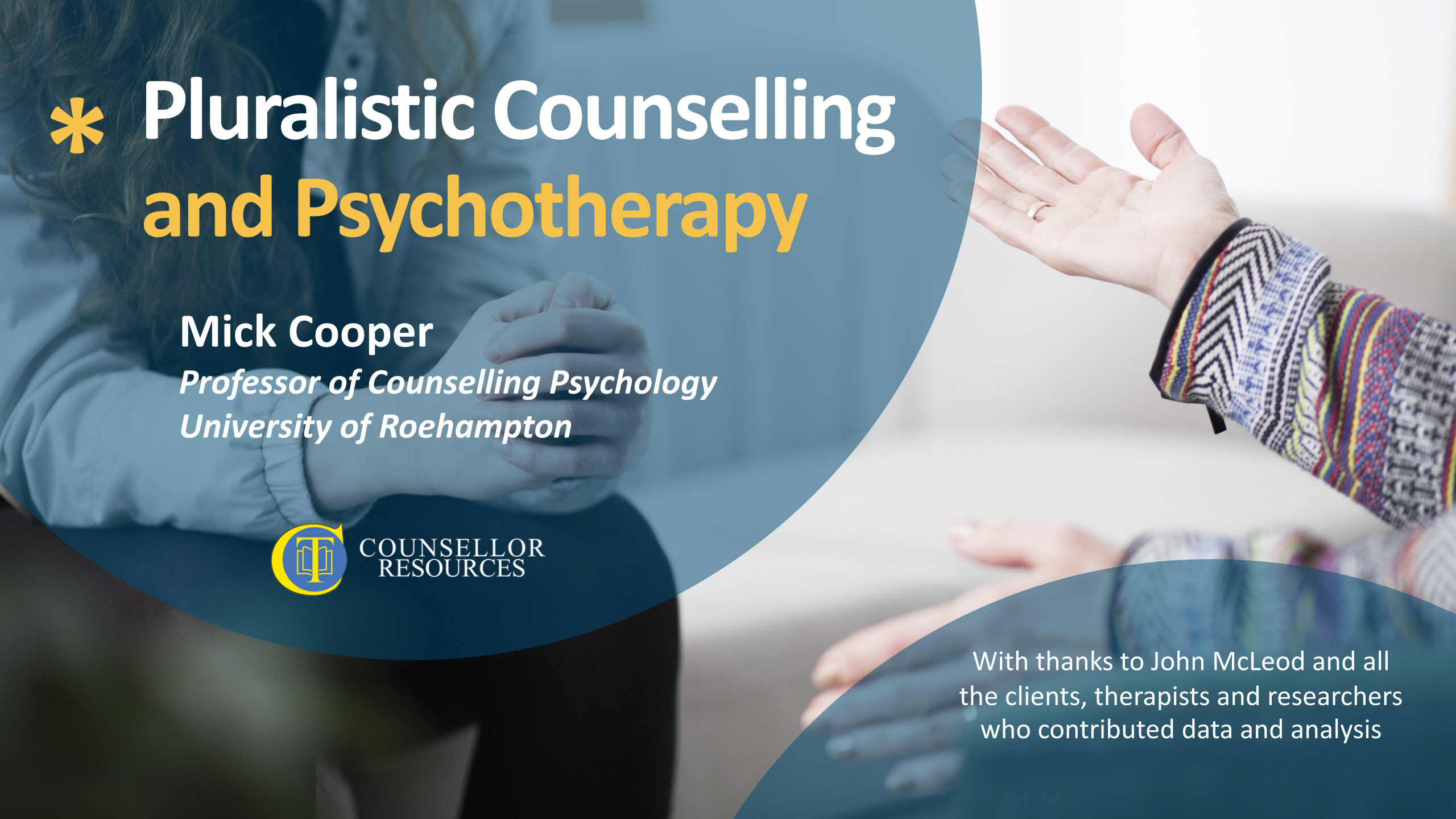

* Pluralistic Counselling and Psychotherapy

Mick Cooper

Professor of Counselling Psychology

University of Roehampton

COUNSELLOR RESOURCES

With thanks to John McLeod and all the clients, therapists and researchers who contributed data and analysis

* Aims and Objectives

AIM: To introduce the Pluralistic Approach both as a perspective on counselling and psychotherapy, and as a way of working with clients

- ✓To help you gain a good understanding of what Pluralistic Therapy is about and how to apply it in your own supervision and practice

Background

2006: Tayside Centre for Counselling

John McLeod, with Mick Cooper, Julia McLeod and colleagues, set up Tayside Centre for Counselling (TCC).

TCC offers free one-to-one counselling for people facing a range of issues.

The TCC is research-active, so clients who attend agree to be part of a research project which aims to explore the ways in which counselling can help those experiencing emotional and psychological problems.

COUNSELLOR RESOURCES

Counselling and Psychotherapy Research, September 2007; 7(3): 135–143

ORIGINAL ARTICLE

A pluralistic framework for counselling and psychotherapy: Implications for research

MICK COOPER[1] & JOHN MCLEOD[2]

[1]*Counselling Unit, University of Strathclyde, Glasgow and* [2]*Tayside Institute for Health Studies, University of Abertay Dundee, Scotland*

Abstract

Historically, training, research and practice in counselling and psychotherapy have been dominated by unitary theoretical models. Although integrative and eclectic positions have been developed as alternatives, these have not been successful in generating research and have resulted in a further proliferation of competing models. In this paper we introduce a 'pluralistic' framework for counselling and psychotherapy and discuss the implications of this framework for research. The basic principle of this pluralistic framework is that psychological difficulties may have multiple causes and that there is unlikely to be one, 'right' therapeutic method that will be appropriate in all situations—different people are helped by different processes at different times. This pluralistic framework operates as a meta-theory within which it is possible to utilise concepts, strategies and specific interventions from a range of therapeutic orientations. The framework is structured around three domains—goals, task and methods—by which therapeutic processes can be conceptualised, critically examined and empirically investigated. These domains, and the relationships between them, are outlined and the collaborative relationship at the heart of the pluralistic framework is discussed. The pluralistic framework provides a means for empirical research directly to inform practice and potential lines of empirical inquiry are outlined, along with findings from a recent study of counselling in schools.

Keywords: *Counselling, pluralism, psychotherapy, research, theory*

> [W]e were struck by the 'either/or' position that many researchers and clinicians seem to take with regard to the variable(s) responsible for change. While some authors seemed to emphasise the importance of relationship above all, others focused on the effects of participant (therapist or patient) factors, and still others drew attention to the salience of certain treatment procedures and models. It struck us that all of these groups of scholars had lost sight of the possibility that relationship, participant factors, *and* treatment procedures were effective and interactive; that the conjunction should be 'and' not 'or' when describing the things that produce change (Castonguay & Beutler, 2006, p. v).

From 2002 to 2004, two of the key international figures in current psychotherapy research, Louis Castonguay and Larry Beutler, chaired a task force charged by the American Psychological Association and the North American Society for Psychotherapy Research with the task of identifying the effective principles of psychotherapeutic change. Their conclusion, above, was that there are *many things* that produce change. However, even if it is accepted, in principle, that therapy should be practiced in a way that is open to multiple pathways of change, the question remains: *how* are we to accomplish this?

Within the UK, unitary models of counselling and psychotherapeutic theory and practice continue to dominate. Within the BACP, less than 25% of therapists are trained in an integrative approach (Couchman, 2006, personal communication); the UK Council for Psychotherapy has recently re-structured along model-specific lines. An orientation-based conceptualisation of counselling and psychotherapy is also apparent in recent UK government directives, with Department of Health and National Institute for Health and Clinical Excellence Guidelines explicitly recommending particular therapeutic orientations for particular forms of psychological distress (Department of Health, 2001). However, many commentators have pointed toward basic weaknesses in unitary models of theory and practice (Feltham, 1997; Hollanders, 1999, 2003; Norcross & Grencavage, 1989). In particular, the pervasive finding that different therapeutic orientations are equivalent in their effectiveness (Wampold, 2001) suggests that no single therapeutic approach has a superior grasp of the truth.

In response to these challenges, some psychotherapists and counsellors have moved towards more integrative approaches to theory and practice. Stricker

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1473-3145 (print)/1746-1405 (online)
DOI: 10.1080/14733140701566282

2007:

First paper on 'pluralistic' framework

2007: Development of training courses

Abertay, Glasgow Caledonian, UEL, Manchester, IICP

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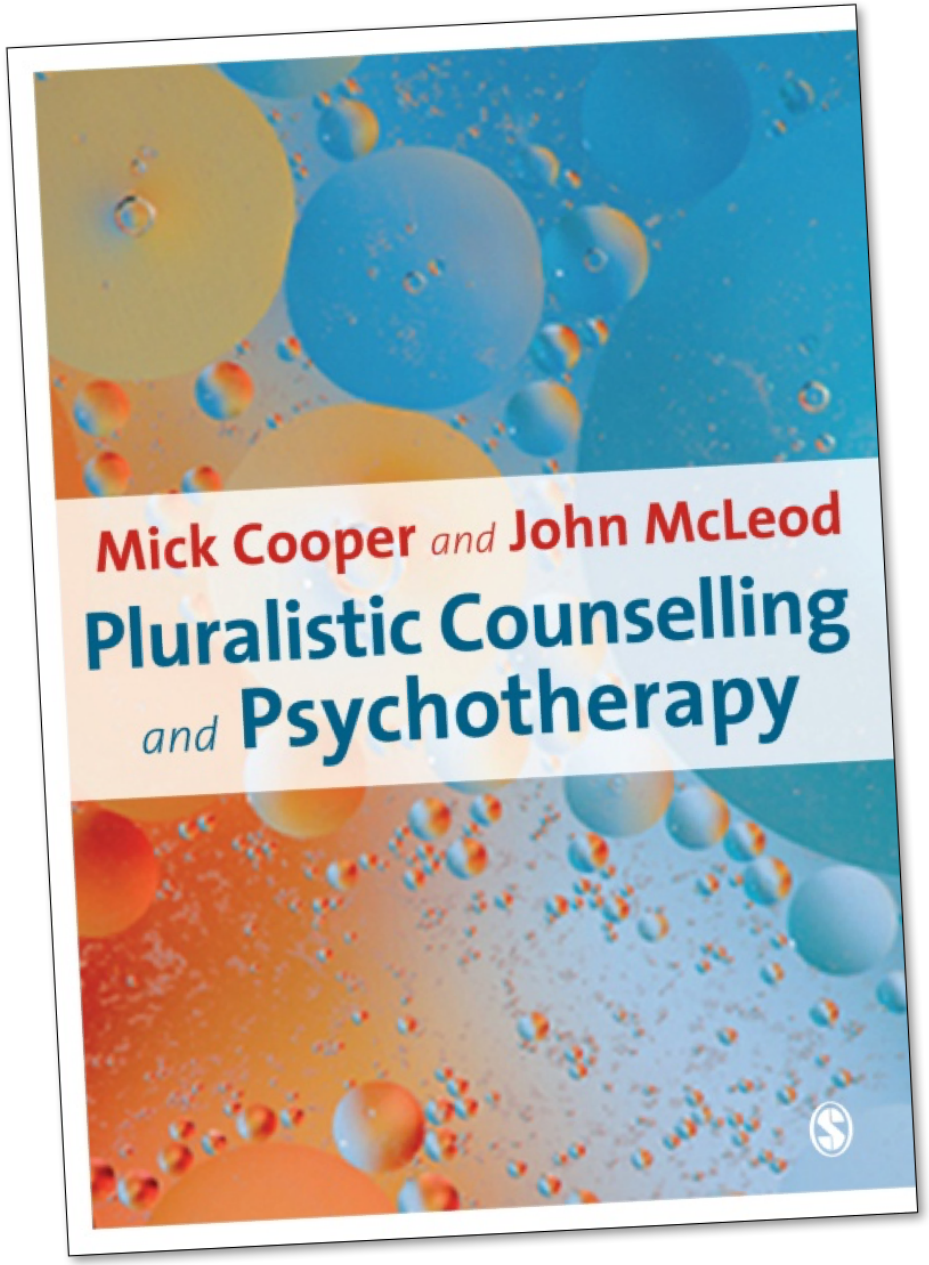


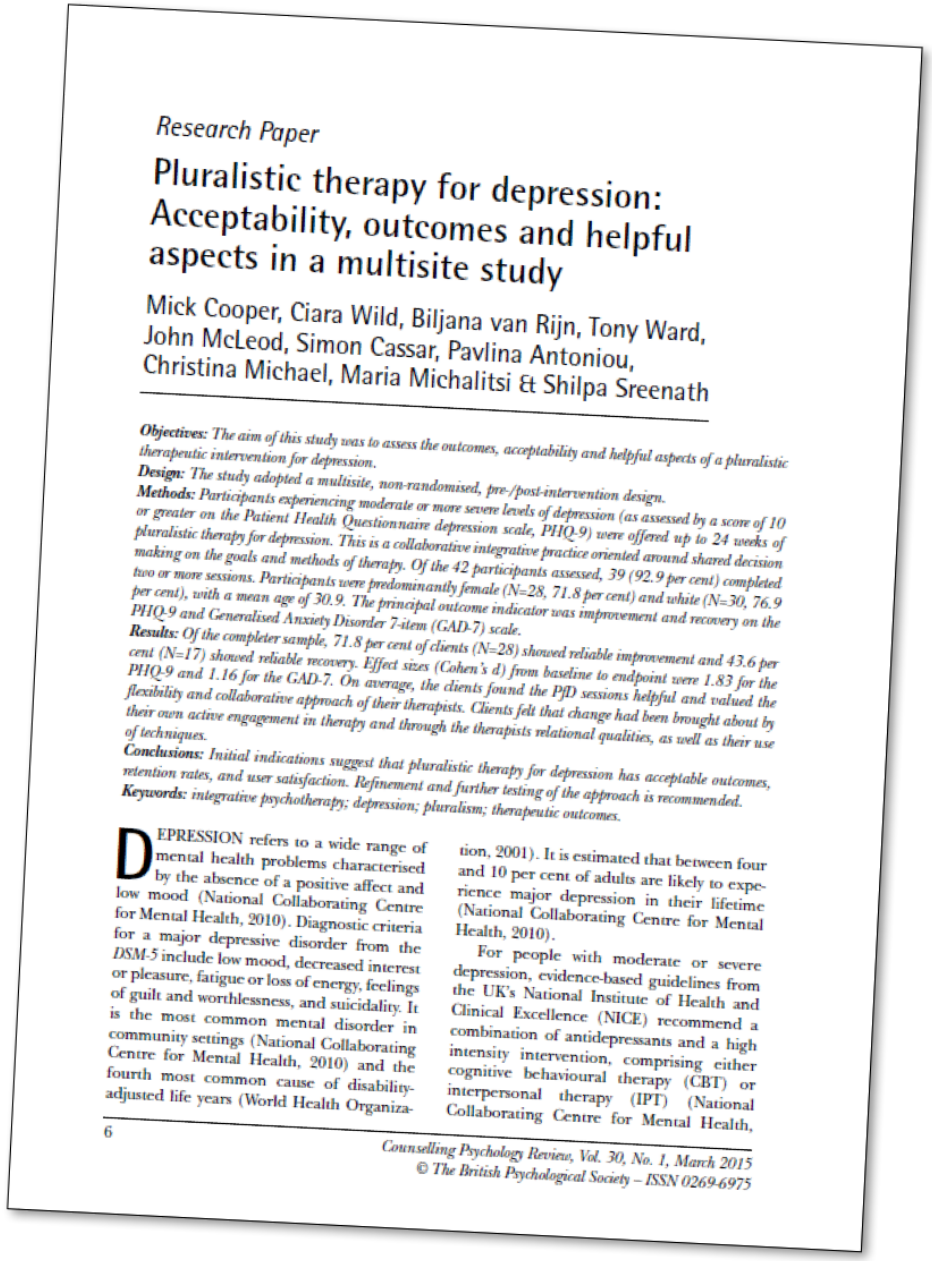
2011:

Our first book

COUNSELLOR RESOURCES

2013-2015:

Pluralistic therapy for depression study, funded by BPS



Research Paper

Pluralistic therapy for depression: Acceptability, outcomes and helpful aspects in a multisite study

Mick Cooper, Ciara Wild, Biljana van Rijn, Tony Ward, John McLeod, Simon Cassar, Pavlina Antoniou, Christina Michael, Maria Michalitsi & Shilpa Sreenath

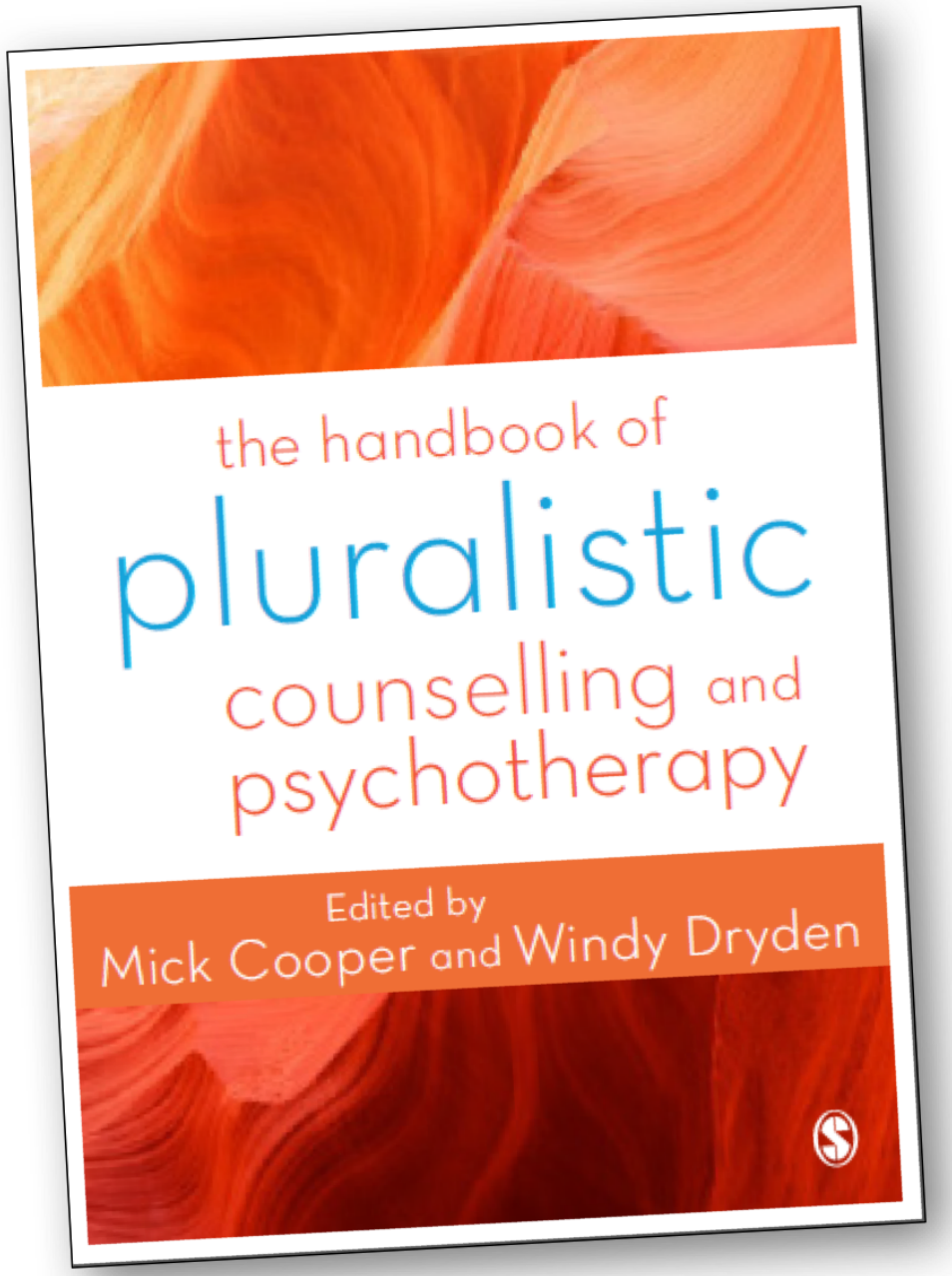
Objectives: *The aim of this study was to assess the outcomes, acceptability and helpful aspects of a pluralistic therapeutic intervention for depression.*
Design: *The study adopted a multisite, non-randomised, pre-/post-intervention design.*
Methods: *Participants experiencing moderate or more severe levels of depression (as assessed by a score of 10 or greater on the Patient Health Questionnaire depression scale, PHQ-9) were offered up to 24 weeks of pluralistic therapy for depression. This is a collaborative integrative practice oriented around shared decision making on the goals and methods of therapy. Of the 42 participants assessed, 39 (92.9 per cent) completed two or more sessions. Participants were predominantly female (N=28, 71.8 per cent) and white (N=30, 76.9 per cent), with a mean age of 30.9. The principal outcome indicator was improvement and recovery on the PHQ-9 and Generalised Anxiety Disorder 7-item (GAD-7) scale.*
Results: *Of the completer sample, 71.8 per cent of clients (N=28) showed reliable improvement and 43.6 per cent (N=17) showed reliable recovery. Effect sizes (Cohen's d) from baseline to endpoint were 1.83 for the PHQ-9 and 1.16 for the GAD-7. On average, the clients found the PfD sessions helpful and valued the flexibility and collaborative approach of their therapists. Clients felt that change had been brought about by their own active engagement in therapy and through the therapists relational qualities, as well as their use of techniques.*
Conclusions: *Initial indications suggest that pluralistic therapy for depression has acceptable outcomes, retention rates, and user satisfaction. Refinement and further testing of the approach is recommended.*
Keywords: *integrative psychotherapy; depression; pluralism; therapeutic outcomes.*

DEPRESSION refers to a wide range of mental health problems characterised by the absence of a positive affect and low mood (National Collaborating Centre for Mental Health, 2010). Diagnostic criteria for a major depressive disorder from the *DSM-5* include low mood, decreased interest or pleasure, fatigue or loss of energy, feelings of guilt and worthlessness, and suicidality. It is the most common mental disorder in community settings (National Collaborating Centre for Mental Health, 2010) and the fourth most common cause of disability-adjusted life years (World Health Organization, 2001). It is estimated that between four and 10 per cent of adults are likely to experience major depression in their lifetime (National Collaborating Centre for Mental Health, 2010).

For people with moderate or severe depression, evidence-based guidelines from the UK's National Institute of Health and Clinical Excellence (NICE) recommend a combination of antidepressants and a high intensity intervention, comprising either cognitive behavioural therapy (CBT) or interpersonal therapy (IPT) (National Collaborating Centre for Mental Health,

Counselling Psychology Review, Vol. 30, No. 1, March 2015

COUNSELLOR RESOURCES



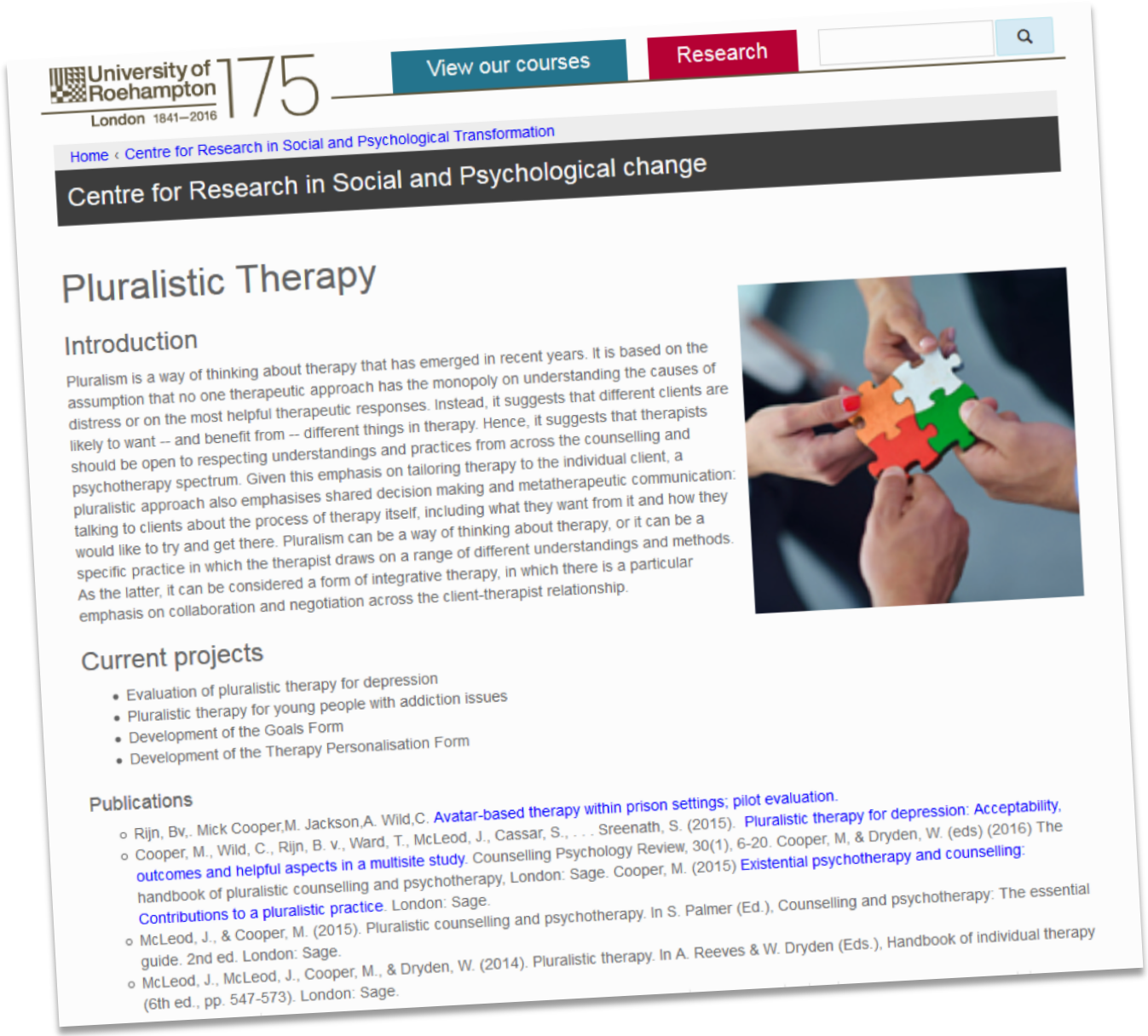
2016:

Our most recent handbook

COUNSELLOR RESOURCES

2018

COUNSELLOR RESOURCES



Around 40 book chapters and journal articles to date

www.pluralistictherapy.com

COUNSELLOR RESOURCES

Beyond Schoolism

COUNSELLOR RESOURCES

* Beyond ‘Schoolism’

- ✓History of therapy characterised by emergence of ‘schools’
- ✓Often segue into ‘schoolism’ and dogmatism: assumed monopoly of truth on aetiology and treatment of problems for all

Pressures in healthcare systems towards therapeutic monoculture:

One size fits all

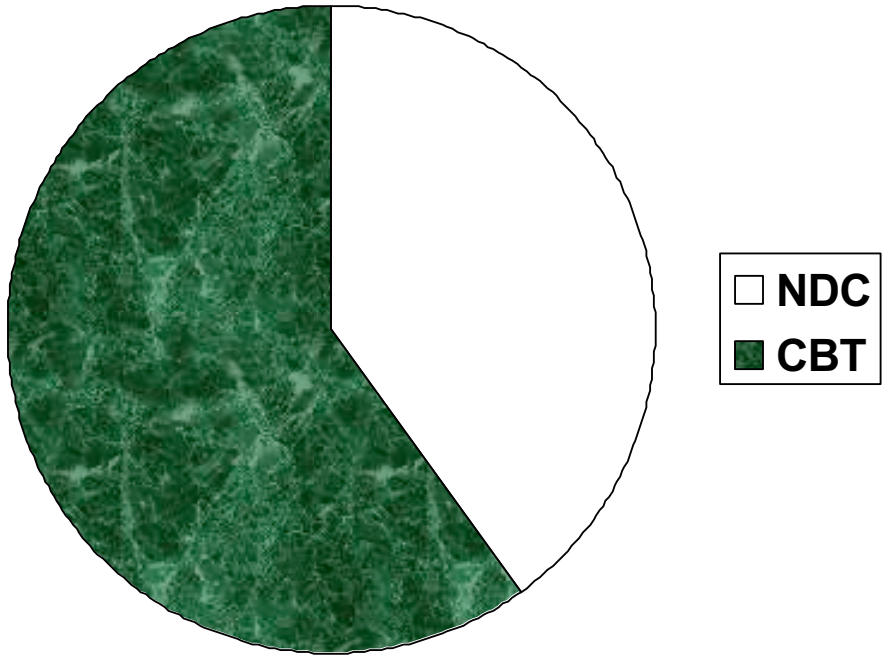
COUNSELLOR RESOURCES

The Evidence Base

COUNSELLOR RESOURCES

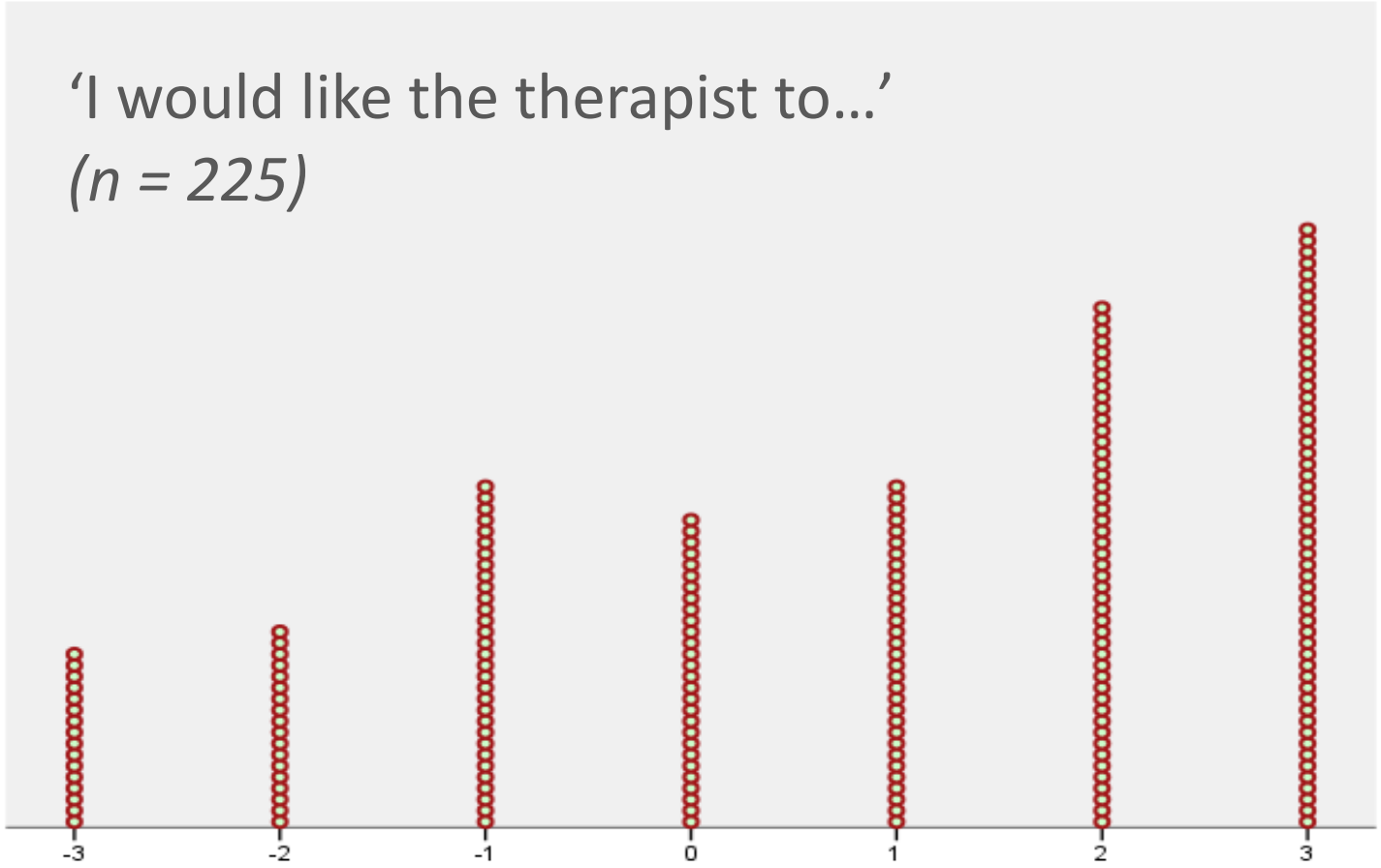
* Different clients want different things

Do depressed clients in primary care want non-directive counselling or cognitive-behaviour therapy (King et al 2000)?



COUNSELLOR RESOURCES

Research indicates wide variations in client preferences, e.g., Level of structure



Allow the therapy to be *unstructured*

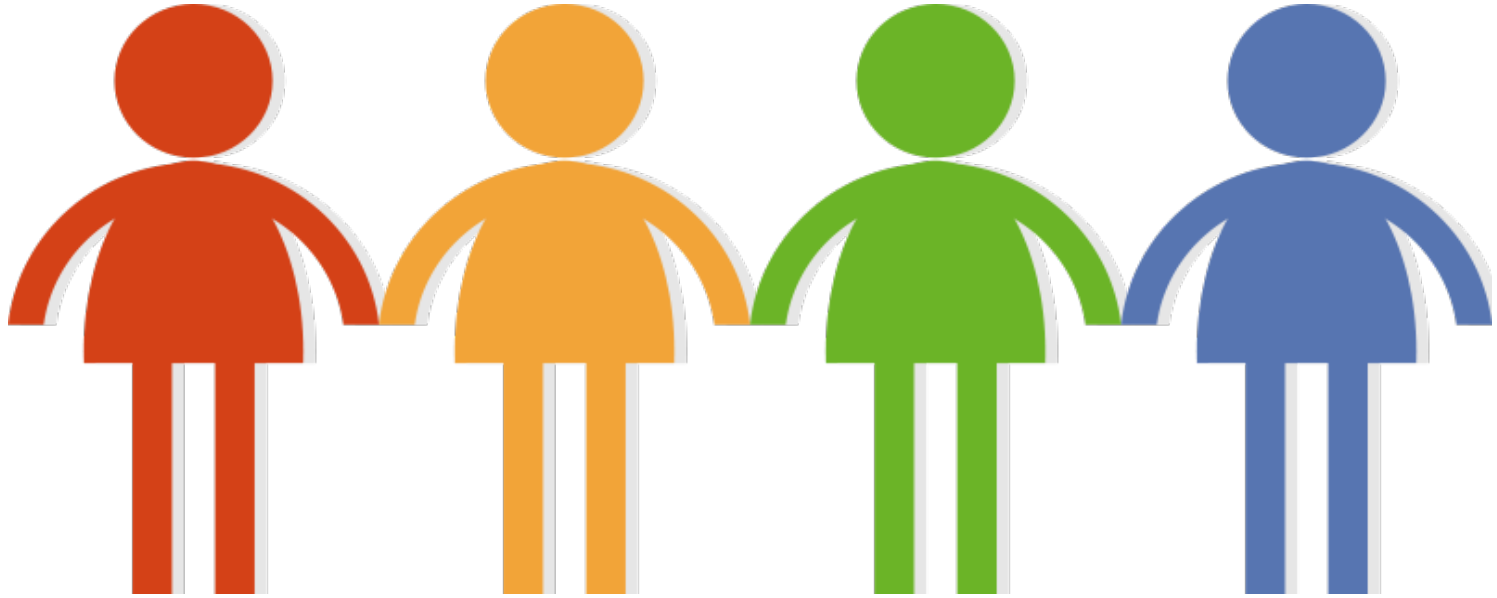
Give *structure* to the therapy

COUNSELLOR RESOURCES

Clients do better in their preferred therapies

Clients who receive their preferred treatment:

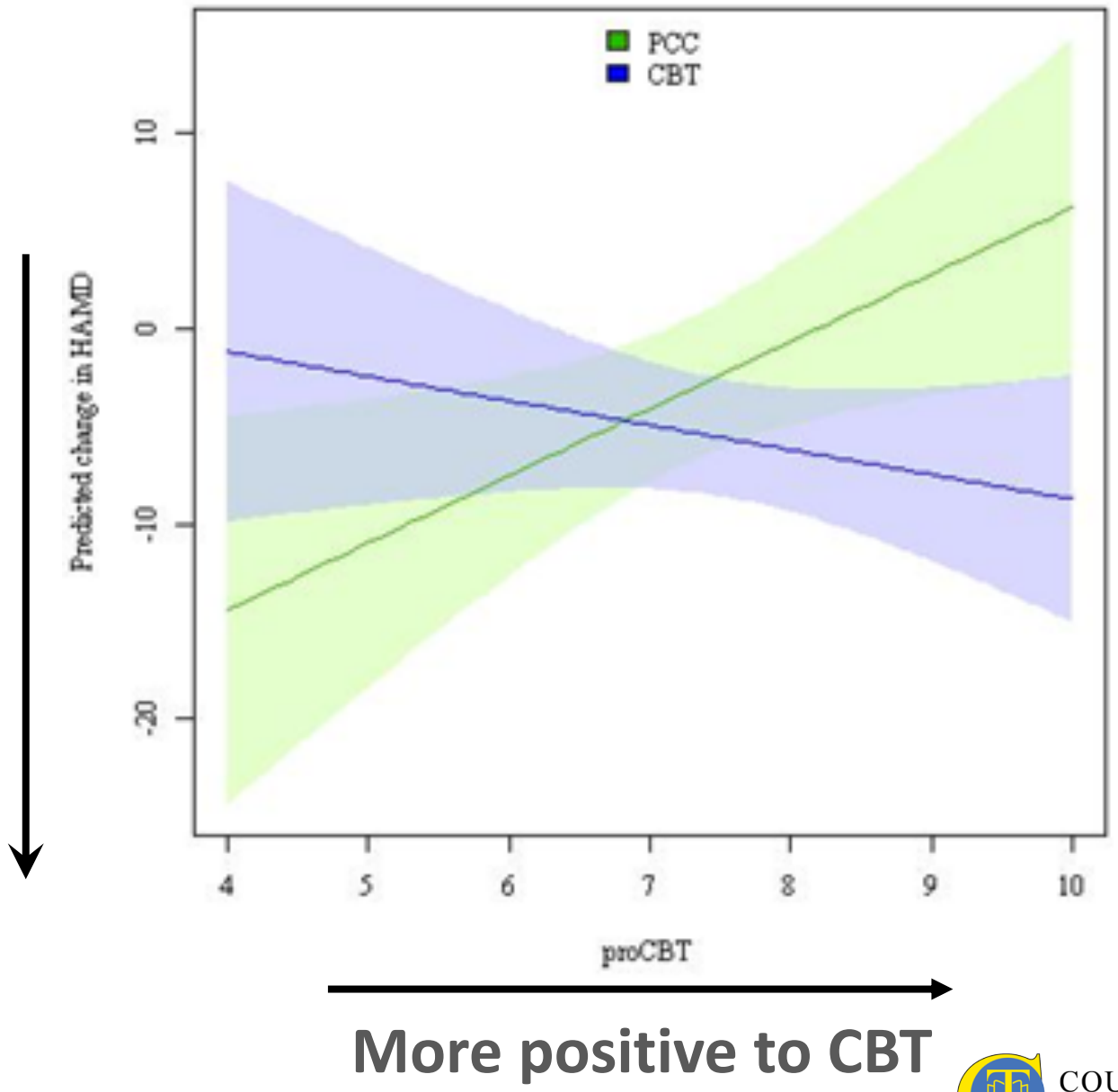
- ✓Small increase in outcomes
- ✓33%-50% less likely to drop out of therapy



Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S. R. (2019). Preferences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (3rd ed.). NY: Oxford University.

Improvements in CBT and PCC by attitude towards CBT

Cooper, M., Messow, C.-M., McConnachie, A., Freire, E., Elliott, R., Heard, D., . . . Morrison, J. (2017). Patient preference as a predictor of outcomes in a pilot trial of person-centred counselling versus low-intensity cognitive behavioural therapy for persistent sub-threshold and mild depression. *Counselling Psychology Quarterly, 1-17. doi: 10.1080/09515070.2017.1329708*



COUNSELLOR RESOURCES

Core Principles

COUNSELLOR RESOURCES

* Aim

- ✓An attempt to transcend schoolism in all its forms (including a ‘pluralistic schoolism’) and re-orientate therapy around clients’ wants and client benefit

- ✓Maintaining a critical, self-reflective stance towards our own theoretical and personal assumptions

* From either/or to both/and

The pluralistic approach strives to transcend ‘black-and-white’ dichotomies in the psychotherapy and counselling field, so that we can most fully engage with our clients in all their complexity and individuality

Practice A

Practice B

COUNSELLOR RESOURCES

Relationship

Techniques

COUNSELLOR RESOURCES

Single-orientation

Integrative/Eclectic

* Basic assumption 1

Lots of different things can be helpful to clients

Pluralism across practices

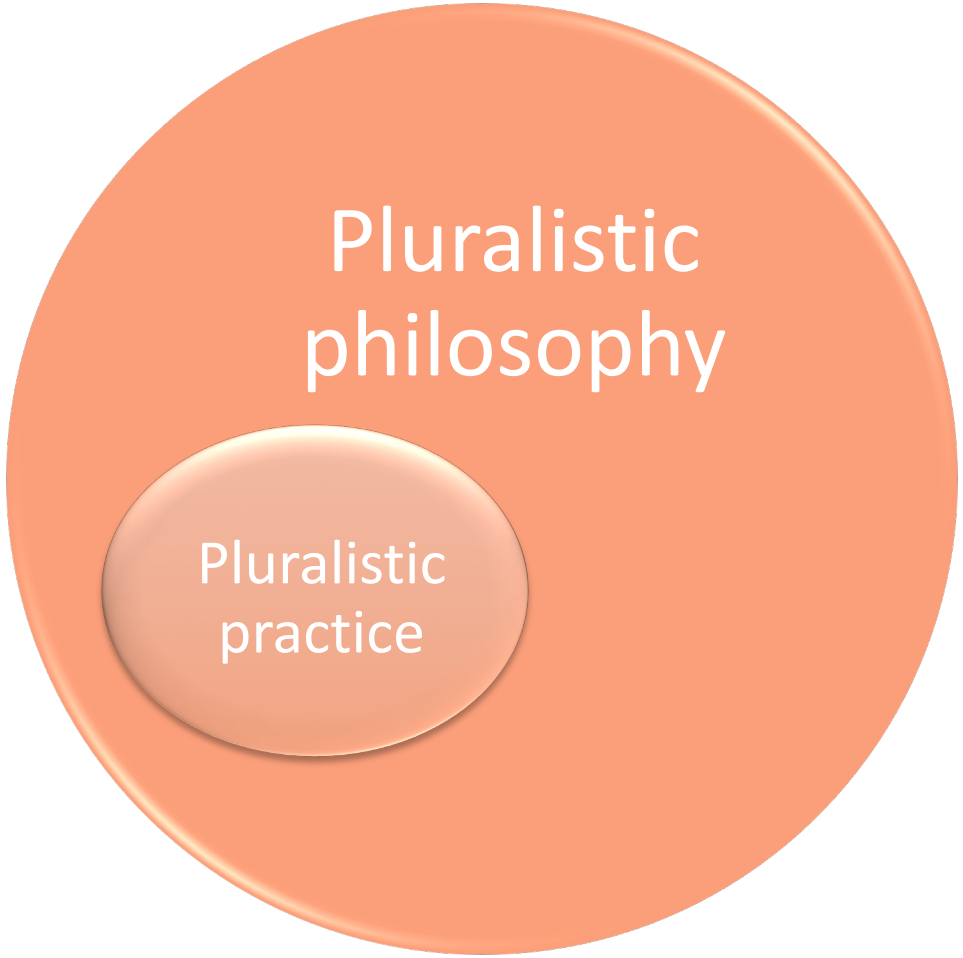
COUNSELLOR RESOURCES

* Basic assumption 2

If we want to know what is going to help clients, let's discuss it with them

Pluralism across therapeutic dyad

Pluralism can be both a general attitude, and a specific practice



* Pluralistic philosophy

The *belief* that different clients are likely to benefit from different things at different points in time

Example items from the Therapy Pluralism Inventory

- ✓I believe that lots of different therapeutic approaches have much to offer
- ✓I do not believe that there is any one, “best” therapeutic orientation
- ✓I think that there is one approach that suits most clients (reversed)

* Pluralistic practice

Adopt a personally tailored approach with each client, including:

- involving clients in conversations about the therapeutic process
- ensuring that the therapeutic approach is suitable from the client's perspective, and
- tailoring therapy to the individual

* Pluralistic practice

Example items from the Therapy Pluralism

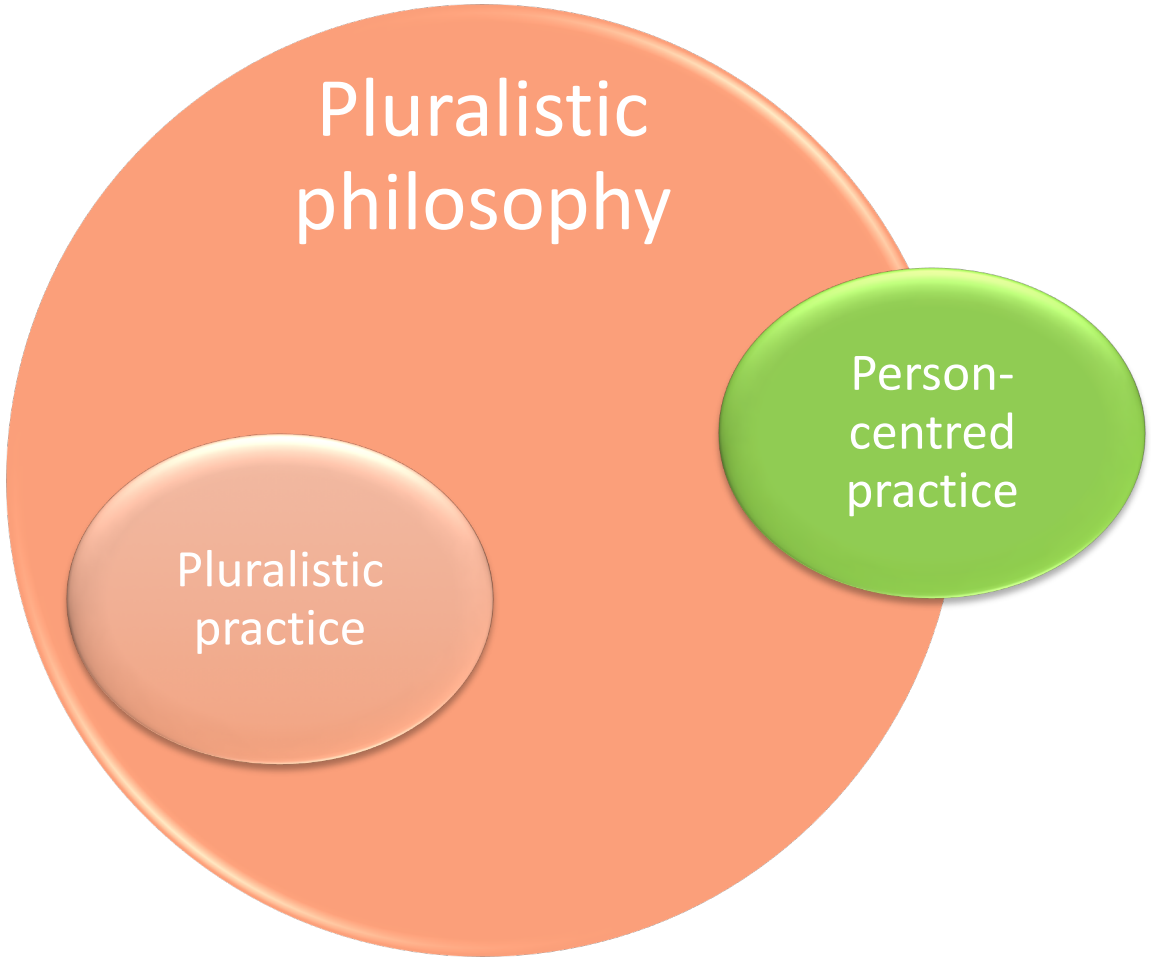
- ✓ I explore with my clients the various ways we could work toward their goals
- ✓ I tailor the way that I work to each individual client
- ✓ I work collaboratively with my clients to agree the direction for therapy

Thompson, A., Cooper, M., & Pauli, R. (2017). Development of a therapists' self-report measure of pluralistic thought and practice: the Therapy Pluralism Inventory. *British Journal of Guidance & Counselling, 45(5), 489-499. doi: 10.1080/03069885.2017.1373745*

COUNSELLOR RESOURCES

Distinction between two domains is important, as can hold a pluralistic attitude, without extensive tailoring of practices:

correlation = .19 (3.6% overlap)



COUNSELLOR RESOURCES

But isn’t pluralism just the same as integrative / eclectic therapy?

COUNSELLOR RESOURCES

Pluralistic practice = collaborative integrative practice, but…

1. Some forms of integration (esp. theoretical integration) can be schools in themselves

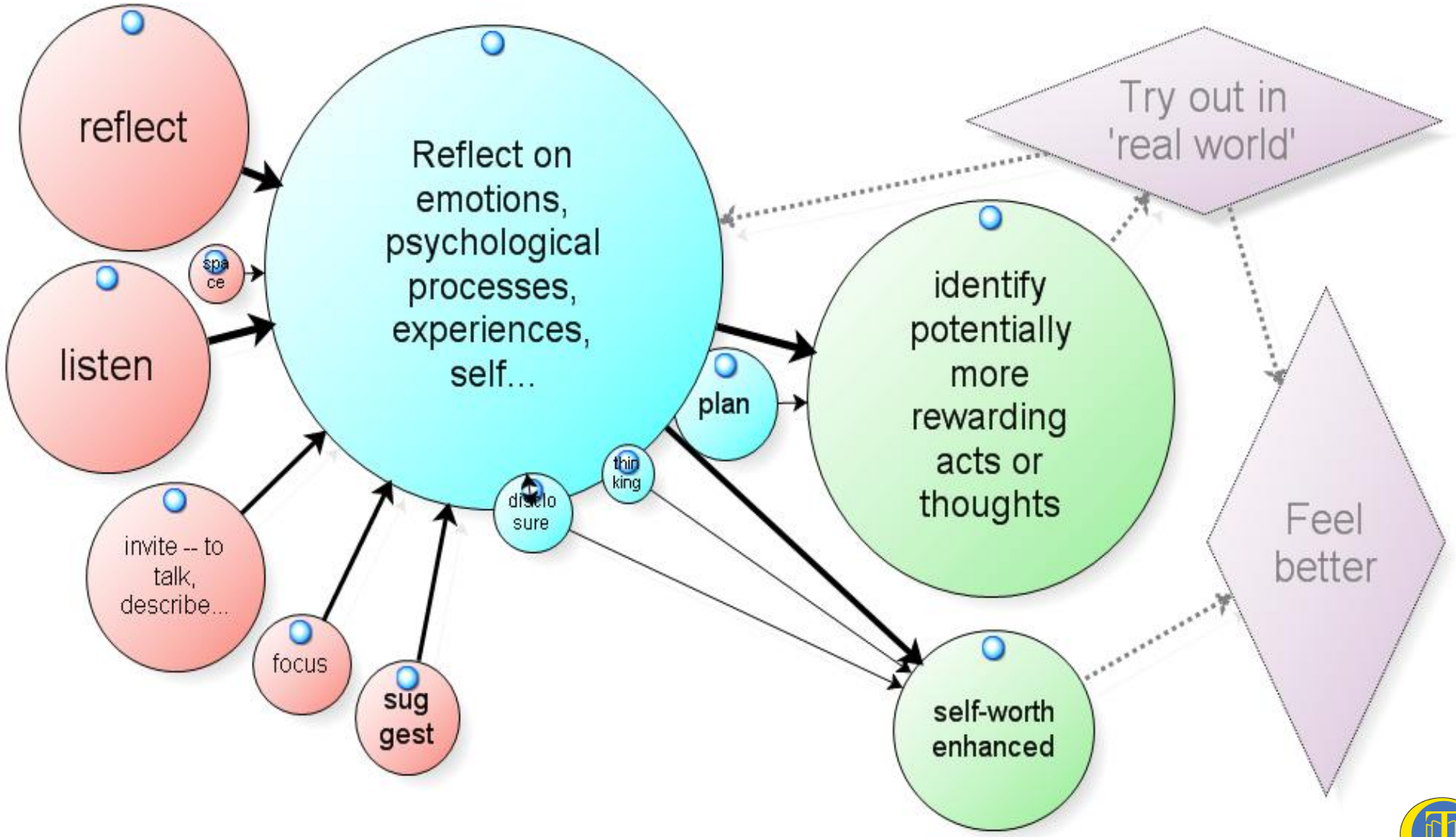
2. Pluralism can be a general attitude, without involving extensive tailoring of practices

3. Integration/eclecticism, per se, does not necessarily have a collaborative emphasis: pluralistic practice is a form of integrative therapy specifically oriented around shared decision-making

Pluralistic practice starts by being clear about what we can offer clients

COUNSELLOR RESOURCES

What I (think I) offer clients



COUNSELLOR RESOURCES

MAKING THE MOST OF YOUR THERAPY

An information sheet for clients

Thank you for your interest in our service.

Therapy is an opportunity to work on things in your life, and to find more satisfying and rewarding ways of living. Research shows that therapy can be very helpful for many people, and that most clients leave counselling or psychotherapy feeling much better than when they started. However, research also shows that the more clients know about therapy before they start, and the more they put into it, the more they are likely to get out of it. For this reason, we have provided an information sheet to tell you about the therapy we offer, and how you can make it as helpful as possible for you.

A therapy 'menu'

At our service, there are many different ways in which we can help you. We like to think of ourselves as providing you with a therapy 'menu', so that you can decide, with our support, what you would most like to work on. Some of the issues that clients often choose to focus on are:

- talking through an issue in order to make sense of what has happened, and to put things in perspective;
- making sense of a specific problematic event that sticks in your mind;
- problem-solving, planning and decision-making;
- changing behaviour;
- negotiating a life transition or developmental crisis;
- dealing with difficult feelings and emotions;
- finding, analysing and acting on information;
- undoing self-criticism and enhancing self-care;
- dealing with difficult or painful relationships.

Often, clients find it most helpful to work on these issues on a step-by-step basis. In all probability, the problem that you bring to therapy will be fairly complex – there will be different aspects of it. What can happen, when someone is trying to deal with a problem on their own, is that all of these different aspects can get mashed together in their head. One of the ways that therapy may help is that your therapist can work with you to disentangle the various strands of the problem, and help you to decide what needs to be dealt with first.

A flexible, personalised approach to helping you

The therapy that we offer is based on the belief that people who come for therapy are experts on their own lives (even if they don't feel like they are), who have lots of potentially good ideas about how to deal with their problems. One of the main roles of a therapist, as we see it, is to help the person to make best use of their own experience and understanding.

This means that our approach to therapy (we call it a 'pluralistic approach') is to try to be as *flexible* as possible in responding to your needs. What we find (this is backed up by research) is that different people are

helped in different ways. For instance, What some people find most helpful in their therapy is to express their feelings – sadness, anger, fearfulness. Other people find it more helpful to take a rational approach to their problems, and use the therapy to 'think things through'. People can shift, over the course of therapy, from finding one kind of activity to helpful, to then preferring to work in a different way with their therapist.

We also try to be as flexible as possible around the practical arrangements for therapy. Most people attend for a one-hour session at the same time each week. For other people, this kind of arrangement may not fit with their lifestyle or their emotional needs. Please feel free to discuss with your therapist if you want to meet more often or less often, or for longer or shorter sessions. There may be constraints on what the therapist can offer, in terms of their schedule and the availability of therapy rooms, but they will do their best to accommodate your needs. Flexibility can involve the choice of therapist. Some people may only feel comfortable talking to a man, or a woman, or someone from the same ethnic group, etc. If you start with one therapist, and then start to feel – for whatever reason – that this is not the right person for you, then it is fine to mention this to your therapist. They will then do their best to find you another therapist who would be better for you.

Flexibility also applies to the *number* of therapy sessions that you receive. Some people come for one or two sessions, and find that this is enough to put them 'on the right track'. Other people attend therapy for many months. What is important is to do what is best for you, personally. One of the options is what we call *intermittent therapy* – if you have some sessions and then want to stop, you can always come back at any time in the future, and pick up where you left off.

The following sections look at some ways you can prepare yourself to get the most benefit from the therapy you receive.

1. Thinking about what you want from therapy

It is important for your therapist to know what it is that you want to achieve in therapy – what your goals are. Your goals are a kind of 'contract' or agreement between you and the therapist, which specify what you want from him or her. If you go to a furniture store to buy a new sofa, then the visit will have failed if you come home with a new bed, or a carpet, no matter how attractive these objects might be. It is the same in therapy – a good outcome of therapy depends on getting what you came for.

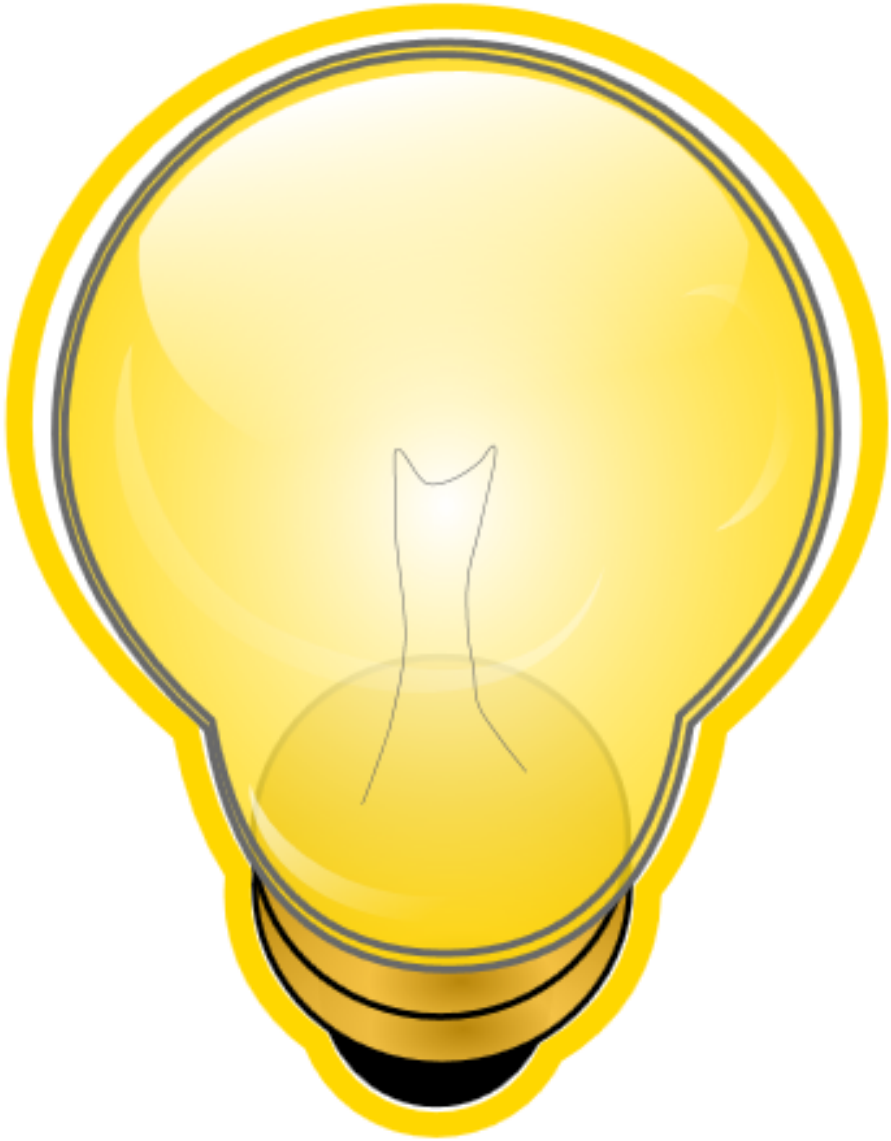
At the start of therapy, most people find it hard to be clear about exactly what it is that they want to achieve. They have maybe only a vague sense of what they hope to get from therapy. This is perfectly normal – your therapist will encourage you to talk about your goals, and gradually they will become clearer. It is fine to have lots of goals, or just one goal. It is fine for your goals to change. What is important is to let your therapist know what it is that you want from therapy.

One of the ways that you can get the most out of therapy is to spend some time on your own thinking about your goals, before the first session, and between sessions. It can be useful to write your goals on a piece of paper, so you don't forget them. It is useful to keep your therapist up-dated, if your goals change.

Meta-Therapeutic Communication

COUNSELLOR RESOURCES

Going beyond intuition

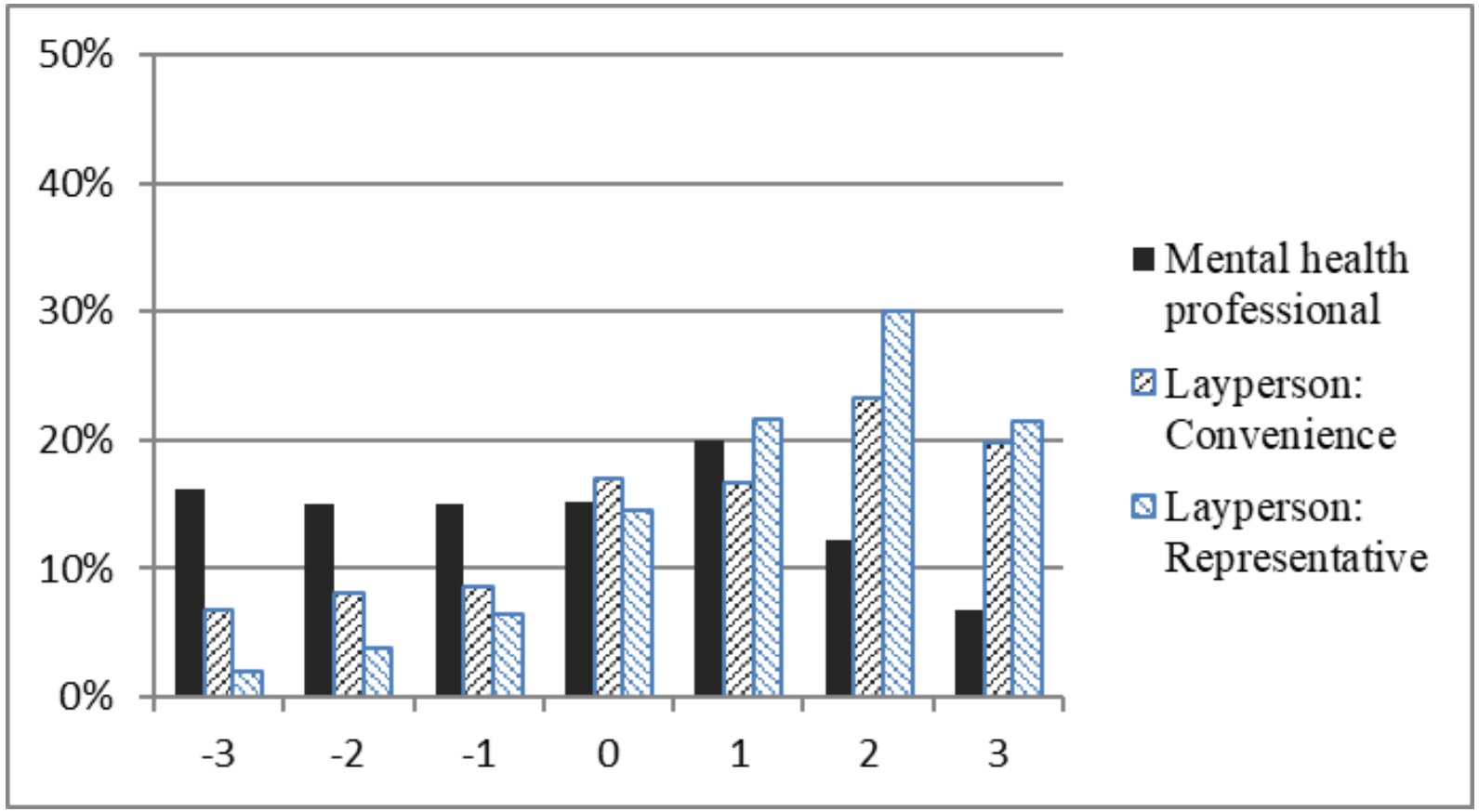


COUNSELLOR RESOURCES

Can we just trust our intuitive sense of what clients need?

A. Research indicates that therapists are generally poor judges of what clients want or experience

We cannot assume that what we want, as clients, is the same as what our clients actually want



Cooper, M., Norcross, J. C., Raymond-Barker, B., & Hogan, T. P. (2019). Psychotherapy preferences of laypersons and mental health professionals: Whose therapy is it? Psychotherapy. doi: 10.1037/pst0000226

COUNSELLOR RESOURCES

Given how much we can miss…

It’s important that we explicitly explore with our clients their wants and goals

COUNSELLOR RESOURCES

Explore

≠

Doing whatever a client initially asks for, and then sticking to it regardless!

=

Dialogue

Subtle, complex, on-going process

Draws on expertise of both client and therapist

COUNSELLOR RESOURCES

Collaboration is not about the uncritical acceptance of the client's viewpoint—it is about moving beyond its uncritical negation

* Co-constructing therapeutic methods I

Following dialogue comes from a first session of therapy between Mick and Saskia

- Mick asked Saskia what she thought might be helpful to her in the therapy/what she had found helpful or unhelpful with previous therapists
- Saskia replied that she had found it unhelpful when there is ‘just a man sitting behind you’ not giving you any feedback -- she said that she wanted lots of input and guidance
- Mick was fairly happy to work in this way, but also sensed that Saskia had a relatively ‘externalised locus of evaluation’ and had some concerns about reinforcing this

* Co-constructing therapeutic methods II

Mick: So it sounds like feedback will be useful?

Saskia: Yeah, yeah.

Mick: Ok.

Saskia: Yes, definitely, because….no matter who we are in the world, wherever we are in life, there is always going to be something that we've missed, either because we don't want to see it, or because we just didn't see it. Even if someone is 90% 'actualised'…they're not going to see everything. [So] you [can] turn around and say: 'You could have said this, you could have done that.' And they're: 'Oh, really, thanks Mick, I never-- I never saw that.'

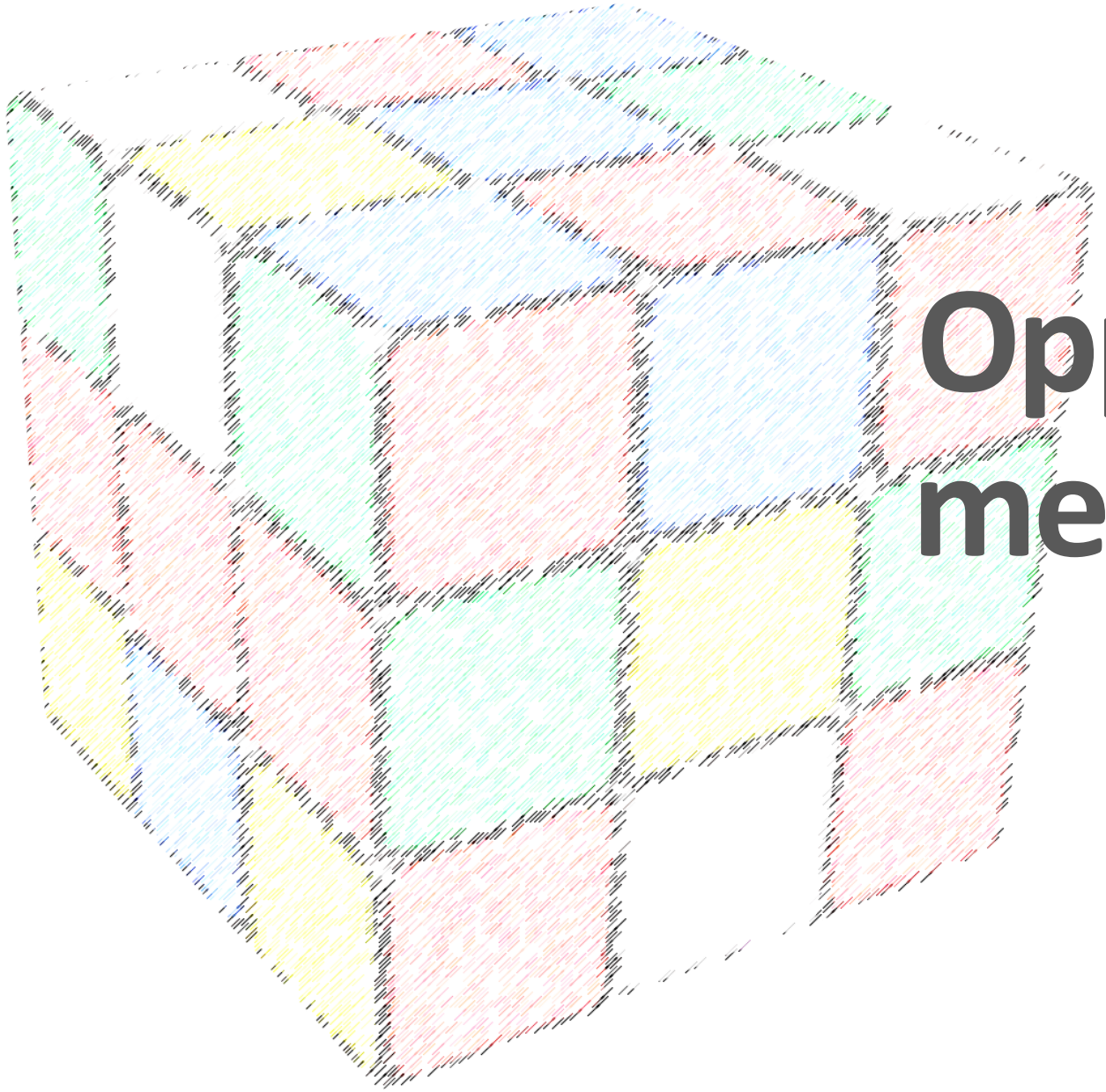
COUNSELLOR RESOURCES

* Co-constructing therapeutic methods II

Mick: I guess the important thing for me, in giving feedback, is that you can say 'That's not right' [Saskia: Sure.]

And you can say, 'No, that doesn't fit,' or 'That's not helpful' [Saskia: Sure, sure.].

I mean, one of the ways that I like to work is-- is very much with feedback…and that needs you to say to me, 'No, don't like that…' 'That's good…'



Opportunities for meta-therapeutic dialogue

COUNSELLOR RESOURCES

BRITISH JOURNAL OF GUIDANCE & COUNSELLING, 2017
http://dx.doi.org/10.1080/03069885.2017.1305098

Metatherapeutic communication: an exploratory analysis of therapist-reported moments of dialogue regarding the nature of the therapeutic work

Fani Papayianni[a] and Mick Cooper[b]

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[b]Department of Psychology, University of Roehampton, London, UK

ABSTRACT

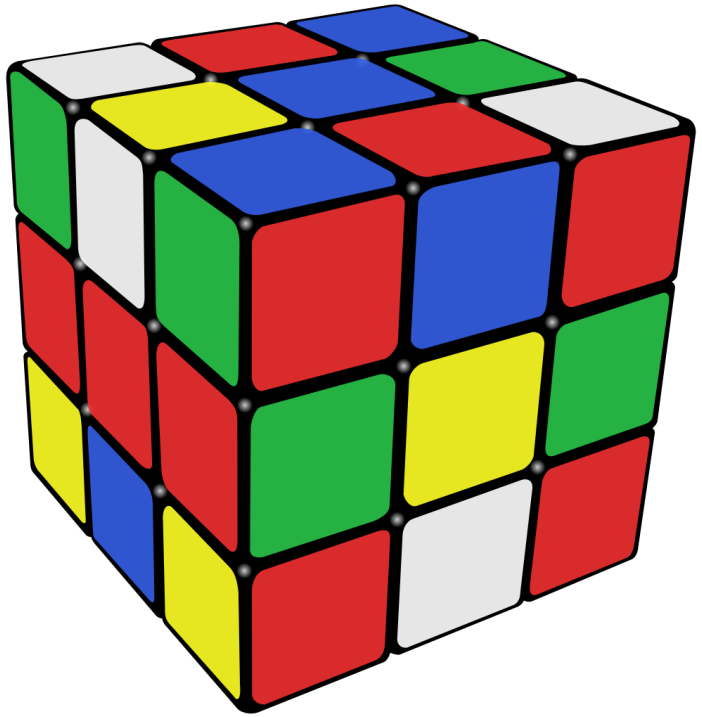
The purpose of the study was to investigate the nature of *metatherapeutic communication* (MTC), defined as dialogue between therapists and clients on the nature of the therapeutic work and the means by which it can be of greatest help to clients. Twelve counselling psychologists, working pluralistically with 35 clients experiencing depression, described on post-session forms moments of negotiation and collaboration around the therapeutic work. Two main dimensions of MTC were identified: the *subject matter* of the MTC and the *temporal focus* of the MTC. In addition, MTC varied by the *time* at which it took place. These findings provide a framework for understanding the nature of MTC in counselling and psychotherapy, and the opportunities for implementing it in practice.

ARTICLE HISTORY
Received 20 September 2015
Revised 22 February 2017
Accepted 5 March 2017

KEYWORDS
Therapeutic alliance; shared decision-making; metatherapeutic communication; pluralistic counselling; collaboration

* Temporal period: When?

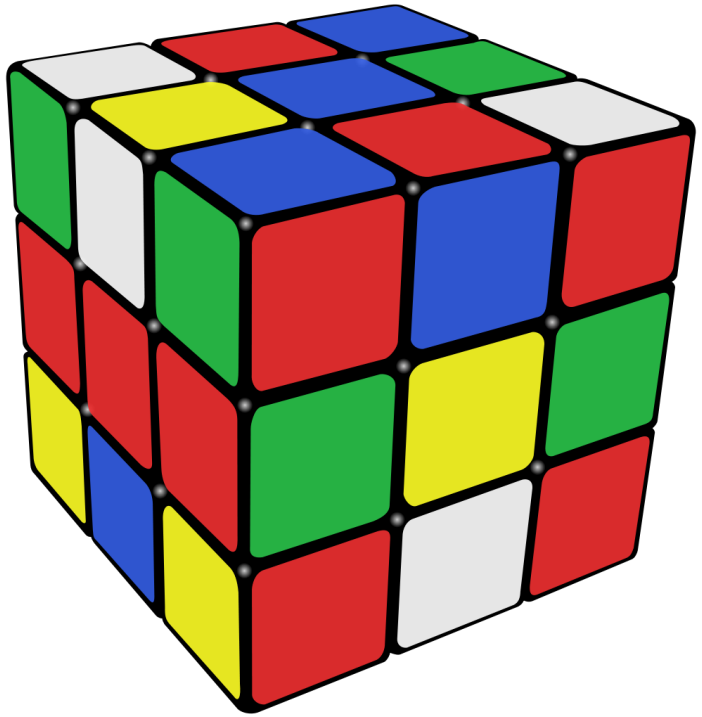
- ✓Before therapy
- ✓Assessment sessions
- ✓Start of sessions
- ✓Within sessions
- ✓End of sessions
- ✓Review points
- ✓Final sessions



COUNSELLOR RESOURCES

* Subject matter: What?

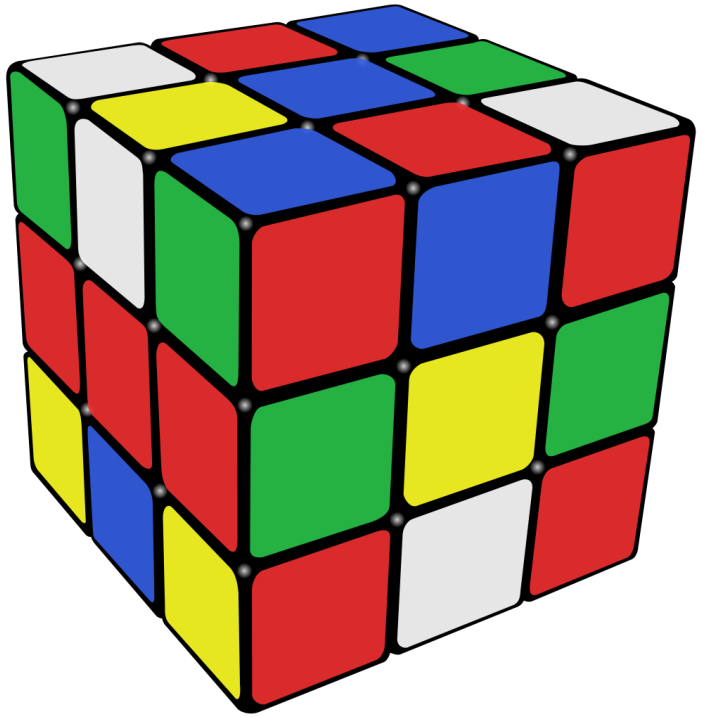
- ✓Goals
- ✓Method
- ✓Content
- ✓Understanding
- ✓Progress
- ✓Experience



COUNSELLOR RESOURCES

* Temporal focus: About when?

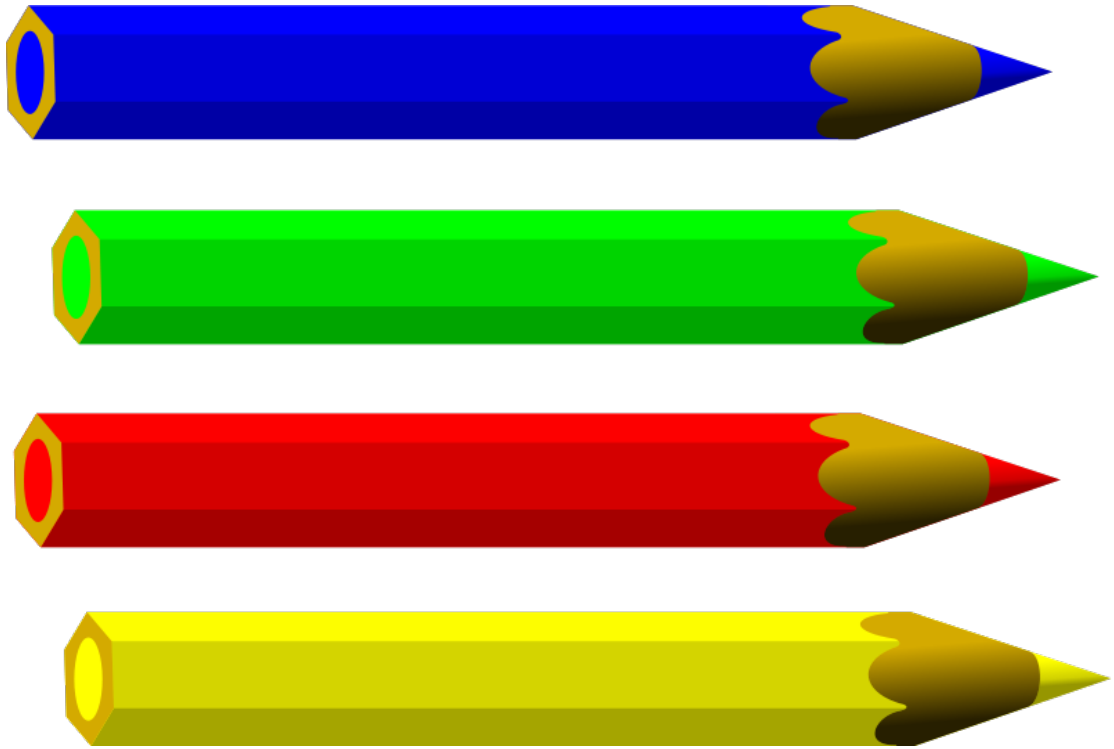
- ✓Previous session(s)
- ✓Current session
- ✓Next session
- ✓Therapeutic work as whole
- ✓Extra-therapeutic activity/homework
- ✓Ending



COUNSELLOR RESOURCES

* Evolving principles of metatherapeutic communication

1. Address metatherapeutic issues from the start
2. Actively invite clients to share their views
3. See MTC as an ongoing process
4. Uncertainty is a predictor of when to MTC
5. Be part of the dialogue
6. Describe what the options might be
7. Tailor levels of MTC to the particular client
8. Adopt a whole service approach
9. Use measures



Using systematic feedback to facilitate meta-therapeutic dialogue

COUNSELLOR RESOURCES

* Systematic Feedback

The integration into therapy of validated methods that invite clients, on a regular basis, to assess their wellbeing (outcome feedback), or experience of therapy and the therapeutic relationship (process feedback)

* Two main types of measures

- ✓**Outcome measures**: feedback on changes in mental wellbeing (e.g., PHQ, CORE)

- ✓**Process measures**: feedback on clients' experiences in therapy (e.g., Session Rating Scale, Helpful Aspects of Therapy)

Pluralistic specific measures…

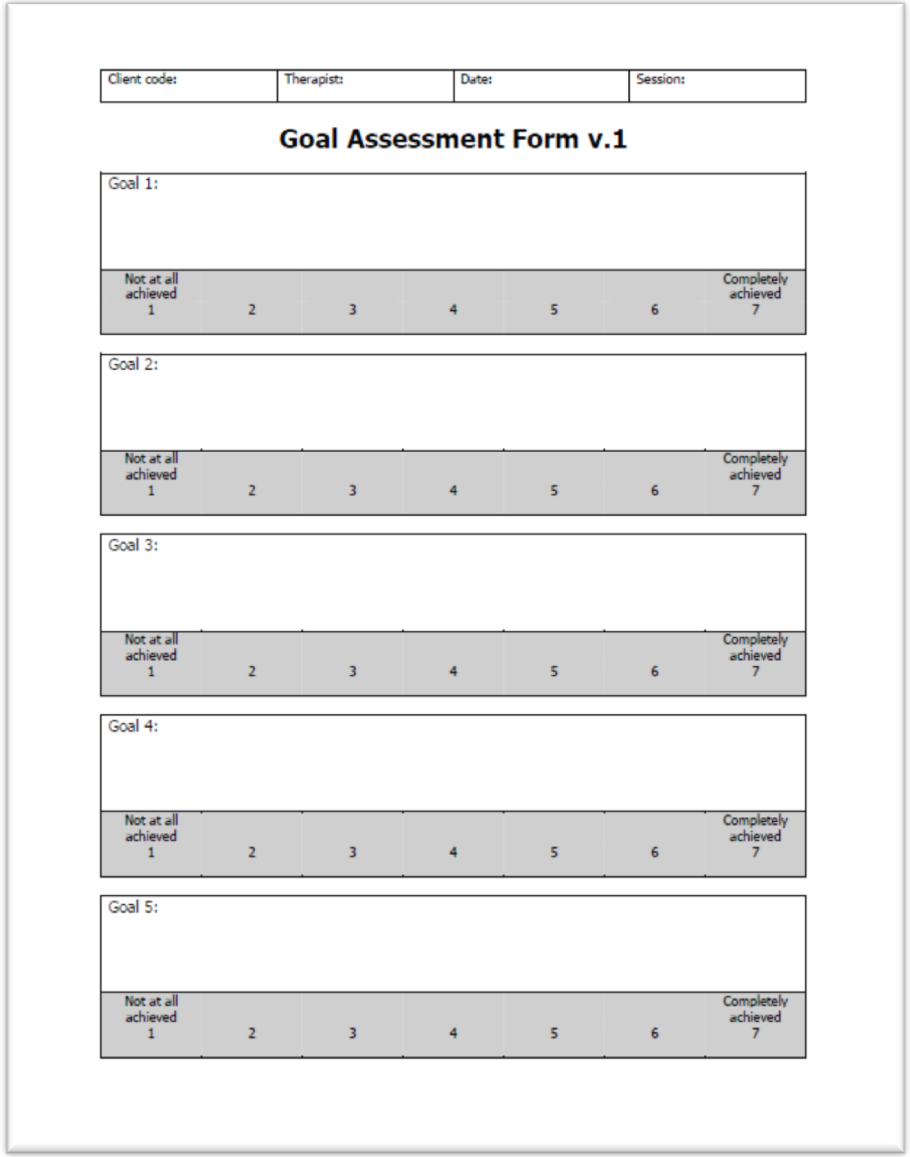
COUNSELLOR RESOURCES

The Goals Form

COUNSELLOR RESOURCES

* Goals Form

- ✓Personalised outcome measure
- ✓Invites clients to focus on what they want
- ✓Discussed and agreed in assessment session
- ✓Rated every subsequent week



Client code:	Therapist:	Date:	Session:

Goal Assessment Form v.1

Goal 1:

Goal 2:

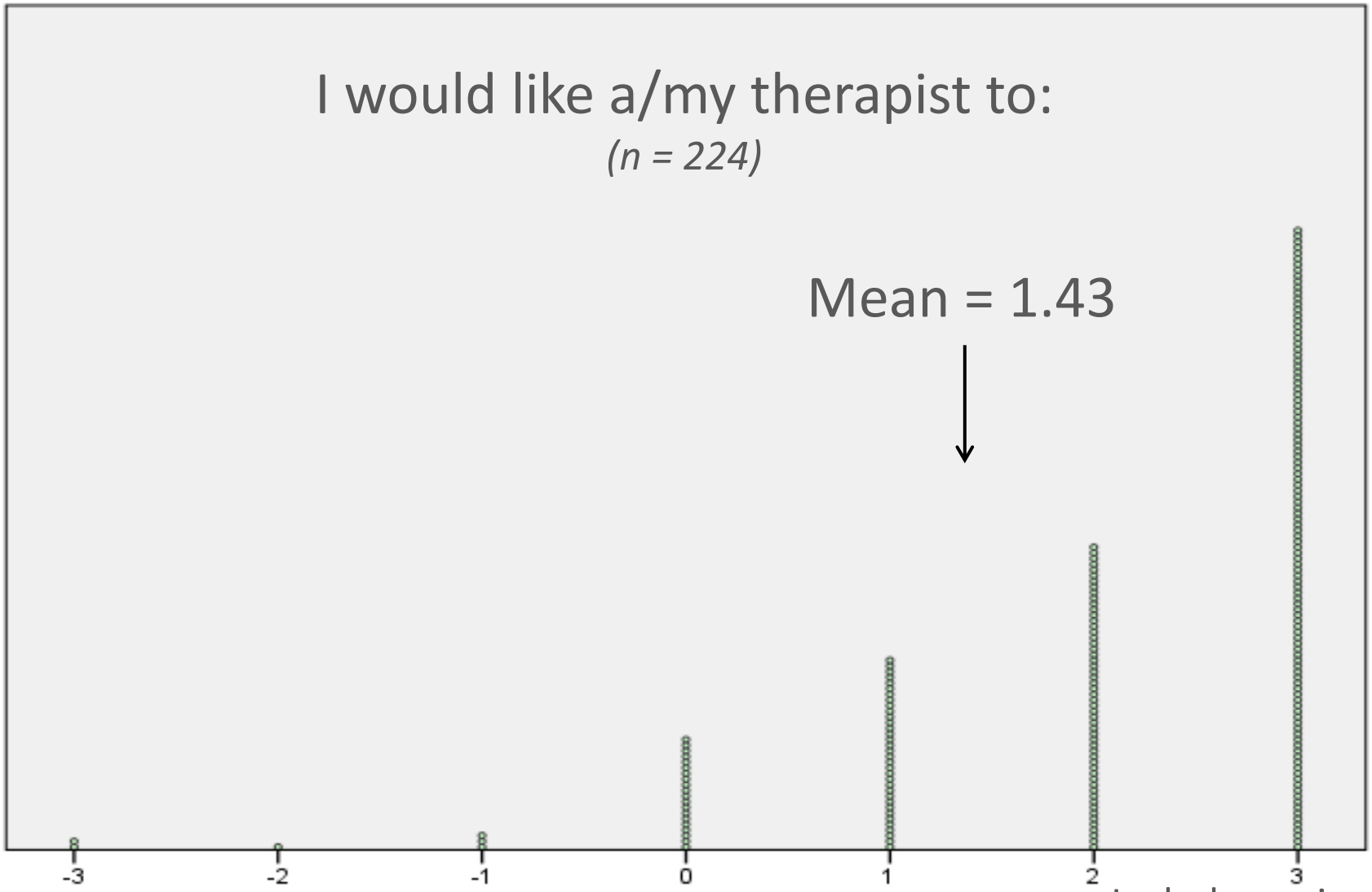
Goal 3:

Goal 4:

Goal 5:

Not at all achieved						Completely achieved
1	2	3	4	5	6	7

COUNSELLOR RESOURCES



COUNSELLOR RESOURCES

* Using the Goals Form

https://vimeo.com/210940525

COUNSELLOR RESOURCES

The C-NIP

COUNSELLOR RESOURCES

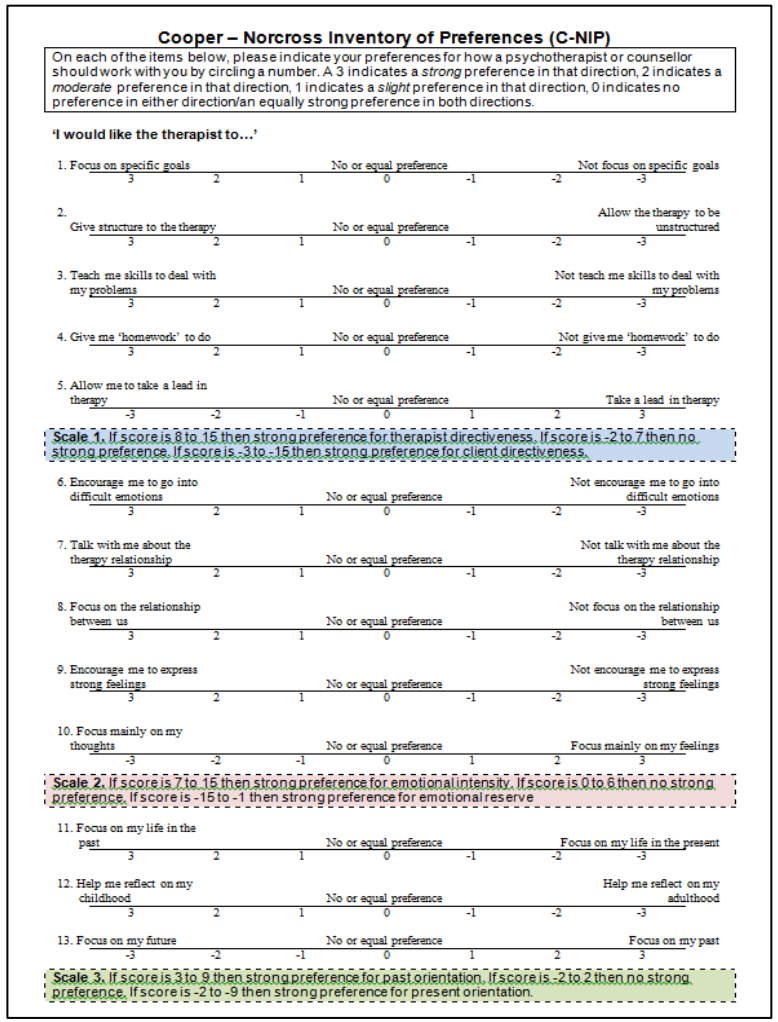
* Inventory of Preferences (C-NIP)

- ✓18 item process measure (free to use) that invites clients to say how they would like therapy to be
- ✓Can be used at assessment and in ongoing therapeutic work/at review
- ✓Four dimensions: directiveness, emotional intensity, past orientation, support
- ✓Additional preference items (e.g., gender of therapist)
- ✓Key issue is **strong** preferences

COUNSELLOR RESOURCES

The Cooper-Norcross Inventory of Preferences (C-NIP)

(Complete online at www.c-nip.com)



Cooper – Norcross Inventory of Preferences (C-NIP)

On each of the items below, please indicate your preferences for how a psychotherapist or counsellor should work with you by circling a number. A 3 indicates a *strong* preference in that direction, 2 indicates a *moderate* preference in that direction, 1 indicates a *slight* preference in that direction, 0 indicates no preference in either direction/an equally strong preference in both directions.

'I would like the therapist to…'

1. Focus on specific goals — No or equal preference — Not focus on specific goals
   3 2 1 0 -1 -2 -3
2. Give structure to the therapy — No or equal preference — Allow the therapy to be unstructured
   3 2 1 0 -1 -2 -3
3. Teach me skills to deal with my problems — No or equal preference — Not teach me skills to deal with my problems
   3 2 1 0 -1 -2 -3
4. Give me 'homework' to do — No or equal preference — Not give me 'homework' to do
   3 2 1 0 -1 -2 -3
5. Allow me to take a lead in therapy — No or equal preference — Take a lead in therapy
   -3 -2 -1 0 1 2 3

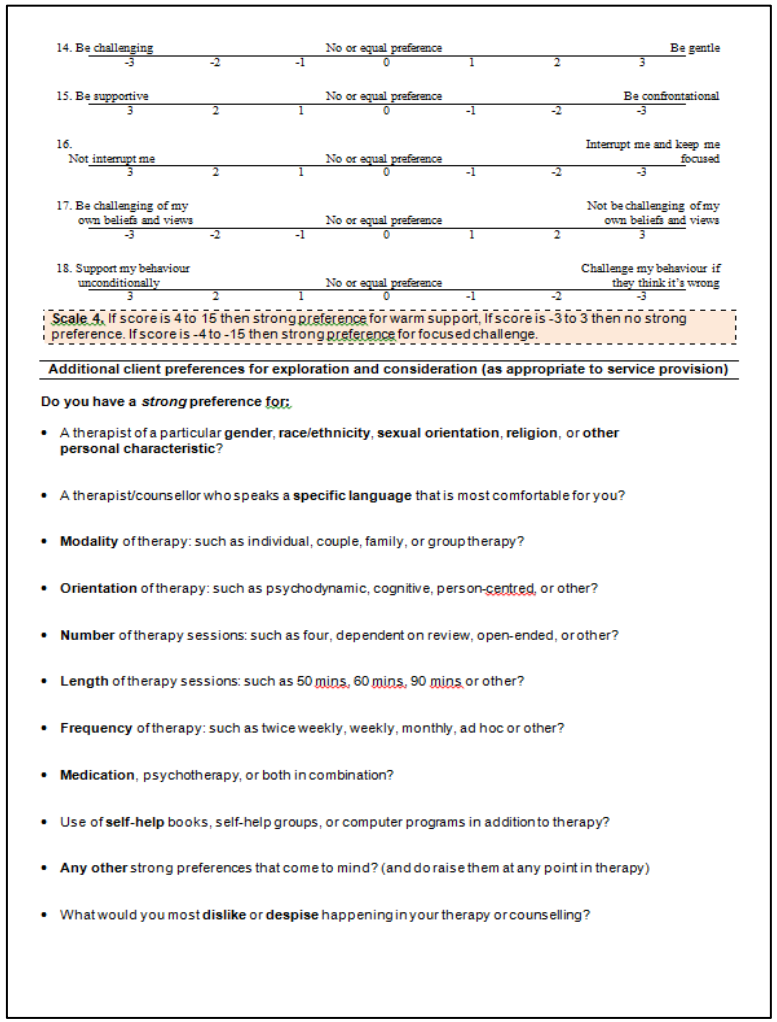
Scale 1. If score is 8 to 15 then strong preference for therapist directiveness. If score is -2 to 7 then no strong preference. If score is -3 to -15 then strong preference for client directiveness.

6. Encourage me to go into difficult emotions — No or equal preference — Not encourage me to go into difficult emotions
   3 2 1 0 -1 -2 -3
7. Talk with me about the therapy relationship — No or equal preference — Not talk with me about the therapy relationship
   3 2 1 0 -1 -2 -3
8. Focus on the relationship between us — No or equal preference — Not focus on the relationship between us
   3 2 1 0 -1 -2 -3
9. Encourage me to express strong feelings — No or equal preference — Not encourage me to express strong feelings
   3 2 1 0 -1 -2 -3
10. Focus mainly on my thoughts — No or equal preference — Focus mainly on my feelings
    -3 -2 -1 0 1 2 3

Scale 2. If score is 7 to 15 then strong preference for emotional intensity. If score is 0 to 6 then no strong preference. If score is -15 to -1 then strong preference for emotional reserve

11. Focus on my life in the past — No or equal preference — Focus on my life in the present
    3 2 1 0 -1 -2 -3
12. Help me reflect on my childhood — No or equal preference — Help me reflect on my adulthood
    3 2 1 0 -1 -2 -3
13. Focus on my future — No or equal preference — Focus on my past
    -3 -2 -1 0 1 2 3

Scale 3. If score is 3 to 9 then strong preference for past orientation. If score is -2 to 2 then no strong preference. If score is -2 to -9 then strong preference for present orientation.



14. Be challenging — No or equal preference — Be gentle
    -3 -2 -1 0 1 2 3
15. Be supportive — No or equal preference — Be confrontational
    3 2 1 0 -1 -2 -3
16. Not interrupt me — No or equal preference — Interrupt me and keep me focused
    3 2 1 0 -1 -2 -3
17. Be challenging of my own beliefs and views — No or equal preference — Not be challenging of my own beliefs and views
    -3 -2 -1 0 1 2 3
18. Support my behaviour unconditionally — No or equal preference — Challenge my behaviour if they think it's wrong
    3 2 1 0 -1 -2 -3

Scale 4. If score is 4 to 15 then strong preference for warm support. If score is -3 to 3 then no strong preference. If score is -4 to -15 then strong preference for focused challenge.

Additional client preferences for exploration and consideration (as appropriate to service provision)

Do you have a *strong* preference for:

- A therapist of a particular **gender**, **race/ethnicity**, **sexual orientation**, **religion**, or **other personal characteristic**?
- A therapist/counsellor who speaks a **specific language** that is most comfortable for you?
- **Modality** of therapy: such as individual, couple, family, or group therapy?
- **Orientation** of therapy: such as psychodynamic, cognitive, person-centred, or other?
- **Number** of therapy sessions: such as four, dependent on review, open-ended, or other?
- **Length** of therapy sessions: such as 50 mins, 60 mins, 90 mins or other?
- **Frequency** of therapy: such as twice weekly, weekly, monthly, ad hoc or other?
- **Medication**, psychotherapy, or both in combination?
- Use of **self-help** books, self-help groups, or computer programs in addition to therapy?
- **Any other** strong preferences that come to mind? (and do raise them at any point in therapy)
- What would you most **dislike** or **despise** happening in your therapy or counselling?

COUNSELLOR RESOURCES

Debates and Challenges

* Implicit needs and processes

- ✓Clients may not be able to say what they want or need
- ✓Implicit, unconscious desires may be very different to explicitly stated wants
- ✓Danger of colluding with clients maladaptive interpersonal dynamics

COUNSELLOR RESOURCES

* Implicit needs and processes

‘Maybe I am getting…my kind of demands, just because I put down something on those papers…. And I questioned whether, whether I should have been giving the opportunity to be kind of designing.

Because I am the one who is unwell, who has been unwell, so giving me to the choice may be…’

(PfD client)

COUNSELLOR RESOURCES

* Being pluralistic about pluralism

Collaboration, MTC, systematic feedback, etc. may not be desirable or helpful for all clients – pluralism invites us to be critical/pluralistic about tools too

* Being pluralistic about pluralism

‘As a client, I felt like she would ask me how the session had been for me at the end of every session as a kind of mini-review and I just felt totally, like, put on the spot, and still trying to process whatever we had been talking about.

So it kind of took me out of what I had been thinking about and I lost touch with the process, rather than become absorbed in it. And then I do the sort of people pleaser thing of trying to be like “Yeah, yeah, it was really good, really helpful”, and really want to answer her question as I do not want to say anything was unhelpful as that feels really uncomfortable. I would never say anything unhelpful.’

(from client experience research by Keri Andrews, counselling psychologist)

COUNSELLOR RESOURCES

* Therapist inauthenticity

‘I think it was an unfair situation on the therapist that I-- that somebody just walks in from the street and gets into the project and says “So I want you to behave like this, this, this and this with me”….

He is not behaving in a way he would naturally would behave.’

(PfD client)

COUNSELLOR RESOURCES

* Towards a *wikitherapy*

An evidence-informed resource for therapists and clients on the different methods that can help clients achieve different goals

COUNSELLOR RESOURCES

If you’re interested in the Pluralistic Approach, go to:

www.PluralisticPractice.com

COUNSELLOR RESOURCES

* Thank you!

Don’t forget to claim your CPD certificate.

COUNSELLOR RESOURCES