Practitioner Perspective

Pluralism: An ethical commitment to dialogue and collaboration

By Dr. Marcella Finnerty, Ms. Caitríona Kearns & Mr. David O'Regan

Students, practitioners and patients, are confronted with confusion, fragmentation and discontent. With so many therapy systems claiming success, which theories should be studied, taught or bought?

(Prochaska & Norcross 2018, p.1).

The early history of psychotherapy and counselling is dominated by the development of different schools, each eager to present its case against the others and each with its own language, which only those committed to its ideas would be likely to understand. The resulting cacophony has been likened by Stanley Messer to the Tower of Babel (2012). A separatist, denominational spirit prevailed in which theory, mainly in the form of dogmatics and lacking any substantial research base, was propounded within an adversarial culture characterised as "dogma eat dogma" (Messer, 2012). Even for clinicians socialised strongly into a particular school of therapy, the failure of any one orientation to demonstrate universal success has been striking (Norcross & Goldfried, 2011). Arguably, in Ireland, the field remains fragmented. This is evidenced in recent position papers drafted by two of the main professional bodies, whereby one asserts that psychotherapy and counselling are distinct professions, with different levels of expertise and competency (ICP, 2015, p.1), while the other maintains there is "no proficiency difference between counselling/ psychotherapy" (IACP, 2015, p.3). When there is conflict, we agree with the view that there are truths to be addressed on each side, which can only be resolved through dialogue. If that perspective is correct, perhaps a pluralistic approach, where dialogue is central, is a way of moving forward. Ultimately therapists need to be competent and comfortable with a variety of methods to face the challenges and privileges their role bestows.

Definition of Key Concepts
Pluralism as a philosophical concept speaks to the idea that multiple truths exist and that many things are helpful to different clients. Cooper and McLeod (2011, p.6) view this as "a way of practising, researching and thinking about therapy", which is all-embracing.

They define it as "a both/and" standpoint, arguing that there is value in the range of available therapeutic models. O'Hara and Schofield (2008) consider that pluralism is an approach to managing the tension created by the use of different theories. Adopting a pluralistic approach enables therapists to use a variety of theories, without the need to reconcile differences. The pluralistic view is predicated on a collaborative relationship between client and therapist, where the client is empowered as the expert in their own life. It is postmodernist insofar as truth is seen as constructed more so than discovered, and the central philosophical underpinning holds that "any substantial question admits of a variety of plausible but mutually conflicting responses" (Cooper & McLeod, 2007, p.137). Messer believes that unity in psychotherapy is not possible because we do not "simply discover what is inherent in nature…we invent our theories and categories and view nature through them… there is no single truth and, by extension, no one unified or integrated theory of therapy to discover" (2008, p. 364). This, therefore, leads to a pluralistic outlook both methodologically and theoretically. It is argued that all integration may be considered as an evolving, processual activity, as well as an implementation of specific integrative models (Oddli, & McLeod, 2017; Oddli & Rønnestad, 2012).

Polkinghorne suggests that the vast array of existing theories provides "prima-facie evidence that no one theory is correct" (1992, p.158). Moreover, he contends that universalising one's experience, as being generalizable to every client in

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every situation is, in effect, a therapeutic error. Cooper and McLeod (2011) maintain that pluralism in psychotherapy is an attempt to establish an approach that has the framework of a set of principles and meta-strategies, which can be easily adopted by therapists from different backgrounds. Pluralism is seen, therefore, as a way to overcome the limitations of other integrative approaches, while at the same time drawing on the most beneficial characteristics of these models. It does not ask anyone to abandon ideas and methods they find useful. It does, however, invite serious consideration of other options alongside the favoured and familiar. Furthermore, while pluralism is a philosophical concept, it can also be conceptualised as a particular way of engaging with clients:

Pluralistic Therapy refers to a specific form of therapeutic practice that draws on methods from a range of therapeutic orientations, and which is characterised by dialogue and negotiation over the goals, tasks and methods of therapy (Cooper & McLeod, 2011, p.8).

A pluralistic stance is associated with a reflective and nuanced approach to the issue of how we know what is true. It implies that there are different types or sources of knowledge, each of which has its own validity. The concept of pluralism functions as a meta-perspective or meta-theory from which

therapy theories as a whole can be examined for their relevance in any particular case (McLeod, 2017). Pluralism indicates a certain pragmatism: an effort to transcend dogmatic adherence to particular traditions or identities, and to draw on a wide theoretical base as appropriate, with the client at the heart of the process.

Practical Application of Pluralistic Counselling and Psychotherapy
When applying this approach to practice, attunement to client goals is paramount for a number of reasons. Firstly, evidence suggests that 'goal consensus' is positively correlated with meaningful outcome (Tyron & Winograd, 2010). More importantly, Cooper and McLeod (2011, p.57) maintain that we can only truly begin collaborative work when we align ourselves to what the client wants. Therefore, the pluralistic framework aims to put the client at the heart of the therapeutic process and attempts to maximise the client's involvement by specifying a set of strategies for creatively drawing on several therapeutic practices and theories. Consequently, working with client goals is both a practice issue and an ethical one. Cooper and McLeod (2011, p.58) describe the focus on client goals in four ways:

• It implies that the client is an active agent, engaged in the process.

• It recognises the client as a separate person,

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who possesses his own perspective.

- It involves a 'deliberate ethical stance', where informed consent is not just a nice idea, but rather intentional practice.

- It is 'a pragmatic strategy' for identifying the resources that the client holds.

Essentially, tasks are defined as "concrete, lower-order goals" (Cooper and McLeod 2007, p.138). Unlike the broader goal, say of 'I want to be confident', a task is action-orientated with the therapist and client collaboratively identifying specific steps to aid the client in attaining confidence. Hence, if the client's goal is to be confident, therapy should involve setting up a task that is likely to address that goal. When considering tasks, the steps proposed by Cooper and McLeod (2007, p. 138) involve:

- Agreeing what the task is;

- Carrying out the task; and

- Knowing when the task has been successfully completed.

Cooper and McLeod (2011, p.61) reason that working with tasks and goals is a 'privileging' of the client's perspective and, moreover, allows one to determine "whether the methods that the therapist can offer fit with this."

In their work, they describe 'methods' as "the actual procedures or actions that a therapist and client jointly perform" in order to achieve the tasks and goals (Cooper & McLeod, 2011, p.93). As collaboration is interwoven into every aspect of pluralism, the practitioner should not decide the selection of methods. Instead, it should emerge from dialogue and conversation with the client. It is incumbent on the therapist to be "willing and able to dismantle…theories in order to be able to identify methods that can be suggested to clients"; additionally, therapists are encouraged to "develop a repertoire of methods that can be offered" (Cooper & McLeod, 2011, p.115). This elicitation of goals, tasks and methods is not a one-off intervention. Instead, consistent attempts at collaboration, dialogue and communication are inherent to the approach.

Even though a central point of the pluralistic approach is focusing on client goals it does not forget the importance of being flexible and allowing for the here-and-now process of therapy. Clients do not generally arrive to therapy with a clear idea of what it is they want from therapy, only to feel better; therefore, initial goals can be vague. In fact, "many who present themselves for counselling are vague or uncertain about what the problem is" (Yeo, 1993, p.109).

Central to building a collaborative therapeutic relationship is

metacommunication Cooper and McLeod describe metacommunication as a conversational strategy that refers to "moments in the conversation where the therapist (or the client) pauses to reflect on the way in which the topic is being discussed". In other words, it is communication about communication (2011, p.46). The pluralistic framework recognises the client's strengths and resources. As therapy is very often not the first port of call for people seeking help, it can be assumed that clients have spent some time coping with their difficulties in other ways. These resources can be either healthy or unhealthy. For example, clients may have used exercise, herbal remedies, friends or family to cope with issues. Similarly, clients may have used alcohol, drugs or other destructive behaviours as a way to survive. With these strengths and resources, comes the idea that the client may have some understanding as to the cause of their problems and can reflect on how using these strengths and resources might help in resolving their difficulties.

While considering clinical work, it is vital to acknowledge that the client will have cultural resources. Cultural resources can include, but are not limited to, spirituality, religion, diet, exercise, creative arts and community. Marley (2011) found that the predominant factor in limiting distress was accessing support from others; Batt-Rawden (2010) noted that participants of their study were helped by music to cope with a range of tasks, problems and symptoms. These studies, among others, imply that there are implications for practice within the pluralistic framework in that it can provide a client with

an array of possibilities (Cooper & McLeod, 2011). However, Sarris, O'Neil, Coulson, Schweitzer, & Berk (2014, p.8) state "some lifestyle choices and "vices" may provide the person self-perceived support and comfort, and in such cases change needs to be handled delicately."

Another important consideration in the pluralistic framework is client preference. According to McLeod (2012), there is a substantial body of evidence that the fulfilment of client preferences has a significant impact on whether a client will stay in therapy. Client preferences can be in relation to broad therapy approaches or a wide range of specific theraputic approaches (Cooper & McLeod, 2011). Being attuned to client preferences and understanding their individual requirements leads to good therapy, demonstrating respect and understanding for the client.

However, as with all aspects of the pluralistic approach, client preferences need to be collaborative, meaning there may be a divide between what the client wants and needs, and differences need to be negotiated. Receiving feedback from clients requires the therapist to remain open minded, and to be willing to share their ideas of the cause of the psychological distress with their client (Cooper & McLeod, 2011). An open-minded therapist will work collaboratively with clients to evaluate realistic goals for therapy.

A Critical Evaluation of Pluralistic Therapy

Underlying Principles
John Norcross maintains that there are some 400+ approaches to therapy. He contends, "rivalry

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among theoretical orientations has a long and undistinguished history in psychotherapy" although he asserts there has been a "decline in ideological struggle" in the past 20 years (Norcross, 2005, p.3). Perhaps this is the case in the USA, however, Cooper and McLeod (2011, p.1) claim orientation-based conceptualisation is still evident in proposals for "highly specific, manualised forms of therapeutic interventions" in the UK. Furthermore, in Ireland, it is evident in moves toward mandatory, manualised CBT training for nursing and clinical staff of the Health Service Executive's mental health and addiction services (HSE, 2012).

Pluralism can be directly contrasted with monism (Cooper & McLeod, 2011). Rather than seeking the "one true meaning" (Strenger & Omer, 1992), pluralism allows that a myriad of approaches to "psychological distress and change may be "true"' (Cooper & McLeod, 2007, p.137). Additionally, the pluralistic approach proposes that it is useful to differentiate between "pluralism as a perspective" and "pluralism as a particular form of therapeutic practice", as even a single-school practitioner may be pluralistic in their perspective, and hold the belief "that there is no one, best set of therapeutic methods" (Cooper & McLeod, 2011, p.7). That said, the idea that someone might believe that there is no one truth, yet holds to monist practice, raises questions of congruence. If a therapist truly

considers that a monist approach will not work for everyone, is there not an ethical obligation to expand one's practice?

According to Cooper and McLeod (2011, p.6), the pluralistic approach "starts from an assumption that different things are likely to help different people at different points of time." Furthermore, they argue that engaging clients in a dialogue about what they believe is likely to help them is a key tenet of pluralistic practice. When reviewing the approach, it is therefore important to examine the two fundamental principles (Cooper & McLeod, 2011, p.6) of pluralistic practice from a critical standpoint:

· There is no one truth. Many things can be helpful to clients; and

· If we want to know what is likely to help, we should talk to the client about it.

Multiple Truths in Psychotherapy?
Like McLeod and Cooper, Norcross (2005, p.5) speaks of a "growing awareness that no one approach is clinically adequate for all patients and situations." The argument for a pluralistic stance, philosophically, is not a new one, but it is useful to consider the counselling and psychotherapy related evidence for this principle.

Perhaps the greatest weapon in the monist's armoury is the proliferation of Randomised Controlled Trials (RCTs) of particular therapeutic models.

There is a large body of literature supporting the idea that clients who receive their preferred method of therapy do better in therapy and are less likely to drop out.

Persons (1998, p.127), in her arguments about the value of RCTs for therapists, proposes that clinical trials are "widely accepted…as the gold standard of evidence about treatment efficacy." She maintains that, when all else is equal, the evidence from an RCT can tell us which therapy is 'superior' to another. Arguably, when it comes to RCTs, one has to ask when exactly is 'all else' equal? By their very nature, RCTs are controlled, and as a result, arguments about generalizability are prolific (Shean, 2014; Clay, 2010; Leichsenring, 2009; Hunt, 2012). Moreover, converse to Persons' argument is a plethora of research suggesting that no model "has reliably demonstrated superiority over any other approach" (Duncan & Miller, 2005, p.4). Bruce Wampold (2011) further argues that the evidence for superior approaches is 'negligible' at best. In contrast, Cooper (2008, pp.53-54) reminds us that this "argument is not without its critics" and that it fails to take into account one of the main pluralistic principles, "that different clients may benefit from very different types of therapy."

While RCTs can espouse evidence that one model of therapy is, in general, more effective than another for a specific problem, methodological issues, such as sampling, must be considered. Shean (2014) reminds us that many RCT psychotherapy studies are limited to participants with a single diagnosis. He asserts

that this "does not mirror the reality of most clinical practice" (p.2). In day-to-day practice, the exclusion criteria in RCTs, such as co-morbidity, may be very much present in our casework.

Even using the 'gold-standard', many RCTs fail to prove that one treatment is better than another. For instance, the Cannabis Youth Treatment Study randomly assigned some 600 cannabis-using youth to one of five different adolescent substance abuse treatment approaches. "Overall, the clinical outcomes were very similar" across the five sites (Dennis et al, 2002, p.197). Additionally, even in RCTs with high success rates, some clients do not improve. In reality, outcome research finds that approximately 5% to 10% of adults receiving therapy actually deteriorate. Furthermore, this statistic is evident in both clinical trials and routine practice research (Shimokawa, Lambert, & Smart, 2010; Hansen, Lambert & Forman, 2002). Consequently, even with the most 'successful' therapy in an RCT, there are clients who do not respond well, lending credence to the argument that clients may possess an "aptitude for certain interventions and a tendency to respond less well to other[s]" (McLeod, 2013, p.1).

The second key principle of Pluralistic Therapy relates to a commitment to engaging clients in dialogue and feedback about therapy, in particular regarding client preferences. This collaboration and communication

with clients is evident in all aspects of pluralistic therapy, from discussions about therapy preferences, goals, tasks and methods, to the use of process and outcome measures as feedback tools.

Client Preferences and Feedback Tools

In his critique of Cooper and McLeod's literature, Richard House (2011), claims their work contains an "absence of considerations of power." This is portrayed as a 'silence', which seems incredible considering the texts he refers to contain multiple implicit and explicit messages related to dialogue, incorporation of client preferences, on-going meta-communication and the idea that the "therapist [should] be guided by the client's preferences and choice" (Cooper & McLeod, 2011, p.41). Arguably, at its very foundation, considerations of power are addressed in pluralistic therapy. The philosophical position and practical application of this approach is specifically geared towards creating a space in which power and choice is with the client. Furthermore, Cooper and McLeod (2011, p.35) clearly state,

> If it is the therapist alone who decides on which therapy interventions and theories to use, then the strengths, capabilities and preferences of the person seeking help are likely to be oppressed and silenced.

One clear way that Pluralistic Therapy demonstrates consideration of power issues is through the elicitation and utilisation of client preferences. There is a large body of literature supporting the idea that clients

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who receive their preferred method of therapy do better in therapy and are less likely to drop out (Swift & Callahan, 2009; Swift, Callahan & Vollmer, 2011; Tomkins, Swift, & Callahan, 2013). For instance, Swift and Callahan claim, 'matched clients have a 58% chance' of better outcomes and are 50% less likely to drop out of therapy (2009, p.368). It is also important to reflect on potential implications when client preferences are not respected. Although citing a medical study on diabetes treatment, Torgerson and Sibbald's (1998, p.316) finding that "resentful demoralisation" occurs when patients do not obtain their preferred treatment may be of relevance to our field. Surely, in a profession that explicitly holds the ethical stance of "client autonomy" (BACP, 2015; IACP, 2015), it should be best practice to include client preference in our case planning?

Notably, not all research finds a positive correlation between outcome and incorporation of client preferences. In their study exploring therapy preference in clients with mild to moderate alcohol dependence, Adamson, Sellman and Dore (2005, p.210) cite Sterling et al., (1997) as an example of research that "found almost no difference in treatment retention or outcome." Furthermore, in their own research, Adamson et al., (2005, p.213) maintain, "there was no significant association between treatment preferences … and any of the treatment process or outcome measures." Interestingly, apart from a timeline follow-back procedure to assess drink-related outcome, the only outcome measure used in this study was the Global Assessment Scale; a clinician

rated tool. Accordingly, one might argue that the 'outcome measures' used were limited and failed to consider the client's perspective. Furthermore, it must be noted that there is a distinct difference between offering someone a choice between two models of therapy and offering them their preferred type of therapy. Arguably, participants in either treatment group in Adamson's study may not have been receiving their preferred therapy at all.

Cooper and McLeod (2011, p.24) suggest that examining "the relationship between clients' preferences" for different therapies and the effectiveness of those interventions' is vital. In pluralistic practice, incorporation of client preferences is not limited to offering clients choice between two (or more) distinct therapies. Certainly, the therapist will present the client with their therapy menu, but more than that, they will strive to identify specific things the client might want. So how is this achieved?

Tompkins, Swift and Callahan (2013, p.280) state that the easiest way to assess client preferences is "to directly ask … which therapy conditions they would prefer." Conversely, Cooper and McLeod (2011, p.5) argue, "even with such direct communication…it can still be difficult for clients to ask for what they want" and they suggest feedback forms as a helpful way of identifying preferences. Bowens and Cooper (2012) highlight a challenge in this, noting that most feedback tools

are designed with outcome in mind, whereas client preferences are clearly in the realm of process feedback. As a result, Cooper & Bowens developed the Therapy Personalisation Form (TPF), which is designed to elicit "a fine-grained understanding of clients' preferences and wants for treatment" (Bowens & Cooper, 2012, p. 48). Early research into therapist experiences of using the TPF noted that therapists found it a helpful way of identifying what clients want from therapy.

On the other hand, in this study, a theme that emerged was the potential negative impact of increased therapist self-criticism and/or of therapists attempting to mould themselves too much, and, as a result, perhaps losing their natural way of being (Bowens & Cooper, 2012). Cooper and McLeod (2011) also suggest that it can be difficult to receive negative feedback from clients. What may be reassuring, when faced with this difficulty, is the "growing evidence that the process of responding to a client's negative feedback… can contribute to the strength of the therapeutic alliance" (Miller, 2012, p.30). As feedback and dialogue with clients about the process of therapy is such an important facet of pluralistic practice, it is useful to examine some of the evidence for this type of feedback. For instance, Miller and colleagues suggest,

When a simple measure of alliance is used in conjunction with a standarized outcome

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measure, available evidence shows clients are less likely to deteriorate, more likely to stay longer and twice as likely to achieve clinically significant change (Miller, Hubble & Duncan, 2008, p.21).

Miller et al., are not alone in their assertion that inclusion of measures improve outcome. Lambert & Vermeersh (2008) argue that therapists who use measures are better at identifying clients who are not improving or who are more likely to drop out of treatment and Bohanskey & Franczak (2010) found that utilisation of such measures reduced cancellation and no-show rates. Arguably, such findings support use of feedback and dialogue with clients. It is to be welcomed that developments in the field are promoting the generation of reciprocal linkages between practitioners and researchers to explore the use of integrative approaches, including pluralism, to improving mental health interventions (Fernández-Álvarez, Consoli, & Gómez, 2016).

Conclusion
A pluralistic framework for counselling and psychotherapy recognizes that psychological distress may have multiple causes and it is improbable that one specific therapeutic approach will be effective in all circumstances. There is also a growing recognition that therapy is rarely "pure-form" in practice or outcome, most therapists routinely incorporate a variety of

methods traditionally associated with diverse systems into their practice, and the therapeutic relationship accounts for more treatment outcome than specific techniques (Geller, Norcross, & Orlinsky, 2005).

Returning to Gordon Paul's classic question in 1967 of what works for whom, it is fair to say that while little progress has been made in more than 45 years of searching, there is wider recognition of the view that there is no one truth, nor is there only one way of accessing possible solutions and insights. While a growing majority of therapists declare themselves integrative, the form this takes would seem to depend on the personal choice of the therapist. Pluralism aims to create dialogue between different modalities; hence it sets the scene for a strengthening and unifying of the profession in Ireland.

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