

CONCURRENT THERAPY

Authored by
mohammad looti

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Primary Disciplinary Field(s): Clinical Psychology, Marriage and Family Therapy, Counseling

1. Core Definition and Dual Contexts

The term **concurrent therapy** operates within two distinct, yet related, clinical contexts. In its broadest definition, concurrent therapy refers to the employment of two or more distinct therapeutic modalities or remedies simultaneously for a single patient. This might involve the use of psychological intervention alongside pharmacological treatment, or the integration of different therapeutic approaches, such as combining Cognitive Behavioral Therapy (CBT) with mindfulness techniques, with the goal of achieving a synergistic effect that addresses the multifaceted nature of complex clinical presentations. The emphasis here is on the simultaneous application of diverse treatment methods targeting different aspects (biological, psychological, or behavioral) of the client's condition.

The second, and often more specialized, context for concurrent therapy lies within **relational therapy**, particularly marriage, couples, and family counseling. In this framework, concurrent therapy describes the treatment structure where individuals who are fundamentally related (e.g., spouses, parent and child, siblings) receive clinical services from the same therapist or team, often involving both individual sessions and joint sessions, all running concurrently within the same treatment period. For example, a therapist might meet individually with a spouse on Tuesday and then hold a joint session with both partners on Thursday. This structural arrangement is designed to address both the individual pathology or distress experienced by one person and the systemic patterns and relational dynamics of the larger unit.

A crucial feature distinguishing concurrent therapy from other forms of structured treatment is the element of time and shared personnel. It differs significantly from sequential therapy, where one intervention is completed before the next begins, and from purely joint therapy, where all involved parties are always present in the room together. By integrating private individual work with shared group work, the therapist gains unique access to the client's internal narrative while also observing how that narrative manifests within the actual interpersonal system, allowing for targeted intervention at both the micro and macro levels of psychological functioning.

2. Historical Development and Theoretical Underpinnings

The conceptual foundation of concurrent therapy emerged from the realization across various medical and psychological disciplines that single-modality treatments often proved insufficient for chronic or deeply embedded issues. In general psychiatry during the mid-20th century, the rise of effective psychopharmacology necessitated the concurrent use of medication management

alongside traditional talk therapies, thereby codifying the general principle of combining remedies for enhanced efficacy. This biopsychosocial model, recognizing the interplay of biological, psychological, and social factors in illness, structurally demands a concurrent approach to treatment that addresses these multiple etiological components simultaneously.

Within the domain of relational therapy, concurrent treatment structures were adopted heavily following the mid-20th century shift toward systemic thinking. Pioneering thinkers in Marriage and Family Therapy (MFT) recognized that an individual's symptoms are often a manifestation of dysfunction within the larger family or marital system. While pure family therapy initially focused solely on joint sessions, the need arose to address individual resistance, past traumas, or deep personal secrets that could not safely or productively be processed in the presence of the relational partner. Concurrent sessions provided the necessary private space to work on individual issues while still retaining the systemic perspective offered by the shared therapist.

The theoretical justification relies heavily on the concept of **systemic leverage**. By treating the individuals involved, the therapist helps each person develop greater insight, healthier coping mechanisms, and improved emotional regulation. These individual improvements subsequently alter the dynamic equilibrium of the relationship system, making the joint sessions more fertile ground for pattern change. Conversely, relational insights gained in the joint sessions can inform the individual work, allowing the therapist to continuously weave together the internal and external realities of the clients. This integrated approach ensures that therapy is neither purely internal nor purely relational but rather a holistic intervention aimed at the entire constellation of distress.

3. Typologies and Modalities of Concurrent Treatment

Concurrent therapy is not a single uniform practice but rather a category encompassing several specific configurations, depending on the modalities being combined. These typologies reflect the varied needs of complex clients and the necessity of applying targeted interventions simultaneously. The simultaneous application of remedies often requires careful coordination and differential diagnosis to ensure the treatments do not conflict but rather enhance overall outcomes.

Psychopharmacological and Psychotherapeutic Concurrency: This is arguably the most common and foundational application, particularly in the treatment of mood disorders (e.g., depression, bipolar disorder) and anxiety disorders. The client receives medication, managed by a psychiatrist or primary care provider, concurrently with weekly sessions of talk therapy (e.g., Cognitive Behavioral Therapy (CBT), psychodynamic therapy). The pharmacological agent addresses underlying neurochemical imbalances, while the psychological intervention focuses on behavioral patterns, cognitive distortions, and emotional processing. Effective concurrent management necessitates open communication between the prescriber and the therapist, though they are often two separate professionals.

Multiple Psychotherapies Concurrency: In cases involving high complexity, such as personality disorders or severe trauma, a single client may benefit from two different psychological orientations applied at the same time. For instance, a client struggling with Borderline Personality Disorder might engage in Dialectical Behavior Therapy (DBT) skills training to stabilize behaviors and emotions, while simultaneously engaging in long-term psychodynamic therapy to explore deep-seated relational patterns and historical trauma. This approach is highly demanding for the client and requires precise boundary setting to prevent confusing or countermanding therapeutic directions.

Somatic and Psychological Concurrency: This model integrates physical treatments with mental health care, often used in conditions characterized by physical manifestation of psychological distress, such as chronic pain or somatic symptom disorders. Physical therapy, occupational therapy, or specialized trauma-focused bodywork (e.g., Somatic Experiencing) are provided alongside psychotherapy to treat both the psychological impact of the physical symptoms and the physical embodiment of the psychological distress. This type of concurrency emphasizes the unity of mind and body and is central to holistic health models.

4. Clinical Implementation in Relational Settings (MFT)

In Marriage and Family Therapy, the clinical implementation of concurrent therapy is structurally rigorous and deliberately phased. The treatment usually begins with a thorough assessment phase, involving both joint sessions with the entire unit and mandatory individual sessions with each involved party. This allows the therapist to gauge the identified patient's distress levels, the systemic contribution to the problem, and the readiness of each partner or family member for change. The resulting treatment plan then weaves these individual and joint sessions together, often with one or more individual sessions per week alongside a shared session.

The core function of the individual session in this model is multifaceted. It provides a safe space for the client to ventilate feelings, discuss secrets, explore personal goals unrelated to the system, and work on skills (like emotional regulation or assertiveness) that they need before they can successfully engage in productive joint work. Crucially, the individual session allows the therapist to build a strong, separate therapeutic alliance with each client. This alliance is vital for when the therapist must deliver difficult or challenging feedback during the joint sessions; because the individual client feels supported and understood privately, they are less likely to perceive systemic feedback as an attack.

The joint sessions, conversely, serve as the laboratory for change. Here, communication patterns are observed and corrected in real-time, boundaries are negotiated, and shared goals are established. The therapist acts as a skilled process consultant, using the information gleaned from the concurrent individual sessions to interpret the systemic dynamics observed in the joint setting.

For instance, if the therapist knows from an individual session that one spouse is deeply afraid of abandonment, they can frame their partner's demanding behavior in the joint session not as aggression, but as a misguided attempt to seek connection, thus transforming the interaction and fostering empathy.

5. Ethical and Confidentiality Challenges

The complexity of concurrent therapy, particularly in relational settings, introduces profound ethical challenges centered primarily around **confidentiality and objectivity**. The fundamental dilemma is managing the information asymmetry created by having individual knowledge about different members of a single system. If a therapist learns sensitive information in an individual session that directly impacts the safety or core functioning of the relationship (e.g., infidelity, substance abuse relapse, plans to separate), they face a conflict between their duty of confidentiality to the individual client and their duty to the system as a whole.

To mitigate this risk, many therapists practicing concurrent relational therapy utilize a strict "no secrets" policy established during the informed consent process. Under this policy, the therapist clarifies that if any information is disclosed individually that they deem critical to the systemic treatment or safety, they reserve the right to bring it up in the joint session or require the disclosing client to do so. While this policy protects the integrity of the systemic work and the therapist's neutral role, it may inhibit the client from fully disclosing necessary information during individual sessions, thereby limiting the depth of that private work.

Furthermore, maintaining **therapeutic neutrality** is exceptionally demanding. The therapist must constantly guard against triangulation, where one client attempts to recruit the therapist as an ally against the other. If one partner perceives the therapist as favoring the other (perhaps because the therapist spends more time validating the pain they heard in an individual session), the therapeutic alliance with the disadvantaged partner can collapse, leading to resistance or premature termination. The high level of skill and self-awareness required to manage these multiple, interconnected alliances underscores why concurrent therapy is considered an advanced clinical practice requiring specialized training in systemic ethics.

6. Advantages of the Concurrent Model

Systemic and Individual Insight: Concurrent therapy provides the therapist with unparalleled comprehensive data. By seeing the clients individually, the therapist understands their internal landscape, historical context, and private coping mechanisms. By seeing them together, the therapist witnesses the raw, unfiltered interactional patterns. This juxtaposition of individual narrative versus relational reality allows for a more accurate and nuanced diagnostic formulation than either modality could achieve alone.

Reduced Relational Resistance: Individual sessions can be strategically used to address resistance that might otherwise derail joint work. For instance, if one client is terrified of confronting their partner, the individual session can be used for deep preparatory work, skill-building, and role-playing, making them more resilient and capable of engaging productively in the joint session, thus ensuring greater productivity when the couple is together.

Enhanced Skill Generalization: The structure facilitates immediate application of newly acquired skills. If a client learns a new communication technique in their individual session (e.g., "I statements"), they have an immediate, guided opportunity to practice that skill in the safe environment of the concurrent joint session. This seamless transition between theory, practice, and real-world application significantly enhances the generalization and durability of therapeutic gains.

Flexibility in Pacing: The model allows the therapist to dynamically adjust the frequency and balance between individual and joint work based on the evolving needs of the clients. During periods of high individual crisis (e.g., job loss, personal health crisis), the therapist can temporarily increase individual sessions. When the system requires renegotiation (e.g., parenting conflicts, major life transitions), the focus can shift back toward more frequent joint sessions, ensuring treatment remains responsive to the primary source of distress.

7. Criticisms and Limitations

Despite its advantages, concurrent therapy faces significant scrutiny regarding the potential for therapeutic conflict of interest and the demanding nature of its requirements. The primary clinical critique focuses on the difficulty, if not impossibility, of a single therapist remaining truly impartial when holding conflicting confidential information from both parties. Critics argue that the therapist may unconsciously prioritize one alliance over the other, or may fail to intervene effectively in joint sessions for fear of breaching a private trust established during an individual meeting. This lack of complete transparency can erode trust in the therapist and the process itself.

From a practical and accessibility standpoint, concurrent therapy imposes a substantial burden on clients. It typically involves a higher frequency of sessions compared to standard individual or couples therapy alone, leading to increased demands on both time and financial resources. This may render the model inaccessible to clients with limited incomes or extremely tight schedules, thus creating equity issues in access to integrated, high-quality relational care.

Finally, the model places considerable strain on the therapist's cognitive and emotional resources. Managing multiple, interwoven narratives and emotional alliances requires exceptional clinical acumen, meticulous documentation, and consistent ethical self-reflection. Failure to adequately manage transference, countertransference, or boundaries can lead to burnout for the clinician or, worse, iatrogenic harm to the clients if the therapeutic structure exacerbates existing conflicts rather than resolving them. For this reason, many clinics prefer to use a modified structure known

as **collateral therapy**, where one therapist handles the individual work and a different, collaborating therapist handles the joint systemic work, thereby distributing the ethical burden.

8. Further Reading

[Family Therapy - Wikipedia](#)

[Cognitive Behavioral Therapy - Wikipedia](#)

[American Psychological Association Ethical Principles of Psychologists and Code of Conduct](#)

[Dialectical Behavior Therapy - Wikipedia](#)

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