Cover feature

How can we move beyond ‘schoolism’ towards a paradigm that embraces the full diversity of effective therapeutic methods and perspectives? Mick Cooper and John McLeod propose a ‘pluralistic’ approach

Pluralism: towards a new paradigm for therapy

by
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Increasingly, counsellors and psychotherapists are becoming concerned that we are moving towards a therapeutic ‘monoculture’ in which cognitive-behavioural therapy (CBT) dominates; and in which other therapeutic orientations – such as psychodynamic, person-centred and integrative – are marginalised: freely-available only for clients who actively decline CBT,[1] or in the private and voluntary sectors.

Yet this current threat can be seen as just one manifestation of a deeper trend within the counselling and psychotherapy world towards splitting and dividing, and to pitting one school of therapeutic thought and practice against another. ‘Over the years,’ write Duncan et al,[2] ‘new schools of therapy arrived with the regularity of the Book-of-the-Month Club’s main selection’. Today it is estimated that there are more than 400 different types of therapy,[3] with the majority of practitioners in the UK tending to identify with one or other of these schools.[4]

Undoubtedly, such diversification can foster much growth and creativity in the field. We are now in a position where clients have a vast diversity of practices to choose from, and where forms of therapy are constantly developed and refined to be of as much benefit as possible to clients. And yet, there is also the danger that the development of ‘schools’ can lead to an unproductive ‘schoolism’, in which adherents of a particular orientation become entrenched in the ‘rightness’ of their approach; closed to the value, skills and wisdom of other forms of therapy. Here, practitioners lose out, embroiled in a competitive, hostile and stultifying culture; but, perhaps more importantly, clients can be severely disadvantaged: inducted into therapeutic discourses and practices that may not be most suited to their individual, specific needs and wants.

And, indeed, it is clear from the research that clients do want and need different things. In a recent trial,5 primary care patients were given the option of choosing between non-directive counselling or CBT. Of those patients who opted to choose one of these two therapies, around 40 per cent chose the non-directive option, while 60 per cent chose CBT. Here, it might be argued that what clients want is not necessarily what they need, but a recent review of the literature found that clients who get the therapy they want are likely to do better than those who get a therapy they do not want, and are also much less likely to drop out.[6]

Furthermore, an emerging body of evidence suggests that some ‘types’ of clients do better in one kind of therapy than another. For instance, clients with high levels of resistance and an internalising coping style tend to do better in non-directive therapies; while those who are judged to be non-defensive and who have a predominantly externalising coping style tend to benefit from more technique-orientated approaches.[7]

The development of integrative and eclectic schools
Since the 1930s, psychotherapists and counsellors have attempted to overcome the problems associated

with single orientation therapies by developing more integrative and eclectic approaches. Growth in this field has been particularly marked from the 1970s onwards, such that it can now be claimed that an integrative or eclectic stance is currently the most common theoretical orientation of English-speaking psychotherapists, with around 25–50 per cent of American clinicians identifying in this way.[3] Furthermore, research indicates that practitioners of all orientations – howsoever they identify – tend to integrate into their practice methods from other orientations. For instance, a US-based study found that psychodynamic therapists, on average, strongly endorsed the CBT practice of challenging maladaptive beliefs, while the vast majority of CBT therapists prioritised the person-centred stance of empathy.[8]

In contrast to a schoolist perspective, integrative and eclectic therapists tend to hold that no one school has all the answers, and that different methods may be of help to different clients. Arnold Lazarus,[9] for instance, founder of 'multimodal therapy', writes that the multimodal therapist asks, 'Who or what is best for this particular individual?', and he describes his approach as both 'personalistic' and 'individualistic,' flexibly tailoring the therapeutic method and style of relating to the individual client.

However, there can be a tendency for many of these attempts to transcend singular models of theory and practice to end up replicating something quite similar: albeit with elements synthesised from a variety of sources. Ryle's[10] cognitive analytic therapy (CAT), for instance, outlines a very particular model of personality functioning; while Egan's[11] problem management approach advocates a highly specified set of procedures for helping clients overcome their difficulties. Even multimodal therapy[9, 12] locates itself within a specific theoretical framework – social-cognitive learning theory – and eschews other understandings.

Moreover, in most of these integrative and eclectic approaches, the decision as to which methods or understandings to use tends to be located very much in the therapist, with little or no consultation with the actual client involved. There is no guarantee, therefore, that the particular practices adopted in an integrative or eclectic approach will be any more tailored to the client's particular wants and needs than any other single orientation approach.

Introduction to a pluralistic approach

Against this background, the two of us have been working for the past five years on developing a 'pluralistic' approach to therapy, culminating in the publication of *Pluralistic Counselling and Psychotherapy* in November 2010. This approach is steeped in the humanistic, person-centred and postmodern values which underpin both our approaches, but aims to be a way of practising, researching and thinking about therapy which can embrace, as fully as possible, the whole range of effective therapeutic methods and concepts.

The pluralistic approach starts from the assumption that different things are likely to help different people at different points in time, such that it is meaningless to argue over which is the 'best' way of practising therapy, per se. It can be summed up as a 'both/and' standpoint – that CBT can be helpful, and person-centred therapy can be helpful, and psychodynamic therapy can be helpful – in contrast to an 'either/or' one. As a corollary of this, the pluralistic approach also assumes that it is not just therapists who should decide on the focus and course of therapy – rather, therapists should work closely with their clients to decide on how the work should proceed. The two basic principles underlying this approach can be summarised as follows: (1) Lots of different things can be helpful to clients; (2) If we want to know what is most likely to help clients, we should talk to them about it.

We have come to describe this approach to therapy as 'pluralistic', as the term seems to describe, very fittingly, these two core principles. 'Pluralism' is a word used in a variety of fields, and refers to the

belief that ‘any substantial question admits of a variety of plausible but mutually conflicting responses.’[13] It is a viewpoint that has become increasingly prevalent in the field of philosophy,[14, 15] and which has had a major role in debates within political science and sociology. Pluralism can be contrasted with ‘monism’: the belief that every question has a single and definitive answer. In other words, a pluralist holds that there can be many ‘right’ answers to scientific, moral or psychological questions, which are not reducible to any one, single truth. Central to this standpoint is also the belief that there is no one, privileged perspective from which the ‘truth’ can be known. That is, neither scientists, philosophers, psychotherapists nor any other kinds of people can claim to have a better vantage point on ‘reality’.

In developing this pluralistic approach to psychotherapy and counselling, we have come to find it useful to distinguish between pluralism as a perspective on psychotherapy and counselling, and pluralism as a particular form of therapeutic practice. A pluralistic ‘perspective’, ‘viewpoint’, or ‘sensibility’ refers to the belief that there is no one best set of therapeutic methods. It can be defined as the assumption that different clients are likely to benefit from different therapeutic methods at different points in time, and that therapists should work collaboratively with clients to help them identify what they want from therapy and how they might achieve it. This is a general definition, which does not make any specific recommendations about how a therapist might go about implementing a pluralistic perspective in their own practice.

By contrast, ‘pluralistic practice’ or ‘pluralistic therapy’ refers to a specific form of therapeutic practice which draws on methods from a range of orientations, and which is characterised by dialogue and negotiation over the goals, tasks and methods of therapy. Making this distinction is important because, although pluralistic practice is rooted in a pluralistic viewpoint, it is also quite possible for therapists to hold a pluralistic viewpoint while working in a non-pluralistic, single orientation way (what we refer to as ‘specialised’ practices). Unlike integrative and eclectic approaches, then, the pluralistic approach does not view multi-orientation ways of working as necessarily superior to single-orientation practices: for some clients at some points in time, a purely non-directive approach, or a highly behavioural approach, may be exactly what they need.

The pluralistic framework: goals, tasks and methods

If a pluralistic approach strives to embrace an infinite diversity of therapies, how does it avoid an ‘anything-goes syncretism’: the haphazard, uncritical and unsystematic combination of theories and practices? Clearly, there needs to be some kind of structure, some focal point for thinking about therapy and what might be effective. Coming from a pluralistic philosophical standpoint with its commitment to prioritising the perspective of the client, the pluralistic approach suggests that the focal point for therapy should be, ultimately, what the client wants from it. That is, not the client’s diagnosis, their assessment, or the therapist’s personal beliefs about what is effective in therapy, but the client’s own goals for the therapeutic process. This then sets the basis for what the client and therapist see as the tasks of therapy (ie the different foci, or strategy, of the therapeutic work) and, from this, the specific methods (ie the concrete activities that they will undertake).

For instance, Dave came to therapy with an overall desire to be happier and less anxious. More specifically, he wanted to look at ways in which he could have better relationships with other people (goals). In discussing this with his therapist it became apparent that one thing he might helpfully do was to look at ways of changing his behaviour, so that he might make himself more available for close friendships (tasks). To achieve this, Dave and his therapist talked about the ways that he behaved in social situations, and what he might do differently. Dave reflected on how he might come across to others, and his therapist gave him feedback on how he perceived him (methods).

Collaborative dialogue

This goal-task-method framework provides a means for therapists to think about what kind of therapeutic practices may be most helpful to a particular client and, indeed, whether or not they have the appropriate methods to help a particular client reach their goals. Of equal importance, however, is that it highlights three key domains in which collaborative activity can take place within the therapeutic relationship.

Haruki, for instance, was a student in his first year at university who suffered from 'performance anxiety' – a crippling fear of speaking (or even worse, presenting a paper) in a tutorial group or seminar. When he came to see John, he was clear that his life as a whole was satisfactory, and that all he wanted from counselling was to achieve his goal of 'being able to take part in seminars'. After some discussion, it appeared that there were three main therapeutic tasks to be tackled for Haruki to achieve his goal: (a) making sense of why this pattern had developed – Haruki did not want a 'quick fix', but felt that he needed to have an understanding of the problem in order to prevent it re-occurring in the future; (b) learning how to control the powerful and debilitating panic that overcame him in seminars; and (c) moving beyond just 'coping', and having a positive image of how he might actually be successful and do well as a 'presenter'. As counselling proceeded, each of these three themes tended to be focused on in separate sessions.

During one of the early sessions that focused on the task of dealing with his panic feelings, John and Haruki talked about the ways that Haruki thought it might be possible for them to address this issue (methods). Haruki began by saying that the only thing that came to mind was that he believed he needed to learn to relax. John asked him if there were any other situations that were similar to performing in seminars, but which he was able to handle more easily. He told John that he remembered that he always took the penalties for his school soccer team, and dealt with his anxieties by running through in his mind some advice from his grandfather about following a fixed routine. John then asked if he would like to hear some of John's suggestions about dealing with panic. John emphasised that these were only suggestions, and that it was fine for him to reject them if they did not seem useful. John mentioned three possibilities. One was to look at a model of panic as a way of understanding the process of losing emotional control. The second was to use a two-chair method to explore what he was saying to himself at panic moments. The third was to read a self-help booklet on overcoming panic. Haruki thought all of these methods had potential value for him. Over the next two sessions, Haruki and John tried out each method, along with suitable homework tasks. Haruki fairly quickly became a lot more confident in seminars.

Conclusion

As a development of integrative and eclectic perspectives, our hope is that the pluralistic approach can help the counselling and psychotherapy field move towards a greater appreciation of all our potentialities; such that, as a community, we can provide therapeutic interventions that are more closely tailored to the specific needs and wants of the clients that we work with. Our vision is to create a research-, theory-and-practice-informed 'open source' repository of information – a 'Wikitherapy' – which outlines all the different methods by which clients might be helped to achieve their goals; acknowledging that some methods may be more helpful for more clients more of the time, but that a vast range of practices still have the potential to be of benefit. More than that, we hope that a pluralistic outlook can help us move beyond the many false dichotomies that plague our field: 'Is it the relationship that heals?' 'Does CBT just provide a short-term "fix"?' 'Do antidepressants work?' From a pluralistic standpoint, these are just the wrong questions to be asking: it depends on the particular client at the particular point in time.

Of course, without doubt, there are already many counsellors and psychotherapists who think and practise in pluralistic ways – perhaps the majority – but they have always tended to be over-shadowed in

the literature and research by more singular, uni-modal thought and practice. Perhaps that is because of the human desire for simplicity: the idea that ‘x is caused by y’ may always be more appealing than the idea that ‘x is sometimes caused by y, but sometimes by z, and w seems to be important some of the time, but we are not really sure.’

And yet, perhaps now more than ever, there is a need for those who hold a pluralistic vision to articulate it as fully as possible, and to look at how it can be developed and applied through research, training, supervision and practice. As William Connolly,[14] political scientist and author of Pluralism writes, ‘Tolerance of negotiation, mutual adjustment, reciprocal folding in, and relational modesty are, up to a point, cardinal values of deep pluralism. The limit point is reached when pluralism itself is threatened by powerful unitarian forces that demand the end of pluralism.’ Here, he states, ‘a militant assemblage of pluralists’ is required to resist such forces, to ensure that diversity, mutual respect and an appreciation of each person’s uniqueness can continue to flourish.

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References:

1. National Institute for Health and Clinical Excellence. Depression: the treatment and management of depression in adults (update). London: National Institute for Health and Clinical Excellence; 2009.
2. Duncan BL, Miller SD, Sparks JA. The heroic client: a revolutionary way to improve effectiveness through client-directed, outcome-informed therapy. San Fransisco: Jossey-Bass; 2004.
3. Norcross JC. A primer on psychotherapy integration. In Norcross JC, Goldfried MR (eds) Handbook of psychotherapy integration. New York: Oxford University; 2005.
4. Couchman A. Personal communication; 2006.
5. King M, Sibbald B, Ward E, Bower P, Lloyd M, Gabbay M et al. Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy and usual general practitioner care in the management of depression as well as mixed anxiety and depression in primary care. Health Technology Assessment. 2000; 4(19):1-83.
6. Swift JK, Callahan JL. The impact of client treatment preferences on outcome: a meta-analysis. Journal ?of Clinical Psychology. 2009; 65(4):368-381.
7. Cooper M. Essential research findings in counselling and psychotherapy: the facts are friendly. London: Sage; 2008.
8. Thoma NC, Cecero JJ. Is integrative use of techniques in psychotherapy the exception or the rule? Results of a national survey of doctoral-level practitioners. Psychotherapy. 2009; 46(4):405-417.
9. Lazarus AA. Multimodal therapy. In Norcross JC, Goldfried MR (eds) Handbook of psychotherapy integration. New York: Oxford University; 2005.
10. Ryle A. Cognitive analytic therapy: active participation in change. Chichester: Wiley; 1990.
11. Egan G. The skilled helper: a problem-management approach to helping. Belmont, CA: Brooks/Cole; 1994.
12. Lazarus AA. The practice of multimodal therapy. Baltimore: John Hopkins University; 1981.
13. Rescher N. Pluralism: against the demand for consensus. Oxford: Oxford University; 1993.
14. Berlin, I. Two concepts of liberty. In Hardy H (ed) Liberty. Oxford: Oxford University; 2002.
15. Connolly WE. Pluralism. Durham: Duke University; 2005.

Article quotes

‘The pluralistic approach starts from the assumption that different things are likely to help different people at different points in time’

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"<p>For several years now I have been of the view that when it comes to creating psychological change or emotional wellbeing, some things work for some people some of the time: this could be psychoanalysis, group therapy, a self-help website or a walk in the countryside</p>"