Pluralistic Counselling and Psychotherapy

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2 Foundations for a Pluralistic Approach

This chapter discusses:

- Pluralism, as a *philosophical* concept, and its relationship to the pluralistic approach to therapy developed in this book.
- *Psychological* research and theory supporting a pluralistic perspective.
- *Psychotherapy* research evidence that supports a pluralistic perspective.
- Contemporary health and social policy developments that are closely aligned with a pluralistic approach.

The aim of this chapter is to present research, theory and policy from a range of fields which support the development of a pluralistic approach to therapy. As stated in the Preface, this chapter is more 'academic' than others in this book, and readers who are primarily interested in practical applications of pluralism may choose to skip over this material for now. However, we do encourage you to come back to it at some point: the pluralistic approach we are introducing is much more than a superficial, anything-goes eclecticism and, in this chapter, we hope to show how deep, strong and contemporary the foundations of a pluralistic approach are.

Philosophical Foundations

Unlike many therapies, the pluralistic approach developed in this book is, first and foremost, rooted in a particular philosophical perspective and set of guiding values. Most significantly, this is the pluralistic philosophy that has rapidly evolved over the course of the twentieth century.

Pluralistic philosophy

Pluralism refers to the belief that any significant question can be answered in a variety of legitimate ways (Rescher, 1993). It signals a preference for diversity over uniformity, multiplicity over unicity (McLellan, 1995), and pragmatism over idealism (James, 1996). It is a way of thinking that goes back to pre-Socratic philosophers (McLellan, 1995), who held that the diversity of nature could not be reduced to a single principle ('monism'). It

is closely associated with postmodern and poststructuralist thinking (McLellan, 1995), which also challenges the idea that there are any single, definitive truths (e.g., Derrida, 1974), or that we can ever fully capture and articulate the totality of being (James, 1996; Levinas, 1969). For Rescher (1993), all understanding is dependent on experience and it is inevitable that, in a complex and imperfect world, human beings will have a range of experiences. Hence, he argues, the normal human condition is 'dissensus' rather than consensus. Similarly, for postmodern thinkers such as Derrida, the fact that all knowledge rests, ultimately, on language, means that we can never penetrate down to the 'true' essence of how things are. Rather, we will always be caught up within a world of perspectives, narratives and discourses.

Another way of thinking about pluralism is that it is the philosophy of a 'messy universe' (James, 1996). In contrast to a monistic perspective, which holds that everything can be reduced down to a definitive set of fundamental laws, it suggests that the universe is 'littered' with a range of laws, values and possibilities, many of which are irreducible to others. Connolly (2005: 73) writes: 'Our experience of the world is more comparable to the relation we have to our desks in the middle of a project than to the desk after the project has been completed.'

As with the pluralistic approach to therapy developed in this book, however, it is essential to recognise that the pluralistic philosophy discussed here is not, primarily, rooted in epistemology (i.e., theories of knowledge), but in ethics. For pluralist philosophers such as Isaiah Berlin (1958), the monist belief that all experiences, realities and values can be reduced down to a 'single formula' – that there is one 'final solution' – is responsible for some of the greatest inhumanities of man to man. He writes:

> For if one really believes that such a solution is possible, then surely no cost would be too high to obtain it: to make mankind just and happy and creative and harmonious for ever – what could be too high a price to pay for that? … Since I know the only true path to the ultimate solution of the problems of society, I know which way to drive the human caravan; and since you are ignorant of what I know, you cannot be allowed to have liberty of choice even within the narrowest limits, if the goal is to be reached. You declare that a given policy will make you happier, or freer, or give you room to breathe; but I know that you are mistaken, I know what you need, what all men need; and if there is resistance based on ignorance or malevolence, then it must be broken and hundreds of thousands may have to perish to make millions happy for all time. What choice have we, who have the knowledge, but to be willing to sacrifice them all? (Berlin, 2003: 15)

Along similar lines, Emmanuel Levinas (1969, 2003) argues that the essence of an ethical relationship is to respect the 'otherness' of the Other, and not to try to squeeze them into our pre-existing constructs and beliefs. In the words of the American pragmatic philosopher William James (1996: 3), 'Individuality outruns all classification.' Recognition of this 'impossibility of conciliation to the same' (Levinas, 1969: 294) allows us to be open to the infinite diversity of others, and to honour and prize them in all their uniqueness.

For Berlin (1958), the assertion that different, mutually exclusive truths can exist is particularly emphasised at the level of values ('value pluralism'). By this, he means that different people will see different things as important and meaningful in life (for instance,

being happy, living life to the full, making a contribution to society) and that we can neither reduce all these values down to one, universally agreed 'supervalue', nor reach an ultimate solution as to which is the right value to hold. *Nor*, for Berlin, should we be trying to: for him, the essence of a liberal, free-thinking society is its capacity to allow others to choose their goals and values for themselves.

Box 2.1: A multiplicity of values requires a multiplicity of therapies

Berlin's (1958) assertion that a plurality of legitimate values and goals exist has important implications for the provision of psychological therapies. Within a medical context, for instance, it might be quite appropriate for just one main treatment to be available for a specific condition – people's bodies and biological functions can be relatively similar. But if we accept that different people have different values, and that some therapies are more aligned to one set of values than another, then the standardisation of psychological treatments becomes much more problematic. What right do we have, for instance, to impose CBT values (that people should think in rational ways) on a client whose goal is to develop their intuitive, spiritual being? Or, similarly, to impose person-centred values (that people should act according to their inner felt-sense) on a client whose sense of meaning comes from being of service to others? And even if it can be shown, through empirical research, that clients, on average, get better in therapy X than in therapy Y, this cannot be taken as evidence that everyone should then be given therapy X. Indeed, to do so would be a bit like finding that, on average, people feel better after seeing an imam than a priest or a rabbi, and thereby concluding that anyone with any spiritual questions should consult an imam, whatever their religious faith. In this respect, an acceptance of value pluralism points towards the need for a diversity of therapeutic provisions; and it is interesting to note that recent moves in the UK towards the standardisation of mental health treatments – the Improving Access to Psychological Therapies programme, which has primarily focused on the development of CBT interventions – is closely associated with the assertion that there is one 'supervalue': happiness (Layard, 2006).

Recommended reading

Connolly, W. E. (2005). *Pluralism*. Durham, NC: Duke University Press. Contemporary, insightful and passionate exposition of a pluralistic politic, philosophy and theology. For a briefer introduction to the development, and scope, of pluralistic approaches in the social sciences, see McLellan's *Pluralism* (Buckingham: Open University Press, 1995).

Humanistic and existential philosophy

The pluralistic approach developed in this book, then, is rooted in a set of ethics. These can be described as pluralistic but, beneath that desire to acknowledge and celebrate diversity, lies a more fundamental 'humanistic/existential' commitment to 'conceptualizing, and engaging with people in a deeply valuing and respectful way' (Cooper, 2007: 11). This ethic is, perhaps, most eloquently articulated in the concept of the 'I-Thou' attitude, as developed by the existential and humanistic philosopher, Martin Buber (1958). Buber describes this stance as one in which we behold, accept and confirm the Other as a unique, unclassifiable and unanalysable totality: a freely-choosing flux of human experiencing. Buber contrasts this with the 'I-It' attitude, in which the Other is experienced as a thing-like, determined object: an entity that can be systematised, analysed and broken down into universal parts. This is very similar to Levinas's ethic of 'welcoming the Other' (1969: 215), in which the 'Thou' – 'the stranger, the widow, the orphan, to whom I am obligated' – is given precedence over the I. The pluralistic commitment to tailoring the therapeutic relationship and method to the individual client's wants and understandings, then, can be seen as an attempt to actualise this humanistic ethic of deeply valuing and respecting the client's individual way of being. Indeed, both James (1996) and McLellan (1995) suggest that pluralism may essentially be synonymous with humanism.

Here, it is important to note that we are not using the terms 'existential' or 'humanistic' to refer to specific forms of therapeutic practice (as these terms are generally used, see, for instance, Cain & Seeman, 2002; Cooper, 2003), but to a general *ethic* (Cooper, 2007) that has the capacity to underpin a very broad range of interventions. Person-centred, gestalt or existential therapy may be expressions of this ethic but, from this viewpoint, it is quite possible to practise CBT or psychodynamic methods from a humanistic philosophical base. Here, what makes a therapeutic practice humanistic is whether it is developed in collaboration with the client, is tailored to the client's particular wants and understandings, and engages with the client as a unique and unsystematisable being. In this respect, a humanistic intervention such as person-centred therapy has the potential to be quite a-humanistic, if it is utilised with a client irrespective of what that client might actually want or prefer.

Coming from a standpoint that wants to value and respect the role of clients, a key humanistic assumption behind the pluralistic framework is also that therapeutic change is not something that therapists do *to* clients, but something that clients actively work to bring about. This is very consistent with the 'client-directed' approach of Barry Duncan and colleagues (2004), which strives to see the client as the 'star of the therapeutic drama' (2004: 22), rather than as an extra or observer to their own change process. Our approach has also been inspired by Art Bohart and Karen Tallman's (1999) classic text, *How Clients Make Therapy Work*, which holds that the 'Client has a strong, proactive self-healing capacity, however emotionally distressed they are' (Bohart & Tallman, 1999: xii). From this standpoint, the therapist is less akin to a medical expert who heals their patients, and more akin to a home decorating consultant, who helps clients identify what they want and how they might go about getting it. A third approach to therapy which shares this emphasis on service user agency and privileging their perspective is contemporary family therapy which, like the pluralistic approach, is closely associated with a postmodern perspective (see Sundet, in press). Most importantly, however, this client-led standpoint is

closely aligned with the views and wants of many health service users (Kaplan, Sheldon, & Ware, 1989). David Crepaz-Keay (2007), for instance, Head of Patient and Public Involvement at the UK Mental Health Foundation, states, 'there needs to be a slight move away from this attitude that we [service users] are passive recipients, eager to receive the wisdom and gifts that you [therapists] all have to offer us in helping us banish this depression that's dogged us for so long.'

Recommended reading

Bohart, A. C., & Tallman, K. (1999). *How Clients Make Therapy Work: The Process of Active Self-Healing*. Washington, DC: American Psychological Association. A brilliant basis for developing and understanding therapeutic practice, starting with the client's own capacity for self-healing and self-direction, and looking at how the therapeutic dialogue can facilitate this process.

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 Fransisco: Jossey-Bass. Wonderfully rhetorical, impassioned call for a client-directed approach to therapy.

For Bohart and Tallman (1999: 209), such a client-directed starting point is actually fairly rare in the counselling and psychotherapy world. They write:

> With very few exceptions … the client as an active, generative thinker does not exist in current theories of psychotherapy. It is as if, in therapists' eyes, clients have become lobotomized when they enter therapy. A perusal of the indexes of most books on psychotherapy either have no references to client thinking at all or have references only to clients' dysfunctional thinking. Clients are not granted the ability to think the same active, generative way therapists do.

Even in person-centred therapy, with its specific emphasis on the client's self-healing capacity, the emphasis tends to be on the therapist as agent of growth. Rogers' (1957) hypothesis regarding the necessary and sufficient conditions of therapeutic personality change, for instance, focuses primarily on the therapist and what they communicate, requiring only that the client is in contact with the therapist, in a state of incongruence, and *receiving* the therapist's empathic understanding and unconditional positive regard to some degree. Here, no mention is made of a necessity for clients to be motivated to bring about change, wanting therapy, or involved in the therapeutic process.

This understanding of the client as an active agent of change, as well as the humanistic commitment to engage with clients in respectful and valuing ways, leads us to put a collaborative therapeutic alliance at the heart of a pluralistic approach to therapy (see Chapter 3). Like Duncan and colleagues (2004: 22), we have a 'revolutionary desire to overthrow mental health practices that do not promote a partnership with clients in all decisions that affect their wellbeing'. Hence, a pluralistic approach to therapy involves

collaboration with clients over all aspects of therapy, including its goals, the tasks that can be undertaken to achieve those goals, and the specific methods that will be used by therapist and client.

Closely related to this concept of the active client and the commitment to deeply respecting service users, the pluralistic approach also draws from existential thinking the idea that people are meaning-seeking, purposeful beings. 'Man first of all,' writes the existential philosopher Jean-Paul Sartre, 'is the being who hurls himself towards a future and who is conscious of imagining himself as being in the future' (1996: 259). What Sartre means by this is that we are not, first and foremost, machine-like 'things' that are caused to act in particular ways by particular forces. Rather, we are future-orientated beings who set for ourselves particular goals and aims, and then find ways of working towards them. From this standpoint, people's actions are also understood as being 'intelligible'. That is, even the most deeply distressed person does things for a reason, and not out of sheer irrationality or pointlessness. This 'teleological' assumption is part of the reason why, as will become apparent in Chapter 4, the pluralistic approach puts the client's goals at the heart of the therapeutic process.

Finally, it should be said that the humanistic philosophy underpinning this approach leads us to adopt a relatively non-diagnostic approach towards clients. This is not to say that we see diagnoses and clinical categories as redundant – from a pluralistic standpoint, they are likely to be helpful for some clients some of the time – but the focal point for the approach is the clients' individual wants from therapy, rather than any generalised assessment or labelling of particular groups of clients.

Multicultural theory

Finally, pluralism in counselling and psychotherapy reflects the increasing degree of cultural diversity in clients and therapists, and the importance of developing therapeutic practice that embraces the multiplicity of beliefs that exist regarding healing and change (Pedersen, 1991). The main approaches to therapy that are most widely used at present, such as CBT, psychodynamic psychotherapy and the person-centred approach, embody assumptions about human nature that reflect Western cultural traditions, but which can be at odds with the worldviews of people from other cultural backgrounds. It seems clear, for example, the Western idea of an 'autonomous, bounded self' represents an individualist stance that may not match the experiences of people from more collectivist cultures (Sampson, 1988). In addition, there exist many indigenous healing practices, such as the use of shamens and other spiritual sources, that are highly meaningful to people from some cultural groups, but which are hard to reconcile with the scientific, rational basis of Western counselling and psychotherapy (Gielen, Fish & Draguns, 2004; Moodley & West, 2005).

As a result, there has been a movement in many counselling and psychotherapy professional associations in recent years to promote the adoption of flexible, culture-centred practices that acknowledge cultural difference. The pluralistic approach is informed by these developments, and has been designed as a way of doing therapy that is maximally sensitive to cultural preferences and the role of constructive dialogue between therapists and clients from different cultural communities. The pluralistic approach to therapy goes beyond merely seeking to develop specific services for clients from Asian, Hispanic,

Muslim or other ethnic or religious groups. Instead, a pluralistic approach acknowledges that different cultural traditions and identities may be represented within any individual person, and that effective culture-informed therapy needs to be able to take account of the multiplicity of cultural 'voices' that may be arise within the therapy process (Pedersen, Crethar & Carlson, 2008).

Psychological Foundations

Are people the product of their genes or their environment? In the 1970s, debates such as these raged. Today, however, few psychologists would argue that any one factor can be held responsible for the totality of human being. Rather, there is a widespread acceptance that human development, functioning and dysfunction is 'multifaceted, multidetermined, and multilayered' (Lazarus, 2005: 112), with a wide range of different factors – including cognitive, genetic, family, social, affective, neurological and volitional – contributing to an individual's psychological processes. Here, not only have psychologists acknowledged a multiplicity of factors, but also the way in which interactions between these factors can play a critical role (Rutter, 1987). For instance, a young girl may be born with a tendency towards extroversion, but the positive response she receives from her social environment for this behaviour may then reinforce this disposition. More broadly, many theorists and researchers now think about human functioning in terms of complex feedback loops between the various different elements of a person's being – 'circular', rather than 'linear', models of causality (Borrell-Carrio, Suchman & Epstein, 2004).

Box 2.2: The plasticity of human functioning

The idea that there exist *multiple* possible ways to achieve the same goal is one of the fundamental principles of a pluralistic approach to counselling and psychotherapy. In this respect, pluralistic therapy is consistent with key ideas in contemporary social and biological sciences. For example, the continuation of the human race requires that people join together in family structures in order to raise children. However, as social anthropologists have shown, there is no single model of family structure that has been adopted within all cultures; by contrast, there can be found a huge array of different living arrangements. In neuroscience, much recent research confirms the plasticity of the brain. In the past, it was believed that brain function was localised – the processing of visual information took place in one area, processing of auditory information in another areas, and so on. However, it has been shown that even if the visual processing system is destroyed (or has never functioned, as in people who are blind), it is possible to establish alternative brain pathways that allow this function to be re-created (Doidge, 2007). The lessons of cultural diversity, neural plasticity, and other examples, such as the resilience of ecological systems, serve as a guiding principle for pluralistic therapists: there are always different means to achieve the same outcome.

Exercise 2.1: Factors that influenced *your* development

Take 10 minutes or so to list all the factors that you think may have influenced your personality and development. For instance: relationship with parents/carers, genes, school environment, relationships with siblings, culture that you were born into, socio-economic environment, choices, birth order, traumatic experiences, physical health.

Spend some time (maybe 10 minutes) reflecting on, or discussing with a partner, whether you think all these factors can be boiled down to a single 'super-factor' and, if so, whether this super-factor is the same for other people. To what extent do your answers to these questions fit with, or challenge, a pluralistic viewpoint?

Such trends towards understanding human being as multidetermined can be seen as part of a wider move within the health field towards 'biopsychosocial' approaches to health and well-being (Engel, 1977). Here, clinicians are invited to consider the full range of biological, psychological and social factors that may lead individuals to experience the problems that they do, and not simply a narrow range of biomedical difficulties.

Along these lines, there are also few psychologists today who would hold that any one theory of personality or development can account for the full spectrum of human being and becoming. Larsen and Buss (2002: 610), for instance, authors of the textbook *Personality Psychology*, write:

> People have many facets, and these facets can be observed and studied from many perspectives. To say that people have evolved psychological mechanisms to solve social problems does not imply that the principles of psychoanalysis are wrong. Similarly, to say that a proportion of the variance in personality traits is due to genetics does not in any way imply that people do not develop or change their personalities in adulthood.

For many psychologists, then, different theories of human functioning and dysfunction can be seen as complementary rather than competing, helping to build up a more complex and multilayered understanding of human psychological distress. Comer (1998), author of the authoritative textbook *Abnormal Psychology*, for instance, gives the example of sexual dysfunctions, which may be caused by a variety of factors: internal conflicts in childhood (psychodynamic), learning incorrect sexual techniques (behavioural) and misconceptions about sex (cognitive). And, again, many of these factors may be understood to interact: for instance, Oedipal fears about intimacy with a woman may lead a young man to avoid sex education classes, which then leads to a lack of knowledge about sexual techniques, which then leads to misconceptions about what a woman may feel about sex, which may then reinforce fears about women.

Another example of a psychological difficulty that has been found to be irreducible to any one cause or understanding is obsessive-compulsive disorder (OCD). Over the last few decades, some cognitive theorists have argued that the core of all obsessional thinking

in OCD is an over-inflated sense of responsibility for harm towards oneself or others (for instance, 'If I don't turn the lights off it might start a fire, and it will be all my fault') (Salkovskis, 1999). However, while there is very good evidence to suggest that this may be true in many cases, research also shows that 'the emphasis on inflated responsibility may not describe significant numbers of OCD sufferers' (Markarian, et al., 2010: 81). For instance, people with obsessive counting, ordering and arranging tendencies seem to do it to reduce feelings of discomfort, and not out of a fear of harm or shame. Summarising the research, Markarian and colleagues state that OCD is a 'symptomatically diverse condition' (2010: 79), and that 'several lines of genetic, neuroanatomical, neurochemical, and psychological research point to OCD as a complex neurobehavioral illness that has multiple etiological determinants' (2010: 79).

Against this background, where leading researchers and writers in the psychological field hold that development and psychological functioning is multifaceted and multi-determined – and still, to a great extent, unknown – therapists would be hard pushed to justify a firm allegiance to any one, orientation-specific understanding of psychological processes. Certainly, theories such as Rogers' (1959) model of self-alienation or Beck and colleagues' (1979) concept of faulty information processing may act as very useful hypotheses in helping to untangle the reasons why clients feel and behave in the way that they do. But to hold any of these theories as self-evident *truths*, and to assume that they will be relevant to each and every client – in the absence of confirmatory psychological evidence – borders on the unethical. This is not, of course, to suggest that it is unethical to practise in any single orientation way: we know from the research, as discussed below, that such practices have the potential to be extremely helpful. But what it does suggest is that we need to distinguish our specialist ability in any one form of practice from an allegiance to the psychological principles on which that practice might be founded.

Box 2.3: Psychological distress as 'problems in living'

Within many psychotherapeutic theories, the reasons that people seek therapy tend to be understood in terms of psychological distress – processes and dynamics that go on *within* the individual: for instance, incongruence between self-concept and actual experiences (person-centred), internal conflicts between id and superego (psychodynamic), or irrational thoughts (cognitive therapy). A pluralistic standpoint suggests that it may be valuable to adopt a wider perspective on reasons for seeking therapy. It is also important to consider factors that exist *outside* an individual, or *between* an individual and their social, cultural or political environment. The concept of 'problems in living', introduced by the psychoanalytic writer Thomas Szasz (1961), provides a useful way to think about this issue. 'Problems in living' refers to anything that may have happened to make a 'personal niche', or 'life space', unliveable in some way, and the assistance of a therapist is sought in order to resolve this crisis. The idea of 'problems in living' implies that the client is active and resourceful in creating a life for himself or herself, but is for the moment stuck in relation to making progress towards their life goals. Problems in living is a concept that is compatible

with psychologically-oriented approaches to therapy, such as psychodynamic therapy and CBT, and also with more socially-oriented approaches, such as narrative therapy and family therapy. As a result, it is a way of thinking about client problems that invites and encourages a plurality of perspectives.

Psychotherapy Research Foundations

The ubiquitous dodo bird

The pluralistic approach is based on the assumption that there is no one, best, therapy. This is very consistent with one of the most commonly cited findings in the counselling and psychotherapy research field: that, overall, there appears to be very little difference in the effectiveness of different therapeutic orientations (see, for instance, Luborsky, et al., 2002; Wampold, 2001). In a study of the comparative effectiveness of different therapies in primary and secondary care, for instance, Stiles and colleagues (2006) found that CBT, person-centred therapy and psychodynamic therapy all brought about relatively similar reductions in levels of distress from pre- to post-therapy. Within the counselling and psychotherapy research literature, this finding of equivalence has come to be known as the 'dodo bird' verdict (Luborsky, Singer & Luborsky, 1975; Rosenzweig, 1936). This is after the dodo bird in *Alice in Wonderland*, who, after judging a race around a lake, declares that 'everyone has won and so all must have prizes' (see Cooper, 2008: Chapter 3, for a more extended discussion).

Not all researchers in the field agree with this interpretation of the data. Some, for instance (e.g., Hunsley & Di Giulio, 2002), argue that there *are* meaningful differences in effectiveness between different therapies (e.g., Reid, 1997), with CBT generally coming out on top (e.g., Shapiro & Shapiro, 1982). However, even if it is the case that one therapy, *on average*, is somewhat more effective than another, it still means that a large number of clients in the 'less effective' therapy will do better than the average client in the 'more effective' therapy (see Box 2.1 on page 16). Hence, the existence of small average differences in effectiveness between two therapies cannot be taken as evidence that *all* clients will do better with one particular approach than with another.

Aptitude by treatment interactions

In support of the argument that different clients need different things, psychotherapy research shows that 'patients with certain characteristics will do better in one treatment than another and that the reverse will be true for patients without those characteristics or with other contrasting characteristics' (Elkin, et al., 1999: 438). This is known as an 'aptitude by treatment interaction', and provides a growing body of support for a pluralistic standpoint. One of the best established of these interactions is that clients with high levels of resistance (i.e., who have a tendency to behave in oppositional ways) tend to benefit more from non-directive practices, whereas those who are judged to be non-defensive seem to benefit more from directive therapeutic procedures (Beutler, Blatt, Alimohamed, Levy & Angtuaco, 2006; Beutler, Engle, et al., 1991). Similarly, clients who have

a predominantly 'externalising' coping style (i.e., who deal with new or problematic situations by behaving impulsively, actively and excessively), tend to do better with technique-oriented therapies than clients with an 'internalising' coping style (i.e., who deal with new or problematic situations by turning in on themselves and becoming self-critical or depressed), and vice versa (Beutler, Machado, Engle, & Mohr, 1993; Beutler, Mohr, Grawe, Engle & MacDonald, 1991).

Preferences and predilections

One special kind of aptitude by treatment interaction, of particular importance to the pluralistic approach, is that of the relationship between clients' preferences for different therapies and the effectiveness of those interventions. It is clear from the research that clients *do* have preferences for different types of therapy to varying degrees (see Box 2.4 below), but does this have any impact on the outcome of different orientations, or do clients improve irrespective of what they actually seem to prefer?

Box 2.4: What kind of therapies do clients want?

Do all clients want the same kind of therapy, or are there substantial differences in preferences? Given the emphasis on user choice within service provision frameworks (see, for instance, *Our Choices in Mental Health*, Care Service Improvement Partnership, 2009) such a question would seem to be of considerable importance, yet it is interesting to note that research in this area is only beginning to emerge. In one of the most relevant studies to date (King, et al., 2000), depressed patients in primary care were given the option of choosing between non-directive counselling and CBT. In non-directive counselling, patients were told that the therapist would give them the opportunity to talk about what was troubling them so that they could explore their thoughts and feelings about it. In CBT, patients were told that the therapist would identify thoughts, feelings and behaviours that affected their mood and help them develop a more positive approach to them. Of those patients who specifically opted to choose one of these two therapies, around 40% opted for non-directive counselling, while 60% chose CBT. Interestingly, however, a follow-up study by Lee (2009) with students found significant differences between males and females, with 74% of males expressing a preference for CBT, but 64% of females expressing a preference for non-directive counselling.

In another study (Bragesjo, Clinton & Sandell, 2004), a random sample of 500 Swedish individuals were asked which of three therapies – CBT, cognitive psychotherapy and psychodynamic therapy – they would choose if they needed psychological help. Again, CBT proved the most popular, with around 35% choosing this option, 27% for cognitive psychotherapy and 16% for psychodynamic therapy. However, Bragesjo and colleagues found that individuals who had had some experience of treatment for psychological distress showed an increased preference for psychodynamic therapy – a finding replicated in a subsequent study (Frovenholt, Bragesjo, Clinton & Sandell, 2007).

Studies such as these suggest that, on average, clients tend to see cognitive-behavioural therapies as slightly more credible than alternative approaches, but there is clearly a large number of individuals who are more drawn to a non-CBT therapy than a CBT one. Given the significant relationship between preferences and outcomes, this suggests that clients should have access to a range of therapeutic options, rather than being squeezed into a 'one size fits all' service provision. It should be noted, however, that none of these studies allowed participants the option of saying that what they would have preferred was a flexible approach that combined elements of different therapies. Instead, these studies reflect the pervasive influence of the idea that therapy needs to be delivered in accordance with the approaches specified by different 'schools' of practice.

In the most thorough review of the research to date, Swift and Callahan (2009) found that clients who received a preferred therapy *did* do significantly better than those who did not. On average, the effect on outcome was small but, in many instances, clients were only given minimal information about the different therapies (for instance, just a paragraph on each to read) on which to base their judgement. The effect was also larger when strongly liked therapies were compared against strongly disliked therapies, rather than being compared against therapies in which the clients had no strong preferences. As an example of the former type, and where clients had substantial information about the different therapies, Devine and Fernald (1973) showed people with snake phobia videotapes of four different therapists describing, and then illustrating, their particular ways of working. Clients were then asked to rate each of the four therapies, and were assigned to a therapeutic condition that they had either rated as strongly disliking or strongly liking. The results of this study showed that clients who had been allocated to their preferred form of treatment did significantly better than those allocated to their non-preferred form of treatment, and they also did significantly better than clients who had been randomly allocated to those therapies. In their review of the research, Swift and Callahan (2009: 376) also found that 'clients who received their preferred treatment were almost half as likely to drop-out compared with clients who did not receive their preferred treatment'. On the basis of such evidence, Swift and Callahan (2009: 378) recommend that treatment selection should be based on 'a collaboration where both parties share information and discuss options and preferences openly'.

Although it may be assumed that clients do better in a preferred therapy because it is more matched to their individual needs and wants, there is also evidence to suggest that they do better because it gives them a feeling of being more in control (Handelzalts & Keinan, 2010). That is, if a client states what kind of therapy they want, and then receives it, they may feel that they have a greater influence on their environment and the kind of provision available to them. This may then enhance feeling of self-efficacy and self-esteem, boosting – or even instigating – a positive feedback cycle of improving mental health.

Research has also examined the relationship between a client's 'predilection' – their beliefs about the origins of their distress and what they expect will be helpful to them (Elkin, et al., 1999) – and the effectiveness of different interventions, and here, too, it indicates that therapies are more effective when they are aligned with clients' beliefs and

Table 2.1: Dimensions of client preferences for therapy (source: Berg, Sandahl & Clinton, 2008)

Outward orientation
It is important to help me define concrete goals.
Good treatment would teach me to behave in a different way.
I would be helped by homework that focuses on applying practical problem-solving.
I need a therapist who can take the initiative and give me good advice when it is needed.
Inward orientation
I need to reflect on painful experiences from earlier in my life.
I want to understand my relationships with others better.
I want to be able to reflect on my dreams together with my therapist.
I want to have help putting my feelings into words.
Support
I need a therapist who can offer support.
I need help from someone who can encourage me.
A good therapist is warm and friendly.
The most important thing is that my therapist likes me.
Catharsis
I need help to become more spontaneous.
It is important for me to express strong feelings in treatment.
A basic requirement for successful treatment is being able to 'blow off steam'.
I need to express feelings that have been suppressed.

values. For instance, Addis and Jacobson (1996) found that the more clients understood their depression in relatively abstract (i.e., cognitive) terms, the better they did in cognitive therapy (which gave them an opportunity to examine their personal meanings), but the worse they did in behavioural therapy (which focused on more discrete behavioural changes). Furthermore, Addis and Jacobson found that the more clients understood their problems in relationship terms, the less well they did in cognitive therapy (with its intrapersonal orientation).

The studies mentioned so far have generally explored client preferences in relation to broad therapy approaches, such as CBT or psychodynamic. However, each of these approaches encompasses a wide range of specific therapeutic activities. A study by Berg, Sandahl & Clinton (2008) invited clients to indicate their preferences for particular therapeutic processes, using a questionnaire (see sample items in Table 2.1 above). These clients, all of whom were suffering from anxiety disorders, were then randomly allocated to two contrasting forms of therapy. At the end of treatment, they completed the questionnaire again, to report on the extent to which their initial preferences had been reflected in the therapy they had received. Berg and colleagues found that clients whose therapy matched their preferences were more likely to get better. In this study, even though one of the therapy approaches proved to be more effective than the other, preferences were a stronger predictor of outcome than was the actual type of therapy that was delivered. This study has important implications for pluralistic therapy. It suggests that being asked to indicate their preference for specific elements of therapy may be more meaningful for clients than preferences for therapy approaches as a whole, and more likely to be linked to good outcome.

A further source of evidence about client preferences for therapy comes from studies that have attempted to explore what happens when clients do not benefit from the therapy that

they have been offered. In a study by Nilsson, Svensson, Sandell & Clinton (2007), clients who had completed either psychodynamic or cognitive-behavioural therapy were interviewed about their experiences. Those clients who had felt disappointed by the therapy they had received consistently reported that there had been 'something missing' in the therapy. They had appreciated the skill of their therapist, and what the therapist had done for them, but they stated that they had known that what their therapist had been doing had not been right for them. The disappointed clients who had received psychodynamic therapy stated that they had wished that their therapist had operated in a more structured manner, using homework assignments (i.e., more like a CBT therapist). The disappointed CBT clients, by contrast, stated that they had wished that their therapist would have been more interested in their feelings, and given them more time to tell their story (i.e., had been more like a psychodynamic therapist). This study suggests that it may not be therapist lack of competence or client lack of motivation that necessarily leads to poor outcomes (although these issues are clearly also relevant). Instead, the extent of client–therapist concordance around preferred ways of working together seems to be the key factor.

Pathways of change: one or many?

Do all clients, or all clients with the same difficulties, change in the same way? Currently, there is very little evidence to indicate that this is the case. Even with clients who participate in the same therapy, the evidence seems to indicate that multiple change processes have the potential to take place. Clarke and colleagues (2004), for instance, conducted interviews with five clients who had received a brief course of cognitive therapy for depression. Some clients, like 'Anna', talked about the value of having their thoughts challenged: '[The therapist] summarized what I had said and checked it back with me, and that would reveal something illogical or contradictory' (2004: 86). But others, like 'Dave', did not, and described instead the value of a 'safe, trusting environment' (2004: 85) as well as 'resistance to some of the techniques and tools' (2004: 84) and 'irritation with the American style' of the cognitive therapy (2004: 84). Similarly, an interview-based study of young people's experience of school-based counselling (Cooper, 2004; see Chapter 7, present volume) revealed that most young people found it very helpful being listened to and having a chance to get things off their chest. But others put particular emphasis on being asked questions by the therapist, or on being offered suggestions and advice. What is also evident in both of these studies is that diversity exists at the intra-individual level as well as the inter-individual one, with each client describing a range of different helpful factors. Such findings do not deny the possibility that many clients may change in similar ways, but they suggest that we should try to stay open to a range of possible change processes in our clients, rather than assuming that one 'super-process' is at work. Even if the latter does turn out to be the case, the empirical research suggests that we are still a very long way off from establishing what that super-process may be.

A collaborative stance

At the heart of a pluralistic approach is the belief that therapists should collaborate closely with their clients on the goals, tasks and methods of therapy. Such an assertion is particularly

well-supported by the empirical evidence, with an abundance of research to indicate that 'goal consensus and collaboration' within the therapeutic dyad is a 'demonstrably effective' element in the therapeutic relationship (Tryon & Winograd, 2002). Indeed, in the largest ever review of research on the therapeutic relationship commissioned by the American Psychological Association (Norcross, 2002), goal consensus and collaboration was found to be more clearly linked to outcomes than many more familiar relational variables, including congruence, unconditional positive regard and transference interpretations. This association is also evident from qualitative, interview-based research. Maluccio (1979), for instance, found that client dissatisfaction was often related to a failure to discuss, or agree, concrete and specific goals between therapist and client. In one 'failure' case, for example, a therapist attempted to help a couple work through their desire to control their son's life, while the parents wanted the therapist to induce their son to return to school.

Recommended reading

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients* (pp. 37–69). New York: Oxford University Press.

Tryon, G. S., & Winograd, G. (2002). Goal consensus and collaboration. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients* (pp. 109–125). New York: Oxford University Press.

In addition, within the psychotherapy research literature, the one factor that has been shown to be more clearly related to outcomes than any other is that of the 'therapeutic alliance' (Horvath & Bedi, 2002; Martin, Garske & Davis, 2000). This is closely linked to goal consensus and collaboration, and can be defined as the 'quality and the strength of the collaborative relationship between client and therapist' (Horvath & Bedi, 2002: 41), particularly collaboration on the goals and tasks of therapy. For instance, the revised short form of the Working Alliance Inventory (Hatcher & Gillaspy, 2006), the most commonly used alliance measure (Martin, et al., 2000), asks clients to rate their therapists on statements like '[The therapist] and I are working towards shared goals', and '[The therapist] and I have established a good appreciation of the kind of changes that would be most helpful for me'. What the research indicates, then, is that clients who more strongly endorse these items also tend to do better in therapy.

Client as active agent of change

Closely related to the emphasis on collaboration, another core principle of the pluralistic approach is that 'clients, not therapists, make therapy work' (Duncan, et al., 2004: 12). That is, the pluralistic approach assumes that it is clients who bring about change in their lives, with therapists as catalysts, rather than creators, of these improvements. Such an assumption is, again, strongly backed by the empirical research. For instance, Michael Lambert (1992), one of the world's leading psychotherapy researchers, has estimated that

around 40% of therapeutic improvement is due to 'client variables and extratherapeutic events'. This increases to 75% if it also includes the client's expectations for change and their contribution to the therapeutic relationship. Bruce Wampold (2001), on the other hand, using a more exact method of calculations, estimates that as much as 87% of change in therapy is down to the client and the events in the client's life.

The idea that 'clients make therapy work' is discussed in detail by Bohart and Tallman (1999), who suggest a number of lines of evidence to support the active client hypothesis. For example, clients can often make substantial gains without any therapy at all or only a minimal degree of therapist input: for instance, through using self-help material (den Boer, Wiersma, & van den Bosch, 2004). Drawing together research findings in the counselling and psychotherapy field, Mick (Cooper, 2008: 157) has written:

> [A]t the heart of most successful therapies is a client who is willing and able to become involved in making changes to her or his life. If that client then encounters a therapist who she or he trusts, likes and feels able to collaborate with, the client can make use of a wide range of techniques and practices to move closer towards her or his goals. For different clients, different kinds of therapist input may be more or less helpful; and there may be certain kinds of input that are particularly helpful for clients with specific psychological difficulties; but the evidence suggests that the key predictor of outcomes remains the extent to which the client is willing and able to make use of whatever the therapist provides.

Box 2.5: Therapist satisfaction and pluralistic practice

How rewarding is it for the therapist to be working in more integrative or eclectic ways? Although evidence on this question is limited, a survey of the experience of around 5000 therapists by the Collaborative Research Network of the Society for Psychotherapy Research (Orlinsky & Rønnestad, 2005d) found that 'therapeutic work is experienced most favourably by therapists who have a broad theoretical perspective' (Orlinsky & Rønnestad, 2005a: 79): that is, therapists who considered a greater number of theoretical orientations as being salient to their practice. The research also found that broad-spectrum, integrative-eclectic therapists experienced the highest levels of growth in their work (Orlinsky & Rønnestad, 2005b). Orlinsky & Rønnestad (2005c: 169–170) suggest that these associations may emerge because a breadth of perspective enables therapists 'to view patients from different angles, and in a multiplicity of conceptual contexts, rather than fitting all patients to a single theoretical template'. They go on to suggest that theoretical breadth 'enhances the therapists' adaptive flexibility in responding to the varying challenges that patients present and enriches the process of "continual professional reflection" … through which therapists learn the lessons imparted by clinical experience'. Orlinsky & Rønnestad (2005a) conclude that therapists who are not experiencing much growth and are in stasis should consider seeking greater variety or diversification in their therapeutic work, with an active openness to different theoretical perspectives.

The effectiveness of integrative therapies

In relation to a pluralistic way of working, we can also ask the question as to whether integrative, eclectic or pluralistic practices have been shown to be any more effective than single orientation ways of working. Integrative practices are, in fact, widely believed by therapists to improve the effectiveness of their work (Schottenbauer, Glass, & Arnkoff, 2005), but research on this question is relatively limited and a specifically pluralistic approach to practice has yet to be tested against any other form of therapy.

Recently, some studies have found that an integrative approach is more effective than the single orientation practice on which it is based. For instance, Constantino and colleagues (2008) found that integrative cognitive therapy (assimilating humanistic and interpersonal elements) was more effective at treating depression than classical cognitive therapy; and Hayes and colleagues (2006) found similar indications for acceptance and commitment therapy (ACT). However, in the main, integrative or 'enhanced' therapies have tended to do about as well as the therapies from which they are derived (Ahn & Wampold, 2001), with a review of the research indicating that they can be effective for a range of psychological problems, but little evidence to suggest that they are superior to single orientation alternatives (Schottenbauer, et al., 2005). From a pluralistic standpoint, however, this finding is not particularly surprising: the application of a standardised integrative practice across all clients would not be expected to be any more effective than the application of a standardised single orientation protocol.

The effectiveness of flexible practice

Is there evidence that more flexible and individually-tailored practices leads to better outcomes? Unfortunately, there have been few studies in this area. This is mainly because most therapy research has tended to focus on the delivery of standardised therapy protocols, where therapist flexibility would be defined as lack of adherence to the protocol, and therefore as a source or error.

Of those studies that have been conducted, there is some evidence that flexibility leads to improved outcomes. Jacobson and colleagues (1989), for instance, found that a clinically flexible version of marital therapy led to better long-term outcomes than a structured approach; Chu and Kendell (2009) found that therapist flexibility led to greater engagement of child clients in certain circumstances; and Ghaderi (2006) found that clients with bulimia did better on some outcome indicators when CBT was delivered in an individualised, rather than standardised, fashion. On the whole, though, these studies have tended to find few differences in outcomes between individualised and standardised treatments, and there are other studies which have found that more standardised therapies have outperformed individualised ones (Schulte, Kunzel, Pepping & Schulte-Bahrenberg, 1992). A key problem with much of this research, however, is that the 'tailored' therapies tend to remain within a relatively narrow band of CBT practices, or are tailored according to specific CBT principles, such that the effect of a wider, cross-orientation tailoring is not clear.

The value of more flexible and tailored approaches to therapy can also be examined by comparing the effectiveness of 'manualised' therapies (i.e., those in which practitioners are required to follow an established set of practice guidelines) against non-manualised

alternatives. Here, again, results are fairly mixed. On the one hand, some studies have indicated that competence in specific manualised therapy techniques predicts the outcome of psychotherapy (e.g., Shafran, et al., 2009; Shaw, et al., 1999), but others have found that use of particular manualised techniques are associated with poorer outcomes (Castonguay, Goldfried, Wiser, Raue & Hayes, 1996), or lead to therapists being experienced as less warm and friendly (Henry, Strupp, Butler, Schacht & Binder, 1993). This suggests that, while knowledge and skills in specific practices may lead to enhanced outcomes, rigidity and inflexibility of intervention does not.

Such a conclusion is supported by research into 'ruptures' in the therapeutic alliance, i.e., times of tension or breakdown in the collaborative therapist–client relationship (Safran & Muran, 2000). Here, research indicates that greater resolution is achieved when emerging ruptures are acknowledged and addressed, and also when therapists adopt a more accommodating stance (for instance, by apologising or by changing their behaviour) rather than being rigid in their behaviours. In support of such findings, Piper and colleagues (1999) have shown how drop-out in psychodynamic therapy is often linked to therapists' persistence in making transference interpretations, at times when clients are raising concerns or frustrations about the work.

Qualitative interviews with clients also suggest that, from a service user's perspective, flexibility is generally experienced as helpful and important to the relationship. For instance, in a recent study of factors that clients in primary care counselling felt had contributed towards long-term successful outcomes, the therapist's ability to adapt to individual need was seen as being a critical ingredient (Perren, Godfrey & Rowland, 2009). One respondent said: 'I felt that she bent … to me. I felt that she sort of moulded herself to me to the way I needed, what I needed, the style I needed. It may not work for everybody; it just fitted perfectly like a glove in a way' (Perren, et al., 2009: 243). In a second study, another client said: 'I do not believe in standardized ways of working, I think the therapist has to be a wise person, someone who has made his knowledge a part of himself, and who sees what needs to be done in the specific situation (Binder, et al., 2009: 253).

An interesting source of evidence around therapist flexibility can also be found within the literature on systematic case studies (McLeod, 2010). Cases that are written up in detail, using multiple sources of evidence, invariably show that the therapist has been innovative or flexible in some respects, even while working within a single orientation (see, for example, Hill, et al., 2008; Hougaard, et al., 2008; Karon, 2008; Kasper, Hill & Kivlighan, 2008; Kramer, 2009).

In summary, then, there is an emerging body of evidence that flexibility and the individual tailoring of therapies *can* lead to improved outcomes, but much more research is needed on the specific circumstances under which it does so – and also the specific circumstances in which it may, actually, lead to a worsening of outcomes. As Schulte (1996) points out, however, we do not need to see tailored and standardised therapies as mutually exclusive. Probably, with certain clients at certain points in time, it is important that practitioners avoid 'therapist drift' (Shafran, et al., 2009) and maintain a relatively consistent way of working; but with other clients at other times, flexibility and responsiveness may be the key. As we will emphasise throughout this book, therefore, a pluralistic approach needs to remain pluralistic about pluralism itself – it should never get to the point where it assumes that one way of working, even a pluralistic one, will be best for all clients at all times.

Policy Foundations: The Personalisation Agenda

As discussed in the Preface, recent shifts towards the commissioning and delivery of 'evidence-based' psychological therapies (such as the UK government's Improving Access to Psychological Therapies programme, Clark, Layard, Smithies, Richards, Suckling & Wright, 2009) may give the impression that public policy-makers are moving towards a more monist agenda. However, within the UK, the shift towards evidence-based practice is just one part of a broader revolution in health and social care policy, many aspects of which are not only consistent with, but at the leading edge of, pluralistic thinking and practice. In the final part of this chapter, we want to discuss some of these developments, showing how a pluralistic approach is aligned with many elements of a contemporary political zeitgeist.

Health and medical care

Consistent with a pluralistic approach, recent years have seen a 'growing trend in health care towards patient empowerment and greater patient choice' (Ford, Schofield & Hope, 2003: 590). This development is nowhere more evident than in the UK Department of Health's (2009) 'New Horizons' programme (www.dh.gov.uk/en/Healthcare/Mentalhealth/NewHorizons). This sets out a cross-party vision and a programme of action for improving the mental health and wellbeing of the population of England from 2010 onwards. The guiding values for New Horizons are almost synonymous with those underlying the pluralistic approach to therapy: equality, justice and human rights; helping people reach their full potential; helping people be in control of their lives; and valuing relationships.

Concomitant with this, one the key developments in the New Horizons vision is a move towards more *personalised*, individually-tailored mental health services. Louis Appleby, former National Clinical Director for Mental Health in England, writes that a key theme of New Horizons is ensuring that care is based on 'individuals' needs and wishes' (Appleby, 2009: 4); with service users 'able to make decisions about their care, treatment and goals for recovery, as well as to monitor their own condition' (Department of Health, 2009: 5). New Horizons, as with the pluralistic approach, also moves towards a greater emphasis on service users' strengths and resources, and away from defining users in terms of mental health problems or diagnoses. 'This is about more than preventing mental illness,' states former UK Prime Minister Gordon Brown, 'it is also about helping individuals and communities to bring the best out of themselves' (www.newhorizons.dh.gov.uk/index.aspx).

Such a shift of emphasis, from mental distress to mental wellbeing, is consistent with many other developments in political circles (see, for instance, the highly influential Foresight Mental Capital and Wellbeing Project, 2008), and with the increasing influence of the 'recovery' agenda (e.g., National Institute for Mental Health in England, 2005). Here, people who experience mental illnesses are seen as still having the capacity to enjoy mental wellbeing. Recovery is about 'building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms and problems' (Department of Health, 2009: 24).

Alongside these shifts in broad health care policy, recent years have also seen a growing interest in developing more collaborative, egalitarian and dialogical ways of working in the

specific physician–patient encounter (Borrell-Carrio, et al., 2004; Makoul & Marla, 2006). Going under such titles as 'shared decision making', 'mutual participation', 'enhanced autonomy', 'evidence-based patient choice', 'client-centred care', 'meetings between experts' and 'relationship-centred care' (Borrell-Carrio, et al., 2004; Ford, et al., 2003; Makoul & Marla, 2006; Suchman, 2006), the emphasis here is on 'discussions between professional and patient that bring the knowledge, concerns, and perspective of each to the process of seeking agreement on a course of treatment' (Makoul & Marla, 2006: 304). As with the pluralistic approach, authors in this field have emphasised that such a collaborative approach does not involve making reluctant patients assume too much of a burden of knowledge about a decision, nor does it imply uncritical acceptance of whatever the patient believes or hypothesises (Borrell-Carrio, et al., 2004). '[B]ut neither does it allow for the uncritical negation of the patient's perspective, as so frequently occurs, for example, when patients complain of symptoms that physicians cannot explain' (Borrell-Carrio, et al., 2004: 578). The emphasis, then, is on a balanced, collaborative 'autonomy in relation', an informed choice supported by a caring relationship, in which the physician can move flexibly from a primarily doctor-led degree of sharing to a primarily patient-led one. Importantly, in support of this approach, evidence indicate that such collaborative activity within the medical encounter does, indeed, improve outcomes (Greenfield, Kaplan & Ware, 1985; Kaplan, et al., 1989).

Social care

In the UK, shifts in health care policy towards more individualised service provisions are mirrored by policy developments in the social care sector. *Putting People First* (HM Government, 2007: 2), the UK government's 'shared vision and commitment to the transformation of adult social care', states that the time has now come to replace 'paternalistic' systems of care with 'high quality personally tailored services'. It goes on to state, 'In the future, we want people to have maximum choice, control and power over the support services they receive.'

Within the social care field, this process of tailoring support to people's individual needs has come to be known as 'personalisation':

> Personalisation means starting with the individual as a person with strengths and preferences who may have a network of support and resources. … Personalisation reinforces the idea that the individual is best placed to what they need and how those needs can be best met. It means that people can be responsible for themselves and can make their own decisions about what they require, but that they should also have information and support to enable them to do so. … Personalisation is about giving people much more choice and control over their lives. (Carr, 2008: 3)

This shift towards personalisation is closely linked to other developments in the social care field, such as 'person-centred planning' for people with learning disabilities, in which the aim is to support them to live as independently as they can (Carr, 2008), and 'person-centred working,' in which people who use care services are helped to have 'as much control over their own lives as possible' (Carr, 2008: 19). Personalisation also links to the social model of disability (in which social factors, such as discrimination, are seen as the

ultimate cause of disablement), the service user movement, and an increasing involvement of 'experts by experience' (Carr, 2008). As with the pluralistic approach, then, personalisation is closely linked to a user-empowerment agenda, and this is not just at the individual level, but at the level of collective organisations (for instance, MIND, Depression Alliance Scotland), which can represent more powerfully the voice of user experience.

Summary

The pluralistic approach to therapy is underpinned, and informed, by a pluralistic philosophical outlook. This holds that many key questions in the human and social sciences have a range of 'right' answers and that, at a moral and political level, it is essential that we can acknowledge and value this diversity and difference. Psychological research, too, supports a pluralistic perspective, by indicating that there are many different reasons why people are the way they are. Likewise, psychotherapy research provides good evidence for a pluralistic perspective by showing that there is no one, 'best' way of helping people; that different clients seem to need different things; and that working collaboratively, supporting client agency, and being flexible in practice are often closely associated with good outcomes. Finally, the pluralistic approach introduced in this book is closely aligned with key contemporary developments in health and social policy, most notably the Department of Health's (2009) *New Horizons* programme, which sets out a vision for addressing mental health difficulties in personalised, respectful and user-empowering ways.

Questions for reflection and discussion

1. To what extent do you agree or disagree with the pluralistic assertion that there are many 'right' answers to the same question?
2. Do you think it is true that personality and human development are influenced by a multiplicity of diverse factors? Are there one or two factors that you think are, universally, much more influential than others?
3. What is your reaction to the suggestion that as much as 87% of the change in therapy is due to the client and factors in the client's life? What implications does this have for how you think and feel about therapy?
4. What flaws do you see in the argument for a pluralistic approach? If you were going to criticise it, what would you say?