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## Pluralistic therapy

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### 1 HISTORICAL CONTEXT AND DEVELOPMENT

Pluralistic counselling and psychotherapy, as a specific form of therapeutic practice, represents a relatively recent development within the domain of individual therapy. Over the history of psychotherapy innumerable attempts have been made to find ways to combine concepts and methods from different approaches, in order to construct a form of therapy that allows clients to benefit from the wealth of ideas that exist within the field of counselling and psychotherapy theory and practice as a whole. None of these attempts to combine therapy methods have been entirely successful. In general, 'eclectic' approaches to therapy have lacked a set of principles to specify when and how certain interventions might be favoured over others. 'Integrative' approaches to therapy have been based on building new models around selective and partial selections of concepts, thereby dismissing the potential value of other ideas that might be equally efficacious. The nature of different strategies for combining therapy concepts and methods is discussed more fully in McLeod (2013). In response to the perceived limitations of existing eclectic and integrative models, and in an attempt to harness the possibilities that are available within the therapy literature, Cooper and McLeod (2007, 2011) formulated a 'pluralistic' approach to conceptualising and practising counselling and psychotherapy that encompassed elements from previous eclectic and integrationist traditions.

This new approach can be regarded as an attempt to explore the implications of the concept of pluralism for counselling and psychotherapy. One of the key attributes of this way of thinking about therapy is that 'pluralism' is not, in itself, a psychological concept, but instead is an idea that has its roots in philosophy, ethics and the social sciences. As a consequence, 'pluralistic' therapy does not favour any particular type of psychological change process, or theory of therapy. Instead, the concept of pluralism introduces a 'meta-therapeutic' perspective from which the contribution of all psychological and psychotherapeutic concepts and methods can be evaluated.

At a philosophical level, the concept of pluralism refers to the view that there exist multiple plausible responses or 'truths' in respect of any significant question. The opposite of pluralism is 'monism': the doctrine that there exists a single truth or right answer in relation to any issue. Although a tension between monism and pluralism has always existed within Western philosophy, this issue only began to receive an increasing amount of tension at the beginning of the 20<sup>th</sup> century, for example through the publication in 1909 by William James of *A plural universe*, in which he argued that intellectual and scientific progress was only possible on the basis of dialogue between opposing sets of ideas, informed by empirical evidence.

One of the most significant implications of this approach, for the practice of individual therapy, lies in the distinction between pluralism and relativism. The concept of

relativism implies that anything can be true or valid, depending on the circumstances. For example, for a relativist, psychoanalysis is neither wrong nor right, but is merely a set of ideas and practices that made sense to a particular group of people at a particular historical time and place. Relativism can reflect an underlying scepticism, which is the position that nothing can be believed. Both relativism and scepticism can be regarded as expressions of a position of *indifferentism*, understood as an unwillingness to take a stance on an issue. Indifferentism can be considered problematic when related to counselling and psychotherapy for two reasons. First, indifferentism does not reflect the way that people live their lives – through experience we acquire definite points of view on at least some matters, and people tend to expect each other to be open about their preferences and values, rather than ‘sitting on the fence’. Second, indifferentism does not seem to represent a sensible or realistic basis for progress in human affairs – scientific advances, and social innovation, are characterised by the willingness of some people to follow through on a specific vision that they hold, often in the face of strong opposition from others.

These reflections imply that pluralism, understood as a distinct position, comprises a willingness to acknowledge and espouse personal beliefs about what is ‘true’, while at the same time acknowledging that other people may espouse quite different beliefs, and accepting the challenge of building bridges across this divide. In such a situation, a monist stance involves arguing that ‘I am right and you are wrong’. By contrast, pluralist stance involves adopting the uncomfortable stance that ‘I am right and you are also right’. Where this leads, in relation to the search for knowledge and understanding, is to a recognition of the importance of dialogue and conversation. From a pluralistic perspective, the best answer arises from conversations between people in which contrasting positions can be explored in a spirit of open dialogue. A pluralistic perspective is therefore also associated with an ethical stance that emphasises the importance in human affairs of acceptance of the ‘otherness’ of other persons, as opposed to any attempt to impose one’s own categories on others.

These philosophical considerations provide a conceptual and moral framework that allows any therapist to adopt a pluralistic way of working. Being pluralistic requires being explicit about one’s own stance, because dialogue can only take place when each participant in a relationship is willing to disclose their stance, in a spirit of being willing to learn and change through their contact with the other. Some therapists espouse a therapeutic stance that reflects one or other of the established ‘brand-name’ therapy approaches. Other therapists articulate their stance in terms of ideas from a range of therapeutic traditions. Most therapists operate somewhere on a continuum between these possibilities. From a pluralistic perspective, each therapist has his or her own ‘starting point. However, working in a pluralistic manner is not defined by the starting point, but by the willingness to engage collaboratively with the starting point of the client.

## **2 THEORETICAL ASSUMPTIONS**

An important assumption within pluralistic therapy, permeating all aspects of practice, is that we live in a social and cultural world that is characterised by a multiplicity of ideas concerning problems in living, the good life, and pathways towards healing. From a pluralistic standpoint, attempts to restrict the understanding of these topics to a single discourse or narrative (for example, the medical model, or religious fundamentalism) are regarded as oppressive and undemocratic, and need to be met with active resistance based on respect for the holders of these ideas and efforts to engage in dialogue.

## 2.1 Image of the person

The image of the person within pluralistic therapy is intentionally fluid and open-ended. From a pluralistic perspective, any statement about the nature of persons invites serious consideration of alternative and opposite formulations. This approach to understanding the person can be illustrated through consideration of some important 'working principles':

*People actively construct and co-construct the world that they inhabit.*

A central working principle of a pluralistic approach to therapy is that a person is not a static entity, but exists in a process of becoming and transforming, characterised by a sense of a preferred future.

*Personal identity comprises an internal multiplicity ('voices', 'parts of the self').*

A pluralistic perspective can be applied to the issue of how people understand themselves, or possess a sense of identity. From a pluralistic stance, an individual person cannot be reduced to a single 'truth'. The phenomenon of internal multiplicity is manifest in a wide variety of ways: people critique themselves, they use phrases such as 'one the one hand...and on the other hand', they contradict themselves, they may even talk about different 'parts' of themselves. However, the opposite of self-multiplicity may also be an important part of the lived reality of some people. There are those who base their identity on singular truths ('without my faith, I would be nothing') or attributes ('I am a depressive').

*Being a person involves existing within a web of relationships.*

People live out their lives within networks of relationships: family, friendships, work colleagues, neighbours, etc. Whatever problem a person brings to therapy will have some relationship aspect to it, however small. Alongside the importance of relationships is the significance of the human capacity to be out of relationship, in such areas as the experience of being alone, and the ability to create imaginary worlds.

*Embodiment is an essential aspect of the experience of being a person.*

The fact of living within a body is an enormously important aspect of being human. There is always a 'given' dimension to embodiment, for instance through being born with a genetic predisposition to develop an autistic disorder, or being male/female, or being tall/short. There are aspects of embodiment that are personally chosen, such as eating too much and being fat, or going to the gym every day and being fit. There are also aspects that are visited upon people, such as developing multiple sclerosis at the age of 50, or being in a car accident. The experience of embodiment also encompasses the experience and expression of feelings and emotions.

*The person exists within a social and cultural world.*

The meaning and expression of these dimensions of human existence – self-construction, self-multiplicity, relational being, and embodiment – are shaped by the social and cultural world within which a person exists. Cultural aspects of person-hood reflect the historical forces and events that shape identity.

These elements of a pluralistic image of the person can be viewed as providing a meta-perspective which makes it possible to be sensitised to the concrete and specific image of the person that may be espoused by each client.

## **2.2 Conceptualization of psychological disturbance and health**

Pluralistic therapy is open to many different ways of making sense of the difficulties that may have resulted in a person making a decision to seek help from a counsellor or psychotherapist. In talking about client problems, it can be valuable to adopt the term ‘problems in living’, originally used by the radical psychoanalyst Thomas Szasz (1961). The concept of ‘problems in living’ draws on the idea that each person possesses some kind of culturally-derived notion of what constitutes a ‘good life’, and becomes troubled when the intended unfolding of this implicit life plan goes wrong in some way.

### **2.2.1 Psychological disturbance**

Practising pluralistic therapy involves being knowledgeable about different frameworks for categorising and assessing client problems, in order to be in a position to engage in conversations with clients around which framework makes most sense to them, or that represents a mutually acceptable meeting point between client and therapist, if each participant in therapy possesses different assumptions. Medical-model diagnostic categories such as depression, anxiety, PTSD and borderline personality disorder make a lot of sense to some clients, while being viewed by other clients as instances of oppressive labelling. Another approach to understanding disturbance that is widely acceptable is to conceptualise problems in developmental terms, for example as crises associated with the transition from one life stage of the life course to the next. Several potentially useful systems for making sense of psychological disturbance exist within the psychotherapy and psychology literature (Bayne, 2012). For some clients, it may make more sense to formulate their problem in social terms, drawing on concepts of social class and gender, or to refer to indigenous cultural concepts. It is also possible to approach psychological disturbance from a phenomenological or descriptive perspective that does not seek to go beyond the concrete experience of the client.

A pluralistic stance is consistent with the use of a wide range of assessment tools, including questionnaires and rating scales, diaries, projective techniques and physiological measures. These techniques represent potentially valuable tools for understanding, as long as they are applied and interpreted in a collaborative manner. Examples of how collaborative assessment can work in practice can be found in Finn, Fischer and Handler (2012). In pluralistic work, the process of assessment comprises a potentially powerful therapeutic method in its own right, for clients whose primary goal at that point in their lives may be to put their difficulties in perspective.

From a pluralistic perspective, it is important to be open to the possibility that ‘psychological’ disturbance is not the only way to make sense of the ‘troubles’ that are reported by clients who attend therapy. There may be instances in which a moral perspective on disturbance is more salient than a psychological approach. A client who is engaged in doing harm to others, for example through violence, abuse or deception, is exhibiting a serious level of disturbance of universally accepted moral rules. A client who is engaged in self-harm may also be considered as morally disordered, although in this situation it could be argued that people have a moral right to decide their own actions as long as these actions do not harm others. There are some issues that are associated with strong culturally-determined

moral beliefs. For example, in some cultures suicide or homosexual activity would be regarded as morally wrong. The point here is that a pluralistic stance requires the therapist to be willing to consider 'disturbance' not merely as a question of psychological functioning, but also as a topic with a moral and ethical dimension.

### **2.2.2. Psychological health**

We live in a culture, and at a point in history, within which there exist many competing ideas about 'psychological health' or what it means to live a 'good life'. Notions of health and well-being differ according to gender, social class, culture and religious faith. For example, for some people, the key indicator of being psychologically healthy is the capacity to achieve material success. For other people, being psychologically healthy may involve loving and being loved, or accomplishing spiritual transcendence, or remaining in control of one's emotions. The conduct of pluralistic therapy is informed by notions of psychological health in two ways. First, the therapist seeks to help the client to articulate his or her own understanding of psychological health, as a means of developing a marker for therapeutic success. Second, the therapist is explicit about his or her assumptions about psychological health, in a manner that does not attempt to impose these values on the client.

## **2.3 Acquisition of psychological disturbance**

Taken together, psychotherapeutic theory and research, and common-sense folk wisdom, provide a rich resource of ideas about how problems in living can be acquired. Among the many possible triggers for psychological disturbance are: luck; loss; trauma; making the wrong choices; exposure to 'conditional positive regard' imposed by significant others; developing coping strategies that were effective at an earlier stage of life but are no longer functional; being subjected to oppression, cruelty and deception; absence of environmental support, resources and learning opportunities; physical illness or disability; the illness or disability of others; and so on. These triggers can occur alone, in tandem or in sequence, and may operate in different ways at different developmental stages.

Pluralistic therapists are interested in the nature and functioning of all possible ways of making sense of the acquisition of psychological disturbance. The aim in pluralistic therapy is to work collaboratively with the client to construct a shared understanding of the origins of their problem that fits the circumstances of their life and which makes sense of them, in terms of their general world-view. Hansen (2006) suggests that theories of therapy (which includes ideas about the acquisition of disorders) can be regarded as narrative 'templates' that are available within the culture as means of making sense of problems. He proposes that one of the goals of therapist training should be to enable practitioners to become fluent in introducing these templates into conversations with clients.

## **2.4 Perpetuation of psychological disturbance**

If the client's problem is viewed not as a set of symptoms, but instead as a story that can be told about a difficult period in their life (Hansen 2006), then the narrative account of the disturbance needs to be extended to incorporate not only the triggering factors or events ('once upon a time...') but also the subsequent ways in which the problem was perpetuated. It is clear that in any individual case, the 'problem story' may be complex and multi-faceted. However, such stories will usually include some reference to intrapersonal, interpersonal and external/environmental processes that were involved.

#### 2.4.1. Intrapersonal mechanisms

The therapy literature provides many examples of intrapersonal mechanisms or processes that may be recognisable or meaningful for a client. For example, if a client attends student counselling to deal with a fear of making a presentation in a seminar group, he may have a clear idea about how the problem was first acquired: 'I can remember in primary school, running out of the assembly hall when it was my turn to speak in front of everyone, and being humiliated by the head teacher for doing this'. The perpetuation of this problem may involve cognitive mechanisms ('I have this image in my head of what happened all these years ago'; 'I tell myself that I can't do it') and also emotional processes ('I just feel sick'; 'I start to have a panic attack'). The CBT literature provides a particularly helpful set of ideas about intrapersonal mechanisms that may contribute to the perpetuation of problems (see, for example, Westbrook, Kennerley and Kirk (2011)).

#### 2.4.2. Interpersonal mechanisms

The therapy literature also provides plentiful examples of interpersonal processes that may be relevant in the construction of a credible 'problem narrative'. In the case of a client struggling to overcome a fear of making a seminar presentation in his university class, it is possible to envisage several possible interpersonal processes that may have contributed to the maintenance of the problem. For example: 'the inconsistent parenting you received in infancy left you unwilling to trust that anyone would be willing to help you'; 'your mother worked long hours and was too tired to listen to your problems'; 'you were the middle child in a large family and were often ignored'; 'you tried to ask your tutor for help but he was not interested'. The literature on psychodynamic therapy and family therapy represent sources of ideas about different kinds of interpersonal problem narrative.

#### 2.4.3 Environmental factors

Within pluralistic therapy, the concept of 'cultural resources' is used to describe the possibilities that exist within the person's life space that can be utilised for the purposes of building a sense of identity, giving meaning to life, and solving problems (Cooper and McLeod 2011). The concept of cultural resource can also be used in constructing an account of the maintenance of a problem. In the case of the anxious student, it could be that 'you developed an interest in science subjects where you would not be expected to make presentations', 'your sister was always confident at making presentations, and offered to help you, but you did not follow up on her invitation' or 'you found a self-help book in the library but have not read it yet'. These elements of the client's problem story point toward environmental factors that could form part of the solution to the problem (e.g., talking to your sister, working through the self-help book, applying the academic skills that you acquired in your science classes to organise a coherent presentation).

### 2.5 Change

The conceptualisation of the change process in pluralistic therapy draws on two key perspectives. The theory of common therapeutic factors (Duncan et al. 2010) suggests that all therapeutic change arises from the implementation of a set of generic healing experiences. Lampropoulos (2001) offers a summary of these basic change processes:

- a relationship of trust with someone who is viewed as a credible source of assistance;
- expression of painful emotions and relief from distress;
- instillation of hope and raising of expectations;

- provision of a theoretical explanation or rationale for the origins and maintenance of the problem, and the ways in which change might be accomplished.

From a common factors perspective, the person who seeks therapy is ‘demoralised’ – he or she has temporarily exhausted their repertoire of coping skills or has run out of people to whom they can turn for help. Therapy provides a context for ‘re-moralisation’. Through the development of trust in the therapist, exposure to the hopefulness of the therapist and being offered a framework for making sense of the problem, the person becomes able to begin to re-activate his or her capacity for learning in relation to the problem that is bothering them.

A further theoretical perspective that is central to a pluralistic understanding of the change process is the concept of *learning style*. There is strong evidence that people who seek therapy have preferences in relation to the kinds of change processes and activities that they believe will be most helpful for them, and that better outcomes are reported when the therapy that is received matches these preferences (McLeod, 2012). An appreciation of a pluralistic perspective on therapeutic change can be illustrated by considering the example of depression, which is one of the most widely-reported problems among client who attend therapy. There is evidence for the efficacy of many different change mechanisms in relation to recovery from depression. Some of the things that seem to help include: gaining insight into the origins of the problem; changing negative thought processes; expressing emotion; being more active; engaging in spiritual practices; taking medication; becoming more connected to other people; changing diet; exposure to sunlight.

### 3. PRACTICE

It is important to recognise that, in practice, pluralistic therapy can take many different forms. An appreciation of the range of possibilities associated with a pluralistic way of working requires recognition of the distinction between *principles* and *contexts*. A pluralistic perspective is associated with a set of general principles of practice, for instance around the significance of flexibility, active client involvement, dialogue, and use of feedback. However, the application of these principles will always depend on the specific context within which therapy is being carried out. There are four primary dimension of context that needs to be considered: the client, therapist, the organisational setting within which therapy takes place, and the broader cultural environment. The practice of pluralistic therapy draws on contextualised knowledge, in the form of what makes sense to specific people in specific places, as well as on knowledge that is derived from more abstract or generalizable theory and research.

The process of pluralistic therapy does not begin with the first meeting between therapist and client, but requires attention to the whole of the context within which therapy occurs. For example, the encouragement of active client participation in therapy can be facilitated through attention to the wording of advertising and publicity materials, the messages given by first-contact reception staff, and the provision of pre-therapy information in the form of reading materials or a website video clip. There are likely to be many latent resources within the broader cultural environment that may be helpful for a client. The more that a therapist has some familiarity with these resources, the more sensitive they will be to the potential value and accessibility of these activities for specific clients. The waiting room in a therapy agency or clinic need not only display copies of popular magazines, but might also display information about education opportunities, outdoor pursuits, complementary therapies, political campaigns, support groups, and other cultural resources. Attention also

needs to be paid to the structure of the therapy that is on offer. Probably most clients find it convenient to attend therapy for one hour on the same day each week. However, there are other clients who might benefit from longer or shorter sessions, or different lengths of time between sessions.

### **3.1 Goals of therapy**

It seems reasonable to assume that clients have some reason or purpose in seeking therapy, and also have some sense of how they will know when or whether therapy should come to an end. At the same time, it is clear that at least some clients find it hard to articulate what they want from therapy. From a pluralistic perspective, agreement around client goals is a central aspect of therapy, because meaningful dialogue that takes place around the best way to work together cannot take place in the absence of a shared understanding of what the work is *for*. A pluralistic approach to therapy accepts that there are many different goals that clients might wish to attain through their participation in therapy. Some clients may want to use therapy to pursue specific behavioural goals: ‘I need to stop drinking and get more exercise because I have been diagnosed with heart disease’. Other clients may express vague goals, such as ‘finding more meaning in my life’. Preparation for working in a pluralistic way involves becoming sensitised to the wide variety of goals that may be identified by clients, and being clear about any goals that the practitioner does not feel able to tackle. In practice, conducting therapy that is appropriately and sensitively goal-informed is based on three main strategies:

*Explicit goal identification:* It is possible for clients and therapists to believe that they have reached a mutual understanding of the purpose of therapy on the basis of the client talking about what is bothering them, and sharing their story. However, in the absence of an explicit goal statement, each participant may be operating on somewhat different premises. As a result, it is helpful for therapists to explicitly articulate their understanding of the client’s goals, and ask if the client agrees.

*Regular goal reviews:* It is unusual for the goal that a client identifies at the start of therapy to remain fixed through the course of therapy. If therapy is going well, it is probable that the client’s goals will become more specific, differentiated and concrete, and more future-oriented. For example, ‘I need to stop drinking and get more exercise because I have been diagnosed with heart disease’ might become redefined in terms of specific challenges around time-management of an exercise regime, and developing skills in saying no to people who exert pressure to drink alcohol in particular social situations. Sometimes the meaning of a goal can shift to another existential level: ‘I need to stop smoking and get more exercise because I have been diagnosed with heart disease’ could become ‘I want to learn how to live my own life rather than blindly following the way of life laid down by my father and grandfather’. These are just some example of ways in which goals can shift over the course of therapy. It is only through regular invitations to re-state goals that a therapist and client can be sure that they are working toward the same ends.

*Sensitivity to implicit, unstated or unconscious goals:* As a therapist listens closely to a client, and observes his or her way of being in the therapy room, it can become apparent that what is being said does not fully reflect the entirety of what is being experienced by the client, the therapist, or both parties. New meanings emerge from the flow of conversation. Good therapists are sensitive to this kind of process, and are willing to try to find words to capture the sense of this implicit or unstated dimension of the interaction. Psychodynamic theory and practice is grounded in this kind of sensitivity to the emotional and relational dynamics that

lie behind consciously-stated goals. Pluralistic practice is enriched by a willingness to make use of a psychodynamic sensibility to be open to ways in which ‘goal conversations’ can be deepened and ‘thickened’. It can also be valuable to explore such topics as: how a person might know that a goal has been accomplished; the existence and salience of competing goals; the distinction between ‘life’ goals and ‘therapy’ goals; who would be pleased to know about your progress towards these goals (or would be displeased)?

The word ‘goal’ is neither adequate nor appropriate for use in some therapeutic conversations. For example, for some people, the term ‘goal’ is spoiled by its association with managerialism. It is always important, therefore, to talk about this area of experience in a way that is meaningful and productive for both client and therapist. Some clients and therapists find value in the metaphor of the ‘journey’, or in holding conversations about ‘preferred’ situations. At a basic level, these conversations are always about inviting the client to acknowledge that the future is part of the present, and to consider the notion that their future is something that they have the power to shape through their own efforts. Conversations about goals can therefore be viewed as part of a broad intention on the part of the therapist to instil hope.

### **3.2 Selection criteria**

There are no selection criteria that are specifically associated with the practice of pluralistic therapy. Pluralistic principles can be applied in work with any client group, or in any therapeutic modality (e.g., couple, groups, email counselling, etc.). From a pluralistic perspective, client suitability is determined by contextual factors, such as the resources and organisational aims of a therapy clinic or agency or the competence and preferences of therapists. For example, a community counselling agency that was struggling to deal with an extensive waiting list might decide that it was not in a position to offer a satisfactory service to people who needed long-term support. A centre that specialised in women’s issues would not be open to male clients. A therapist who had little experience in working with extreme trauma might choose to advise such a client to work with a colleague with training and experience in EMDR.

Alongside the criteria that may be used by a therapy organisation, or an individual practitioner, to select clients or patients, are criteria used by clients themselves. From a pluralistic perspective, effective therapy depends on a capacity to make use of the resources of both the client and the therapist. Each client has some sense of what is most likely to be helpful for them, based on their prior experience of coping with problems in living, their observation of how others cope, and their reading or general exposure to cultural images of therapy. This sense of what might help is the basis of client *preferences* for different therapeutic activities and ideas. Pluralistic practice requires engagement with client preferences, both at the outset of therapy (e.g., intake and assessment procedures) and through the course of therapy (McLeod, 2012).

#### **3.2.1 Unsuitability criteria**

It is not possible to identify any general suitability criteria associated with recruitment of clients into pluralistic therapy. As discussed in the previous section, there will always be local criteria that are specific to each particular therapist, therapy agency, and client. Pluralistic practice involves engaging in as open a dialogue as possible about what these criteria are, and how they apply in each case. This conversation needs to be informed by the general duty of care that is accepted by anyone offering a therapy service.

### 3.2.2. Suitability for individual therapy

Whether a client is best served by individual therapy, or would receive more effective assistance from couples work, group therapy, medication, self-help or some other form of intervention, is a question that needs to be explored at an early stage in therapy. There are two main reasons why this is important. First, the ethical principle of informed consent calls for such a discussion to take place. Second, opening up exploration of the relevance of various possible ways of addressing a problem in living represents an invitation to the client to begin to consider multiple options, and conveys to the client that the therapist takes the client's views and preferences seriously.

### 3.3 Qualities of effective therapists

The question of what makes an effective therapist is an issue of central importance to pluralistic practice. Pluralistic therapy rejects the 'monist' position that there will be one valid therapy approach or protocol for each condition and that the role of the therapist is to function as a technician who ensures that these procedures are applied in each case. Instead, a pluralistic perspective implies that there are many interventions that may be of potential value for any particular client. The role of the therapist is therefore expanded to include facilitation and monitoring of choice of theory and method. The practice of pluralistic therapy is also informed by the findings of an expanding body of research that has documented significant differences in the levels of effectiveness of individual therapists (see, for example, Kraus et al., 2011). This research suggests the eventual outcome of therapy is determined to only a limited extent by the model of therapy that is used, and depends instead on the qualities of the therapist, and the capacity of therapist and client to establish a collaborative relationship.

#### 3.3.1 The personal characteristics of effective therapists

There are three main sources of information about the personal characteristics of effective therapists. One body of research has been based on interviews with practitioners who are senior members of the profession, or are nominated by their peers as 'master therapists' (Jennings and Skovholt, 1999). These studies have consistently identified a cluster of therapist characteristics associated with professional success. Highly-regarded therapists are people who are open to learning, by means of feedback from clients, personal therapy, reading, and on-going professional development. This lifelong curiosity is underpinned by a belief in the complexity of human beings and relationships. No matter which therapy model they might formally espouse, master therapists are eager to learn about other perspectives. These therapists regard their own life experience as a valuable source of therapeutic learning, and work hard at maintaining a work-life balance. A further body of research has examined the differences between therapists who record the best client outcomes, as assessed by changes on standard pre- and post-therapy measures, and those whose clients do less well. There are two key characteristics that have emerged from this type of investigation. Therapists who are more effective have higher levels of interpersonal skill, which they are able to maintain even when under pressure (e.g., if a client gets angry with them) (Anderson et al., 2009). In addition, more effective therapists are self-effacing, and express less confidence in their ability (Nissen-Lie, Monson and Ronnestad, 2010). A further dimension of therapist effectiveness refers to the goodness of fit between the therapist and the therapy context within which he or she works. For example, the personal style of some practitioners may be conducive to brief therapy, whereas colleagues with similar skills and training may be more

effective working with long-term clients. Similarly, therapists vary in their effectiveness across client groups (Kraus et al., 2011).

The evidence from these studies provides some useful pointers in relation to therapist selection and training, and the practice of therapy. Good therapists have a pluralistic attitude to their work, in terms of an appreciation of the limits of their knowledge and appreciation of the potential value of a range of perspectives. Good therapists are willing to explore difficult and sensitive issues with clients, because they feel secure enough, in relation to their own lives, to handle whatever comes back at them.

### 3.3.2 The skills shown by effective therapists

There exists a wide range of generic counselling skills that form the bedrock of any form of therapeutic practice. Beyond these core skills, there are three areas in which pluralistic therapy requires the development of specific skills. In order to respond in a flexible way to the preferences of different clients, pluralistic therapists need to be competent in facilitating a number of different types of change process. These domains include: meaning-making and building a sense of self and identity (humanistic and person-centred skills); becoming aware of and working through the implications of early life experience (psychodynamic skills); structured facilitation of cognitive and behavioural change (CBT skills); and addressing issues arising from the functioning of family systems (systemic skills).

Surveys of experienced therapists, where they are asked to indicate the frequency with which they use certain interventions, suggest that the majority of practitioners routinely operate across all four of these domains (Thoma and Ceccero, 2009). The expectation that pluralistic therapists should be at least minimally competent in each of these areas does not therefore represent an unrealistic burden. The other area of therapeutic skill that is specifically highlighted in pluralistic therapy consists of the capacity to engage in collaborative action and decision-making. There are several facets of collaboration as a therapeutic skill. Collaboration draws on an array of ways of using language, for example metacommunication and attention to implicit meanings within client language (for example, meaning that is conveyed by metaphor or silence). The skill of collaboration may encompass the use of tools and instruments, such as questionnaires that are completed by the client and then discussed. Collaboration may also involve a willingness to wait until the client is ready to articulate his or her wishes. The third area of skill that is particularly important within pluralistic therapy can be characterised as *active cultural curiosity*. From a pluralistic perspective, consulting a counsellor or psychotherapist is likely to be only one among many initiatives undertaken by a person who is struggling to deal with a troublesome problem in living. The therapist therefore needs to be able to learn about these parallel initiatives, and the cultural context that supports them, in order to be able to begin to explore with the client the ways in which therapy can be aligned alongside the use of other life resources. In this context does not refer merely to situations in which client and therapist come from obviously different cultural backgrounds, but also to the more subtle but at the same time significant ways in which people from the same community may espouse different beliefs and lifestyles.

## 3.4 Therapeutic relationship and style

### 3.4.1 Therapeutic relationship

From a pluralistic perspective, there are many different types of therapeutic relationship that may be helpful for clients. Moreover, an individual client may exhibit different relationship

needs at different points in therapy. These principles represent a major challenge for anyone seeking to conduct therapy in a pluralistic manner, because it is probable that the therapist has his or her own preferred and familiar style of relating to others, and will find it hard to shift into other modes of relationship. People who seek to become therapists are drawn to specific schools of therapy because their preferred approach embodies a way of relating to others with which they are comfortable. By contrast, being a pluralistic therapist requires a willingness to extend one's personal relationship repertoire.

Relating to clients in a pluralistic manner requires being willing to be open to the many different forms of therapeutic or healing relationship that are possible. This involves being willing to be critical of existing theories of the therapeutic relationship. For example, the concept of the 'therapeutic alliance' represents a way of thinking about healing relationships that has been highly influential and facilitative over several decades. But some clients, at some points in therapy, may want their therapist to be an adversary rather than an ally, or to be a mother, or to experience a sense of belonging. There are some clients who gain most from a minimal therapeutic relationship, for example by learning coping skills by using a self-help book or on-line package. Working pluralistically means knowing about well-established frameworks for understanding relationship processes in therapy, such as attachment theory, the concept of transference, and the person-centred core conditions model. It also calls on a capacity to regard these processes as part of a complex relational field that is multiply structured in respect of gender, age, cultural identity and other factors.

### 3.4.2 Therapeutic style

The discussion of the concept of pluralism that was offered at the beginning of this chapter placed a strong emphasis on the idea that genuine pluralism is based on a willingness to own one's own personal 'truth' while at the same time being open to the 'truth' espoused by others. It is therefore necessary for pluralistic therapists to identify and accept their own personal style of relating to others, and to use this style as their starting point in work with clients. By contrast, attempting to mimic a way of relating that has been modelled by a leading figure in a school of therapy, or specified in a treatment manual, runs the risk of being seen as false by the client, and does not represent an authentic starting point for any subsequent efforts to meet the client halfway. It is extremely unlikely that the relationship repertoire that has been developed by a trainee therapist over the course of several decades of their life will readily map on to the relational style associated with any particular brand of therapy. From a pluralistic perspective, this is an advantage, because it acts as a reminder to therapists that there are ways that they are capable of being in relationships that transcend any specific model.

### 3.5 Assessment and case formulation

Assessment and case formulation are central to a pluralistic way of working. Only when the therapist is willing to make an open and explicit statement of his or her understanding of the client's issues, is the client in a position to decide whether or not what is on offer is relevant and useful to them. In order to engage the client in a meaningful process of collaborative decision-making, the therapist needs to be able to convey his or her understanding in a respectful manner, using plain non-technical language, and in a style that allows space to the client to adapt, modify or decline the therapist's formulation. It is also necessary to keep the shared understanding under review, to allow emergent ideas and insights to be incorporated into the therapeutic process. The scheduling of the assessment and

formulation process will depend on contextual factors such as the existence of time limits for therapy. A pluralistic perspective invites practitioners to consider the potential contribution of the many different traditions of formulation and assessment that are described within the therapy literature (see, for example, Eells, 2007), and to incorporate elements of these strategies into their own personal style.

### 3.5.1 Assessment

A pluralistic stance allows therapists and clients to consider as wide a range of sources of information as possible when constructing a formulation: brief outcome and process scales; ratings of therapy goals; open-ended questionnaires; interview schedules; projective techniques; client diaries, letters and emails; autobiographical writing; art work and photographs made by or selected by clients; official documents (e.g., medical or school reports); and the views of significant others. The intention is not that the therapist arrives at a single authoritative appraisal of these data. Instead, the aim is to arrive at a shared understanding, guided as far as possible by the client's frame of reference.

### 3.5.2 Case formulation

As a means of emphasising the collaborative nature of therapy, it can be useful to externalise the formulation, or a version of it, as a diagram on a flipchart page, a written report, or a letter. The activity of co-creating an external object allows the client and therapist to work side-by-side on a shared task, rather than being engaged in a face-to-face discussion that may be all too readily dominated by the therapist's greater experience and authority. It is useful for the therapist to try to incorporate perspectives from a range of everyday discourses about the causes, maintenance and resolution of personal problems. For example, it makes sense to most people to think about an issue such as low mood or depression as reflecting any or all of the following factors: (a) a pattern of thinking and feeling that has its origins in difficult experiences in childhood; (b) faulty or irrational thought processes; (c) problems in relationships with others; (d) suppressed emotions; (e) an unhealthy lifestyle; (f) an absence of a sense of meaning and purpose in life, or (g) a response to social injustice. Each of these narratives can be linked to various healing processes and therapy methods. From a pluralistic perspective, the point in therapy where a collaborative formulation is accomplished can be regarded as a process of creating a space for consideration of the possibilities afforded by these cultural discourses.

## 3.6 Major therapeutic strategies and techniques

### 3.6.1 Major therapeutic strategies

The primary therapeutic strategy within a pluralistic approach is to find and make use of specific learning experiences that will allow a specific client to make progress in the direction of his or her goals at a specific point in time. There is no assumption that what works for one client will necessarily be helpful for other people, or even for the same person at a different stage in his or her life. Furthermore, there is no assumption that the learning experience will occur within a therapy session, or that it will be recognisable as an identifiable therapeutic intervention. The intention in pluralistic therapy is to create an environment in which the client's problem can be viewed from different perspectives. On the whole, people seek therapy because they feel stuck. The metaphor of life as a journey has meaning for most people. In general, people who come into therapy have a sense of where they want to get to in their lives, and what they need to do to get there. However, for whatever reason their progress

has come to a halt, or has been reversed. Therapy provides a space apart from everyday life, where the person can look at what has gone wrong, and discover a new route, mode of transport or destination that will allow the journey to resume.

### 3.6.2 Major therapeutic techniques

Much of the time, a client will have access to resources within their own life space and life history that will form the basis for creating a new way of moving forward in life. For a client, their therapist will almost certainly represent the person they have met who has the most knowledge of how people get stuck and how they can become unstuck. It can be a puzzle and source of disappointment for clients when their therapist is not willing to share this knowledge with them. The aim of pluralistic therapy is to arrive at a place in which both client and therapist knowledge, along with external cultural resources, are harnessed together in the service of the client. Taking these sources of knowledge as a whole, there are always multiple possibilities that can be brought to bear on the client's problem. The implicit message, communicated by a pluralistic therapist through such actions as emphasising the importance of active client involvement in therapy, using feedback tools, using metacommunication, and co-constructing a formulation and shared understanding, is a reinforcement of a 'both/and' philosophy of life: there are many small things that can make a difference rather than one big thing.

The 'meta-strategy' of identifying the specific remedies that make a difference for each client leads to episodes in therapy where client and therapist work together on applying these remedies. While it is important to be open to whatever change methods and strategies are suggested by the client, or emerge from collaborative exploration of what might seem useful, it is also necessary for pluralistic therapists to be able to draw on techniques and interventions that are well established within the world of counselling and psychotherapy. To be able to respond flexibly to the issues presented by clients, a therapist needs to be able to engage constructively with the following therapeutic tasks:

- making meaning: talking through an issue in order to understand things better;
- making sense of, and coming to terms with, specific problematic events and experiences;
- problem-solving, planning and decision-making;
- changing behaviour;
- negotiating a life transition or developmental crisis;
- dealing with difficult feelings and emotions;
- finding, analysing and acting on information;
- undoing self-criticism and enhancing self-care;
- dealing with difficult or painful relationships.

The capacity to facilitate completion of these tasks is based primarily in the life experience and interpersonal skills of the therapist. Entry into training as a counsellor or psychotherapist requires evidence of a baseline of competence in these areas (or example, demonstrated through relevant work experience). Therapy training provides opportunities to reflect on, and refine these competencies. Specific therapy interventions, such as two-chair work for unfinished business, or CBT protocols for working with OCD, comprise sequences of basic counselling and interpersonal skills. The field of counselling and psychotherapy embraces multiple, alternative approaches to conducting productive therapeutic work in each of these task areas. There is no way that pluralistic therapists can be familiar and competent in all of these approaches. Instead, each therapist needs to start somewhere, in terms of being able to

facilitate behaviour change, help the client come to terms with traumatic events, and other tasks.

### **3.7 The change process in therapy**

A pluralistic standpoint holds that there can be multiple change processes in therapy; but it can generally be understood as a cyclical process that moves back and forward between phases of involvement in specific activities that are intended to produce change, and standing back from these activities to reflect on whether they have made a difference. The kind of change that occurs within the phase of using specific methods to accomplish therapeutic tasks is no different from the kind of change that might occur in any form of therapy. For example, if a client is working on how to be less anxious and more confident and assertive in social situations, then the outcomes would be expected to be similar to what might be expected from the use of CBT or EFT for social anxiety, and a similar change process might be observed. By contrast, the change that is enabled through taking part in collaborative conversations about the direction and progress of therapy opens up possibilities around processes that are concerned with enabling the person to learn meta-strategies that they can carry with them for the rest of their lives. This higher level change can be characterised as a form of ‘learning how to learn’, and comprises such elements as:

- becoming more aware of one’s personal learning style, strengths and resources, and how these attributes can be used to prevent, mitigate and deal with issues that arise in the future;
- acquiring, or developing an appreciation of, a ‘pluralistic worldview’ that invites consideration of a problem from multiple perspectives, and willingness to seek creative ‘both/and’ solutions;
- practical knowledge of what is involved in working collaboratively with another person, and being engaged in open dialogue.

A pluralistic perspective is not based in an assumption that the formation of a therapeutic alliance needs to occur in advance of productive work on therapeutic tasks. Instead, each successful turn of the action-reflection cycle serves to build a relationship. In other words, a strong client-therapist relationship, observable in later stages of therapy as episodes of relational depth and open dialogue, is built on and arises out of practical achievements.

An important change event within pluralistic therapy is the discovery or creation of a therapy method that fits the client in respect of the particular problem with which he or she is struggling. Arriving at point of being able to see that ‘this works for us’ is typically energising for both client and therapist, and leads to a phase of intense and productive activity. There are many ways that pluralistic therapists can facilitate the search for ‘what will work’: asking the client; exploring what was worked in the past; inviting client suggestions and paying attention to what they say; being alert for problem-solving processes that are enacted in the client’s everyday life or in the therapy room; encouraging the client to try something they have never done before, to see whether it would be helpful; reviewing activities and interventions that have been used, and modifying and adapting them; exploring the possibilities inherent in culturally available resources; improvising idiosyncratic rituals and procedures.

## 4. CASE EXAMPLE

The therapist in this case was Julia McLeod, a counsellor in a university student counselling service that allowed clients to continue in therapy for as long as they needed, subjected to regular review.

### 4.1 The client

When she entered counselling, Ellie was 24, single, and a university student in the second semester of the first year of a social science degree. Ellie had felt increasingly anxious and worried during the first semester of her studies, and unable to sleep. She had visited her GP, who suggested that Ellie should try the university counselling service as a first resort, but that he would be willing to prescribe sleeping tablets and antidepressants if the counselling did not work. At our initial meeting, I (Julia) invited Ellie to tell me about her problem, the people and activities that were important in her life, and her goals for counselling. I also asked her about any previous counselling she had received, or other strategies that she had used to cope with her worries. Toward the end of that session I also talked about what counselling involves, and how it might help, and asked Ellie to complete the CORE outcome measure ([www.core.ims](http://www.core.ims)), a therapeutic goals rating form, and the assessment version of the Therapy Personalisation Form (Bowen and Cooper, 2012). At the end of the first session we agreed to meet again. At the start of the second session I began by asking Ellie whether there were any questions that she had about what we had discussed at the previous meeting, or further thoughts about her problem that had arisen during the ensuing week. I then asked her whether it would be all right for her if we just continued to talk about what was happening in her life for, so that we could get a better understanding of the issues that were bothering her. We also had a brief discussion of her responses to the scales she had completed, and I told her that, if acceptable to her, I intended to use some of the time in our third session to share my understanding of her difficulties, and look at some possible ways of dealing with them.

During these first two sessions, Ellie described herself as a 'complete failure'. She was the oldest of four children, and always felt under pressure to do well at school. Ellie was close to her grandmother, who died when she was 16. She told me that she had never felt that she received enough support or encouragement from her parents. Her mother was an alcoholic, who would disappear from the home for days at a time, leaving Ellie to take care of her brothers and sisters. Her father was a remote figure, who did not seem to be interested in his children, other than to criticise them for not doing well enough at school. He had a job that involved a great deal of travelling. Ellie had failed to get good grades in her university entrance exams, and worked in a shop for a year before doing an 'Access to University' course at a community college. She described herself as 'living a lonely existence', with no friends or boyfriend. She found it difficult to talk to her flatmates. She had 'no idea' what she was going to do after graduating. Ellie regarded herself as being seriously overweight, as a result of eating too much chocolate. She avoided writing essays, and spent a lot of time reading detective novels rather than doing academic work. When asked about activities other than her studies, Ellie mentioned that she had enjoyed singing in a choir in school, but was 'too fat' to join the university choir. In respect of what she thought might be helpful in counselling, she replied that she has never had any therapy before, but she needed advice on how to handle situations in her life, and was worried about the risk of being overwhelmed by bad feelings and past memories. When asked about how she made sense of her difficulties, Ellie replied that she did not have enough "will-power" to make herself do what was needed to be a success in life.

During the course of these early meetings I was aware that Ellie came across to me as rather emotionally distanced, detached, and harshly self-critical. Ellie seemed to use metaphors and images associated with fighting, such as “It was a battle to get to University”, and “I retreat into my bed with a carton of ice cream”. I was aware of a vague sense of sadness, and wondered whether Ellie would come back for further sessions. I had a sense that I had let Ellie down, and had not done enough for her.

## **4.2 The therapy**

Therapy with Ellie continued for almost three years, punctuated by pauses and vacations. We met weekly for the remainder of her first year of study, then through the second year of her course. This was followed by occasional consolidation and ‘crisis prevention’ sessions in the final year of her degree and over the summer following graduation.

### **4.2.1. Development of the therapeutic relationship**

There were two main strands of my relationship with Ellie. At one level, we worked together in a practical and purposeful manner to explore possible ways that the problems that Ellie was experiencing might be addressed. At another level, I was aware Ellie’s wish to receive the kind of love that had not been available to her when she had been a little girl. I was also aware that her neediness elicited the mothering side of me, along with occasional feelings of frustration and resentment around being asked to ‘take care’ of her. Ellie was around the same age as my own daughters, and there were times when I needed to use supervision to make sure that I was not importing patterns from my own real-life parental role into my relationship with Ellie. A turning point in our relationship, described below, occurred about halfway through therapy. After this episode, we seemed to move onto a new phase of relating, where Ellie became more active in defining how she wanted to use our time together, and both of us became more able to say what we thought and felt.

### **4.2.2. Assessment and formulation of the client’s problems**

My assessment incorporated an appraisal of the strengths and resources available to Ellie, as well as the problems in her life and her goals for counselling. I also sought to identify her preferred learning and relationship style, although it took many sessions before I began to gain a clear understanding of these factors. At the start of our third meeting, I asked Ellie if it would be a good time for me to share some of my thoughts about what she had told me up to that point, and outline some possibilities for ways that we might work together to help her to move on in her life. With her agreement, I used a sheet of flipchart paper and some coloured pens to draw a time-line of key episodes in her life, and how they might be connected to her current problems. I told her that what I was depicting was only a preliminary understanding of what was happening in her life, and that it would be useful if she could clarify any misunderstandings I might have, or add further relevant information. Figure 1 provides a simplified version of the diagram that we created together. The ‘starburst’ concepts at the top of the diagram represent strengths and resources. What I was trying to do, through this technique, was to introduce multiple ways of understanding her problems, in a way that would allow her the possibility of selecting which perspective might be most relevant for her at this point in time. I was also hoping to create a scaffolding for collaborative work, in the sense of offering a framework that could be modified and adjusted in line with her own ideas and experience. The ‘formulation timeline’ reflected what I could offer Ellie, in terms of my own skills and knowledge as a therapist – another therapist working with the same client would have different things to offer.

(Figure 1 about here)

#### 4.2.3. Therapeutic strategies and techniques

Ellie agreed that all of the potential counselling tasks identified in the timeline diagram made sense to her, and were important. Her immediate priorities were to ‘fight my fears by getting a handle on how much I am stressed out by my academic work’ and to find ways to ‘get more support’ from other people in the university. She saw these two issues as closely linked, and that it would only be possible for her to tackle the other tasks outlined in the timeline once she ‘felt a bit more secure’. The next six sessions followed a pattern of work that was informed by ideas from cognitive and behavioural therapy and social skills training, and my own experience as a university tutor. We identified the specific situations in which Ellie felt anxious and engaged in unproductive rumination, analysed the triggers for these events, the negative thoughts associated with them, and the interpersonal skills that were used by Ellie to avoid difficult situations and (occasionally) face up to them. We worked together to devise ideas for how to handle these situations in a more constructive way, which Ellie tried out and reported back on.

In her feedback to me, Ellie used the Therapy Personalisation Form to convey that she wanted me to offer her more structure, guidance and challenge. This information was extremely valuable in helping me to re-align my therapeutic style in accordance with Ellie’s needs at that time. Gradually, in the remaining weeks of that semester, Ellie began to believe that she might have a viable future as a student. In the final session before the summer vacation, we reviewed progress so far, and agreed to keep in touch by email and meet at the start of the next academic year.

Ellie then went off to spend the summer in her family home. It was clear from the few emails that Ellie sent me over the vacation that all was not well at home. When we met in September, she talked at length about the lack of interest that her parents had shown in her, other than to be critical of the grades she received in exams. Our sessions over the next three months consisted largely of a review of what it had been like for Ellie to grow up with a mother who had caught up in a cycle of alcohol misuse and depression. I was aware that Ellie had become highly sensitive around my acceptance and support. I talked to her about my experience of being her, and invited her to consider whether and how this perspective might be relevant to the work we were doing.

This intense connection came to a climax one week when I was five minutes late for the start of a session, and arrived at the counselling room to find Ellie beside herself, caught up in tears and rage because I had forgotten about her. I carefully explained that I had been held up by a phone call that had come in immediately after a previous appointment, that I had never let her down before, and that if I ever needed to miss a session I would make sure that she was informed in advance. We talked about her response to my absence, and she realised that her response that morning had been a replay of what had felt on many occasions when her mother had not been in the house when she came home from school. Working through the meaning of that episode had the effect of allowing Ellie to become more confident in her relationship with me. She became more proactive in setting the agenda for counselling, and more able to say what she felt. This shift began to be apparent in relationships with other people.

The final year of intermittent contact was characterised by a sense of two people being in open dialogue with each other, as Ellie moved to a stage of using me as a sounding

board to talk through specific issues that arose, such as joining the university choir, looking at her options following graduation, and dealing with her fears around committing emotionally herself in a relationship with a new boyfriend. During this period, Ellie also attended an ‘Understanding your Eating’ (Buckroyd, 2011) course that was running within the university community.

My work with Ellie involved using ideas, methods and relational styles drawn from CBT, Transactional Analysis, person-centred and psychodynamic approaches, at various points in the process of therapy.

#### 4.2.4. Therapeutic outcome

Ellie accomplished the goals that she had identified at the start of counselling – to handle the demands of university life, and to be less alone and isolated. The CORE-OM scales that she had completed on a regular basis over the course of therapy indicated a reduction from a moderate/severe level of distress to a score that hovered around the threshold of the ‘normal’ range. By the end of therapy, Ellie had gained a degree, left home once and for all, was in a stable and loving relationship, and had a job that was satisfying to her. She had stopped talking about ‘fighting’ and instead was busily ‘building’ a new life. She still felt unhappy and unsure of herself at times, and had a tendency to resort to secretive binge eating when under stress.

## 5. OTHER PRACTICE CONSIDERATIONS

A pluralistic stance in relation to therapy practice invites consideration of the potential contribution of all available therapy theories and methods, as well as a wide range of cultural resources. As a result, there are many ways in which pluralistic principles can be articulated in therapy practice. At the present time, only a few of these possibilities have been explored.

### 5.1 Developments

#### 5.1.1 Brief therapy

A pluralistic framework provides both therapist and client with a range of strategies for working effectively within time limits. The process of identifying specific therapeutic tasks, and prioritising which tasks are most urgent, allows client and therapist to make choices around what can be done in the time that is available. The pluralistic model of practice incorporates several therapeutic procedures that are found in empirically validated brief therapy protocols, such as the adoption of a strengths paradigm, attention to the potential value of extra-therapeutic resources, and flexible scheduling of sessions.

#### 5.1.2. Working with diversity

The pluralistic framework for practice described in the present chapter represents a therapy approach that places cultural factors, and sensitivity to human diversity, at the heart of therapy. The flexibility of pluralistic therapy, and the specific procedures that are used to engage with client preferences and cultural resources, mean that the cultural identity of every client is regarded as playing a central role in the process of therapy. Pluralistic therapy is open to the incorporation in therapy of a many different modes of delivery, such as groupwork, the use of email and letters, outdoor therapy and bibliotherapy. Further developments in pluralistic therapy include the use of client-therapist collaborative decision-making around the length and scheduling of sessions, and services that enable joint working

between psychotherapists and practitioners of complementary therapy, education, social work, healthcare, outdoor pursuits, fitness training, yoga, and many other activities that promote personal growth, healing and learning. A pluralistic framework provides a robust framework for carrying out therapy in setting that impose time limits, because it includes a structured approach to arriving at an agreed focus for therapy and agreeing on what can be achieved within the time that is available. A pluralistic framework also calls on the therapist to explore extra-therapeutic resources that a client might utilise.

## **5.2. Limitations of the approach**

An important limitation of all forms of individual therapy concerns the capacity to respond adequately to the needs of people who have been severely damaged in their lives, or who lack social support. In such instances, responsible practice involves the exploration of other sources of help that might be pursued alongside, or instead of, individual therapy. Clients who present with highly specific problems, such as severe and long-term depression, eating disorders obsessive-compulsive disorders or other psychiatric categories may benefit from working with therapists who can draw on advanced training and lengthy experience in a particular area. An example of a pluralistic approach to working with clients with a specific disorder (in this instance, depression) can be found in Levine (2007). Pluralistic therapy is also likely to be of limited value for clients who seek a specific type of therapy experience. For example, a client may have read about, or attended a workshop on, Gestalt Therapy, psychoanalysis, narrative therapy or any other ‘brand name’ approach, and decide that they would like to commit themselves in that way of working.

## **5.3. Criticisms of the approach**

There have been three different types of critical response that have been made in relation to the development of pluralistic therapy. First, it has been suggested by some commentators that it is unhelpful or even confusing to use the concept of pluralism to characterise a particular approach to therapy, rather to retain it as a term that describes a more general attitude or value position. Second, there have been strong objections to pluralistic therapy by individuals who uphold the central or fundamental significance of a single change process or conceptual model. For example, anyone who believes that good therapy requires analysis of the transference, or access to primary emotions, or uncovering negative automatic thoughts, is likely to believe that a pluralistically-oriented attention to client preferences and multiple change processes merely represents a distraction from what the client ‘really’ needs. A third area of criticism of pluralistic therapy concerns aspects of how it is implemented in practice. Examples of this area of critical response include questions around the nature of training in pluralistic therapy, the possibility that explicit client-therapist collaborative conversation may exclude the emergence of unconscious material, or the risk that the client’s preferred way of working may represent an avoidance strategy. Each of these critical perspectives represents a valuable contribution to the development of a pluralistic framework for practice, within the spirit of a pluralistic ‘both/and’ dialogue.

## **5.4 Controversies**

At the present time, there have been no specific controversial issues associated with the use of a pluralistic framework for practice.

## **6. RESEARCH**

As a recent development within the field of therapy, the pluralistic approach has yet to generate a substantial evidence base. However, the development of pluralistic therapy has been strongly influenced by research in a number of areas, such as the importance of client-therapist goal consensus, the nature of client preferences for therapy, and the power dynamics of the therapeutic relationship (see Cooper and McLeod, 2011; McLeod, 2012). From a pluralistic standpoint, research evidence is not considered a 'royal road' to understanding what works in therapy, but is considered one important means – alongside clinical experience, theory and life experiences – of attuning more closely to what clients may find helpful.

Current research projects include studies of the experience of training in pluralistic therapy, the use of feedback tools, and the effectiveness of a pluralistic approach in therapy with people suffering from depression. Research, using qualitative interview methods, has also focused on the aspects of therapy that particular groups of clients find helpful, such as HIV-positive clients, and clients with cancer (Omylinska-Thurston and Cooper, in press). Because a pluralistic perspective calls for the adaptation of therapy methods within the specific context of each client, systematic case study methods represent an appropriate means of documenting and analysing the process and outcomes of pluralistic therapy (McLeod and Cooper, 2011; McLeod, 2013; Miller and Willg, 2012). There is also an interest in developing tools that can facilitate client-therapist collaboration and the tailoring of the therapeutic relationship, such as the Therapy Personalisation Form (Bowen and Cooper, 2012), and goal outcome measures (see [www.pluralistictherapy.com](http://www.pluralistictherapy.com)).

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