THE ROLE OF COMMON FACTORS IN PIVOTAL MOMENTS IN COUPLE AND FAMILY THERAPY

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To my dearest parents, Nurcan and Levent Bingöl

ABSTRACT

The aim of the current study is to investigate the role of common factors specific to CFT in the pivotal moments of CFT sessions. Participants of the study are 10 practicing couple and family therapists from Ozyegin University CFT master's program and their 13 clients. The researcher conducted interviews with therapists and clients after the first three sessions. Thirty-five interview was conducted and analyzed with Grounded Theory Methodology. Findings showed that clients reported more pivotal moments in the second session and third session compared to first session. In addition, clients and therapists reporting of pivotal moments are matching, however therapists report more pivotal moments for the same session compared to their clients. The findings of the study will inform researchers and therapists regarding in session experiences of pivotal moments which are considered to be associated with clients' change mechanism in relational/systemic therapy. In addition, the current study possesses clinical implications in terms of guiding clinicians work in understanding how pivotal moments occur.

Keywords: pivotal moments, common factors, couple and family therapy

ÖZET

Bu araştırmanın amacı çift ve aile terapisine özgü ortak faktörlerin seanslarda deneyimlenen önemli anlardaki rolünü incelemektir. Araştırmanın katılımcılarını Özyeğin Üniversitesi Çift ve Aile Merkezi'nde stajlarını yapmakta olan 10 yüksek lisans öğrencisi ve 13 danışan oluşturmaktadır. Katılımcılar ile birinci, ikinci ve üçüncü seansları sonrası toplamda 35 görüşme yürütülmüş ve bu görüşmeler Temellendirilmiş Kuram yöntemi ile analiz edilmiştir. Bulgular, seans içinde önemli an deneyimlerinin terapistin yaklaşımı, terapistin danışanın problemdeki rolünü sorgulaması ve diğer aile üyelerinin gelişimine tanık olma ile ilintili olduğunu ortaya koymuştur. Önemli an deneyimlemenin sonucunda umut, rahatlama, üzüntü ve perspektif değişimi olduğu bulunmuştur. Bu araştırmanın sonuçları, danışanların ilişkisel/sistemik terapide değişim mekanizması ile ilintili olduğu düşünülen seans içi deneyimleri hakkında araştırmacıları bilgilendirecek, terapistler için ise danışanları ile çalışmalarında yol gösterici olacaktır.

Anahtar Kelimeler: seans içinde deneyimlenen önemli anlar, ortak faktörler, çift ve aile terapisi

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CHAPTER 1

INTRODUCTION

Common factors are proposed as the mechanisms of change that are present in all psychotherapy models by common factors paradigm proponents (Sprenkle, Davis, & Lebow, 2009). However, research investigating the role of common factors in the field of Couple and Family Therapy (CFT) is scarce (D'Aniello, 2015). The aim of the current study is to investigate the role of common factors specific to CFT in the pivotal moments of CFT sessions. With this aim, following four research questions are posed in the current study: 1) What moments do CFT clients and couple and family therapists view as pivotal (significant, different, helpful, meaningful) in individual, couple and family therapy sessions? 2) What makes these moments pivotal for each and what do they attribute its importance to? 3) Do clients' and therapists' views match? If so which ones do? If not, which ones do not? 4) Are these pivotal moments related to the CFT common factors or not?

In the following sections, I will first describe the history of psychotherapy outcome research in general since CFT common factors emerged as an extension of the debate between model-driven/specific factors versus common factors paradigms. Later I will describe the common factors paradigm specific to CFT and then introduce the aims of the present study in more detail.

1.1. Psychotherapy Outcome Research

Research investigating the factors affecting client outcomes in psychotherapy is defined as psychotherapy outcome research. The two main psychotherapy outcome research are efficacy and effectiveness studies. Efficacy studies are generally conducted in highly scrutinized

conditions (i.e., laboratory environment) with specific populations (i.e., no comorbidity). Although, controlled nature of study designs in efficacy studies increases the internal validity of their findings, their applicability to real-life settings declines (Blow et al., 2009). On the other hand, effectiveness studies investigate the impact of psychotherapy under real life circumstances. In real-life settings, psychotherapy is not generally conducted in a laboratory setting and there is often comorbidity in the psychological problems that clients bring into therapy (Blow et al., 2009).

Although few psychoanalytic institutions had published outcome reports in 1930s and 1940s (Obendorf, Greenacre, & Kubie, 1948), the first exhaustive psychotherapy outcome research was conducted by Hans Eysenck in 1952 (Eysenck, 1952). Nineteen outcome studies of both psychoanalytic and eclectic therapies which covered eight thousand cases were compared based on four categories of patient outcome. The categories were cured/much improved, improved, slightly improved, and not improved/left treatment/patient died. The groundbreaking study's findings did not support the effectiveness neither for psychoanalytic, nor eclectic psychotherapy (Eysenck, 1952). He asserted that psychotherapy is ineffective and redundant. As Eynsenck (1952) pointed out:

> Patients treated by means of psychoanalysis improve to the extent of 44 per cent; patients treated eclectically improve to the extent of 64 per cent; patients treated only custodially or by general practitioners improve to the extent of 72 per cent. There thus appears to be an inverse correlation between recovery and psychotherapy; the more psychotherapy, the smaller the recovery rate. (p. 320)

This study had several methodological issues. Firstly, eclectic psychotherapy was not defined, thus the readers do not have the information on what constituted eclectic therapy. Secondly, diagnostic information was not provided except for stating that some have organ

neurosis, psychopathic states and character disturbances. Since these are not specific diagnoses, one cannot state whether psychotherapy was useful for a specific disorder. Thirdly, therapy outcome categories were not clear in terms of the measures used for assessment. Finally, therapy drop-outs and deaths were categorized with clients who did not show improvement which increased the ineffectiveness of psychotherapy inaccurately. The study also did not have clear inclusion criteria. Although Eysenck's study had serious methodological issues, the study was very important for its initiative role in the area of psychotherapy outcome research. The findings of the study had led researchers to focus more on comparative psychotherapy studies. Although some studies found significant effects of behavioral psychotherapy (Bergin, 1971), overall there were no robust findings supporting the positive effects of psychotherapy until 1975.

Luborsky, Singer, and Luborsky (1975) conducted a meta-analysis which included eleven psychotherapy outcome studies. The therapy models which were included in the meta-analysis were client-centered, psychoanalytic, behavioral, and Adlerian. All studies included in the meta-analysis had a control group, although not all studies used randomization. The outcome was measured via either therapists' or clients' ratings on reaching the therapy goals. The results of the study showed that clients in all psychotherapy models showed better outcome results compared to control groups. However, the results did not find a significant difference among different psychotherapy models. Thus, the findings of the study significantly supported the effectiveness of psychotherapy regardless of the model. Luborsky and colleagues (1975) used the term 'Dodo-bird verdict' which inspired the title of the famous article "Everybody has won and all must have prizes." Some researchers challenged the findings of the study, suggesting that results might be due to methodological issues (Stiles, Shapiro, & Elliott, 1986), however Luborsky et al's study (1975) had led to a new paradigm: nonspecific factors. Nonspecific factors paradigm is defined

with the components that all psychotherapies have regardless of the therapy model. These include; therapeutic alliance, therapist empathy, client motivation, client openness to receive help, therapist congruence and genuineness, therapist hope for client recovery, therapist unconditional positive regard, therapist supports self-efficacy, therapist feedback, therapist combats client's feelings of isolation, and therapist serve as a role model (Stamoulos et al., 2016). Thus, a new debate begun concerning the psychotherapy outcome research where the question of the effectiveness of psychotherapy was replaced with the question of whether all efficient psychotherapies have common factors that work. In the next section I will define specific and nonspecific factors paradigms in detail, then I will discuss the dichotomization of the two paradigms.

1.2. Specific versus Nonspecific Paradigms

For over 60 years, psychotherapy outcome research was dominated by two different paradigms (Butler & Strupp, 1986). Both the specific and the nonspecific paradigms concerning psychotherapy outcome pose certain hypotheses about why psychotherapy works. The difference between the two paradigms stem from the answers they give to this question. According to the specific paradigm, client change is due to the specific and unique elements of the specific therapy model. For instance, a cognitive behavioral therapist would attribute client change to cognitive restructuring, whereas a therapist who adheres to the psychodynamic approach would attribute change to catharsis.

On the other hand, nonspecific paradigm is defined with the factors related to client change that efficient therapy models have. Thus, the proponents of the nonspecific paradigm asserts that regardless of specific interventions, different therapy models share some core factors that facilitate psychotherapy outcome. For example, therapeutic relationship is a key mechanism

of change regardless of the therapists' choice of therapy model. Although different therapy models might have a different approach to therapeutic relationship, all effective psychotherapy models incorporate and emphasize client-therapist relationship. As mentioned in the above section, nonspecific factors paradigm has its roots in the psychotherapy outcome research that found no differential effectiveness among different therapy models (Luborsky et al., 1975). Frank (1973) suggested an explanation to why there is no difference in the effectiveness among the various psychotherapy models. Accordingly, although clients come to therapy with various problems, they all experience some kind of 'demoralization'. According to the demoralization hypothesis, clients feel hopeless, unable to cope, and worthless. Frank then suggested that different psychotherapy models work well with clients due to the models' shared components that target this sense of demoralization. Nonspecific factors were attributed as "placebo effect" in medical trials. Therefore, in order to eliminate the placebo effect and to determine the specific interventions that cause client outcome, Rosenthal and Frank (1956) suggested the adaptation of medical placebo trials to psychotherapy outcome research. Analogous to medical placebo trials, psychotherapy researchers adapted randomized controlled trials (RCTs). The adaptation of RCTs to psychotherapy was criticized by many researchers for several reasons. Blind procedures which were used in placebo trials was not possible in psychotherapy research, since neither therapists nor clients can be blinded in psychotherapy. In addition, researchers cannot be sure whether client change was due the specific interventions of the model or due to "placebo effect" of coming to therapy (Wampold & Yulish, 2016).

Ahn and Wampold (2001) conducted a meta-analysis with 21 studies in order to investigate whether theoretically stated effective components of psychotherapy models (specific ingredients) have higher outcome results. The studies that were involved in the meta-analysis had

an experimental group in which the clients received specific components and had a comparison group lacking one, two or three of those active components. For instance, while clients in 'more components group' received both cognitive therapy (CT) and progressive muscle relaxation (PMR), clients in 'less components group' received only PMR. The cognitive component of CT was tested via comparing the two groups based on the client outcomes. The components that were tested based on client outcome included: progressive muscle relaxation (PMR), cognitive restructuring (CR), self-control desensitization, relaxation skills, cognitive component, behavioral component, cognitive component and self-control desensitization, social support, generalized training and affective exploration, behavioral activation, modification of automatic thoughts, exposure in vivo, tension techniques, advanced CBT with a focus on coping skills and cognitive interventions, religious content modified to fit CBT, family support, size perception training, cognitive social learning and group discussion. According to specific paradigm, these techniques were mechanisms of client change. However, the results showed that when more components and less components groups were compared; no significant difference was found on therapeutic change. That is, being exposed to more techniques did not result in better client outcome than receiving less techniques. Thus, the findings of the study did not support the effects of specific components on better client outcome.

Common factors in psychotherapy are established as mechanisms of change by various studies. Cuijpers et al. (2012) conducted a meta-analysis in order to estimate the effects of common factors in treatment of depression. Nondirective supportive therapy (NDST) was used as a common factor therapy model since NDST does not involve any 'specific' treatment agents other than emphatic listening, reflection, and support. Thirty-one studies included in the meta-analysis used randomized clinical trials in which NDST were compared with a waitlist group

and/or with a different type of psychotherapy/pharmacotherapy. In addition, studies that used instruments such as the Beck Depression Inventory or the Hamilton Rating Scale for Depression were included in the meta-analysis. Firstly, researchers estimated the improvement between baseline and post-treatment in the control conditions, in order to determine client change caused by extra-therapeutic factors spontaneous recovery and/or community support. Secondly, the role of non-specific factors on change was determined based on the effect size difference between NDST (common factor therapy model) and control group post-treatment. Lastly, effect size indicating the difference between NDST and other therapy models (cognitive-behavioral, experiential psychotherapy) was used to estimate the role of specific techniques on client outcome. Results showed that extra-therapeutic factors (spontaneous recovery and/or community support) contributed 33.3% to client improvement, whereas specific factors such as cognitive structuring contributed 17.1%. Moreover, results showed that common factors such as empathic listening and support contributed to 49.6% of client improvement. Contrary to the specific paradigm which focuses on proving the efficacy of specific treatment techniques for particular disorders, common factors focused on process research examining the 'relationship factors'. These are; therapist variables, client variables, and client-therapist relationship variables (Norcross, 2002).

In one such study examining therapy process Lafferty, Beutler, and Crago (1989) investigated therapist variables (i.e., client involvement, therapist emotional adjustment, therapist credibility, therapist support), client-therapist relationship variables (i.e., unconditional acceptance, empathic listening) and theoretical orientation variables (i.e., cognitive-behavioral, experiential, psychoanalytic). Participants of the study included thirty therapists who were doing their internship in university clinic and their sixty clients. 75% of clients were diagnosed with

anxiety and/or affective disorders, whereas 15% of clients were wither diagnosed with adjustment disorder or were not diagnosed to a specific disorder. Majority of therapists' choice of therapy model were psychodynamic (59.3%), following by eclectic (29.6%), client-centered (7.4%), and behavioral therapy (3.7%). Therapists were divided in two groups based on their randomly chosen two clients' pre- to post-treatment score on the Global Severity Index (GSI) of the SCL-SO-R. That is, in one group fifteen therapists had clients with better outcomes (more effective group), and in other group therapists had clients with no improvement (less effective group). Therapists in both groups were assessed on emotional adjustment, relationship attitudes, support, credibility, and theoretical orientation. Therapists' emotional adjustment was assessed via Neuroticism scale of the Eysenck Personality Inventory. The Barrett-Lennard Relationship Inventory was used to assess therapists' relationship attitudes such as unconditional acceptance and empathic understanding. Support was assessed via Psychotherapy Process Inventory in which the therapists scored themselves on the degree of support and concern that they experienced during the course of therapy. Clients completed The Therapist Credibility Scale in order to assess client perception of therapists' expertise. Finally, The Therapist Orientation Scale was used to assess therapists' beliefs regarding what constitutes change in therapy. Results showed that more effective group had higher therapist empathy, patient involvement, and therapist support compared to the less effective group. Moreover, therapists' theoretical orientation was not related to better client outcome. A major methodological issue of this study was stemming from the choice of measures. The clients were asked to assess their therapists only for credibility. For example, therapists' self-assessment of support may be different from their clients' perception of therapists' support.

Although common factors are not placebo effects, and rather established mechanisms of change they are not separate from specific factors of psychotherapy. Gurman, Wampold & Bruce (2014) discussed the damages of the debate between two paradigms, asserting that common factors approach is another evidence-based approach which will improve our understanding of how and why therapy works. Analogous to the debate between specific factors and common factors in psychotherapy outcome research, there are also two paradigms in the field of CFT that currently dominate the field. However, CFT has its own theoretical common factors as well. Next, I will introduce the common factors specific to CFT.

1.3. Common Factors

Similar to the psychotherapy outcome research, early CFT outcome studies concentrated on comparing CFT with no treatment and alternative treatment groups. For example, Hazelrigg, Cooper, and Borduin (1987) conducted one of the first outcome studies in the field of CFT. Twenty studies that included a control group with a minimum of one parent and child was included in the study. The studies involved varying therapy models including structural family therapy, strategic family therapy, and behavioral family therapy. Marital therapies that did not involve children were excluded. The clients were with problems such as children and adolescents with behavioral problems, adolescent juvenile offenders, and adults in inpatient treatment. Client outcome was measured in three categories. First category of client change was family interactions since family systems theory asserts that changing family interactions is one of the common goals of CFT. Family interaction was measured via self-reports of families in some studies, while others used trained coders who coded families' interactions in terms of presence of conflict and participation of each member to the discussions. Secondly, behavior ratings were measured by parents', teachers', and/or research teams' reports of identified patient's problem

behaviors. And thirdly, the recidivism rates were measured by identifying clients' return to clinic with the same presenting problems. Results showed that 67% of clients in no treatment group showed less desirable outcomes in family interactions and 69% of clients in no treatment group had less favorable behavior ratings. When compared with alternative treatment groups (group therapy, behavior modification, and medication) clients in family therapy showed better outcomes. 74% of clients in family therapy group showed better results in their family interaction ratings whereas 60% of clients in the alternative treatment group showed less favorable results in their behavior ratings. Follow-up data ranging from six weeks to three years with alternative treatment controls showed that 36% of clients in the family therapy group recidivated whereas 58% of clients in the alternative group returned to therapy. Recidivism was not a measure in no treatment group due to small number of follow-up data (Hazelrigg, Cooper, & Borduin, 1987).

As more and more research supported the effectiveness of CFT, researchers started to ask more specific questions such as: "Are there any specific disorders or problems that CFT works better with?" and "Are certain CFT models better than the others?" Shadish et al., (1993) conducted a meta-analysis which included 163 randomized trials to investigate the differences among various therapy models. The inclusion criteria for the study were following marital or family therapy and having randomization. The studies that involved marital therapy was 62 and number of family therapy was 101. Seventy-one studies used control groups, whereas 105 studies used alternative treatment groups. The therapy models included in the study were behavioral and psychoeducational, contingency contracting, behavior exchange, cognitive-behavioral approaches, problem solving, communication training, parent management training, relaxation training, desensitization, systemic, Milan systemic, triadic, strategic, structural,

integrated structural-strategic, functional, humanistic, Satir, Rogerian, psychodynamic, Adlerian, psychoanalytic, psychodynamic, and eclectic. The presenting problems included in the studies varied; conduct disorder, school achievement, phobias, major affective disorder, schizophrenic symptoms, marital dissatisfaction, substance abuse, medical problem coping, sexual dysfunction, communication/problem solving, and divorce problems. The mean number of sessions included in the meta-analysis was eight. When post-test effect sizes of all outcome studies included in the meta-analysis were compared, the findings showed that all therapy orientations produced significant results in terms of client outcome except humanistic therapy model. In addition, the study compared different CFT models when applied to the same presenting problem. In some studies, different systemic therapy models were applied to the same presenting problems of relational dissatisfaction and child conduct problems. There was no significant difference between systematically oriented therapies (systemic, Milan systemic, structural, Satir, strategic, integrated structural-strategic) when compared based on the outcomes of child conduct problems and marital dissatisfaction. Thus, the findings of the study showed that CFT was effective regardless of the model that was used (Shadish et al., 1993).

1.4. Process Research in CFT

There is limited number of process research in CFT. In this section I will summarize these studies and their link with the current study. The one study that focused specifically on pivotal moments was conducted by Helmeke and Sprenkle (2000). Helmeke and Sprenkle (2000) investigated the pivotal moments in couple therapy using the Grounded Theory method. Three couples and their therapist were interviewed within two to ten weeks after termination or the completion of the tenth session. The presenting problems were related to marital/relational problems. The same therapist conducted the couple sessions was a doctorate student in a

marriage and family therapy program. Participants filled out the Post Session Questionnaire (PSQ) after the completion of each session which included questions such as whether they thought something has changed in-session. All sessions were recorded with the permission of clients and the therapist. In each interview, participants watched the videotapes of identified pivotal moments so that they can better recall these moments. Interview questions differed from participant to participant as it is done in Grounded Theory, however all participants were asked what might cause them to experience a pivotal moment. Results showed that majority of pivotal moments were experienced in the beginning stage (first three sessions) of therapy compared to later stages. The therapist reported more pivotal moments compared to her clients. However, clients' and therapists' reports of pivotal moments were not in cohesion. But the causal processes of experiencing a pivotal moment were different for clients and the therapist. Also, couples lacked concurrence regarding pivotal moments. That is, pivotal moments were more likely to be personal and husbands and wives did not match in their reports of pivotal moments. However, all clients' reports of pivotal moments were overwhelmingly related to the presenting problem. This study was important for showing the processes behind occurrence of pivotal moments in-session. The current study's interview questions were based on this study.

Another study that focused on process research was conducted by Christensen, Russell, Miller, and Peterson (1998). In this study researchers also focused on pivotal moments in CFT, however, they did not name these change experiences as pivotal moments. In their qualitative study, Christensen, Russell, Miller, and Peterson (1998) investigated how couples change in therapy via using constant comparison method. Twenty-four partners who were receiving couple therapy were interviewed. Their nine therapists were receiving training in a marriage and family therapy program. Partners were interviewed separately by two researchers. However, interviews

were not conducted immediately after sessions. Interview questions were semi-structured and included questions that inquired what their therapist did to promote change, what was the turning points in which they thought or felt that something has changed. Participants were also asked what were the important factors that helped clients with their presenting problem. Findings showed that participants reported change in three clusters which were interrelated to one another. The three clusters of change included, change in cognition, change in affect, and finally change in communication. Findings also showed that change might begin in one specific cluster, however in general participants eventually showed change in all three clusters. That is, change in one cluster would facilitate change in other clusters. For example, one client's change in view of her relationship (cognition) would facilitate how she feels about her relationship (affect) whereas one client's change in the way her description of the problem would facilitate change in how she views her problem (cognition). Thus, findings of the study showed that each participant have unique paths in their change process, nonetheless affect, cognition and communication were present in every path.

One study specifically focused on change progress by receiving feedback from clients after every session. Pinsof, Goldsmith, and Latta (2012) discussed the use of the Systemic Therapy Inventory of Change (STIC) in a case example of a couple. The STIC is a client feedback system which focuses on assessing client change and therapeutic alliance in individual, couple and family sessions. In the case example, the clients who came to couple therapy for extramarital affair completed STIC throughout therapy. The therapist reviewed his clients' reports before every session and discussed it with the clients. At the beginning of the sessions, both clients' alliance with each other and with the therapist was low. The therapist was able to catch and target the weak alliance by using this client feedback program. In addition, the

therapist could monitor his clients' reporting of change. Thus, rather than assuming that change was happening he knew the progress of clients' from their perspective. This study was important for promoting the integration of alliance assessment into every stage of therapy.

Davis and Piercy (2007) investigated the role of psychotherapy common factors on client change in three CFT models. In this Grounded Theory study, three therapy model developers (Dr. Susan M. Johnson, Emotionally Focused Therapy, Dr. Frank M. Dattilio, Cognitive-Behavioral Therapy; and Dr. Richard C. Schwartz, Internal Family Systems Therapy), their former students and clients were interviewed via telephone. Interview questions were related to understanding the participants' perceptions regarding the factors that facilitated change in the therapy process. The researchers found that there are certain themes in the therapy process that facilitate client change in all therapy models. These themes were; therapist variables, client variables, therapeutic alliance, and expectancy and motivational factors. For therapist variables, patience, cultural and religious sensitivity, and being caring and having boundaries appeared as common characteristics for the therapists. Former clients described their therapists as respecting their pace in therapy and not forcing them to go fast. In addition, therapists were described as warm and caring and accepting towards their clients while still challenged and encouraged their clients to take risks. For cultural and religious sensitivity, therapists were aware and responsive to clients in their belief and values which in turn strengthened the therapeutic relationship. For client variables, humility, commitment, hard work, and being psychologically and systemically aware were the common client factors. Humility was described as clients' ownerships of their problems and their role in the solutions of their problems. The study showed that by the end of therapy all clients perceived themselves as taking responsibility for their problems that they bring to therapy and as willing to take risks to solve their problems. Most clients reported

themselves as committed to the therapy process. They reported that they were willing to keep working on their relationship and were committed to try new things. For psychological and systemic awareness, clients were able to understand abstract concepts which were introduced by the therapist in relation to clients' psychological and systemic problems. The researchers suggested that this understanding was helped and fostered clients' change process. For therapeutic alliance, mutual trust and respect appeared as the common factors. Both clients and therapists reported respect and trust for each other. Therapists reported that as they observe clients as hard working, their respect and trust towards their clients increased. For clients, when they viewed their therapists as able to handle hardships and tensions their trust and respect increased.

Davis and Piercy's (2007) study was important in terms of showing that common factors that apply to psychotherapy in general also apply to CFT. However, systemic perspective, which is at the basis of all CFT models is particularly different than the other mental health disciplines that emphasize psychopathology and view it as stemming from inside the individual (D'Aniello, 2013). To further emphasize the differences between CFT and other mental health disciplines, in the next section I will present and discuss the common factors which are specific to CFT.

1.5. Common Factors Specific to CFT

Common factors paradigm in the field of CFT suggests that although different CFT models might use different intervention techniques and a unique language, all CFT models include some shared factors that guide the therapists. Sprenkle, Davis, and Lebow (2009) specified the common factors that are specific to CFT. The four common factors that are specific to CFT are; a) relational conceptualization, b) expanded direct treatment system, c) expanded therapeutic alliance and d) disrupting dysfunctional relational patterns.

1.5.1. Relational Conceptualization

The difference between CFT and individual psychotherapy is that couple and family therapists conceptualize problems in terms of clients' contexts and relationships. Thus, even when working with individuals, systemically oriented couple and family therapists include clients' spouses/partners, parents, siblings in the therapy process. The inclusion process might involve asking clients relational questions such as "What do you think would be the response of your mother if she was here?" or "What might your wife feel when you do not respond?". Thus, clients' answers to such questions help therapists to understand the reciprocal interactions that foster clients' complaints (Sprenkle et al., 2009).

Davis and Piercy (2007) found that although above mentioned three model developers (Dr. Susan M. Johnson, Emotionally Focused Therapy, Dr. Frank M. Dattilio, Cognitive-Behavioral Therapy; and Dr. Richard C. Schwartz, Internal Family Systems Therapy) used a unique language specific to their models, there was an overlap in how model therapists conceptualize the problems. The differences among the three models were related to the elements that were emphasized in each model. EFT emphasized emotions, CBT emphasized cognitive and behavioral elements while IFST emphasized all of these elements. However, the findings of the study showed that all therapy models conceptualized the problems in relational terms.

Although there is no research investigating the role of relational conceptualization on client change, relational conceptualization is present in various CFT models. According to EFT which is based on the attachment theory, both partners have the needs of feeling loved, cared, and to feel trust in their relationship. When partners' needs are not met in the relationship they start to communicate with harsh, secondary emotions (i.e., anger) rather than soft, primary emotions (i.e., sadness). In the conceptualization stage, an EFT therapist would conceptualize the

problem in terms of the negative interaction cycle of the couple. This cycle of the couple can be thought as patterns of communicating that the partners cannot break even if it does not work for the couple. Thus, the problem is not seen within one partner or another but viewed as a relational problem that cause difficulties in both partners' lives (Johnson, 2004). Solution-focused therapy assumes that problems should not be the focus of the therapy, since clients are already preoccupied with problems. Solution-focused therapists' main concern is related to the solutions of the problem and clients' perceptions regarding creating and maintaining them. In addition, in conceptualization solution-focused therapist incorporate the clients' perception about the role of significant people's contribution to the problem. For instance, De Jong and Berg (2008) presented an individual therapy case with a woman whose presenting problem was her daughters laziness. The mother was expecting the solution (the change) from the daughter. Thus, the therapist did not conceptualize the problem in terms of the child's problem behaviors, rather facilitated mother's perception of herself as part of the solution (D'Aniello, 2013).

Sprenkle, Davis, & Lebow (2009) suggested that meta-analyses showing the effectiveness of CFT models, are indirect evidence to common factors specific to CFT, since all CFT models conceptualize problems in relational terms. Stratton et al., (2015) systematically reviewed meta-analyses of CFT outcome research. The inclusion criteria for the 386 articles was that sessions were with a family, couple, or had systemic orientation with groups or individuals. The presenting problems include behavioral problems (i.e. adult substance abuse), mental and psychical health diagnostics (i.e. adult schizophrenia, child eating disorders), and adult relationship problems. The results of the study showed that no study reported client deterioration, 16% did not report significant favorable outcome, while 75% of the studies reported better client outcomes compared to control groups.

1.5.2. Disrupting Dysfunctional Relational Patterns

Couple and family therapists aim to disrupt or change the dysfunctional relational patterns as one of their therapy goals (Sprenkle, Davis, & Lebow, 2009). After conceptualizing the case relationally, the 'stuck' cycles are identified and targeted. Davis and Piercy (2007) also found in their above mentioned study that EFT, IFST, and CBT targeted dysfunctional relational patterns. The difference found between the three models was related to their way of targeting the dysfunctional relational patterns, as EFT emphasized emotions, CBFT to cognitive and behavioral elements, and IFTS emphasized emotions, cognitive and behavioral. According to the EFT model problems in relationships occur due to the loss of secure emotional bond between partners and to the negative interaction patterns that maintain this loss (Johnson, 1988). Another assumption of EFT is that insecure attachment is feeding the negative interaction cycle and negative interaction cycles further damage the secure bond. EFT therapists identify and target these negative interactional cycles in order to disrupt the dysfunctional relational patterns. After identifying the underlying attachment problems in relation to the couples' conflict themes, the EFT therapists identify the stances the partners take in the negative interaction cycle. The two stances in the negative interactional cycle are pursuer and withdrawer. Pursuer seek closeness and intimacy via behaviors such as complaining and demanding which is perceived by the withdrawer as not being good enough and useless. The withdrawer then in response generally alienates, stays silent or appears as minimizing the problem (Johnson, 1988). EFT therapists aim to show the purpose of this cycle as a need to create connection to the couple via reframing the cycle in terms of an attachment lens. Underlying the cycle, pursuer is feeling lonely, sad and have an attachment need to feel loved and secure, while withdrawer feels unwanted, helpless and have an attachment need to be appreciated and to be accepted. In CBFT (Dattilio ad Epstein,

2005), therapists disrupt dysfunctional relational patterns through cognitive restructuring. Cognitive distortions, or schemas that individuals' have regarding relationships are targeted. CBFT assumes that partners' cognitions and schemas regarding their partners are closely related to relationship satisfaction. Thus, cognitive restructuring help decrease in cognitive distortions which is harmful to their relationship. Although these models use different techniques, they both aim to target and disrupt dysfunctional relational patterns.

1.5.3. Expanded Therapeutic Alliance

Therapeutic alliance in psychotherapy is the most studied and established common factor which has been proven as an indicator of outcome success regardless of the therapy model (Martin, Garske, & Davis, 2000). Expanded therapeutic alliance is a CFT specific common factor. When working with more than one person in the therapy room, therapists make sure that alliance is formed with all clients. All the members in the therapy room should feel understood, validated, and important. There is no direct evidence showing that expanded therapeutic alliance is a mechanism of change in therapy. However, there is research showing that having alliance with one member but not with the other member(s) (split alliance) is detrimental to the therapy process. Escudero, Boogmans, Loots, & Friedlander (2012) investigated markers of alliance ruptures and repairs in family therapy with a single-mother and daughter. One of the ruptures identified in the study was related to therapists' suggestion to mother regarding the negative effects of mother's stress on her daughter. Little, Turner, Dakof, Alexander, & Kogan (2006) investigated the relation between the expanded alliance and drop-out in the first two sessions of multidimensional family therapy. Participants included 30 adolescents with substance abuse problems and their families. All five therapist participants had a systemic orientation and their clinical experience ranged from 2 to 7 years. Alliance was measured by the revised version of

Vanderbilt Therapeutic Alliance (VTA-R) which consist of 26 items to assess each members' therapeutic alliance with the family therapist. The results showed that among drop-outs, the reports of alliance declined for both parents and adolescents, but there was no decline in reports of parents and adolescents who remained in therapy. The findings of the study show the importance of forming alliance with each member of the therapy for the progress of CFT. Thus, expanded alliance has different components than alliance in individual psychotherapy such as forming and strengthening alliance with each member and checking for possible split alliance.

1.5.4 Expanded Direct Treatment System

Similar to including relationships with relatives/romantic partners, systemically-oriented therapists also incorporate the larger systems (ie., culture, political discourse) of the client to their conceptualization of clients' problems and treatment planning. The incorporation of the larger systems is viewed in therapists' work from assessment to intervention. The rationale of expanding the treatment system is that change in the larger systems is closely interrelated with clients' change in the micro systems (Sprenkle, Davis & Lebow, 2009). For example, context is at the core of narrative family therapy (Freedman, & Combs, 2008). Narrative family therapists go beyond the family system and incorporate broader contexts such as the clients' culture and society both in conceptualization and treatment of the problems. An assumption of narrative family therapy is that people live their lives by organizing meaningful events in their lives into key narratives, stories (D'Attilio, 2013). The stories they held true about their lives and themselves, then become the dominant story. Narrative family therapy also assumes that people come to therapy when the problems become the dominant story. Narrative family therapists, expand the direct treatment systems by identifying and targeting the perspective of clients about the problem-saturated narrative of how society and culture further maintains the problem

(D'Attilio, 2013). For another example, contextual family therapy was evolved as a response to social and political realities (Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). An assumption of contextual family therapy is that families come to therapy when they are isolated, overburdened and fragmented as a nuclear family. Therefore, contextual family therapists do not view the nuclear family as the sole system to be treated, rather include various dimensions of relationships into their treatment system. The four dimensions of relationships include; facts, psychology, transactions, and relational ethics. The facts dimension is more related to broader contexts of culture and society. According to contextual family therapy, some facts such as ethnicity, adoption, and illness are unavoidable or given. In contrast, there are some facts which are constructed by people such as agency and choice. Contextual family therapists assert that people inherit legacies of unavoidable facts from previous generations such as injustices made to one's ethnic group. The historic injustices, then become the legacy imperative of the next generation. Thus, contextual family therapies include broader systems in their therapy approach and target the facts and legacy issues of their clients. Although the language which is used in narrative family therapy and contextual family therapy are different, both CFT model include broader contexts into their treatment system.

1.6. The Current Study

Pivotal moments are described as any moment in session where clients and therapists consider helpful/important/meaningful (Helmeke & Sprenkle, 2000). The importance of pivotal moments is stemming from its relation to client change. In these moments, clients experience small change moments. As the paradigm in psychotherapy effectiveness study shifted to a more inclusive scope where process is also deemed important as the outcome is (Greenberg & Pinsof, 1986), investigating pivotal moments which are considered to be associated with clients' change

mechanism in relational/systemic therapy is crucial for understanding the experience of change from the eyes of clients and therapists.

Scarce research that exists on CFT common factors mostly focused on individual psychotherapy common factors and its relation to change process in CFT (Blow, Sprenkle, & Davis, 2007; Blow et al., 2009). Theoretically, common factors specific to CFT and individual psychotherapy are radically different from one another and these CFT common factors are the CFT mechanisms of change. To fill the gap in the CFT common factors literature, the current study aims to investigate the CFT common factors that can be identified in therapy sessions. More specifically, the aim of the study is to examine the CFT clients' and therapists' in-session experiences with a focus on pivotal moments. The research questions of the current study are as follows:

Research Question 1: What moments do clients and therapists view as pivotal (significant, different, helpful, meaningful) in individual, couple and family therapy sessions?

Research Question 2: What makes these moments pivotal for each and what do they attribute its importance to?

Research Question 3: Do clients' and therapists' views match? If so which ones do match? If not, which ones do not match?

Research Question 4: Are these pivotal moments related to the CFT common factors or not?

CHAPTER 2

METHOD

2.1. Participants

Client and therapist participants were recruited from Ozyegin University Couple and Family Therapy Center in Turkey. Purposive sampling was used to recruit participants. The inclusion criteria for client participants were being over 18 years old, attending systemic therapy, and being at the beginning stage (first three sessions) of therapy. From fifteen client participants who were invited to participate, thirteen agreed to be interviewed (5 men and 8 women). Three client participants were attending individual therapy and ten client participants were attending family therapy together. Thus, five family and three individual clients were interviewed for the current study. Clients' presenting problems included stress, depression, computer addiction, child behavioral problems, co-parenting, difficulties with puberty, relational difficulties, feelings of inadequacy, and social phobia (see Table 1). Therapists of the participating clients were also invited to the study. All nine therapists agreed to be interviewed (1 man, 8 women). The therapists were graduate students at the Ozyegin University Couple and Family Therapy master's program who have been receiving training and supervision in systemic therapy. Therapists' choice of therapy models included; Emotion-Focused Therapy, Solution-Focused Therapy, Structural Family Therapy, and Integrative Family Therapy

Table 1. Distribution of presenting problems by clients

Presenting Problems	N	%
Stress	2	15
Depression	1	8
Computer addiction	1	8
Child behavioral problems	2	15
Co-parenting	3	23
Difficulties with puberty	1	8
Relationship difficulties	1	8
Feeling of inadequacy	1	8
Social phobia	1	8
Total	13	100

2.2. Procedure

Upon clients' first contact with the clinic, secretary of the clinic who take the first application information from clients introduced the study and asked the callers whether they would be interested in participating. The way the secretary introduced the study was: "In our clinic, we have an ongoing study with the title 'The Role of Common Factors in Pivotal Moments in Couple and Family Therapy' which studies the factors that play a role in therapy sessions. The nature of participation is voluntary. If you agree to participate you will be interviewed by the researcher after your first three sessions. The duration of the interviews is generally 20 to 30 minutes. You may withdraw from the study at any time without any penalty. Do you agree to participate?". Clients who agreed to participate was contacted face to face by the researcher at the end of their first session. The researcher introduced herself to the participants, answered questions regarding the nature of the study and obtained informed consent. Participants were asked whether they need a break before starting the interview since the interviews were immediately after their sessions. At the beginning of the interview, researcher emphasized that

there is no right or wrong answers to the questions. If the questions were not understood, researcher repeated the question and gave time for participants to process the question.

With the therapists who participated to the study, the researcher introduced the study in the same manner as with the client participants. Therapists who agreed to participate was contacted at the end of their first sessions. The researcher followed the same informed consent procedures with the therapists. After the client interviews were complete, the researcher interviewed the therapist participants with same questions. Overall, a total of 43 interviews were conducted with all participants (see Table 2). Three interviews could not be completed due to client drop-outs.

Table 2. Session distribution for clients and CFTs interviewed

Interview	Client	Couple and family therapist
First session	13	10
Second session	5	7
Third session	4	4

2.3. Interview

Session Experiences Interview was developed for the purposes of this study based on Helmeke & Sprenkle's (2000) study in order to gather information regarding clients' and therapists' perceptions of the pivotal moments in therapy. The interview format was open-ended and semi-structured. The questions were designed to understand the process of why and how participants attributed these moments as pivotal. Five questions of the interview are: 1) a. Was there an important moment for you/your client in this session? b. In what ways this moment was important for you/your client? c. What lead you to think/feel that this was an important moment for you/your client? 2) a. Was there a moment for you in the session in which you/your client felt/thought differently about yourself/themselves? b. In which ways this moment made you/your

client feel/think differently about yourself/themselves? c. What do you think might cause you/your client to feel/think differently about yourself/themselves? 3) Was there a moment for you in the session in which you/your client felt/thought differently about your/their romantic relationships/spouse? b. In which ways this moment made you/your client feel/think differently about your/their romantic relationships/spouse? c. What do you think might cause you/your client to feel/think differently about your/their romantic relationships/spouse? 4) a. Was there a moment in this session that helped you/your client regarding your/their reason to come to therapy? b. In what ways this moment has helped you/your client? c. What made this moment effective in helping you/your client? 5) Was there any other moment in this session that was meaningful for you/your client that I did not ask? Follow-up questions were also asked according to participants' answers: "Can you elaborate on how "having another person in the room" has helped you?" Since the interview was shaped by the participants' answers, the duration of the interview was not firmly set. However, the average interview duration was fifteen minutes. For participants who participated in all three interviews we also asked "How was it for you to answer these questions after sessions?"

2.4. Analysis

The Grounded Theory approach was used for the purposes of the present study (Strauss & Corbin, 1990). Grounded Theory (GT) approach allows qualitative researchers to develop a theory that explains social and psychological processes from the perspective of people who experience these processes. In the current study, the goal was to develop a theory that explains the process of experiencing a pivotal moment in-session from the perspective of clients and therapists. The theory developed in this study was based or "grounded" in data collected from the client and therapist participants. Upon every interview conducted with participants, the

researcher transcribed audio recordings. The transcribed data were analyzed by the researcher, using MAXQDA Analytics Pro (VERBI Software, 2016).

There are three stages of analysis in GT including open coding, axial coding and selective coding (Strauss & Corbin, 1990). The researcher coded and categorized the data during the open coding phase. In axial coding, the researcher synthesized the data by connecting the subcategories and categories. In selective coding, the researcher selected a core category, relate the core category to other categories and validate the relationship between the core category and other categories (Rafuls & Moon, 1996). After the completion of the analysis, a storyline emerged that explained the phenomenon under study. In the following section, in line with this study's purposes I will present the storyline of experiencing a pivotal moment in CFT sessions.

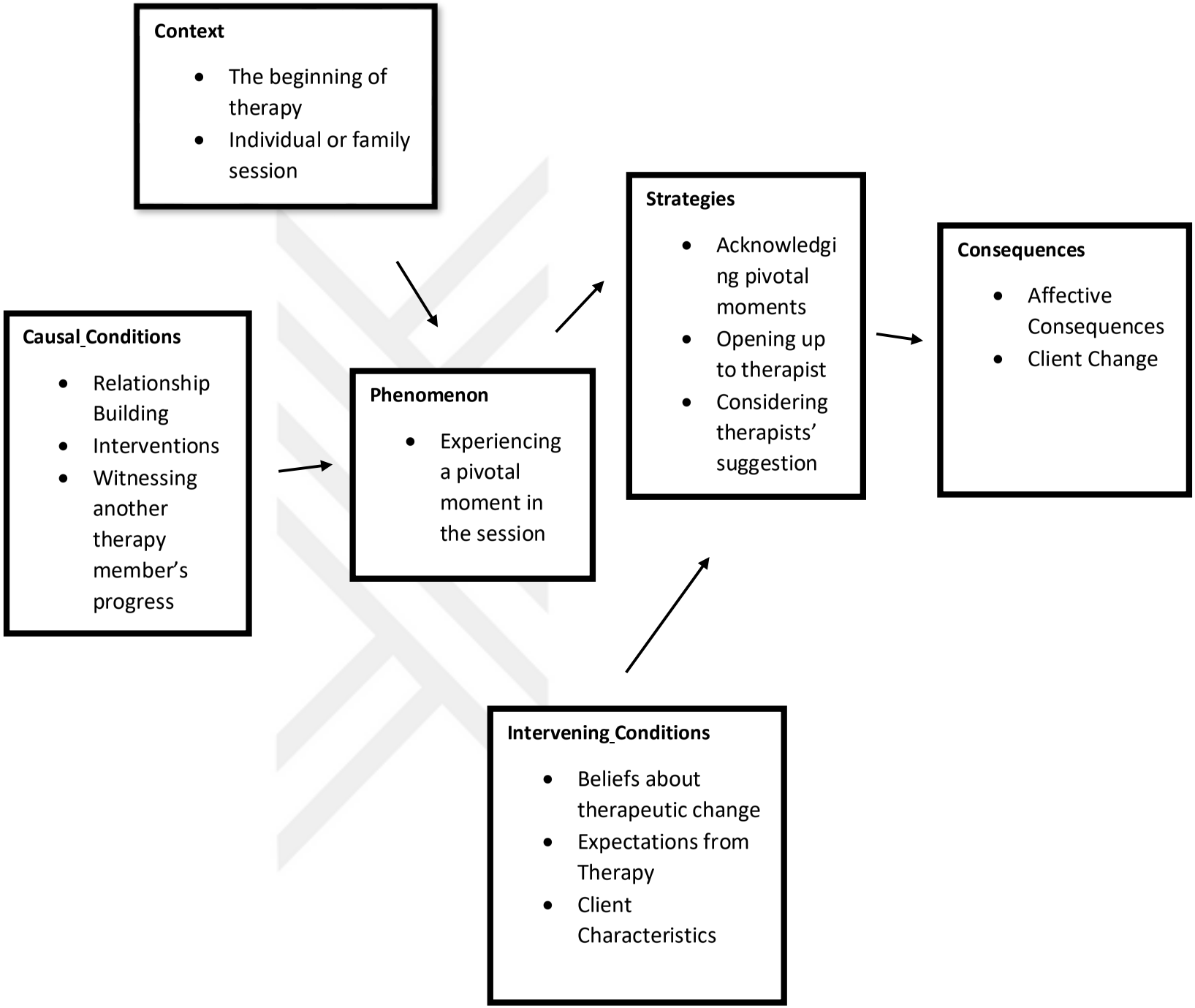
For the trustworthiness of the study, two other researchers overviewed the codes, categories and memos throughout the analysis process. In addition, member checking was conducted after the completion of analysis. The researcher emailed all the categories and subcategories to the participants and explained the theory that emerged. The researcher asked the participants whether they wanted to include something to the theory. Also, participants were asked about their opinions whether there was anything missing. Two weeks later, I sent reminder emails to participants stating that if they do not return, I will assume that they were pleased with the results. Only one client and one therapist replied. Client participant stated, "We were very happy to participate in your study, I thought interviews were also helpful for our sessions. We were really pleased to get to know our therapist and lucky to work with her. Thank you for your e-mail." The therapist participant stated that "I thought this study was nicely done. Congratulations!"

CHAPTER 3

RESULTS

The current theory is based on the core category of "experiencing a pivotal moment" (see Figure 1 for the theoretical model). Based on the client and therapist participants' interviews, pivotal moment can be described as: A momentary process where clients experience themselves and/or their relationships differently. Various experiences can lead to a pivotal moment such as sharing a difficult information, hearing a family member's story, or being introduced with a new idea. When clients experience a pivotal moment they respond or manage it in different ways. For example, a client who experiences a pivotal moment as a result of therapists' non-judgmental approach, may choose to consider the therapist's suggestion whereas, another client may not. These strategies differ according to certain intervening conditions that hinders or facilitates clients' choice of response such as client characteristics. As a result of the interaction between causal factors and strategies, clients experience the consequences of experiencing a pivotal moment such as hope. In the following chapter, I will describe these processes in more detail.

Figure 1 Theoretical Model of Experiencing a Pivotal Moment in CFT Sessions



3.1. Causal Conditions

3.1.1. Relationship Building

When asked what was effective in experiencing a pivotal moment, majority of clients (76%, n=10) reported that relationship factors were effective. On the other hand, only one third of the therapists (n=3) mentioned relationship factors as leading clients' to experience a pivotal moment. Three main relationship factors that participants reported were therapists' being non-judgmental, support, and trust.

Non-judgmental approach of therapists facilitated clients to experience a new kind of relationship in which their problems were not minimized, but valued. For example, two sisters who attended a family session together said:

> Client 10 (female, 32, co-parenting, family session 1): "It was good to sit and chat like friends do. You don't really know the person at all but you can chat…You are not judged. This was the first conversation I had without the other person making comments, it was nice."
>
> Client 11 (female, 29, co-parenting, family session 1): "When she (therapist) told me that of course you must have felt lonely, I thought I was not exaggerating this problem. Other people made me feel like I was exaggerating."

Client 11 described experiencing something different in terms of the way she was approached. Differently from what she experienced with other people in her life, she perceived the therapist as someone who will not minimize her experience. As a result of this, she was also able look at herself from a more positive lens. Client 10 did not only view the therapist as a friend, but also trusted that the therapist will not judge her. Furthermore, the experience of having a conversation without feeling judged was a first time experience. Their therapist also acknowledged this moment as a pivotal one: "They might feel like I understood them when I acknowledged the

difficult times they've been through. I think the approval of yes indeed this was a difficult time might felt good."

Trust was another relationship building subcategory which led clients to experience a pivotal moment. Clients explained trust as the trust they had in therapists' competence:

> Client 7 (female, 22, stress, individual session 2): I trust him (therapist). Because umm… I am not aware if I am doing right or wrong. I believe he knows the right way that's why I'm coming here.
>
> Client 9 (male, 31, child behavioral problems, family session 1): It's hard to communicate with children. I mean they (co-therapists) were able to communicate with them. I mean they are trained to this. I believe they (co-therapists) are really good at seeing things that we can't. It's like an outside… like maybe we are doing something wrong.

These clients viewed therapists as authorities who advice and guide them. According to client 7, the therapist is skilled and in a position to tell her what is wrong and what is right. Similarly, Client 9 stated that he has difficulties with understanding the inner-world of his children, and he sensed that the therapists were able to access children's inner-worlds. Clients' trust in therapists' abilities and competence led them to believe that the therapists can help them with their presenting problems. Therapists did not report clients' trust in their competence, rather they emphasized on relational trust that they assumed clients' felt towards them. For instance, one therapists stated that: "She said she laughed when talking about difficult subjects. When I pointed on this, she did not laugh when she was nervous. This change showed me that she trusted me." According to this therapist, his client experienced a pivotal moment when she trusted him enough to show her emotions and be vulnerable with him.

Finally, therapists' support appeared as casual factor for experiencing a pivotal moment. When asked "What was effective in experiencing a pivotal moment", clients replied:

> Client 7 (female, 22, stress, individual session 1): We talked about what I can do gradually to overcome my stress, like making a schedule. Like if I can manage my time I can feel more relaxed and happy. And I felt like this therapy will help me or like umm… I mean I guess the support was important. Like you are trying to reach your goal not alone but with the help of someone.
>
> Client 3 (female, 50, child behavioral problems, family session 2): When they (co-therapists) offered to make a schedule it felt very specific and good. It was like a weight lifted and I felt like there is a team with me who share my problems.

These two clients who attended different therapies both mentioned making a schedule. However, the pivotal part was not related to the actual making of the schedule, rather the feeling that they were not alone in handling their problems. The therapist of client 7 reported a similar causal factor for his client experiencing a pivotal moment: "Just being understood, I mean seeing that someone else is there to listen and understand things that sometimes even herself cannot understand helped with reducing her stress." Whereas, the therapist of client 3, attributed the causal factor to the actual making of the schedule: "They were able to see the bigger picture with this schedule. Like there is a map in front of them." This therapist attributed the importance of the moment to the intervention she used, whereas her client attributed its importance to the relational feeling in which she felt emotionally supported by the therapist. Thus, even when clients and therapists made mention of the same important moment, they can differ in their reasoning behind clients' experiencing a pivotal moment.

3.1.2 Therapist Interventions

All therapists (n=9) mentioned therapist interventions as a causal condition for clients' experiencing a pivotal moment. Whereas, only six clients reported therapist interventions as effective in their experience of pivotal moment. Both clients and therapists, reported

normalization, confrontation and not being-symptom focused as leading clients to experience a pivotal moment.

Therapists' use of normalization was important for clients according to both therapist and client participants. When I asked one client "What was effective in thinking that you are not selfish?" she replied: "Umm, well the stuff that my therapist told me. Umm… actually I felt like I was a bad person because I was selfish and now it's like maybe being selfish is not bad or I am not a bad person because of it. Like, it is normal to think about yourself, it was something like that and it was supportive I felt like I am not alone it this." This participant considered taking care of herself as a selfish act. However, normalizing self-care has led client to experience a pivotal moment in which she was told that she should not feel bad because it is normal to care about oneself. Further, this moment was important for this participant for not just normalizing aspect of the experience, but she also felt supported by the therapist when her experience was normalized. Her therapist also reported normalization as the causal factor for his client's experiencing a pivotal moment: "My client has some assumptions regarding selfishness. Like selfishness is bad or I am not socially capable. I think when I asked questions regarding her beliefs she saw that the things she did like thinking about herself like these are normal." In this example, both client and the therapist considered normalization as leading to a pivotal moment. Nonetheless, there was a difference in clients' and therapists' answers in terms of the process of why this moment became an important one for the client. According to the therapist this moment was important due his questioning which he assumed to led client question her thinking about selfishness. Whereas, according to the client this moment was important because the therapist was there to understand and support her. Thus, although this client and therapist matched in reporting the event that was important for the client, they differed in their attributions. The

therapist attributed its importance to the intervention he used and the client considered this moment an important one as a result of feeling supported by the therapist.

Therapists' challenging clients was also a causal factor for pivotal moments. Being challenged by the therapist was experienced by clients in two different ways. Firstly, therapists confronted clients to consider their own role in the presenting problem. Secondly, therapists challenged clients to take their family members' perspective. Here is a quote from an interview in which the client expresses his experience when confronted by the therapist to consider his role in his son's excessive computer use:

> Client 2 (male, 52, computer addiction, family session 3): It was like I was not able to bring this (computer usage) under control, I mean I felt inadequate for a second. And when Ms. Selin (the therapist) asked why you didn't put a ban on his computer…At the beginning of every term, my wife and I make a decision about banning or keeping it at the minimum. We put away the computer, but after a while like after a week or ten days, the computer comes back. Umm… we cannot like… we cannot stand behind our words. I thought maybe I was inadequate, because I took that computer away but then my wife and my son soften me or put pressure on me (laughing), then I bring the computer back. I don't know whether it would solve the problem if I didn't bring it back. I don't know if there is inadequacy on my part.

This participant was directly confronted by the therapist to consider his responsibility in the presenting problem of his son's excessive computer usage. He expresses as a result of being challenged he felt inadequate and also ambivalent about his rule setting behaviors. As a result of this confrontation he started to question his part in the presenting problem. Although this moment may not be a necessarily pleasant one, it was an important moment for him. Distinctly from his previous view of his son as the cause of the problem, here the therapist introduced him to the new perspective that there are several contributing factors to the maintenance of his son's

problem. This client's therapist also considered confrontation as a pivotal moment for their clients:

> "I mean; I think it was important for them to confront their lack of setting rules. I was more confrontational compared to the previous session. I also gave examples to rule setting. Those examples might also have helped. Umm… confronting helped them question themselves like what did we do and we didn't."

This therapist used confrontation with her client and asked him why did he not put rules in computer gaming. This therapist believed that being confrontational has helped the client to question himself in terms of their parental role as setting boundaries. The client and the therapist were in cohesion in which they both considered this moment important due to leading client to question his own responsibility in the presenting problem.

Being challenged to take other family members' perspective also led participants to experience a pivotal moment. As mentioned previously, participants of the study were attending both family and individual sessions. Therefore, some client participants were in therapy with their family members, whereas some were alone with the therapist. So, even when the clients were seen individually in therapy, the therapists' challenges to take other family members' perspective led to experiencing a pivotal moment for them as well. For instance, one participant who attended individual therapy said:

> Client 1 (female, 22, depression, individual session 3): Well, I said my mom does things and tell things that I cannot understand why, and I also told that she doesn't understand my explanations. And my therapist said that maybe she wants to be valued. And I was like, I realized that even though I explain things to her, my explanations were not what she needed.

This participant is describing experiencing her relationship with her mother differently than usual. This difference was stemmed from perceiving her mother's behaviors from another lens. Instead of looking from her own, the therapist challenged the client to take her mother's perspective when trying to understand her behaviors. As a result, the client experienced a "realization" that her perception of what is happening may be very different from her mothers. When I asked this client's therapist "Was there an important moment for your client in this session" she replied:

> "She said she was not able to make sense of one specific behavior of her mother's. I made her see what is the underlying motivation of that behavior. When I did this she was like oh yes I've never thought she would feel like this. I felt like she was able to empathize with her mother. I mean I didn't feel it she said that she never looked at it like that."

This therapist made a suggestion to her client in terms of mother's intentions. The challenge here is for her client to take her mother' perspective momentarily. And in this moment, the client was able to look at events from her mother's eyes. And according to the therapist, this challenge facilitated client to emphasize with her mother and view their relationship differently. Additionally, this therapist did not assume why this moment was important, rather she was told by the client. Therefore, differently from above examples, this therapist was certain about the processes behind her client's pivotal experience.

Finally, five clients and their therapists reported that therapists' not being symptom focused was leading to experience a pivotal moment. Generally speaking, CFT therapists do not focus on the symptom or the presenting problem that their clients bring to therapy. This does not mean that CFT therapists do not care about clients' problems. Rather than focusing on the symptom, CFT therapists aim to discover underling relational problems that are theorized to be

triggering or enhancing client symptoms. Five client participants reported that therapists asking relational questions and not focusing on the symptom has led them to experience a pivotal moment in session. Below are examples of two clients' quotations which shows the effect of therapists' not being symptom focused:

> Client 1 (female, 22, depression, individual session 1): "If it weren't for the therapists' questions, I would not talk about my family. If she was like yes, why you are here today I would talk about what I head in mind. But she wanted to get to know me, and talk about my family and stuff. I mean I'm not good at explaining myself. So when she asked like about my household, or like how many siblings you have, I opened up."

> Client 7 (female, 22, stress, individual session 2): "I actually came here for stress and better scheduling my time. Then, I realized I talked about something and I realized I am not here for scheduling. I realized that my real purpose for coming here was different. It's like scheduling time was a medium… Me… I blamed my family, blaming my family for feeling inadequate. He asked me if I ever told this to my family, and whether they know I am blaming them. In that moment, I felt sad about my relationship with my brother like our bond is not good, we don't talk a lot. I think our focus in session has changed and I realized some topics to talk about. That moment was important to me, yes."

Both clients are talking about therapists' questions as facilitating viewing their presenting problems from a relational perspective. These clients came to therapy to cope with stress. However, in both interviews clients experienced a pivotal moment when the therapists focused on relational aspect of their problems rather than the problem itself. For client 1, not focusing on the problem helped her with feeling more relaxed in therapy room. And client 7 experienced a pivotal moment regarding her perception of the presenting problem. She assumed that they would focus on time management and stress. But when therapist asked relational questions, she realized that stress was just a "medium" for her to ask help for her underlying problems. And as a result her perception of the problem was changed from more symptom-focused to a relational

one. According to their therapists', not being symptom focused facilitated their clients' viewing of their problems relationally:

> Therapist 1 (client 1): "It was like she was able to gain a new perspective into her problem rather than just focusing on the symptom. I mean like okay what she brought as a symptom is really a painful experience but she also started to realize that relationships can be healing. And as we were talking she was like oh my problem was more related to relationship problems."
>
> Therapist 4 (client 7): "She came to therapy for her lack of time for studying and that she was not able to manage her time and how this causes stress. But seeing that this was only a part something bigger and reflective of her relationship dynamic will help her in thinking more in-depth about her presenting problem."

These therapists are describing a process of helping their clients to see the underlying relational problems behind the symptom. According to them, the therapy should not be about reducing the symptom, rather the relational dynamics which they taught to be causing the symptom should be the focus of the therapy. Therapists have a clear mind about what should be the goal of the therapy. They do not want to focus on the symptom and try to facilitate clients' awareness regarding relational viewing of problems.

3.1.3 Witnessing Another Therapy Member's Progress

Witnessing another therapy member's progress was a causal factor for only clients who attended family sessions (N= 7). When clients witness their partners, spouses or children making a progress in therapy, they felt or thought differently about their relationships. Witnessing a family member's opening up to the therapist, or seeing their child bonding with the therapist was an important moment for clients. Even when their presenting problem was not related to that family member, witnessing their experience was deemed as important. For instance, clients witnessing their partners' or spouses' personal experience led to a pivotal moment even when

their presenting problems were related to their children. Whereas, therapists noticed clients experiencing a pivotal moment only when clients witnessed their children's progress. Therapists missed pivotal moments when stemmed from clients' witnessing their spouses'/partners' progress in session.

Clients experienced a pivotal moment when their family members did "something different" actually in the session. Observing family members' showing vulnerability or opening up to the therapist were significant moments for the clients. A client who came to therapy with her family for child behavioral problems said:

> Client 6 (female, 33, difficulties of puberty, family session 1): Umm… my husband does not express himself very often, he is a bit of a closed book. I can understand his feelings from his behaviors and I think that's because I know him very well, but I don't know. But he told everything in there. I watched him talking, I mean I didn't expect him to tell things but when he told some things about his childhood, yeah I think this will help in overcoming many difficulties. Actually, it feels like all these questions (interview questions) are targeting my husband, it's like we didn't come to this therapy for our children. Umm… my husband is like a very private and proud person. These type of people don't express or share, and they are always like that. And as I said when he said some things here…for example he told he used drugs in the past and he never talks about that. And he also said that he made mistakes and stuff like that. I just sat there and gawked at him talking because frankly, I didn't expect him to tell these things.

This participant was surprised that her husband was opening up to the therapist because she was not used to it or it was out of his "character". Witnessing this moment led to her having hope for "overcoming" their problems. According to this participant, her husband would never share personal information with the therapist, and when the opposite happened she thought that if this happened maybe somethings could have changed after all! And she was not alone in emphasizing hope as a result of observing family members' in-session progress. On the other hand, her therapist did not mention witnessing husband's opening up as an important moment for the wife.

One participant who again attended family therapy briefly explained how and why she felt hopeful in session: “When he (his son) cared and listened to therapist’s words I took a deep breath (used as a sign of relief in Turkish language). I mean if he really willingly does what he is been told, it’s like I mean it felt like things are going back to normal and there is light at the end of the tunnel.” This client felt hope as a result of witnessing his son making a progress in session. Her therapists also acknowledged this moment as an important one: “I think for parents, because they think their son is reserved, it was important to see their son’s willingness to cooperate.” For both client participants, the pivotal moment experienced was relational rather than personal. It was not personal because their focus was not on themselves or they did not feel or think differently about themselves. Instead, there was a change in how they viewed their family members.

3.2. Strategies and Intervening Factors

Participants used different strategies in how they responded to pivotal moments that they experienced in session. First strategy that participants used was acknowledging or disregarding a change-related moment. When participants experience a change-related moment, they can disregard or acknowledge it. Disregarding or acknowledging a change-related moment is predicated on two interactive factors. First intervening factor is participants’ beliefs about change. Beliefs about change can be described as set of assumptions that client and therapist participants have towards therapeutic change. The two sets of beliefs about change are: “Change would not occur in the beginning stage of therapy” and “Change is a road and every little step counts”. If participants do not believe that change can happen early in the therapy process, they are then likely to disregard change-related in-session moments. Conversely, if participants

believe that change is analogous to a path and comprised of small change moments, they tend to acknowledge these moments as change.

Clients and therapists who believed that change would not occur in the early stage of therapy explained their goals and assumptions regarding the first session:

> Therapist 5 (child behavioral problem, family session 1): "Umm... I mean I don't think I helped them with viewing things differently because this was the first session. But there were some moments where talking about some stories or family of origin issues which are related to the presenting problem has helped them realize things. But other than that umm… I don't think I was very helpful."
>
> Therapist 7 (stress, individual session 1): "Well this was the first session so I don't think she experienced something like that. This was more about getting to know each other"
>
> Client 4 (female, 44, stress family session 1): "I did not try to think differently about myself in this session. Since this was the first session my aim was to meet with the therapist and to tell about my problems. I'll see it in the future sessions."
>
> Client 12 (male, 34, co-parenting, family session 1): "Umm…Like I've said, this is so new I mean I can't say like this specific thing happened. We were the ones talking and not many questions were asked, maybe because we were four or I don't know maybe they (co-therapists) couldn't get a word in edgeways. Maybe the next time I can give you a better answer but yes, this was something new so, we did the talking."

Client participants stated that they did not try to view themselves differently or evaluate their situation in the first session, rather they just disclosed their problems. They did not expect nor believed that they could change in the first session. Similar to clients, therapists' purpose for the first session was to get to know the family and to identify the presenting problems. Since therapists' plan for the first session was to gather information regarding the family but not to intervene, they did not assume that change-related moment would occur. Nonetheless, the same participants reported change-related moments in others parts of the interview:

> Therapist 5 (child behavioral problem, family session 1): "I did a reflection. And that reflection was not like you are acting like this and that but more like what I'm hearing is

> that you need this and that. And when I reflected his needs, he realized that he needed his son to have the same values about life."
>
> Therapist 7 (stress, individual session 1): "While talking about their story, we had moments where they realized things that were related to their family of origin issues."
>
> Client 4 (female, 44, stress family session 1): "For me…I mean at first it was just about our children…like I called for the children. But I think this will also be good for our other difficulties with my husband."
>
> Client 12 (male, 34, co-parenting, family session 1): "They (co-therapists) were very good with our children. When I observed them talking I felt like they can help us here."

Although these therapists did not believe that change would occur in the first session, they stated a change-related moment regarding a realization of family-of origin issues or a change in view of themselves, others or their presenting problem. However, according to their change belief this moment does not constitute a change. Client participants also believed that change would not occur in the first session nevertheless they also stated change-related moments. one client's perception of the presenting problem was changed from child behavioral problems to relational difficulties. Both clients and therapists reported change-related moments even though they did not believe that change would occur in the early stage of therapy.

Participants who acknowledged change-related moments tended to view change as analogous to a road. The road metaphor was based on this client participant's change description:

> Client 2 (male, 52, computer addiction, session 1): "Umm…I felt like Ali (his son) started to gain awareness as a result of these conversations. When the therapist asked what kinds of activities are you doing in your family time Ali couldn't give an answer. And I think this will create awareness like oh yes we don't do much, I wonder why…and like even this much awareness is enough for now. Like I don't how long this therapy will last, or when we will stop coming here, but my ultimate goal is for Ali to spend less time on computer and take more responsibility when it comes to his academic performance. This is our end goal and in this session I've felt like we took a new step in this road and got closer to our goal."

In this interview, the father is describing his change beliefs by using a metaphor. According to him, change is analogous to a road: one can reach the end of the road by taking one step at a time. The end of the road represents the endmost goal which to him is the decrease in amount of time spent on computer. Nevertheless, he acknowledged his son's awareness in this session regarding their limited family time as a change moment, because he believes in this moment his son took one step further in their road to change. Similarly, some therapist participants also believed that change can happen at the beginning of therapy:

> Therapist 1 (stress, individual session 1): I believe I facilitated client to have a new perspective on the presenting problem. How can I explain this…? Even from the first session, she was able to view her problem from a different point of view. I believe being able to differentiate the symptom from the underlying relational problem is an adequate goal for the first session.
>
> Therapist 2 (depression, individual session 1): Umm… I think in this session; she better saw her part in the problem. She was able to look at things from a different place. Like she didn't… or wasn't able to express herself emotionally in her relationship…and nor did the other side.

Both therapists reported change in the first session regarding their clients' viewing of their problem. Although therapists who believed that change would not happen in the beginning stage of therapy also reported similar pivotal moments, they did not acknowledge these moments as change. The difference, then stems from their beliefs in what constitutes change. Based on my interviews with these participants, it does not appear that not believing in the early occurrence of change makes a difference in experiencing a change-related moment, but makes a difference in acknowledging it.

The second intervening factor for acknowledging a pivotal moment is being a visitor of therapy. Client participants who viewed themselves as "visitor of therapy", did not consider themselves as the actual client of the treatment. Rather, their focus was on their family members

whom they considered as the real clients of therapy. Clients who are visitors of therapy tend to disregard personal change-related moments:

> Client 9 (male, 31, child behavioral problems, family session 1): "Umm… I didn't really assess myself because my focus was on my child. I mean because I am not the topic of the session I didn't think about myself. I they can communicate with the children which I think they are able to do because they were trained to this. I believe they can see things more clearly than us."
>
> Client 12 (male, 34, co-parenting, family session 1): "I don't think this is about me. I think this will be important for my son's mother. It will be important for them since they live together. Frankly, I think this is not important for me, but for them it is important because she (ex-wife) has to deal with Ali's (his son) problems. We are here because there are some problems. But, this is not about me."

These participants did not personally seek therapy, rather they came for the sake of their children. Also, they would consider sessions useful if they would help their family members. Therefore, if clients view themselves as visitors they tend to disregard personal change-related moments even though they experience such moments.

Another strategy that clients used was opening up to the therapist. This opening up might include being vulnerable or sharing more personal information with the therapist. Opening up to the therapist is predicated on the client characteristic of being reserved. Clients who describe themselves as "reserved" tend to disclose less personal information compared to clients who are "unreserved. For instance, one client describes himself as:

> Client 13 (male, 46, relational difficulties, family session 1) "I am actually, how can I put it… like a bit reserved. I mean umm… I like to deal with issues on my own. Umm… but sharing with others…I'll see. I'll see how it goes in future sessions."

This client is used to keep difficulties to himself. He does not share and try to solve problems on his own. He also described his hardship in opening up here. Thus, his "reserved" characteristic is hindering using the strategy of opening up to the therapist.

Some clients chose to consider therapists' suggestions as a strategy. For instance, when I asked one participant "What led you to think or feel differently about yourself in this session?", she replied: "I thought about what she (the therapist) said. She said that, quote unquote, from what I understand, you want to be understood. Then we talked about this a while and I thought about what she said. In a way, I corroborated on something that I did not really thought about before." This client chose to consider her therapists' suggestion about her desire to be understood by other people. Considering therapists' suggestion is predicated on the client characteristic of being open-minded. Being open-minded facilitates clients' considering therapists' suggestions. For instance, one participant emphasized her open-mindedness on how she was able to consider her therapist's suggestion: "If I was a fixated person or not open-minded I would not consider her (therapist) suggestion".

3.3. Consequences

There are some consequences of client experiencing a pivotal moment. As a result of the interaction between causal factors and strategies that clients use, different consequences appear. The two main consequences of experiencing a pivotal moment were affective consequences and change-related consequences.

3.3.1 Emotional and Affective Consequences

Clients reported experiencing various emotions as a result of experiencing a pivotal moment. Emotional consequences for experiencing a pivotal moment included hope, relief, happiness, and sadness and motivation. Hope was experienced by clients as having hope for the

solution of their problem or believing that relationships will become better over time. Some examples of clients feeling hope included expressions such as “I felt like we can overcome this problem”, “I mean maybe this won’t go on. Like we can better understand each other”, and “I felt hopeful at the end of the session.” One participant reported the relief she felt at the end of session: “I feel like I am relieved because even my stomach feels a bit more relieved and relaxed.” Another participant reported feeling sad as a result of a pivotal moment in which she realized that she was purposefully avoiding thinking about a difficult period in her life: “I was asked about how I felt and how I made it through when my father passed away. And as I was telling (the therapist) that I was relaxed and not unhappy, now I realize here that I was actually sad. It is like you are pushing these bad things aside, like actually I realized that I was pushing bad memories aside. And that is sad, I feel sad about this.”

Some participants reported feeling happy as a result of being able to communicate problems and felt as being heard after difficult times. For instance, one participant said: “The therapist told me that I had a difficult time with my previous marriage. When she said that, yes she was the first person to tell me that. She said that it must have been a difficult time. And right now I feel at peace and very happy.” Motivation was another consequence of experiencing a pivotal moment. Some clients reported feeling motivated to continue with the sessions. For instance, one client reported that: “It’s really interesting. I felt like we started go back to normal and when I felt that I started to think about the next session. Like if Ali (her son) accepted therapists’ suggestion in this session, I think about where he could go next.” This client experienced a pivotal moment when she witnessed her son’s willingness to participate in the session. As a result of this pivotal moment, she started to imagine what would happen in the future sessions and was motivated to come back.

3.3.2 Client Change-related Consequences

Client change for participants included three subcategories; change in self-perception, change in view of relationships and adopting a systemic perspective of viewing presenting problems. Change in self-perception is described by clients as the change in how they view themselves. For example, when I asked "Was there a moment in this session where you felt or thought differently about yourself?" one participant said: "I mean I thought I was a selfish person, but when my therapist told me that thinking about yourself is normal and like not equal to selfish, I thought maybe like I was not so selfish or being selfish is not so bad". This participant was blaming herself as the causal of her relationship problems. However, as a result of the therapist's normalization and her use of strategy of considering therapists' suggestion this client started to consider taking care of oneself as a not being selfish.

Clients reported change in view of their family members, friends and/or partners. For example, one client described the change in perceiving her mother: "I was talking about a behavior of my mother. And I've never thought that she was doing this because she needs something from me." When her therapist suggested to take her mother's perspective when trying to understand her mother's actions, this client chose to consider this suggestion rather than denying it without giving it a thought. As a result of the interaction between therapist's suggestion and client's use of considering therapist's suggestion, this client experienced a change in view of her relationship with her mother.

Final consequence of experiencing a pivotal moment was adopting a systemic perspective of viewing presenting problems. When therapists used not being symptom focused as an intervention, clients tend to adopt systemic viewing of their problems. For example, one client described the change in her view of the presenting problem as "Actually we focused on a

different subject in this session. But I started to feel like everything is connected with each other… like I don't know how but talking about my relationship with my family helps with my anxiety. I mean I came here for my anxiety regarding my academic life but I realized this isn't the real issue. The real issue is why I am so anxious about my grades or… why can't I talk these with my mom." This client expected sessions to focus on her presenting problem of anxiety. However, when the therapist did not focus on the symptom, and relationally conceptualized her problems she experienced a change in view of her problem. Her thinking of the problem has changed from a more symptom-focused to a more systemic way of viewing her problems.

The causal factors, strategies, intervening factors and consequences of experiencing a pivotal moment were identified in this chapter. However, the goal of Grounded Theory approach is to give a story of how that phenomenon is construed and experienced. In order to give a full picture of experiencing a pivotal moment, we created scenarios based on participants' reports. People in the following scenarios are not real, rather clients' experience was combined so that collective experience of participants would be more clear to the reader.

"Melisa" is a twenty-two-year-old Turkish female who is a sophomore in law. Melisa has a history of good academic performance. However, Melisa started to feel more and more anxious about her grades when she got B- from one class in previous semester. In the last month, thoughts about academic failure ran through her mind almost every day, making it difficult for her to sleep. Finally, Melisa decided to attend therapy in her university's clinic. When Melisa finally came to first session, she thought they would talk about her anxiety. At first, she was very nervous and did not know how to begin. To Melisa's surprise, the therapist did not focus on her anxiety in the first session. The therapist asked questions about her family and wanted to learn more about her social life (not being symptom focused). This made Melisa feel more relaxed in

the therapy room, because she was worried to talk about her anxiety problem. Instead, Melisa started to talk about her parents. Her parents were divorced when she was fifteen and her father moved outside the country. Before her parents' divorce, there was an alliance between her and her father, and her mother and brother was a unit. After the divorce Melisa lived in Bursa with her mother and brother. But she often felt left out and missed her father. However, she did not share her feelings so that her mother would not feel guilty. Melisa now lives in university dorm in İstanbul. As Melisa was talking about her parents she felt sad and alone but did not share it with the therapist. Then, the therapist said "Correct me if I'm wrong, but I bet it's difficult to live far away from your parents and be a law student when you deal with all the pressure on your own" (support). Hearing this was great for Melisa. She felt like the therapist can understand her. In this moment, Melisa felt like maybe she is not alone anymore and she has someone to trust and support her. In this moment, she decided to open up to the therapist. She talked about feeling lonely and how difficult it is for her. She was not used to share her vulnerability with other people. But to her surprise, opening up felt really good. As a result of this moment, she felt relieved and started to have hope for overcoming her difficulties.

"Mehmet" and "Selin" are a Turkish couple who are married for twenty-one years. They have two sons together. Their older son "Can" is a nineteen-year-old who moved out for college. And their other son "Ali" is a seventeen-year-old who is a senior in high school. Mehmet and Selin decided to see a family therapist for their son Ali. Ali had a history of excessive computer use from childhood. This year, Ali had poor academic performance and became more shy and unsocial. Mehmet and Selin reported being unable to deal with their son excessive gaming and convinced Ali to come to a family session. At the first session, Mehmet and Selin talked about their son's shyness and excessive gaming. Mehmet and Selin believed that the therapist will help

their son about his problem and that they will be there to support him (being a visitor of therapy). After Mehmet and Selin give information about their son's problem, the therapist said "We can talk about your reason to come here more later and I want to absolutely hear it, but if that is alright I want to get to know you more as a family, how do you spent time together?" For a moment all of them stood in silence, thinking about their answer. Ali answered first: "Umm… actually we don't do much. I usually spend time in my room." Then the therapist asked Ali: "And how long have you been not doing much?" Ali replied: "I'm not sure, I can't remember when we did something together as a family". Mehmet was very happy to see his son admitting to their limited time together. Mehmet thought this was a significant moment. He believed that they have a long way to become a family that have tight bonds but he believed his son took an important step in this session (change beliefs). He felt like his son gained awareness (witnessing family members' progress). Witnessing this also encouraged Mehmet to open up the therapist. He decided to disclose information about his childhood. He said to the therapist: "Not spending time with my son is especially hard for me because that's all I wanted from my father when I was a child. He wasn't there to guide and support me. So I always tried to be not like my father. And now even though I tried I feel like I failed." Selin looked at her husband in surprise. She was not used to see her husband share any vulnerability (witnessing family members' progress). At that moment, she felt like something has changed. She started to think about their marriage. Mehmet didn't share his feelings with her either and that was one of the problems in their life. Selin knew that this was very important both for her husband and their relationship. She felt like if Mehmet keep opening up in these sessions, maybe it will also be helpful for their relationship (hope). Selin knew they came here for the child, but she started to think maybe these sessions

can help them with their relational problems (adopting systemic perspective). She said to herself "If this happened in this session, I wonder how far we can go as a family" (motivation).

CHAPTER 4

DISCUSSION

4.1. Experiencing a Pivotal Moment

In every interview, clients reported experiencing a pivotal moment. Pivotal moments occurred more in the second session and third session compared to the first session according to the numbers of clients' reports on pivotal moments. This finding supports Helmeke and Sprenkle's (2000) study on pivotal moments in couple sessions in which they found that more pivotal moments occur in the first three sessions, but especially the most pivotal moments occurred in the second session. In the current study, majority of the clients (n=8) reported that their aim for the first session was to meet with the therapist and communicate their problems and difficulties. Also, they reported that they did not expect any change from the first session. Results showed that acknowledging change-related moments was predicated on change beliefs. Believing that change would not occur in the first session was hindering clients' acknowledging change-related moments. The scarce reports of pivotal moments for the first session in Helmeke and Sprenkle's (2000) study might also stemming from the intervening factor of believing that they will not experience any change-related moment in the first session.

Clients and therapists tended to match in their reports of what moment was important for the client. However, the process behind why this moment was important was different for clients and therapists. Clients attributed the importance of the moment to more relational factors such as support and trust. Whereas, therapists were more likely to report the actual intervention as the causal factor for clients experiencing a pivotal moment. Except for one therapist, all therapists

assumed to know the process behind what constituted a pivotal moment for the client. When therapists thought that clients experienced a pivotal moment, they did not ask their clients whether their assumption was real for the client. Assuming to know clients' pivotal experience might carry a risk for therapists. If therapists' assumptions are wrong, they can miss clients' change-related moments and continue to intervene or focus on their assumption of pivotal moments. Assessing clients' in-session pivotal experience can enhance therapists' knowledge regarding their clients' current change status. In order to check whether answering pivotal questions had an effect on clients' and therapists' therapy experience, we asked participants who participated in all three interviews: "How was it for you to answer these questions after sessions?" Below are some examples from therapists and clients regarding their experience on answering pivotal moment questions after sessions:

> Client 1 (female, 22, depression, individual session 3): Well, I mean… Since we talked immediately after the session, I felt a little bit… "O-oh, what did we talk, what happened…" since my head is a bit flooded right now. But when I look at it afterwards, if we were to talk about it later, it could have been worse because then, heat of the conversation would disappear. That's why, it felt like, we are going over the session, after the session. It helped me organize my thoughts a little bit better.
>
> Client 2 (male, 52, computer addictions, family session 3): Well, it is nice in the way that makes me think because whatever work you do [with your therapist], you do it within only an hour. After you leave [the session], you do not reflect on it a lot, it happens there and it goes. Well, right now, we are talking about it, so this helps me to go over again what I have talked earlier. Consequently, I believe it is important in terms of insight. I can think of it again, as I say "Was I right? Did I miss anything?" and this is self-critique of a sort. I would have long forgotten what I have talked [in session] if it was not for this conversation that we are having right now.
>
> Therapist 2 (depression, individual session 3): At least, it helps me think about the next and last session. I mean, I get a chance to reason how well the session went or how bad was it. I can be in the shoes of them [clients], it provides me with a better perspective, a better point of view.
>
> Therapist 4 (stress, individual session 3): I mean, it was nice to talk about these. Well, it forced me to think about points that I never thought about before. Since I talked about these unexplored spots, it enabled me to comprehend what I was able to and not able to do during the session. For example, that last question, whether they saw a benefit of

> coming here or not, and me answering that question as a straight "no" was beneficial for me. You know, I was reading this as something that inexperienced family therapist frequently trapped in and yet, here I am, realizing this fact because I think about it and answer that question, otherwise I would not. Umm, yeah, this was a plus for me.

Clients stated that answering questions regarding pivotal moments helped them gain awareness about their in-session change experience. Furthermore, both clients stated that if they did not answer these questions they could more easily forget or disregard the change-related moments they experienced in session. For therapists, thinking about pivotal moments were important for several reasons. Firstly, by answering pivotal questions they were able to evaluate the session from clients' perspective. Secondly, it was useful to them when planning for the next session. In the light of therapists' and clients' reports of positive effect of assessing pivotal moments on therapy process, we suggest incorporating these questions to sessions. By asking directly "What was useful/helpful/important/meaningful in this session, therapists can catch little change moments that clients experienced and further process and strengthen these moments.

4.2. Relational Pivotal Moments

Participants who attended family sessions, perceived another therapy members' experience as pivotal. This finding is conflicting with Helmeke and Sprenkle's (2000) study in which they interviewed clients on pivotal moments in couple sessions. According to their finding, clients reported more personal moments as pivotal, rather than reporting their spouse's in-session experience as pivotal. In the current study, witnessing spouse's opening up to the therapist or witnessing children's relationship with the therapist was causing clients to experience a pivotal moment. This difference might stem from both methodology and cultural differences. Firstly, the current study included questions specifically targeting relational pivotal moments such as; "Was there a moment in this session where you felt or thought differently about your relationships (family, spouse, or partner)"? Asking a relational question might had led

to more relational answers from clients. However, some participants also reported relational pivotal moments to other questions such as; “Was there a meaningful moment for you in this session?”. Also, in the current study, participants’ presenting problems were related to their children. No participant indicated marital/relational problem as the causal for coming to therapy. Hence, clients were in therapy with the belief that their children were the “real clients” of therapy and they were visitors. That is to say that, they did not seek to personally benefit from the therapy. This could make a difference in our client participants’ increased reports of relational pivotal moments. If they do not seek to personally benefit from the therapy, they would not expect to experience a personal change, which in turn could affect their acknowledging or noticing personal pivotal moments.

Clients’ focus on family members’ experience in-session does also culturally makes sense. From clinical experience, it is thought that Turkish clients are more likely to attend therapy for problems related to their family or children compared rather than relational or personal difficulties. Public’s view of psychotherapy in Turkey is different from other European or American contexts. Dereboy, Şenel, Öztürk, Şakiroğlu, and Eskin (2017) investigated the role of sociodemographic factors in knowing, demanding and receiving psychotherapy among 240 psychiatric outpatients. Participants were also asked to complete the Mental Health Services Questionnaire which included questions such as “Have you ever heard of psychotherapy?”, “How do you define the help you received the first time you referred to the psychiatric hospital?” “Were you informed about the type of treatment you will get?”. Results showed that the only difference among high and low socioeconomic status were related to knowing of psychotherapy. That is, participants with higher levels education and income were more likely to have heard of psychotherapy compared to participants who had lower levels education and income. Among all

participants, only 41% had heard of psychotherapy before. In addition, among participants who heard of psychotherapy before only 3% heard it from a mental health professional whereas 45% of participants heard of psychotherapy from media such as TV, internet, and newspapers. Also, participants overwhelmingly received only drug treatment (82%) whereas only seven (5%) participant received psychotherapy. Due to limited number of participants, these findings cannot be generalized to the population. However, this study is important for being among few studies in Turkey that shows the public's view of psychotherapy in Turkey.

Another explanation to why more relational pivotal moments were reported in the current study could be related to needs of autonomy and relatedness. Traditionally, individualistic cultures were construed as more autonomous, whereas collectivistic cultures were considered as more interdependent. Over the recent years, this paradigm of the dominance of two opposite orientations (autonomous vs. interdependence) in individualistic and collectivistic cultures has changed (Guisinger, & Blatt, 1994). According to Kağıtçıbaşı (1996), a person is not solely individualistic or collectivistic, but one can have both orientations. Furthermore, people can show different orientations on different contexts. As stated previously, client participants who attended family therapy in the current study came for child-related problems. That is, it is possible that in the current study client participants' relational self was more salient in the therapy context than their private self.

4.3. The Role of Common Factors

Clients did not describe the actual specific intervention techniques as part of their experience of pivotal moments. However, therapists' validation, non-judgmental approach, and normalizing were present in almost every interview. Although validation, being non-judgmental and normalizing are not specific CFT common factors, they are common factors of

psychotherapy (Norcross, 2002). For common factors specific to CFT, clients' reports showed some association with pivotal moments and relational conceptualization and expanded therapeutic alliance. Clients experienced a pivotal moment when therapists challenge them to take perspective of family members. Therapist being challenging about taking perspective of other family members is related to CFT common factors. Regardless of the therapy model, systemically oriented CFT therapists relationally conceptualize presenting problems. Even in individual sessions CFT therapists ask relational questions that foster clients' viewing of problem as cyclical such as "What do you think would be the response of your mother if she was here?" According to clients, therapists' relational questions were important. Thus, relational conceptualization was triggering clients to experience a pivotal moment.

Expanded therapeutic alliance state that there are multiple therapeutic relationships in systemic therapy. CFT therapists are expected to form relationships with every member of the therapy. Interestingly, clients also reported that witnessing the relationship between their family members and the therapist is an important moment for them. This finding shows us that when a client observes a family member opening up to the therapist, the client then views this as a sign of possible change. Witnessing the relationship between other family member and therapist is a source of hope for overcoming difficulties. Interestingly, therapists did not notice when clients experienced a pivotal moment regarding their spouse, but they were more likely to catch pivotal moments when it was related to clients' children. This could be due to the presenting problems of clients. Since clients' presenting problems were related to their children, therapists might had focus on pivotal moments which were related to clients' children. Again, this shows that therapists' should not assume to know clients' pivotal moments.

4.4. Limitations and Future Directions

One of the goals of using a Grounded Theory approach is to have an in-depth understanding of social and/or psychological processes. These processes happen in a certain context and for certain people. The current theory explains thirteen Turkish client participants and nine CFT therapists experience of pivotal moments in CFT sessions. Therefore, the generalizability of the findings is limited and was not the goal. Another limitation of the current study is that the findings of the study could be affected by the researcher's involvement in systemic therapy paradigm. The researcher is also a master's degree student in CFT program, therefore the training received in the systemic therapy may have affected the way she views change. Although, the possibility of any bias cannot be ruled out completely, several steps were taken in the analysis phase to minimize this effect. Firstly, two other researchers overviewed the memos, categories and codes. Secondly, the researcher did not conduct an extensive literature review before completing analysis to be able to build the theory on participants' data. Finally, the researcher conducted member checking with participants (see methods section for detail). Only two participants (one client, one therapist) responded to the researcher's e-mail regarding member checking. However, only four client participants participated to the third interview, since other client participants dropped out from therapy. Nonetheless, the researcher could try different ways of communication such as text messaging in order to obtain more rate of return from participants.

Another limitation of the study was related to dropouts. The first interview which was conducted after the first session was completed with thirteen client participants. Eight client participants dropped out from therapy, therefore five clients participated to the second interview. One participant also dropped out from therapy after the second session. Thus, the third interview was conducted with four client participants. Among three individual clients, one client dropped

out from therapy, whereas among 10 family clients, eight clients dropped out. Therefore, the dropout rate for family clients were overwhelmingly more than individual clients. Although this difference in dropout rate might make a difference in results, the main goal of the study was related to clients' pivotal moments in-session but not related to psychotherapy outcome. Interestingly, there were no differences in terms of quantity in clients' reports of pivotal moments in the first interview between participants who completed all three interviews and participants who dropped out. Since the number of thirteen clients and nine therapists is not sufficient for developing a theory, the ideas developed as a result of this study should be considered as an "emerging theory". Unfortunately, due to time limitation we could not continue recruiting more participants. Thus, the current study can be interpreted as an emerging theory, rather than establishing the theory of pivotal moments. In future studies, more participants can be interviewed over the course of therapy sessions, so that how and why pivotal moments occur will be better understood.

One of the aims of the current study was to determine which moments were pivotal for clients and therapists in session. Although we conducted interviews right after the session, the exact moment in which participants experienced a pivotal moment may not be determined in the interviews. In future studies, video recordings of sessions can be reviewed by clients and therapists so they can pinpoint to the exact pivotal moments. Also, it would be interesting to investigate the therapist-client dyad in terms of similarities and differences in their reports of pivotal moments.

4.5. Clinical and Training Implications

As stated in the above section, the findings of the study can be specific to the current study's participants. However, the findings of the present study would help couple and family

therapists to understand clients' perceptions regarding what was useful, or meaningful during therapy sessions. This in turn, would give therapists freedom to accustom or tailor their interventions according to the needs of their clients. The findings of the study showed that therapists in the current study were more likely to assume than ask clients about their in-session experience. Moreover, therapists' assumptions of why the client experienced a pivotal moment were overwhelmingly wrong. According to clients, the importance of pivotal moments was the feeling that clients experienced. Whether it was making a schedule, normalizing or confrontation clients focused on the different feelings and thoughts they went through during the session. Thus, even when clients reported specific interventions, they did not report interventions as the actual causal factor. Therefore, the specific intervention was not important. Knowing that various interventions can lead to experiencing a pivotal moment might feel as a relief to most therapists. In contrast to strictly following a model, therapists may choose different roads that lead clients toward therapeutic change. However, this is not to say that therapy models are useless or unnecessary. On the contrary, various studies show that adopting a therapy model and believing to the model's efficacy is very crucial and helpful to both therapists and the therapy process (Sprenkle et al., 2009; Laska, Gurman, & Wampold, 2014). Using the common factors framework, therapists can incorporate various techniques and models according to their clients' process in the therapy based on clients' needs. That is why assessing pivotal moments and what made that moment pivotal for the client is important. Rather than assuming the clients' attributions to the important moment therapists can assess in every session about pivotal moments in order to receive more information regarding their clients' change process. Therapists can ask questions regarding clients' in session experience such as: "In what ways clients feel that there was a change for them during sessions?" "What helped clients in experiencing a difference

in this session?" "Did clients feel something was different in how they experienced their family members/friends/partners?". These questions may help and guide therapists' work regardless of the model they use.

The current study's interview questions might have influenced how therapists and clients perceived change. Answering questions regarding in-session experience might have led clients to think more about the little change moments. As stated in the discussion section, some clients and therapists reported that answering the interview questions were helpful in terms of reflecting and processing the different thoughts and feelings that they experienced in-session. This in turn, could have affected their perception of change regarding therapy. Thus, therapists' asking these questions would be helpful for keeping them change-oriented in the session. And also, assessing clients' in-session experience would facilitate clients' being more change oriented.

Mastering a specific therapy model's techniques and believing its efficacy is important for both therapists' expertise and clients' view of therapist as competent. However, the current study's results showed that in the beginning stage of therapy, relationship building factors such as support and non-judgmental approach were most vital for clients' pivotal experience. Research also consistently showed that therapeutic relationship is strongly correlated with client outcome (Horvath, Del Re, Flückiger, & Symonds, 2011; Knobloch-Fedders, Pinsof, & Mann, 2007). Therefore, therapists' knowledge and skills in relationship building is as important as, if not more, mastering a therapy model. Therapists may improve client outcome by constant assessment of therapeutic relationship. Generally speaking, although practicum classes in CFT programs focus on forming therapeutic alliance, theory classes emphasize learning different therapy models. Since, research consistently shows the importance of therapeutic alliance, relationship building should be more incorporated to the CFT curricula.

Moreover, CFT programs inclusion of common factors training would beneficial for clinicians practice. Fife, D'Aniello, Scott, & Sullivan (2018) conducted a phenomenological study to investigate seventeen master's degree students' experience with having common factors training included in their curriculum. Participants kept reflective journals about their common factors class during the semester. Also, after the semester was completed focus group interviews were conducted with eleven students where group discussions were done regarding their experience in common factors training. Findings showed that most of the participants reported increased understanding of therapy process and appreciation for mechanisms of change. In addition, participants reported that learning common factors had helped them combine different approaches to their clinical work. Training in common factors, had helped these students with appreciation of different models and their shared mechanisms of change. The ability to integrate and switch between effective therapy models can help therapists with matching their skills to their clients' need.

The current study's findings also showed that clients and therapists who believed that change would not happen in the early stage of therapy tended to disregard pivotal moments. In addition, some therapists and clients did not match in their change beliefs. For example, a therapist who believes that change can happen in every session may wrongly assume that his/her client acknowledged experiencing a pivotal moment. Conversely, a therapist who believes that change do not happen in the early stage of therapy might miss his/her clients' experiencing a pivotal moment. This in turn, could be detrimental to the change process due to the mismatch between therapists and clients view of their change experience. To avoid this problem, therapists should overview their own change beliefs and then assess their clients' beliefs and expectations regarding therapy. Also, it was surprising for us to see that some of the therapist participants who

were receiving training in the systemic therapy did not believe in change from the early stage of therapy. Generally speaking, systemically oriented therapists believe that change process begin from the first session, if not from the initial call. However, the current study's therapist participants were beginning therapists who were in their first year in the program. Therefore, it may be the case that therapists need more experience in order to internalize being change-oriented from the first session.

The current study's findings showed that therapists' use of confrontation lead clients to experience a pivotal moment. According to Prochaska and DiClemente (1983) change is predicated on clients' motivational stage. Five stages of motivation include precontemplation, contemplation, preparation, action, and maintenance. In the precontemplation phase, clients are not yet ready to make a change. From a systemic point of view, we can say that they are not motivated to take risks, rather motivated to preserve the current homeostasis. In the contemplation phase, clients generally experience sadness and despair which lead them to think about pros and cons of taking action in handling the problem. In the preparation phase, clients decided that pros of changing outweigh the cons and they are ready to make a plan. Clients who are in the action phase, on the other hand, have made a change in how they deal with the problem. Lastly, in the maintenance phase, clients are motivated to continue and preserve the changes they had accomplished. Although some clients in the current study reported therapists' confrontation as beneficial for their pivotal experience, the degree of the challenge must be proportionate to the clients' motivational stage. Both going ahead or behind the client can be detrimental to the clients' change process.

APPENDIX A

(Client Participant Demographic Form)

Danışan Katılımcı Demografik Bilgi Formu

Ad Soyad: **Başvuru şekli:** - Kendi isteği - Yönlendiren Kişi/Kurum:	**Tarih:** **Başvuru Tarihi:**
Yaş: **İletişim Bilgileri:** Telefon: (cep) (iş) (ev) E-mail: Ev Adresi:	
Çalışıyor musunuz? ☐ **Evet** ☐ **Hayır** ☐ **Öğrenci** **Evet ise; Mesleğiniz** _____ **Öğrenci iseniz;** - **Okulunuz:** - **Bölümünüz:** - **Sınıfınız:**	
Medeni Durum: **İlişkide** ☐ **Süre:** _____ **Evli** ☐ **Süre:** _____ **Ayrı** ☐ **Süre:** _____ **Boşanmış** ☐ **Süre:** _____ **Bekar** ☐ **Yaşama şekliniz:** ☐ **Aile** ☐ **Arkadaşlarla** ☐ **Tek başına** ☐ **Diğer**	

Terapiye başvuru nedenleri: **1.** **2.** **3.**
Daha öce psikolojik/psikiyatrik yardım aldınız mı? ☐ **Evet** ☐ **Hayır** **Evet ise, Hangi konuda?** **Kiminle görüştünüz?** **Hangi yıl?** **Ne kadar sürdü?**

APPENDIX B

(Therapist Participant Demographic Form)

Terapist Katılımcı Demografik Bilgi Formu

Ad Soyad:	**Tarih:**

Yaş:

İletişim Bilgileri:
Telefon: (cep)
(iş)
(ev)

E-mail:
Ev Adresi:

Lütfen aşağıda aldığınız ve devam etmekte olduğunuz dereceleri işaretleyip hangi okullardan aldığınızı yazın.

Doktora ☐ **Kurum: _____** **Bölüm: _____**

Yüksek Lisans ☐ **Kurum: _____** **Bölüm: _____**

Lisans ☐ **Kurum: _____** **Bölüm: _____**

Sertifika Programı ☐ **Kurum: _____** **Bölüm: _____**

Medeni Durum:

İlişkide ☐ **Süre: _____**

Evli ☐ **Süre: _____**

Ayrı ☐ **Süre: _____**

Boşanmış ☐ **Süre: _____**

Bekar ☐

Yaşama şekliniz: ☐ **Aile** ☐ **Arkadaşlarla** ☐ **Tek başına** ☐ **Diğer**

APPENDIX C

(Session Experiences Interview)

Seans Deneyimleri Görüşme Soruları

Bu görüşme soruları danışan ve terapistlerin seans içeresinde önemli gördükleri deneyimleri anlamak için dizayn edilmiştir. Sorulara başlamadan önce yapılması gerekenler:

1) Katılımcılara seans sonrası mola vermeye ihtiyaçları olup olmadığı sorulur
2) Soruların doğru veya yanlış cevapları olmadığı belirtilir
3) Soru anlaşılmaz ise soru tekrar edilir ve soru ile ilgili ek bilgi vermeden önce katılımcılara süre verilir.
4) Olabildiğince az yönlendirme yapılır.

Soru 1)

A) Bu seansın başını düşündüğünüzde şu anda nasıl hissediyorsunuz?

Soru 2)

A) Size bu seansta önemli gelen bir an var mıydı? Var ise b ve c soruları ile devam edin
B) Bu an sizin için hangi açıdan önemliydi?

C) Bu anın önemli olduğunu bu seansta nasıl anladınız?
D) Aklınıza gelen başka bir an var mı? (Var ise B-C-D'ye geri dön.)

Soru 3)

A) Bu seansta kendinize farklı baktığınız veya kendiniz ile ilgili farklı hissettiğiniz bir an var mıydı? Var ise, b ve c soruları ile devam edin.
B) Bu an hangi açıdan kendinize farklı bakıp/hissetmenize yol açtı?
C) : Bu seansta kendinize farklı bakıp/hissetmenize ne yardımcı olmuş olabilir?
D) Aklınıza gelen başka bir an var mı? (Var ise B-C-D'ye geri dön.)

Soru 4)

A) Bu seansta, aileniz, arkadaşlarınız, romantik ilişkilerinize/eşinize farklı bakmanıza/hissetmenize sebep olan bir an var mıydı?
B) Bu an hangi açıdan ilişkilerinize farklı bakmanızda/hissetmenizde etkiliydi?
C) Bu seansta ilişkilerinize farklı bakıp/hissetmenize ne yol açmış olabilir?
D) Aklınıza gelen başka bir an var mı? (Var ise B-C-D'ye geri dönün)

Soru 5)

A) Bu seansta terapiye gelme sebebiniz ile ilgili size yardımcı olduğunu düşündüğünüz bir an veya anlar var mıydı? Var ise b ve c soruları ile devam edin.

B) Bu an size hangi açıdan yardımcı oldu?
C) Bu anın size yardımcı olmasında bu seansta neler etkiliydi?
D) Aklınıza gelen başka bir an var mı? (Var ise B-C-D'ye geri dön.)

Soru 6)

A) Sormadığım ama size bu seansla ilgili anlamlı gelen başka noktalar var mıydı? Var ise b ve c soruları ile devam edin.
B) Bu an sizin için ne açıdan anlamlıydı?
C) Bu anın size anlamlı gelmesinde bu seansta neler etkiliydi?

D) Aklınıza gelen başka bir an var mı? (Var ise B-C-D'ye geri dön.)

Sadece son görüşme (3. Seans) sonrası sorulacak:

Soru 7:

A) Seanslardan sonra bunları konuşuyor olmak nasıldı?

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