzed and resulted in the conceptualization of five important turns to a good outcome. Although these cases were purposively selected, an analysis of other similar cases could potentially add knowledge regarding the observed patterns. Additionally, an analysis of completed long-term cases that did not achieve a good outcome as a contrast to the three cases already analyzed could both strengthen and nuance the model outlined. Such similar but

contrasting cases are suitable for deepening our understanding of change processes in IPV therapy

Furthermore, to select data that are suitable for informing our research questions, we leaned on clients' and therapists' reflexive notes on the helpfulness of the sessions and the clients' and partners' descriptions of the client changes at T2 and T3. However, these reflexive data were rather shallow and did not allow for a more detailed analysis of how the client and the therapist perceived the therapy process or how both the client and the partner made sense of the clients change process. More in-depth interviews with therapists and clients about their reflections on the therapy process could provide access to their conscious intentions in therapy and thus further inform the observed patterns. Moreover, such interviews with clients and their partners about client change could illuminate the meaning of change in IPV therapy at a denser level than that obtained using self-reports of perpetration or victimization of violence.

Implication of the Conceptual Models for Clinical Practice

By studying the practice of ATV therapists and their clients, three conceptual models of alliance formation and in-session change were developed. The intention of these models is to guide therapists in identifying facilitative and hindering aspects of their moment-to-moment interactions with their clients. Hence, I formulated a set of clinical principles for facilitating change in voluntary therapy with men perpetrating violence against their female partners.

The therapist should make an effort to be curious about and explore the client's inner experiences around the violent events. Explorative strategies appear to help the client engage in self-exploration and change work and appear to be crucial for establishing an early alliance and facilitating change.

At the beginning of therapy, therapists must be attentive to their own tendencies to pull the client in the desired direction of taking responsibility for ending his violent actions and the client's compliant responses because this interaction pattern appears to hinder client engagement in therapy.

Furthermore, therapists must search for the client's gateways and invitations to an alliance because these invitations indicate the client's important values and their goals for life and therapy. The client's invitations to an alliance appear to be a good starting point for finding a common ground for work.

Moreover, therapists should be cautious in adapting problem-solving interventions early in therapy because these interventions will not help the client develop beyond his initial

coping strategy of ‘not letting the other get to me’. However, this recommendation does not exclude routines of helping clients regulate anger by for example time out techniques.

Throughout the course of therapy, therapists must endure their clients’ repetitions of stories of ‘the annoying other’ and encourage the clients to share these experiences. Daily experiences with ‘the annoying other’ is the key to IPV therapy and offers an opportunity to get to know the client and what is at stake for him in significant events. Therapy for men perpetrating IPV must cover a certain length of time to allow for the repetitions that are necessary for the client to change.

Finally, I recommend that therapists focus on facilitating their clients’ self-awareness rather than helping them take responsibility and admit abuse. This recommendation does not indicate that their responsibility for acting violently should be ignored. At the beginning of therapy, responsibility is aided by the client sensing that he creates his violent behavior. Through therapy, the client develops his responsibility as he expands his capacity to recognize the consequences of his actions and allow this insight to influence his future contributions in his relationship with his wife and children.

An additional question is whether these clinical principles can be converted to practice. At one of the ATV clinics, we are applying the principles of alliance formation. By watching video recordings of the beginning of therapy, we searched for strong invitations to an alliance and experimented with how to intervene to transform weak invitations into stronger invitations and become aware of how the therapists’ interventions form different interaction patterns. We have experienced that this work gives space to the therapists to practice particular skills, which is an example of deliberate practice that has been found to increase therapists’ effectiveness (Chow, Seidel, Miller, Kane, & Thornton, 2015; Goldberg et al., 2016).

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Appendix

Figure 1.

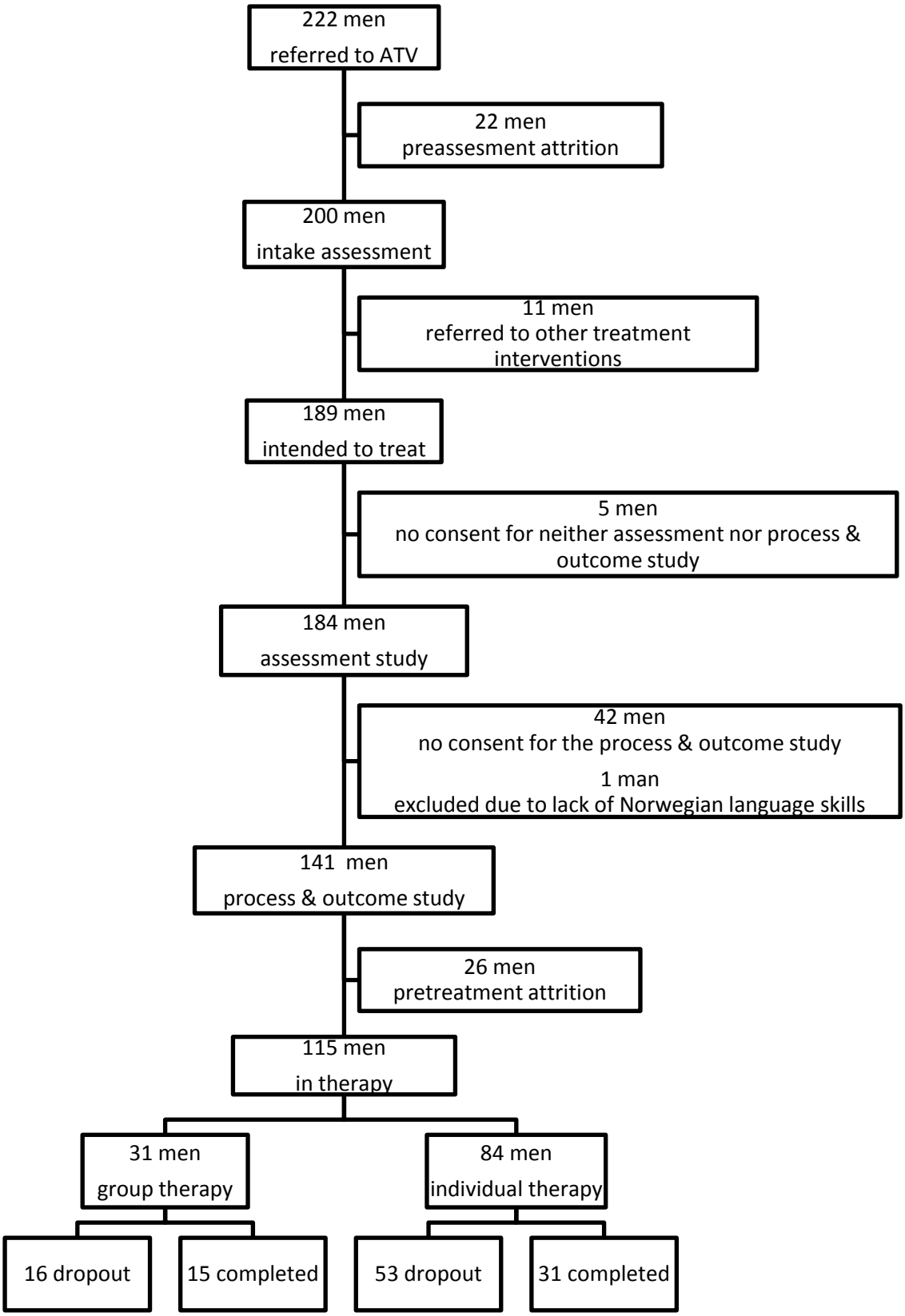


Table 1

Gateways to an alliance as offered by 20 men in intimate partner violence treatment

Gateways and invitations with numbers of men from completed (C) and dropout (D) therapies	Examples of client invitations to a working alliance
Seeking therapy	
as one's own choice (7C, 4D)	It (psychological violence) shall not affect my children or my partner. So coming here is for my own sake.
as avoidance (3C, 3D)	She wants to leave me, but she knows I want to change. All I want to know is that I have a chance to continue to be with her…
as a mistake (3D)	I really don't remember [If I was the one calling this clinic]. It may be me, but it's not important. Eh I'm here but not because I find it right, absolutely not.
Notions of change	
I want to stop using violence (9C)	It is unwanted behavior. I want to get rid of it. I must learn to deal with my anger. I have some dammed up anger inside of me.
Violence is not acceptable, but... (1C, 6D)	I have been physical when others are physical. When you're a guy of 90 kg and you're together with a girl of 45 kg, there is no excuse for throwing her to the floor... I have used violence. But it has been adequate violence. I have not been the one to escalate it.
My partner is the problem (4D)	I'm not a violent man, because I use my head to think. My wife has beaten me but I can't report her to the police, you see. Ehh, I'm sorry but I have to say this, we're sitting here because she also needs help.
Disclosure of violence	
as a personal narrative (4C)	I need a lot of attention. I'm very insecure, so I go on asking: "Do you want this, is something wrong?" Then she gets tired of me asking and it turns into a discussion, then I get frustrated and have to throw something onto the floor or I hit her arm or pull her by the hair or push her down into a chair… things like that. And then I feel everything is very sad.
as a scene (2C, 1D)	It was an episode at Easter. I call it physical… I've been more short-tempered, more acute anger. I do not kick her, I do not hit her in the face either, but I have hit her shoulder. Not with full force but, smack, here. I have never thought of hitting her in the face.
as a fragment of one's life (3C, 4D)	I have kind of thrown her to the ground and... She has kicked me and scratched and it has sort of been… but in a way it has never been violence, it's been more frustration.
as something else (1C, 5D)	A lot of words are coming out of me. I often get eager, so to speak. But she tells me that we should not discuss when alcohol is in the picture, but she will never discuss.

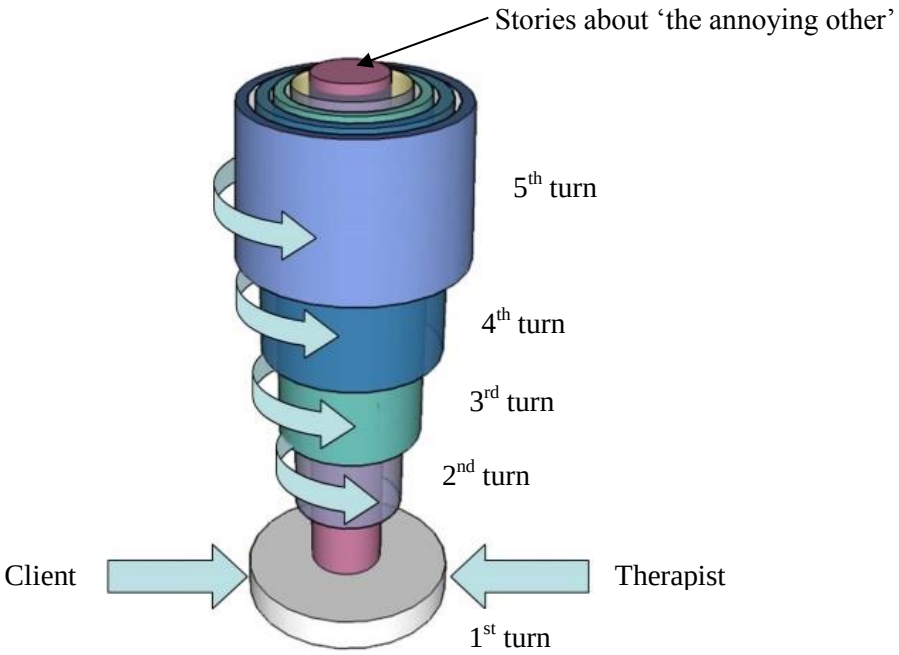
Table 2: *Distribution of completed and dropout cases across interactive patterns and client invitations*

Completed and dropout cases	Interactive pattern	Strength of client invitations during the first session	Attended Sessions	Therapist	Therapist gender
C1	Co-creative interaction	Strong (6)	21	T5	Female
C2	Co-creative interaction	Strong (6)	31	T9	Male
C3	Co-creative interaction	Strong (6)	25	T10	Female
C4	Co-creative interaction	Strong (5)	10	T2	Male
C5	Co-creative interaction	Strong (5)	40	T9	Male
C8	Co-creative interaction	Vague (4)	18	T2	Male
C10	Co-creative interaction	Vague (3)	36	T7	Male
C6	Pull-avoid interaction	Strong (5)	12	T7	Male
C7	Pull-avoid interaction	Strong (5)	9	T6	Female
C9	Pull-avoid interaction	Vague (4)	13	T11	Female
D1	Co-creative interaction	Vague (4)	1	T5	female
D10	Co-creative interaction	Weak (0)	3	T7	Male
D8	Co-creative interaction	Weak (2)	6	T11	Female
D2	Pull-avoid interaction	Vague (4)	1	T4	Female
D3	Pull-avoid interaction	Vague (3)	5	T6	Female
D6	Pull-avoid interaction	Weak (2)	3	T8	Male
D7	Pull-avoid interaction	Weak (2)	3	T1	Male
D9	Pull-avoid interaction	Weak (1)	3	T5	Female
D4	Tiptoeing softly interaction	Weak (2)	2	T3	Male
D5	Tiptoeing softly interaction	Weak (2)	5	T2	Male

The invitations in the three gateways to an alliance ranged from weak = 0 and medium = 1 to strong = 2. Each client received a score ranging from 0 (therapy is a mistake, my partner has to change, no description of violent acts) to 6 (my own choice to enter therapy, I want to change my violent behavior, disclose violent behavior as a personal narrative) as a maximum. 6-5 = strong, 4-3 = vague, and 2-0 = weak invitations to an alliance.

Figure 2.

Conceptual model of five important turns to become a safe husband and father



1st turn= Finding common ground on violence as a personal problem; 2nd turn= Exploring clients experiences of 'the annoying other'; 3rd turn= Clarifying personal patterns of being an intimate partner and father; 4th turn= Creating a cohesive self-narrative as a boy and a man; & 5th turn= Including the state of mind of the other when feeling attacked.