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## Comparing individual and couples/family therapy : practitioners' perspectives

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## ABSTRACT

This qualitative study examines social workers' perspectives on the similarities and differences between individual and couples/family therapy. Particular attention is given to similarities and differences between individual and couples/family therapists' use of self, orientation towards conflict, and relationship factors. The investigation is based on semi-structured interviews with 10 master's level social workers who specialize in either individual or couples/family therapy.

A number of interesting trends emerged in the findings of this research. Therapists in both modalities perceived couples/family therapists' use of self to be more active and directive than individual therapists, and described more behavioral interventions when working with couples/families. Therapists also perceived a qualitative difference between management of conflict with couples/families versus with individuals, and described conflict in individual therapy, where the clinician is targeted as the object of the conflict, as more difficult and uncomfortable to manage than conflicts located in the client family system. The results to questions about relationship factors and therapist traits demonstrate that therapists perceive a wide range of characteristics and approaches to be viable for both individual and couples/family therapists. Additionally, the exploratory interviews generated some interesting results regarding the variables that influence specialization, and clinicians' biases around their own and other practice modalities. Implications for practice and future research are discussed.

COMPARING INDIVIDUAL AND COUPLES/FAMILY THERAPY:  
PRACTITIONERS' PERSPECTIVES

A project based upon an independent investigation, submitted  
in partial fulfillment of the requirements for the degree of  
Master of Social Work.

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2012

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## **CHAPTER I**

### **Introduction**

The purpose of this study is to explore the ways therapists specializing in either individual or couples/family therapy perceive each modality as similar and/or different from the other. The specific research question is: do individual and couples/family therapists believe there are differences in use of self, orientation towards conflict, and effective therapist traits across these two major modalities.

In the introduction to his text, *Foundations of Family Therapy*, Nichols (2009) asserts: “Family therapy isn’t just a new set of techniques. It’s a whole new approach to understanding human behavior” (p. 3). Assertions like this one imply that couples/family therapy is distinct from individual therapy in some significant ways. The literature does support the possibility that such differences might exist; however, it has failed to elucidate specific ways in which the modalities differ.

The most clear and basic difference between individual therapy and couples/family therapy is that couples/family therapy involves working with more than one client simultaneously. It is possible that this basic difference gives rise to a number of other differences. The couples/family therapist is tasked with providing a therapeutic experience to two or more people at the same time, who may have differing expectations about therapy, different goals, and different personalities. In order to accomplish that, does a couples/family

therapist need to use him/herself in a different way from an individual therapist? This is one of the questions addressed by this study.

Another possible source of difference between individual and couples/family therapy is the way that interpersonal conflict is experienced in session, and the role the therapist plays in managing conflict. In couples/family therapy, clients often come to sessions in the midst of interpersonal conflict which they are having difficulty managing on their own (Sommers-Flanagan & Sommers-Flanagan, 2009). The couples/family therapist is often in a position to support the clients in managing that conflict *in vivo* during sessions. Because this is a unique feature to couples/family therapy, it may be another area wherein the therapist uses him/herself differently in this modality to provide a therapeutic experience.

While the therapist's use of self, and management of conflict may arise as areas of difference between the modalities, there are other ways in which the modalities may be similar. Recent research in the field of couples and family therapy has begun to explore how "common traits" among successful family therapists and family therapy approaches contribute to their success (Blow, Sprenkle & Davis, 2007). Similarly, research in individual therapy has indicated that the therapist's therapeutic alliance with the client is more important than their training, experience, practice modality, or medication (Zuroff & Blatt, 2006). Prior research has not attempted to describe, however, whether the features that make therapy and therapists effective are more similar or different across the modalities of individual and family therapy. The limited research that exists in the areas of use of self, orientation towards conflict, and therapist traits, are explored in further detail in Chapter 2.

The current exploratory study seeks to clarify possible differences and similarities between individual and couples/family therapy, from the perspective of the therapists



themselves, using qualitative interviews with ten master's level clinical social workers who report working primarily with individuals or primarily with couples/families. The semi-structured interviews elicited narrative descriptions of these therapists' perceptions of the similarities and differences between the modalities of individual and couples/family therapy, and the differing ways that the therapists experience their use of self, conflict management, and relationship factors across both modalities. A qualitative design also allowed for open-ended responses and the generation of unanticipated themes around this topic. The design and procedures are explained in detail in Chapter 3.

The results of this study, as described in Chapter 4, may serve the wider social worker community on a number of levels. While many therapists have strong ideas about the differences between working with different practice modalities, little research has been done to clarify and operationally define these differences. By beginning to define the core similarities and differences between modalities, we will have more information to utilize in training social workers to practice in varying fields. The results of this study contribute to this process by elucidating possible similarities and differences between two modalities frequently used by social workers: individual and couples/family therapy. Finally, the results of this study suggest that biases may exist about different practice modalities, perhaps based on lack of discussion or exposure to practice experience in different modalities. Further implications and limitations of the study are discussed in greater detail in Chapter 5.

## **CHAPTER II**

### **Literature Review**

In his introduction to his text, *Foundations of Family Therapy*, Nichols (2009) asserts, “Family therapy isn’t just a new set of techniques. It’s a whole new approach to understanding human behavior” (p. 3). A social work student reading this text might be inclined to believe that individual and family therapy are quite distinct disciplines. Yet, as the following literature review will demonstrate, there is little empirical research establishing core differences between individual and family therapy, which begs the question: Is family therapy really a very different approach to practice, or does it closely resemble individual therapy? This chapter will address the current literature on the possible core differences between individual and family therapy and the common factors among effective therapeutic interventions across these modalities.

#### **Differences Between Individual and Couples/Family Therapy**

Researchers in social work are constantly striving to prove and improve the effectiveness of therapeutic interventions. Studies explore the different ways that therapists promote psychological, emotional, and behavioral change in clients, whether it is through the use of different practice frameworks, or through the way they use themselves in building alliance, showing empathy, and offering insight. Research has failed to demonstrate, however, whether family therapists use themselves in a different way from individual therapists, or whether the similarities between these modalities are greater than their differences.

The basic structural difference between individual and couples/family work is clear. Individual therapy involves one client and one therapist. Family therapy on the other hand involves at least one therapist and a client system. A system is defined as,

A functioning whole composed of all the interrelated parts and processes. Systems may include an individual, a family, a community, an organization, or a nation. The human system is made up of one person, whereas social systems are made up of interacting people. (Boyle, Hull, Mather, Smith & Farley, 2006, p. 57)

In the context of family therapy, a system refers to the family unit including each individual in the family as well as the dynamic way they function and influence one another (Nichols, 2009). In this paper, the word “system” will be used to describe the dynamic relationship of a couple or family unit.

This basic difference, that systems therapy involves work with multiple clients at once, is obvious, but does this difference translate into a fundamentally different role for the therapist? Writing on the differences between individual and family therapy is primarily found in foundational textbooks in counseling. Based on looking at these textbooks, one might assume that individual therapy and family therapy look quite different. Most introductory individual therapy textbooks will include chapters on foundational concepts and skills such as: basic listening skills, use of questions, alliance building, transference, and termination; as well as an overview of commonly used practice frameworks such as: solution-focused therapy, psychodynamic therapy, relational therapy, cognitive-behavioral therapy, and narrative therapy (Brandell, 2010; Cooper & Lesser, 2008; Sommers-Flanagan & Sommers-Flanagan, 2009). Looking at an introductory textbook on family and couples therapy, one is likely to find some frameworks which have been adapted for use with families such as cognitive-behavioral family

therapy, narrative family therapy, and solution-focused family therapy, as well as a number of frameworks unique to family therapy such as structural family therapy, strategic family therapy, and Bowenian family systems therapy (Nichols, 2009).

One feature which distinguishes couples/family therapy is the fact that almost all couples and families come to therapy because they are engaged in some form of conflict with one another and are lacking in the skills to manage that conflict on their own (Sommers-Flanagan & Sommers-Flanagan, 2009). Regardless of practice framework or theoretical approach, the job of the couples or family therapist is to determine what is causing and perpetuating conflict in the system, and to intervene in such a way that reduces and helps members of the system to more successfully manage their conflict. In practice, this means that conflict will frequently be in the room during couples and family therapy, and that the therapist's role may often be to guide the clients through a new form of conflict resolution. Conflict can, and does, arise in individual therapy sessions between client and therapist, but conflict in couples/family sessions is distinct in that there is a potential for family members or loved ones to emotionally harm one another in the session by expressing their thoughts and feelings. This potential for interpersonal hurt changes the feel of conflict in a couples/family session.

Systems therapy also differs from individual therapy in that it challenges therapists to provide a therapeutic experience to multiple clients simultaneously. However, there are numerous components to providing a therapeutic experience to multiple clients simultaneously. Members of the system may have different motivations for coming to, and expectations about therapy, which must each be assessed and addressed. Frequently one or more members of the system are coming to therapy unwillingly, which creates a barrier to productive therapeutic work. In addition to the challenge of assessing multiple people at once throughout the therapy,

the clinician must hold balanced alliances with each member of the system despite the fact that they are frequently at odds with one another; the therapist must be joined with everyone (Sommers-Flanagan & Sommers-Flanagan, 2009). As Sommers-Flanagan and Sommers-Flanagan put it,

Working with couples and families usually involves a joining that is more pronounced than in individual work. It is analogous to empathy but perhaps more inclusive. This joining involves coming not only into the worldview of each individual, but also into the worldview of the relationship(s). (p. 397)

By joining with the system, becoming part of the system, the family therapist changes it. While individual therapists build an alliance with a single person and help effect change in that individual, systems therapy emphasizes forming alliances with the entire system to effect changes in all the individuals as well as in their group dynamics.

In summary, the basic features that distinguish systems therapy from individual therapy are: couples/family therapy involves multiple people and therefore multiple simultaneous assessments and alliances, it often contains more conflict in session, and it demands a complex form of joining with the client system. The next segment of the literature review will discuss common features that make therapy effective.

### **Similarities Across Modalities**

Earlier in this discussion, we considered the multitude of frameworks from which individual and couples/family therapists practice. An enormous body of research has been dedicated to studying the effectiveness of each of these models; this has been the rise of “evidenced-based practice.” However, a competing body of research suggests that outcome depends more upon the therapeutic relationship than on the theoretical approach. The Theory of

Common Factors states that different models of therapy work primarily as a result of elements common to all the therapies rather than because of the differences between the models (Blow et al., 2007). For example, structural family therapy and emotion-focused family therapy are both empirically successful but are drastically different approaches. The Theory of Common Factors posits that these therapies are not successful because of their unique features (or “specific factors”) but rather because of their common features, such as having a therapist accurately reflect the client’s emotional state and the conflict they are experiencing, and using themselves actively and directly in session with clients to redirect conflict.

As research has begun to study common factors, it has become more and more clear how little we know about the impact of therapist variables on practice outcomes. The American Psychological Association Presidential Task Force in 2006 examined the early research on therapist variables and declared that:

The individual therapist has a substantial impact on outcomes, both in clinical trials and in practice settings...The fact that treatment outcomes are systematically related to the provider of the treatment (above and beyond the type of treatment) provides strong evidence for the importance of understanding expertise in clinical practice as a way of enhancing patient outcomes. (p. 276)

Researchers would often like to think of therapeutic interventions just as one would think of medications: something to be administered in order to achieve a desired result. Common factors research emphasizes the fact that therapy is not a pill; perhaps it matters less what treatment is being administered, but rather who is doing the administering (Sprenkle & Blow, 2007).

Research on common factors among individual therapy approaches has identified a number of empirically supported common factors contributing to therapeutic change, including:

therapeutic alliance, empathy, goal consensus, client motivation, client expectation and therapist-client collaboration (Norcross, 2002; Westra, Constantino, Arkowitz & Dozois, 2011). Some of these common factors are located in the client and in external factors such as client motivation and client expectations of therapy, but many common factors relate to therapist characteristics and use of self.

The extent to which therapist characteristics and therapists' use of self influence client outcomes is difficult to measure. Therapist characteristics are particularly difficult to differentiate from therapeutic alliance. The term "relationship factors" has been used to encompass both therapeutic alliance and individual characteristics of the therapist. Researchers estimate that relationship factors account for 30% of client change (Hubble, Duncan, & Miller, 1999), making it a very significant piece of the overall outcome of therapy. In other words, the relationship that the therapist builds with the client accounts for more of the variance in outcomes between practice frameworks, than the specific differences between therapeutic approaches; it is a powerful common factor.

### **Effective Therapist Characteristics Across and Between Modalities**

Simon (2006) proposed a compromise between the perspectives of the Common Factors Theory and a more traditional view wherein a model is judged on its own merits regardless of who is administering it. He hypothesized that therapy is most effective when therapists adopt a model of practice that is congruent with their own worldview (Simon, 2006). Other researchers have termed this "allegiance," and define it as a practitioner's belief and commitment to a particular approach (Duncan, Miller & Sparks, 2004). At the beginning of this chapter, Nichols (2009) was quoted as saying that family therapy is a "whole new approach to understanding human behavior." In the context of Simon's writing, this raises the question, do family therapists

really have a differing outlook on human behavior than individual therapists, or do family therapists only perceive their worldview as different? Does this perception perhaps reflect a particularly strong allegiance family therapists have to their mode of practice? Hopefully, the results of this study will clarify the answer to this question.

It may be that therapists who elect to work with couples/families tend to use themselves differently in their work than therapists who work with individuals. While some therapist uses of self are widely favorable, some therapist uses of self should be adapted to suit the needs of the client. Directiveness, for example, has been shown to be counterproductive in individual therapy when client resistance is high (Beutler, Consoli, & Lane, 2005), suggesting that the ability of the therapist to use themselves flexibly may be an important contributor to positive outcomes. In contrast, for couples/family therapists, a high level of activity and directiveness has been shown to be an important therapist variable in predicting positive outcomes (Bischoff & Sprenkle, 1993; Lebow, 2006). This factor is particularly important in the field of marital and family therapy because the conflict that arises in session often makes it necessary for the therapist to interrupt dysfunctional patterns of conflict and communication in order to prevent therapy from becoming a repetition of previous arguments.

Research about which specific personality traits are most favorable in therapists has been inconclusive thus far (Beutler et al., 2004). Blow et al. (2007) hypothesize that this may be because different therapeutic styles are effective with different people and in different stages of treatment. More research is needed in the field to explore whether effective therapist traits are the same for both family therapists and individual therapists, or whether differences exist between what is effective in each of these modalities.



It is clear that in the case of couples/family therapy, a therapist must be able to adjust to and juggle the personality styles of multiple family members at once, and this comfort in juggling personalities may be one of the features that distinguishes marital and family therapists from those who feel most comfortable working with individuals (Blow et al., 2007). Furthermore, since systems therapy is inherently directive (Sommers-Flanagan & Sommers-Flanagan, 2009), it requires a willingness to take control and manage conflict in the moment. It requires a willingness to sit in the room with conflict on a daily basis, which begs the question of how counselors feel about addressing conflict.

Some have speculated that there may be other ways in which couples/family therapists differ in the way in which they engage with clients (Nichols, 2009), beyond a greater degree of directiveness. Some researchers have explored the possibility that family therapists have a different orientation towards use of self and self-disclosure (Jeffrey & Austin, 2007). Preliminary findings tend to indicate that many marriage and family therapists hold a belief that self-disclosure encourages an atmosphere of honesty, while individual therapists more likely hold the belief that self disclosure weakens the therapeutic relationship (Jeffrey & Austin, 2007). This study found that individual therapists were more likely to agree with the statements, “Disclosing information about oneself weakens the therapeutic relationship” and “Therapists should remain as objective as possible with clients” while family therapists typically endorsed the statement, “Clinician self-disclosure encourages an atmosphere of honesty” (Jeffrey & Austin, 2007).

In conclusion, research has established that family therapists juggle multiple assessments and alliances at once, employ a directive use of self, possess a tolerance for conflict, and may engage in a greater level of joining and self disclosure. These differences provide the foundation

for the hypothesis that clinicians who elect to practice couples and family therapy may tend to use themselves in fundamentally different ways from individual therapists

### **Research Hypotheses**

The existing literature reviewed in this chapter raises the possibility that differences may exist between individual and couples/family therapy, and between effective therapists practicing each modality. The current study seeks to clarify possible differences and similarities, from the perspective of the therapists themselves. Based on the literature, it is hypothesized that individual and couples/family therapists will differ in directiveness, ways of addressing conflict, and feelings about addressing conflict, but will be similar in relationship factors. However, because the literature is so limited, this study will also seek to elicit from therapists what additional variables they consider to be similar or different. The next chapter, Methodology, will describe the manner in which this study attempts to investigate these hypotheses.

## **CHAPTER III**

### **Methodology**

A qualitative research design was implemented in order to gather and analyze data from clinical social workers practicing therapy with individuals or couples/families. The research question was: Do individual therapists and couples/family therapists believe significant differences exist between these two modalities in terms of use of self, orientation towards conflict, and effective therapist traits? The study was designed to be exploratory due to the dearth of existing research in this area. Semi-structured interviews were conducted with currently practicing clinical social workers.

### **Sample**

The participants in this study represent a non-probability convenience sample located using a snowball sampling method. A convenience sample was used on the basis that the study had no monetary resources, a limited time span, and was exploratory in nature (Rubin & Babbie, 2010). A snowball sampling method was used, beginning with eligible social workers known to the researcher, who were each sent a recruitment email (Appendix A), which included a description of the study objectives, the nature of participation, and contact information. This initial group was encouraged to forward the recruitment email to any additional friends and colleagues who might be interested in participation. Recipients who were interested in participation contacted the researcher via phone or email, at which point they were screened for inclusion criteria (Appendix B). The study was limited to currently practicing social workers in

Massachusetts who hold a graduate degree in the field of social work, and who practice either with at least 90% individuals or with at least 90% couples/family clients. Participants were required to be English speaking, as translation services were not available. Ten clinical social workers were interviewed for the purposes of this study between March and April of 2012.

## **Procedures**

The procedures and ethics of this study were approved by the Human Subjects Review Board of Smith College School for Social Work (Appendix C). Participants were provided with a copy of the informed consent letter (Appendix D) via email prior to participating in the interview, and given an opportunity to respond with any questions or concerns. The informed consent letter outlined the purposes of the study, the potential risks and benefits of participation, and procedures to maintain participant confidentiality. Upon arrival for the interview, participants signed a hard copy of the informed consent.

The method of data collection for this study was open-ended, semi-structured interviews. Interviews were conducted face-to-face at a time and location deemed convenient and confidential for each participant. Locations included participants' offices and conference rooms at the investigator's workplace. Interviews ranged in duration from 25 minutes to 95 minutes. A semi-structured interview guide (Appendix E) was used to structure the interviews and ensure certain information was gathered from every participant; however, probes and additional follow-up questions were used to solicit details when important themes and information arose. Participants were reminded not to share confidential information about their clients, and could refuse to answer any question, end the interview, or withdraw from the study at any time during data collection.

Interviews were audio recorded and later transcribed by the researcher, removing all identifying information. Transcripts were labeled only by code numbers and stored as electronic documents under password protection. All direct quotations and case illustrations which are included in this publication have been carefully disguised to ensure the participants cannot be identified based on the given information.

Demographic data were collected from each participant at the start of the interview to address the variables of age, gender, years of experience in the field, fields of practice experience, as well as their motivation for specializing in their field of practice. The second set of interview questions was designed to elicit clinicians' perspectives on the core similarities and differences in the clinicians' use of self in individual and couples/family therapy including their self described interaction style, flexibility in use of self, and feelings about self-disclosure, and use of transference. The third set of interview questions focused on the clinicians' orientation towards conflict including feelings about managing conflict, managing conflict with an individual, and managing conflict between couples and families. The fourth set of questions addressed relationship factors which includes the therapeutic alliance and the therapist's personal characteristics. Finally, clinicians were asked to synthesize their sense of the core similarities and differences inherent in the modalities.

### **Data Analysis**

All the transcribed interviews were read and coded for themes salient to the current research. The first step of coding was delineating whether an item of data described a similarity or difference between individual and couples/family therapy. Next, themes were identified within the subcategories of similarity in difference. These themes included but were not limited to the three themes specified in the research question: use of self, management of conflict, and

therapist effectiveness. Finally, subthemes were identified capturing the differing perspectives of individual and couples/family therapists on the aforementioned themes.

The data from the individual therapists and the data from the couples/family therapists were separated and compared and contrasted on the dimensions of themes and subthemes looking for patterns in thought. Data were also ordered by years of experience and again compared and contrasted by theme and sub-theme for patterns.

## **CHAPTER IV**

### **Findings**

The purpose of this study was to explore whether individual and couples/family therapists believe significant differences exist between these two modalities in terms of use of self, orientation towards conflict, and effective therapist traits. Ten master's level social workers participated in this study, 5 individual therapists and 5 couples/family therapists. This chapter includes analysis of their responses to a semi-structured interview (see Appendix E), as described in the previous chapter.

#### **Demographic Data**

Of the ten participants, 5 clinicians reported working primarily as individual therapists, and five clinicians reported working primarily as couples and/or family therapists. All ten participants identified as female and Caucasian. Participants ranged in age from 27 to 62, with a mean age of 48.9 and a median age of 54. Participants reported social work experience ranging from 5-25 years, with a median of 17 years and a mean of 15.8 years (see Table 1). All of the participants in the study had some experience doing both individual and couples/family work.

#### **Specialization**

Participants were asked at the beginning of the interview to describe their area of specialization, their experience in each of the two modalities, and the reason they chose to specialize in their current modality. All participants have some experience working in both modalities, however there was variation in terms of how much experience working outside their

current modality therapists had. The years of experience participants have in each modality is outlined in Table 1.

Table 1

*Demographic Characteristics of Respondents*

| n = 10                    | Age                    | Total Yrs of Experience | Yrs of Indiv. Experience | Yrs of Couples/Family Experience |
|---------------------------|------------------------|-------------------------|--------------------------|----------------------------------|
| Individual Therapists     | mean=45.8<br>median=44 | mean=17.4<br>median=17  |                          |                                  |
| Participant 1             | 39                     | 10                      | 9-11 yrs                 | 0-2 yrs                          |
| Participant 2             | 44                     | 17                      | 17-19 yrs                | 0-2 yrs                          |
| Participant 3             | 35                     | 10                      | 9-11 yrs                 | 6-8 yrs                          |
| Participant 4             | 52                     | 25                      | 23-25 yrs                | 3-5 yrs                          |
| Participant 5             | 59                     | 25                      | 20-22 yrs                | 9-11 yrs                         |
| Couples/Family Therapists | mean=52<br>median=56   | mean=14.2<br>median=17  |                          |                                  |
| Participant 6             | 62                     | 7                       | 0-2 yrs                  | 6-8 yrs                          |
| Participant 7             | 27                     | 5                       | 3-5 yrs                  | 3-5 yrs                          |
| Participant 8             | 56                     | 17                      | 0-2 yrs                  | 17-19 yrs                        |
| Participant 9             | 56                     | 18                      | 9-11 yrs                 | 9-11 yrs                         |
| Participant 10            | 59                     | 24                      | 6-8 yrs                  | 23-25 yrs                        |

Participants were asked to describe their reasons for specializing in either individual therapy or couples/family therapy. Among the five individual therapists, two described their motivation as arising in part from an aversion to working with children. One of these participants stated that “actually sitting in the room with an adolescent is something I’ve avoided like the plague,” while the other stated, “I was always scared of working with children... Family meetings were very intimidating to me.” The other three individual therapists described it as a “familiar,” “more enjoyable,” and useful to a particular population of interest, respectively.

Among couples/family therapists, two participants described being motivated by a belief that couples/family therapy is the more effective modality for creating change. One of these participants stated that she “enjoyed doing individual therapy...but then I started to realize that



you can't make much change without involving the family," while the other said, "I had always believed that my relationship in many of the settings could only go so far in helping, that it was really imperative to bring in outside supports." The other three couples/family therapists expressed feeling that their family lives had made them "naturals" to work in family therapy. Two of these therapists described themselves as having a parentified role in their families growing up, while the other cited her history raising five children and maintaining an intact marriage as experiences that steered her towards a focus on families.

### **Use of Self**

Participants were asked a series of questions designed to elicit descriptions of their use of self in therapy. Participants were first asked broadly to describe how they use themselves in their clinical work and to describe their presence in the room. Specific questions were also asked about self-disclosure, and perceived differences between the two modalities.

**Flexibility in use of self.** All five of the individual therapists (100%) led the discussion of use of self with the qualification that they use themselves flexibly and variably, while three out of five (60%) of the couples/family therapists also volunteered that they use themselves flexibly. A number of factors were identified as influencing the therapist's flexible use of self. One variable mentioned was how long the therapist has known or been working with a client, or the "stage of treatment." Two individual therapists out of five (40%) noted stage of treatment as an important variable. Another variable was the anticipated length of treatment, which one individual therapist described as important. One individual therapist of the five (20%) also identified the client's diagnosis as an important variable in the flexible use of self. The most commonly cited variable, however, was the client's personality/presentation. Two individual therapists (40%) and two couples/family therapists (40%) said that the client's personality and

interactional style influences their flexible use of self. Both an individual therapist and a couples/family therapist who work with teenagers noted ways they use themselves differentially with a teenage population as opposed to an adult population.

**Differences in use of self.** When asked to specifically distinguish between use of self in different modalities, a number of common themes arose in the participants' responses. Three out of five individual therapists (60%) and two out of five couples/family therapists (40%) said that they are "more active" or "very active" when conducting a couples/family session. Four individual therapists (80%) and four couples/family therapists (80%) described couples/family therapy as more directive, or discussed using more behaviorally-based, guided interventions in couples/family therapy. As one individual therapist described it, "[in couples/family therapy] you're setting up some kind of intervention, like, 'why don't you say this to so and so'...you're shaping and directing." One couples/family therapist with significant experience with individuals said, "When I'm working with parents particularly I'm a little more task oriented and working on parenting skills and behavior management techniques...When I'm working with an individual I'm much more reflective and just talking with them." Another couples/family therapist said, "I tend to give homework more with couples and families." One individual therapist explained her level of activity as being more variable in couples/family therapy and more constant in individual therapy. She described it as,

Initially in [couples/family] treatment I might be more active than at the end of a treatment, when I feel like I often will sit back and let a process unfold more...whereas in individual therapy I feel like my activity level remains a bit more constant.

Some of these differences may relate to practice framework/theoretical orientation, as will be discussed in Chapter 5.

Interestingly, in describing the active and directive role in couples/family therapy, two individual therapists (40%) and two couples/family therapists (40%) used sporting metaphors such as: “balancing a lot of balls,” “coach of a team,” “cracking the whip in the 3-ring circus,” “setting rules,” and two therapists used the term “referee.” No such active sporting metaphors were used by any participant to describe individual work. The directive role of the couples/family therapists will be discussed further in the section on management of conflict.

Therapists were less clear about describing their use of self in individual therapy, and mostly used comparisons to couples/family therapy to say what they might do differently. One couples/family therapist said of individual work, “I tend to take more of a back seat and sit back.” Another couples/family therapist noted a greater emphasis on exploring the client’s history in individual therapy.

Additionally, therapists distinguished between their mental use of self in individual and couples/family work. They discussed that in couples/family therapy they are “having to think exponentially,” and “balancing a lot of balls as opposed to just focusing and being present.” This thinking style will be addressed in greater detail below in the section about relationship factors.

**Self-disclosure.** In the literature, it was suggested that couples/family therapists believe more in the use of self-disclosure to strengthen the therapeutic alliance than individual therapists, and that individual therapists were more likely to feel that self-disclosure weakens the therapeutic relationship. The interviews in this study did not support this hypothesis: both groups expressed a variety of opinions and comfort levels regarding self-disclosure. All five of the individual therapists made remarks about self-disclosure, while only three out of five of the couples/family therapists mentioned self-disclosure. The individual therapists had a variety of

feelings about the use of self-disclosure. Two out of five individual therapists (40%) made positive statements about the use of self-disclosure; one said,

I always let people know they can ask whatever question they want to ask me and I will be honest and I will share with them what I think will be helpful in their process...over the years I've gotten more open-minded about how I think about that and what I might choose to share.

The other individual therapist explained her belief that self-disclosure is an important part of alliance building with the geriatric population. Two individual therapists (20%) simply said "sometimes" they feel self-disclosure is useful in therapy, and one individual therapist (10%) said "I don't tend to share personal experiences."

Of the three couples/family therapists who mentioned self-disclosure there was also variability in how useful they felt self disclosure is in their work. One couples/family therapist said, "I use a lot of examples from my life and my family." Another couples/family therapist took a somewhat more cautious approach to self-disclosure saying, "I'm careful not to use too much of a sense of self...But I draw from stories of bringing up kids when it seems called for." The third couples/family therapist said, "I don't necessarily go into stories about my own life." Therefore there was more variability in the way that therapists felt about the use of self-disclosure within modalities than there was between modalities.

**Use of transference.** The way that the therapist uses transference within the therapy was not specifically addressed in the interview questions; however, it arose as a theme in five out of the ten interviews as a perceived difference between individual and couples/family therapists' use of self. Transference is defined as:

A mechanism whereby feelings and attitudes originally associated with important people and events in one's early life are attributed to others in current interpersonal situations, including psychotherapy. The phenomenon is used as a tool in understanding the emotional problems of the patient and their origins. (Mosby, 2009, p. 1182)

All five therapists who mentioned transference, two individual therapists (40%) and three couples/family therapists (60%), agreed that the use of transference is different and more intense in individual therapy. As one individual therapist put it:

Transference has a completely different place because you have the actual relationship there [in couples/family therapy]...In individual therapy part of the goal is to allow the therapeutic relationship to be the primary relationship transitionally...It doesn't seem to me that would be particularly useful in couples and families.

She went on to explain that individual therapy, and the transference the client has towards the therapist, is at times a metaphor for other relationships, whereas that transference "metaphor" is not as needed when the primary attachment relationships are present in the room, as in couples/family therapy.

### **Orientation Towards Conflict**

Participants were asked to describe their feelings about managing conflict and the ways that they manage conflict both when it arises in individual sessions between themselves and a client, and when it arises in couples/family sessions between clients. Results from this line of inquiry were mixed.

**Variables impacting feelings about conflict management.** The client population or diagnosis came up frequently as a crucial variable influencing participants' management of conflict. In particular, three individual therapists and two couples/family therapists (50%)

identified a diagnostic group with which they find conflict especially challenging: personality disorder diagnosis came up in three (30%) of the interviews, and paranoid symptoms came up in two (20%) of the interviews. As one couples/family therapist put it, “Some patients do make me more anxious, like someone with a severe Borderline Personality Disorder or Narcissistic Personality Disorder. I’m like, okay this feels like we’re out in the jungle right now. It can feel fierce.”

Two participants (20%) also noted that the quality of the relationship with the client has an impact on how they feel about managing conflict. One of these participants, an individual therapist, explained: “If I have a decent relationship with somebody I feel like I can use [the conflict], when there’s not much of a relationship there I’m more apt to shut down or set a limit.”

**Managing conflict between therapist and client.** In individual therapy, conflict is typically directed at the therapist, because no other persons are present. Only one of the five couples/family therapists (20%) discussed managing conflict between themselves and an individual client and none of the couples/family therapists made a comparative statement about whether conflict is easier or more difficult to manage in individual therapy. The one couples/family therapist who mentioned conflict with an individual stated, as mentioned above, that managing conflict with an individual could be difficult when a personality disorder was involved. The other four couples/family therapists did not discuss what it is like to manage conflict between themselves and a client.

The five individual therapists interviewed did discuss what it feels like to manage a conflict between themselves and a client. Four of the five individual therapists (80%) expressed negative statements about managing conflict when it arises in the individual therapy relationship. These therapists made statements like, “I find it hard to work with,” and “I would just kind of

shut down a bit...mainly get very quiet and just kind of sit and take it.” One individual therapist explained the particular difficulty of this kind of conflict, saying: “I would tend to feel worse when the conflict is between myself and a patient.” Another individual therapist added:

For me personally, that is not my greatest strength in individual therapy...it scares me, conflict...I worry like a lot of people do about a rupture. I find myself getting defensive if I'm attacked...some people can take it much more easily and not as personally. I tend to struggle with that.

The last two comments highlight the challenge in individual therapy of being the target of the attack or the source of anger for the client, as opposed to when clients are angry with one another. The next section will demonstrate that some of these individual therapists feel more comfortable with conflicts between clients. The fifth therapist did not describe strong feelings about managing conflict either way. She, along with three other individual therapists, all psychodynamically oriented, talked about addressing conflict with individuals within the relationship and through the transference.

**Managing conflict between clients.** Both individual and couples/family therapists described feelings about managing conflict that arises between clients. Three couples/family therapists (60%) expressed a high degree of comfort in managing this type of conflict. One couples/family therapist went so far as to describe liking the task of managing conflict between clients. As she describes it:

I actually like working with angry people...I like the ability to stand in the face of somebody else's anger and not be afraid of it...just to be with the person who's angry and let them continue to be angry and...help them move to a more thoughtful place...I think I'm good at that.

On the other hand, two of the five (40%) couples/family therapists made negative statements about managing conflict between clients, saying, “I think it’s really hard,” and “conflict is difficult...my tendency when conflict arises is to sort of pull back...I work very hard against my instinct to pull back.”

In describing working with conflict between clients, two individual therapists (40%) expressed a higher degree of comfort in managing conflict between members of couples/families than with an individual. One individual therapist said:

When I’m seeing a couple, I have a certain tolerance or appetite for letting the conflict unfold and being able to sit with it and tolerate it...I feel I have a pretty high tolerance for not feeling distressed in that kind of conflict.

Another individual therapist said, “It’s very different with couples, much easier. With couples I’m a very strong mediator and it doesn’t scare me the same way.” These individual therapists emphasize the difference in their role when managing conflict between clients as a mediator or outside party, as opposed to feeling they are the center or target of the conflict.

**Perceived differences in conflict management between modalities.** While there was substantial variability within both groups about how therapists felt about managing conflict, there was much more agreement in terms of the key differences between how conflict management occurs in individual versus couples/family therapy. The words and phrases used to describe conflict in individual therapy included: “use the relationship,” “take it on in the transference,” “opportunity to explore,” “talk through some of the feelings,” “try to make the patient right, there’s a reason they’re having a reaction, there’s some truth in it,” and “validate.” Both individual and couples/family therapists used words that emphasized feelings, support, and validation in describing the process of addressing conflict with individual clients.



In contrast to the above descriptions, words and phrases that came up in describing the management of couples/family conflict were: “I have to be very forceful in stopping arguments,” “getting people to pull back,” “made them all sit in different corners of the room,” “try to understand,” “say, excuse me I have to stop you right now,” “say, we’re setting rules and here’s the rule for the session,” “stopping the argument in its tracks rather than letting it unravel,” “interrupt,” “I’m the referee, I’m the only person who can interrupt here,” “don’t like to let it play out too much,” “bring out separate narratives,” “shut it down,” and “facilitate effective communication.” These words and phrases are consistently more firm, active, directive, and behavioral. These differences in the type and quality of words that were used to describe individual and couples/family conflict were consistent across both groups of therapists.

### **Relationship Factors**

In the literature, relationship factors, defined as the combination of the therapeutic alliance and the therapist’s personal characteristics, were identified as variables in effective treatment. In order to explore therapists’ views on this dimension, participants were asked to describe the personal characteristics that make for good individual therapists, and good couples/family therapists. On this dimension, individual therapists and couples/family therapists responded similarly. Across the board, therapists tended to agree that there are some core qualities that make a good therapist, but that there is room for a lot of different personal characteristics in good therapists, and that one can learn the particular skills needed for different types of therapy. Therapists also agreed, however, that there were certain characteristics which might make some people more naturally suited to individual or couples/family therapy.

The participants identified a wide range of traits that seem favorable to performing well in any type of therapy. Although there was limited overlap between participants, the following

are among the traits most frequently identified as important for both individual and couples/family therapists. Thirty percent of therapists said, “empathic,” “warm and open,” and “knowing oneself,” were key traits. Twenty percent of therapists indicated that “intelligence,” “flexibility,” and “loving what you do,” were essential traits for any therapist.

It was difficult for some participants to articulate whether there were traits particularly suited to individual work. Most individual therapists reiterated the traits that were deemed favorable in any type of therapy, such as empathy and intelligence, not adding any additional qualities. One individual therapist added that being “able to sit with silence” is a key trait for individual therapists; that sentiment was echoed by a couples/family therapist who said the same. When couples/family therapists were asked to address what qualities make for a good individual therapist, four out of five (80%) used the phrase “they might be more comfortable with individuals,” specifying that they may be more comfortable with “being quiet and focused,” “containment,” and “familiarity.”

The personal traits that were perceived as useful for a couples/family therapist seemed a bit easier for both individual therapists and couples/family therapists to identify. Three of the five couples/family therapists (60%) indicated that a “brave” or “gutsy” or “not too afraid” person would do well in couples/family therapy. Two individual therapists (40%) and one couples/family therapist (20%) talked about an “enjoyment” or “desire,” to work with “chaos, conflict, and activity.” Two individual therapists (40%) and one couples/family therapist (20%) also felt that an “interpersonal comfort level,” or “extroverted” personality type would do well in couples/family therapy. Two individual (40%) and two couples/family therapists (40%) indicated that couples/family therapists need “added degrees of flexibility” and “an ability to hold multiple perspectives,” or “see things from a multi-lensed point of view.”

One individual therapist hypothesized that some couples/family therapists “don’t like the quietude that comes with individual therapy...the dyadic is too amorphous or too quiet or too intense.” One of the couples/family therapists made a related point, saying that the quality of the relationship in individual therapy is more intense than in the couples/family relationship. As she described it:

[In individual therapy] you’re forming a relationship that you will use in the treatment to help inform your clinical decisions about how you move forward in treatment. This is true in couples too but you’re privileging the couples relationship...you do, in fact, I think have more of a peripheral role or peripheral relationship in that your relationship is important but it’s not everything.

These statements indicate that some therapists perceive the individual therapy relationship to be more intense than the relationship of the couples/family therapist to the client system.

### **Core Similarities and Differences**

At the end of the interviews, the participants were asked to synthesize their thoughts on the topic and try to summarize what they felt were the core or fundamental similarities and differences between the modalities of individual therapy and couples/family therapy.

When describing the fundamental similarities between individual therapy and couples/family therapy, three individual therapists (60%) and four couples/family therapists (80%) answered that the goals are the same, including trying to help people, support change, seek insight, and foster human connection. Two individual therapists (40%) and two couples/family therapists (40%) also reiterated that the basic characteristics of a good therapist are similar across modalities. Several of these clinicians reiterated that the therapist uses herself to convey empathy and promote connection consistently regardless of practice modality.

Participants largely agreed on the core differences between the modalities as well. Two individual therapists (40%) and four couples/family therapists (80%) cited a core difference being the multiple perspectives and complexity of working with systems. As one couples/family therapist described it, “you’re dealing with a whole host of these dynamics that you’re probably not getting in an individual session,” or as another said, “you’re attending to more than one relationship...it’s a bit more complicated in terms of holding a lot of different things that are happening and having to attend to those simultaneously.” Three individual therapists (60%) reiterated that the clinician’s use of self, or the way the therapist directs the therapy is the key difference between the modalities.

### **Modality Bias**

One final theme that emerged in the interviews was a sense of a bias than some therapists have in favor of their own practice modality. While it was never specifically addressed in the interview questions, one out of the five (20%) individual therapists, and three out of five (60%) couples/family therapists made statements during the interviews expressing a strong commitment to their area of specialization. Only one individual therapist expressed a clear bias towards individual work, saying that, “I tend to think of couples and family as adjunctive work not primary work.” She was then quick to admit that this sounded like a bias to her, to which she would like to give further thought. It was not clear from the other interviews whether other individual therapists felt a bias in favor of their modality that they did not express in the interview, or whether such allegiance was not felt.

One of the individual therapists actually offered a bias in favor of couples/family therapy saying that, “a lot of times to be a good individual therapist you need to understand how to be a good family therapist.” She went on to explain that in many cases she had seen children or teens

removed from individual therapy by their parents when the individual therapist failed to conceptualize the individual therapy in terms of its impact on the entire family unit. The sentiment of that individual therapist was echoed by one of the couples/family therapists, who explained:

There's a real danger that the individual alliance between the therapist and the client could create a bias wherein the individual therapist ends up being so aligned with the client that she doesn't get to see that there's another side to this... People who think in systems might have a little bit of an advantage over people who don't. If you're not thinking in a systems way you're not always really going to be helping necessarily the patient with their relationships in the world, which is really where we grow.

These two therapists both felt that thinking in a systems-oriented way is a critical component to be a good individual or couples/family therapist. Two of the other couples/family therapists went one step further to say that couples/family therapy is the more efficacious modality in general. These two therapists expressed skepticism that long-term results can be expected from therapy that does not involve family, loved ones, or outside supports. One stated: "Not that [individual therapy] doesn't work, because it certainly does, but you're not going to reach your ultimate result unless you're involving the family in some way." One of these couples/family therapists went on to imply that it might just be too overwhelming to do couples/family therapy for some individual therapists, saying: "some people find [couples/family therapy] over-stimulating."

## Summary

The findings of this study illustrate the complexity of trying to describe the similarities and differences between practice modalities, and therapists' use of self. Despite the complexity of responses, some trends emerged.

**Agreement and disagreement between practitioner groups.** In many areas, therapists from the two modalities were in agreement with one another, while in other areas there was more variability within the groups than there was between them.

The first point at which the individual and couples/family therapists diverged from one another was in the discussion of their path to specialization. Some individual therapists described having an aversion to work with child populations, which kept them away from family work. In contrast, some couples/family therapists talked at length about how their early life had groomed them to do well in couples/family therapy. Several couples/family therapists also described being motivated to specialize by a belief in the higher efficacy of their modality.

Participants varied within the groups on their comfort level with managing conflict. The groups, however, were very much in agreement about the fundamental differences between how they address conflict with individuals compared to how they would address conflict differently within a system.

Couples/family therapists were more likely to say that the difference between the modalities is the complexity of working with multiple perspectives. Individual therapists on the other hand were more likely to point to the therapist's use of self as the key difference between the modalities.

**Similarities and differences between modalities.** The idea of use of self was a complicated one for therapists to describe for many reasons, not the least of which being that

their use of self changes depending on a number of variables. There were, however, some common sentiments. Many therapists felt that they are more active when conducting a couples/family session, and a majority of therapists described couples/family therapy as more directive and more behaviorally based. A number of therapists added the transference is used differently in individual and couples/family therapy.

One difference between the modalities that emerged was that conflict in individual therapy is largely between the client and therapist. The individual therapists who described this experience largely agreed that being part of conflict with a client in individual therapy is challenging and often unpleasant. In contrast, conflicts in couples/family therapy can be between a client and therapist, but are largely between clients themselves with the therapist in an outside role, which was sometimes described by participants as mediator or referee, and is generally experienced as easier to manage than conflict with an individual. There were also differences between the descriptions of conflict management with individuals and with systems.

While most therapists said that there may be different personal traits that make for a strong couples/family therapist, there was no clear agreement about what those traits would be. In the final summary, the most widely accepted similarity between individual and couples/family therapy is that they look to achieve similar outcomes and goals. The implications of these findings will be explored in the next chapter.

## CHAPTER V

### Discussion

The purpose of this study was to explore whether individual and couples/family therapists believe significant differences exist between these two modalities in terms of use of self, orientation towards conflict, and effective therapist traits. The study utilized exploratory, semi-structured interviews with 10 master's level social workers, five of whom specialize in practice with individuals, and five of whom specialize in practice with couples/families. The previous chapter detailed the results of those interviews. The following is a discussion of the implications, remaining questions, and limitations of those results.

#### Major Findings

The question at the root of this study was whether individual and couples/family therapy are very different approaches to practice, or whether they are more similar to one another than they are different. The results of this study demonstrate that this is a complex topic, influenced by a number of variables. Despite the complexity, there were some interesting findings that warrant discussion and further exploration.

**Specialization.** The literature provided no basis for a hypothesis about the variables that influence a social worker's decision to specialize in a particular modality; therefore, the question asking participants why they specialized in either individual or couples/family therapy was purely exploratory. In the context of this study, specialization was limited to either individual or couples/family therapy. This may not accurately reflect, however, the way that many clinicians



think about their area of specialization. In discussing specialization, many clinicians discussed the client population they work with, such as adolescents, geriatric clients, or trauma survivors. In fact, client population may have been a more significant factor influencing area of specialization for many clinicians than whether they would be working with individuals or client systems. In future research, client population would be an important variable to consider when looking at specialization.

Despite the limitations of this study in addressing specialization, one trend did emerge. Several couples/family therapists stated that they had a parentified role in their families growing up, which they believe influenced their choice to focus on working with couples/families. For some couples/family therapists this could be strength, but it could also be a limitation. As a possible strength, clinicians who grew up with experiences of staying calm and taking a supportive role in the midst of family turmoil are less likely to be overwhelmed or overstimulated by family conflict, and therefore may be very well suited to couples/family therapy. On the other hand, it is possible that clinicians who grew up in a parentified family role may experience more countertransference and may be more likely to reenact their own family dynamics in a family therapy session. It raises further questions about how the parentified role growing up impacts the therapists' view of themselves in working with other families.

Several of the individual therapists who were interviewed mentioned an aversion to working with children and adolescents. One of these therapists went on to explain that part of her aversion to working with children and conducting family therapy sessions stemmed from unpleasant experiences participating in family therapy as a child. These examples are only a few of the possible ways that family of origin may be impacting specialization choice. The fact that more than one therapist cited her role in the family of origin as a factor in her choice of

specialization suggests that the field could benefit from more research regarding how a clinician's family of origin impacts his/her vocational path, practice modality, and even use of self in the therapeutic work.

**Use of self.** Many participants in this study noted that the therapist's use of self needs to be flexible to accommodate a number of changing variables. It was a goal of this study to gauge whether there might be some overall patterns in clinicians' uses of self in different modalities, despite the multitude of variables. Many foundational therapy textbooks consulted in the review of literature alluded to the idea that managing multiple clients, each with their own personalities and goals, sets couples/family therapy apart as critically different from individual therapy. This study tried to address what that difference means for the therapist's use of self. One of the most significant findings of this study is that both individual and couples/family therapists perceive the therapist's use of self in couples/family to be more active and directive than in individual therapy.

Previous literature (Bischoff & Sprenkle, 1993; Lebow, 2006) has suggested that a high level of activity and directiveness is an important variable in predicting positive outcomes in couples/family therapy. The results of this study confirm previous findings and contribute data indicating that the majority of individual and couples/family therapists perceive their use of self to be more active and directive when working with couples/families. Therapists from both groups described using more behavioral interventions and more directive approaches with couples/families, including setting rules for the session, and directing clients as to what they should say to one another. Some therapists also described the necessity for remaining mentally active with couples/families in order to process what is happening for multiple clients in the room at once. However, while this was one of the stronger and more consistent findings of the

study, it is likely complicated by the theoretical orientations of the study participants, and we will return to a discussion of that limitation further on.

The role of transference was not addressed in the literature review, nor in the interview questions; however, it was a topic that came up in numerous interviews as a difference in the therapist's use of self between these two modalities. Transference is a psychodynamic concept referring to clients' responses that are based on experiences with past relationships with significant persons rather than the current therapeutic relationship. Therapists use it to understand and interpret their clients' responses, in the context of past and present relationships. The participants in this study who discussed transference believe that, while it is an important tool for individual therapists in several practice frameworks, it may be less useful in couples/family therapy, where the persons and relationships upon which transference might otherwise be based are actually present in the room. Some individual and couples/family therapists described a sense that this makes for a more intense use of the therapeutic relationship in individual therapy than in couples/family therapy. A counter-argument could be made in favor of the use of transference in couples/family therapy, based on the way childhood experiences impact the way parents interact with their spouses or children; however, this was not asserted by any of the participants in this study. A fuller exploration of the literature and future studies examining the use of transference in different modalities would be useful to expand upon the results found here.

**Orientation towards conflict.** The participants' responses to questions about conflict in individual and couples/family therapy took an unanticipated direction. Based on the fact that couples and families often enter therapy in conflict with one another, it was predicted that couples/family therapists would be more interested in and comfortable with managing conflict

than individual therapists. This hypothesis was not supported by the participants' responses. The responses to questions about conflict, however, highlighted a key difference between conflict that arises in individual therapy versus conflict that arises in couples/family sessions. In the context of individual therapy, the therapist is frequently the target of conflict, whereas the conflict in couples/family therapy is typically located within the family system while the therapist directs or referees from the sidelines. Therapists reported that it is much less comfortable to be the source or target of a client's anger than it is to support clients in managing their anger with one another. Therefore, results do not indicate that individual therapists are less comfortable managing conflict, but that they are confronted with a qualitatively different kind of conflict, and one that is inherently less comfortable for both individual and couples/family therapists.

There are many areas for future research to expand on these results. One area to explore is the frequency with which conflict management is necessary in different modalities. It seems possible that conflict management in individual therapy is more challenging and uncomfortable, but also less frequent than the type of conflict management that arises in couples/family therapy. Another factor in conflict management is the interaction between conflict and client population, and how the quality of conflict differs with different types of clients. For practicing social workers, these results indicate that both individual and couples/family therapists encounter the challenges of managing conflict in different ways, and that different approaches to conflict management might be necessary within different practice modalities.

**Relationship factors.** It was hypothesized that, while there may be some substantial differences in the therapists' use of self and conflict management between modalities, relationship factors would be an area of similarity. Previous research has found that there are

“common traits” among therapeutic approaches that play a large role in making therapy effective (Blow et al., 2007). It was hypothesized, therefore, that therapists would perceive the traits of a good individual therapist and a good couples/family therapist to be more similar than they are different. The results of this line of questioning are fairly inconclusive. There were no traits of an effective therapist that were mentioned by more than 30% of participants. One interpretation of this result is that there is a wide range of traits that make a therapist effective. Another interpretation could be that therapists are not aware of what traits are most important in making their work effective. With such a small sample, no definitive conclusions can be drawn from these results, except to say that therapists do not unanimously perceive any particular traits to be necessary for individual or couples/family therapists to be successful.

**Bias.** In many ways, the individual and couples/family therapists were in agreement on many of the topics addressed by this study. One place where the couples/family therapists diverged was that more couples/family therapists expressed a bias in favor of couples/family therapy as a more effective modality. Several couples/family therapists stated that they felt long term change could only come from involving the family system in the therapy process. Only one individual therapist made a statement expressing a bias in favor of individual therapy, stating that she felt individual therapy is where the primary work happens and that couples/family therapy seems adjunctive to her.

It is notable that the majority of couples/family therapists expressed a bias such as this, while only one individual therapist did so. It brings back the topic of allegiance, which was raised in the literature review. Duncan et al. (2004) defined allegiance as the practitioner’s belief in and commitment to a particular therapeutic approach. Couples/family therapists in this study seemed to have a greater allegiance to their practice modality than individual therapists. With

such a small sample, it is impossible to generalize this finding to the larger couples/family therapist community; however, it is an interesting area for further exploration. Future research might explore whether there is a difference between individual and couples/family therapists in terms of their bias in favor of their own modality, and if so, to explore what the reasons might be for that bias. It would also be interesting to see if stronger allegiances and/or biases would be found based on practice frameworks/theoretical orientations, rather than modalities.

### **Influence of Practice Framework/Theoretical Orientation**

It is likely that most, if not all, the results of this study were heavily influenced by the participants' theoretical orientations and practice frameworks. In the literature review, it was noted that within the modalities of individual and couples/family therapy there are a wide range of practice frameworks/theoretical orientations that therapists apply to their work, including psychodynamic therapy, cognitive behavioral therapy, Bowenian family systems, dialectical behavioral therapy, and many others. In this study, the participants' practice framework/theoretical orientation was noted, but was not a main focus for the results because it was beyond the scope of the research question. It became clear in the process of data analysis, however, that this dimension has the potential to influence all the major areas studied: use of self, orientation toward conflict, and relationship factors.

Most of the individual therapists who participated consider themselves to be psychodynamically-oriented clinicians, whereas the couples/family therapists were either Emotion-Focused therapists or working from more cognitive-behaviorally oriented short term intervention models. It seems likely that, were more of the individual therapists working from a behavioral orientation, many of the findings would be impacted. For example, in the population interviewed for this study, couples/family therapists were much more likely to describe directive

interventions when describing their work; however if the individual therapists interviewed had been Cognitive-Behaviorally oriented therapists, they might also have referred to a number of active and directive interventions they use in their individual work. The lack of variability in the practice frameworks/theoretical orientations of the clinicians interviewed, particularly among individual therapists, may have led to a confounding of modality and framework/orientation in the data analysis of this study. Due to the small sample size and the lack of variability between participants, no clear conclusions can be drawn as to how practice framework played a role in this particular study; however, future research into the differences between individual and couples/family therapy would benefit from taking a close look at how practice framework/theoretical orientation impacts views on use of self and orientation towards conflict.

### **Limitations**

There are a number of limitations to this study. The method of sampling was a convenience sample of therapists located in Massachusetts. The resulting sample was very homogenous, consisting of all Caucasian, female participants, representing only a few major practice frameworks/theoretical orientations. The sample size for this study was also small (n=10). All of these factors limit the generalizability of the findings. Future research would benefit from a larger and more diverse sample of participants.

An inherent and unavoidable limitation of this type of study is the possibility of researcher bias. Due to the fiscal limitations of this study, all interviews were conducted, transcribed, and interpreted by the primary investigator. All possible effort was made to interpret the results of this study impartially; however, it is impossible to completely negate the biases and expectations that this researcher had when conducting interviews and interpreting the data. One aspect of that bias was in grouping couples and family therapy into one category of systems

therapies. It was clear in several of the interviews, however, that while some individual therapists would not consider working with children and adolescents, they will work with couples. Another aspect of researcher bias was that it was hoped that the hypotheses laid out in the literature review would be confirmed by the participants' responses. Therefore, it is possible that unanticipated similarities or differences between these modalities may have been missed in both interviews and data analysis.

Another complication to the results of this study is that many of the subjects were known to the primary investigator, and knew that she was working in couples/family therapy at the time of this research. It seems likely that subjects' responses to some of the questions were influenced by this knowledge. For example, couples/family therapists were more likely to express a bias in favor of couples/family therapy as a more efficacious modality. It is possible that a similar subset of individual therapists holds a bias in favor of individual therapy, but may not have expressed it based on the knowledge that the primary investigator was working with couples/families. Ideally, interviews would be conducted by a neutral party, and results would be interpreted by several investigators to control for researcher bias and ensure the inter-rater reliability of the results.

### **Directions for Future Research**

This study was limited in many ways, and only an exploratory examination of the similarities and differences between working in different therapeutic modalities. One of the clear directions for future research is to expand this study to address some of the variables that complicated the interpretation of results in this study. The two variables that were not addressed in depth in this study that would be most important to include in future research are theoretical orientation/practice framework and client population. Both of these aspects of therapy came up



as important variables in numerous interviews. The differences, for example, in the therapist's use of self when working individually with a child versus a teenager versus a senior citizen, likely have an enormous influence on the therapist's use of self.

It would also be interesting in future research to explore additional modalities beyond the two mentioned here. For example, several participants noted that their use of self in group therapy is different from both individual and couples/family therapy.

### **Implications for Social Work Practice**

The scale of this study was much too small to have any great implications for the field of social work; however, it is possible to consider what some of the future implications might be, should some of the findings of this study be replicated and clarified in future studies. Three main areas were considered in this study: use of self, orientation towards conflict, and relationship factors. The findings in each of these areas could contain implications for how future social workers are trained in working differently depending on their modality.

In the area of use of self, directiveness in particular stood out as an important use of the therapist's self in couples/family therapy. Therefore, clinicians who are learning to conduct couples/family sessions for the first time may need additional training and support in how to be more directive in setting rules or limits for the session, guiding family members in communicating with one another, and deescalating conflict between clients.

Another important implication for social work training and practice was in the findings about orientation towards conflict. Many participants asserted that managing conflict between the client and the clinician is particularly difficult and categorically different from managing the conflicts that arise between clients. This is an important distinction to prepare clinicians for when entering practice, or when beginning practice with a new modality.

There is a positive message for social workers in the results on relationship factors and therapist traits. No clear consensus was reached among clinicians interviewed about what traits are necessary for one to be a successful individual or couples/family therapists. The implications for social work practice are that a wide range of people and personality types may be successful in different modalities, and there is room for stylistic differences, people of different backgrounds, and different viewpoints on the work.

Bias became a notable factor in some of the participants' responses during this study. In social work practice, bias has potential to be both a help and a hindrance to effective clinical work. A belief in the efficacy and importance of one's practice has been shown to be useful in helping therapists be effective (Simon, 2006). Therefore it is advantageous for therapists to enjoy their area of specialization and believe that it is a viable way to help clients promote positive change. However, after a point, too strong a bias could interfere with clinicians making decisions in the best interests of the client, such as making an appropriate referral to another clinician/modality, or working cooperatively with a collateral contact in another discipline. For example, when couples/family therapists from this study expressed a perception that lasting change can only be achieved through working with the entire family system, it raises questions about whether these clinicians would make a referral for individual therapy when it became appropriate for one of their clients. Therefore, it is important in training and practice to maintain a balance of enthusiasm for one's own work, and respect for the efficacy of other approaches.

Finally, there may also be implications for clinical supervision in what we have learned about clinicians' motivation for specialization. It may be important to explore with clinicians who are on the path to specializing in a particular modality why they have chosen their area of specialization, and to support established clinicians, through peer supervision, to examine how

personal factors such as family history impact their continuing work with clients.

## **Conclusion**

This study was only a beginning foray into understanding the complexity of the similarities and differences between different therapy modalities. This study was undertaken in order to create a starting place for further studies about the differential uses of self, orientation towards conflict and relationships factors in two common modalities. By expanding our knowledge on how therapists use themselves differently in different modalities, we can continue to improve training for future social workers, and help practitioners to anticipate the ways they can use themselves most effectively in different settings.

## References

- American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*, 271–285.
- Beutler, L. E., Consoli, A. J., & Lane, J. (2005). Systemic treatment selection and prescriptive psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 121–143). New York, NY: Oxford University Press.
- Beutler, L. E., Malik, M. L., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S., & Wong, E. (2004). Therapist variables. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 227–306). New York, NY: Wiley.
- Bischoff, R. J., & Sprenkle, D. H. (1993). Dropping out of marriage and family therapy: A critical review of research. *Family Process, 32*(3), 353–375.
- Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital & Family Therapy, 33*(3), 298-317.
- Boyle, S. W., Hull, G. H., Mather, J. H., Smith, L. L., & Farley, O. W. (2008). *Direct practice in social work* (2<sup>nd</sup> ed.). Boston, MA: Allyn & Bacon.
- Brandell, J. R. (2010). *Theory & practice in clinical social work* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Cooper, M.G., & Lesser, J. G. (2008). *Clinical social work practice* (3<sup>rd</sup> ed.). Boston, MA: Pearson Education, Inc.
- Duncan, B. L., Miller, S.D., & Sparks, J. A. (2004). *The heroic client: A revolutionary way to improve effectiveness through client-directed, outcome informed therapy*. San Francisco, CA: Jossey-Bass Inc.

- Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change: What works in therapy?* Washington, DC: American Psychological Association.
- Jeffrey, A., & Austin, T. (2007). Perspectives and practices of clinician self-disclosure to clients: A pilot comparison study of two disciplines. *American Journal of Family Therapy*, 35(2), 95-108.
- Lebow, J. (2006). *Research for the psychotherapist: From science to practice*. New York, NY: Routledge.
- Mosby, Inc. (2009). *Mosby's medical dictionary* (8<sup>th</sup> ed.). Philadelphia, PA: Elsevier Inc.
- Nichols, M. P. (2009). *The essentials of family therapy* (4<sup>th</sup> ed.). Boston, MA: Pearson.
- Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York, NY: Oxford University Press.
- Rubin, A., & Babbie, E. (2010). *Essential research methods for social work* (2<sup>nd</sup> ed.). Belmont, CA: Brooks/Cole Cengage Learning.
- Simon, G. M. (2006). The heart of the matter: A proposal for placing the self of the therapist at the center of family therapy research and training. *Family Process*, 45(3), 331–344.
- Sprenkle, D. H., & Blow, A. J. (2007). The role of the therapist as the bridge between common factors and therapeutic change: More complex than congruency with a worldview. *Journal Of Family Therapy*, 29(2), 109-113.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2009). *Clinical interviewing* (4th ed.). New York, NY: Wiley.
- Westra, H. A., Constantino, M. J., Arkowitz, H., & Dozois, D. A. (2011). Therapist differences in cognitive-behavioral psychotherapy for generalized anxiety disorder: A pilot study. *Psychotherapy*, 48(3), 283-292.

Zuroff, D. C., & Blatt, S. J. (2006). The therapeutic relationship in the brief treatment of depression: Contributions to clinical improvement and enhanced adaptive capacities. *Journal of Consulting & Clinical Psychology, 74*(1), 130-140.

## Appendix A: Recruitment Email

Dear [Mr. / Ms. LAST NAME],

My name is Rebecca Lawrence and I am an MSW student at the Smith College School for Social Work. I am writing to tell you about a study I'm conducting for my master's thesis. I received your name through [PERSON'S NAME] who thought you might be interested in participating as a subject in my research.

The purpose of this research study is to expand our understanding of the differences between clinical practice with individuals and with couples and families. Participation requires that you meet with me at a designated time and location of your choosing to discuss your experience and views on this topic for approximately 35 minutes. There is no monetary compensation for participation, but I will be more than happy to provide refreshments and of course, gratitude.

You may be eligible for this study if you have a graduate degree in social work and have been practicing clinically for 5 years or more with either individuals or families.

If you think you might be interested in participating or have further questions about this research, please contact me at [\(Omitted\)](#) or by phone at: (Omitted). Your participation is completely voluntary and you do not have to respond if you are not interested in participation. If you do not respond, no one will contact you further.

Thank you for your time and consideration. I look forward to hearing from you!

Sincerely,

Rebecca Lawrence

## Appendix B: Screening Questions

Thank you so much for contacting me and for your interest in my study. If you have a few minutes I have a few brief questions to ask you to determine if you meet the criteria for participation.

Can you please tell me what educational degree you hold?

And how long have you been in clinical practice?

What is the primary modality you work with clients in? For example, individual therapy, family therapy, group therapy, case management, and so on.

And what percentage of your clients would you say fall within that modality?

**If they do not meet criteria:** Thank you so much for your time and your interest in my project. Unfortunately you don't fall into the specific category of people we're looking for in this particular research.

**If they do meet criteria:** Thank you for answering those. Your answers do qualify you for participation in the study if you choose. If you're interested, I can email you a copy of the informed consent letter, which contains additional information about the study, and we could arrange a time and place for an interview. Do you have any questions for me about participation? Thanks again for your time.



## Appendix C: Human Subject Review Board Approval Letter

School for Social Work  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

March 1, 2012

Rebecca Lawrence

Dear Rebecca,

Very nice and thoughtful responses! Your project is now officially approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project!

Sincerely,

David L. Burton, M.S.W., Ph.D.  
Chair, Human Subjects Review Committee

CC: Natalie Hill, Research Advisor

## Appendix D: Letter of Informed Consent

Dear Participant,

My name is Rebecca Lawrence, and I am a second year graduate student at the Smith School for Social Work. I would like to invite you to participate in a study about the differences between individual therapy and therapy with couples and families. The purpose of this study is to enrich our understanding of these differences so that we can prepare future social workers for the challenges of various types of work. The information gathered from this interview will be used in an MSW thesis for presentation to the Smith community.

For the purposes of this study, you will be interviewed regarding your experiences practicing therapy with individuals and families, and about your perceptions of that work. You have been invited to participate in this study based on the fact that you are a social worker holding a graduate degree and practicing in direct care with patients. The interview is likely to take 30 to 45 minutes. I will ask you a series of questions which will be audio recorded, and which I will later transcribe. The content of that tape and transcription will be kept completely confidential.

There is minimal risk participating in this interview. There is no sensitive information required for participation. You have the right not to answer a question, or stop the survey at any time, for any reason. You will have the benefit of contributing to knowledge in our field. There will be no monetary compensation for participating in this study.

Every effort will be made to maintain your anonymity in this study. The content of your interview will be transcribed by me and then stored under a code number, not by name, and password protected. The only persons who will have access to this information will be my research advisor and myself. In the final publication or presentation the information I collect in these interviews will be presented as a whole, and in cases where brief quotes are used they will be carefully disguised. After completion of this study, all data collected during the research process will be kept securely encrypted for a period of three years as required by Federal guidelines and then they will be deleted. If the materials become needed beyond the three year period, they will continue to be kept securely encrypted and password protected and then will be destroyed when no longer needed. Please remember, if you choose to discuss your practice in this interview, be careful to maintain the anonymity of your clients.

Participation in this study is completely voluntary. You may choose not to participate in this study, withdraw from the interview at any time, or not to answer a question at any time during the interview. After the interview, if you choose to retract your interview, it will be possible to do so up until April 31<sup>st</sup>, 2012. Should you choose to withdraw, all materials pertaining to you will be immediately destroyed. Your decision to participate or not participate in this study will not have any adverse effects. If you have any questions about the study, about your rights as a participant, or choose to withdraw your information at any time, the primary researcher can be contacted at: [\(Omitted\)](#), or the Chair of the Smith College School for Social Work Human Subjects Review committee can be reached at: (413) 585-7974.

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE**

**ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Primary Investigator's Signature

\_\_\_\_\_  
Date

Rebecca Lawrence  
(Contact Information Omitted)

Thank you so much for your participation!

## Appendix E: Semi-Structured Interview Guide

### Introduction:

*As you know, I'm interested in understanding how you view individual and family therapy. I'm here to learn more about your experiences and opinions on different therapeutic practices, including the way you use yourself in your therapeutic work, your presence in the room, and your views on how that might change depending on the modality you're using. I'd like to hear stories that illustrate your experiences and beliefs, as well as thoughts you may have on modalities that you use less often. I may ask you about things you haven't given much thought to before, and that's perfectly okay, just answer as best you can. Do you have any questions before we start?*

1. First I have a few basic demographic questions. Can you please state your gender? And what is your current age? How do you identify racially/ethnically?
2. Thank you. Could you begin by telling me a little about yourself, what was your educational background, and how long have you been practicing for?
3. What sorts of clients are you currently working with predominantly? What kind of setting is that in?
4. Have you had any additional training or special certifications since you finished school?
5. What led you to choose to work with the modality you now work with?
6. Have you ever worked with (the modality you don't typically work with)? If so, what experiences have you had doing that?
7. Can you try to describe to me the way you use yourself with clients? I'm looking for stories or experiences that really illustrate your persona in the room with clients.
8. What do you see as being important personal characteristics for [individual or couples/family] therapists?
9. How would you describe the way you deal with conflict when it arises in session? Can you think of an example of a conflict that came up in session either between clients or between yourself and a client and how you dealt with it? How do you feel about having to manage conflict when it arises?
10. In your opinion and experience, what might be different about the way you used yourself if you were working in [the other modality]? (Follow up: Do you have a sense of where your ideas about those differences comes from?)

- 11.** Do you think that the personal characteristics of someone who specializes in working with [the other modality] might be different in any way than someone who works in your specialty? Why?
- 12.** In your mind, what makes these two modalities similar? And what do you think makes them different?
- 13.** Is there anything else I haven't asked you about that you'd like to say?

That's all the questions I have, and so that concludes our interview. Thank you so much for your participation, your time, and your thoughtfulness in answering my questions.