

How Counsellors and
Psychotherapists
Make Sense of Pluralistic Approaches
to Therapy

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Abstract

This thesis explores how therapists themselves make sense of pluralistic approaches to therapy. Interview data was used to develop a contextual understanding of pluralism within the therapy professions.

Semi-structured interviews were conducted with therapists who identified with different approaches via opportunity sampling. 12 therapists were interviewed: 4 participants were male and 8 were female. Their ages ranged from 29 to 74 and post-qualification experience varied from 1 to 28 years. The overarching question was: 'How do you make sense of pluralistic approaches to counselling and psychotherapy?' with sub-questions exploring the therapists' experiences and practices in relation to the main question.

Seven themes were identified. Three themes ('Identity and Approach', 'The Flexibility-Rigidity Continuum', and 'It's the Relationship') were interpreted as belonging to 'contentious issues' that fed into a central theme 'Debates about Pluralistic Approaches to Therapy'. These debates, in turn, lead to three additional themes interpreted as 'diplomatic attempts at resolution' ('The Practice of Metacommunication', 'The Uncertainty-Understanding Continuum', and 'Common Factors').

The interviews allowed for the identification and interpretation of themes which could form the basis for further research for the benefit of practitioners, providers and clients. How this sample of therapists makes sense of pluralism in relation to their own practice demonstrates how pluralism might be better understood as a continuum or dimension of therapeutic practice rather than a differentiated way of practising. Pluralism is an important concept to understand for framing how training, practice and policies might be developed in the future. However, this research suggests that therapists are less convinced by the *practice* of 'pluralistic therapy' than they are by pluralistic therapy as a perspective. This research contributes an understanding of how pluralism as a perspective might be used politically to increase patient choice within organisations such as the NHS.

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List of abbreviations

ACT – Acceptance and Commitment Therapy

AHP – Association of Humanistic Psychology

AMA – American Medical Association

APA – American Psychological Association

BAC -- British Association for Counselling

BACP – British Association for Counselling and Psychotherapy

BMRC – British Medical Research Council

BPC – British Psychoanalytic Council

BPS – British Psychological Society

CfD – Counselling for Depression

CPD – Continuing professional development

DH – Department of Health

EAP – Employee Assistance Programme

EBP – Evidence-based practice

EST – Empirically supported treatment

FIT – Feedback informed treatment

FREGC – Faculty Research Ethics and Governance Committee

GAD – Generalised Anxiety Disorder

HPC – Health Professions Council

IAPT – Increasing Access to Psychological Therapies

II – Interpretive Interactionism

IPA – Interpretative Phenomenological Analysis

IPT – Interpersonal Therapy

MBCT – Mindfulness-Based Cognitive Therapy

MTC – Metatherapeutic communication

NAPT – National Audit of Psychological Therapies

NHS – National Health Service

NICE – National Institute for Health and Care Excellence (previously National Institute for Clinical Excellence)

NPM – New Public Management

OCD – Obsessive Compulsive Disorder

PBE – Practice-based evidence

PCA – Person-Centred Approach

PHQ – Patient Health Questionnaire

PWP – Psychological Wellbeing Practitioner

RCP – Royal College of Psychiatrists

RCT – randomised controlled trial

REBT – Rational Emotional Behaviour Therapy

RMN – Registered Mental Nurse

SEMI – severe and enduring mental illnesses

SEPI – Society for the Exploration of Psychotherapy Integration

SI – symbolic interactionism / symbolic interactionist

SPR – Society for Psychotherapy Research

SR – statutory regulation

TAU – Treatment as Usual

TPF – Therapy Personalisation Form

TPF-A – Therapy Personalisation Form -- Assessment

UKCP – United Kingdom Council for Psychotherapy

Preface

This thesis provides an exploration of how pluralism and pluralistic therapy has impacted, is impacting, and might impact the therapeutic professions.

The research addresses the current state of therapy in the UK and the importance of pluralism and pluralistic therapy in its evolution. Pluralistic therapy relates to a variety of concerns in the provision and practice of therapy, including research methodologies, knowledge bases, professionalisation and regulation. These issues are discussed in the thesis in relation to: the interview data, the sociohistorical context in which pluralistic therapy has manifested and relevant literature.

The thesis demonstrates that pluralistic therapy is extremely relevant to contemporary issues and controversies in counselling and psychotherapy. The interviews with the participants bring a qualitative depth and breadth to the subject that will be of significant value to practitioners, providers and clients in thinking about therapeutic practices and how best to provide therapy in the future.

There are many controversial topics within the psychotherapeutic and mental health professions. Throughout my career I have been particularly interested in issues raised by debates about commonalities and differences between therapeutic approaches. The publication of Cooper and McLeod's (2011a) book *Pluralistic Counselling and Psychotherapy* intensified the controversy of these debates around various issues, such as whether some approaches are superior to others, and whether practitioners should identify with only one approach or integrate different ones. Whilst integrative therapy, before it, has a long history, the publication of Cooper and McLeod's book provided a focal point for a new 'pluralistic' agenda. Pluralistic therapy, whilst it may not be that established as a 'brand' outside the profession, is well-known within it, and I was confident that interviews with practitioners would enable me to explore the impact that Cooper and McLeod's articulation of pluralistic therapy is having on professionals and their practices.

For clients, the pluralistic agenda has implications about what therapies are offered to whom, and how much choice or collaboration clients

are allowed. If choice and collaboration are valued -- which they might not be (for various reasons) -- then the pluralistic agenda is centrally important to how therapy is provided in the future. I was curious to discuss with practitioners their understandings and views about pluralism because, for the pluralistic agenda to take hold, practitioners will need to support it. Without this support, pluralistic therapy will not solve problems that it implicitly, and sometimes explicitly, sets out to solve. Cooper and McLeod's advocacy of pluralistic therapy, as a perspective and practice, has instigated division amongst practitioners, with some embracing it, some more neutral, and others who reject it. My research explored how and why therapists support it, and how and why they do not.

Pluralistic therapy, as it is most commonly perceived by practitioners, is a form of therapy, for practice and research, first articulated by Mick Cooper and John McLeod (2007). It is a relatively recent phenomenon within the world of therapy that offers some hope of bringing peace to 'wars' over different approaches (Saltzman & Norcross, 1990). It also offers a pragmatic, research-friendly framework that might make some impact on the provision of therapy in an era of 'evidence-based' practice, professionalisation, regulation and 'audit cultures' (e.g. King & Moutsou, 2010). Therapy is at a 'critical juncture' (Aldridge, 2011), in which counsellors and psychotherapists are often side-lined, in favour of the creation of new types of paraprofessionals (e.g. Department of Health, 2008). Also, in recent years, and particularly within a UK context, there has been a hegemonic rise of cognitive behavioural therapy (CBT) within the NHS and other providers, which has marginalised more traditional and more 'relational' therapies -- humanistic and psychodynamic therapies, in particular (e.g. Barkham et al., 2017).

So, in my view, there is a pressing need to ensure continuing respect and valuing of the practice of therapy. If therapy, as it has been known and practised, is to survive and thrive, the need for therapists -- of all approaches -- to unify is of paramount importance. In that sense, does pluralistic therapy offer any solutions? Questions such as these provided the impetus for my research and reasons for pursuing it.

This research, with its in-depth qualitative interviews, explores therapists' understandings of how they practise and how they view their practices in relation to pluralism and pluralistic therapy. The participants shed new light on how and why therapists respond positively, neutrally or negatively to the pluralistic agenda proposed by Cooper and McLeod.

There is also the question of whether pluralistic therapy offers anything more (theoretically, practically and pragmatically) than integrative and eclectic approaches, which are its most obvious precursors. Some writers also talk about 'transtheoretical' approaches (e.g. Prochaska & DiClemente, 2005), which also offer something akin to pluralistic therapy.

Within these theoretical and practical alternatives to the common emphasis on celebrating and rewarding particular approaches, another question arises as to whether pluralistic therapy is helping or hindering progress with evaluating therapy in new and different ways. Cooper and McLeod implicitly suggest the 'unique selling point' of pluralistic therapy is that they have articulated something that can be researched more effectively (in terms of convincing providers) than integrative and eclectic approaches. It is notable that rather than challenging the currently dominant research methodologies, which might be the preferred route for some pluralistic therapists (or those sympathetic to pluralistic perspectives and practices), they are allowing those research methodologies to challenge them. This has implications for how they articulate pluralistic therapy.

Therefore this research matters to counsellors and psychotherapists whose practices might become severely marginalised and devalued unless the pluralistic agenda makes some progress in the coming years. It also matters to clients who might want to access different types of therapies and/or therapists able and willing to work flexibly. More and more, different types of therapy and therapists, unable to gain admittance to or dismissed by the public sector, are retreating to or finding refuge in the private sector. If providers want different kinds of therapies to reach beyond the financially solvent, then the pluralistic agenda needs to gain traction. If, as it is presently articulated and presented, it is failing in this, then understandings need to be reached as to how it might be re-articulated and re-presented. The depth and breadth of the interviews in my research illustrate how these

therapists position themselves in relation to pluralism, where they are in agreement in how they theorise and practise, and where they are not. Their interpretations, and my interpretations of their interpretations (a hermeneutic circle), point to how those in favour of pluralistic perspectives and/or practices might re-articulate their ideas, to convince practitioners themselves and, by proxy, providers and clients, to facilitate and enable the long-term survival of counselling and psychotherapy, characterised by a healthy proliferation of different approaches.

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Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed

Dated

1: Introduction

1.1 Counselling, Psychotherapy, Therapy, Clients and Patients

One problem, inherent in debates about pluralistic therapy, which needs to be discussed in advance of any other issues, is the use of the different terms 'counselling', 'psychotherapy' and 'therapy'. For linguistic ease, and throughout this thesis, I will be mostly using the word 'therapy' to refer to 'counselling' and 'psychotherapy', the word 'therapist' to refer to 'counsellor' and 'psychotherapist', and the word 'therapeutic' to refer to 'psychotherapeutic'. Sometimes, for reasons of either syntax or meaning, those rules are broken. This decision is not uncontroversial: there are some 'counsellors' and some 'psychotherapists' who insist that there are real differences in their practices, and I am not wholly unsympathetic to their arguments. However, it is arguable whether there are any essential differences between 'counselling' and 'psychotherapy'. Dunnet et al. (2007) assert that there is a 'lack of any reliable evidence indicating a difference between the practices of "counselling" and "psychotherapy"' (quoted in Cooper, 2008, p. 9). This is an issue that I shall return to in later parts of this thesis.

One additional point concerning the meanings of 'counselling', 'psychotherapy' and 'therapy' is that these terms can refer to the people who practise such activities, organisations who engage with these activities, as well as the practice itself, in a similar way to how the words 'medicine' and 'law' are used (Aldridge, 2011).

There is also debate and confusion about whether people who attend therapy should be called 'clients' or 'patients'. Again, for linguistic ease I will be calling all these people 'clients'. I also own that I am doing this because of the association of the word 'patient' with the medical model, which I believe reflects a dominant ideology that needs to be challenged, in discourses such as this, by careful use of language. I am aware that other writers would want to use the word 'patient' in support of the dominant ideology and that, therefore, my use of language represents a point of view rather than any irrefutable 'truth'.

1.2 Introduction and Outline of the Chapter

Pluralistic therapy is a form of therapy, for practice and research, most notably articulated by Mick Cooper and John McLeod (2007). The notion of pluralistic therapy had been articulated before (e.g. Samuels, 2011/1997, Samuels, 1989a; Samuels 1989b), and has been articulated by others since (e.g. McAteer, 2010), but it is mostly associated with writings and research by Cooper, McLeod and their associates. Pluralistic therapy has a pre-history in theory and research about integrationism and eclecticism; and how it differs from those conceptualisations of therapy (if at all) is explored in subsequent chapters.

‘Pluralism’, as a philosophy, which underpins pluralistic therapy, is also explored in later chapters. It has various meanings depending on disciplinary context; for instance, it is closely associated with multiculturalism. Although multiculturalism, one type of pluralism, does relate to developments in therapy, in this thesis a pluralistic approach to therapy mostly refers to tolerance towards, and the promotion and practice of, different therapeutic approaches. In my research I was concerned with the impact of pluralistic approaches on therapy: for its practitioners, for other stakeholders, and for therapy as a practice. In this thesis, I often refer to pluralistic ‘approaches’, ‘perspectives’ and ‘practices’ because I see pluralism as something that is not ‘owned’ by Cooper and McLeod; simultaneously I do recognise that when practitioners refer to ‘pluralistic therapy’ they are usually referring to Cooper and McLeod’s approach. The focus of the research was on how therapists make sense of pluralistic approaches. However, the relationship between pluralistic therapy as a practice and pluralism as a philosophy/perspective is of central importance and, to a certain extent, they are inextricably linked. So questions that came up fairly early in the research were: What does pluralism mean? Is Mick Cooper and John McLeod’s articulation of a pluralistic therapy actually pluralistic? In subsequent sections and chapters, wider questions such as

these are also addressed, as well as the tighter focus on therapists' perceptions and experiences of pluralistic therapy.

The subsequent sections of this chapter consist of: (1) an introductory personal statement; (2) the research context, (3) the rationale, aims and objectives of the thesis; and (4) an outline of the thesis.

1.3 Introductory Personal Statement

I have been working as a therapist since 1997. I also worked as a mental health project worker for five years before, during and after undertaking training to become a therapist. Shortly after gaining a Postgraduate Diploma in Counselling I gained an MA in Counselling Studies, examining what influenced therapists to want to become therapists using quantitative methods. I have worked mostly in private practice seeing a mixture of private clients, and clients from Employee Assistance Programmes (EAPs), Bupa (the private health insurance company) and other insurance companies. I also worked for a year in the National Health Service (NHS) for a local surgery before the Increasing Access to Psychological Therapies (IAPT) programme was introduced. Additionally, I was the editor, for a few years, of *Sussex Counselling and Psychotherapy News*, a magazine for therapists in the county of Sussex in the UK. I have been actively engaged with therapy practitioners for many years and involved in debates and discussions that permeate the profession.

These debates and discussions happen at various levels: organisational (such as statements, conferences and policies by the British Association for Counselling and Psychotherapy [BACP] and the United Kingdom Council for Psychotherapy [UKCP]), small groups (such as small-scale group practices, therapists undertaking 'continuing professional development' [CPD], voluntary agencies and group supervision), individual supervision and individual practitioners engaged in one-to-one dialogues about their concerns. I have engaged at all these levels with issues that have come up for the profession since I started practising just over 20 years ago.

There are a multitude of issues that cause divisions in the psychological therapies. For instance, regulation and professionalisation, most particularly statutory regulation (SR), caused a lot of turbulence amongst practitioners, especially when the government proposed it via the Health Professions Council (HPC) in 2004 (Aldridge, 2011). With a change of government those proposals were shelved and a voluntary registration scheme introduced in its stead, but this attempt to statutorily regulate counselling and psychotherapy was controversial and divisive, and the issue of SR remains active (e.g. Department of Health, 2017; UK Parliament, 2017). Some practitioners shake their head in dismay that the professions have not yet been statutorily regulated, whilst others warn that SR might be the death of therapy as we have known it. Concerns about regulation and professionalisation are explored in this thesis in relation to my main questions. However, I have been most interested in the issue of pluralism itself which is why I came to focus on it in particular. Ever since I began my training and became aware of the internecine conflicts in the profession over different therapeutic approaches, I have been fascinated, if sometimes also disillusioned, by these competitive and ideological splits. These kinds of sentiments are also reflected in the interviews I conducted that are elaborated upon further in the Findings and Discussion chapter.

The felt need to prove superiority of one therapeutic approach over another has never resonated with me. From the beginning of my training in 1996 I was aware of the 'different words for the same thing', so prevalent in therapy theories, which some participants also mentioned. In my first year of training, I was fortunate enough to attend a lively seminar with Petruska Clarkson. I was impressed by her framework which articulated how therapy can be viewed as operating within five different types of relationship (Clarkson, 1995). This seemed to me to be a coherent way of understanding therapy and how to practise it, and to make more sense than attempting to stay within one approach.

Many of my colleagues identified with the person-centred emphasis of my training. However, it was a humanistic rather than a person-centred course, and I was also introduced to Gestalt therapy, Transactional Analysis (TA), existential philosophy and other approaches; I experienced the course

as an integrative one. I also saw the person of the therapist as centrally important. My own path to training came from attending therapy with a private practitioner and, some way into that, having a sense that I could be a practitioner myself, a path she encouraged me to follow. I never even asked nor cared what approach she was using. At that time what I needed and received was an empathetic practitioner who I felt genuinely cared about my life story and current confusions. She had the generic qualities that some of my participants spoke about, such as warmth and the ability to connect. The valuing of these simple relational qualities, since I first went to that therapist in the late 1980s, seems to have been drowned out by the clamour for other ways of identifying effectiveness and efficiency. Rather than the best person for the job, it seems as if providers are looking for the best 'abstract approach'.

My own experience – as a client, a trainee therapist and a qualified therapist – has led me to evaluate the quality of therapy and therapists in ways that do not align with current assumptions of how therapeutic effectiveness should be researched. A common critique of pluralism, as with integrative therapy before it, is that it proposes that 'all should have prizes' and signifies, perhaps, a defensive posture that cannot tolerate ideas of 'winners and losers' or 'better and worse'. I accept that there may be better and worse therapy; what I do not accept is that 'better' and 'worse' can really be located within approaches. My view is that there are better and worse therapists, so clients are best advised to look for *who* rather than *what*.

So I did come to this research with an owned subjective bias which, with reservations, accepts the spirit, if not the letter, of the pluralistic approach. However, I did, simultaneously, and genuinely, want to know how this particular group of therapists made sense of pluralism and therapy. I was not trying to be coldly objective: I owned and do own my subjectivity, but I do not believe my subjectivity was an impediment to the aims of the research. In the interviews my questions were open questions designed to facilitate the disclosure of the participants' views rather than to get them to hear my own. The whole process – from formulating my research question, reading the literature related to the question, devising the questions for the semi-structured interviews, and transcribing and analysing the interview data

– left me with a much more nuanced and critical view of the phenomenon of pluralism in therapy, aware of its strengths and weaknesses, and its potential to offer some solutions whilst leaving other problems unsolved.

The focus of my MA dissertation was on what influences counsellors to become counsellors. In a way this research thesis continues that investigation into the deeply felt and embodied experience of being a therapist, and how therapists practise in the light of all their personal and professional experiences. The argument for a more pluralistic perspective for therapeutic provision and practice has come from microsocial conversations among researchers, practitioners, clients themselves, and within professional bodies such as the BACP and user groups such as MIND. These groups share a fear that, without a pluralistic perspective, valuable and valid practices might be lost if they are not lost already (they may not use the word 'pluralistic', but in effect they argue for a more pluralistic perspective for therapy provision). The current research allowed further microsocial dialogues to take place which offer the professional community, and by extension, clients who might benefit from access to different modes of practice, an in-depth view of how practitioners perceive the current state of therapy in relation to a monistic–pluralistic continuum of policy and provision. It also gives thick descriptions of how practitioners make sense of their practice through the lens of a pluralistic conception of therapy.

Further back, my BA(Hons) was a modular degree in Humanities in which I studied English Literature, Modern Theatre Studies and Philosophy. Although I have sometimes wished that I had chosen to do a Psychology degree, in other ways I think a Humanities degree is perhaps a better foundation for the practice of therapy than psychology. After all, whether clients bring short stories of incidents that might have only occurred in the last week (as might interest a cognitive-behavioural therapy [CBT] practitioner) or long stories reaching back to infancy and childhood (as might interest psychodynamic and TA practitioners), the interpretation of stories is an art that belongs to the humanities just as much as, or more than, the discipline of psychology. The need for human beings to experience their lives as meaningful and thus prevent dysfunctional setbacks also seems to fit into the discipline of philosophy more than psychology. The centrality of

narratives and meaning for the practice of therapy and in the humanities served me well as a foundation for my postgraduate training as a counsellor/therapist (see also Hansen, 2018).

This point of view does clash, to a certain extent, with the assumptions of more scientifically minded biases expressed in influential branches of psychology. For instance, in the American Psychological Association's (APA) *History of Psychotherapy* (Norcross et al., 2011), which one might assume to be a relatively neutral take on its title, psychotherapy is unproblematically conceptualised throughout as a medical-psychological practice. There seems to be a culture in the USA in which the practice of therapy is commonly viewed as a sub-branch of clinical psychology. Although similar views do exist in the UK, the recognition of therapy as a distinct practice delivered by trained professionals, who may or may not have a background in psychology, seems to have taken root more successfully in professional and public discourse. The explicit agenda of organisations like the APA is to situate therapy within scientific and medical discourses (e.g. Friedman, 2018). These discourses, in the UK, are more likely to be challenged because a significant proportion of UK practitioners have not had initial trainings in either medicine or psychology. Perhaps this is a good thing, since the breadth and depth of what needs to inform therapeutic practice – a dialogue between two human beings about existence itself – is too restricted within the narrow confines of merely medical and psychological discourses.

As mentioned previously, I worked for several years as a 'mental health project worker' in a 'Care in the Community' project. Although in my current practice I do occasionally see people diagnosed with 'severe and enduring mental illnesses' (SEMI), it was a particularly enlightening experience to work with that client group within the public mental health system. It allowed me to witness how people diagnosed within it can be 'treated' by those who profess to 'care'. In many ways the projects I worked for were benign, especially within the limits of the human and financial resources available. Conversely, there was an uncritical acceptance of the medical model in which the dispensation of medications was a central task, and it seemed as if we were powerless to provide significant psychological

help. The model was at best a biosocial one. For some residents, this could lead to a helpless acceptance of a diagnosis such as 'schizophrenia', with a contiguous belief that they could not hope for a life without their 'illness'.

I now practise with clients who usually accept less severe diagnoses or none at all, framing their problems in living as stress, anxiety, depression, or merely coping with situations they perceive as problematic. Yet there is a background to the work that I do in which I see some issues which I perceived in the mental health system also applying to client groups presenting with less severe and less enduring problems. I have retained a keen interest in the broader mental health field of which the psychological therapies form just one part.

So my interest in the research question: 'How do counsellors and psychotherapists make sense of pluralistic approaches to therapy?' is situated within a broader interest in 'mental health' as a whole. Within that field I have trained as a therapist, so my focus on mental health has narrowed down to the theory, practice and research of therapy. Pluralism and pluralistic therapy particularly fascinate me so those phenomena became the focal points of my research question.

1.4 The Research Context

In this section the focus will be on how my research fits within research about pluralistic therapy. Research about this approach exists within a wider context of research about therapy as a whole, which will be explored more thoroughly in the Sociohistorical Context and Literature Review chapters.

The research focusses on pluralistic approaches to therapy, and how therapists themselves make sense of these approaches and issues associated with them. The majority of studies about pluralistic therapy are quantitative and often designed to illuminate it in terms of its processes and outcomes (e.g. Cooper et al., 2015; Miller & Willig, 2012; Watson et al., 2012). In this qualitative, interview-based study, whilst processes and outcomes – in relation to pluralistic approaches – are discussed, they only form two aspects of how the theoretical and practical implications of holding

or not holding pluralistic positions, with regard to therapeutic practice, are experienced and reflected upon by the interview participants. Using a qualitative methodology allowed me to develop a 'more nuanced and contextualised understanding' (Tilley et al., 2015, p. 181) of how pluralistic therapies are understood and experienced by some practitioners.

In research by Tilley et al. (2015) they state that their aim was 'to contribute to an understanding of the values of counsellors who identified themselves as using a pluralistic model of therapy' (ibid.). In my research the aims were similar but not the same. First, the focus was more open because I was not necessarily seeking out the values of the therapists I interviewed. The focus was the practitioner's own thoughts, feelings and experiences about therapeutic practice in relation to pluralism. This initiated dialogue about values but also responses that were more pragmatic and experiential in relation to pluralism-related issues. Secondly, the participants in my study, bar one practitioner, did not identify as pluralistic. My interest was not in how pluralistic approaches to therapy affect those who already identify with it, and therefore could be seen to be more certain about it, but rather with therapists who know about it in varying degrees, and have differing opinions along a favourable-unfavourable continuum. Therefore, it was possible to explore reflections on how pluralistic approaches are impacting therapists as a whole. In interpreting the interview data it also appears that the black/white conceptualisation of pluralistic/non-pluralistic practitioners challenges the foundation of studies which make that assumption. Most of the participants identified to some extent with pluralistic 'values' whilst not identifying themselves as 'pluralistic'. This suggests that, for many practitioners, pluralism is not so much a 'brand' as a qualitative continuum along which practices move, depending upon persons and context.

Therefore this research makes a contribution to knowledge because it focusses on pluralism qualitatively with a category of participants that have not been previously researched. It also focusses on it in a way that includes values but also encompasses other aspects of how pluralistic approaches have impacted therapists and their practices. There have not been any studies, to my knowledge, asking these questions of therapists in this way.

Further justification and evidence for the above assertions are related in the 'Literature Review' chapter.

The pluralistic agenda, in my view, is a 'peace' agenda for the psychological therapy professions, which also relates to issues and debates about professionalisation and regulation. Therefore, engaging with how therapists support or challenge its tenets and practices is important in contributing to understanding the ongoing struggle of the therapy profession with embracing difference and presenting itself as a united front for its own survival and progress. This research presents a nuanced and complex analysis of how the pluralistic agenda is both failing and succeeding to convince therapists that it is important or useful.

Since therapists have significant power in how therapy is 'constructed', how they do decide to construct it (which is accomplished at both macrosocial and microsocial levels) is of paramount importance to what is likely to be offered to providers and the public in future. Therefore this research offers a 'thick description' of how pluralistic therapy is currently perceived by some practitioners. Of course, therapists have limited power – organisations and 'consumers' themselves interact with what therapists offer, and accept or reject those offers. The interactions between these groups can be conceptualised as an ongoing dialogue with empowered and marginalised voices within it. In this thesis the voices of the therapists to whom I have spoken are contextualised within that broader conversation; and within that conversation I would argue that therapists' voices are somewhat marginalised in a culture that devalues personal, subjective testimony in favour of impersonal, objective evidence. Therefore this thesis provides a space for those voices to be heard, interpreted and understood as fully as possible. I would hope that their voices might be amplified by this research, thereby adding to the important conversations happening in the UK about the future of therapy and therapy provision.

The articulation of pluralistic therapy, from 2007 onwards, has a specific and important sociohistorical context that I elaborate upon further in the next chapter. Although there is a significant amount of 'crossover' in developments in therapy between countries, especially between the USA and the UK, the development of 'pluralism', at least as an identifying label if

not a distinct idea, seems to me to be quite localised to the UK (for instance, book sales are much higher in the UK than the USA), and has been developed in response to the UK's sociohistorical context. The trajectory from Freud in Vienna to pluralism in the UK is explored in the subsequent Sociohistorical Context chapter so that the phenomenon of pluralism can be contextualised within broad therapy movements such as 'integration', and narrower developments more particular to the UK such as IAPT and the National Institute for Health and Care Excellence (NICE).

1.5 The Rationale, Aims and Objectives of the Thesis

The aim of my research was to explore the question, 'How do counsellors and psychotherapists make sense of pluralistic approaches to therapy?'. This research question is an important one at this time in the history and culture of therapy. It is estimated that there are at least 400 different types of therapy (Kazdin, 1986), and 'critical commentators suggest the creation of so many models reflects the scientific discipline of a field in which, it seems, "anything goes"' (Feltham, 2014, p. 10). This state of affairs can be seen as 'unwieldy, confusing, and not credible' (ibid.).

Moreover, the assumption that different models are responsible for different levels of therapeutic effectiveness is highly questionable: 'Lambert (1992) has argued from evidence that a mere 15 per cent of client improvement is accounted for by techniques specific to designated therapy models' (ibid., p. 11). [See also Bohart (2000), Cooper (2008) and Wampold (2010) for more research that supports Lambert (1992)]. Yet so much research in therapy continues to ask whether therapy x is better than therapy y. It could be argued that these kinds of research projects are asking the wrong questions and then coming up with answers that reflect the wrongness of the initial questions. For instance, randomised controlled trials (RCTs) are seen as the 'gold standard' for therapy research by bodies such as NICE (e.g. Reeves, 2014). However, to believe in the validity of the results, one would have to assume that any given therapy acts in as predictable a manner as any medication in measured doses. Research that

attempts to measure the efficacy of therapy as a kind of medicinal treatment misses the importance of the lived experience of therapists and clients in relationship to each other and in relationships external to therapy. It misses factors that are, for instance, 'common... extratherapeutic... [or] placebo' (ibid.). Recently, NICE's 'flawed methodology' (see Thornton, 2018) with regard to its guidelines for depression has been challenged by several MPs (UK Parliament, 2018). NICE took this seriously enough to agree to a second consultation. The consequent revised guidelines, however, were also badly received by several stakeholder organisations including but not limited to the Royal College of Psychiatrists (RCP), the British Psychoanalytic Council (BPC), the British Psychological Society (BPS), the Society for Psychotherapy Research (SPR), MIND, the BACP and the UKCP (Thornton, 2018; SPR, 2018). Their responses are comprehensive and thorough with the main agreements between these diverse organisations being that the NICE guidelines still base themselves on 'wide ranging and fundamental methodological flaws for establishing effective treatment' (Thornton, 2018). Moreover the coalition of organisations warns that if the guidelines are published as they stand they 'will seriously impede the care of millions of people in the UK suffering from depression' (ibid.). A major reason for this is that the guidelines 'will result in patients being offered a limited selection of treatments, which may not be the treatments that have the best chance of relieving their suffering' (SPR, 2018). The implicit demand for a more pluralistic approach to mental health is clear.

There has been a history of moves towards integration since the 1970s (Feltham, 2014), but this has only added to the number of therapies on offer, and has not succeeded in bridging the gaps between 'schools'. So, pluralism, at least as a perspective and, more arguably, as a therapeutic practice, might provide a way of embracing both singular and integrative approaches. However, even the word 'pluralism' is a bit 'unfriendly' and not familiar to some therapists.

From my own experience as a therapist, and from many conversations with therapists, I am aware of some distance between practitioners and academics/researchers that is also reported in the literature (e.g. Norcross & Lambert, 2011b; Reeves, 2014). So whatever the

theoretical, practical and pragmatic merits of pluralistic conceptualisations of therapy may or may not be, how practising therapists experience and position themselves in relation to these ideas will ultimately be the crux on which these ideas live or die. I have spoken with therapists who take a casual approach to working across approaches, but to others who insist on the rightness of their single approach without 'contamination' from other ideas that are perceived as inconsistent with their model. What are the issues here? Why does the theoretical bother some but not others?

There are many unanswered questions around how therapists react to purist, integrative and pluralistic conceptualisations of therapy which I felt were best explored within a constructivist paradigm. If 'pluralism' and 'purism' can be seen as positions, then therapists take up their own positions relative to them, either practically and/or conceptually. The interviews would allow for a deep exploration of these positions and how therapists make sense of them.

It is extremely difficult, if not impossible, to pinpoint just what 'purism' and 'pluralism' consist of, in the 'real world' (Robson, 2011). The words are terms which some therapists have used to construct meanings about therapy. Therefore a constructivist paradigm fits with the overall research question and other questions that might be explored in the asking of that question. The realities that I wanted to investigate would be 'local and specific' (Guba & Lincoln, 1994) with possible implications for other localities and specificities; however, the aim was not to discover universal truths but rather interpret how some therapists made sense of these issues at this point in the history of therapy within particular contexts. The interviews would therefore not be looking for anything 'objective'. Rather the subjectivity of the therapist was what I wanted to know about; and my own subjectivity, whilst secondary in importance to that of the participant, would inevitably influence the dialogue we had and the questions I chose to ask or not to ask.

I believe that people as subjects are not fixed in one position but rather engage in a process in which they experience a multiplicity of positions, both intrapersonally and interpersonally (e.g. Hermans & Hermans-Konopka, 2010; Raggatt, 2012). With this view of the 'self', as

multiple and dynamic, I anticipated that the research would lead to a complex of dialectics that would '[create] findings' (Guba & Lincoln, 1994).

The main aim for the research was to facilitate deeper and more complex understanding of how therapists make sense of pluralistic therapy, theoretically and practically. The findings – whether dismissive, enthusiastic or neutral towards a pluralistic perspective or practice – would have implications for how commissioning bodies, therapists, trainers and researchers develop and focus their practices, and whether pluralistic conceptualisations are worthy of consideration. The main objective for the research was therefore to inform the debates around purism and pluralism. I was interested in how the participants thought and felt about the implications of pluralism for their practices. I anticipated the research would, amongst other things, be exploring the implications of pluralism in therapy for professional identity (Hemsley, 2013a).

I needed a research strategy that would allow me to 'delve deeper into complexity' (O'Leary, 2010, p. 94). The methodological strategy that seemed most appropriate to me for this kind of exploration was to situate thematic analysis within an interpretive interactionist (II) methodology. II itself sits within a symbolic interactionist (SI) epistemology, informed by a social constructivist ontology, within an overall interpretivist paradigm. The detailed rationale for these specific choices is elaborated further in the Research Design (Methodology and Methods) chapter (Chapter 4).

I wanted the rich descriptions (O'Leary, 2010) that therapists brought to the interviews about pluralistic therapy to provide the data for an original thesis. The emphasis and aim were for a free exploration of pluralism and pluralistic therapy as constructed 'objects' (as they would be seen in SI) which attempts to describe practice. Importantly, the participants were not expected to conform to any predetermined meanings applied to pluralistic conceptualisations about therapy. I was interested in both the participants' descriptions and interpretations, and the role of my own subjectivity. When interpreting the transcripts, I wanted to have a 'reflexive, constructive and critical interaction' (Sullivan, 2012, p. 11) between myself and the texts, and I expected meanings to emerge from those interactions (ibid.).

In sum, my aim for the research was that description, interpretation, analysis and discussion of the data would be able to add knowledge to the therapy profession about its practices. Implications for practice and policy, in the light of increased understanding of pluralism and pluralistic therapy, might be inferred through this research process, alongside examination of the sociohistorical context, understandings gained from previous literature, and insights gained about how practitioners make sense of their practice in relation to pluralism. Overall, the research aimed to explore how therapists make sense of pluralism and pluralistic therapy for the benefit of the therapy profession and the people it serves.

1.6 Structure and Outline of the Thesis

There are six chapters in this thesis: (1) Introduction, (2) Sociohistorical Context, (3) Literature Review, (4) Research Design: Methodology and Methods, (5) Findings and Discussion, and (6) Conclusions. In addition to the chapters and the title page there are also: (1) an abstract; (2) a table of contents; (3) a list of tables; (4) a list of figures (5) a list of abbreviations; (6) a preface; (7) acknowledgements; (8) a declaration; (9) references; and (10) appendices. The chapters, with the exception of this Introduction, are summarised below.

1.6.1 Sociohistorical context

This chapter explores the sociohistorical context that led, by around 2007, to the manifestation of 'pluralistic therapy'. To understand the history of therapy and pluralism, this chapter initially has a broad focus, taking in developments in several countries and which then narrows down to how this history has specific contexts and issues within the locality of the UK.

The publication of *Pluralistic Counselling and Psychotherapy* (Cooper & McLeod, 2011) is seen as a major 'critical juncture' (e.g. Aldridge, 2011) when the conceptualisation of 'pluralistic therapy' became widespread within the profession and reignited debates about it and related issues.

Developments since that time, which also contextualise the research, are also explored.

Issues that are covered within the Sociohistorical Context chapter include: (1) a general history of psychoanalysis, psychotherapy and counselling, referring specifically to how these professions have been prone to splits from their early days; (2) developments in research and therapy leading up to the privileging of the RCT; (3) the knowledge bases of therapy (4) professionalisation, regulation and the impact and implications of guidelines produced by such bodies as NICE and IAPT in an 'audit culture' characterised by 'managed care' and 'evidence-based medicine'; (5) CBT; (6) implications of sociohistorical developments for private and third sector provision; and (7) how integrationism gave rise to pluralistic perspectives and practices.

1.6.2 Literature review

The literature review examines how previous literature and research has led to what I describe as a 'pluralistic turn' in therapy.

One philosophical root of this turn goes back to William James, who was the first psychologist to write about the importance of pluralism in his *A Pluralistic Universe* (James, 2011/1908). Therefore there is some discussion of this text and its relevance to pluralism in general and pluralistic therapy in particular.

Pluralism is a term which has a multiplicity of meanings. In order to understand pluralistic therapy it is necessary to understand what pluralism means, so the literature review explores the meanings of pluralism with reference to philosophy from the pre-Socratic philosophers to more contemporary interpretations and critiques.

The main focus of the research, however, was the application of pluralism as a philosophy to the perspective and practice of pluralistic therapy in particular. Therefore, once the more philosophical aspects have been covered, the literature review focusses down on to the theoretical and research contributions made by Mick Cooper, John McLeod, their associates and others, about pluralistic therapy in particular. Cooper and McLeod contribute a great deal of theory and research for counselling and

psychotherapy across a variety of topics and research methodologies, and their contribution to research about pluralistic therapy has been significant, either leading or supporting research projects. There are other more independent researchers, such as myself, but to date a great deal of the research has been connected to these two major counselling and psychotherapy figures. Their influence is international but is particularly strong in the UK, which is perhaps why pluralistic therapy has gained more coverage in this country compared to others. Consequently this section of the literature review refers to Cooper and McLeod extensively, not out of any bias or lack of a comprehensive review, but simply because they have been the major contributors to theory and research about pluralistic therapy.

Overall, this section summarises the research about pluralistic therapy in order to contextualise my own research and demonstrate that it is original, interesting and potentially useful for practice and policy.

1.6.3 Research design: methodology and methods

In this chapter methodological issues are addressed regarding how I approached methodological choices in relation to my research question, 'How do counsellors and psychotherapists make sense of pluralistic approaches to therapy?'.

I identify my methodology as II and my method as thematic analysis, and elaborate on the meanings and implications of the methodology and method in relation to the research. The research paradigm or theoretical framework (interpretivism/constructivism) is justified whilst acknowledging postmodern concerns that efforts to locate research within paradigms reflect a more modern drive to find foundations that do not necessarily exist. With reference to this concern Brinkmann and Kvale's (2015) more pragmatic conceptualisation of paradigms as 'ways of *doing*' (p. 274, emphasis in original), akin to a 'craft tradition' (p. 275) is cited. The chapter also explores paradigms, ontologies, epistemologies, methodologies and methods not used in order to explain the rationale for the choices made. By doing this it was also possible to point at some ideas for future research in advance of the Conclusions chapter, which makes other suggestions inspired by the findings and discussion about those findings.

There is also a full description of how I actually did the research from recruiting participants (including summaries of the main characteristics of the participants), and collecting data by recording interviews, and transcribing and analysing the interview data.

In addition, this chapter provides a rationale for supporting the research as rigorous and of good quality as well as addressing ethical issues involved in the research.

The chapter includes a self-reflexive statement about the research, relevant to the research design, in addition to the personal statements I have made in the Introduction and Conclusions chapters. These statements are all formalised as sections within chapters but my subjectivity comes through in less formal ways throughout the thesis. This section supports reflexivity and subjectivity as an important ingredient of qualitative research.

1.6.4 Findings and discussion

In this chapter an explanation is given of the choice to merge the findings and discussion about the findings (including implications) into one chapter. Then I briefly describe how I constructed themes from candidate themes and codes before naming the themes that I identified: (1) Debates about Pluralistic Approaches to Therapy; (2) Identity and Approach; (3) The Flexibility–Rigidity Continuum; (4) It's the Relationship; (5) The Practice of Metacommunication; (6) The Uncertainty–Understanding Continuum; and (7) Common Factors (I also discovered other themes that were not relevant and so were discarded). The chapter is divided into sections exploring those themes.

Some themes are considered to belong to overarching themes (Braun & Clarke, 2013, p. 231): 'Contentious Issues' and 'Diplomatic Attempts at Resolution' which surround the central theme of 'Debates about Pluralistic Approaches to Therapy'. A diagram is provided in the text to give a simpler visual representation of these themes and overarching themes (Figure 5.1). Within the themes I also identify subthemes. These three layers of subthemes, themes and overarching themes are similarly displayed in a table (Table 5.1). The themes I identify are supported by extracts from the interview data.

This chapter interprets the interview data both inductively from the findings of the interview data, and deductively by contextualising the data within the sociohistorical context and relevant literature. Whilst some researchers might argue that interpretations of data should be either inductive or deductive, it is seen as permissible within thematic analysis to discuss themes both inductively and deductively within the same research project (Braun & Clarke, 2013).

Issues discussed in this chapter, in addition to the identified themes, which relate to pluralistic therapy include: pluralism as therapeutic perspective versus pluralism as therapeutic practice; anxiety in the psychotherapeutic professions; differences between private therapy and 'state therapy' (Samuels, 2016, p. xi); the NHS, IAPT and NICE; CBT; client/patient choice; research methodologies and evidence; psychotherapeutic theories and their philosophical underpinnings; regulation (including SR); managed mental health care and audit cultures; training and identity; being versus doing; relational versus instrumental aspects of therapy; professional contentions over whether there is any difference between counselling and psychotherapy; and the relation of financial and political power to therapy.

This chapter also draws together how the identified themes, and issues associated with them, relate to me on a personal level and, more broadly, to the profession. The most pressing issue that relates to pluralistic therapy is the increasing marginalisation of a variety (or *plurality*) of different approaches within the NHS and other therapy providers (e.g. BPC/UKCP, 2015). Although pluralistic therapy offers some hope that a greater variety of therapies might be offered to clients/patients in the future, and some campaigning organisations (e.g. MIND and the BACP) openly call for more choice for clients, it is not an unproblematic panacea for the difficulties that many therapies and therapists (and, by implication, clients) currently face. Despite Cooper and McLeod's determination to defend their arguments and make pluralistic therapy as inclusive as possible, it remains – especially as a practice (as opposed to perspective), and especially as a practice which attempts to mirror the Cooper and McLeod template for it – open to serious and convincing critiques. These critiques are discussed (some previously

articulated and some my own) throughout this chapter, balancing my sympathies for the approach with my disappointments.

Overall, it is concluded that the research has achieved its aims (although its limitations are acknowledged and discussed) in exploring how therapists make sense of pluralistic approaches to therapy. The research does not claim to provide answers to the problems posed by pluralistic therapy, but it does make suggestions as to how research might take the arguments forward. Qualitative research does not aim for 'finalisability' (e.g. Bakhtin, 1973) so the Findings and Discussion chapter, as well as the thesis as a whole, aims to open up and inform future dialogues, rather than close them down with definitive and final 'answers'.

1.6.5 Conclusions

The Conclusions chapter restates the research aims, summarises the findings and contextualises the major issues raised by the research and their implications.

A central conclusion is the importance of understanding modern versus postmodern paradigms in relation to pluralistic therapy. This has been referred to in previous chapters, but is clearly emphasised in the Conclusions as central to understanding the debates around pluralistic therapy and related issues.

How the themes discussed in earlier chapters relate to issues of professionalisation and regulation is also discussed, and tentative conclusions reached, with specific reference to how an 'audit culture', related to professionalisation and regulation, might impact on the ambitions of pluralistic therapy.

The Conclusions chapter also makes reference to other issues including: methodology; limitations of the research; questions raised by the research and potential for further research; a concluding personal statement about how the research has impacted me, both personally and professionally; and a final statement supporting the thesis as an original contribution to knowledge.

2: Sociohistorical Context

2.1 Introduction

The sociohistorical context of pluralism and therapy, and how the two eventually come together to be named as 'pluralistic therapy' at the beginning of the twenty-first century, is a potentially vast topic, with all kinds of tangents, variables and factors that might be argued to be important and relevant. Therefore, for the aims and purposes of this chapter, some restraints are needed. First, the contextualisation will focus on the development of pluralism and therapy in the UK as opposed to Europe, the USA and other countries. However, since there is so much cross-over in terms of history, research, practice and policy internationally, especially between the USA and the UK, there will inevitably be reference to other countries. This research may have implications for therapy outside of the UK but, in the first instance, it has been an exploration with a view to understanding and contextualising how pluralistic therapy has come to be an issue within it.

Secondly, although the plurality and regulation of psychological practitioners, such as Psychological Wellbeing Practitioners (PWP), counsellors, psychotherapists, clinical psychologists, counselling psychologists, psychiatrists, to name just some, is in itself an issue and relevant to this chapter and this research, they will be referred to for the purpose of understanding the context for those identifying specifically as counsellors and psychotherapists. In addition, therapy between one therapist and one client (dyadic therapy) is the subject of concern (couples therapy and family therapy will not be explored) due to the constraints and focus of the thesis as a whole. The importance of the sociohistorical context for all those differentiated professions would make for interesting further research that there is not sufficient space for here.

Thirdly, the more philosophical aspects of pluralism will be discussed in the Literature Review. Historically, the naming of 'pluralistic therapy' is a recent development although pluralistic practice, not named as such, might be argued to go back much further: it could be said to be a development of –

or perhaps even *part of* – what has been called integrative therapy. Some might suggest that it hardly differs from integrative therapy at all. These issues will be further explored in the Literature Review chapter. How integrationism developed a pluralistic wing or offshoot, depending on one's point of view, will be explored in the section 'Integrative Therapy to Pluralistic Therapy' towards the end of this chapter.

The chapter will be sequenced in the following way: (1) an exploration of the general history of counselling and psychotherapy to demonstrate how a plurality of approaches evolved in the history of therapy since the birth of psychoanalysis; (2) a discussion of the development of research and therapy and the joining of these practices leading up to the privileging of the RCT in therapy research -- pluralistic therapy and the debates it fosters being as much debates about research as about practice: research determines what should or should not be considered valid therapy practices, therefore what research methodologies are considered valid directly impacts pluralistic therapy as a perspective and/or practice; (3) the knowledge bases of therapy; (4) an exploration of the impact and implications of professionalisation and regulation in an 'audit culture' more generally, especially with regard to the NHS (this focus, however, inevitably has implications for private and third-sector provision, which does not necessarily have to mirror how therapy is provided in the NHS -- for better or worse, these sectors can provide therapy in ways that the general regulations and audits of the NHS do not presently allow); and (5) an exploration of the way in which integrationism might have given rise to a pluralistic perspective and practice, pointing to further exploration of these issues in the Literature Review. These sociohistorical developments illustrate the context for purist/pluralist debates within the therapy profession.

2.2 Psychoanalysis, Psychotherapy, and Counselling

A fundamental point about the history of therapy is that therapy evolved in the 'modern' era (e.g. McLeod, John, 2013a), and struggles to find a

'legitimate' place for itself in a 'postmodern' age (e.g. Polkinghorne, 1992). Indeed, perhaps one major difference in the profession is between those who wish to claim legitimacy for therapeutic practices as, for example, 'scientific' and 'evidence-based', and those who see such achievements, or even attempts to claim them, as spurious or irrelevant to the unpredictable dialogical encounters between human beings taking on identities as 'therapists' and 'clients'/ 'patients' (e.g. Polkinghorne, 1992; Yalom, 2015).

From a broad cultural perspective, various commentators have identified themes that facilitated the growth of therapy in 'Western societies', including the 'increase of individualism', 'fragmentation in [people's] sense of self', 'pressure on individuals to act rationally and control their emotions', a 'way of constructing an identity', replacing 'spiritual/religious systems [with] scientific models', and 'increasing emphasis on medical solutions to social and personal problems' (see McLeod, John, 2013a, pp. 28–29). Some of these themes will be explored in more detail in the rest of this chapter, with a view to specifically understanding the sociohistorical context of the intersection of pluralism with therapy.

Therapeutic practices resembling the therapy of today arguably go back to the beginnings of history, and perhaps even pre-history (e.g. Alexander & Selesnick, 1966). This section will restrict itself to those historical developments most relevant to understanding contemporary therapy – that is, from 1859 onwards when 'The Boston School of Psychopathology' was founded. William James, an important figure both for psychology and pluralism, was a member of this group which became the 'epicenter of the new talk therapy' (Wampold & Imel, 2015, p. 17). The group was important in the long-term for beginning to establish talking therapies in the USA as a legitimate medical/scientific activity. The wish for scientific and/or medical credibility for therapy by interested groups is deeply rooted. It might be argued that the pluralism of therapy begins at this stage, when potential conflicts between newer, medicalised, scientific versions of therapy and earlier, non-medicalised, intuitive, 'spiritual' or artistic versions of therapy are situated in an historical context where it seems these apparent opposites are irreconcilable (Wampold & Imel, 2015).

On the other side of the Atlantic, in 1879, Wilhelm Wundt opened what has become known as the first psychological clinic (Danziger, 1990). This was an important development in that it 'established experimentation in psychology' (Wampold & Imel, 2015, p. 11) and the beginnings of trying to provide scientific methodologies and evidence for theories and practices about the psychology of human beings. This development reflects a scientific drive in psychology that runs throughout its history, and which would eventually lead to the contemporary prominence of 'evidence-based therapies'. The latter will be discussed at greater length in later sections about the impact of research and regulation on therapeutic theory and practice.

Sigmund Freud also wanted psychoanalysis to be seen as a science (Orlans & Van Scoyoc, 2009; Tudor, 2018a), and in 1886 he began practising and researching what is most recognisably the root of the talking therapies today, even those therapies whose proponents are most dismissive of his contributions. The fundamental basics of meeting in a particular space, at a particular time, to have a dialogue in which it is explicitly or implicitly emphasised that one partner is mostly to listen, and one partner is mostly to speak, was established by Freud's practice of psychoanalysis. There are others such as Breuer, Janet and Charcot who might, contestably, be seen as 'getting there first'; but in terms of the magnitude of influence, Freud's practice of psychoanalysis is, almost unarguably, the initial point at which contemporary therapy, in all its present pluralities, started. In contextualising pluralism and its relation with therapy today, Freud's psychoanalysis is most easily understood as the 'original' model of therapy, notwithstanding, as previously mentioned, an interesting history of psychological healing before psychoanalysis (e.g. Alexander & Selesnick, 1966).

The drive to 'medicalise' therapy has roots that go back to William James, who was himself trained in medicine (Wampold & Imel, 2015). At first, the medical profession was confused by a practice which used a non-medical intervention (i.e. 'talk') but would come to claim this practice as its own. In 1894, James himself urged 'medicine' to study and ascertain the laws of 'mental therapeutics' (*ibid.*). The first physicians to actually label

themselves as ‘psychotherapists’ were Van Renterghem and Van Eeden ‘who opened a clinic of Suggestive Psychotherapy in Amsterdam in 1887’ (McLeod, John, 2013a, p. 22). It might be argued that the wish to associate talking therapies with medicine was motivated by a need and desire to gain status not so easily accomplished in other disciplines.

The publication by Freud of *The Interpretation of Dreams* in 1900 marked the beginning of psychoanalysis as a nascent theory as opposed to just a practice. He brought his psychoanalytic ideas to America in 1909 via a series of lectures at Clark University, where he also met and talked with William James. Wampold and Imel (2015) state that ‘[w]ithin six years psychoanalysis had become the predominant form of psychotherapy in the United States’ (p. 18). If Freudian psychoanalysis might have been a unified idea and profession, as Freud initially hoped for (see e.g. Ekins & Freeman, 1994), it was already splitting by this time due to the personal and theoretical arguments developing between Freud, Joseph Breuer, Alfred Adler and Carl Jung. Thus, in 1911 Adler introduced ‘individual psychology’ and by 1913 Jung was working out ‘analytic psychology’; so an originally unified psychoanalysis was developing pluralities of thought and practice. It is also notable that a major reason Jung split from Freud was because Freud dismissed the importance of religion and spirituality, aspects of what has become known as the ‘transpersonal’ (e.g. Rowan, 2005a). Jung might be said to have laid the foundations for the many different types of transpersonal therapies that were to emerge from that point onwards.

This ‘splitting off’ or ‘segmentation’ has been recognised in the sociology of the professions as part of a process of professionalisation in which different groups compete with each other for prestige, money and other forms of overt and latent power (e.g. Waller & Guthrie, 2013; Bucher & Strauss, 1961). I refer to the sociology of the professions further in a later section.

Thus, from the beginning, therapy has been prone to splits, segments or – more positively expressed – branches. There has never been a time of unity, and even if it were argued that there was, it did not last long. From the 1900s, the plurality of therapies consisted of different branches within psychoanalysis. Freud insisted that his methods should be regarded as

scientific and rational. Conversely, Jung found himself exploring a path that regarded myths, 'archetypes' and mystical experiences as just as relevant, if not more so, as theories supporting therapeutic practices. These profound philosophical differences about the purpose and understanding of therapy as, on the one hand, a medical intervention designed to 'cure' conditions, and on the other, a more intuitive, healing practice aimed at the whole embodied and 'storied' (e.g. McAdams, 1996) person, have continued to the present day. Medical versus non-medical ways of understanding therapy is a major point of difference and conflict. These are the kinds of differences that pluralistic therapy would eventually attempt to contain by emphasising that 'there can be many "right" answers' (Cooper & McLeod, 2011a, p. 6).

In the 1920s the relative simplicity of splits within a basically psychoanalytic, cognitive and emotional model of therapy began to be challenged by the rise of behaviourism, which was 'openly disdainful' (Wampold & Imel, 2015, p. 20) of Freudian theory. This intensified the desire of various theorists and practitioners to be 'better' than their contemporaries or forebears. The behaviourists, especially, wanted to claim a superior scientific status – hence their focus on behaviour – which can allegedly be objectively observed, as opposed to thoughts and feelings, which are inherently subjective and open to dispute and interpretation.

The competitiveness between these different approaches, and their assertions of superiority, was challenged as nonsensical and invalid as early as 1936 with the publication of Saul Rosenzweig's paper 'Some implicit common factors in diverse methods of psychotherapy': 'At last the Dodo said, "Everybody has won and all must have prizes"' (Rosenzweig, 1936). This paper foreshadows the development of a 'common-factors' approach to therapy in the second half of the twentieth century. It also points to another kind of split within both the profession and researchers, between those who advocate that there are better and worse approaches (in themselves and excluding *other factors*), and those who are more sympathetic to the idea that perhaps it is not the approach that matters so much as those *other factors*. The latter view is crucial to understanding the development of pluralism and its potential importance, since it challenges the basis of so much research. Most therapy research that is taken seriously by

policymakers and providers makes a fundamental assumption that effectiveness as a variable is determined by approach. If this assumption is erroneous, then so are the results. The implications of Rosenzweig's paper have led to professionals and researchers talking with each other about the 'dodo bird verdict' (e.g. Cooper, 2008; Wampold & Imel, 2015) with some advocating for this verdict to be accepted and others challenging it (see also Purton, 2016).

By the 1930s there were two major competing theoretical approaches, those broadly psychoanalytic and those broadly behavioural. Within those approaches there were also subdivisions brought about by differing attitudes, perspectives, theories and practices. During this time, a third approach, a 'humanistic' approach, was beginning to develop, even though it was not named as such at the time. Karen Horney, identified then and now as a 'psychoanalyst', began to challenge major tenets of Freudian theory, including 'penis envy' and a perceived over-emphasis on biological factors and childhood. Horney also suggested that other aspects of human experience needed to be understood more fully by therapists and their clients; most importantly, in relation to the later development of humanistic therapies, the idea of 'self-realisation', which was a major focus of her 1950 book *Neurosis and Human Growth* (Horney, 1950; see also Horney, 1937) – not that different to the term 'self-actualisation' first used as a term, prior to Horney's 'self-realisation', by Abraham Maslow in 1943 (Maslow, 1943).

Maslow was to become one of the innovators and figureheads of what eventually became known as 'humanistic psychology', which formed the theoretical basis for humanistic therapies, and which would also be seen as the 'third force' in psychology (e.g. Maslow, 1968). Interestingly, although humanistic psychology might be perceived by some as in opposition to psychodynamic theories, Maslow himself saw his theory of motivation as an integration of (1) functionalism as proposed by James and John Dewey, (2) holism as proposed by Wertheimer, (3) Gestalt Psychology, and (4) even what he calls the 'dynamicism' of Freud and Adler, suggesting that humanistic psychology might be seen as a 'general dynamic' theory (Maslow, 1943). As psychology evolved into apparently different entities, enabling a pluralistic array of therapies, at least some of the branches did

not dismiss or let go of previous concepts, but engaged with them, and sometimes integrated them. This evolution might be compared to Wilber's notion of holarchies, in which evolution in theory and practice does not discard but builds upon previous manifestations to 'transcend' but also 'include' (see e.g. Wilber, 2000).

In 1942 Carl Rogers published *Counseling and Psychotherapy* (Rogers, 1942). This work laid down the basic tenets of a non-directive therapy, at that time referred to as 'client-centred', which would come to take a prominent place in the array of humanistic therapies. A further split, evident in the title of Rogers's (1942) book, was the ongoing development of another profession -- 'counselling'. In the UK, counselling had also begun to take root -- in organisations such as the Western Electric manufacturing company, which set up an in-house 'employee counselling scheme' in 1936, and two years later, in 1938, the National Marriage Council developed to eventually be formally established as the Marriage Guidance Council (now RELATE) in 1942 (McLeod, John, 2013a). In the USA the APA founded a division in Counselling Psychology not too much later, in 1945 -- although a 'counselling psychologist' might be argued to be something different to a 'counsellor' in the developing plurality of professional titles. The former title was, perhaps, a way for psychologists to claim an activity as their own that, it might be claimed, comes from social movements focussed on particular areas and issues, rather than a psychological model focussed on the individual (McLeod, John, 2013a). In the UK, the BPS laid claim to both counselling and psychotherapy with the formation of a counselling psychology section in 1982 and establishment of a register for psychologists specialising in psychotherapy in 2004 (BPS, 2009). However, McLeod suggests that counselling should be seen as coming from education and voluntary organisations, in sharp contrast to the more scientifically and medically inclined psychotherapists and psychologists (McLeod, John, 2013a).

In the 1940s psychotherapy 'was the province of medicine' (Wampold & Imel, 2015, p. 20) so Rogers, who was a psychologist and not a doctor, was not allowed to use the title 'psychotherapist'. In the UK, although there were no regulations to prevent non-medical practitioners from using the title,

in effect psychotherapy was seen as a medical practice until the end of the 1960s (e.g. see Balfour, 1995). So borrowing the title 'counsellor', which had previously been associated with careers guidance and education, to enable practice by non-medical practitioners, might be seen as a completely pragmatic move intended to enable non-medical practitioners to practise; however, this division of practitioners into 'counsellors' and 'psychotherapists' has become another unresolved area of dispute and controversy in the field. Some practitioners are supportive of this distinction (e.g. McLeod, John, 2013a) and others are not (e.g. BACP, 2010a). Although 'psychotherapy' could eventually be practised by non-medical practitioners, the wish to hold on to a perceived difference and/or superiority continued, adding another dimension to the steady increase of divisions within the practice of therapy. This development in the profession illustrates conflicts that continued to manifest around medicine/science/expert models of therapy versus philosophy/art/facilitator models, with the latter being more associated with humanistic therapies.

In the same year that Rogers published the latest update of his ideas in his book *Client-Centered Therapy* (Rogers, 2003/1951), Gestalt therapy made its presence felt with the publication of *Gestalt Therapy* (Perls et al., 1951). Therefore, by the 1940s/1950s the foundations of three distinct and competing approaches had been established, with the humanistic therapies as the most recent addition. In the aftermath of the Second World War there was pressure to provide more psychological help for soldiers returning to civilian life, and Rogers's client-centred therapy was seen as an inexpensive option for providing briefer interventions with a workforce that would not need too extensive a training. This led to client-centred therapy (as it was then called) eventually becoming 'the dominant therapeutic approach in the USA and then worldwide' (McLeod, John, 2013a, p. 26).

In 1952 the American Personnel and Guidance Association, later to become the American Counseling Association, was founded (McLeod, John, 2013a) -- the same year the Diagnostic and Statistical Manual of Mental Disorders (DSM) was first published. Retrospectively it is possible to see the birth of movements, with different philosophical assumptions and opposing ideas about how best to practise, that would eventually develop into therapy

cultures destined to be at odds with each other. The DSM created a common resource for the diagnosis of disorders that gives the impression of a scientific-medical certainty about human experience that would build upon the predominantly medicalised approach of psychotherapy in this period. The model was of patients consulting experts who could diagnose and then offer treatments that were preferably validated by some kind of scientifically-based research. This approach contrasts significantly with the humanistic and person-centred approaches being developed during the same period. The former might be seen as more valuing of an 'instrumental' approach, whilst the latter humanistic and person-centred approaches might be seen as more 'relational' (Rowan, 2016), although those terms had not yet been formulated.

Behavioural therapy fitted well with the medicalised, scientifically-informed approach to therapy, and throughout the 1950s behaviourism made further progress in developing therapeutic approaches. The most important contributions were made by B. F. Skinner (1953); Albert Ellis (1955) acknowledging the importance of thoughts and feelings as well as behaviour in his aptly-named Rational Emotive Behavior Therapy (REBT); and Wolpe's 'reciprocal inhibition' (1958). It was also 'about the same time the medical barrier was lowered and psychologists began to practice psychotherapy more prevalently' (Wampold & Imel, 2015, p. 20) – although in New York State, it was a close call, as the American Medical Association (AMA), in 1955 and 1956 (what Rollo May called the 'dangerous years'), attempted to legally 'make all psychotherapy a branch of medicine', which would have 'outlawed' psychologists from practising psychotherapy (May, 2011/1992, p. xxiii).

Although those initially trained or educated in psychology are represented in all therapeutic approaches, the particular emphasis on a more scientific sense of psychology is particularly associated with behaviourism and its associated therapeutic approaches, later to be most commonly practised as CBT. It could be argued that these kinds of therapies have, as at least part of their agenda, the wish to promote psychotherapies closely aligned with the discipline of psychology (as opposed to philosophy, for instance). This reflects another aspect of the professional splitting and

divisions around the practice of therapy, and disputed boundaries around who is – and who is not – thought fit to practise.

Despite these developments, humanistic therapies continued to gain influence especially via Maslow (1954) and Frankl (1959), the latter bringing a more existential aspect to humanistic psychology with the extremely popular and influential *Man's Search for Meaning*, much admired by Carl Rogers. The *Journal of Humanistic Psychology* was founded in 1961 and the Association of Humanistic Psychology (AHP) in 1963 (Orlans & Van Scoyoc, 2009). Also, in the 1960s, the medical model itself began to be challenged more overtly by authors such as Szasz (e.g. 1960, 1961) and Laing (e.g. 1960), the latter also bringing an existential influence to bear on the practice of therapy. The Esalen Institute, founded in 1962 in Big Sur in California, was associated with humanistic psychology, especially with respect to its use of 'encounter groups'. Carl Rogers gave lectures there, and both Fritz Perls and Gregory Bateson, leading luminaries of humanistic thought and practice, lived at Esalen for a number of years. It was closely allied with the 'human potential movement' (e.g. Rowan & Glouberman, 2018), and humanistic psychology, due to its association with places such as Esalen and the people who frequented such places, was identified with the counter-cultural movement that took off in the mid to late 1960s (see, for example, Grogan, 2013). It could be argued that this association with its 'new age' connotations may still be an element in the conscious, or perhaps unconscious, marginalisation of the humanistic therapies. Similarly it might be said that this cultural/counter-cultural division is part of the ongoing 'paradigm war' in contemporary culture between a technocratic modernity and a more 'postmodern' impulse.

Halmos (1965) 'documented the correspondence in the twentieth century in Britain between the decline in numbers of clerical personnel and the rise in numbers of therapists' (McLeod, John, 2013a, p. 27). Cultural manifestations such as Esalen might be said to be filling a kind of spiritual gap for people who could not resonate with traditional religious practices. New healing practices and rituals, including psychotherapeutic ones, could fulfil some of the same purposes as traditional religious congregations, such as feeling bonded to others within common reference points, and the

acceptance of and wish to discover nebulous, mystical states (e.g. Frank, 1961). For those who found that too 'spiritual' or 'religious', Maslow provided the psychological (and, therefore, more rational-sounding) term 'self-actualisation'. In the 1960s the cultural exchange between the USA and the UK was intense, with each country influencing change in the other. Esalen formed a prototype for creating contexts for people to encounter each other that was soon copied in the UK (e.g. House et al., 2013).

Simultaneously, in the USA federal employees and others began to benefit from health insurance policies that started to cover psychotherapy from the late 1960s onwards, and in the UK the NHS has provided therapeutic services since its foundation, allowing increasingly more people to access therapy (e.g. Tavistock & Portman NHS Foundation Trust, 2017).

The 1970s continued to see a rise in the popularity of 'transpersonal' therapeutic approaches aimed at the development of the whole person in unashamedly spiritual terms, even whilst more 'rational' approaches to particular symptoms such as depression (e.g. Beck, 1967) began to gain favour within medical establishments. It could be argued that there is a fundamental conceptual split between symptom-focussed therapies, what Halmos (1965) called 'mechanotherapy', which is aimed at perceived illnesses within a whole person, and holistic/narrative therapies which are aimed at the entire person and whose 'illnesses' might improve from exploration of the whole self (e.g. Grogan, 2013). I would argue that this split, which is one reflection of the culture/counter-culture discourses from the 1960s and 1970s onwards, forms part of the current debates about pluralism. Pluralistic therapy argues for the provision of humanistic therapies whether by individual practitioners or mental health services. Humanistic therapies usually have an ethic of working with people over symptoms, and in that sense the pluralistic agenda might be seen as a way of getting humanistic therapies back into circulation. In this way, pluralistic therapy might be seen to be as much about rescuing humanistic therapies from its falling out of favour with established providers, as offering choice and its other ideals – a brazen attempt to challenge the dominance of symptom-based therapies with a more holistic approach.

As counsellors and psychotherapists began to professionalise themselves and organise associations (e.g. the Standing Council for the Advancement of Counselling in 1971, which became the British Association for Counselling (BAC) in 1976), humanistic approaches began increasingly to fall outside of the mainstream (Rice & Greenberg, 1992). Although therapy as a whole was gaining popularity, the BAC only had a membership of about 1000 in 1977, so it was not nearly as strong in influence or numbers as it is today. The professionalisation of psychotherapists in the UK could be viewed as not so much a proactive choice but a reactive one, namely to their fear of being seen in the same category as Scientologists, who claimed to be practising psychotherapy, and whose practices had led to the publishing of the Foster Report (1971), discussed later in section 2.5.1 .

If the history of therapy from the time of Freud up to the late 1970s can be characterised as the 'modern' era of therapy, from the 1980s onwards therapy, along with other professions and cultural practices, entered the 'postmodern era' – as McLeod (2013a) states: 'Among sociologists and philosophers, there is a broad agreement that the past 30 years have marked a significant shift in culture and society, and the ways in which people relate to each other and view the world' (p. 30). The term 'postmodern' had been used in various fields, such as the arts, and had various meanings, but it was around this time that philosophers (e.g. Lyotard, 1984/1979) began to use it to advance 'a sceptical stance towards... "grand narratives", or totalizing truth claims, such as Marxism, psychoanalysis, Christianity... and their replacement by more relativistic, nuanced local knowledges' (McLeod, John, 2013a, p. 30). This attitude towards knowledge is intertwined with pluralistic conceptualisations; in fact, some writers do not differentiate between pluralism and postmodernism (e.g. Wilber, 2000). The philosophical foundations (or lack of) for a postmodern attitude towards therapy, and within the profession itself, were being laid from this time onwards, and provide the context in which pluralistic philosophy would come to have an influence on the future of the profession. Another fundamental division, in addition to the symptom/holism split, can be seen between those promulgating a more 'modern' framework for the practice of therapy, and those challenging these modern conceptualisations

from a postmodern perspective. The former implicitly and/or explicitly believe in totalising, scientific, 'evidence-based' *truths*, such as one approach is definitively and unarguably better than another, whilst the latter postulate that therapy cannot be understood in these terms, and is a practice which fundamentally does not have concrete theoretical 'foundations' of any kind (e.g. Loewenthal, 2011; Polkinghorne, 1992).

Even from a 'modern' perspective the notion that when trying to understand the efficacy (or not) of therapy, *different approaches* should be the variable to investigate, was beginning to be dismissed, if not outside the profession, certainly from a large proportion of practitioners within it (e.g. Stiles et al., 1986). One variable that was being posited to be more important, for instance, was that of the person of the therapist (e.g. Gilbert et al., 1989) rather than any particular technique or approach they employed.

The idea that there were all kinds of factors that might explain the effectiveness of therapy, of which the 'approach' was merely one, began to be argued by practitioners, particularly those who began to advocate 'integrative' therapy (e.g. Saltzman & Norcross, 1990; Norcross & Goldfried, 1992). A growing interest in integrative therapy parallels the increasing influence of postmodernism. It was marked by such events as the founding of the Society for the Exploration of Psychotherapy Integration (SEPI) in 1983 and the founding of the *Journal of Integrative and Eclectic Psychotherapy* in 1991 (Hollanders, 2014). The history and context of integrative therapy, and how that led to pluralistic therapy will be explored further in the last section of this chapter.

Some theorists responded to postmodern ideas directly, such as White and Epston (1990), whose 'narrative therapy' aimed, amongst other things, to externalise problems rather than locating them within the individual. This was a response to the common critique of therapy as too focussed on essentialist conceptualisations of the individual 'self' rather than upon the social structures in which the individual lives. Overall, critics sympathetic to a postmodern deconstruction of therapy problematised its practices as uncritically – and perhaps damagingly – colluding with the problems of postmodern society. Some of these critics argued that therapy provided one more way of filling the 'empty self' (e.g. Cushman, 1990), or

intensified the 'social construction' of individuals being in 'deficit', rather than the postmodern society characterised by insecurities and uncertainties (e.g. Furedi, 2004; Gergen, 1990; Smail, 2005). Others were even harsher with their critiques of the role of therapy in contemporary society. Masson, for example, referred to psychotherapy as being a 'tyranny' (Masson, 1992).

Masson's attack, it might be argued, was effectively only attacking a 'modern' practice and conceptualisation of therapy. Postmodernism puts up a kind of defence against attacks such as Masson's. Polkinghorne (1992), for example, suggested that psychology might be seen as divided into two main camps of 'academic' and 'practice', terming the latter the 'second psychology' (Polkinghorne, 1992, p. 146). He suggests that the underpinnings of this second psychology are postmodern, in the sense that there are no 'truths' of practice as such, only 'pragmatic usefulness in accomplishing a task' (ibid., p. 147) based on the 'actual interactions between practitioners and clients' (ibid., p. 146). This interpretation of postmodernism emphasises a 'neopragmatic' (e.g. Rorty, 1991) rather than an ideological or theoretical foundation for practice, and with its emphasis on goals, tasks and methods sets a tone that supports both proponents of integrationism and, later, pluralism (e.g. Safran & Messer, 1997; Cooper & McLeod, 2011a).

Therapy began to be more widely accepted and practised, leading some to suggest that its influence was creating a noticeable 'therapy culture' (e.g. Furedi, 2004) with influence going far beyond its practice and into mainstream discourses. The BAC boasted a membership of over 8,000 in 1992. Yet despite the influence of postmodernism, the power bases of psychology and therapy (such as the BAC, UKCP, BPS) continued to accept, if not support, the conceptualisation of treatments and disorders as outlined in publications such as the DSM (e.g. American Psychiatric Association, 1980).

The wish to understand the factors of what makes therapy work continued to interest practitioners, and the idea that it is not the approach, not the relationship, not even the therapist that might be the most important factor but actually *the client* – began to be voiced by some (e.g. Bohart & Tallman, 1999; Duncan et al., 2004); another theoretical foundation that

would later come to resonate with the pluralistic emphasis on collaboration with the client. This paralleled cultural shifts in viewing the patient as an expert in the health professions and more transparency between health professionals and patients (e.g. Department of Health, 1999).

In 2001 the British Association for Counselling (BAC) became the British Association for Counselling and Psychotherapy (BACP). The United Kingdom Council for Psychotherapy (UKCP) retains significant recognition; however, arguably, the BACP is better known by the public, practitioners, providers and policymakers. It is, therefore, a significant power in terms of influence on various aspects of the profession. For instance, it does not recognise a difference between counselling and psychotherapy, which is a firm stance to take in a still quite controversial topic within the profession. The division between 'counsellors' and 'psychotherapists' adds another aspect of pluralism to the profession. Should the titles be integrated into a new unitary title such as 'therapist' or should distinctions be made and defended? For the sake of readability, and also out of an admittedly personal bias and preference, for the most part I use the word 'therapist' for both professions throughout this thesis; but I am aware of, and sympathetic to, some of the arguments about the need for a distinction. The push for integration of these titles by a body as important as the BACP might also be seen as another manifestation of the profession prioritising integration over difference and pluralism. Others might say that by becoming an umbrella organisation for both counsellors and psychotherapists it has also achieved more power, influence and monetary expansion than it would have done by representing one or the other. Overall, however, the BACP, by changing its name, and in its policies and statements, shows itself to be sympathetic to a pluralistic stance in which different therapies are valued. Politically and economically, perhaps, it has no choice, since it represents counsellors and psychotherapists of many different persuasions.

By 2005 the political influence of psychotherapy integration on the profession was firmly established and marked by the second edition of the *Handbook of Psychotherapy Integration* (Norcross & Goldfried, 2005) in which the editors assert that 'integration has grown into a mature and

international movement' (p. v). This will be elaborated on further in the 'Integrationism to Pluralism' section of this chapter.

Before that trajectory is explored, however, the influence of research practices, knowledge bases of therapy, professionalisation, regulation and, as in other professions, the impact of an increasingly felt need to audit and monitor practice in terms of outcomes, and other criteria, will be argued to be as important in the development of pluralistic therapy as the more evident philosophical and practical splits outlined above.

2.3 Research, Therapy and the Randomised Controlled Trial (RCT)

The 'cases' that were Freud's first 'patients' in Vienna in 1886 could be viewed as forming the beginnings of research in therapy (e.g. Tudor, 2018a). The case study approach has continued to be used as a research method, and there have been attempts to make it more rigorous and credible; but even within qualitative research it still struggles to be accepted (e.g. McLeod, 2010). The association of psychotherapy with psychology (especially in the USA) (Norcross et al., 2011), and the drive for scientific credibility within psychology, have fostered a culture in which quantitative research about therapy, in particular the RCT, has been taken more seriously, by both researchers and providers, than case studies and other forms of qualitative research (e.g. Tudor, 2018a).

The first randomised designs were developed in the 1920s and 1930s. They did not dominate research methodologies, however, and in terms of therapy research it was actually Carl Rogers, who could be argued to have made the most impact, in the 1940s, with his research based on transcripts of therapy sessions from audio tapes (McLeod, John, 2013a). Rogers focussed on process and the *how*, which remains an important area of therapy research, but less favoured by providers who prefer 'outcome' research. He was interested in outcome as well, but not at the expense of researching process. Emphasising the importance of process as much as outcome aligns with the idea of common factors, so researchers interested in trying to determine the generic 'ingredients', as it were, of successful

practice, emphasise process factors. Some generic factors are associated with positive outcomes but not aligned to any particular approach (see e.g. Wampold & Imel, 2015) which supports integrative and pluralistic approaches from a 'process' point of view. 'Outcome' research is effectively designed to establish winners and losers via statistical results based on 'rigorous', and consequently 'rigid', definitions and delivery of particular approaches.

The first RCT 'is typically dated to... 1948' (Bothwell & Podolsky, 2016) when the British Medical Research Council (BMRC) tested a drug 'for the treatment of tuberculosis' (ibid.), and the RCT is still mostly associated with attempting to determine the effectiveness of medications. In the 1950s the 'randomized placebo control group design' was developed, and has become a standard way of evaluating the efficacy of medications (Wampold & Imel, 2015). Scientific evidence was used to diminish the importance of psychotherapy when, in 1952, Eysenck 'claimed that the rate of recovery of patients receiving psychotherapy was equal to the rate of spontaneous remission' (Wampold & Imel, 2015, p. 24; Eysenck, 1952). In other words, it was claimed that therapy was not effective – quite a damaging claim for the profession, and one that was widely disseminated in mainstream as well as academic media. In response to these claims researchers attempted to increase the rigour of their studies. Rosenthal and Frank (1956) 'recommended the use of placebo-type controls in psychotherapy research in order to establish the specificity as well as efficacy of psychotherapy' (Wampold & Imel, 2015, p. 24). The use of this kind of research laid the basis for 'conceptualizing psychotherapy as a medical treatment' (ibid.) – a conceptualisation that is still with us, and which has become a point of division between practitioners who support or deny the practice of therapy as a medical endeavour.

Despite the severity of Eysenck's attack on psychotherapy, Wampold and Imel (2015) suggest that psychotherapy was found to be 'efficacious' by a 'meta-analysis of psychotherapy outcome studies' (Smith & Glass, 1977) which was later summarised in a book about the 'benefits of psychotherapy' (Smith et al., 1980). Although meta-analyses of therapy were themselves a focus of Eysenck's critique, by this time meta-analysis was the 'standard

method of aggregating research results in education, psychology, and medicine' (Wampold & Imel, 2015, p. 25), so lending strong support to the claim that psychotherapy was indeed effective.

One major problem in research about therapy, then and now, is that for an RCT to be methodologically sound, unwanted variables need to be flattened, or taken into account, so that tentative conclusions about the trial can be made. One variable that needs to be constant for the trial to have any significance (within its own paradigm) is that the 'treatment' or type of therapy needs to be the same, no matter which clinician is delivering it, otherwise the definition of what the therapy actually is becomes too broad to have any effective meaning. Despite the likelihood that practitioners who identify with a particular approach, especially those with more experience, will vary widely in how they practise, for the sake of a successful RCT differences between them must be minimised or eliminated. Therefore it became necessary to work out how a treatment might become sufficiently standardised to allow scientifically valid RCTs to be undertaken.

In 1979 *Cognitive Therapy of Depression*, the first 'treatment manual', which describes not only how to practise a particular approach but also how to practise that approach with a view to treating a particular disorder, was published (Beck et al., 1979). This manual was produced by the proponents of cognitive therapy. Cognitive therapy would later be the basis for CBT, and could be seen as the first RCT-friendly treatment that could easily provide the kind of medicalised research, comfortable with providing treatments for symptoms -- as opposed to therapeutic relationships for people -- that was and is favoured by medical providers.

By 1984 Luborsky and DeRubeis made the claim that psychotherapy treatment manuals had engendered 'a small revolution in psychotherapy research style' (Luborsky & DeRubeis, 1984, p.5). The focus on the manualisation of therapy, arguably for the sake of research, changes the nature of the observed object – in this case, therapy. Those therapies able to comply with manualisation self-evidently would be advantaged as the most favoured for research. The demand that the approach be the solitary variable meant the effacing of the individual expertise of therapists and, indeed, any factors that might lie outside anything other than the approach.

Some therapies and some therapists, for either practical or theoretical reasons, resist manualisation, and with the dominant rise of the RCT it would seem that it was a foregone conclusion that manualised therapies would consequently become the therapies perceived to be scientifically validated. The hegemony of RCTs can therefore be seen as leading to a monoculture of therapy provision from medically-based or -informed providers. This historical development of therapy research might be seen as a major factor in practitioners gravitating towards more non-competitive, integrative models of practice that would later lead to a pluralistic framework and approach. The human element of the practitioner needing to be effectively erased for the sake of validation seemed, for some practitioners and many researchers, a step too far. Other ways of evaluating therapy from more integrative and pluralistic standpoints began to be called for by those who problematised RCTs as an ineffective research model for both process- and outcome-based research.

Overall, the drive was towards standardisations of therapies and standardisations of 'disorders' in order for research to have more validity within medical models of practice. Standardisation is achieved by controlling for the variables of the therapist, the client and the presenting symptoms to ensure that the only variable being measured is the effectiveness of a particular approach. RCTs, therefore, are also problematic because what is being measured becomes something which, it might be argued, is not recognisable as what most therapists and most clients have experienced as therapy (e.g. Wampold & Imel, 2015). Yet within medical systems, general functions of therapy such as examining the unexamined life (Plato/Tredennick & Tarrant, 2003/1954) are considered too vague to be 'medical'. Therefore research about therapeutic approaches, so that they might gain influence within medical establishments, needed to demonstrate that they could treat specific 'disorders' via 'clinical trials' to 'establish the viability of particular treatments for particular disorders' (Wampold & Imel, 2015, p. 24).

It could be said that the practice of research about therapy became akin to the tail wagging the dog, in the sense that therapeutic practice, at least in a research context, was being led by what research required it to be,

rather than research being required to adapt to the idiosyncrasies of therapeutic practice. Therapeutic practice within the RCT method is problematised in the same way as medications for physical diseases. The assumption is that the therapist is much like a doctor treating a mental 'disease', so the RCT methodology is not seen as problematic. Although some argue that research is important for practitioners to learn from, this particular kind of research led to a 'gap' between those who researched therapy and those who practised it, and for some it felt irrelevant to their practice (e.g. Talley et al., 1994).

Yet therapists within medical systems are in competition with other psychological professionals, and in order to survive and thrive within those systems need to prove equivalence, if not superiority, to those other professionals; hence, the willingness of therapists and their representatives to conform to medical models and research methodologies. In particular, psychiatrists who, on the whole, pushed a biological model with treatments based on medications, practised in a way that enabled 'numerous double-blind placebo trials' (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). If therapists wanted to compete with psychiatrists they needed to allow therapy to be conceptualised as something much akin to a medication, not to compete on the level of actual efficacy, but on the level of being able to adhere to privileged research methodologies. In order to do this and establish 'empirically supported treatments' (ESTs) all that needed to happen was for therapy to accept and 'adopt a Medical Model' (Wampold & Imel, 2015, p. 27). In the medical model, a 'biological explanation' is usually the basis for explaining a 'disease or illness' so the 'only modification needed for the psychotherapy version [was] that the biological explanation [be] transformed into a psychological explanation' (ibid., p. 28). The survival of therapists within medical systems gradually intensified the relation of therapy with the medical model. As stated in the previous section, this intensified and politicised a fundamental divide within therapy, between those supportive of the medical model and those uncomfortable with its gradually increasing dominance over the conceptualisation and practice of therapy. It might be argued that this trend reflected an internal split within the therapeutic profession itself, but it can

also be seen as a pragmatic position taken by a professional group in order to have the opportunity to dialogue, and gain acceptance, with the medical establishment within which they hoped to practise.

Because of this tension, in the 1990s the relationship between researchers and practitioners remained difficult (e.g. Greenberg, 1994), and some researchers began to criticise the dominance of RCTs and other privileged methodologies (e.g. Goldfried & Wolfe, 1996). There was optimism that 'consensus' (e.g. Goldfried, 1999, 2000) between researchers and practitioners might be reached for the sake of the profession, so that therapy might be able to communicate on its own terms with third-party providers, and, importantly, be financially rewarded by them.

Attempts were made and continue to be made to bridge the practitioner/researcher divide in the therapy profession by encouraging the idea of 'practitioner research' (e.g. McLeod, 1999). Whether more practitioner researchers have influenced significant change in how providers evaluate therapy, however, is a moot point. The hope that practice-based evidence (PBE) (e.g. Lees & Freshwater, 2008) might be valued as much as evidence-based practice (EBP) still seems some way off being realised (e.g. Hanley & Winter, 2016), with RCTs, especially, at the top of the hierarchy of credibility with bodies such as NICE. This reflects the current 'politics of research' (Parker, 2015).

The importance of NICE, geared to recommending fewer approaches, might be considered to be one factor that developed a need for more types of therapies to be deemed worthy of commissioning, and could therefore be seen as an important element in the eventual articulation of a pluralistic framework for practice. NICE and other governmental and organisational developments will be explored in subsequent sections. For now, the main point to note is that the way research about therapy developed, with increasing emphasis on medical and scientific credibility led to increasing alienation between practitioners, researchers and providers (e.g. Dattilio et al., 2010).

The pluralistic framework that eventually came in more recent years to be developed could be viewed as a kind of polite fight-back for an array of therapies which were getting 'lost' not just in the 'therapy wars' (Saltzman &

Norcross, 1990) but also in the ‘research wars’. The main line of attack on ‘evidence-based practice and empirically supported treatment movements’ was that the factors of therapeutic effectiveness that therapists themselves believe to be important – namely the variables of the therapist, the relationship and ‘other common factors’ – were effectively ignored by this kind of research (Wampold & Bhati, 2004).

Whilst the pluralistic approach, in my view, does not have quite the same agenda as those pushing for integrative/common-factors approaches to research and practice (which will be further explored in the Literature Review and Findings and Discussion chapters), it does share the same goal of trying to encourage different ways of practising, supported by research (e.g. Cooper & McLeod, 2011a; Norcross & Goldfried, 2005). The pluralistic approach has also gained far more influence and renown within the UK than it has in the USA so it could be seen as a particular articulation or version of integrative therapy aimed at influencing UK stakeholders. Reasons as to why pluralistic therapy has gained a much stronger foothold in the UK than in the USA are unclear, and this could make an interesting area for further research.

In the next section I explore the difficulties in gaining consensus around what the knowledge bases for therapy should be (an important foundation for professionalisation) before focussing directly on the professionalisation and regulation of therapy in the UK.

2.4 The Knowledge Bases of Therapy

McLeod (2013a) argues that therapy has a ‘long-standing tradition’ of being an ‘interdisciplinary activity’ (p. 43), whilst suggesting that it is also perceived more and more as a branch of psychology. He suggests that the ‘use of the term “psychological therapies” and the expansion of counselling psychology have reinforced this trend’ (ibid.). He argues that there are other disciplines which are important knowledge bases for therapy such as philosophy and neuroscience, amongst others. Rabu and McLeod (2018) similarly argue that

therapy 'draws on multiple sources of knowledge, including personal knowledge... theoretical knowledge... and scientific knowledge' (p. 776).

Psychology is a major foundation for diverse therapies and it is not surprising that the multiplicity of psychological theories is reflected by a multiplicity of therapeutic approaches. Often no distinctions are made between psychology and therapy, which has implications for claims of distinct and clear knowledge bases for different therapies, no matter the psychological approach upon which they draw.

From a philosophical perspective different therapeutic theories might be perceived to reflect different worldviews, and there is some research that supports the view that therapists are attracted to different therapeutic approaches on the basis of their philosophical positions (e.g. Lyddon & Bradford, 1995).

Neuroscience is seen as being more and more important for the knowledge bases of therapy, and many theoreticians argue that therapists should at least have a basic understanding of the subject (e.g. Montgomery, 2013). Whilst important advances have been made, the relevance of these findings to understanding human experience in its own idiosyncratic contexts is arguable, and some renounce the enthusiasm for neuroscience in the fields of psychology and therapy as a contemporary 'neuromania' (for example see Tallis, 2011).

McLeod (2013a) asserts that '[a]ttempts to fuse counselling and psychotherapy into a single *psychological* therapy will never be successful' (p. 53, emphasis in original) because, he argues, the influence of multiple disciplines on therapy is too important for its practices to be only located within psychology. However, because from an academic point of view singular disciplines are more powerful, and the discipline of psychology is particularly powerful, there has been a tendency for trainings to locate therapy within it. Pluralism and pluralistic therapy directly challenge this tendency towards wanting to integrate counselling and psychotherapy within psychology. This may be theoretically responsible but, professionally and academically, it is disadvantageous. The philosophical basis of pluralistic therapy faces challenges on this pragmatic front.

However, a pluralistic understanding of therapy has the potential to include all the potential knowledge bases of therapy into education and training. This pluralistic perspective would not obligate educators and trainers into providing a training/education in everything, but would emphasise that trainings – ‘counselling’ or ‘psychotherapy’ at postgraduate, masters or doctoral levels – are merely introductions into a practice which relies mostly on experience and continuous, open-ended learning (McLeod et al., 2016). This may go against instrumental notions which demand that a trainee knows everything they need to know before they can be seen as ‘qualified’, but it is probably a more realistic view of what actually happens in practice. Some of the participants in the current research reflected this view in discussing how they were still uncertain about their abilities in the early days of being officially qualified.

McLeod (2013a) argues that psychotherapists base their practice on one approach whereas counsellors draw on different approaches depending on ‘their relevance to a particular client or group’ (p. 58). He seems to be making the case for counselling as pluralistic in nature, and this view was also reflected by one of the participants in my research. I would suggest that this attempt to distinguish counselling and psychotherapy by arguing the former to be more pluralistic is arguably a disingenuous, misguided attempt to find a unique jurisdiction for ‘counselling’ that is unnecessary and undermines the personal and professional potential of all therapists including ‘counsellors’.

Therefore, I make an assumption that both counselling and psychotherapy have similar and overlapping knowledge bases, and issues about pluralism apply to one as much as the other. I hold this view whilst acknowledging that wanting to distinguish counselling from psychotherapy does respect a pluralistic position.

From this perspective both counselling and psychotherapy, or ‘therapy’, can be seen to have evolved a multiplicity of approaches through the development of distinct theories, languages, practices, ‘knowledge communities’, values and mythologies (McLeod, John, 2013a).

McLeod (2013a) suggests that the multiplicity of approaches and the debates they foster may be less about actual differences and more about

what languages are best to articulate practice – an idea reflected by some of the participants in a sub-theme ‘Different names for the same thing’.

McLeod (2013a) further asserts that the manifestation of these various approaches reflects normal commercial interests in establishing ‘brand name therapies’ (see also Gopaldas, 2016 on therapy as a ‘marketplace icon’) which are selling more or less the same thing (despite his insistence that there are real differences between counselling and psychotherapy).

Schwarz (1955 cited in O’Connell, 2005) identifies ‘three stages through which new theories pass’ (ibid. p. 8) which consist of, first, the ‘Essentialist’ stage in which ‘competing schools... [claim] superiority’ (ibid.), secondly, the ‘Transitional’ in which ‘followers themselves begin to recognise limitations to their model’ (ibid.), and thirdly, the ‘Ecological’, which is a ‘process of integrating with other ideas, accompanied by an understanding of the constantly evolving nature of the field. In this stage, a more eclectic position may emerge’ (ibid.). Therapy, in a ‘holarchical’ (e.g. Wilber, 2000) way, that views evolution as transcending yet including what has come before, seems currently to reflect all three stages. The first stage is encouraged by a research culture which wants answers to what schools are superior (as discussed in the previous section), the second and third stages might be seen as reflecting integrative and more recently pluralistic movements in the field.

Whether or not different therapeutic approaches are describing the same phenomena they do all lay claim to a specialist body of theory and knowledge, and it is these theories and knowledge bases that fundamentally allow therapists to make a claim to be ‘professionals’. A distinguishing feature of a ‘professional project’ (see Larson, 1977) is that there is a recognisable knowledge base, the use of which should be restricted to the recognised members of the profession (Waller, 2009). The multidisciplinary nature of therapy, however, challenges the articulation of a consensual knowledge base. In other words, the pluralism of knowledge bases for the practice of therapy, which some would suggest includes not just a multitude of psychological theories but also different philosophies and the humanities, has led to differences of opinion as to what, precisely, constitutes the

knowledge bases of therapy. The literature, and the interview data of this research, suggests that the factors of effective therapy, sometimes at least, do not go much further than the client, the therapist and the relationship they create between them. In other words, the very need for knowledge bases for the practice of therapy is debatable, and if that is contestable then so is the view of therapy as a profession. If therapy is an activity in which ‘personality’ is more important than ‘theory’, then the normal criteria for professionalisation are difficult to apply (Waller, 2009). Nevertheless, despite these difficulties, the professionalisation of therapy (both ‘counselling’ and ‘psychotherapy’) continues unabated: for instance the BACP, UKCP and BPC have recently joined forces to ‘map professional competencies for our professions’ (BACP, 2018b) – and this process of professionalisation (premised on educational criteria) is further explored in subsequent sections.

2.5 Professionalisation, Regulation, Audit Culture, Managed Care and Evidence-Based Medicine

2.5.1 Therapy and the sociology of the professions

Historically, until the late 1960s sociologists took more of a functionalist ‘trait’ approach to the professions, as if they were static entities that were more or less benign, and would survive as long as they served some useful purpose for the wider society (e.g. Durkheim, 1957).

Bucher and Strauss (1961) suggested a ‘process model’ which acknowledged ‘how difference, variation and conflict within a profession act as a driver for change’ (Waller & Guthrie, 2013, p. 5). They argued that

professions are ‘loose amalgamations of segments’ which are ‘more or less held together under a common name for a period of time’ [Bucher & Strauss, 1961, p. 326]. These segments are undergoing continual change. Existing segments develop, join up with other segments, or split, and new segments are formed. So there is never a point at which a profession is a static thing....

(ibid.)

Similarly, Larson (1977) advocated an ‘interactionist approach’ which ‘encourage[d] the researcher to regard social processes as the product of individual and collective actions’ (Macdonald, 1995, p. 13). This forms one basis for this research: an exploration of how therapists as individual

practitioners, and the organisations that represent them, are making sense of pluralism and pluralistic therapy.

Macdonald (1995) states that '[n]o monopoly can be obtained and guaranteed... without the active cooperation of the state... the state is the omnipresent external feature of the professional project' (p. xiii). Therefore, it might be argued that it was just a matter of time before bodies representing counsellors and psychotherapists would begin to want the state to sanction its activities.

Counselling and psychotherapy can be viewed as being in the midst of a 'professional project' (e.g. Larson, 1977), which in the UK, particularly, has been beset by problems. Pressure groups, such as the Alliance for Counselling and Psychotherapy (originally called the Alliance for Counselling and Psychotherapy Against State Regulation), actively campaigned against SR, resisting the furtherance of the project, which was simultaneously supported more keenly (although still with some ambiguity) by therapy's professional or 'occupational' associations such as the BACP and the UKCP. Macdonald suggests that a 'feature of the professional project is the internecine strife that occurs in the early stages, as different occupational strands or professional philosophies contend for power' (Macdonald, 1995, p. 138). Pluralism, in this sense, can be seen as related to professionalisation and regulation, and is common to occupations who are engaged in a professional project to achieve social closure, market control, status and respectability (e.g. Macdonald, 1995).

Macdonald (1995) asserts that in the '[state/profession relationship]... conflicts tend to get resolved in the long run' (p. 119). Whether this turns out to be the case for counselling, psychotherapy and whatever other names might be applied to therapeutic activities, remains to be seen. The intangible nature of the meaning of 'therapy', and the multiple divisions of opinion about its meaning, might have produced a knot too difficult to untangle. This is in addition to the issue of differentiating counsellors, psychotherapists, clinical psychologists, mental health nurses and other allied professionals who practise therapy. There are many professionals who claim they can, and indeed do, practise therapy, who do not bear the titles of either 'counsellor' or 'psychotherapist'. Macdonald (1995) refers to the 'Marxian

sociology of the professions' (p. 22) which, as well as highlighting the relationship of professionalisation to the state, also observes the 'proletarianization of professional occupations' (ibid.), especially, one might add, when they have not achieved social closure. The practice of therapy by allied professionals such as nurses, and the newly titled 'Psychological Wellbeing Practitioners' (PWPs), exemplify a profession that has failed to accomplish 'social closure' (e.g. de Swaan, 1990). Similarly, a weakness in the professionalisation of CBT is the perception of it as a collection of techniques (which, therefore, might not need a specific kind of professional to deliver them), as opposed to a highly skilled activity because 'association of technique with knowledge is one of the potential weak points in the professional armour, for if the technique can be separated from knowledge then the door is opened for other occupations to encroach' (Macdonald, 1995, p. 184).

In relation to the conflict between 'counselling' and 'psychotherapy' it has failed to achieve 'dual closure' which is when 'occupations... having been successfully excluded by an occupation, strive to carve out their own occupational field, distinguishing it from that of other, probably dominant groups but establishing at the same time their own exclusionary practices' (ibid., p. 133). This is problematic in the counselling/psychotherapy divide because some psychotherapists, especially in the private sector, would be disadvantaged by being unable to offer 'counselling', and it is arguable that counsellors do not offer 'psychotherapy' – so jurisdiction of both activities (if, in fact, they do differ) is often claimed by counsellors and psychotherapists.

In the sociology of the professions it is recognised that 'problems... confront many occupations pursuing their professional project' (Macdonald, 1995, p. 140) because it is difficult to '[define] themselves, their work, their jurisdiction and their market in a way that will satisfy all interested parties' (ibid.); and further, 'professional unity is necessary if a professional body is to be sufficiently impressive to obtain state recognition' (ibid., p. 199). These insights foreshadow the problems, which attempts to professionalise therapy have encountered. These problems and other issues are explored in an overview of the professionalisation of therapy in the next section.

2.5.2 The professionalisation and regulation of therapy

Some commentators (e.g. Waller, 2009) refer to the nine features and 'obligations' of a profession, articulated by Lord Benson in 1992 (HL Deb, 1992), as reflecting the 'definition of a profession that is commonly used by learned bodies and regulators today' (Waller, 2009, p. 203). These features, succinctly, are: (1) control by a governing body [e.g. BACP, UKCP] , (2) that governing body 'set[s]... standards of education' (HL Deb, 1992) for entry into the profession, (3) the governing body 'set[s]... ethical rules and professional standards' (ibid.) [e.g. BACP, 2010b], (4) the rules and standards are for the benefit of the public, (5) the 'governing body must take disciplinary action... [if] the rules and standards [are not] observed' (HL Deb, 1992), (6) often the work of the profession is reserved by statute for the protection of the public, (7) there is 'fair and open competition' (ibid.) for services, (8) 'members of the profession... must be independent in thought and outlook' (ibid.) and (9) a 'profession must give leadership to the public it serves' (ibid.).

It is notable that Lord Benson favours self-regulation over SR as long as these obligations are met. For counsellors and psychotherapists, I would argue that they are – with the exception of SR. Since, theoretically, anyone can call themselves a 'counsellor' or 'psychotherapist', some perceive this as dangerous to the public and this fear drives much of the push for regulation associated with the further professionalisation of therapy. Others, however, point out that this assumption of vulnerability in clients can lead to therapists themselves becoming 'victims of controlling systems' (Hall, 2018, p. 283). Additionally, SR can threaten Benson's eighth feature of professional practice, the ability of professionals to be 'independent in thought and outlook' (HL Deb, 1992).

Aldridge (2011) defines 'professionalisation' as the 'process by which an occupation achieves recognition as having specialist skills and knowledge and autonomy in the exercise of such skills and, as a result, is granted privileged status' (p.30). In other words, professionalisation involves claims of expertise which fit with conceptualisations of therapy as consisting

of an expert (therapist) subject treating a non-expert object (patient or symptom). This is more problematic for those therapies which conceptualise therapy as a process in which a non-expert (therapist) subject facilitates healing and/or growth in another subject (client). Therefore privileged status, which many professionals or would-be professionals might automatically value, is questioned by many therapists (e.g. Mair, 1997/2011): the professionalisation of therapy has become a contentious issue that has historically been challenged, particularly by humanistic therapists who emphasise the importance of a subject–subject or I–Thou relationship (e.g. Clarkson, 1995).

Professionalisation, from a feminist standpoint, can be viewed as collusive with patriarchal values (Hearn, 1982). Since the therapy professions have a proportionally large female workforce (about 74–84 per cent [Brown, 2017]), the drive for professionalisation by therapy organisations is sometimes argued to compromise feminist values. Whilst some practitioners, male and female, yearn for their practice to be seen as ‘scientific’ and ‘professional’, others are content for their practice to be seen as ‘artistic’ and ‘caring’. Aldridge (2011) identifies counselling and psychotherapy as ‘caring profession[s]’ like ‘nursing, midwifery and social work’ (p. 102). Whilst this categorisation of therapy is contestable, that is often how it is perceived, and caring professions are typically associated with predominantly female workforces engaged in “‘female” work’ (Aldridge, 2011, p. 103).

Counselling and psychotherapy, as caring professions, are therefore entangled with issues around gender and patriarchy (e.g. Witz, 1992). The wish to gain professional status supports ‘masculinisation’ of the caring profession seeking such status (e.g. Aldridge, 2011; Hearn, 1982; Hugman, 1991). This masculinisation of would-be professions occurs in the context of a patriarchal society which devalues occupations associated with predominantly female workforces. Thus professionalisation can be seen as a process in which practitioners disempower themselves in order to gain status by mirroring and conforming to a patriarchal system (e.g. Abbott and Wallace, 1990; Aldridge, 2011). Whilst there are strong arguments for suggesting therapists need to be recognised as professionals, and need

such legitimisation to work in the public sector, there are different types and levels of professionalisation (e.g. Aldridge, 2011), some of which may be more suitable for therapists than others. Some have argued that professionalisation does not suit therapy at all (e.g. Mowbray, 1995).

There have been attempts to regulate psychotherapy since the 1970s (Aldridge, 2011). In 1971, Sir John Foster compiled a report on Scientology which concluded that psychotherapy should be regulated (Foster, 1971). In response, a working group was set up by several therapy-related associations who, in their own report (Sieghart, 1978), stated that they had 'serious doubts whether psychotherapy as a function could be defined precisely enough by statutory language to prevent evasion' – a problem that arguably remains unresolved. They suggested that this might be avoided by regulation of title rather than practice. However, similar problems occur with trying to regulate titles because unscrupulous (or principled non-complying) practitioners can easily invent unregulated titles. Eventually, in 1981, notwithstanding these problems, a private members bill to regulate psychotherapy was brought to the House of Commons but it was not passed.

The difficulty in defining 'counselling' and 'psychotherapy' – and in identifying the extent to which there are any substantial differences between them -- is a major obstacle for attempts at regulation. For instance, the NHS attempted to define 'counselling' as 'eclectic or a-theoretical in comparison to psychotherapy' (Aldridge, 2011; Parry & Richardson, 1996). This can be true, but 'counsellors' can adhere just as rigidly to a single theoretical model as any 'psychotherapist'. In addition, many person-centred counsellors shun eclecticism because they believe that their effectiveness is based on consistently delivering the 'core conditions'. This example of Britain's NHS making basic errors about the differences between counselling and psychotherapy illustrates the challenge of differentiating the two activities, even if an assumption is made that they are, in fact, different.

In 1999, Lord John Alderdice brought together stakeholder groups in order to statutorily regulate 'psychotherapy' but not 'counselling'. The BAC (as it was then) was unhappy about being excluded, and Alderdice remembered saying: 'I'm not talking about regulating what you are

describing and if there are any of your people who are psychotherapists of course they would be able to be regulated' (Alderdice, 2009 in Aldridge, 2011). This statement demonstrates a surprising lack of knowledge and confusion from someone nominally directing the regulation of psychological therapies. Even if the only point of consensus is that both psychotherapists and counsellors talk to people in confidence, if one profession was felt to be in need of regulation then that would imply regulation of the other, as a major stated aim of regulation is to 'protect' the public. If psychotherapists alone were regulated, then unscrupulous or regulation-averse practitioners would merely have to change their title from 'psychotherapist' to 'counsellor' to enter an unregulated profession. This confusion about 'counselling' and 'psychotherapy', and whether one is more 'professional' (and therefore more worthy of being regulated), again remains unresolved. As Aldridge wittily put it in her research journal: 'It seems that there is now a direct confrontation facing us between the evidence that finds no difference between counselling and psychotherapy and the political view, that there is a difference even if we don't know what it is' (Aldridge, 2011, p. 390). In any case Alderdice's private members bill attempting to regulate psychotherapy was rejected by the government in 2001.

In 2005, Sir John Foster once more reviewed the regulation of psychological therapies, and in 2006 the major professional therapy associations proposed that they should be regulated by a 'Psychological Professions Council', but this was rejected by the Department of Health (DH). It was only in 2007, with the publication of the White Paper 'Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century' (e.g. Department of Health, 2007; see, for example, HCPC, 2017) which proposed that counselling and psychotherapy be regulated by the Health Professions Council (HPC), that the potential reality of SR began to gain momentum. On the recommendation of this paper, in the same year the HPC 'announced [their] intention to investigate and make recommendations to the Secretary of State for Health on the statutory regulation of counsellors and psychotherapists' (Lawton & Nash, 2013, p. 44) and duly formed a Professional Liaison Group (PLG) to help them in this aim.

The UKCP from the late 1980s onwards established a section known as the 'Humanistic and Integrative Section' (HIPS) to include humanistic and integrative therapies. It is notable that the DH, when setting out a 'modality training list for psychotherapy', excluded '*Humanistic and Integrative Psychotherapy* from this list' (ibid.) at about the same time as it was inviting the HPC to consider the possibility of regulating counselling and psychotherapy. Even though this was claimed to be a 'mistake', at least from a Freudian point of view it is an interesting one. It might be said that, at the first fence, Skills for Health had failed to acknowledge the potential importance of a pluralistic perspective for regulation. The impression of organisations representing humanistic and integrative therapies was that there was an attempt to marginalise them, and many individuals and organisations campaigned for humanistic and integrative therapies to be included.

But again, in 2008, Skills for Health excluded humanistic and integrative modalities, claiming that 'other modalities are variants of [psychoanalytical/psychodynamic, cognitive behavioural and family/systemic]'. The Prime Minister's Office stated that '[w]e wish to avoid an increase in different types, or modalities, of psychotherapy' (cited in Lawton & Nash, 2013, p. 46). Eventually the Prime Minister's Office retracted its initial statement that regulation would be restricted to only three modalities; but these events illustrate a wish to simplify the plurality of the psychological therapies from perhaps hundreds of approaches (e.g. Orlans & Van Scoyoc, 2009) to, in that instance, just three. Those who wish to professionalise and regulate have a simultaneous interest in homogenisation and standardisation so that standards and rules can be more efficiently designed; and on this basis alone there is resistance to a pluralistic agenda.

There is a strong desire, however, for the perceived professional status of being regulated, so the UKCP HIPS section eventually agreed that they would refer to themselves as "Humanistic Integrative" or "Integrative Humanistic" (Lawton & Nash, 2013, p. 46), as if the two related but distinct meanings could merge without controversy. Although some theoreticians perceive integrative therapy as existing within a humanistic umbrella (e.g. Gilbert & Orlans, 2011), it is possible to be humanistic but not integrative,

and integrative but not humanistic. Definitions and distinctions were fudged in the hope of achieving regulated status, demonstrating how practitioners and regulators can misunderstand and deceive each other for their own ends. In relation to pluralism and therapy, specifically, it might be argued that because the PLG did not support regulating specific modalities it was supportive of a pluralistic agenda; but in general, common misunderstandings such as failing to differentiate between humanistic and integrative therapeutic approaches is indicative of the challenge to recognise, celebrate and tolerate difference that is central to the pluralistic agenda.

The controversy and polarisation of opinion about regulation was demonstrated by the election of Andrew Samuels as chair of UKCP in 2009. This was despite a warning from an unelected 'political group' within the Humanistic Integrative group itself that '[t]o elect a chair who is associated with the leadership of the "Alliance for the Counselling and Psychotherapy Against State Regulation" [formed in 2009]... would undermine the UKCP's central aims, purpose and function for the last twenty years' (UKCP: HIPS, 2009, in Lawton & Nash, 2013, p. 50).

The HPC published its report 'Consultation on the statutory regulation of psychotherapists and counsellors' in 2009 (HPC, 2009). With regards to pluralism the BACP (2009) agreed with the PLG's recommendation to the HPC that the regulation of approaches was too problematic. The most controversial aspect of the report was how the PLG wanted to differentiate between counsellors and psychotherapists. There are various complaints in the BACP response to the HPC report but it mostly elaborates on their insistence that there should be no differentiation between counselling and psychotherapy, and therefore no differentiation between counsellors and psychotherapists, although they do agree with both professions' titles being protected. The argument that there is no distinction between counselling and psychotherapy, yet agreement that there should be two separate and different titles for practitioners of the same activity (rather than one title such as 'psychological therapist'), seems contradictory. In relation to pluralism, attempts to erase difference between counselling and psychotherapy might

be seen as an attempt at integration, whereas to try to tease out differences respects a more pluralistic position.

Although the BACP does not recognise any difference between counselling and psychotherapy some practitioners do perceive differences. Some counsellors would like to claim jurisdiction over some practices, such as basing themselves in community-based projects rather than health centres (e.g. McLeod, John, 2013a), and some psychotherapists would like to claim jurisdiction over other practices, such as working at a 'deeper... level... over a longer period, usually with more disturbed clients' (ibid., p. 11). Both claims are extremely arguable, and even McLeod, who favours making distinctions, suggests that these differences, amongst several he identifies, be seen as a 'direction of travel' rather than a 'fixed map' (ibid., p. 13).

Amidst the controversy within the profession about regulation the proposals of the PLG were shelved for an indeterminate period with a change of government in 2010. There was a short period of confusion about what was going to happen next, but this was brought to an end by a definitive statement, in March 2011, from Anne Milton MP to the HPC, stating that 'it is not currently our intention to proceed with statutory regulation of psychotherapists and counsellors' (HCPC, 2017) .

Objections to regulation include arguments that as soon as there are strict rules about how to practise based on what has come *before*, then creativity and innovation are discouraged, and certain types of therapy would become disadvantaged if they did not conform to regulations (e.g. House & Totton, 1997). In addition, if a type of practice did not conform to the language used by regulatory bodies, it would find itself excluded. Hence, it could be argued that there are distinct threats to a more pluralistic perspective to therapy from regulation, particularly if it is insensitive to – or ignorant of – the varying needs and values of different approaches. Nevertheless, those in favour of regulation argue that it only seeks to protect the public and encourages innovation.

The importance of regulation, and in particular SR, is a significant controversy in the background to debates about pluralism. One reason, of many, that the most recent attempt to statutorily regulate the psychological

therapies failed might be understood as a consequence of the pluralism of approaches, ideologies and professional titles within the field. The pluralism of the psychological therapies, from a regulatory point of view, is an inconvenience, since regulation requires clarity; and for the psychological therapies, with so many opposing and confusing positions, that clarity does not exist. However, it could be argued that other professions, such as clinical psychologists, also struggle with opposing and confusing positions and have yet managed to regulate their practices.

It is difficult to foresee what SR would actually mean for therapists – to assert what would or would not happen – but one possibility might be the demarcation of approaches/practices leading to professional inflexibility across approaches and professions (Morgan-Ayrs, 2016). In this sense, the issue of regulation hovers in the background of debates about pluralism and purism, since how the professions might be regulated has implications for how pluralistic perspectives and practices might thrive – or not – in such regulatory frameworks. This is especially true for the NHS if not the private sector. Morgan-Ayrs (2016) has concerns that regulation could lead to ‘the session being a tick box series of tasks to be covered in such and such a way’ (p. 11), which seems similar to how Cooper and McLeod (e.g. 2011a) articulate their version of pluralistic practice. Therefore, it could be argued that their framework is not just tailored for favoured models of research, but also for potential regulatory frameworks. This regulation-friendly therapy differs from what Morgan-Ayrs (2016) describes as the ‘spontaneous conversation associated with humanistic or most psychoanalytic sessions’ (p. 31); however, the intangible nature of therapeutic practice goes against what regulatory bodies want to hear. For instance, Szasz (1988) asserts that therapy is nothing more than, at best, rhetorical conversation, and therefore cannot logically be seen as a medical treatment. This might be a valid argument, but it is one that challenges the notion of psychological therapies as ‘health’ treatments, and by implication the placing of these practices in a ‘health’ service. Indeed, the resistance to the medical model from – in a broad sense – humanistic practitioners, leads some to suggest that therapy does not even belong in the NHS (e.g. Lawton & Nash, 2013), since from a

humanistic point of view, mental suffering is not a 'health' issue, but based in existential conditions common to all of us.

Issues around professionalisation and regulation continue to be of central concern to the profession, and have most recently manifested with the DH's 'g professionalism, reforming regulation' consultation document (Department of Health, 2017) and responses to that document from the BACP, UKCP and BPC (e.g. BACP, 2018a).

2.5.3 Audit culture, abjection and the social defence model: anxiety in organisations

Researchers and theoreticians have long been aware of anxiety in organisations. For instance, the 'Tavistock model' uses 'Kleinian psychoanalytic thinking to articulate how organizations structure themselves and the subjectivities of staff in order to defend against primitive anxieties' (Rizq, 2016, p. 72). Rizq further identifies Kristeva's (1982) conceptualisation of 'abjection' to argue that 'NPM philosophies' (New Public Management), based on free market or 'neoliberal' ideologies, enact "rituals of verification", typical of the "audit society" (Rizq, 2016, p. 74; Power, 1997; see also King & Moutsou, 2010), in order to defend against perceptions or feelings of chaos by attempting to impose a sense of order within the organisation. The chaos needs to be 'out there' and the order needs to be 'in here', within the organisation, a kind of projection of what is uncomfortable outwards – hence the term 'abjection'. These rituals of verification necessitate 'increasingly standardized and regulated forms of practice within public sector services' (Rizq, 2016, p. 76). In turn, these require the 'overt privileging of targets and data-collection' (ibid., p. 78).

The willingness to conform to pressures to reach targets, and collect the data that proves or disproves the gaining of these targets, is characterised by Rizq, following Derrida, as a 'phallogocentric' way of caring versus the 'emotional, messy – and maternal – aspects of caregiving' (ibid., p. 79). From this point of view it is possible to conceptualise that more 'masculine' ways of understanding and practising therapy have been privileged within these NPM cultures, whilst more 'feminine' ways have been marginalised. This could be seen as a fundamental divide between different

therapeutic approaches. It would be possible for both 'feminine' and 'masculine' ways of researching and practising therapy to be set on an equal footing; however, in practice, the phallogocentric approach to therapy and therapy research has come to be dominant.

The rise of a pluralistic framework can be understood, on one level, as an attempt to reintegrate the masculine and feminine within therapeutic approaches, and to find a way of reintroducing therapies to providers such as the NHS by, for instance, systematising previous practices so that they can be successfully measured and audited. The so-called 'Counselling for Depression' (CfD) model, for example, is a manualised, RCT-friendly version of the person-centred approach (PCA), stretching its ethical and theoretical stance to allow a symptom to be 'figure' over the 'ground' of the person, at least at the levels of research, assessment and referral (Sanders & Hill, 2014). The establishment of this model, and its uptake within the NHS, might be seen by some as a kind of 'victory', whilst for others it might be seen as an ideological, if not practical, 'defeat'.

2.5.4 Managed care

The concept of 'managed mental health care' refers to the attempt to manage costs within healthcare systems (e.g. Bento, 2016). Therapies that are seen as cost-effective and efficient seem to have inevitably come to dominate provision, to the extent that there is little if any choice of therapeutic approach or practice for clients seeking their health care via organisations such as the NHS. This puts pressure on therapists, and the proponents of the therapeutic approaches they use, to demonstrate efficiencies of practice that were not traditionally part of the psychotherapeutic agenda. For some therapists, the reduction of a Generalised Anxiety Disorder (GAD) score is enough and proves efficiency; for others, it merely scratches the surface of a broader self-narrative in which it is possible, for example, that even a reduced score might actually be reflective of learning how to bury a problem rather than cope with it. The principles of managed health care, which inform how large organisations such as the NHS and some EAPs conceptualise provision of therapy, have

serious implications for the provision of pluralistic perspectives and practices.

The relationship between the UK and the USA is a profound and influential one, and concerning the therapy profession, as with many professions, models of practice developed in the USA are often followed in the UK (e.g. Lees, 2016). So it was that principles of managed care that began to appear towards the end of the 1980s in the USA (e.g. DeLeon et al., 2011) also began to be applied within similar UK organisations. According to Bento (2016), 'there is yet to be any conclusive research establishing the fact that using data driven methods improves the quality of care' (p. 41), yet a felt need to 'standardize treatments and provide evidence of efficacy' (Wampold & Imel, 2015, p. 26) led to a financially driven rationale for therapy to be researched in terms of its cost as well as its effectiveness, based on the idea that standardised models could be created, and unwaveringly applied and monitored.

In the USA, mental health professionals did raise concerns (DeLeon et al., 2011) about the implications of managed care for psychotherapy practice (e.g. Fox, 1995; Karon, 1995). Psychotherapists themselves reported that managed care 'was having a negative impact' (DeLeon et al., 2011, p. 49), yet their concerns were not responded to in either the USA or the UK.

The most apparent effect of the growing influence of managed care policies was the drift of therapeutic provision to the briefest forms of therapy, and also those that could claim 'evidence-based' status. This would, perhaps inevitably, lead to a narrowing of choice, both for therapists and clients, in relation to how they could conform to the expectations of providers. This narrowing of choice would also set the ground from which a call for a more pluralistic approach might become more vocal and challenging of the existing order.

At philosophical and ethical levels, therapists have also been obligated to accept conceptualising therapy as part of a larger 'kind of medical consumerism' (Cushman & Gilford, 1999). The ideologies of managed care could not help but influence how therapists practise and its implicit assumptions seep into the therapeutic relationship. Cushman and

Gilford (1999) suggest that: '[d]espite consumer satisfaction-like questionnaires and post-test measures, the overall power relation of expert to object seems to continue unabated... in the social terrain of managed care, patients come to light as objects of technician intervention' (p. 25).

Further, Cushman and Gilford (1999) suggest that managed care, in its impact on the practice of therapy, reflects a culture in which 'everyday survival strategies necessitate a life devoid of a deep self with a complex – and singular – subjectivity', since such a self is 'conterminous with the intensified valorization of speed, efficiency, and productivity' (p. 27). In this culture the 'concerns of labor are erased by an unquestioned acceptance of management's profit motive' (p. 28). In the way that practices reflect the wider cultures around them this would apply not just to workers locating their problems within themselves, and their perceived inability to cope with environmental pressures (rather than unreasonable demands by employers, perhaps), but also therapists submitting to, or uncritically accepting, the demand that their practices should prioritise efficiency over effectiveness.

In the UK the growth of managed care in its health systems began with the introduction of free market ideology in the 1980s (Lees, 2016) and the ideas of the NPM (Ferlie et al., 1996). For managers to make the best decisions, however, they needed evidence – hence the importance of evidence-based medicine and, consequently, evidence-based therapies.

2.5.5 Evidence-based medicine, evidence-based practice, NICE, IAPT and CBT

Evidence-based medicine can be conceptualised as a three-legged stool in which 'the use of evidence (first leg) is to be balanced with the expertise of the clinician (second leg) and characteristics and context of the patient (third leg)' (Wampold & Imel, 2015, p. 11). It has been further described as making 'use of individual patients'... preferences in making clinical decisions about their care' (Sackett et al., 1996, p. 71). Sackett et al. (1996) warn that 'without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient' (p. 72). It is important to note that in these conceptualisations of evidence-based medicine, which are mostly sympathetic to and uncritical of it, evidence is not seen as superior to

'clinical expertise', and in relation to pluralistic approaches to therapy, it is also not seen as superior to patient choice. Yet arguably, in the practical application of evidence-based medicine, it seems as if two legs of the stool have been taken away, with just the first leg (that of evidence) being considered, with the wishes of clinicians and patients being demoted if not forgotten. This was how some practitioners viewed the impact of evidence-based medicine in the USA, and it is also how many practitioners began to view it in the UK, especially since the establishment of the National Institute for Clinical Excellence (NICE) in 1999 (its title was later changed to the National Institute for Health and Care Excellence, but it uses the same abbreviation).

NICE states that their aim was 'to ensure that the most clinically and cost effective drugs and treatments were made available widely on the NHS in England and Wales' (NICE, 2016, online) and to 'speed up the pace at which good value treatments were used' (ibid.) They also claim that they 'established a worldwide reputation for producing authoritative, evidence-based advice and guidelines' (ibid.). In this self-appraisal it is worth noting the casual use of the phrase 'evidence-based', which has fully seeped into everyday discourse and is used, without any need of explanation or critique, throughout the media. Everyone knows, or *thinks they know*, what it means. It is also worth noting the managed-care implications of 'good value treatments' putting the cost of treatments as a central concern. NICE is, unsurprisingly, supportive of the medical model, and this necessarily has implications for the provision of therapy. Therapy was perceived by NICE as a medical treatment like any other, and it seemed as if therapeutic practices were shoehorned into the medical model, without any consideration that they might not be as straightforwardly understood in the same way as drug treatments or medical devices.

This is partly due to NICE's privileging of RCT evidence over any other kind (see, for example, NICE, 2014/2017, p. 103 cited in Barkham et al., 2017). The BACP in its response (BACP, 2017a) to the NICE draft guideline for depression note that RCTs are seen as superior to even the 'very large... IAPT dataset' (ibid., comment 8) and therefore does not even follow 'NICE's own procedural manual' (ibid.). As Loewenthal puts it: 'whilst

[NICE] recognises many of the issues concerning its methodology, it ends up acting as if they don't exist' (Loewenthal, 2016, p.18). Loewenthal (2016) suggests that therapy's historical and contemporary practices of supervision, writing and presenting papers provide a functional way of monitoring and evaluating practice which is superior to RCTs which he asserts are 'against the very nature of what for many is the therapeutic enterprise' (p. 14). He perceives the emphasis on RCTs, and similar forms of privileged quantitative research, shaping practice detrimentally, and mourns '[t]heoretical explorations' not being seen as research at all. He cites the APA's encouragement of a pluralistic approach to research methodologies to suggest a way forward for NICE and IAPT, whose over-adherence to a medicalised symptom-based model constructs a version of therapy, and ways of researching therapy, which can only be useful for therapists and clients if they are in agreement that the latter's problems fit neatly into diagnostic labels. Real consequences of the monistic, quantitative and scientific approach to approving therapies are that choices for NHS patients are, self-evidently, limited to the approaches that have been approved, and therapists, some with decades of clinical practice and experience, who have not trained in these approved practices, are perceived as having nothing to offer. This issue has been highlighted by research undertaken by the BACP (Perfect et al., 2016) in their document *Choice of Therapies in IAPT: An overview of the availability and client profile of step 3 therapies*. Barkham et al. (2017) also make the point that 'improving patient treatment choice improves therapy outcomes' (ibid., p. 264), so reducing choice is counter-productive. Additionally, despite the success of CfD in RCTs leading to it being nominated by NICE as an 'evidence-based' therapy, CfD practitioners only make up '6% of the high-intensity therapist workforce' (Drewitt et al., 2018). In other words, even providing the required evidence does not seem to have made much impact in improving choice of different therapies for clients.

The biggest change affecting the provision of therapy in the UK was the formation of IAPT. This has been dated to 2003 when Lord Layard met Professor David M. Clark at a British Academy tea party (Evans, 2013). From an SI perspective it is notable that perhaps the most important

development in the provision of therapy in the UK this century occurs in a microsocial context.

On one level, the introduction of IAPT, when it came, was a giant leap for the provision of therapy in Britain, as '[b]efore IAPT, the NHS spent just 3% of its mental health budget on talking therapy' and 'IAPT... tripled that budget' (ibid.). However, with the publication of the NICE guidelines for depression in 2004, it was disappointing for therapy professionals that only two types of therapy were recommended – namely, CBT and a time-limited, structured therapy called interpersonal therapy (IPT). All other approaches were not recommended for depression because, according to NICE's definition of evidence, all other approaches did not have enough to gain the status of 'evidence-based'. Even accepting that therapeutic approaches should be seen as targeting specific disorders, and prove their effectiveness at targeting them, the guidelines were problematic, as the evidence was clearer for 'severe' as opposed to 'mild' or 'moderate' depression. Therefore a potential danger, recognised by medical professionals themselves, was that clinicians/patients might take on a more serious 'depression' diagnosis in order to obtain treatment that would not be available with a less serious or non-medicalised complaint. However, the evidence of what worked for mild or moderate depression was not as robust so, ultimately, there was not sufficient evidence that people with mild or moderate depression were actually getting evidence-based treatment (Middleton et al., 2005).

In January 2005, Layard and Clark presented their recommendations at 10 Downing Street, and proposals for IAPT went into the Labour Party's manifesto for the 2005 general election (Evans, 2013; Cohen, 2008). One major reason that Layard and Clark were able to get the Labour government to commit to an IAPT programme was because 'CBT had built up a big evidence base to show it worked' (Evans, 2013, online; see also Research Excellence Framework, 2014) – although the superiority of CBT to counselling and other psychological therapies is easily disputed (e.g. Barkham et al., 2017). When what has come to be known as Layard's 'Depression Report' came out in 2006, CBT was recommended as a therapeutic approach that would not just be effective, but also inexpensive and efficient (CEPMHP, 2006). In the report CBT was described as the 'most

developed of [the evidence-based psychological therapies]' (p. 1). Of the 10,000 new therapists that they proposed should be trained in delivering CBT, they suggested that half of them should be 'clinical psychologists', and the other half trained from the existing workforce of 'nurses, social workers, occupational therapists and counsellors' (p. 7). It is interesting to note that counsellors are enumerated last in that list, and their expertise in delivering therapy only acknowledged as equivalent to the other professions that precede their mention. Psychotherapists receive no mention at all. This powerful document, whose effects are still reverberating around the provision of therapy in the NHS, effectively discounted the expertise of therapists (both psychotherapists and counsellors) already working in the NHS, and the models they had trained in, as insufficient for the task of 'improving access' to psychological therapies. Documents like this came to create a cultural ground in which CBT became privileged as the best therapeutic approach at the expense of others. Perhaps the only 'winners', in terms of increased employment opportunities and power, were psychologists associated with CBT: recent figures (IAPT's own) state that 42 per cent of the IAPT workforce are CBT practitioners (Drewitt et al., 2018).

Therefore, in the sociohistorical developments of the therapy profession in the UK, a trajectory can be traced from competing interests within the profession itself, leading to an emphasis on research which then leads to an emphasis on the RCT. In response to the context of a developing audit culture and that culture's need for evidence and efficiency, CBT, with its evidence base and perceived efficiency, then comes to dominate the provision of therapy, and other approaches lose their status and are marginalised, if not erased, from public providers. The private sector continued to provide employment opportunities for other approaches (and this issue will be explored in other chapters) but, within the NHS, CBT, to a great extent, began to monopolise therapy provision.

CBT can be likened to the 'elephant in the room' not just for the current research but for the pluralistic agenda more generally. One of my participants, a CBT practitioner himself, described it as 'flavour of the month'; but it might be said to have been the flavour of the past decade in the NHS and beyond. In terms of public relations it has also made great

achievements in influencing the media, usually uncritically, to accept it as the only evidence-based therapeutic approach for a wide array of disorders. Simultaneously it has come under attack from therapists who do not follow the approach, perhaps with some rationality, but also with emotional defensiveness (e.g. Leader, 2008). For therapists who do not follow the approach, and have belief in the efficacy of their own non-CBT approaches, it can seem like watching helplessly as one pupil gets all the prizes.

A common critique of CBT, articulated in different ways, is that it reflects a wider neoliberal agenda in which teaching “technologies of the self” to the CBT patient echo Foucault’s notion of “disciplinary power”... where the state uses subtle power to mould its subjects into acquiescence’ (Watts, 2016, p. 89). Unsurprisingly, CBT practitioners and their proponents rebuff these kinds of criticisms as a caricature (e.g. Veale, in Samuels & Veale, 2009).

In 2008, adding to the plurality of psychological practitioners, the DH produced an implementation plan for the training of ‘low-intensity therapies workers’ who would facilitate the use of CBT via ‘guided self-help and computerised CBT’ (Department of Health, 2008, p. 3). These workers would come to be known as ‘Psychological Wellbeing Practitioners’ (PWP) who would be perceived as fit to practise after 45 days training (ibid.). One advantage, in terms of cost, is that these practitioners could expect a maximum pay rate less than even a trainee psychotherapist. Therefore therapists in the NHS were not only coming under pressure in terms of their approaches being devalued, but also in terms of their professional opportunities being ‘undercut’ by the creation of jobs/titles purportedly needing less expertise, a ‘proletarianisation’ of therapeutic practice referred to in a previous section.

It is against this background of an audit culture which based its decisions about therapy provision on narrow definitions of evidence that led, from a pluralistic perspective, to the monistic hegemony of CBT. The pluralistic framework of Cooper & McLeod (2007, 2011a) could be interpreted as an evolutionary response to these developments. It might also be interpreted as a response specific to the UK (its influence seems not to have impacted the USA significantly), as a way of presenting therapeutic

practices to UK stakeholders in a comprehensible manner, using a new term that was not as tired or as researched as 'integrative'. How integrative therapy came to develop or engender pluralistic therapy, and what, if any differences there are between the two approaches, will be the focus of the next section.

2.6 Integrative Therapy to Pluralistic Therapy

One of the first figures to be associated with the development of integrative therapy was French (1933). In 1932, he delivered a talk at a meeting of the American Psychiatric Association, and this was later published as a paper, with contributions from himself and others who had attended the meeting (Goldfried et al., 2011). In his talk and paper, French 'drew links between the work of Freud and Pavlov' (ibid., p. 270). Some practitioners were supportive of this attempt to integrate behaviourism and psychoanalysis, whilst others were disparaging.

A few years later, Rosenzweig (1936) published a paper in which he argued that beneficial therapeutic factors might not be those which any given therapeutic theory postulates but less obvious 'common factors', such as the 'therapist's personality' (p. 413), which might apply across a range of theories. To illustrate how far the beneficial factors might be from those purposefully employed by the therapist, he suggests that a successful course of therapy with a psychoanalyst could be explained by Pavlovian behavioural changes rather than Freudian theory, perhaps making a nod towards French's paper. Rosenzweig's most important contribution is the identification and naming of 'common factors' which would come to be revisited and rearticulated by integrative theorists and practitioners some decades later. Whilst acknowledging that some approaches might be more effective with particular problems, Rosenzweig's view, on the whole, is that 'it is of comparatively little consequence what particular method [the] therapist uses' (p. 415). It is also interesting to note, from a pluralistic perspective, that Rosenzweig suggests that the 'therapist should have a repertoire of methods to be drawn upon as needed for the individual case' (ibid.).

Watson (1940) suggested that there were 'areas of agreement in psychotherapy' such as a common belief in the importance of the therapeutic relationship. Another important point he made was that 'agreement is greater in practice than in theory' (p. 708). This reflects, similarly to the research/practice gap, that there is also a theoretical approach/practice gap. In other words, the way practitioners actually practise does not necessarily line up with the principles of their identified approaches (e.g. Spurling, 2016). It might be argued that some practitioners pay barely any attention to theoretical principles of different approaches, except in the most cursory sense. This experience was reflected in some of my research interviews, and has also been theorised in different ways by some academics and researchers (e.g. Loewenthal, 2011). Further exploration of this aspect will occur in the Literature Review and the Findings and Discussion chapters.

Arguments for and against more integrative ways of perceiving therapeutic practice continued (e.g. Dollard & Miller, 1950), but it was the publication of Frank's *Persuasion and Healing* (1961) which suggested that common factors should not just be recognised in the relatively recent, Western practice of therapy, but for many healing practices across different cultures. Frank's (1961) book gave the integrative agenda the boost and visibility it needed to have more impact on practitioners. Two more editions of the book have also been published (Frank, 1973; Frank & Frank, 1991), and all editions have greatly influenced the proponents of a more integrative approach to therapy (e.g. Wampold & Imel, 2015).

Frank effectively created a 'common-factors' model which Wampold and Imel (2015) acknowledge as being the basis for their later Contextual Model. Frank argued that 'people seek psychotherapy for the demoralization that results from their symptoms rather than for symptom relief' (ibid., p. 48). In other words, it is by engaging with the demoralisation rather than the 'depression', for instance, that makes therapy effective: a subtle but profound differentiation to symptom-based models of research and practice. The main common factors that Frank and Frank (1991) identified were:

[1] an *emotionally charged, confiding relationship with a helping person*... [2] the context of the relationship is a *healing setting*... [3] there exists a *rationale, conceptual scheme, or myth* that provides a plausible explanation for the patient's symptoms... [and] [4] a *ritual or procedure*... consistent with the rationale that was previously accepted by the client. (Wampold & Imel, 2015, p. 48; italics in original).

Lazarus (1967) 'introduced the concept of *technical eclecticism*' which proposed 'using therapy methods advocated by different orientations without having to accept the theoretical underpinning of those orientations' (Goldfried et al., 2011, p. 273). The pragmatic nature of this attitude to practice would later be reflected in the pluralistic approach. A few years later he formalised his ideas as a distinct approach that he named 'multimodal therapy' (Lazarus, 1970).

Wilber's (1979) *No Boundary* focussed specifically on how Western therapeutic approaches might be compared to and contrasted with Eastern spiritual practices, and how specific therapeutic approaches might be more or less useful for specific stages of development. Although he has generally not been acknowledged by mainstream practitioners and researchers, Wilber foreshadows the integration of meditative practices into therapy. One example of such integration is what CBT practitioners in the 2000s termed 'third wave' CBT, consisting mostly of a generic Mindfulness-Based Cognitive Therapy (MBCT) programme. These practitioners did not acknowledge Wilber's influence, but his influence is acknowledged more openly by those identifying overtly as 'transpersonal' psychologists or therapists, especially in the USA. In the UK, the late John Rowan was the leading exponent of Wilber's ideas (e.g. Rowan, 2016), but Wilber's influence on therapy in this country is not widespread. Nevertheless, the idea that different therapies might be useful for different stages of personal development has parallels with what the pluralistic approach would be arguing some years later.

The integrative movement as a whole was based on 'dissatisfaction with individual theoretical approaches' (Wampold & Imel, 2015, p. 45). By the early 1990s, Arkowitz (1992) was able to identify three distinct movements within the integrative movement: (1) theoretical integration, (2) technical eclecticism and (3) common factors. Theoretical integration 'is the

fusion of two or more theories into a single conceptualization' (Wampold & Imel, 2015, p. 46); technical eclecticism attempts to tailor therapeutic approaches and techniques by considering the specifics of clients, therapists and problems; and the common-factors movement, as its name suggests, and which has been discussed previously in this section, 'attempts to identify and codify the aspects of therapy common to all psychotherapies' (Wampold & Imel, 2015, p. 47). Gilbert and Orlans (2011) suggest there are four definitions of integration which may or may not overlap with each other in any given integrative approach: (1) a 'holistic view of the person... as an integrated whole', (2) the 'integration of theories and/or concepts and/or techniques', (3) the 'integration of the personal and the professional' and (4) the 'integration of research and practice' (pp. 22–23). Other ways of integrating therapies include '[a]ssimilative integration', '[h]olistic integration', '[d]isorder-specific or problem-oriented integration', '[m]ulticultural and culturally adapted therapy', 'feminist therapy', and 'collective integration' (McLeod & Sundet, 2016, pp. 159–160).

In the early 1990s, postmodernists such as Polkinghorne (1992), discussed in a previous section, were also making strong theoretical statements challenging the claim that any one theory could claim precedence over any other, whilst simultaneously arguing for the acceptance that the experience of actual practice, by individual therapists with individual clients in particular contexts, was more important than theoretical constructs. In postmodernist terms that elude modernist certainties, Polkinghorne argued that:

therapists use previously effective actions as a guide for their future actions; their clinical experiences are the source of their knowledge. Yet experience is not seen as a foundation for sure knowledge. Experience itself is the repository of previous constructions. (Polkinghorne, 1992, p. 158).

Polkinghorne further suggests that '[s]uccessful therapy has been accomplished by therapists committed to various conceptual networks and practicing a variety of techniques. The psychology of practice accepts the concept of equifinality – that the same result can be achieved through a variety of approaches' (ibid., p. 161). The neopragmatic, postmodern sensibility of these kinds of arguments reflects almost exactly what Cooper

and McLeod (2007), who acknowledge postmodernism as a major influence on their pluralistic approach, will be saying in the first decade of this century.

Petruska Clarkson (1995) also wrote with a sensibility influenced by postmodernism. Her writings did not have much impact in the USA, but were acknowledged and respected in the UK. Clarkson conceptualised an integrative framework based on five different types of therapeutic relationship, which she suggested 'are potentially present in any psychotherapeutic encounter' (p. xii). This model was influential enough to form the basis of some integrative trainings in the UK, and helped in advancing the cause of integrative therapy more generally.

The literature, supporting an integrative view from theoretical, research-driven and practitioner perspectives, expanded throughout the 1990s (e.g. Hubble et al., 1999; Miller et al., 1997) in both the UK and the USA. There was a certain amount of mutual support and influence between the two countries around integrative therapy, but it is noticeable in the literature that there is not as much exchange as might be expected between practitioners and researchers sharing the same language, if not the same country.

The contexts of provision vary widely between the USA and the UK: in the former, a culture exists in which health costs are mostly funded by health insurance; and in terms of providing therapy, a culture in which for the most part, psychologists have pushed for their profession to be the licensed providers of therapy. In the UK, in the context of the NHS, although clinical psychologists have been successful in staking their claims of expertise, the separate and differentiated trainings of counsellors and psychotherapists have been more clearly acknowledged in terms of recognition and professionalisation. In other words, the notion of counsellors and psychotherapists as differentiated professions with different skill-sets to psychologists and other 'psy professionals' (e.g. Walker et al., 2015) has been established more successfully. In the USA, from the literature (e.g. Norcross et al., 2011) it often seems that psychotherapy is viewed as a practice that belongs to an array of practitioners, from social workers to psychiatrists, but especially psychologists; whereas in the UK the idea that psychotherapy belongs to psychotherapists and counselling belongs to

counsellors, seems relatively more embedded. This is not to say, however, that other professions laying claim to both counselling and psychotherapy is not also problematic in the UK, as mentioned in previous sections. As has been previously discussed, the structures of training cannot help but change the way practitioners practise; and, arguably, the ways in which 'counselling' and 'psychotherapy' are conceptualised by practitioners and clients in the USA and the UK are very different. Space precludes a further exploration of this issue here, but in contextualising integrationism and pluralism in the UK it needs to be borne in mind. As has been argued earlier, pluralism might be seen as a particularly 'local' version of American integrative therapy, responding to local circumstances more effectively than might be afforded by identifying with the older, more established integrative movement.

Practitioners themselves have responded positively to integrative ideas. Hollanders and McLeod (1999) surveyed over 300 British therapists and found that '49 per cent... reported themselves as *explicitly* eclectic/integrative, with another 38 per cent being *implicitly* eclectic/integrative (identifying themselves with a single theoretical model but also acknowledging being influenced by other models)' (McLeod, John, 2013a, p. 362, italics in original). The large number of therapists who identify with single approaches but actually derive their practice from more than one approach supports the contention that there is a gap between espoused theories (how therapists think they practise) and how they actually do practise. This gap is also revealed at points in the interviews of this research.

These kinds of theory–practice–research gaps are problematic for the therapy profession, as '[o]n the one hand most practice guidelines and research, and many training courses, are organised after single-model lines. On the other hand, the majority of practitioners describe themselves as deploying some kind of combination of approaches' (McLeod & Sundet, 2016, p. 159 in Cooper & Dryden, 2016a; Norcross et al., 2005; Thoma & Cecero, 2009). It is not surprising that organisations responsible for providing therapy understand it as a competition between single models, since this is the way in which the therapy profession has historically presented itself, even though many practitioners are not actually wedded to single models. The integrative movement and, latterly, the pluralistic

approach have attempted to transform the conceptualisation of therapy; and although they may have won over therapists themselves (to some extent) they certainly have not, on the whole, won over the institutions and organisations within which they practise.

Cooper and McLeod (2007) responded to this conundrum by proposing a 'pluralistic framework for counselling and psychotherapy'. Their rationale for doing so, and suggesting that this was a development that differentiated itself from integrative and eclectic positions, was that '[integrative and eclectic positions] have not been successful in generating research and have resulted in a further proliferation of competing models' (p. 135). They also suggest that their pluralistic approach operates as a metatheoretical model rather than as a theoretical model in itself. Yet the idea that therapy can be conceptualised to work at different levels of abstraction (technical, strategic and theoretical) has been part of therapeutic literature and practice for many years (e.g. Wampold & Imel, 2015). In particular, the conception of metatheoretical positions could be argued to go back as far as Wilber (1979); and by the time Cooper and McLeod (2007) suggest their pluralistic framework, there actually exist a host of metatheoretical conceptualisations about therapy. Therefore we are faced with the paradox that metatheories, at least partly designed to transcend competition between theoretical models, have, at a different level, created further competition.

As suggested previously, however, a metatheoretical framework had not, perhaps, been articulated so well in the UK. Cooper and McLeod (2007) seem particularly concerned about the consequences of the lack of pluralistic theory and practice, especially with regards to training, NICE guidelines and therapy provision within the NHS. This reflects a local agenda and supports the notion that the creation of pluralistic therapy, as a way of understanding and practising therapy, had specific ambitions within the UK. The subtitle of their 2007 paper is 'implications for research', which also reflects their ambition that their conceptualisation should create evidence that will change the provision and practice of therapy (in the UK, particularly). The use of the word 'pluralism' (and the underlying philosophies associated with pluralism) also suggests a postmodernist perspective more

overtly than the titling of other theoretical or metatheoretical models. This is in some ways a brave move, but in other ways, it could be seen as an obstacle to therapists with a less philosophical attitude, who might be discouraged from using the ideas for their own practice or research. There is an additional problem with the oxymoronic notion of a singular 'pluralistic therapy'. This might be less problematic if Cooper and McLeod did not suggest relatively comprehensive protocols for practising pluralistic therapy in relation to goals, tasks and methods.

In terms of differentiating integrationism from pluralism, by the time Cooper and McLeod published their book on pluralistic therapy (Cooper & McLeod, 2011a), they were still attempting to differentiate it on grounds of having a philosophical rather than a psychological base and their emphasis on collaboration with the client. Yet at least some integrative therapists would also articulate integrative therapy as having a philosophical base and valuing collaboration (e.g. Gilbert & Orlans, 2011; Miller et al., 2005b). Therefore, it is perhaps not surprising that there is an admission that '[p]luralistic therapy is an integrative approach' (Cooper & McLeod, 2011a, p. 6). In later publications pluralistic therapy is described as a "collaborative integrative" way of working' (Cooper, 2015, p. 4), a 'meta-integrative framework' (McLeod & Sundet, 2016, p. 158) and a 'radical eclectic approach' (ibid., p. 167) – phrases that seem to struggle to encapsulate substantial differences to integrative and eclectic approaches.

These issues about whether pluralistic therapy really can claim to be anything different from what has come before will be raised and elaborated further in subsequent chapters of this thesis.

2.7 Conclusions

This chapter has demonstrated how the history of psychoanalysis, psychotherapy and counselling, led to research methodologies that fit in with – and encouraged the acceptance of – audit cultures, managed care and evidence-based practice, in what might be succinctly described as the postmodern, neoliberal era from the late 1980s onwards. The

professionalisation and regulation of therapy run alongside these developments, and all these issues have caused, and continue to cause, divisions amongst practitioners. Integrationism in therapy, on one level, might be seen as a reaction to modernist views on the practice of psychotherapy – views which led to a ‘winner-takes-all’ attitude to different therapeutic approaches. The belief that different therapies can be measured and validated efficiently – and unproblematically – alongside the construction of specific forms of quantitative research (i.e. RCTs) has threatened the evolution of a dynamic pluralistic therapy culture.

The context in which pluralistic therapy came to manifest in the UK in the first decade of this century demonstrates that the therapy profession still had a great deal of confusion around the theories that were driving its practices. This confusion has led to disagreements and attempts to somehow create a more inclusive way of conceptualising practice. Some practitioners, however, remain sympathetic to a ‘modern’ sense of quasi-certainty which allows that some therapeutic approaches be seen as definitively better than others. Certainly there are advantages and disadvantages for different types of practitioners holding onto modern or postmodern conceptualisations of therapy. In that sense these differences reflect extant ‘therapy wars’ (Saltzman & Norcross, 1990).

Theoretical positions have ‘real world’ implications for practice, and pluralistic therapy perhaps arose out of a felt need to change therapy’s theoretical foundations so that it might be provided differently, especially in a UK context. Although there is a lot of exchange between the USA and the UK amongst theoreticians, practitioners and researchers, there are significant contextual differences, so that pluralistic therapy might be seen as a geographically localised response whose importance is thus far, primarily or even exclusively, located in the UK. The agenda, fairly openly, is to change policies, via practices that can be researched, using, on the whole, favoured methodologies. The end goal could be construed as ensuring stronger influence on politically powerful providers such as NICE and the NHS, which have, up to now, in their responses to research and practice, encouraged the shutting down rather than opening up of options for therapists, clients and researchers.

These issues will be further elaborated, explored and discussed in subsequent chapters, starting with the most relevant literature in the following Literature Review chapter.

3: Literature Review

3.1 Introduction

I searched for relevant literature using databases provided by the University of Brighton, such as PsychInfo, Proquest Hospital Collection, Ingenta Connect, Embase and Web of Science. I also accessed online journal websites and other useful websites, blogs and web-based material. I used various search terms, such as 'pluralis*', 'psychotherap*', 'therap*', and 'counsel*,' in combinations and separately. This generated many results which I narrowed down by considering what was most relevant to my research question: 'How do counsellors and psychotherapists make sense of pluralistic therapy?'

This introduction will briefly outline the major contributions to the literature that have led to what might be termed the 'pluralistic turn' in psychology and therapy. It will provide the context for pluralism in general and its importance for therapy in particular. This literature sits within a broader context of research and literature in psychology and the psychological therapies.

The sociohistorical context of pluralistic approaches to therapy has been discussed in the previous chapter, so in this introduction I will briefly summarise the main points of that sociohistorical context, as it relates to the literature specifically, before discussing the literature about pluralism and pluralistic approaches to therapy in more detail.

Freud and Breuer (1895) were the first figures to research what is now recognised as 'therapy'. From the mid-20th century their case study methodology, whilst still used extensively by writers/researchers, gradually lost credibility within academic and research communities which preferred quantitative and scientific methods. However, since the 'narrative turn' in the 1980s, in which qualitative methods have begun to receive more credibility, the use of the case study in therapy research has gradually come back into favour. McLeod (2010), amongst others (e.g. Etherington, 2010; Fishman, 1999; Hill, 1989; Stiles, 2007; Strupp, 1980), argues for the case study as a useful research method.

Although there is a long history of 'splits' (or 'segments', as referred to in the previous chapter when discussing the sociology of the professions) within therapeutic approaches, a common way of viewing the development of therapy has been to divide it into three major 'umbrella' approaches: (1) the psychoanalytic/psychodynamic, (2) the behavioural/cognitive-behavioural and (3) the humanistic/existential (e.g. Milne, 2003). Some commentators will also add: (4) the transpersonal (e.g. Rowan, 2005a). A competitive rivalry between these domains has developed, notably exemplified by Eysenck's renowned (1952) paper, which not only acted to proselytise the behavioural approach but also to attack psychoanalysis.

All these approaches have themselves been challenged by postmodernist critics who argue against their uncritical assumptions regarding their own 'truths' and unproblematic 'modern' beliefs in a theory-practice axis (e.g. House, 2003; Parker, 1999a, 1999b; Polkinghorne, 1992). The postmodern condition is described by Polkinghorne (1992) as being one of 'foundationlessness' and 'fragmentariness' (ibid.). From this point of view the attempt to make a 'modern' sense of things, including therapy, goes against a postmodern sensibility. Jung himself said that '[t]herapy is different in every case... psychotherapy and analysis are as varied as are human individuals' (Jung, 1963, p. 131, in Szasz, 1988, p. 175). However, modern attempts to bring the fragments of therapy together into practices with theoretical foundations continue unabated, whether that is in the development or creation of particular schools, or in attempts to theorise integrative models.

The division of therapy into major approaches, and schools within those approaches, with each arguing for their own effectiveness and superiority, remained relatively unchanged and unchallenged until the late 1960s, when Lazarus (1967) wrote in favour of 'technical eclecticism'. Since then various practitioners and researchers, within the psychotherapeutic literature (e.g. Frank, 1973; Goldstein & Stein, 1976; Garfield, 1980; Gurman, 1980), have made additional arguments for a movement towards integration. Norcross and Salzman (1990) discuss these movements towards integration and 'rapprochement' (p. 1) in their book *Therapy Wars*. They identify the main movements supporting 'psychotherapy integration'

(ibid.) at their time of writing as being 'eclecticism', 'integration' and 'common-factor approaches' (p. 3). By the 1990s another form of integration, 'assimilative integration', in which practitioners integrate from a base in a single approach, as opposed to 'theoretical integration' in which theoretical approaches are synthesised, is also recognised as belonging to the integrative 'canon' (Norcross, 2005). This is similar to but not the same as Bott and Howard's (2012) 'cross-modality approach' which 'does not advocate eclecticism or integration' (p. 2).

The case for a 'common-factors' approach has been most notably argued for by Hubble, Duncan and Miller (1999). In a similar vein, around the same time Bohart and Tallman (1999) argued that it is clients who make therapy work over other factors, including therapeutic approach. Both these texts, and their associated researchers and theoreticians, would become extremely influential on Cooper and McLeod's (2011a) pluralistic approach.

All these integrative approaches reflect an implicit or explicit belief in 'organicism versus pluralism' (Safran & Messer, 1997, p. 143). There is an underlying hope, or assumption, in integrationist thought that 'fragments have a tendency to be resolved by incorporation into an organic whole' (ibid.). Safran and Messer (1997) articulate how a pluralistic vision of therapy differs from an integrative one, arguing for a 'more fruitful cross-theoretical dialogue rather than the advocacy of a premature, unified paradigm' (p. 149). Their paper helps clarify what makes a pluralistic approach to therapy different to integrative or eclectic approaches. Nevertheless, tendencies, in both theory and practice to blur these differences still arise, as I will illustrate in my review of some recent research papers in a subsequent section of this chapter.

There have been calls for specifically pluralistic perspectives and/or practices for therapy from the late 1980s onwards (Ross, 2012). Samuels might lay some claim for bringing the word into mainstream therapeutic discourse (Samuels, 1989a; 1989b), yet the focus of these earlier works is mostly a Jungian discussion about the psyche, with only one chapter articulating a quite generalised pluralistic view of therapeutic practices. House and Totton (2011a/1997) more explicitly suggest the importance of pluralism for therapeutic practice in their book *Implausible Professions:*

Arguments for Pluralism and Autonomy in Psychotherapy and Counselling, especially in regard to issues of professionalisation, regulation and other political aspects of therapy. Samuels (2011/1997) also has a chapter in this book which, amongst other issues, addresses the importance of a pluralistic attitude in training. This chapter could be said to lay the basis of arguments for a pluralistic therapy elaborated on by Cooper and McLeod (2007) a decade later. *Implausible Professions* is discussed in more detail in a later section. At this juncture, the main point is to note that in the same way that they later come to criticise Cooper and McLeod for leaving out politics, their book could be criticised for leaving out ideas for actual practice. Although it can be argued that their avoidance of prescribing how to practise respects a pluralistic position.

By 2003 the idea of pluralistic therapy had been established enough for it to be named as such in the *Handbook of Counselling Psychology* (Woolfe et al., 2003). Yet it is mentioned only within a chapter on the 'eclectic and integrative approach' (Hollanders, 2003) and is not given much space. Further, there are assertions that 'a practitioner who takes up a pluralist stance will work within a single approach', and 'if she feels confident and competent enough to work with a number of different approaches she will be happy to do so, but not with the same client' (p. 280). Neither of these claims are substantiated, and I would argue that they were not true then or now, and indicate that what pluralism could mean for therapeutic practice was still not generally understood or seriously explored.

Pluralism and its relevance to therapy continued to be discussed by major figures in the therapeutic research world (e.g. Wolf, 2003), but it was not until Cooper and McLeod's first paper appeared (2007) that a framework for pluralistic theory and practice was directly articulated, demonstrating what a specifically pluralistic approach could be, and how it might be practised.

The pluralistic approach, especially as articulated by Cooper and McLeod (2007), forms the focus of my research. The participants whom I recruited understood the meaning of pluralism within therapy as being in relation to these central figures who have been promoting pluralistic practice since 2007. My research question was: 'How do counsellors and

psychotherapists make sense of pluralistic approaches to therapy?' The literature of most relevance to this question concerns: (1) pluralism and its roots in the work of William James; (2) the meanings of pluralism; (3) the theoretical contributions of House, Totton, Samuels et al.; and (4) the theoretical and research contributions by Cooper, McLeod et al. Therefore the rest of this chapter will narrow its focus down to those particular sections of the literature.

3.2 Pluralism and Pluralistic Therapy

3.2.1 William James and *A Pluralistic Universe*

William James (2011/1908) is the first author in the field of psychology to make the case for a 'pluralistic universe'. In *A Pluralistic Universe*, based on a series of lectures he delivered in Oxford, James does not distinguish between 'humanism' and 'pluralism' (p. 1), and the main thrust of the book's argument is to argue for empiricism as opposed to idealism and rationalism. Humanism and pluralism are in direct relation because in the same way that humanism, as James interprets it, emphasises the centrality of experience over ideas, so too does pluralism. The multitudinous nature of human experience does not mean that this 'pluralism' needs to be integrated into – or sourced from – one idea, such as 'God'. This leads to a stance in which the necessity for one idealistic Truth, or even 'truths', is secondary to knowledge that is gained empirically (the relation between empiricism and pluralism is acknowledged and discussed by James). Pragmatism sits comfortably with this pluralistic view as it prioritises the utility of empirical knowledge over adhering coherently to a singular philosophy.

This pioneering work, whilst it might be seen as unrelated to how pluralism eventually comes to be discussed in the context of therapy, does set the markers for some current debates. For instance, on one level it might be perceived that trials of one therapeutic approach versus another have an unproblematic basis but, with James's work in mind, we can understand that 'ideas' about therapy are what drives a lot of research. The unproblematic perception of aggregated, apparently unitary approaches based on ideas leads to research that, in a philosophical sense, privileges nomothetic 'top-

down thinking' as opposed to an idiographic 'bottom-up' approach rooted in empirical realities. A parallel to this dichotomy in contemporary therapy research is between 'evidence-based practice' (e.g. Spring, 2007) (where, arguably, 'ideas' are pitted against each other in advance of any researched sessions taking place) versus 'practice-based evidence', in which therapeutic sessions are evaluated by instruments such as CORE forms before determining which ideas might or might not have informed those particular therapeutic sessions (e.g. Shepherd et al., 2007).

The philosophical debate at the heart of *A Pluralistic Universe* is between empiricism/pluralism, which James characterises as the 'habit of explaining wholes by parts', versus rationalism/monism, which James characterises as the 'habit of explaining parts by wholes' (p. 2). Again, the relevance of this text to contemporary issues in therapeutic research is similarly apparent: 'whole' approaches are evaluated as worthy or not worthy and then directed at the 'parts', namely therapists and clients in practice, for instance with manualised treatments; whereas therapists and clients in practice as 'parts', I would suggest, are not as influential in directing how 'whole' therapies might be delivered. There has been a significant amount of 'process' research (e.g. Rhodes & Smith, 2010; Theriault & Gazzola, 2008, 2006), some of it coming from research about pluralistic therapy itself (e.g. Watson et al., 2012). However, despite the amount and quality of process research it still does not impact decisions about policy and provision as much as the more influential symptom-driven approach of RCTs, as previously discussed.

The tendency towards wanting definitive and timeless answers as to whether therapy *A* is better than therapy *B* also reflects an idealistic, rationalistic and monistic basis which James challenges in this text: 'The commonest vice of the human mind is its disposition to see everything as yes or no, as black or white, its incapacity for discrimination of intermediate shades' (p. 26).

In sum, this text is important not just for how 'pluralism', in more recent times, becomes applied to the theory and practice of therapy, and ideas about how therapy might conceptualise itself for future practice, but

also for how therapy in itself is researched, and assumptions about the validity of that research.

3.2.2 The meanings of pluralism

Pluralism has a wide range of meanings and uses; therefore, in the first instance, a wide sweep of the various meanings of pluralism will be considered before focussing down on the particular meanings it has in relation to therapy.

In general, pluralistic paradigms advocate and encourage the acceptance of multiplicity and disagreement – ‘any substantial question admits of a variety of plausible but mutually conflicting responses’ (Rescher, 1993, p. 79) – and within multiplicities the acceptance of differing perceptions about phenomena whatever those phenomena might be. This generalised idea has then been theorised and applied to particular fields such as culture, methodology, politics, religion and philosophy.

Pluralism can be seen as dialectically opposite to monism in these various fields (e.g. McLennan, 1995). In philosophy the conflict between pluralism and monism goes back to ancient Greek philosophers such as Parmenides, who ‘posited the essential, indivisible and eternal Oneness of being’ as opposed to philosophers such as Empedocles and Democritus, who believed that ‘the various elements and kinds in the world had substantial identities all of their own’ (ibid., p. 26). In relatively more recent Western philosophy, Leibniz opposed Spinoza’s idea of an ‘infinite, logically necessary Substance’ existing in God and nature by proposing an ‘infinite series of particulars’ (ibid., p. 27) whose only commonality is that they are in relationship to each other.

At the turn of the twentieth century William James challenged Hegelian idealism with pluralism (2011/1908), as previously discussed. Bertrand Russell (e.g. Russell, 1959) and James Ward (1911) also supported pluralistic positions, the latter proposing a kind of pluralism within a unifying frame, what might be termed a ‘moderate’ pluralism (e.g. McLennan, 1995). These philosophical inquiries into issues engendered by conceptualising monism and pluralism inform the more specialised debates about pluralism as it crosses over into other fields (ibid.).

McLennan describes pluralism as existing on three levels: (1) as a 'political science tradition of "empirical democratic theory"'; (2) as a 'more general intellectual orientation'; and (3) as a 'temperament, a ... psycho-personal frame of mind' (p. 1). He suggests that pluralism is more easily understood as a "'modal" concept', a way of seeing, rather than a 'substantive "end-point" doctrine' to believe in (p. ix). In other words, it is a philosophy that can be applied as a way of thinking about many different theories and practices, rather than necessarily encapsulating a theory and practice of its own. McLennan states that the common meaning of pluralism 'indicates our acknowledgment of multiplicity and difference across and within particular social fields and discourses' (ibid.). Within social science and politics the term was formerly most associated with empirical democratic theory that was current from the 1950s to the early 1970s (ibid.). However, since that time the word and its associated ideas have spread further out in social science, politics and other subject areas.

McLennan points out that in order to be able to comprehend potential meanings of pluralism we need to understand its 'conceptual opposite or "boundary condition"' (p. x). He suggests that this opposite is a 'sense of unity and integration' (ibid.). This point reflects an important difference between 'integrative' approaches to therapy and 'pluralistic' ones, on which I will elaborate further in subsequent sections.

Another point McLennan makes, which similarly resonates with the conceptualisation and practice of pluralism in the 'social' field and 'discourses' of therapy, is that 'the assertion of pluralism in any particular field does not in and of itself usually produce any clear *solution*' (ibid; italics in original). It might be argued, for instance, that a pluralistic perspective in the field of therapy might struggle to impact the field on any kind of pragmatic level. The insistence of a pluralistic perspective that the answer(s) to any given question might be plural rather than singular, and might be dynamic rather than static, does not fit prevailing paradigms in which it is 'common sense' that there should be one answer that remains true from one year to the next. For example, the question of whether CBT is more effective than person-centred therapy is often seen by commissioning bodies as needing a binary yes/no answer, and therefore the dominant strategy for

researching therapeutic effectiveness assumes that any particular approach has a constant 'efficacy' akin to any standardised pharmaceutical medication. A pluralistic intellectual orientation and temperament does not fit well into this prevailing *modus operandi*.

One charge that might be made against pluralism in many fields, including therapy, is that its flexible, accepting, inclusive nature 'appeal[s] to the overly-tolerant, *pseudo*-tolerant, ostensibly humanistic, and intellectually eclectic sort of person; the sort of person who does not really have any clear opinions on anything' (ibid., p. 2; italics in original). The pluralistic temperament/perspective in the field of therapy supports the 'dodo verdict' (e.g. Cooper, 2008; Luborsky et al., 2002; Luborsky et al., 1975; Rosenzweig, 1936) in which all must have prizes, and in which there is an avoidance and fear of winners and losers. This sits within a more general post-structuralist and postmodernist paradigm in which pluralism in particular '[enshrines] the principle of "equal but different"' (McLennan, p. 3). McLennan (writing in 1995) calls these more postmodernist, post-structuralist meanings of pluralism, a 'new pluralism' (ibid.) whilst simultaneously recognising that its newness is arguable. The accepting, inclusive nature of pluralism has most markedly been criticised for leading to an 'anything goes' conclusion (Ayer, 1984; McLennan, 1995) since it seems to advocate a 'potentially endless multiplication of valid ideas' (McLennan, p. 8).

Wilber (2000) similarly associates 'pluralistic relativism' – although it is arguable that pluralism is relativistic (see e.g. Connolly, 2005; Lassman, 2011) – with postmodernism. He perceives it as manifesting in particular phenomena amongst which he includes 'Rogerian counseling [sic]' and 'humanistic psychology' (p. 50). The implications of the affinity (or not) between pluralism and these particular psychological/psychotherapeutic approaches will be discussed further in the following section. Wilber further associates 'integrative' with the idea that 'knowledge and competency should supersede rank, power, status or group' (p. 52). This has implications for how therapy is conceptualised, researched and delivered which, again, I will elaborate in subsequent sections and chapters. For now, it is important to emphasise, in terms of the meanings of pluralism, how entwined it is with meanings of postmodernism. Wilber characterises postmodernism as an

'attempt to be inclusive' (italics in original). In this sense Wilber associates postmodernism with “‘diversity” (or “multiculturalism” or “pluralism”)’ (p. 159). His view is similar to McLennan’s, who tentatively suggests that ‘[p]ostmodernism... can be redescribed perhaps as the generalized affirmation of pluralism and heterogeneity’ (McLennan, 1995, p. 21). Wilber, on the whole, is supportive of pluralism, whilst criticising its potential to ‘[level]... qualitative distinctions’ (Wilber, 2000, p. 160). Overall, however, Wilber supports a constructivist, contextualist interpretation of reality, from which he asserts that an integral-aperspectivist position must follow. By ‘integral-aperspectivist’, a term he attributes to Jean Gebser, he means ‘cognition must... unduly privilege no single perspective’ (ibid., p. 163). The relation of this view to how pluralism comes to be understood in the field of therapy is a close one.

3.2.3 Theoretical contributions by House and others

About a decade before Cooper and McLeod were advocating a pluralistic perspective and approach for therapy, House, Totton and others were arguing for a pluralistic response to issues around professionalisation in their edited book *Implausible Professions* (1997), which had as its subtitle *Arguments for Pluralism and Autonomy in Psychotherapy and Counselling*.

The book deliberately emphasises political issues; and how a pluralistic perspective might practically be delivered is left more to practitioners’ imaginations. There is a noticeably different tone than is found in Cooper and McLeod’s writings from 2007 onwards. Indeed Totton (2011) argues that there are ‘two sorts of therapy’ (p. 8): an ‘expert systems’ approach and a ‘local knowledge’ approach (p. 9). He favours the latter, which relies on, he boldly states, ‘intuition and wisdom in preference to technique and research’ (ibid.). This view challenges the assumed importance of techniques and research, strongly advocated by Cooper and McLeod who, arguably, favour a more ‘expert systems’ approach. Both House et al. and Cooper et al. see pluralism as providing solutions for the politics and practice of therapy, and some of their arguments cross over; but they come from radically different philosophical and psychological bases.

House and Totton (2011b/1997) proudly view counselling and psychotherapy as non-scientific disciplines. They claim that 'psychotherapy and counselling are not, and in principle never can be, scientific disciplines with a reliable, replicable, predictable and generally agreed body of expert knowledge' (p. 11). They recognise that '*some forms* conceivably might be', but argue that 'this would not privilege them over other forms' (ibid., italics in original). If that is the case then it implies that a pluralistic attitude to the practice of therapy is the only logical basis for practice, as science does not have the ability to prove some forms of practice as superior to others. This, House argues, is because 'factors like existential aliveness, the quest for personal identity, spiritual well-being, the enhanced meaningfulness of lived experience' are '*inherently and in principle unquantifiable* (House, 2011c, p. 76, italics in original).

Samuels (2011/1997) argues that the various debates in therapy, of which debates about approaches is just one, is a way to define what therapy *is*. In that sense, 'debate, dispute and difference' (p. 222) are beneficial for therapy. Pluralism, he argues, is not about a woolly tolerance but a hard acceptance of different and emotionally charged positions. He actively wishes to encourage the disputes and arguments associated with the *fact* of pluralism (by which I mean the fact that there are different and sometimes irreconcilable positions about phenomena), which accords with other writers, who advocate pluralism as a philosophical viewpoint which opposes the 'demand for consensus' (e.g. Rescher, 1993).

In sum, Samuels views pluralism as an 'attitude to conflict which tries to reconcile differences without imposing a false resolution on them or losing sight of the value of each position' (Samuels, 2011/1997, p. 223). His arguments might pithily be expressed by William Blake's saying that 'Without Contraries is no progression' (Blake in Keynes, 1957, p. 149, capitalisation in original); and these contraries can remain opposed without yielding to a false unity. In a similar way to McLennan (1995) he also views pluralism as a mode, as a process, or in his words a 'tool or instrument' rather than a 'desirable state or goal' (Samuels, 2011, p. 229). For Samuels, pluralism is not as an ideal end-point for the profession, but is a way of understanding, and using, the reality of differences for the benefit of everyone.

In the conclusions of the second edition of *Implausible Professions*, House (2011b) wishes to distance their book from the ‘quasi-modernist approach to “pluralism”’ that he perceives in Cooper and McLeod’s version. Their different way of viewing how pluralism might be of use to thinking about and practising therapy demonstrates that defining pluralistic therapy and attempting to ‘own’ it is a hard and controversial task. Nevertheless, since 2007 Cooper and McLeod might be seen as having attempted to do just that. Since that time, the vast majority of the literature about pluralism in relation to therapy has been produced by them and their colleagues (e.g. Cooper & McLeod, 2012; Cooper & McLeod, 2011a; Cooper & McLeod, 2007; Cooper et al., 2015; McLeod et al., 2014; Thompson & Cooper, 2012; Thompson et al., 2017; Watson et al., 2012), marked by an emphasis on process and outcome research (as opposed to, for instance, theory-building). This literature is explored in more detail in the following section.

3.2.4 Theoretical and research contributions by Cooper and others

Although Cooper and McLeod had already delivered at least two presentations about a pluralistic approach (e.g. Cooper, 2005; Cooper & McLeod, 2006), it was not until 2007 that they coherently articulated and argued for a ‘pluralistic framework for counselling and psychotherapy’ in a published paper (Cooper & McLeod, 2007). In this paper they assert that ‘psychological difficulties may have multiple causes... 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’ (p. 135).

They suggest that the pluralistic framework allows for a way of practising therapy ‘from a range of therapeutic orientations’ (ibid.), and suggest that therapy can be understood to operate within ‘three domains – goals, tasks and methods’ (ibid.). They theorise these domains, not just as a way of conceptualising therapy for the benefit of therapists and clients, but importantly, because they believe these domains are a ‘means for empirical research directly to inform practice’ (ibid.).

The paper as a whole is subtitled ‘Implications for research’, which points to their interest in therapy, and their ideas about and for therapy, to be conceptualised in ways that make its being researchable a central concern.

This may seem *prima facie* unproblematic; however, it is also arguably indicative of a profession subservient to research-driven and political agendas, most implicitly the need for approaches, including Cooper and McLeod's own newly articulated framework, to prove themselves as efficacious and effective in order to assume or retain professionally powerful and respectable status.

Perhaps it is for this end that Cooper and McLeod postulate three domains of therapeutic practice that might be perceived as generic and uncontroversial enough to be 'trans-theoretical' (p. 137), and not rankle any 'interest groups' in the profession. However, even the utilitarian language of 'goals', 'tasks' and 'methods' challenges at least some therapists' understanding of the nature of therapy. For instance, Rowan asserts that 'goals get in the way of the relationship and distort it mightily' (Rowan, 2015, pers. comm.). More generally, on a political level some critics see their framework as just another example of a 'politically expedient' move within the 'psy-complex' (Grant, 2015, pers. comm.); however, the difficulty of 'selling' the pluralistic agenda to therapy providers who tend to prefer a more assertive monistic 'answer' such as CBT might be seen to contest this view.

Cooper and McLeod reference Castonguay and Beutler (2006) to support the argument that 'relationship, participant factors, *and* treatment procedures' all need to be seen as 'effective and interactive' (p. v, italics in original). This argument, supported to some degree by research (e.g. Cooper, 2008), draws attention to potential flaws in research that only tests for treatment procedures, even if one accepts that treatment procedures can be isolated from other variables. The idea that 'unitary models' are the basic 'currencies' of therapy with greater or lesser values in relation to each other is, on the whole, accepted by such influential bodies as NICE (Department of Health, 2001), whilst it is simultaneously claimed by many researchers that 'different therapeutic orientations are equivalent in their effectiveness' (Cooper & McLeod, 2007, p. 135).

Cooper and McLeod distinguish their pluralistic approach from integrative approaches by characterising the latter as paradoxically more prone to creating new unitary models. This is, they assert, in contrast to a pluralistic approach which is 'open to an infinitely wide range of ways of

engaging with individual clients' (p. 136). They argue that their pluralistic conceptualisation of therapy, unlike eclecticism, offers a metatheoretical framework in which different therapies can be 'organised, contrasted and evaluated' (ibid.). The 'goals, tasks and methods' (p. 135) that form the cornerstones of their framework can all be enumerated and evaluated, easily fitting into dominant research methodologies. In that sense it might be argued that their version of pluralistic therapy is eclecticism 'organised' for purposes of evaluation; however, their main argument is against the need to 'reduce' the multiplicity of models into one. It is in this way that pluralism differentiates itself from the basic ideology of integrative therapies.

Cooper and McLeod (2007) situate the philosophical basis for pluralism in the work of Rescher (1993), and they also align it with postmodernism. Like McLennan (1995) and Wilber (2000), they emphasise the centrality of being 'inclusive' in postmodern/pluralistic thinking and view this as an 'ethical and political commitment' (Cooper & McLeod, 2007, p. 136), not just at a philosophical level but also within the therapy profession towards other practitioners and clients. Cooper and McLeod further associate this understanding of pluralism 'as a form of humanistic-existential ethic' (Cooper, 2007, p. 11, cited in Cooper & McLeod, 2007, p. 136). This explicit humanistic-existential leaning hints at a potentially problematic bias for practitioners who are not so broadly humanistic-existential in orientation. Similarly, those more sympathetic to the assertion that the 'principles underlying [humanistic-existential] approaches are of universal relevance to the practice of psychotherapy' (Cooper, 2007, p. 11) might find themselves more aligned with Cooper and McLeod's pluralistic ideas. The explicit humanistic-existential underpinning might also be seen as a more 'political move' (see research participant Paul, R41) to re-brand humanistic therapies in a way that makes them more acceptable to the more powerful therapy providers such as the NHS.

On a more practical level, Cooper and McLeod make suggestions for pluralistic practitioners in terms of goals, tasks and methods which they perceive as generic processes in therapy. Although they attempt to present this practice as a flexible one, it is presented within a rigid structure that, it might be added, makes 'rigorous' research more attainable. In other words,

by pinning down therapeutic processes to three domains, they subsequently articulate 'standards' within those domains by which therapists may be judged to be practising effectively or otherwise.

For instance, in terms of goals, they write: 'Another important skill... involves checking out with the client that the work is on track to fulfil a previously-agreed goal' (Cooper & McLeod, 2007, p. 137). So a therapist, who disagrees with the implicit value of 'metacommunication' (Cooper & McLeod, 2007; Kiesler, 1988), or goal-setting of any kind, would not be seen in this protocol as practising effectively. There is a paradox and difficulty in trying to prescribe a pluralistic practice and remain pluralistic. Cooper and McLeod argue that their use of the word 'goals' is meant quite loosely as 'goals that are *already there*, in terms of being implicit in the structure of the person's engagement with his or her life-space' (ibid., italics in original); yet some practitioners, such as Rowan, are uncomfortable with the use of the term in itself. For other practitioners it might be that this word/domain and its relation to the associated explanation of a possible pluralistic practice is merely misunderstood or misconstrued. Nevertheless, misunderstood or not, the terminology of their model might be one reason for a more general resistance by some parts of the therapy profession to engage with at least their model for pluralistic practice.

The use of the word 'tasks' similarly emphasises and suggests an approach to therapy that seems to be more about 'doing' than 'being' (Rogers, 1980; Rowan, 2005a). Cooper and McLeod (2007) suggest that the ability to explain the current therapeutic task is helpful for clients and demystifies therapy; however, this term is also aimed at 'stakeholders' so that they can understand what 'counselling or psychotherapy has to offer' (p. 138). Again, the conceptualisations seem to have been partly created so that pluralistic practice can be sold in the marketplace. Cooper and McLeod state that their 'research agenda' is to provide 'outcome research' because it 'provides evidence for healthcare systems that legitimises expenditure on therapy from scarce financial resources'; and whilst they do question the emphasis on outcome research which compares different approaches, they fully accept it if only it would change focus to such things as 'investigating the goals of particular client groups' and the 'effectiveness of specific

task/method packages' and thereby, they assert, become 'more socially meaningful' (p. 142). A 'task' can be viewed quite broadly, for instance 'talking openly and meaningfully about current problems in living' (ibid.), and the flexibility in their intended meaning of the word 'task' might be seen to be enough to hold critics at bay. Yet when the word can be used so widely, it might be argued, like Alice with Humpty Dumpty (Carroll, 1872), that it begins to lose any kind of definition.

The flexibility in 'methods' is probably what most professionals and laypersons assume to be the main feature of a pluralistic practice. Cooper and McLeod (2007) draw upon an example of a bereaved person to illustrate how different approaches have different methods to work with such a client. They explain that a pluralistic practitioner would discuss the different methods they could use with the client before prescribing any methods from within a solitary model. This collaboration with the client about how they want to work, rather than assuming the methods of the practitioner's preferred model are needed and wanted, is a main feature of pluralistic practice. There is also emphasis on client choice, rather than the client being allocated to a therapeutic approach without consultation and information-giving – a fairly normal occurrence outside private practice. In this spirit, pluralistic practice can be accused of encouraging therapists to be 'therapeutic Jacks of all trades and masters of none' (Grant, 2015, pers. comm.). Cooper and McLeod's recommendation is that therapists should not practise outside of their competence: if, through collaborative metacommunication about therapeutic methods, it is concluded that the way the client wants to work cannot be offered at a competent level by the therapist, then the pluralistic solution would be to refer that client on, or for the therapist to educate/train him- or herself to a sufficient level of competence (assuming that to be practicable).

Another criticism that can be levelled at the inclusive attitude towards different therapeutic methods is that it reflects an "anything goes" syncretism' (Cooper & McLeod, 2007, p. 139). Cooper and McLeod reject this argument by saying that they see situations in which some methods may not be useful for clients, and that the same method might be helpful or unhelpful for different clients at different times. The importance of methods

for effectiveness means the client's opinion becomes the main way of determining whether a method has value (Cooper & McLeod, 2007). The trust and belief shown in clients in determining the therapeutic value of methods illustrate the closeness of broadly humanistic and specifically person-centred values to this kind of pluralistic practice. Simultaneously, and perhaps more problematically, it positions clients as 'expert consumers' (Chatriot et al., 2006; Loewenthal, 2012).

The valuing of both client and therapist perspectives is central to Cooper and McLeod's pluralistic practice, and leads to their particular emphasis for it to have a 'collaborative relationship' at its 'heart' (Cooper & McLeod, 2007, p. 139). In this regard, pluralistic practice seems to be an attempt to maximise the benefit of the 'working alliance' and the 'therapeutic relationship' (Clarkson, 1995), which is seen by many researchers and practitioners as a key factor in therapeutic effectiveness (e.g. Fluckiger et al., 2018; Horvath & Greenberg, 1994). Cooper and McLeod (2007) cite further research evidence (e.g. Addis & Jacobson, 2000) to support their view that the collaborative qualities they associate with pluralistic therapy improve outcomes.

At the time of writing their 2007 paper, Cooper and McLeod were just beginning to research pluralistic practice. The framework they articulate, as I have suggested previously, is intensely influenced by the felt need to have it researched. They propose that the overall research question for a pluralistic framework might be Paul's (1967): '*What* treatment, by *whom*, is the most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?' (p. 111, italics in original). They also recommend that for a pluralistic practice the question needs the addition of 'for *this* individual on *this* specific occasion' (Cooper & McLeod, 2007, p. 140, italics in original). This question implicitly endorses researching abstractions over and above the relationship itself, and the focus on effectiveness also seems to imply a bias towards quantitative outcome-based research.

However, they do encourage qualitative research, such as interviewing clients and therapists to generate 'process maps' of practice that clients have experienced as helpful (Cooper, 2004). They also call for research that might support their view that the more clients are informed

about and understand therapy, the better their experience of it. Otherwise their focus is on outcome-based research which they suggest has been pointlessly focussed on proving ‘the relative superiority of competing unitary models of therapy’ (Cooper & McLeod, 2007, p. 142). They claim that Wampold (2001) and other researchers have ‘conclusively demonstrated that theoretical orientation makes only a marginal difference to outcome’ (Cooper & McLeod, 2007, p. 142); so their call is for outcome-based research to focus on more generic and ‘[tailored] task/method packages’ (ibid.).

In late 2010 Cooper and McLeod disseminated their ideas for a pluralistic approach to the wider therapy community in *Therapy Today*, the magazine for BACP members (Cooper & McLeod, 2010), and in a book (Cooper & McLeod, 2011a) available at the same time as the article’s publication. In their article they explicitly describe their pluralistic approach as forming a basis for a counter-position to ‘schoolism’, which they mention in this article to describe a phenomenon ‘in which adherents of a particular orientation become entrenched in the “rightness” of their approach’ (Cooper & McLeod, 2010, p. 10).

They also recognise the concern that therapists have about the dominance of CBT, which might have been read into the subtext of their original paper but was not named. They cite a recent research review (Swift & Callahan, 2009) which supports their claim that where clients are offered treatment choice, outcomes are improved (ibid.), and other research evidence that supports pluralistic principles of tailoring therapies for clients (e.g. Cooper et al., 2015; Jacobson et al., 1989; Perren et al., 2009; Swift et al., 2011). They acknowledge the pluralistic aspects of both integrative and eclectic approaches, but reiterate that it is only in their pluralistic approach that collaboration is central – in other words, they are suggesting that it is possible for therapists to be integrative or eclectic but not involve clients in decision-making about therapeutic methods. They also more explicitly acknowledge that their approach is informed by ‘humanistic, person-centred and postmodern values’ whilst claiming that it also ‘aims to ... embrace ... the whole range of effective therapeutic methods and concepts’ (Cooper & McLeod, 2010, p. 11).

It is in this article that they first articulate an extremely important distinction between pluralistic 'perspective' and 'practice'. The perspective allows for therapists to have a pluralistic 'sensitivity,' without prescribing particular ways of achieving a pluralistic practice, and to value single-approach practice for clients who might benefit from a more tightly held unitary model. They argue that this further distinguishes their approach from integrative and eclectic views of therapy. As in their original 2007 paper they call for practitioners who share their pluralistic perspective to explore 'how it can be developed and applied through research, training, supervision and practice' (ibid., p.14). The article acts as a succinct summary of their book *Pluralistic Counselling and Psychotherapy*, which remains the most extensive articulation of their view of what defines pluralistic therapy as a perspective and practice (Cooper & McLeod, 2011a). Some key points from this text are explored later in this section.

The humanistic-existential philosophical basis for their pluralistic approach might alienate practitioners who do not come from that philosophical position. Cooper and McLeod (2011a), as before, anticipate that resistance, and attempt more fully to make their humanistic position inclusive of all practitioners by framing it as one which is a general 'ethic', rather than any kind of specific therapeutic practice – one that might apply to any kind of therapy, including CBT. They argue that collaboration is what makes any kind of therapy humanistic, so that even person-centred therapy, if it is delivered without client involvement, could be non-humanistic. This is a valiant attempt to bridge divides; nevertheless, it does come across as trying to claim humanistic values as more universally accepted than is perhaps the case. It might also be seen as wishful thinking that their values have the potential to be trans-theoretical when perhaps that potential is actually problematic and limited.

A core issue for practitioners and clients that becomes more apparent in their book is the 'push' for a more 'instrumental' strategy in the delivery of therapy (Rogers, A., 2010, online). In the appendices Cooper and McLeod (2011a) have a suggested 'information sheet for clients' (ibid., Appendix A) aimed at clients who might have chosen a pluralistic service and services/therapists who might offer one; a 'Therapy Personalisation Form'

(ibid., Appendix B) which uses a 5–0–5 Likert scale; and a ‘Goals Form’ (ibid., Appendix C) designed to be used weekly. These kinds of forms, and the encouragement of their use both for therapeutic and research purposes, can be interpreted as signalling an underlying assumption that the client and therapist are engaged in an instrumental, ‘technical’ process with an easily identifiable ‘outcome’. The forms and how they are used similarly assume that therapeutic processes can be measured, evaluated and deemed effective or ineffective even at the micro-level between one client and one therapist. The use of these forms might be seen as inconsequential, but might also be seen as a kind of distraction from two human beings having a ‘principled, ordinary and authentic encounter’ (Rogers, A., 2010, online). However, Cooper and McLeod are enthusiastic about monitoring and evaluating practice with these instrumental methods, and they cite research that suggests that the regular use of forms to ‘track... progress’ (Cooper & McLeod, 2011a, p. 44) improves outcomes (e.g. Lambert, 2007; Miller et al., 2005b). The encouragement of this kind of practice as a pluralistic approach to therapy risks alienating some therapists and undermining the pluralistic aim of including all practitioners. Cooper and McLeod value their aims for research as unproblematic, yet some practitioners remain wary of therapy being perceived as such an easily measurable, trackable and reducible process (e.g. Rowan, 2001). It can be argued that the introduction of these forms marked a point at which their ambition to monitor and evaluate therapy trumped their ambition to include all practitioners in a pluralistic project.

There are other critical points to be made in relation to pluralistic therapy which Cooper and McLeod (2011a) summarise in their final chapter by answering ‘Frequently Asked Questions’ (pp. 154--159). Their answers (summarised in the following paragraph) attempt to rebut the most common criticisms of the pluralistic framework which, put succinctly, include: (1) there are too many therapies to learn, (2) clients don’t understand therapy enough, (3) clients want therapists to take the lead, (4) sometimes the therapist does know best, (5) the pluralistic framework is too task-orientated, (6) it’s anything goes, (7) it’s superficial and incoherent, (8) you can’t mix up different philosophical and psychological assumptions, (9) most therapists already are ‘pluralistic’ so it’s not that important, (10) it’s not so easy to be

that open-minded, and (11) pluralism itself is a monism saying it's a better way to do therapy (ibid.). Interestingly, in a book about counselling skills it seems as if McLeod and McLeod (2011) are to some extent distancing themselves from a labelled pluralistic approach by describing pluralistic ways of working in chapters about 'goals, tasks and methods' (pp. 68--86) and another about 'working collaboratively' (pp. 125--150), but downplay its relation to a pluralistic framework.

Cooper and McLeod (2011a) rebut the main criticisms by claiming that: (1) therapists do not have to learn too many therapies, as long as they are aware of their limitations and/or refer on – and, in fact, that it is possible to have a pluralistic perspective from within a single-approach practice; (2) collaboration with clients does not mean that clients have to understand therapy as such, but more that they begin to co-create with therapists a 'culture of feedback' (p. 154); (3) the pluralistic approach allows for therapists to take the lead if that is what seems most appropriate; (4) therapists can communicate their expertise as long as what clients want is respected; (5) the use of terms like 'tasks', 'goals' and 'methods' in the pluralistic framework should not be read too literally, so that 'being' with a client and other 'subtle, non-conscious and organismic processes' (p. 156) can be conceptualised within the pluralistic framework; (6) a pluralistic approach recognises that some methods may be better or worse for different clients at different times so, in that sense, it is far from advocating 'anything goes'; (7) there is a central focus to pluralistic therapy which is 'client's goals' (ibid.) and a fundamental coherence provided by the underlying philosophical and ethical principles of the approach; (8) there is no reason to believe that holding a philosophical or psychological view makes other philosophical or psychological views 'untrue' so, if that is the case, then the pragmatic application of different philosophies and psychologies (whilst their 'truths' are still open to contestation) for the benefit of clients is an ethical way to practise; (9) therapists do often practise a pluralistic approach, even if they do not label it as such, but Cooper and McLeod argue that their book is the first comprehensive articulation of such a perspective and practice, that their version is 'uniquely inclusive and collaborative' (p. 157), and that an important part of their articulation of pluralistic therapy is its framework and

research agenda; (10) it is difficult to be open-minded for a variety of reasons such as, amongst other things, the felt need to identify, black-and-white thinking/'splitting', security, belonging to an 'in-group' (Tajfel & Turner, 1979 cited in Cooper & McLeod, 2011a), cognitive dissonance (Festinger, 1957 cited in Cooper & McLeod, 2011a), and defending against uncertainty, but it is possible to 'learn to acknowledge, and bracket, our biases and prejudices towards other methods and practices' (p. 158); and (11) they remain open to the possibility that a pluralistic approach to therapy may not be as effective as single approaches and that the idea of 'normative pluralism' (as opposed to 'foundational pluralism') allows a pluralistic perspective to be rooted in some values that are non-negotiable (Cooper & McLeod, 2011a).

Some of these issues were raised by my research participants, and those issues and others are further discussed in later chapters. For now, I think that the rebuttals by Cooper and McLeod are, on the whole, convincingly argued. However the instrumental emphasis of their framework or approach is not so easily defended. Although they say they value therapies that might be characterised as more 'relational', it does seem that the spirit of their approach is more about 'doing' than 'being'. Their wish for pluralism to be seen as pragmatic and tangible necessarily devalues approaches that might be seen as idealistic, and which value more intangible aspects of the therapeutic relationship as a healing process. Their adherence to the idea of 'goals' as a basis for a pluralistic approach is, for example, not inclusive of all therapies and therapists. Perhaps this is related to their prioritising of the ease with which their framework might be researched, which could be perceived, at least by some, as problematic in itself. The assertion that their version of pluralistic therapy is 'uniquely inclusive and collaborative' (ibid., p. 157) is also extremely arguable, as various integrative therapists have argued for similarly inclusive and collaborative approaches to therapy (e.g. Gilbert & Orlans, 2011), before and since Cooper and McLeod first articulated their version of pluralistic therapy. Their framework is also not as original as they claim it to be, and it might be argued that Wilber offered a much more comprehensive and

comprehensible 'pluralistic framework' as far back as 1977 (for example see Wilber, 1977) more fully developed by 2000 (see Wilber, 2000).

Cooper and McLeod's (2011a) framework has been quite well received by some, such as the then editor of *Therapy Today*, who welcomed their ideas in her November 2010 editorial in stating that 'arguing over which single therapy is the most effective in general seems ridiculous and futile [which is] the gist of what Mick Cooper and John McLeod are saying' (Browne, 2010, p. 3). There were a series of letters to the editor in which others responded with less enthusiasm -- noticing, for example, an implicit person-centred/humanistic bias, the problem of therapists usually knowing more about therapeutic methods than clients, and their prescriptions for pluralistic practice perhaps creating just one more 'integrative' approach (Hough, 2010).

McLeod and Cooper (2011a) responded to these criticisms of their pluralistic framework in a letter to *Therapy Today* published in the February 2011 issue. They stated that they agreed with some of the points made, including: the need to acknowledge the work of Andrew Samuels (2011/1997) who had written about pluralism and therapy in a similar way a decade earlier, the centrality of the therapeutic relationship, and the importance of not confusing the client with a 'smorgasbord of techniques' (Siddique, 2010); yet there were other points that they challenged. They implied that their critics were adopting 'either/or' positions to issues that might be better resolved with both/and thinking: for example, some clients want to ameliorate symptoms and others want to look at 'wider existential issues' (McLeod & Cooper, 2011a). Further, they agreed that 'many counsellors already adopt a pluralistic stance in practice', but stated that their 'hope' was that their contribution could be seen as 'a framework that allows these practices to be developed – through theory, research, practice and dialogue' (ibid.). They argued that 'our interest is much less in defining *how* therapists should tailor their practice... and much more in opening up a space in which we can explore this issue' (ibid., italics in original); however, the quite prescriptive nature of how to practise pluralistically, complete with instrumental forms, in their book (Cooper & McLeod, 2011a) seems to belie that argument.

In the same issue, Richard House, in a letter, lends some support to their 'pluralistic paradigm' (House, 2011a) but challenges whether it is 'new' because of the book *Implausible Professions*, edited by himself and Nick Totton, discussed in the previous section (House & Totton, 1997). Indeed, the second edition (House & Totton, 2011) of the same book was pipped to the post, by just a few months, by Cooper and McLeod (2011a). House's letter in *Therapy Today* is a long one and contains a multiplicity of critiques, but his main criticism of Cooper and McLeod (2011a) is that they do not engage with the '*politics* of the psychological therapies' (House, 2011a, italics in original) and the 'audit culture' that surrounds it (ibid.), particularly in regard to issues of professionalisation and regulation. House also suggests that Cooper and McLeod are 'perhaps... reproducing... quasi-"schoolist" political manoeuvrings' (ibid.) Similarly, he is sceptical that their pluralistic approach, despite allying itself with postmodernism, engages with postmodern thinking, and accuses them of being more 'modern' in their 'privileging of "goals", "skills", [and] "methods"' (ibid). In a similar vein, Rowan (2015) felt that Cooper and McLeod 'have fallen captive to the instrumental approach to therapy', and that they seemed to have created a 'new school of therapy' (ibid.).

Since 2011, Cooper and McLeod have continued to vociferously proselytise for their version of pluralistic perspectives and practices in other papers and books (e.g. Cooper & McLeod, 2011b; Cooper & Dryden, 2016b). The first academic journal to seriously engage with their ideas was the *European Journal of Psychotherapy*, which dedicated a special issue to pluralism in March 2012, edited by Del Loewenthal and co-edited by Mick Cooper, John McLeod, Windy Dryden and Alistair Ross. The focus of the special issue was to highlight the 'developments and challenges' (Loewenthal, 2012, p. 1) of pluralism in relation to therapy. Contributors to the issue included Mick Cooper, John McLeod, Alistair Ross and Windy Dryden. These authors engage with different issues about pluralism from a mostly theoretical perspective. Referring to Cooper and McLeod's 'frequently asked questions' summarised previously Loewenthal (2012) challenges them on both (1) and (2) which are, respectively, that there are too many therapies to learn, and that clients don't sufficiently understand therapy.

More interestingly, Loewenthal takes a postmodern position and questions whether therapy has *any* foundations (such as theories) (e.g. Loewenthal, 2011), and suggests that therapy is better seen as a practice (Loewenthal, 2012, p. 2). Further, he questions whether the kind of research that Cooper and McLeod extol 'has... relevance to our therapeutic practices' (Loewenthal, 2012, p.3).

Dryden's (2012) main critique of the pluralistic approach seems to be – referring to Cooper and McLeod's 'frequently asked questions' no. (4) – that sometimes the therapist does know best. He articulates this by suggesting that a pluralistic approach 'privileg[es] client views in therapy' (p. 106). This criticism is arguable, as Cooper and McLeod (2011a) quite clearly state, in regard to this issue, that a 'pluralistic approach does not require therapists to put their own understandings, perceptions or expertise to one side' (p. 155). Dryden, in arguing this point, refers to 'research literature' (Dryden, 2012, p. 106) to back up his claim that a typical client would not be helped in examining his Obsessive Compulsive Disorder (OCD) by exploring his childhood, and that the therapist has to let this typical client know that this is the case.

With this argument, Dryden misses the point that a *raison d'être* of the pluralistic approach is to treat clients as individuals and help them to tailor an individual and unique way of working. The research literature (possibly) confirms that exploring childhood does not *generally* help clients with particular disorders *in general*; however, from a pluralistic perspective, the fact that it might help this individual at this particular time needs to be considered. Dryden either does not notice or ignores this important aspect of a pluralistic practice, and envisions a pluralism where clients are 'informed about... relevant research findings' (p. 110).

More reasonably, Dryden critiques the potential bias towards humanistic-existential interpretations of what pluralism means for practitioners, even in this special journal issue, by pointing out that all the papers have been written by pluralistic or broadly humanistic-existential practitioners. He therefore names this approach as 'humanistic existentially based pluralism (HEP)' (p. 108). Ross (2012) also points this out as a potential problem in the end-piece of the journal. Dryden (2012) further

reflects that pluralism might benefit from allying itself with ‘working alliance theory’ (Bordin, 1979). This theory accords with his own conceptualisations of how therapy can be seen to have trans-theoretical, generic components (see, e.g., Dryden, 2011) and does not, in my view, differ that greatly from Cooper and McLeod (2011a).

There are some research-informed papers in the special issue.

McLeod, for example, makes a useful contribution with a ‘practice-friendly review of research into client preferences’ (2012a). Both McLeod and Cooper see an engagement with client preferences as central to a pluralistic practice, and the paper serves as a useful summary of research demonstrating that engaging with client preferences improves outcomes (e.g. Swift et al., 2011). It is illustrated through the use of an interesting case study, yet the point of view is entirely McLeod’s interpretation and reporting of events, supported by one quantitative measure. The client in the case is also able to direct the therapy away from exploring traumatic childhood experiences that might be responsible for present-day anxiety into more pragmatic ‘breathing and relaxation exercises’ (McLeod, 2012a, p. 27). Whether this is a good demonstration of pluralistic practice is ambiguous.

Miller and Willig (2012) present a grounded theory analysis of three ‘pragmatic case studies’, exploring how HIV clients experienced the process of pluralistic therapy. This is a thorough study in which they used a grounded theory methodology for analysing 36 hours of therapy sessions and the subsequent transcripts. The paper is drawn from Miller’s (2009) doctoral thesis so it is an extremely succinct summary of that research.

Six categories were identified, and for the purposes of the paper are discussed in relation to one category ‘*creating a shared understanding*’ (Miller & Willig, 2012, p. 40). For Miller and Willig, this category is associated with a pluralistic approach to therapy – and a potential drawback is that this generic category could be associated with other therapeutic approaches; so in that sense, it does not really discover anything ‘new’ about pluralism per se.

Other limitations are also pointed out by the authors: Miller was both the practitioner and the researcher so there might have been a bias of interpretation in favour of the ‘effectiveness of the work and the pluralistic

approach' (ibid., p. 43); the client group only represented 'a group who had lived with HIV for some time' (ibid.) and therefore was not, qualitatively or quantitatively, representative of all HIV-positive clients; and there was no use of quantitative data 'which could have been used to triangulate the qualitative analysis' (ibid.). The latter self-criticism seems to pay obeisance to the epistemological priorities of quantitative research without acknowledging that generalisability is not a priority of qualitative research. It does, however, correlate with a 'pluralistic' sensibility towards research, where both/and solutions, such as 'mixed methods', tend to be celebrated (e.g. Hanley & Winter, 2016).

Bowens and Cooper (2012) contribute a 'qualitative study of therapists' experiences of using the Therapy Personalisation Forms'. A Therapy Personalisation Form (TPF) was introduced in Cooper and McLeod (2011a), and therapists were encouraged to use this form in pluralistic practice. The Bowens and Cooper study also included another form called the Therapy Personalisation Form – Assessment (TPF--A). The study found that '[t]herapists were generally positive' about these forms, although participants also 'felt that the forms could lead to increased therapist self-criticism and over-moulding to the clients' wishes, and may be too complex or bureaucratic for some clients' (Bowens & Cooper, 2012, p. 47).

Two main limitations to the study recognised by the authors were that: (1) clients' experiences of using these forms were not explored; and (2) the researchers/participants were likely to be biased towards a favourable opinion of the forms (the authors helped develop them and the participants were known to the authors). A more general limitation is the implicit assumption that 'instrumental' questionnaire-based forms, designed to 'measure' relational processes, are more useful to clients, therapists and researchers than less formal 'relational' dialogue. Further research might explore not just how clients experience using these particular forms, but forms in general.

One study in the special issue begins to approach the area of my research, namely, Thompson and Cooper's (2012) 'Therapists' experiences of pluralistic practice'. The participants for this study consisted of 'therapists who described themselves as working pluralistically' (p. 63). The participants

readily identify with pluralistic practice and only problematise it to a limited extent. My research differentiates itself from this latter research because it focusses on therapists who are aware of pluralism but, bar one participant, have not identified with it. My participants might be described as the 'swing voters' which the pluralistic project needs to convince for it to achieve more success in the therapeutic world. Conversely, Thompson and Cooper's research concentrates on the 'converted', using Interpretative Phenomenological Analysis (IPA) with seven participants. Within its own terms the study is an effective one that identifies useful themes about these therapists' experiences, but it does not demonstrate how therapists in the wider profession are impacted by pluralistic ideas.

Watson et al. (2012) contribute a thematic analysis about how clients described 'client activities... therapist activities... and the perceived impact of these activities' (p. 77). The data were collected using a Post-Session form. The tendency to use forms to collect data, even within a qualitative thematic analysis, rather than less structured interviews, demonstrates the tendency of Cooper and his colleagues to avoid research that relies on more open, dialogical research methodologies and methods. Nevertheless, in the Discussion they do suggest that future research might make use of 'interviews or interpersonal process recall' (p. 86).

There are other limitations to the study that they acknowledge and illuminate, for example 'attributional errors' (ibid.). Overall, a major limitation, not described as such, is that the therapists did not identify as 'pluralistic', rather as person-centred and existential; instead, we are assured that 'the practice was also informed by pluralistic principles' (p. 81). Thus, the research is not about a pluralistic practice/perspective as such; rather, it is about generic processes that might just as easily apply to other specific approaches.

At the 18th Annual BACP Research Conference (2012), John McLeod chaired a symposium on 'Research into pluralistic approaches to counselling and psychotherapy: client experiences of multiple change processes', which I attended. Lynsey McMillan presented her research on '[c]lient experiences of change processes... for emotional eating problems' (McMillan, 2012, May). This mixed-methods study concluded that it was important to

recognise that 'psychological treatments which address underlying emotional barriers to weight loss have an important role to play' (ibid.). McMillan recognised the limitations of the research regarding sample size and lack of a longitudinal dimension (the perceived benefits of their group might have been short-lived). However, in my view, the biggest limitation is that the connection to pluralism, as the topic under discussion, seemed tenuous. This paper and others explored how clients change and other topics, but did not seem to be directly linked to pluralism (e.g. Omylinska-Thurston, 2012, May; Sundet, 2012, May). The papers seemed more akin to a 'common-factors' approach which, as previously discussed, is not the same as a pluralistic approach. A similar criticism could be aimed at the Baxter (2012, May) paper, except for the conclusions that the study claimed to '[provide] support for the validity of collaborative working... [and] the process of conceptualising... experience in terms of tasks was reported as positive' (ibid.). Collaboration and tasks are central organising concepts for pluralistic therapy and both are often critiqued as problematic in the provision of it. Baxter's study pointed to the possibility that some clients do like to work in this pluralistic way.

In another symposium at the same conference, also chaired by John McLeod, new research was presented exploring the potential for 'systematic case study research to develop a pluralistic framework for counselling in long-term health conditions'. Thurston (2012, May) presented findings from a single case study about working with sight loss within a pluralistic framework. Limitations of this study were identified as only working with one type of several types of sight loss. The findings, at best, would only support working in this way with that particular type of sight loss. Another limitation might be that the research seemed to be more about promoting a specific research method (systematic case study research), which McLeod wants to be more prominent (e.g. McLeod, 2010; McLeod & Cooper, 2011b), than it was about pluralism.

A case study approach was also used for Julia McLeod's research into 'process and outcome in pluralistic transactional analysis counselling for long-term health conditions' (McLeod, Julia, 2012, May). This study claimed to demonstrate that identifying the 'core therapeutic tasks' such as

developing a 'collaborative relationship' (key to Cooper and McLeod's pluralistic approach) contributes to good outcomes. Limitations to the research were identified as a low sample size (3), no male clients, and all the clients having been diagnosed for a long period (if they had just been diagnosed, results might have been different).

An overall criticism of both symposia could be that Cooper and McLeod's agenda for their version of pluralistic therapy to be researched with a distinct emphasis on outcomes begins to blur the philosophical bases of pluralism. The conceptualisation of helpful factors and processes, and the focus on identifying these helpful factors and processes for particular client groups, or to identify methods that might be of use to the pluralistic therapist, come close to being indistinguishable from the more established 'common factors' theoretical and practice-based research (e.g. Hubble et al.,1999). It is not clear whether Cooper and McLeod envision, in the end, a more generic, integrated future for therapy with a base of 'evidence' for particular interventions, or a pluralistic future for therapies. They might see this view as falling into the trap of either/or thinking; but the difference between a unified, integrated, generic 'therapy' and a plurality of 'therapies' could be said to represent opposite ends of a continuum of how therapy is theorised and practised, and might be theorised and practised. The research which they have produced or encouraged – and the flexibility of their definitions of a 'pluralistic' approach – supports the view of some critics that their approach lacks philosophical coherence and integrity. Most of the research about the pluralistic framework, up to this point in the summer of 2012, seems to have one pragmatic aim of proving itself to potential providers.

In contrast to process- and outcome-based research, Scott and Hanley (2012) published a paper focussing on the experience of 'becoming a pluralistic therapist' (p. 28). This paper covers similar ground to Thompson and Cooper (2012) but examines the process of someone encouraged by their training to take a pluralistic view of therapy. The main author (Scott) explores his training as a counselling psychologist, specifically in relation to Cooper and McLeod's (2011a) pluralistic framework. His professional title has implications for any discussion about pluralistic approaches because '[c]ounselling psychology training courses in the UK are required to focus

upon at least two therapeutic approaches' (Scott & Hanley, 2012, p. 28) – in contrast to most counselling and psychotherapy trainings in which it is most likely that only one approach forms the basis of training, even if that approach is 'integrative' or 'pluralistic'. It might be argued that training in only one approach sets up the conditions for an identity based on only one approach. The training for counselling psychologists in the UK does not reflect this initial training influence. The 'pluralistic stance [is] often advocated in the theoretical writings of counselling psychologists' (ibid.), and therefore the counselling psychologist trainee is located in a culture where pluralism is the 'norm', as opposed to counsellor/psychotherapist trainings where monism is the 'norm'. Indeed, there is often an explicit or implicit assumption in therapy trainings that it is best for trainees to focus on one approach so that their training leaves them with an unconfused and coherent view of how to practise therapy (e.g. Feltham, 1997).

Scott and Hanley employ a case study design in which the data in a reflexive journal form the basis of a thematic analysis. The themes identified by the authors were 'four selves: the Reflective Self, [the] Thoughtful Self, [the] Relational Self, and [the] Skilled Self' (ibid.). Scott followed the protocols of pluralistic therapy as devised by McLeod and Cooper (2011a). He also used the forms which they suggest are useful to monitor the therapeutic goals and processes of a pluralistic approach. However, when he reflects on his therapeutic work and struggles with identity issues, it is 'the philosophy behind pluralism... rather than the structure of goals, tasks and methods' which grounds him (Scott & Hanley, 2012, p. 36). Scott points to the view of some that pluralism makes more sense as a philosophical basis for practice rather than as a prescribed way to practise (p. 39).

Scott also suggests that 'none of the themes that I created from the data are distinctly associated to the pluralistic framework and could feasibly fit any therapeutic approach' (p. 37). This observation resonates with my own view that it is arguable whether some of the research already mentioned, although interesting and useful, is about something definitively 'pluralistic'. Some limitations to the study are that although he self-reportedly wrote his journal after sessions, as a 'stream of consciousness' (p. 31), he knew that these writings would form the basis of his thematic analysis. It is

hard to conceive that he would have been able to write this journal without that in mind. Also, there is an uncritical conflation of the identifying labels of 'integrative' and 'pluralistic', which suggests that the authors have not attempted to differentiate the meanings of these terms or see them as interchangeable, but do not explain why they see them as interchangeable. Scott identifies for himself that the study is limited by only being one voice. He suggests that the research would have been more 'effective... if a number of students' experiences were presented' (p. 38). My research does not explore students' experiences, but it does explore a number of therapists' experiences.

In 2013, Dryden (Dryden, 2013), in a chapter in *The Future of Humanistic Psychology* (House et al., 2013), suggests that 'one of the most exciting trends to emerge recently in the field of counselling and psychotherapy has been that of pluralism' (p. 122), and that 'Humanistic Psychology... should align itself with the pluralistic movement' (pp. 122–123). This praise from such a major figure in the therapy world, together with the addition of a chapter on pluralistic therapy in the 2014 *Handbook of Individual Therapy*, demonstrates its increasing prominence and recognition in therapeutic discourse (McLeod et al., 2014). The chapter in Dryden & Reeves (2014) also includes an illustrative case study of long-term therapy by Julia McLeod, which demonstrates that working collaboratively with the client and using 'CBT, transactional analysis, person-centred and psychodynamic approaches' over a three-year period had a good outcome. This case study, like all single case studies, is limited by its lack of generalisability, but otherwise is a clear explanation of how it is possible to work effectively with a pluralistic framework and practice.

Further, in 2013 John McLeod, in a dedicated chapter to pluralism in his comprehensive text *An Introduction to Counselling*, claims that 'the concept of *pluralism* offers a solution' to the problems of fragmentation within counselling (i.e. the problems engendered by the existence of many different approaches and many different types of practitioners) and offers 'an organizing framework for counselling practice' (McLeod, John, 2013a, p. 384, italics in original). McLeod also suggests that the 'pluralistic framework for practice... is particularly appropriate in situations where one-to-one

counselling is offered in the context of a “frontline” community counselling agency’ (p. 394). He speaks of the need for ‘generalist counsellors’ for these kinds of agencies and primary health care, and suggests that ‘single-orientation’ psychotherapists are more appropriate in ‘private practice or in secondary care’ (p. 395). These ideas for practice are not critically examined and make assumptions that are problematic, most notably the differentiation between counselling and psychotherapy, which McLeod advocates (see pp. 31--34), and the attempt to blur a distinction between counselling and pluralism, whereas ‘counsellors’ are just as likely to identify with particular approaches as are ‘psychotherapists’.

McLeod, Cooper, and others associated with their pluralistic project have continued to publish theoretical and research-based papers (e.g. McLeod, John, 2013b; Scott, 2013; McLeod, Julia, 2013), and the push for pluralistic approaches to therapy by Cooper and McLeod has continued to foster controversy, most noticeably in the pages of *Therapy Today* magazine. For example, the magazine featured it as a ‘debate’ with Michael Owens arguing ‘against factionalism’ (Owens, 2014) and Chris Molyneux arguing for a recognition of ‘the problem with pluralism’ (Molyneux, 2014). The latter piece criticised the approach for the eighth of McLeod and Cooper’s (2011a) frequently asked questions: viz. you can’t mix up different philosophical and psychological assumptions. Molyneux specifically argues the case that the PCA cannot be mixed with other approaches such as CBT if the PCA is deeply and philosophically understood. These articles set off another flurry of letters arguing for and against both purism and pluralism. It is a perennial topic of debate that refers now specifically to pluralism as an identifying label distinct from integrationism and eclecticism.

At the 2014 BACP Research Conference, which I also attended, McLeod and Cooper presented another symposium about research on pluralistic therapy. Cooper presented a paper on the ‘outcomes of pluralistic therapy for depression’ (Cooper, 2014a, May) and ‘client-identified helpful factors in pluralistic therapy for depression’ (Cooper, 2014b, May); Patricia Joyce presented on a ‘comparison of pluralistic counselling and counselling as usual for young people with addiction issues’ (Joyce, 2014, May); and Ellen Tilley presented on ‘values issues associated with training and practice

in pluralistic counselling' (Tilley, 2014, May). Tilley's qualitative thematic analysis is another example of a research area that gets close to my own, as it focusses on the experiences of trainees on a pluralistically informed training. That pluralistic therapy is now being offered as a type of training demonstrates how far the pluralistic approach has come since Cooper and McLeod first started articulating a practical framework for it in 2007. However, it might also be said that it has not had that much impact since there are only two trainings in the whole of the UK (plus one in Ireland) that specifically identify themselves as pluralistic (Abertay University and Roehampton University) with which McLeod and Cooper are respectively associated. My research focusses on the impact of pluralism on therapists who have not been trained in this way who form by far the majority of therapists – the number of therapists who have trained pluralistically (specifically) would be very few – and therefore explores how therapists in general are reacting to the pluralistic phenomenon impacting the field of therapy.

Also, in 2014, the first annual IAPT report was published. Vicki Nash, the Head of Policy and Campaigns at MIND (the leading mental health charity), was critical of the results, pointing out that amongst other problems there was a

lack of choice in the sort of talking treatment [clients] are offered. Different therapies work well for different people, so it's crucial that everyone is able to choose the type of therapy that's right for them.... Mind is calling on the NHS in England to offer a full range of psychological therapies to everyone who needs them. (Private Practice, 2014, p. 8).

This illustrates how the pluralistic debate had by this point embedded itself in discourses about mental health services, and how pluralistic ideas were being articulated in support of a different way of viewing the importance of theoretical approaches and the public provision of therapy.

In 2015 the results of a research study into 'pluralistic therapy for depression' (PfD) were published by Cooper et al. (2015). This study was a small-scale, mostly quantitative study (n=39), using the Patient Health Questionnaire (PHQ-9) depression scale and other instruments such as the Generalised Anxiety Disorder 7-item (GAD-7) Scale. The participants, who

were selected (non-randomly), all had moderate to severe levels of depression, according to the PHQ-9, and the average number of sessions was 14.4. The 'pluralistic therapy was delivered in accordance with a treatment manual' (p. 12) whilst simultaneously 'draw[ing] on... a wide range of change processes' (ibid.). There was also a qualitative dimension to this research in the use of thematic analysis for analysing data from structured interviews. The findings of this study 'suggest that the majority of clients in pluralistic therapy for depression experienced improvements' (p. 16). The quantitative data to back up this suggestion are extensively explained and demonstrated. The authors recognise the limitations of the study as being the small sample size that was also 'select', in that most of the participants were university students. The therapists were also trainees, and although there was a manual for delivering the approach, the adherence was not 'formally audited' (p. 17). In regard to the latter point, Cooper and his colleagues suggest that further research needs to help develop an 'adherence scale for PfD' (ibid.). This suggestion is made with regard to wanting trials against other approaches to measure outcomes.

There are, however, methodological problems in attempting to manualise and check for adherence to a 'pluralistic' approach: it is almost a contradiction in terms. The enthusiasm of Cooper and his colleagues for providing the kind of evidence that is perceived to matter to major therapy providers comes up against a dilemma in which the attempt to make therapists behave within the protocols of comparison trials simultaneously lessens their ability to work pluralistically. This is a major hindrance in researching pluralistic therapy in this way. It is also a problem in researching other therapies when practitioners have to deliver their 'brand' of therapy in a certain way for it to be seen as valid because then only a certain kind of delivery of any particular therapy is allowed; but it is particularly problematic in the attempted outcome-based research of pluralistic therapy. This problem is one major reason why the energies of the therapeutic professions might be better aimed at arguing for the recognition of 'practice-based evidence' (PBE) – as opposed to 'evidence-based practice' (EBP) – rather than trying to placate the research culture as it currently exists.

At the 2015 BACP Research Conference just one paper was presented directly engaging with pluralistic therapy, titled: 'Meta-therapeutic communication: What, when and how do therapists talk to clients about the process of therapy?' (Cooper & Papayianni, 2015, May). This study was developed out of the research of Cooper et al. (2015), using thematic analysis to analyse data collected from 'post-session note forms'. The study was small and tentative, and only claimed that it might contribute to 'more fruitful therapy outcomes'.

Tilley et al.'s research into 'values issues associated with training and practice in pluralistic counselling' (Tilley et al., 2015, p. 180), which I have previously mentioned in relation to the 2014 BACP Research Conference, was published in 2015 in the *Counselling & Psychotherapy Research Journal*. It covers questions and issues that are close to my research. All the participants identified with the pluralistic approach. In Tilley et al.'s concluding remarks they suggest that

[i]t would be helpful if further research could develop a more differentiated picture of pluralistic values... by including therapists from other approaches who have adopted the pluralistic framework later in their careers... or therapists who have rejected or moved away from a pluralistic approach (ibid., p. 186).

In my view these suggestions for further research assume an either/or pluralistic/non-pluralistic dichotomy. It might be that pluralism is more like a continuum that ranges from extreme purism to extreme pluralism and, in the spirit of a pluralistic perspective, it might also be that therapists position themselves along that continuum in different places at different times for different clients. If this is the case, then my research, focussing on therapists who do not completely identify or completely dis-identify with a pluralistic approach, reflects a different way of conceptualising how therapists relate to pluralism and its place in the therapy field. In this way my research covers the question of how therapists as a professional group are accepting or rejecting of Cooper and McLeod's pluralistic approach. I would suggest this question is logically the first question to pose, since without the support of the profession the ideas associated with potential pluralistic practices are not likely to propagate.

A multitude of issues related to the pluralistic approach was published in 2016 in *The Handbook of Pluralistic Counselling and Psychotherapy* (Cooper & Dryden, 2016). The handbook covers the 'fundamentals' that have been articulated in this section, the relationship of pluralism to specific orientations, specific client symptoms and professional issues. The chapters expand on ideas that have already been explored and/or will be explored in the Findings and Discussion chapter. In terms of research there is no new research in the book or in its citations.

In 2016 at the 22nd Annual BACP Research Conference Sarah Cantwell delivered a paper entitled 'A conversation analytic survey of how clients and therapists talk about what might be therapeutically helpful in pluralistic therapy' (Cantwell, 2016, May). She presented examples from her analyses of therapists attempting to apply pluralistic protocols with varying degrees of success. These analyses were made from audio-recordings used for other research projects previously conducted by Cooper in Glasgow. It suffers from not having video recordings so that body language might be seen, but otherwise seems extremely useful for the pluralistic project since it roots how pluralistic therapy works (or not) in actual therapy sessions with clients.

In 2017 two more relevant articles were published. One article (Antoniou et al., 2017) was based on the paper delivered at the 2014 BACP Research Conference (Cooper, 2014b, May) about 'helpful aspects of pluralistic therapy for depression' which has previously been discussed. The same criticism of quite what distinguishes this kind of research from 'common factors' remains unclear. The other article by Thompson et al. (2017) was entitled 'Development of a therapists' self-report measure of pluralistic thought and practice: the Therapy and Pluralism Inventory'. In terms of content, again this gets close to the focus of my research; however, the research is quantitative and is aimed to be 'used in process and process-outcome... research' (p. 8). The deeper, 'thicker' meanings of pluralism for therapists are not developed – the tool is viewed in an entirely pragmatic way to 'articulate, audit and assess a pluralistic approach' (p. 9). Therefore, the qualitative approach of my research allows for deeper and broader

interpretations of how therapists experience and make sense of pluralism in theory and practice.

In 2018 John McLeod published a book entitled *Pluralistic Therapy: Distinctive Features* (McLeod, 2018). This book is part of a series called 'Psychotherapy and Counselling Distinctive Features', edited by Windy Dryden, and there is a sense that McLeod is responding to the criticism that there is not much that is distinctive about pluralistic therapy, especially in relation to integrative therapy. He states that '[t]he main principle of pluralistic therapy is that people who enter therapy are experts on their own lives' (p. 1). This does not stray far, if at all, from the PCA and some other humanistic approaches. Otherwise, McLeod emphasises the collaborative heart of pluralistic therapy, which is a claim that could easily be made by other approaches, especially those under the integrative umbrella (e.g. Gilbert & Orlans, 2011). McLeod clearly accepts the categorisation of pluralistic therapy as an integrative approach, if 'integrative' is defined as 'combin[ing] ideas and methods from several (or all) purist approaches' (p. 21). However, whilst he admits and elaborates on what the similarities between pluralistic and integrative therapy are, he also insists that there are differences.

Before elaborating on these differences McLeod argues that the purist/integrative binary is unhelpful and perhaps mistaken. So-called 'pure' models, for example, are themselves usually integrations of various 'ideas and methods that were in circulation at the time they were founded' (p. 21). He also points out the commercial implications of tangible models versus practitioners just practising who are not motivated to take their ideas 'to market'. The idea that 'all therapy is one thing' (p. 22) is also referred to, which, if true, has implications for the idea of pluralistic therapy, and would point to the acceptance of a more 'common-factors' approach.

Some arguments that McLeod suggests distinguish pluralistic therapy from integrative therapy are that: (1) pluralistic therapy allows for the creation of different types of integration, (2) it rejects current assumptions about 'integrative' and 'purist' therapy, and (3) it might be redefined as 'plain old therapy' (Allen, 2012) which is 'the best efforts of front-line therapists to respond constructively to the needs of their clients or patients' (McLeod,

2018, p. 23). It is not clear whether these distinctions justify pluralistic therapy as being that different to a type of integrative therapy that might be argued for within that umbrella. Likewise it is not clear whether McLeod and others associated with the pluralistic project accept their therapy as an integrative one, or prefer to see it as distinct.

In March 2018, the '1st International Conference on Pluralistic Counselling & Psychotherapy', at which I attended and presented, was held in Dundee. The organisers recognised pluralistic therapy as a 'relatively new approach' which they characterised as 'offering flexible, collaborative forms of help to our clients and service users' (Abertay University, 2018). Presentations of new research directly connected to pluralistic therapy included using a pluralistic approach with young people with special educational needs and disabilities, goal negotiation, experiences and evaluations of pluralistic training, using Gardner's theory of multiple intelligences in pluralistic therapy, pluralistic therapy with sand-tray interventions, pluralistic therapy for women affected by pregnancy sickness, pluralistic counselling with young people who present with issues of addiction, and using a pluralistic approach in the treatment of 'bipolar disorder' (ibid.). Interestingly, both Cooper and McLeod in their keynotes did not speak about pluralistic therapy per se but Cooper re-articulated 'goals' as 'directionality', perhaps in an attempt to include those with an aversion to the concept of goals, whilst McLeod spoke about the importance of 'resources' outside the therapy room. Both of them explicitly discounted their own motivation to lead a pluralistic therapy movement and tried to explain the concept of pluralistic therapy as a kind of 'wiki'. It was a good first conference but it seems as if others were being asked to take up the mantle practically and politically.

In summary, there has been an extensive literature, much theoretical but some research-based, regarding the pluralistic approach to therapy. The majority of the studies have been quantitative, using a variety of process and outcome measures, and there have been some qualitative studies that have focussed on therapists' experiences of the pluralistic approach. The latter studies have focussed on therapists who already identify as pluralistic or who are sympathetic to the pluralistic framework. Therefore my research

explores new territory, since it explores with non-pluralistic therapists the question 'How do counsellors and psychotherapists make sense of pluralistic approaches to therapy?' The themes that have been constructed from the interview data illuminate how some therapists are reacting to the theoretical and practical developments of pluralism in the profession.

3.3 Conclusions

The psychological therapies exist in a culture where '[public] mental health services are now dominated by IAPT' (Proctor, 2015, p. 20). The consequences of this have been mental health services in which choices for patients have been reduced. A focus on the types of therapy delivered (allegedly 'proven' by RCTs), rather than the accumulated knowledge and experience of therapists, means that a 'new industry in training already trained and experienced clinicians in an evidence-based therapy' has been created, which has the effect of 'demoralising and devaluing the existing workforce' (p. 21). Proctor offers a compelling critique of the 'tick box culture' (p. 24) and the threat it poses to counselling and psychotherapy within the NHS. The values of pluralism, either within a single therapist's approach, or within larger-scale providers of therapy, impact directly on how therapy is provided and who is allowed to provide and access it. The issue is of vital importance, so how therapists are responding to it and interpreting its meaning, especially in relation to how they practise, is also of vital importance. This is the focus of my research which has not previously been studied in this way.

4: Research Design: Methodology and Methods

4.1 Introduction

The question addressed in this research is: 'How do counsellors and psychotherapists make sense of pluralistic approaches to therapy?'. I approached this question within an II methodology (Denzin, 2001) using the method of thematic analysis (e.g. Braun & Clarke, 2006) to analyse interviews I undertook with therapist-participants.

The rationale for this methodology and method, and the paradigmatic, ontological and epistemological assumptions on which they rest, will be elucidated in subsequent sections of this chapter. My objective was to inform the debates around purism (or 'monism') and pluralism, for the benefit of the profession and the clients it serves, through an exploration of how therapists make sense of pluralistic approaches to therapy. These approaches, as perspectives, and particularly as self-conscious practices, are a 'relatively recent development' (McLeod et al., 2014, p. 570). Debates in the profession in relation to pluralism include: (1) whether pluralism should refer to a perspective or a practice; (2) the incompatibility of pluralism with a belief in the 'fundamental significance of a single change process or conceptual model' (ibid., p. 571); and (3) the potential of a collaborative therapeutic approach, which both pluralist perspectives and practices encourage, to be counter-therapeutic (ibid.).

Since pluralism as a perspective and practice is such a recent development in the therapy profession, there has been a relatively limited amount of research about it. How therapists make sense of pluralism has been researched, but only by 'therapists who described themselves as working pluralistically' (Thompson & Cooper, 2012, p. 63). Therefore in this study my aim was to explore how therapists who were not explicitly signed up to a pluralistic perspective or practice made sense of the phenomenon. For over a decade now, pluralistic therapy has been proactively proselytised by its advocates, so enough time has passed for assessing how it has impacted the wider therapy community's professional identity and self-definition(s).

The findings, in terms of the descriptions and interpretations of interview data, might be dismissive, enthusiastic or neutral towards pluralistic perspectives or practices in therapy. This might have implications for how commissioning bodies, therapists, trainers and researchers develop and focus their practices, and for whether pluralistic conceptualisations are perceived as worthy of consideration in these developments. Whilst it is difficult to establish the 'truth' or appropriateness of any particular approaches to therapy, including pluralistic ones, the additional knowledge about how therapists make sense of issues relating to pluralistic practices and perspectives might contribute to an increased awareness with which influential persons and bodies make their decisions. This is a pragmatic aim that does not need to simultaneously claim that this additional knowledge consists of any certain, generalisable and unchanging truths. A pragmatic approach to research – in which both quantitative and qualitative methodologies about the same or similar topics can be viewed as different but complementary – is supported by many qualitative researchers (e.g. Smith, 2011; Smith et al., 2009; Vogt, 2008). Therefore this research can also complement other quantitative research in this area. The main focus was on how therapists made sense of their own practice in relation to pluralistic approaches, and on the implications of pluralistic approaches for practice, more widely. For example, one issue that arose in the data is the tension that pluralism in therapy can create for professional identity (Hemsley, 2013b).

This chapter will be structured in the following sequence: research design (methodology and methods), participants, ethics, data collection, data analysis and summary.

4.2 Research Design (Methodology and Methods)

4.2.1 Self-reflexive statement about the research

The therapy profession is riddled with problems of identity, professional status and differentiations of roles and approaches. It is also in competition with other methods and professions such as pharmaceutical interventions

and psychiatry. This context often means that therapists struggle with where they locate themselves in relation to concepts and practices such as the 'medical model'. I find myself uncomfortable with the amount of confusion and conflict this causes at both intra- and inter-professional levels, and it has been part of my character to look for ways that, in different areas, include rather than exclude, integrate rather than separate. So, from early on in my therapy training and practice, I have found myself drawn to therapeutic theories that aim to transcend 'schoolism' (Cooper & McLeod, 2011a). The first text that I found convincing and impressive in this area was Petruska Clarkson's *The Therapeutic Relationship* (1995). This offered a model based on the 'relationship' which, in my view, and supported by research (e.g. Hubble et al., 1999), is the generic common factor of all therapies; and it elucidated how all therapies operate within five different kinds of relationship that can all be useful to different clients at different times. I discovered that this kind of argument/theory/approach fell under the 'umbrella' term of 'integrative psychotherapy', and I was happy to identify myself with this broad term.

Then, shortly before beginning my doctoral studies in 2011 I began to see a new phrase cropping up in the literature – 'pluralistic counselling and psychotherapy'. I did not know what it meant, but after reading a couple of articles and then reading Cooper & McLeod's (2011a) book on the subject I realised that I had come across a perspective that more exactly described how I understood therapy, and how I had been practising, without having a word for it, for many years. The similarities and differences between an 'integrative' and 'pluralistic' therapeutic perspective/practice have been elaborated upon in the Literature Review, and there will be further elaboration in the Findings and Discussion chapter. For now, the main point that needs to be emphasised, is that as a researcher and a practitioner, I need to 'own' my biases as being favourable towards pluralistic conceptualisations of therapy.

I have been uncomfortable with 'schoolism' (e.g. Cooper & McLeod, 2011a) ever since I became aware of it during my training. I was never attached to the idea that the approach in which I was training was necessarily the best approach or that other approaches were not as good. I

even undertook my personal therapy requirement with a psychodynamic practitioner despite being on a humanistic training course; and similarly for many years I also had a psychodynamic supervisor for my mostly humanistic practice. I found that observing my practice through a different theoretical lens led to clarity rather than confusion. In this spirit, therefore, I do not have the same struggle as some practitioners (e.g. Molyneux, 2014) in combining or changing therapeutic practices or perspectives over time (whether that be over a short course of therapy and/or in my career as a practitioner). Therefore, the argument that it is a virtue to be attached to a single approach, and particularly the idea that it is possible and desirable to demonstrate the superiority of any one approach over others does not resonate with me.

However, there are some practitioners who do commit themselves to one approach, and of those, some will do so evangelically, in espousing their approach as superior, whether explicitly or tacitly. The former group can still be 'pluralistic', as a pluralistic perspective on therapy is supportive of single-approach practitioners, as long as there is simultaneous respect for other approaches, and recognition that any favoured approach has its own limitations as well as advantages. However, the latter group can be described as 'monistic', meaning that they have an assumption that it is possible to prove – as a singular, incontestable 'truth' – that one approach is better than another, rather than the possibility that there is a multiplicity of potential truths that are context-dependent (Thompson & Cooper, 2012). In short, I acknowledge my bias towards a pluralistic perspective on therapy.

In the course of my research, I managed this bias because I was not undertaking the research to convert practitioners to a new perspective. Rather, I was undertaking the research out of a genuine curiosity as to how practitioners relate to pluralistic practices and perspectives. Further, in my view there is not a strict either/or divide between those who practise pluralistically and those who do not; rather, there is a continuum of practice from strictly fixed singular approaches to flexible multiple approaches. I was curious about where practitioners find themselves on this continuum.

I own my bias towards a pluralistic perspective but this is not at the expense of intolerance for those of a monistic persuasion. Simultaneously,

my bias towards pluralistic perspectives and practices does not mean that I do not see flaws or problems with them. I looked forward to discovering in the interviews how pluralistic approaches to therapy might be experienced in both positive and negative ways. A paradox of a pluralistic perspective is that it is open to new and different points of view, including those that are critical or antagonistic. It could even be seen as an impossibly and annoyingly inclusive philosophical/pragmatic perspective that defends itself with a kind of circular thinking. In other words: 'If you think something else - okay, we can include that in our pluralistic perspective.'

I was not motivated in this research to find data that supported pluralistic approaches. Rather, I was genuinely and open-mindedly interested in how and what therapists think and feel about it, and where they position themselves in current debates. As many therapists do identify themselves as integrative or eclectic (Norcross, 2005), then I might have expected that at least some of my participants would identify with integrative/eclectic or pluralistic orientations, or be sympathetic to them. Integrationism and eclecticism are not the same as pluralism, but on the monism--pluralism continuum they are further away from purism/monism, and closer to pluralism. It was not an unreasonable expectation, therefore, that therapists who self-identified as integrative or eclectic might be sympathetic to pluralistic perspectives and practices, even if they did not describe themselves as 'pluralistic'. However, there are others who are not sympathetic, and argue the case for a purist, single approach to therapy (e.g. Molyneux, 2014); and it was to my advantage rather than disadvantage to be able to interview someone who held a more purist/monist position.

My ideal for the therapy profession is a future in which professional, economic and ideological interests cede to a more 'dialogical' approach in which different voices/positions talk with one another, not to dominate or marginalise but to understand and negotiate more complex and nuanced positions (e.g. Hermans & Gieser, 2012). For me, this ideal is not just an intellectual, theoretical view but heartfelt and embodied. My awareness of a dialogical perspective was a key for me being able to bracket off my own positions for the interviews and initial interpretations of interview texts. From a Heideggerian perspective it was awareness of biases and assumptions

that paradoxically made them less rather than more problematic for research (e.g. Smith et al., 2009).

My biases and assumptions emphasised the need for me to have a reflexive awareness (Etherington, 2004). By this I mean that throughout the research I was reflecting on how I was, as an individual, influencing and being influenced by it. I needed to be aware of how my personal history influenced the research, from my choice of question to research aims, participant selection, data collection (interview process) and analysis. I was aware that as a therapist practising for over 15 years (at the time of doing the interviews) I had developed assumptions and biases, and I believed the best way of working with them was to acknowledge them rather than pretend they did not exist. I was also aware that my gender, class and cultural background also influenced how I positioned myself in relation to both data collection and analysis (ibid.). I wanted to bring in my subjectivity to the research as and when it needed to be acknowledged. However, I did not want to bring it in any more than necessary for the aims of the research. I wanted to avoid reflexivity in my research spilling over into 'solipsism, self-indulgence, navel gazing [and] narcissism' (ibid., p. 31).

Etherington (2004) summarises researcher reflexivity 'as the capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid and changing) inform the process and outcomes of inquiry' (ibid.). I minimised my own personal position influencing the research by 'bracketing off' my assumptions in the formulation of questions/topics for the interview schedule and in ensuring that the dialogue was focussed on the other when undertaking the interviews. In the analysis my priority was as far as possible to understand the narratives of participants from their own subjective position. This was emphasised by a phenomenological attitude. However, that attitude was balanced by a hermeneutic approach, in which I could subsequently understand the same text from my own subjectivity as *long as I was conscious of that and acknowledged that that was what I was doing.*

To summarise, I wanted to explore deeper and nuanced interpretations of how therapists make sense of therapy in relation to single, integrative and pluralistic approaches at the current historical juncture. I was

fully open to what they had to say about their personal experiences and interpretations of these different phenomena, and was and am not aware of any personal investment in their agreeing, or not, with my own views on pluralism in therapy. At the same time, I acknowledged that how I interpreted their interpretations would necessarily be subjective (Smith et al., 2009).

4.2.2 Research paradigm

In the social sciences, a paradigm refers to the ‘theoretical framework with which to read and understand one’s empirical materials’ (Brinkmann & Kvale, 2015, p. 274). This theoretical framework consists of ‘a set of interrelated assumptions about the social world’ which allows ‘the organized study of that world’ (Filstead, 1979, p. 34). Paradigms inform and influence how research is planned, carried out, analysed and disseminated. Although some are dismissive of the emphasis on paradigms in the social sciences (e.g. Hacking, 1995) as a misguided search for foundations in a postmodern world (e.g. Brinkmann & Kvale, 2015; Thomas, 2013), I would argue that they are necessary not just at a theoretical level but for how the research is eventually conducted in the ‘real world’ (Robson, 2011).

The paradigm that the researcher assumes and/or embraces has implications for the researcher’s subjectivity and worldview, and is important throughout the research process. Brinkmann and Kvale (2015) argue that ‘paradigms are not simply ways of *seeing* but ways of *doing*’ (p. 274; italics in original) so that a paradigm can be seen as reflecting not solely a theory with which to view the world (and subsequently one’s research) but a ‘craft tradition’ (p. 275). Lather (2006) also argues for viewing paradigms as ‘thinking tools that express different interests’ (quoted in Brinkmann & Kvale, p. 275). This is, perhaps, a rather pragmatic perspective on paradigms, but the controversy about ‘paradigm talk’ (ibid.) needs to be acknowledged. Similarly, the assumption that a researcher needs to be firmly rooted in one paradigm rather than in a mix of paradigms has also been challenged (e.g. Frost, 2009). Indeed, it might be seen as slightly paradoxical to be researching pluralism from within a single paradigm.

My own view reflects a postmodern and pragmatic position in which the value of paradigmatic frameworks relates directly to their practical value

to research questions and aims. Ultimately, the value of a research project is not in the philosophical position which underlies it but in the value of the knowledge it discovers or creates for the world (even if that world is a microcosmic professional one).

The two main paradigms that inform the social sciences are 'positivism' and 'interpretivism' (Thomas, 2013). (Other paradigms include 'postpositivism' and 'critical theory', amongst others [Denzin & Lincoln, 2011b], and for clarity and coherence, I will discuss these alternative paradigms in the next section.) A positivist view of the world values objective knowledge, that which can be 'straightforwardly perceived and recordable without too many problems' (Thomas, 2013, p. 107). My question sought to find out how participants made sense of a phenomenon (pluralistic approaches to therapy) impacting their professional field which could not be directly answered by observation and recording.

Therapists make sense of pluralistic approaches via understandings, perceptions and views. They also experience and have had experiences of pluralism and pluralistic approaches, I would argue, in the following ways: (1) on an individual level there are embodied tendencies towards or away from a pluralistic 'way of being' (Rogers, 1980); (2) in trainings there may have been more or less emphasis on pluralism as a perspective or practice; (3) therapists may have sought out to greater or lesser extents different ways of practising since an initial training; (4) therapists may have been impacted by other approaches (e.g. CBT); and (5) therapists may embody a pluralistic perspective or practice without naming it as such. In sum, I wanted to know what therapists thought about pluralism, what they felt about it, how they experienced it in their own practice, and how they perceived themselves in relation to it.

Pluralism is a 'constructed' idea about how to approach practice either indirectly or directly (Cooper & McLeod, 2011a) to which therapists react in different – sometimes polarised – ways (e.g. Molyneux, 2014; Owens, 2014). The phenomenon itself consists of interpretations and positions relating to therapy as a whole, which is articulated within the therapeutic profession and impacts therapists subjectively (i.e. there is confusion and difference in what therapists perceive pluralism to be, and therefore confusion and difference in

how they describe, experience and understand it) (e.g. Molyneux, 2014). I wanted to explore therapists' descriptions of their experience of the phenomenon which from an interpretivist viewpoint are necessarily interpretations. Subsequently, no matter how focussed I became on understanding their descriptions/interpretations rather than my own, I would not be able to do this without interpreting their interpretations – what has become known as the 'double hermeneutic' (Smith et al., 2009). The question I was asking – with multiple layers and relationships of complex interpretations – could not be answered in sufficient depth within a positivist paradigm, nor did it lend itself to a quantitative approach.

Conversely, within an interpretivist paradigm the social construction of 'pluralism' could be engaged with directly. Both social constructionism and interpretivism reject 'methodological positivism' (Brinkmann & Kvale, 2015, p. 14). A social constructionist perspective sees interviews as 'an active process where interviewer and interviewee through their relationship produce knowledge' (ibid., p. 21) and 'the interviewer and interviewee as coconstructors of knowledge' (ibid., p. 22). This perspective is compatible with an interpretivist paradigm, and reflects a postmodern view of the world in which 'knowledge as a mirror of reality is replaced by a conception of the social construction of reality, where the focus is on the interpretation and negotiation of the meanings of the social world' (ibid. p. 61).

There is, however, an important distinction to be made between social *constructionism*, which often discounts the importance of the subjective, and 'social *constructivism*', which perceives the subjective as important whilst holding that there is also a socially constructed world (e.g. Polkinghorne, 2004). I identify myself as a social constructivist, and I will elaborate further on this important difference later in this section. In these interpretivist or constructivist frameworks (e.g. Denzin & Lincoln, 2011c), the theoretical/intellectual component of pluralism and therapy can be seen as valid phenomena to have studied; the data that participants generated, even from a small sample, can be seen as having added to knowledge; and my own subjectivity's impact on the research can be acknowledged and accommodated. I was more concerned with interpretations of meanings than with facts, and this emphasis led me to an interpretivist position and an

interpretivist approach to my research question. I wanted to explore how therapists made sense of pluralism in therapy in both its forms, as perspective and practice. I was interested in the subjectivity of my participants, and my own subjectivity was not problematic as long as I was reflective about it (in ways described in the previous section).

An interpretivist assumption is that there is 'no clear, disinterested knowledge – people have feelings and understandings and these affect the ways they perceive and interpret the world' (Thomas, 2013, p. 109). This assumption informed the way that I perceived my participants and how I perceived my own position as a researcher. Moreover, it was this subjectivity that formed the basis of interpretation (ibid.). I am a therapist and I have been a therapist for over 20 years. This experience makes up part of my 'self-narrative' (e.g. Polkinghorne, 2004), and my own particular and unique story of 'being-a-therapist' makes it very difficult, if not impossible, to bring an 'objective' position to research about therapy. However, within an interpretivist paradigm, this subjective experience and knowledge, as long as I bring it to light and reflect on how it affected the research, has the potential to be of overall advantage to the quality of the research, as a reflective awareness of one's subjectivity allows greater discrimination of what belongs to the self, what belongs to the other and what belongs *between* in interviews and interpretations of texts.

Within the interpretivist paradigm, I was aiming to explore how particular therapists made sense of pluralism in its particular relationship with therapy. This may contribute to knowledge about therapy as a whole. As a therapist I brought 'inside' knowledge to the interviews and to my interaction with participants. This 'lived experience and member status are no longer stigmatised among social scientists' (Johnson & Rowlands, 2012, p. 103). However, there are disadvantages as well as advantages to being an 'insider'. One disadvantage is that what the participants chose to tell me may have been more defended rather than less, and how I presented myself might also have been more defended since we were fellow professionals, and both of us might have fallen into an 'impression management' style of relating (Carter & Bolden, 2012, p. 264). I needed to be aware of this, and I attempted to ensure a trusting relationship.

In addition, the insider/outsider dichotomy is not a straightforward one (e.g. Foley, 2012). For instance, although I might be an 'insider' in terms of being a therapist I might be an 'outsider' in terms of, for example, not being 'person-centred'. The insider/outsider experience is one that resonates with therapists in relation to monism/pluralism, and was reflected on in the interviews, most pertinently in relation to feeling inside/outside CBT. These subjective experiences of feeling inside/outside different groups within the profession offered opportunities for questions and dialogue that enabled clarification of these positions/experiences. That allowed for a within-the-interview process of checking the importance of these issues with participants, both in themselves, and also in relation to interview process and content (Brinkmann & Kvale, 2015). The main advantage of being an insider was that I might be able to 'gain truer and richer data' from my participants (Foley, 2012, p. 310).

Foley (2012) herself is sceptical that insider/outsider status is as important as some researchers suggest, and notes that researchers argue for the benefits of both. This particular research question and the topics it sought to explore are subtle and complex. Therefore, in my view a non-therapist would not have had sufficient personal knowledge (Polanyi, 1964) and experience to be able to undertake the research unless the interview schedule was pre-written and fully structured. I would argue that my status of in some ways being 'inside' the same world as my participants, was necessary. However, I did need to be aware of using that insider status to my advantage, and so I attempted to minimise the disadvantages.

Within this interpretivist (sometimes called 'constructivist') paradigm (e.g. Denzin & Lincoln, 2011c), I subscribe to a relativistic view of the world. It is also important to understand the difference between a social *constructivist* as opposed to a social *constructionist* view of the world which I alluded to earlier in this section (Polkinghorne, 2004). Some refer to the former as 'soft' social constructionism (e.g. Shotter, 1993; Sullivan, 2012); but having a related but different name, I would argue, highlights that there are important differences in their underlying assumptions.

The differentiation between the two is that social constructivism allows for the importance of consciousness (Sullivan, 2012), and maintains that

meaning is constructed from the self as well as from the social system (Polkinghorne, 2004). For a 'hard' social constructionist, this view of the importance of the self's subjectivity is misplaced. I perceive the world as formed of 'local and specific constructed and co-constructed realities' (Lincoln et al., 2011, p. 98) where 'truths' are often context-dependent. I perceive phenomena in the social world as dependent on the constructions of people concerned with them; yet I simultaneously believe that phenomena in the world can exist independently of observers (i.e. I believe trees exist even when people are not looking at them and naming them as such).

However, phenomena in the social world, such as pluralism, even though they may have an embodied dimension, are socially constructed, even if it is only in the naming of the phenomenon. The meanings of named phenomena then become open to argument. For instance, therapy is an embodied practice, but the meaning of 'therapy', as a named object, is open to and provokes contestation. In my view, we are all in relationships to these phenomena, and our situation in time and space influences how we experience and understand them. The phenomenon of 'pluralism' is a construction that is experienced in a 'local' way by therapists. However, this construction does have an embodied, lived reality to it. In the same way as 'love' can be seen as a construction but can also exist as an embodied experience I would suggest that pluralism can be experienced by therapists as an idea and as a 'way of being' (Rogers, 1980). Moreover, this experience can be one of degree, such that therapists might *feel* more or less pluralistic on a continuum as opposed to locating themselves on one side of an either/or divide.

Although pluralism is a concept that is applied in many fields I am researching how it is applied particularly in therapy. In an ongoing dialogue between therapists through everyday conversations and various media such as conference presentations, journals, books and online forums, this construction is dynamic, fluid and more precisely, *co-constructed*. The meaning of pluralism, as a concept in itself and for therapists, is subject to dialectical processes: the reality of pluralism is not just 'local' to therapists in geographical space but also 'local' in historical time, and the meanings of

therapy and pluralism as individual and related concepts shift between different practitioners and across time.

It might be argued that this aspect of therapy/pluralism suggests that a dialogical approach to data analysis might have been useful. A dialogical approach embraces Bakhtinian concepts of 'truth' as both "lived" (*pravda*) and "abstract" (*istina*)' (Sullivan, 2012; Bakhtin, 1993) in a similar way to my earlier suggestion that love might be both an abstract and a lived phenomenon. Sullivan illustrates this idea thus: 'To experience somebody as attractive or funny... depends on both our abstract ideas of what these qualities are and our immediate experience of these in the specific encounter with another' (Sullivan, 2012, p. 3). Bakhtin also argues that 'true knowledge' comes from 'personal participation' which consists of a 'dialogue with ideas of others' (Sullivan, 2012, p. 4).

The ontological position of dialogical analysis suggests that 'people depend on others for values or embodied ideas to give a clear sense of who they are' (Sullivan, 2012, p. 5). These ontological and epistemological assumptions might have fitted well with an inquiry into how therapists 'dialogue' with pluralism and how they embody these ideas and that embodiment's relation to identity. A dialogical approach to analysis also emphasises the importance of the subjective. Sullivan (2012), following Parker (1997), refers to this subjectivity as 'complex', meaning that it allows for 'individual intentions and desires... enmeshed and "tangled up" in social structures and discourses' (Sullivan, 2012, p. 30) – similar to my position articulated earlier as a social constructivist. A dialogical approach, moreover, challenges a 'conventional time-sequence reporting of events' in research with an 'understanding [that]... the question may shift and change as one interacts with the data and other people' (Sullivan, 2012, pp. 154--155). There were advantages to thinking dialogically about the data and perhaps applying specifically dialogically informed methods. However, it was arguable whether a dialogical perspective might not have been more easily integrated into a more general interpretive approach. In my view dialogical analysis also had too narrow a definition of how to understand and interpret dialogue to fully embrace the themes that might come from my data.

The local and specific natures of pluralism/therapy reflect how some phenomena cannot easily, if at all, be captured by universal generalisations. Within an interpretivist/constructivist paradigm my epistemological position is that there are no universal truths – rather, I view knowledge as being constructed by individuals or groups with varying degrees of consensus (Lincoln et al., 2011) and this knowledge is always contextual. This epistemological position fits well with the nature of subjectivity, such a central characteristic of therapy – the subjectivity of a person referred to as a client encountering the subjectivity of a person called a therapist (Bott & Howard, 2012). Whilst the struggle to be objective about these intersubjective processes is to be admired, it also points to the aptness of working within a paradigm, ontology and epistemology that supports the knowledge claims of the subjective when inquiring about therapy.

I needed to engage with therapists personally so that I could obtain ‘thick description[s]’ (Geertz, 1975) of their subjective experiences and reflections on pluralistic approaches. It might be argued that a questionnaire or similar could have generated data. However, this would have been highly restrictive, and would not have allowed for an open dialogue about the phenomena. As a therapist, I had the knowledge and experience to enable informed engagement with the participants. The subjectivity of both myself and my participants allowed for a dialogue and a relationship in which findings and knowledge were co-created or co-constructed (e.g. Brinkmann & Kvale, 2015; Lincoln et al., 2011). Neither I nor my participants could objectively look at either pluralism or therapy. As therapists we had prior understandings about both of these phenomena. The phenomena, as we understood them, were experienced within our own situated ‘bodyminds’ (e.g. Aposhyan, 2004; Dychtwald, 1986). As therapists we understood these phenomena from a particular angle. Whilst all therapists share the ‘beingness’ of ‘being-a-therapist’, that does not mean that how they make sense of being a therapist or how they experience what it is they are doing are the same. How they made sense of pluralism and pluralistic approaches to therapy was what my research aimed to explore: through an intersubjective interview process, knowledge was generated; *‘we are shaped by our lived experiences, and these will always come out in the knowledge*

we generate as researchers and in the data generated by our subjects' (Lincoln et al., 2011, p. 104, italics in original). This view reflects my epistemological position that what we claim to know is a construction validated by more or less consensus. Although I value etic inquiry I believe that emic inquiry is equally valid. Even etic inquiry exists within an emic framework since whatever we say about anything is communicated via language, music and other human symbol systems (Wilson, 1990). I view this within a pragmatic philosophical position which emphasises the usefulness of knowledge over its supposed 'truth' (ibid.).

Thus, within this interpretivist paradigm, and the ontological and epistemological understandings of the nature of reality and what can be known about the world that fit within this paradigm and discussed within this section, I concluded that the best way to research my question and fulfil its aims was to work within an II methodology. Further exploration of this methodology will follow in section 4.2.4, after I discuss paradigms and methodologies I did not choose to follow, and the rationale for discounting them for this particular research question/project.

4.2.3 Other paradigms and methodologies

In this section I will explore paradigms and methodologies that I did not choose and why I did not select them. The main paradigms in research are: (1) positivism, (2) postpositivism, (3) critical theory and (4) constructivism/interpretivism (Lincoln et al., 2011). I have already identified interpretivism as the paradigm that informed the research so I will only indirectly discuss that paradigm here as it relates to the others.

Positivism is the paradigm that is most concerned with and focussed upon the idea of an objective reality 'out there' that is separate and different from the subjective reality 'in here' of the observer-scientist. This leads to an epistemological position that unquestionable objective facts about the world can be found and these are what researchers need to be pursuing when wanting to make claims about the world (ibid.). There is an underlying belief in a 'single identifiable reality' (ibid., p. 102) and that the researcher can and should research that reality in a way that is neutral and objective.

The 'world' of therapy does not easily fit into this kind of objectivity. The meanings of therapy and phenomena within it – and associated with it – are contested. Although there are attempts to 'fix' therapy in place via manualised practices and techniques, this is not how most therapy is delivered; and in practice it is difficult to implement. The human relational element is always there – 'in the room'. The meaning-making around 'being-a-therapist' is ultimately subjective and defies attempts at circumscribing it into objective definitions. There is potential for positivist studies to be made about therapy and, indeed, this makes up the vast majority of research into it; but for this research a positivist approach was inadequate for the research question and aims (ibid.).

Postpositivism questions assumptions that objective, static truths can be found but does not go too much further in valuing qualitative knowledge about human experience. Postpositivism still emphasises the objective over the subjective; so for similar reasons to the inadequacy of positivism for my research question and aims, postpositivism also fell short (ibid.).

Critical theory is a paradigm that might have illuminated some aspects of the topic of my inquiry. The therapy world is one which is often driven by 'social, political, cultural, economic, ethnic and gender values' (ibid., p. 98). The way it is practised and the practitioners who practise it are 'situated' in those spheres. In the time of Freud, psychoanalysis, the prototype for counselling and psychotherapy, was a minority interest. Today therapy is provided for many different types of people through insurance schemes, private and public health services, EAPs and the voluntary sector. It has immersed itself in the culture, and is represented on television, radio and the internet via spokespersons from organisations like the BACP and UKCP. Therapy is also popularised in fictional representations such as *Anger Management* (2003) and *In Treatment* (2008--2010), to cite just two popular examples of entertainment with therapeutic practice as the central theme. This increasingly prevalent provision and representation of therapy throughout Western and Westernised cultures signifies its importance within contemporary discourse. In therapy there are also deep and long-term political struggles around various issues. One of those issues that has been struggled over since its beginnings are theoretical and technical approaches

to therapy that are given unifying labels, such as 'psychodynamic', 'humanistic' or 'cognitive behavioural', which are then researched and discussed in ways aiming to prove efficacy, superiority or inferiority.

The pluralistic approach to therapy, following in the wake of a long history of integrative and eclectic approaches, is the latest attempt to lay out a position which articulates its discomfort against this 'brand-x-versus-brand-y' conceptualisation of therapy in general and for research in particular. Political struggles are often hard to disentangle from economic ones, and the struggle for therapies, of whatever stripe, to prove their efficacy and/or superiority, is often entangled with economic interests of professionals wanting to dominate particular 'markets', such as the NHS. Therapy, as practised in the UK, is a mostly white, female and middle-class profession (e.g. Brown, 2017), so race, gender and class issues are also important in any full discussion about therapy.

Critical and feminist theory would provide useful paradigms to explore these more political aspects in and around pluralism and therapy. A feminist study of pluralism and therapy would be particularly interesting as there are a host of feminist issues around both and the relationship between them. For instance, how significant is the influence of patriarchal values on competitiveness versus cooperation (between approaches), precision versus flexibility, and certainty versus uncertainty? Also, importantly, how significant are patriarchal values in the evaluation of research?

However, I was not aiming to critique the politics of the phenomena but, rather, I was aiming to explore how therapists make sense of pluralism and therapy. That is not to deny that the 'personal is political' and that it is difficult to divide individual professionals from their political significance (of varying degrees: some therapists hold more political power than others) but to affirm that my emphasis was on personal, subjective experience, and understanding of pluralism and therapy. I was not politically motivated to make the case for or against particular currents in the politics of therapy or to analyse its power struggles. My motivation was to find out how therapists were making sense of the politics in which they found themselves, whether or not they enjoyed, disregarded or just endured them. So, although critical theory and its associated paradigms such as feminist theory would have

been interesting paradigms within which to explore various research topics in this area, my particular questions and aims fell outside their scope.

Within the interpretivist/constructivist paradigm other methodologies outside II that I might have used included phenomenology, grounded theory, narrative analysis and discourse analysis, amongst many others (Smith et al., 2009). Phenomenology seemed too constricting to me as it emphasises experience over understanding, perceptions and views which I did not want to exclude from my exploration of the research question. Grounded theory could generate interesting knowledge in this area; however, it was not my intention in this research, to develop a theory. I analysed in detail the transcripts of twelve participants but I was not aiming to be able to make any theoretical generalisations from the transcripts.

Regarding narrative analysis, it was likely that the interviews would generate 'stories' of various kinds. Therefore I could have used narrative analysis as a methodology. However, my interpretations of participants' interpretations would have been significantly impeded if I had been trying to identify and interpret the data by narrative structures alone. In relation to my research question and aims the identification of themes rather than narratives seemed more appropriate. While some research suits narrative analysis well it does not suit all research and was not suitable for this research in particular (Frosh, 2007).

Discourse analysis would also have been a feasible methodology. However, I was concerned with my participants' subjective experience and perceptions rather than with linguistic analysis. My approach to the language used by participants veered more towards a hermeneutic 'trusting', so I was not so concerned with covert implications of power in the linguistic discourse. Similarly, therefore, this methodology would not have been suitable for my research aims. Using II as a methodology to inform a thematic analysis allowed me to collect and analyse interview data in relation to my particular question and the epistemological position it implied. I believed II, applied through the method of thematic analysis, to be the most suitable methodology.

There was also the option of using a mixed methodology. However, to answer my research question, a mixed methodology was not necessary.

Also, the depth and breadth of research informed by II did not leave enough room for another methodology to be incorporated into the research, in a way that could do it justice, in terms of being able to develop the necessary skills to implement another methodological approach, and to be able to comprehensively discuss the implications of another set of data in my thesis.

Therefore, having reflected upon the different paradigms, I concluded that the interpretivist/constructivist paradigm was the best fit for my research question and aims. Within that paradigm, although there are other potential methodologies that could have generated interesting knowledge, II was the methodology that included the elements I wanted to bring to my research. Additionally, the one-to-one interview, which is how I wanted to collect data, is also recommended for an II methodology (Denzin, 2001).

4.2.4 Interpretive interactionism (II)

According to Denzin (2001) the 'heart of interpretive interactionism lies in thick description, thick interpretation, and deep, authentic understanding' (p. 54). These fundamentals of the methodology were applied to the thematic analysis of the interview data as reported in the subsequent Findings and Discussion chapter.

Denzin also advises that 'interpretive researchers should provide thoroughgoing critiques of the social structures and social processes they investigate' (ibid.). The therapy professions are deeply entangled with such structures and processes, and throughout the thesis I have attempted to illuminate these entanglements and the problems associated with them. Indeed, my participants spoke about these issues themselves, so the interview data itself allows light to be shed on these issues.

My question is a 'how' question (as opposed to a 'why' question), which Denzin says is necessary for an II approach. The question also needs to be located within my 'personal history' and be some kind of 'problem' (Denzin, 2001). As a therapist the issue of how to practise is never 'finalised' (Sullivan, 2012) and, it could be argued, is a constant 'problem' for therapy as a whole, and therapists in particular, as a group and as individuals. Denzin suggests that once a problem has been identified then the next step is to '[discover] how this problem, as a private trouble, is or is becoming a

public issue that affects multiple lives, institutions, and social groups' (Denzin, 2001, p. 71). The issues associated with pluralism and therapy are problematic for practitioners as individuals, but also create problems between practitioners and in therapeutic and related professional institutions. Ultimately, these issues are also public ones, because they are felt by the public in terms of how services are delivered, and what experiences of therapy members of the public will or will not be able to access.

II sits within an SI perspective in which how people communicate and 'interact' about the symbols they share is the main focus (e.g. Blumer, 1969). In this research the 'symbols' are 'pluralism' and 'pluralistic approaches to therapy' as words that symbolise 'objects', as 'constructed' ideas, that have meanings, albeit contested, which therapists can easily point to when discussing specific issues about therapy. It is through these dialogues that shared meanings are constructed and lay the foundations for the semiotics of therapy. It is the micro-processes of interaction that, from an SI perspective, create the macro 'constructions' of social constructionism. In this sense, the interactions I had with the participants about pluralism and therapy are symbolic interactions, and we engaged in dialogues about the symbolic interactions/dialogues of others. Denzin summarised II as an 'attempt to join traditional symbolic interactionist thought with critical forms of interpretive inquiry' (Denzin, 2001, p. xi). This forms the methodology behind my thematic analysis. II has mostly been used in research studies about health and nursing (e.g. Jefford & Sundin, 2013) but not, to my knowledge, for research about therapy.

It might be argued that II, as usually understood in sociological terms, only applies to 'personal troubles' in relation to 'public policies' (Denzin, 2001, p. 2). However, this unnecessarily narrows the range of objects which can be researched with this useful methodology, and does not reflect Blumer's (1969) view that SI is based on how human beings interact with 'everything that the human being may note in his world... categories of human beings [e.g. therapists]...institutions [e.g. institutions connected to therapy and therapists]...guiding ideals [e.g. pluralism, purism and other concepts]' (p. 2). In using this methodology I am 'working within and against' it (Kovo-Ljungberg, 2016, p. 6). Kovo-Ljungberg suggests '[m]ethodological

language and labels are presented within a particular time, space and cultural context' (ibid., p. 11) and at the time that Denzin was conceptualising an II methodology he defined social science research as being in its 'seventh moment' (Denzin, 2001) in which he was committed to 'post-Marxism and communitarian feminism' (ibid., p. 4). Whilst there are both Marxist and feminist interpretations and critiques of therapy to be made, they only form a couple of strands with which to view the issues on which my research focuses. Simultaneously, the aim to 'understand how power and ideology operates' (ibid.) is one which is both implicit and explicit in my research, from conceptualisation through to data collection and analysis. This grappling and dialectic with the methodology has allowed, and allows, for a methodology which acknowledges its base but which tailors it to the idiosyncratic nature of the question and the particular culture in which it originates. From a postmodern perspective, tolerating uncertainty about methodology avoids a simplistic route to the 'legitimizing language' of 'labels' (Kovo-Ljungberg, 2016, p. 14) and allowed me to collect and analyse data with a less constricted and more 'fluid' attitude that reflects that 'methodology, its labels, and its concepts are in constant flux' (ibid., p.40). Kovo-Ljungberg states that '[m]ethodologies are being reduced to technologies... textbooks are mass-producing recipes for valid and trustworthy qualitative research. Students interested in qualitative research are caught between the expectations of academic conformity, linearity, audit culture, and external control' (ibid., p. 7). Thus, there might have been some temptation to use one of the standardised methodologies, such as Interpretive Phenomenological Analysis (IPA), so that the research would have had a more recognisable basis; but ultimately, I perceived that the IPA methodology did not resonate with me or with the research question. Finlay (2014), in a personal communication, also supported this view. II, with its sympathies for both social constructionism and SI as perspectives through which to view the social world, resonated most fully with me in how I wanted to engage with the data. Simultaneously I wanted to stay open to what the data wanted (Kovo-Ljungberg, 2016) and allow for an II methodology that was a 'situational, complex... [structure]... in flux' (ibid., p. 79). II then informed the flexible method of thematic analysis (e.g. Braun et al., 2015; Braun & Clarke,

2013; Braun & Clarke, 2006) for my exploration of the question/topic. A brief outline of thematic analysis follows in the next section.

4.2.5 Thematic analysis

Braun et al. (2015) state that '[o]ne of the hallmarks of thematic analysis is its flexibility', and in contrast to '[m]ost qualitative analytic approaches', it is '*just a method*' (italics in original) (p. 185). Consequently, as a method it does not come with a pre-packaged methodology attached to it. This means that the researcher needs to be reflexive and actively make choices with regards to how one's analysis will be situated in terms of methodology, epistemology, ontology and paradigm. I have made reference to these issues in previous sections and I will also refer to them in later sections.

In relation to therapy they suggest that it is a good method to explore various questions, including 'How do particular groups (of clients/therapists) experience and/or conceptualise therapy?' (ibid., p. 187) which is similar to my own research question.

Thematic analysis advises a 'six-phase approach':

1. Familiarisation with the data: *reading and re-reading the data.*
2. Coding: *generating succinct labels that identify important features of the data relevant to answering the research question; after coding the entire data set, collating codes and relevant data extracts.*
3. Searching for themes: *examining the codes and collated data to identify significant broader patterns of meaning; collating data relevant to each candidate theme.*
4. Reviewing themes: *checking the candidate themes against the data set, to determine that they tell a convincing story that answers the research question. Themes may be refined, split, combined, or discarded.*
5. Defining and naming themes: *developing a detailed analysis of each theme; choosing an informative name for each theme.*
6. Writing up: *weaving together the analytic narrative and data extracts; contextualising the analysis in relation to existing literature.*

(Braun et al., 2015, pp. 188--189, italics in original)

I will explain further how I applied this six-phase approach to my data in the Data Collection and Data Analysis sections.

4.2.6 Rigour and quality of the research

The knowledge generated by this research was constructed by the therapists making sense of pluralism and pluralistic approaches to therapy. The research brought an added sophistication and challenge to assumptions in the literature and other areas of discourse about pluralism. Such knowledge cannot lay claim to any generalisability, but in dialogue with others and previous knowledge/experience, inferences and claims might be made that support the research's idiographic findings – a 'transferability' rather than 'external validity' (Finlay, 2011).

Brinkmann and Kvale (2015) suggest that the knowledge that comes from interviews has seven features. These are that the knowledge is: (1) produced, (2) relational, (3) conversational, (4) contextual, (5) linguistic, (6) narrational and (7) pragmatic (ibid.). The knowledge being 'produced' refers to the interview being a 'production site of knowledge' emphasising that knowledge is not just 'found' but also created by the interview; the knowledge being 'relational' refers to the knowledge being neither objective nor subjective but intersubjective (Sullivan, 1954); the knowledge being 'conversational' alludes to the validity of conversation to produce knowledge about 'the true, the good, and the beautiful' and that this 'doxa' knowledge is as valid as 'episteme' knowledge; the knowledge being 'contextual' alludes to hermeneutic philosophy's view of 'human life and understanding [as] contextual, both in the here and now and in a temporal dimension' (Brinkmann & Kvale, 2015, p. 64); the knowledge being 'linguistic' refers to the language itself used in the interviews as an access to knowing in its oral and written forms and open to various forms of analysis; the knowledge being 'narrative' refers to the telling of stories in interviews being able to inform the researcher about the phenomenon being explored; and finally, the knowledge being 'pragmatic' is an argument by Brinkmann & Kvale (2015) that suggests that whether or not the knowledge that comes from interviews is 'scientific' is less important than whether the knowledge produced is 'useful'. They recognise that what 'useful' means is open to question, but make the implicit point that if the knowledge gained is in some way useful then that adds to its validity. My research relied heavily on interviews for gaining knowledge, and that knowledge embraced all the above features.

The small-scale nature of this II/thematic analysis study leaves it open to criticism by some that its rigour and quality might be suspect. This criticism is also levelled at other types of qualitative research, such as case studies, that use small sample numbers. Flyvbjerg (2006) rebuts these criticisms by arguing that 'concrete, context-dependent knowledge' is as important as 'general, context-independent knowledge' because 'human activity is situated in local contexts of practice... context-dependent knowledge is more valuable than a vain search for universal, predictive theory' (Brinkmann & Kvale, 2015, p. 298). Flyvbjerg also argues that case studies can act as 'black swans' that can 'falsify generally accepted beliefs' (ibid.) and can be used to develop general theories.

Qualitative methods in general are criticised by authors such as Proctor and Capaldi (2006), who do not recognise that the point of a qualitative approach is to generate local knowledge that is valued in its own right, and does not need to be understood in the same terms as the general knowledge most often found through a positivist, rationalist route in mainstream quantitatively based science. They argue for a view of science that reflects 'scientism', which is 'the view that the characteristic inductive methods... of the [natural sciences]... alone can yield true knowledge about man and society' (Bullock & Trombley, 2000, p. 775). This view dominates research discourses, assuming that quality and rigour can only be found within a 'narrow view of science' (Denzin & Lincoln, 2011a, p. 7). If qualitative research is evaluated within positivist paradigms it will inevitably be found to be lacking in quality and rigour within that paradigm. The quality and rigour of qualitative research needs to be defined by other criteria not limited to such methods of evaluation as 'objectivity' and 'replication'.

The rich descriptions of phenomena in interviews and transcript analysis are, arguably, able to capture an individual's experience and understanding far more comprehensively than quantitative methods, even if these methods can be seen as 'unreliable [and] impressionistic' (ibid., p. 9). The emphasis on the 'purpose of inquiry in the human sciences' – in contrast to the natural sciences – as 'understanding... rather than proof or prediction' (Erickson, 2011, p. 43) goes back to Dilthey (1883/1989). More recently, Geertz has suggested that the attempt to equate inquiries into the social

world as a kind of science that parallels the science that inquires into the physical world is misguided (Geertz, 2001).

Therefore, in qualitative research the criteria used to evaluate quality and rigour generally differ from those used to evaluate quantitative research. These criteria vary over the continuum of qualitative research, and different ideas, phrases and words are used by different authors. Lincoln and Guba (1985) suggest 'four criteria of credibility, transferability, dependability and confirmability' (Finlay, 2011, p. 262). These criteria offer alternatives to the more standardised, quantitative criteria usually applied to quantitative research. 'Credibility' means that the findings 'make sense' and 'replaces... "internal validity"' (ibid.). 'Transferability' means that there is enough knowledge generated by the research to 'judge the applicability of the findings to other settings... and 'replaces... "external validity" and "generalisability"' (ibid.). 'Dependability and confirmability' means that if researchers 'provide a transparent and self-critical reflexive analysis to act as an audit trail about their research processes' (ibid.), then these criteria can replace the more conventional 'scientific' criteria of 'reliability' and 'objectivity' (Finlay, 2011). It is also often advised that the researcher keeps a detailed 'audit trail' about the research, which adds to the dependability/confirmability of the research in an idiographic sense, and also provides the information necessary if anyone wanted to emulate the research in another idiographic context and discover how themes emerged there.

Smith et al. (2009), following Yardley (2000), suggest 'four broad principles for assessing the quality of qualitative research' (Smith et al., 2009, p. 180). These are: (1) sensitivity to context, (2) commitment and rigour, (3) transparency and coherence, and (4) impact and importance (Yardley, 2000). Finlay (2011) summarises these criteria in the following way:

Sensitivity to context relates to the extent the researcher shows awareness and skill in the research process. **Commitment and rigour** concerns the researcher's investment and the effectiveness of research conducted. **Transparency and coherence** refers to how clearly the different stages of the research are presented in any write-up and if the argument hangs together. The criteria of **impact and importance** point to

the test of research being whether or not it says something useful or interesting. (p. 271, bold in original)

In practical terms these criteria meant that I needed to be sensitive to the interview context to enable the best possible interview. The interviews generated the data and the research could only reflect the quality of the data. Interpretations of the data are also contextualised and supported by verbatim extracts. Similarly, the data generated by idiographic research can be supported by any relevant literature/research that provides a context in which my particular research sits. The general interest and enthusiasm I have received from members of the therapy profession towards my research suggest that this community will find the research useful and interesting, and that it contains substantive implications for future research and practice.

Another way for research to be evaluated that is suggested by Finlay (2011) is by 'the 4 R's [sic]'(ibid. p. 264). These refer to '*rigour, relevance, resonance* and... *reflexivity*' (ibid., italics in original). Rigour and relevance refer to the kinds of criteria discussed previously, whilst resonance and reflexivity refer to more intangible qualities such as the overall effect of the research on readers (resonance) and the quality of the reflexivity of the researcher on multiple levels regarding the research (reflexivity). These are all evaluative criteria that I have brought to my research.

'Triangulation' can also be used to enhance the credibility of qualitative research. I have used other research to support my discussion of themes. It might be argued that I could have added a quantitative method, such as a questionnaire, with more participants, which might have offered a parallel inquiry into my research topic. This mixed methods or 'pragmatic' approach to research has many advocates (e.g. Cherryholmes, 1992; Cresswell, 2008; Greene, 2007; Teddlie & Tashakkori, 2009). However, this would have created too much data for one thesis and there was sufficient support in the existing literature. Simultaneously, whilst I brought such qualities, as discussed above, to my research, it does need to be emphasised that these qualities as criteria for fair evaluation are not so easily accepted by all researchers. These alternative criteria reflect a consensual approach to qualitative research that in some respects are

different to – but still try to emulate – a more conventional scientific approach.

Schwandt (1996) suggests that in social inquiry, 'aesthetic, prudential and moral considerations' (p. 59, in Lincoln et al., 2011) are as important as scientific concerns and, indeed, he calls for a 'farewell to criteriology', despite going on to describe some of his own criteria. Scheurich (1997) and Smith (1993) are also cynical in relation to standardised criteria for assessing research validity. Guba and Lincoln (1989) suggest that "valid" constructivist or phenomenological inquiry' (Lincoln et al., 2011, p. 122) reflects criteria based on authenticity; and they name these criteria as 'fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity' (ibid.).

Fairness refers to the research being inclusive of all voices within it; *ontological and educative authenticity* refers to the research having some impact on researchers and research participants, in terms of a raised awareness that allows for engagement with moral issues, or what Schwandt (1996) calls a 'critical intelligence'; *catalytic and tactical authenticity* refers to the research's impact on participants and the researcher's ability to provide social and political training for those who desire it (Lincoln et al., 2011). In my research, I ensured that the voices of my participants were heard, and the interviews did raise moral and political issues. Guba and Lincoln's (2011) criteria for catalytic and tactical authenticity, in my view, comes closer to a Critical Theory paradigm (e.g. Lincoln et al., 2011), and I do not see it as my role, as a researcher, to encourage or discourage political or social action. It is possible that the research might act as a catalyst for participants to take actions in relation to the research topic, but for me that was not a research aim.

In sum, qualitative research often operates within paradigms that do not reflect the aims and questions of mainstream science. Therefore the criteria for mainstream science do not apply. Alternative criteria of varying kinds, some similar, and some very different to mainstream scientific criteria, have been developed over the decades to secure validation of quality and rigour in social inquiry. I pursued my research question and aims with these criteria consciously, whilst also being critically aware that some qualitative

researchers are sceptical even of these alternative criteria as being too subservient to a dominant scientific discourse.

4.3 Participants

The participants were qualified and experienced therapists, recognised as such by either the BACP or the UKCP. They were at least one year post-qualification, with most participants having significantly more experience than that, with one participant on the verge of retirement after 16 years of practice whilst another had 28 years of post-qualification professional practice. Since they are all recognised by the BACP or UKCP they will have been trained at a reputable institution. The particular values that their institutions promoted around therapy, and how this might have influenced them, was part of the research inquiry, so I did not want to attempt to make where they trained any kind of constant. The criterion that all the participants needed to be qualified meant that the therapists had the necessary experience to undertake the interviews with minimal risk of any harm. The therapists needed to be confident that the research felt safe. Their knowledge and experience, combined with my knowledge and experience (I am a BACP Senior Accredited counsellor/therapist), provided a safeguard against the possibility of the interview being harmful.

Their knowledge and experience also meant that issues of their own, around being a research participant, and possible personal and professional implications, were more likely to be positive. If they felt negatively about any issues, they were more likely to have had the professional maturity to process these self-reflexively and in clinical supervision. Additionally, BACP-registered practitioners abide by the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP, 2010b) and UKCP-accredited practitioners 'commit to and maintain' (UKCP, 2009, p. 2) the UKCP Ethical Principles and Code of Professional Conduct (UKCP, 2009); so there was already an ethical basis on which my participants and myself were operating. Furthermore, the BACP's ethical framework (to which I subscribe) explicitly states that the principles apply to any connected

professional role in which the practitioner might be involved, including research. These mutually shared commitments stood as a firm base to ethical considerations before, during and after interview recordings and the writing-up process.

My recruitment strategy consisted of, first, contacting two potential participants, Paul and Joanne, who knew about my project from informal conversations, by email. They had already expressed interest and said they would like written information about the project as soon as ethical approval was granted. I asked Joanne if she could put the word out that I was looking for participants and through her other participants contacted me to say they were interested. I had asked Joanne to make sure any interested participants understood that they needed to contact me to take part rather than the other way around. In this way I was able to recruit ten participants through word of mouth and 'snowballing'. However, I realised this word of mouth / snowballing method within my own therapy 'world' in Sussex had led to an array of therapists with different approaches but mostly -- besides Heidi -- practising under the humanistic umbrella. I wanted two more participants who were not humanistic. I posted on a few professional therapy groups on LinkedIn and Christine, a psychodynamic practitioner, contacted me wanting to take part. I knew John, the CBT practitioner, and when I told him that I was keen to interview someone who identified as a CBT practitioner he expressed interest in taking part. The inclusion criteria were for qualified and experienced therapists (defined as being recognised as such by the BACP or the UKCP). In retrospect, I realise that it would have been interesting to have more non-humanistic practitioners in the sample, especially CBT practitioners since CBT became such a central issue but I had not predicted that in advance of the interviews taking place. Most of the therapists' experience had also been in the private/independent sector. Again, in retrospect it might have been interesting to have had more participants from the NHS/IAPT sector. However, overall, hearing these voices from the 'frontline' of practice, rather than academics/theoreticians gave a voice to those whose voices are too often marginalised. If I had not attracted enough participants I would have put notices in appropriate professional media such as *Sussex Counselling and Psychotherapy News*, a regional magazine;

Private Practice, a BACP magazine for the subdivision of BACP that represents private/independent practitioners; *Therapy Today*, a BACP magazine aimed at all its members; *The Psychotherapist*, a UKCP magazine aimed at all its members; and via the online BACP Research Practitioner's Network. (See appendices A and B for templates of emails and notice.)

Currently, there is a lot of interest in the counselling/psychotherapy community about pluralism – for instance, pluralism is a perennial focus of interest at BACP Research Conferences. There have also been perennial debates about it and related issues in articles and letters in *Therapy Today*, the magazine for BACP members. In conversation with therapists about my intended research, I received enthusiastic feedback and a wish to take part. None of these potential participants were called out of the blue or pressurised in any way. They genuinely wanted to take part from their own side. Information sheets and consent forms (see Appendix C and Appendix D) were sent to participants, and interviews scheduled between November 2014 and May 2015.

Since II/thematic analysis has an idiographic emphasis the sample size did not need to be large. For my study I had twelve participants, with the sample representing therapists as a homogeneous, generic group.

Since I was inquiring into how therapists, in general, make sense of pluralism and pluralistic approaches to therapy – rather than therapists who subscribe to a particular approach – I needed to be aware of the participants' identified approaches for my research to reflect therapists as a whole, rather than any type of therapist in particular. My therapists identified as person-centred (4), psychodynamic (2), humanistic (1), humanistic/integrative (1), TA (1), CBT (1), integrative (1) and pluralistic (1). It might be argued that the sample is skewed towards person-centred therapists, but half of my participants did not identify as person-centred so the research could not be said to be a study of person-centred therapists. It was interesting to have interviewed someone who did identify as 'pluralistic' and this was balanced, in a qualitative sense, by an interview with another therapist who consciously had criticisms to make of pluralism as a perspective and a practice.

The aim was not to create generalisable knowledge but to discover, at more depth than previously, how some therapists (this particular sample)

made sense of pluralistic approaches to therapy. It was interesting to see how the self-identified pluralistic therapist's interview data converged and diverged with the interview data of the other participants. The participant who identified as 'integrative' was also of interest for this reason.

The sampling procedure was 'purposive' and the participants were recruited through a mixture of 'opportunities' and 'snowballing' (Smith et al., 2009). Although a majority of therapists are female, I needed to ensure that there were at least some males so that my interview data did not just reflect 'female therapists'. The gender balance was 8 females and 4 males.

The opportunities and snowballing sampling method resulted in my participants being situated mostly in the private/independent sector since that is the sector in which I work, although there were some participants with substantial experience of working in the NHS, which is reflected in the data generated by their interviews. It might be argued that the research overly represents independent practitioners. However, a large proportion of therapists do work in the private/independent sector (about half of the BACP membership in 2017 [BACP, 2017b]) so private practitioners are just as reflective of therapeutic practice as those who work in the NHS – though again, I am making no claim that my sample is in any way 'statistically representative' of the therapy field as a whole.

In geographical terms, due to my sampling method my participants were all relatively local to me, bar two therapists from northern England whose interviews were conducted by Skype. This means that the study might effectively be seen as just being about 'South East England therapists'. However, I must re-emphasise that this qualitative research does not claim to be able to make generalisations on its own; and any claims for therapists as a whole, especially in geographical terms, nationally or internationally, would need to be heavily supported by substantial amounts of other research. This would also be the case with most quantitative as well as other types of qualitative research about therapy. The idiographic nature of this research means that the possibility that the data are idiosyncratic will always be present, but from a qualitative researcher's perspective, the knowledge generated has validity because it has a depth that is not possible

with larger, methodically 'representative' samples, as discussed in more detail in a previous section.

I did not ask for socio-economic information because I believed that asking for this information might disturb the dynamics of the interview. For instance, one participant refused to give demographic information about her age, training institution, professional memberships and other roles/jobs outside of private practice (e.g. NHS or charity work). Sensitivity is needed around how participants might react to being asked for even the most basic information, and socio-economic information can potentially be very sensitive information to disclose. However, a diversity of race and class may not be represented within the sample – certainly, my impression was that most participants appeared to be middle class and white. Perhaps this is fairly representative of the therapy profession as a whole, but it does still need to be indicated. The issue of class did, in fact, become a major issue in one interview and, at least implicitly, that participant identified as being from a working-class background. Socio-economic issues were reflected on inasmuch as they arose in the data and in noticing what was 'missing' in the interview data, as well as what was there.

All the names of the participants below have been changed.

4.3.1 Paul

Paul is a white British male therapist, aged 55 at the time of the interview. He identified quite strongly with the PCA and had been qualified for 14 years. Outside of private practice he is also a lecturer on a humanistic training course, a supervisor and an independent trainer. One significant factor in Paul taking up his first introductory training was a relative suggesting that he might 'make a good counsellor' after he had informally helped her through a difficult relationship.

4.3.2 Joanne

Joanne is a white British female therapist, aged 48 at the time of the interview. She identified with the PCA and solution-focussed brief therapy (SFBT) and had been qualified for twelve years. As well as working in private

practice she is a service manager, supervisor and workshop facilitator. In the interview she pointed to the idea that being a 'wounded healer' as well as a 'family therapist' for her family-of-origin might be what led to her training to become a therapist.

4.3.3 Nicola

Nicola is a white British female therapist, aged 55 at the time of the interview. She identified with the humanistic approach and had been qualified for a year. She also had a part-time job in an unrelated field. Like Joanne she identified with the idea of being a 'wounded healer'. She reported her childhood as being 'troubled', which then stalled her academic career. She came to train in therapy via first doing a bachelor's degree in social science as a mature student.

4.3.4 Amanda

Amanda is a white British female therapist, who did not want to disclose her age. She had been qualified for 28 years. She identified with TA and she was originally a social worker. It was whilst doing a course related to social work that she came across TA. Subsequently she obtained a degree in psychology and trained as a TA therapist. She also spoke about how her own personal troubles were helped by her exploration of psychology and therapy.

4.3.5 Lisa

Lisa is a white British female therapist, aged 53 at the time of the interview. She identified as a pluralistic therapist, although this was quite a new identification, and in response to reading about pluralistic therapy in advance of our interview. She had been qualified for 22 years. She also works as a supervisor and trainer. Originally she had been trained as a psychiatric nurse and had worked abroad in this role.

4.3.6 Debora

Debora is a white British female therapist, aged 48 at the time of the interview. She identified as a humanistic-integrative therapist and had been qualified for 13 years. As well as private practice she also works as a therapist in GPs' surgeries. She is a psychology graduate who had initially

wanted to train in clinical psychology but found her entry into that profession financially and practically impeded, so she decided to train as a therapist instead. Her original training was psychodynamic, but through different kinds of trainings she ended up feeling more comfortable within a humanistic-integrative approach.

4.3.7 Susan

Susan is a white British female therapist, aged 45 at the time of the interview. She identified as an integrative therapist and had been qualified for 13 years. She had 'drifted' into the financial sector after leaving school but was 'really bored'. After a relationship crisis spurred her into having counselling, her own experience of 'how transformative it was' led her into training. She also loved and loves the academic side of the therapeutic world.

4.3.8 Robert

Robert is a white British male therapist, aged 74 at the time of the interview. He identified as a person-centred therapist and had been qualified for 16 years. He became interested in therapy from his experience of working with offenders and as a social worker. Whilst he was working in these roles he became seriously ill and was advised to leave these jobs. Despite a plan to take early retirement he trained as a therapist and gradually built up a private practice. He still sees a few clients.

4.3.9 Peter

Peter is a white British male therapist, aged 29 at the time of the interview. He identified strongly with the PCA and had been qualified for six years. As well as private practice he also practises as a group supervisor, college counsellor and personal development group facilitator. He suggested that he was influenced by his mother having therapeutic roles within her job. But it was seeing a therapeutic scene in a film which more narrowly defined for him that therapy was what he wanted to pursue as a career. He started his initial trainings into therapy alongside a bachelor's degree.

4.3.10 Heidi

Heidi is a white British female therapist, aged 50 at the time of the interview. She identified as psychodynamic and had been qualified for six years. As well as private practice she also practises as a therapist and supervisor for an independent clinic, as a 'bank' therapist for a university, as a volunteer therapist for a charity and as an assessor for a charity. She became interested in becoming a therapist from undergoing therapy herself and also from her experience of working in other helping professions.

4.3.11 Christine

Christine is a white Eastern European female therapist, aged 42 at the time of the interview. She identified as psychodynamic and had been qualified for five years. As well as being a therapist working in private practice and schools she also works as an interpreter and nanny. Her own experience of immigrating to the UK instilled in her a wish to 'find out more about human relationships' and use that knowledge for helping. Initially, she helped others voluntarily and informally in a church setting but wished to professionalise her skills so began looking for a course. A psychodynamic training 'really caught my attention' and she enrolled.

4.3.12 John

John is a white British male therapist, aged 54 at the time of the interview. He identified as a CBT therapist and had been qualified for 13 years. As well as private practice he also works in GPs' surgeries, is an occasional lecturer, and a registered mental nurse (RMN). Whilst doing a Masters in mental nursing he met a CBT practitioner and envisioned that when he left nursing, practising as a CBT therapist might interest him. Despite some initial self-doubts he eventually pursued an M.Sc. in CBT.

Table 4.1 Main demographic information about the participants

Participant name	Gender	Ethnicity	Age	Identified Approach(es)	Years post-qualification
Paul	M	White British	55	PCA	14
Joanne	F	White British	48	PCA/SFBT	12
Nicola	F	White British	55	Humanistic	1
Amanda	F	White British	?	TA	28
Lisa	F	White British	53	Pluralistic	13
Debora	F	White British	48	Humanistic- integrative	13
Susan	F	White British	45	Integrative	13
Robert	M	White British	74	PCA	16
Peter	M	White British	29	PCA	6
Heidi	F	White British	50	Psychodynamic	6
Christine	F	White Eastern European	42	Psychodynamic	5
John	M	White British	54	CBT	11

4.4 Ethics

My intended research was subject to approval by the University of Brighton's Faculty Research Ethics and Governance Committee (FREGC) and was passed after some revisions. Working on the submission to the ethics committee and in response to the reviewers' comments allowed me to critically reflect on ethical concerns in relation to qualitative research in general, and in relation to research based on interviews and transcript analysis in particular. When I modified my research question and needed ethical approval for the new question, this same process was useful for similar reasons.

Fundamental ethical and procedural considerations required that potential participants understood what the research was about, and what might be expected of them as a participant via information sheets and a consent form. An information sheet for participants was sent to those therapists who expressed interest in the research (see Appendix C). Informed consent was on-going and was obtained via a consent form before the recording of the interview (see Appendix D). Discussions with the participants ensured that they fully understood the information given to them and that they wanted to take part. Written consent was gained when meeting with the therapists for the interview. One important point to which the participant was consenting was their understanding that if any disclosures were made in the collection of data – i.e. in the recordings of interviews – that called into question whether or not breaches of the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP, 2010b) or the UKCP Ethical Principles and Code of Professional Conduct (UKCP, 2009) had occurred, then I would consult with my research supervisors.

I have already covered some ethical issues in relation to participants and participant recruitment in the previous section, but I summarise those and also add other relevant ethical considerations below.

Brinkmann and Kvale (2015) identify 'four fields of uncertainty' in relation to ethical implications of interviews in qualitative research. These are: 'informed consent, confidentiality, consequences, and the researcher's role' (p. 99).

All participants in my research were aware that taking part was voluntary and that they could remove their consent to participate at any time. They also knew that if they participated, they could ask for any data generated by them to be removed from the study at any point after data collection. I also sent them, for their approval, extracts in which their words featured from any documents that would be submitted for the thesis. If there was any disagreement or upset with what I had written, then that would be negotiated, and if necessary I was prepared for the possibility that some dialogue might be deleted. I wrote detailed information sheets and comprehensive consent forms. Participants were also able to personally ask me for any information before formally consenting to take part. The confidentiality and anonymity of the participants were also similarly assured.

In terms of 'consequences' I needed to be aware of the possibility that participants might be upset after the interviews had taken place or if/when they saw transcripts and/or interpretations of those transcripts. Similarly I was prepared for possible upset within the interview itself. I was prepared to work openly with whatever came up at the various stages of data collection and analysis, and all participants knew they had the right to withdraw from the research at any time, as mentioned above. Ultimately, from my position as interviewer the ethical integrity of the research was mostly dependent on my ethical skills in the conducting of the interview. This is one aspect of what Brinkmann and Kvale (2015) mean by the ethical importance of the role of the researcher. In this regard, Brinkmann and Kvale (2015) also point out that 'empathy' as a quality in the interview is not necessarily ethical. So I needed to be critically aware of relational qualities that, as a therapist, I might automatically adopt – when they were appropriate or inappropriate in relation to the research and the ethics of the research process – and to remind myself that a research interview/conversation is not the same as a therapy session.

Another ethical aspect of my researcher's role which I needed to consider was the power dynamics inherent in the interview situation itself. The interview, in which the participant's experiences, thoughts and feelings as the foci of the inquiry were more important than mine, meant that there was an inherent conversational/dialogical imbalance. As an experienced

therapist I had many years of developing interpersonal skills when engaged in dialogues with others. I needed to bring these skills into my research interviews in an appropriate contextual way to minimise negative effects and potential ethical problems stemming from the power imbalance between the researcher and the participant. I wanted to bring a 'dialogical' spirit to the interview, meaning that I was engaged with the participant, and that I allowed myself to be seen and appropriately transparent, as well as trying to see the other. I did not try to remain an objective and neutral observer in which I might be experienced as 'cold'. Rather, I brought warmth to the interview situation, which made it more likely that participants would feel comfortable. This could be a difficult balance to sustain – the need for the interview to provide credible data versus the need for the interview to be experienced as respectful – but with critical self-awareness I believe that subtle balance was struck.

4.5 Data Collection

The data were collected via semi-structured interviews. (For the interview schedule please see Appendix E.) The interviews were digitally recorded and then transferred to encrypted memory sticks.

I conducted twelve interviews ranging in length from 55 minutes to 1 hour and 51 minutes, the average being about 1 hour and 31 minutes. I then transcribed the interviews, but not verbatim. (For an example of a transcript, see Appendix F.) Although transcribing verbatim is sometimes recommended (e.g. Finlay, 2011), I felt that this was not necessary for my research question and its related aims and objectives. It felt more important that the transcripts should be produced for sense and readability in preference to the ideal of complete accuracy. As Edwards (1993) states: 'Different methods of transcription highlight different types of information, which may be more or less relevant depending on theoretical orientation and purpose underlying the research' (p. 28). For ease of reading, therefore, the transcriptions excluded most of the 'ums' and 'uhs', as well as some immediately repeated words and some repetitive colloquial phrases such as

'sort of', 'kind of', 'you know', 'I mean', 'do you know what I mean?', 'I don't know' and 'basically', amongst others; however, it did sometimes seem preferable to leave them in for sense and rhythm. Most brief verbal and paraverbal interventions, such as laughter and significant pauses were noted, but not all. It would have been possible to conduct second interviews for further clarification and/or data, but enough data for the purposes of this research were collected through the first interviews; and moreover, to ask participants for a second interview might have been difficult from an ethical point of view and unduly demanding of their already generously given time.

There are other methods of data collection I could have used for thematic analysis, such as diaries and focus groups; but for my particular topic and my particular research skills, I believe interviews were clearly the most appropriate method.

For the interviews, I thought about the kind of questions I wanted to explore with my participants, in relation to the research question, the topic of pluralism and pluralistic approaches to therapy (see Appendix E for the interview schedule used). These questions formed the basis of a semi-structured interview; however, they did not need to be referred to when the interviews flowed smoothly without them. The schedule was there more as a back-up in case the interview got stuck, and as an aide-memoire to ensure that the key topics/questions that I wanted to explore with participants did get covered.

The interviews took place at locations of the participants' choosing that were deemed safe for them and for me. Two interviews took place via Skype. The locations were, for the most part, quiet. On one occasion there was unexpected building work which was somewhat distracting but surmountable; and on another occasion, the interview was interrupted in the participant's home by an emergency plumber and a barking dog; but these obstacles did not obstruct or compromise the successful completion of the interviews. The first part of the interviews consisted of informal conversation which allowed the participants and me to feel more at ease. Then I asked some general questions before asking the first scripted question and facilitating dialogue around the first topic.

Once an interview had been conducted and transcribed it was possible for me to learn from that interview before conducting the next one.

The data and all documents were stored safely and securely on a password-protected memory stick while the research was being written up. All data (recordings, transcriptions and documents) will be destroyed within five years of the time of recording the interviews or whenever the data is no longer required, whichever comes sooner. The data will be disposed of sensitively and securely. The memory sticks will be destroyed and all interview-related documents will be shredded.

Before submitting the thesis I offered participants the opportunity to see extracts in which they featured to ensure their continuing consent and confidentiality (see Appendix C).

4.6 Data Analysis

I transcribed all the interviews in Word documents, noting down 'initial ideas' as they occurred to me (Braun & Clarke, 2013, 2006) during and after the transcribing (see Appendix F). I then developed codes for each transcript on separate Word documents using the same transcripts, followed by the development of candidate themes for each transcript (see Appendix G). I then reviewed the codes and themes, and via a process of refining, splitting, combining and discarding (Braun et al., 2015) I found a way to distil these codes and candidate themes into seven themes that seemed to me to tell the 'story' of the data (see Appendix H).

It is sometimes seen as advantageous to keep the codes and themes for each transcript in different columns in the same Word document. I decided against this as, in my view, it did not allow for the columns to be wide enough to be useful. Also, the sequencing of these documents is plain to see, approximately dated, and forms an audit of the research process. With a modern computer in which one is able to open multiple documents it was also relatively easy to simultaneously see the ideas, codes and themes for any particular section of transcript. For coding I was able to use the Word highlighter pen function to clarify which text belonged to which code by

colour. In Word I was also able to use the useful 'Find facility (Ctrl+F) to find strings of text or important words' (Thomas, 2013, p. 244). I did do some training in NVivo, but ultimately it did not seem to offer anything of relevance that I could not investigate via existing computer functions.

I kept an audit trail of everything I did whilst I carried out the research. I also kept a research journal that I wrote throughout data collection, data analysis and write-up. I have kept relevant hand-written and Word documents that form parts of the 'trail' leading to the final write-up. Some of this material, for instance the interview schedule, is part of this thesis as an appendix, whilst the rest is available for the record but not as part of the thesis. Keeping an audit trail in qualitative research is seen as a way of supporting validity (Yin, 1989) and 'good discipline' (Smith et al., 2009, p. 183).

The main criticism to be made of the II/thematic analysis methodology/method I have chosen is that the subjectivity of the researcher, which from an interpretivist/constructivist perspective is not only inevitable but desirable, can be seen as problematic. For instance, the selection of themes and extracts to support those themes, is usually made by one researcher, and in this research was made by one researcher. It can be argued that biases inherent in the researcher will be reflected in the analysis (e.g. Golsworthy & Coyle, 2001). Most qualitative researchers make use of an audit trail to combat such criticism but if each individual's reading of data creates different themes then the validity of those themes can still be perceived as questionable.

Some researchers have developed analytical methods to lessen the impact of the lone researcher's subjectivity by having interpretations checked and validated by other academics, professionals or participants (e.g. Alexander & Clare, 2004; Duncan et al., 2001; Smith et al., 2002). The main advantage of the latter 'checking' with participants, known as 'member validation', is that interpretations of their 'own understanding' (Brinkmann & Kvale, 2015, p. 290) can be asserted or disputed from the 'source' of that understanding. The main disadvantage is that the subject does not have a 'truth' monopoly on their own understanding. In other words, it is arguable whether member validation increases validity in itself. Charmaz (2014), for

instance, expresses the problem of participant responses not being 'trustworthy'. Furthermore, if the researcher's own interpretation, 'audience validation' and 'peer validation' are seen as equally valid, then relying on 'intersubjective validation may... imply a lack of work on the part of the researcher and a lack of confidence in his or her interpretations, with an unwillingness to take responsibility for the interpretations' (Brinkmann & Kvale, 2015, pp. 290–291).

Qualitative researchers often defend their analyses by suggesting that each study illuminates one possible way, out of many possible ways, of looking at the data. More generally, they also challenge traditional definitions of validity by suggesting that validity goes beyond triangulation (the triangle) into more complex and imaginative metaphors of knowing such as crystallization (the crystal) (Richardson, 1994; 1997). Credibility, rather than validity, is ultimately the criterion by which qualitative researchers feel their research should be evaluated (e.g. Osborn & Smith, 1998).

In common with qualitative analysis as a whole, evaluating the methodology of II and the method of thematic analysis is ultimately subjective and difficult to reconcile with a linear, positivist worldview. However, by bringing critical self-reflexivity to my analysis, I was able to analyse the data in a way that possesses credibility, and renders the generated knowledge useful to the therapist community and, by implication, to the public that community serves. This provides, at the very least, a pragmatic justification for the research about how pluralism is impacting professional therapists which I was able to undertake with an II methodology and the method of thematic analysis.

4.7 Summary

In this Research Design: Methodology and Methods chapter I have articulated issues around my research question, 'How do counsellors and psychotherapists make sense of pluralistic approaches to therapy?', and how that question related to the aims of my research. These aims included

exploring how this phenomenon has impacted and impacts therapists, and the implications for practice in light of the data that have been generated.

The chapter was divided into seven sections: introduction, research design, participants, ethics, data collection, data analysis and this summary. These elements are interconnected so it is difficult to position all the relevant issues definitively in one section or another; but as far as possible, and searching for coherence in the parts as well as in the whole of the chapter, issues were separated within these headings.

In the section focussing on research design I decided that it was useful to have the following subheadings: self-reflexive statement about the research; research paradigm; other paradigms and methodologies; interpretive interactionism (II); thematic analysis; and rigour and quality of the research.

In the self-reflexive statement I positioned myself as a researcher and emphasised the importance of reflexivity in qualitative research. I explained some of my personal and professional background to this research and what motivated me to undertake it. The reflexive statement also allowed me to openly own some of the biases I might have brought to the research. I was aware of these potential biases in advance of data collection, which meant that rather than them being an obstacle to validity I could work with them to the advantage of the research project.

I then explored how paradigms or worldviews have been perceived in the history of social research up until the present day, and how the paradigm that I hold informs my ontological, epistemological and methodological positions. My research question influenced these positions in how I sought to answer it. In this section I explained how my question and research aims linked directly to an interpretivist/constructivist paradigm and how, within that paradigm, II was the most suitable methodological approach for my research aims.

I also looked at other overarching paradigms and methodologies that were not selected, and elucidated why those other paradigms and methodologies were not suitable, before exploring the use of II as a methodology.

I explained the relationship between social constructionism and SI to demonstrate how II is situated within a SI tradition. I also referred to Kovo-Ljungberg (2016) to support using the methodology as something that I was working both with and against. There are other approaches informed by social constructionist and SI perspectives, and I explained why II was the most suitable for my particular research.

Within the research design section I concluded with issues about rigour and quality in my proposed methodology.

In the section on participants I explained how I recruited participants and discussed issues that arose in that recruitment process, including sampling and inclusion/exclusion criteria, before introducing the participants with brief 'pen portraits'.

In the section on ethics I looked at various ethical issues that needed to be reflected upon when interviewing voluntary participants and using the subsequent data. These include the well-known requirements for transparent information-giving and informed consent, but also subtler ethical issues.

Finally, in the final two sections I went into detail about data collection and data analysis, and articulated the precise steps I used in that process.

Overall I believe that the methodology and methods behind the research have been sufficiently explored to justify the rationale for their use and for their effectiveness. I have also situated the methodology within a more comprehensive elaboration of paradigmatic, ontological and epistemological issues. Qualitative research is always evolving, and the constant search for innovation inevitably brings challenges and problems. However, I would argue that using thematic analysis within an II methodology was the most suitable approach for my research question and aims, and the most likely to generate interesting and useful knowledge.

5: Findings and Discussion

5.1 Introduction

Initially, I was confused about how to structure the findings and discussion about those findings in this thesis. The Findings chapter is often separated from the Discussion chapter, especially in more linear and quantitative studies; however, it seemed to me overly artificial to separate the findings from the discussion as it was very difficult to make a coherent division between a more descriptive and a more interpretative chapter, to present 'pure' findings without discussing them or to have 'pure' discussions without bringing in findings. As I wrote up these chapters I wondered if the two chapters could be merged into one chapter and since this research is interpretative I wondered if I could have just one chapter in which the findings are discussed more seamlessly. I wanted to explore the meanings of the findings by further interpretation of the semantic content itself, and also the interpreted meanings of that semantic content in relation to the socio-historical context and relevant literature. The findings themselves refer to the data generated by the participants in response to questions I asked them about their practice, pluralism and pluralistic therapy. The distinction between pluralism as a philosophy, pluralistic therapy as a practice and pluralistic therapy as a perspective are important distinctions that I shall elaborate on throughout this chapter and in the Conclusions.

I spoke to one senior academic and he suggested that I did not need Findings or Discussion chapters at all. He suggested that I have several chapters, each one the title of a theme. I liked that idea but simultaneously felt it was a risky strategy. I sought advice from my supervisors – should I have separate Findings and Discussion chapters as is the normal, established way or would it be okay to merge them into one chapter? They could not give me a definitive answer and said it was up to me. I was struggling with this difficult either/or dilemma when one day I was reading around methodology more generally and I came across the following quotation: 'For a more interpretative piece of research you will not want to separate parts... it is inappropriate to impose a strict line between analysis

and discussion. One suffuses into the other' (Thomas, 2013, p. 273). In that moment I felt my intuition about merging the chapters had been correct and the struggle about how to write up the chapter was resolved. The decision also reflected a pluralistic perspective as it might be said that different research findings need different structures at different times -- the scientific model of findings followed by discussion often mirrored in the social sciences was not appropriate for this data. In addition, I felt the reader would more easily understand the significance of my results by having the Findings and Discussion chapters merged into one chapter with the themes as headings. Within those headings I could discuss both descriptions and interpretations of the data, with reference to the context within which the data resided. The themes, in my interpretation, tell a story about the findings, and point to their wider implications. The headings name the themes I identified and under these headings there are descriptive reports of the data to support my naming of the themes, and then further analysis, discussion and suggested implications of these findings.

I transcribed, coded and developed themes from recorded interviews with twelve therapists. The participants (four male and eight female) varied in age and experience and identified with a variety of approaches as described in the previous Research Design chapter. As discussed in that chapter (section 4.3) retrospectively it is possible to argue that the sample might have contained more approaches from outside the humanistic umbrella -- in particular more data from CBT practitioners whose approach might be said to have benefitted most from monistic culture. Likewise the research might also have benefitted from hearing the voices of those counsellors and psychotherapists who still remain in the NHS and IAPT who are most threatened by that monistic culture. However, one finding that most surprised me was the overall lack of concern with identifying labels by the participants. When I asked participants how they described their practice (a deliberately open question) not one of them said 'I am psychodynamic' or 'I am TA' or 'I am person-centred'. All of the participants answered with more generic descriptions of how they presented themselves as practitioners in dialogue and in relationship with clients. This suggests to me that the emphasis on particular approaches in research for

'evidence' is not one shared by practitioners. The assumption that practitioners are most concerned with their identifying label arguably does not travel down to how frontline practitioners actually practise. In that sense too much concern with the labels of my participants is misplaced as it is also misplaced in far too much mainstream research. This discovery ultimately led me to think of pluralistic therapy (or perhaps more precisely pluralism in therapy) not as a distinct approach like other labelled approaches but rather as a dimension or continuum that runs through all therapists and therapies much like 'relationship factors' are also common to all therapists and therapies.

I identified a multiplicity of codes in my exploration of the twelve interview transcripts, far too many to effectively be conceptualised as codes. After discussion with my supervisors it was decided that they were more akin to 'meaning units'. I reconceptualised and condensed these meaning units into codes, eventually generating 'candidate themes' (see, for example, Braun et al., 2015); and from these candidate themes I identified seven that all the participants talked about, in various ways, across the interviews.

The seven themes I identified are: (1) Debates about Pluralistic Approaches to Therapy, (2) Identity and Approach, (3) The Flexibility–Rigidity Continuum, (4) It's the Relationship, (5) The Practice of Metacommunication, (6) The Uncertainty–Understanding Continuum and (7) Common Factors. Participants also spoke about other themes, but these were not relevant to the research question/topic so for current purposes they were discarded.

The themes viewed as being relevant to the research question/topic break down into three sequential parts. The first part describes 'contentious issues' that lead to 'debates about pluralistic approaches to therapy', which in turn lead to 'diplomatic attempts at resolution'. These sequential parts I also conceptualise as *'[o]verarching themes'* (Braun & Clarke, 2013, p. 231). Contentious issues come from 'identity and approach', 'the flexibility–rigidity continuum', and assertions, negations and uncertainty around 'it's the relationship'. Diplomatic attempts at resolution include 'the practice of metacommunication', 'the uncertainty–understanding continuum' and the recognition, or not, of 'common factors'. (See Figure 5.1.)

In addition within these themes I identified 'sub-themes' (viz. influences on approach; therapist identity and approach; experience leading to discovery and practice of other approaches; therapist attitudes to theories; commercial/professional implications; horses for courses: different clients need different things; one size fits all: therapist attitudes to single-approach practice; therapist attitudes to pluralism; the continuum of client uncertainty–understanding; the continuum of therapist uncertainty–understanding; it's the client–therapist relationship; being versus doing; different names for the same thing; recognising common factors). These are explained in more detail in later sections (see also Table 5.1.)

Figure 5.1 Thematic map of overarching themes and themes

Contentious Issues

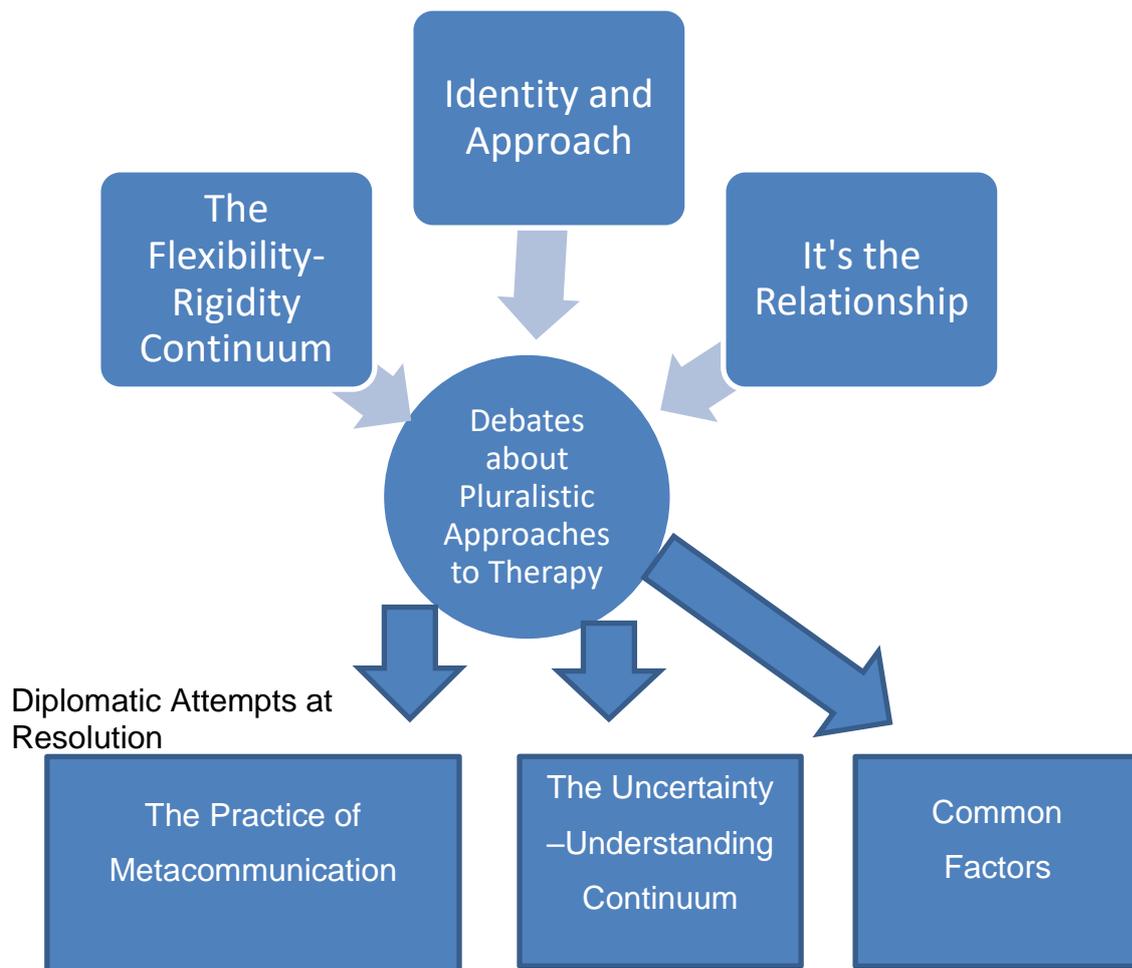


Table 5.1 Themes and sub-themes

Themes	Sub-themes
Identity and Approach	Influences on approach, therapist identity and approach, experience leading to discovery and practice of other approaches
The Flexibility–Rigidity Continuum	Horses for courses: different clients need different things, one size fits all: therapist attitudes to single-approach practice, therapist attitudes to pluralism
It’s the Relationship	It’s the client–therapist relationship, being versus doing
Debates about Pluralistic Approaches to Therapy	Therapist attitudes to theories, commercial/professional implications
The Practice of Metacommunication	[no sub-themes identified]
The Uncertainty–Understanding Continuum	The continuum of client uncertainty–understanding, the continuum of therapist uncertainty–understanding
Common Factors	Different names for the same thing, recognising common factors

In subsequent sections, I will expand on these themes, overarching themes and sub-themes by describing and interpreting their importance to the participants, the therapeutic ‘world’ to which the participants belong, and the social ‘world’ in which that therapeutic world is located. I will make reference to the interview transcripts to support the interpretations of the participants and my interpretations of their interpretations. Both participants and I as the researcher sit in a ‘hermeneutic situation’, also called a ‘hermeneutic circle’, in which all interpretations are contextual, historical and structural (Denzin, 2001).

Any excerpts from the transcripts are referenced by the participant’s name and identified approach. Also, for potential referencing purposes, a number follows this information, which identifies where the quotation is located in the transcript. If any interested reader wants to see the original

transcripts I will gladly send them via email, subject to the usual confidentiality safeguards.

In Section 5.5 I draw some tentative conclusions about the findings, interpretations about them and the context. This final section points the way to the Conclusions chapter, which will summarise the important points and implications raised in the thesis as a whole.

5.2 Contentious Issues

There are a host of contentious issues in discourses about therapy, both from within and outwith the profession. In these particular interviews about this specific topic, the contentious issues that participants spoke about revolved around: (1) Identity and Approach, (2) The Flexibility–Rigidity Continuum and (3) It's the Relationship. Contention around different approaches to therapy has been current in therapy since its beginnings – for instance, the notorious personal and theoretical split between Freud and Jung – although there have been numerous splits ever since that time within psychoanalysis and in other schools. These contentious issues have been noted and explored by various authors, including those in Saltzman and Norcross (1990), whose subtitle to their edited book *Therapy Wars* is 'Contention and Convergence in Differing Clinical Approaches'.

5.2.1 Identity and approach

'Identity and approach' was a central theme in the interviews. Within this theme I perceive two important sub-themes which take a temporal dimension: *influences on approach* leads to *therapist identity and approach*. Sometimes a therapist's identity and approach remains relatively static, with no significant shifts, once initial influences have been absorbed, but in other cases there is *experience leading to discovery and practice of other approaches/techniques*, which is an important third sub-theme.

Three of the twelve participants identified as person-centred, and one identified as having a hybrid person-centred/SFBT approach, so there was a substantial amount of discussion about what being person-centred meant for

these participants (Paul, Robert, Peter and Joanne). The PCA was also discussed by the more broadly humanistic-integrative/pluralistic practitioners (Lisa and Debora). In addition, the perceived potential for philosophical contradictions in attempting to practise with more than one approach, or using particular techniques, was mentioned by some participants, with this issue being particularly emphasised by practitioners either identifying as, or influenced by, the PCA.

The main influences on approach were reported to be training (Paul, Joanne, Nicola, Lisa, Debora, Susan, Robert, Peter, Heidi and Christine); supervision (Paul, Nicola, Lisa, Susan and Robert); experience of similar activities to therapy and personal experience of different approaches (Paul, Lisa, Debora and Robert); personal therapy (Nicola and Debora); and literature (Paul and Peter). Two participants reported that they had stayed close to their original training and that it informed their practice (Amanda and Susan), whilst almost half of the participants described themselves as having a practice very different to their original training (Amanda, Lisa, Debora, Robert and Peter).

It is notable that Amanda described herself as both having stayed close and gone far away from her original training. This might demonstrate some confusion around this issue or, more likely, that the meanings identified with approaches and their associated 'trainings' are difficult to decipher. In other words, when someone says 'I am person-centred' or 'I am a CBT practitioner', the meanings of these statements are, to an extent, 'fuzzy'. It is possible to identify as 'person-centred' yet understand that designation as something quite different to what one learnt it to mean during training or what other practitioners take it to mean. These labels for therapeutic approaches are not fixed; they are dynamic and in flux, and therefore are potentially confusing not just for the public and providers, but also for practitioners themselves. This 'fuzziness' also supports the notion that perhaps most practitioners are pluralistic to some extent.

The initial training that therapists undertake was seen to lead to identification with particular approaches:

people get very attached to the particular school that they trained in (Heidi, Psychodynamic, 10: R29)

maybe... what's happening in your training you're going through that developmental stage where you have to have 'I'm psychodynamic – I totally believe in this and anyone else that doesn't like it is rubbish' (Heidi, Psychodynamic, 10:R43)

I do love my core training and I think it informs my practice (Christine, Psychodynamic, 11:R3)

The influence of training on the participants' identified approach went back in two instances to introductory courses:

I went on a ten-week Introduction to Counselling course just to feel my way in to see what it was like, and what resonated with me straight away was when the tutor started talking about person-centred ideas (Paul, PCA, 1:R1)

the foundation courses that I did... there was more of an emphasis of person-centred counselling which I really absolutely loved... so that's why I went on and did the person-centred course (Joanne, PCA/SFBT, 2:R4).

Supervision, especially group supervision (which trainees often have), was reported as a site where practitioners are influenced by learning about different approaches and being challenged about commitment or lack of commitment to them (Paul, Nicola, Lisa, Debora, Susan and Robert). Group supervision was sometimes experienced as hostile to a participant's approach (Paul, Susan and Christine). For example, Paul reported that in one supervision group

the supervisor was quite psychodynamic and my experiences [sic] in that was often feeling that coming from a person-centred place I often felt like I had to defend my way of working (Paul, PCA, 1:R4)

Christine had a similar experience, being the only psychodynamically orientated practitioner in a group:

I used to feel very uneasy when I'm in a group of... colleagues that use different approaches (Christine, Psychodynamic, 11:R29)

Yet now, she perceives the differing points of view of practitioners offered in group supervision as valuable:

it's actually something precious to have a group of people that -- each and every one can contribute in a different way, from

different strands of understanding into the pot; even when presenting clinical material sometimes it's just tiring to listen to the same things over and over again – I can certainly learn... from humanist to integrative counsellors and I'd hope they can learn something from me as well, so I think this is enriching experience rather than something that separates people (Christine, Psychodynamic, 11: R29)

Supervision, whether individual or group, appears to be a major site of contestation for more or less pluralistic and puristic attitudes to therapy, and there is the potential for interesting research about pluralistic approaches to therapy in this area.

The initial training in which practitioners qualify can lead to the initial identity-label of a practitioner for professional purposes:

Well, I suppose I put 'humanistic counsellor' because that's my qualification... that's what I'm qualified theoretically in, so that's the title I feel I should use (Nicola, Humanistic, 3:R12)

At later stages, trainings and CPD (that practising therapists are required to undertake) have a strong potential to influence a practitioner's approach:

the course I did, traumatology, I wasn't aware that I was going to be doing so much more solution-focussed CBT type training, and having done it I definitely want to incorporate some of that into my work (Lisa, Pluralistic, 5:R7)

I will now turn my attention to what participants reported about relatively static senses of identity and approach – once the influences have, as it were, set in. Some participants pointed to the connection between whom they feel themselves to be and the choice of an approach. For instance, Paul, in discussing his first feelings of identification with the PCA, stated that it fitted in 'with my sense of who I was' (Paul, PCA, 1:R2). This statement illustrates a profound connection between sense of identity and approach that was common to many of the participants. Christine, similarly, had a deep identification with the psychodynamic approach: 'it's in my blood, I can't even get it off me' (Christine, Psychodynamic, 11:R6). Identification with approach can be an intellectual one, but for most of these participants it was deeply connected to whom they experienced themselves to be as people.

This sense of identification of approach with one's own fundamental experience of being is connected simultaneously with ethical values and philosophical positions (Paul, Joanne, Nicola and Peter). These values and positions are perceived as directly connected to particular approaches. Thus, approach and identity get seemingly inextricably linked, and for some practitioners with particular interpretations of ethical-philosophical positions, this means that parameters must be drawn and boundaries defended, in order to preserve consistency and coherence of both personal and professional identity. This view was clearly believed in and apparently understood by some participants:

I feel like I'm expressing a meaningful philosophy rather than doing an approach to therapy (Paul, PCA, 1:R8)

This notion of some therapeutic approaches having a more philosophical basis than representing a coherent approach is also discussed in some literature (e.g. Tudor, 2018b). Other participants were more sceptical and/or confused by these rationales for holding on tightly to particular positions/approaches. For instance, Joanne had difficulty reconciling the way she actually practises with the perceived philosophical foundations of the PCA:

I guess some person-centred therapists would say that you can't say that you trust in the... client's process... and be broadly non-directive and at the same time bring in other things... it's just not possible to believe in one underlying philosophy yet do the other... and that's why I was laughing and thinking about how... I feel... there's a bit of confusion in me still around that – like how it's possible to do one with the other – and whether it's okay to accept paradoxes... in my mind I have a circular argument around it that I never really get out of (Joanne, PCA/SFBT, 2:R25)

There was emphasis by two of the participants (Paul and Peter) on the importance in the PCA of the therapist not being an expert. Yet any simplified notions of what 'person-centred' means are simultaneously quite 'slippery':

it's just like I feel that therapy's really complicated and I can say 'I'm classically person-centred'... but I feel that I'm probably different with every client inasmuch for me being, working in a person-centred way means offering the core

conditions but doesn't really prescribe how to do it (Paul, PCA, 1:R6)

Fixed identities and approaches are difficult to hold on to because there are contradictions and confusions, even within a singular label like 'person-centred'. For instance, the meaning of a label can be loosely interpreted, which creates the potential for other approaches to come into a nominally single approach. This confusion problematises identities and approaches as it is possible for practitioners to identify and theorise themselves as, for example, 'person-centred', yet practise in a way that other therapists might describe as 'integrative', 'eclectic' or 'pluralistic'.

It might be argued that this 'adding on' and/or integration of other approaches/techniques is inevitable to some degree, as the qualified practitioner will likely be exposed to other approaches throughout their career. Many practitioners will have *experience leading to discovery and practice of other approaches/techniques*. This additional learning about – and perhaps practice of – other approaches/techniques may or may not be seen by practitioners as meaning that their practice needs to be identified to either themselves or others as having changed from an original training/approach. Whether these kinds of changes are viewed as additions to practice or integrations of practice is subjective, and therefore adds to the confusion around approach terminologies.

One post-qualification experience that might lead to a change in practice is working with specific client groups. For instance, Joanne, in her work with traumatised clients, was taught psycho-educational techniques by the agency for which she worked. At first this left her feeling uncomfortable in relation to questioning her adherence to the principles of the PCA, as previously discussed. She then experienced how helpful, in her view, these techniques and information-giving could be for clients, and this led to her adding or integrating them into her own practice. In her own words:

so for example a lot of my own work has been in working with clients who have experienced trauma, and specifically young women who've experienced sexual violence, and in doing that work I've slowly discovered that there are other things that are helpful other than the person-centred approach, and I guess it's – at first when I started working in that area it was a bit of a wrench to think about bringing something else into the practice

and thinking about 'Is this okay? Does this mean that I'm going against my person-centred roots, and what does that mean for me...?' (Joanne, PCA/SFBT, 2:R8)

John described the bringing in of other techniques and approaches as paralleling increased confidence over time, using the metaphor of increased confidence in one's driving skills:

when you're doing your training you tend to be like taking your driving test, aren't you – it's all mirrors, signals and you're doing things by the book, but I think as years go by you become more eclectic in terms of treatment and what you choose to use for treatment... yeah, much more therapeutic toolkit you drag around and you just pull out various tools to suit (John, CBT, 12:R7)

This statement challenges the view that approaches can be strictly defined and/or manualised. The idea that experience leads to more eclecticism was shared by many of the participants. If this is the case then RCTs and their strict criteria for defining approaches might be seen as only applicable to less skilled and less experienced practitioners.

Of the twelve participants, one participant described herself as integrative, one as humanistic/integrative, and one as pluralistic. These identifications imply a theoretical and practical orientation that allows the practitioner to draw upon different approaches. A large proportion of practitioners identify with the integrative approach (Hollanders & McLeod, 1999; McLeod, John, 2013a) and an integrative approach to therapy, named as such, has been theorised and practised since the 1980s (Norcross & Saltzman, 1990). An integrative label does not necessarily mean integration of humanistic therapies exclusively (for instance, cognitive-analytic therapy is an integrative therapy); although, confusingly, integrative therapy is often associated with them, to the extent that one of the UKCP's colleges is called the 'Humanistic and Integrative Psychotherapy College'. So it is not too surprising that one participant identified as humanistic-integrative. The participant who identified as pluralistic might have done so as the result of our interview, and the term is a lot more recent and still relatively unknown and unused compared to 'integrative'. Whilst I have argued that there are significant differences of meaning between integrative and pluralistic, some

might perceive that these differences do not exist – or if they do exist, they have not been theoretically or practically adhered to in the evolution of pluralistic therapy. It could be said that both the theoreticians and practitioners of pluralistic therapy have not adequately differentiated themselves from the integrative umbrella. Indeed, three factors that Norcross and Saltzman (1990) perceive to be causes of the interest in integration are:

- (1) The proliferation of brand-name therapies, leading to fragmentation, a deafening cacophony of rival claims, and excessive choice
- (2) The nascent consensus that no one approach is clinically adequate for all problems, patients, and situations
- (3) The equality of therapeutic outcomes, with some exceptions, ascribed to empirically evaluated therapies

(ibid, p. 3)

These factors are noticeably similar to what Cooper and McLeod (e.g. 2011a) use as central arguments for their more recent pluralistic therapy.

The other therapies with which the participants identified were TA, humanistic (as an overarching label but not integrative), BSFT, person-centred, psychodynamic and CBT. I will expand on how all these identifications with approaches did or did not relate to the participants' sense-making of the debates about pluralism and pluralistic approaches in the following paragraphs.

For most participants, over time, there was fluidity of identity and approach in their practice. Only three participants reported having stayed close to their original training, whilst five participants reported that their practice was very different to their original training, and for four participants it was more ambiguous, with a paradoxical sense of having moved away and stayed close simultaneously. Other influences which may have come into play before, during or after initial training included supervision, broadly therapeutic experiences, other professional experiences, personal therapy and literature. Subsequent to initial training, participants varied in how other approaches and techniques impacted their practice and their positioning on what I have identified as a 'purism--pluralist continuum'. The latter phrase was coined during the research process as it seemed more useful to me to conceptualise purism and pluralism as resting on a continuum, with some therapists more to one end than the other, but with hardly any therapists

being absolutely pluralist or absolutely purist. It is also notable that the labels, such as 'CBT' or 'person-centred', are themselves fluid, and subject to change over time and in different contexts.

The identity/approach of the practitioner is usually relatively unchallenged in the context of training. Even if the course encourages critical thinking it will inherently believe in its own value and therefore implicitly encourage and inculcate the concepts and values of its own approach. Therefore, in therapy trainings, there is often a cosy consensus amongst the trainees and staff about the 'rightness' of their particular approach. The first context in which this consensus is likely to be challenged is in supervision, particularly as most courses rely on voluntary placements, where the trainee is likely to meet other trainees from differing orientations and, indeed, the group supervisor may also adhere or subscribe to a different approach. As illustrated earlier in this section this experience was reflected by Paul, whose group supervisor was psychodynamic, when he was on a humanistic course and already identifying as person-centred. He talked about feeling he had to 'defend' his way of working. The organisation and division of trainings into different approaches can be seen as a seed in the flowering of felt needs to defend one's own identified approach or to attack others. This has implications for whether trainings should be conceptualised in terms of different approaches (e.g. Rowan, 2005b) and whether more pluralistic trainings, such as counselling psychologists undergo (with a requirement to be familiar with at least two approaches), might inculcate less contentious attitudes.

Training leads to having a qualification, so even if the newly-qualified therapist is unsure or confused about the identification that has been bestowed upon them, it is professionally advantageous to identify with the term that has been assigned to one's training and, perhaps, ethically dubious to claim experience or knowledge of other approaches outside of that training. Nicola felt that her identification as 'humanistic' was based on the title of her qualification rather than on a deeply felt identification with humanistic therapy itself.

Conversely, other practitioners, represented by some of the participants in this research, connect deeply, not just to the pragmatic

aspects of the approaches in which they have trained, but to the philosophical foundations of those approaches. The push for more generic types of therapy, based on not just evidence-based approaches but evidence-based *interventions* within therapeutic sessions, threatens to undermine approaches which have strong theoretical foundations for working with clients in idiosyncratic ways (such as the psychodynamic and person-centred approaches). Pluralistic therapy seems to offer a both/and solution in which therapists can strongly identify with particular approaches if they want to, without simultaneously needing to hold a position that devalues those that are pragmatic, eclectic or integrative.

Influences on approach, the identity and approach of the therapist as more or less static or more or less dynamic, and experiences leading to discovery and practice of other approaches and techniques, provoke contestations and conflicts (both inner and outer) around identity and approach. These contestations and conflicts, in turn, lead to differing views about how flexible or rigid therapists and the provision of therapy should be – a ‘flexibility–rigidity’ continuum. Should therapists and the provision of therapy be driven by a ‘horses for courses’ or a ‘one size fits all’ attitude? The participants’ views and experiences of this issue form the basis of the discussion with regard to the next theme.

5.2.2 The flexibility–rigidity continuum

There was recognition and discussion by the participants of what I have called *the flexibility–rigidity continuum*. It is unlikely that any therapist is completely flexible or completely rigid in their practice. Therefore, it is helpful to conceive this flexibility–rigidity as a continuum in which practitioners locate themselves more towards one end than the other.

Amanda used the everyday phrase ‘horses for courses’ to describe her belief that different clients need different things and as her everyday phrase for pluralism: ‘horses for courses – that’s where I see pluralism’ (Amanda, TA, 4:R48). This belief was shared by other participants, and this view forms a sub-theme, *horses for courses: different clients need different things*. Conversely, views about a single-approach practice in which, at least implicitly, a ‘one size fits all’ attitude (Debora, Humanistic-Integrative, 6:R54)

might prevail forms another sub-theme, *one size fits all: therapist attitudes to single-approach practice*. This variation of attitude amongst practitioners between ‘horses for courses’ and ‘one size fits all’ is a significant cause of professional arguments about pluralistic perspectives and/or practices: so, following on from participants’ discussion of *the flexibility–rigidity continuum* in terms of ‘horses for courses’ and ‘one size fits all’, there is also within the overall theme the important sub-theme of *therapist attitudes to pluralism*, in which participants discussed ‘pluralism’ directly, in terms of how it relates to therapy.

As indicated in the previous section about ‘identity and approach’, it is possible to be very flexible even within an approach identified as singular. For instance, Paul only has two rules which allow him to consider his interventions as person-centred:

if it feels empathic and is non-judgemental then it’s passed the test so it’s in the room (Paul, PCA, 1:R23)

Similarly, for Amanda her singular TA approach

is open to other influences – I can bring in behaviourism, I can bring in humanistic stuff, I can bring in cognitive stuff (Amanda, TA, 4:R10)

And Heidi, although identifying as psychodynamic, said:

I think you have to be flexible, and if it feels like something else is gonna work better then that’s the thing that will be most useful to your client, so I personally don’t have a problem with it (Heidi, Psychodynamic, 10: R14)

Christine, also psychodynamic, said:

I would use different approaches – more cognitive and more – it just depends on the situation, it depends on the person as well and how they are in this moment... I don’t know why wouldn’t you use any approach, given that it falls into the ramification of the professional standards and if you have a person who can’t tolerate strong emotions, why wouldn’t you refer him to CBT, why wouldn’t you help him in that way by homework and making him think about things? (Christine, Psychodynamic, 11: R13, R31)

John, the CBT practitioner, said:

the more different strains, the different things I can bring in, the more I can adapt my response to whatever people present

with... it changes constantly... there's no two people that sit in session and gets the same experience from me because it's just never gonna happen (John, CBT, 12:R5, R6)

This statement, similar to a quotation by John in the previous section, again challenges the rationale of providers who respond to RCTs and the underlying assumption that practitioners do adhere to strict implementations of their approach (McLeod, John, 2013a).

Later in the interview, in describing this flexibility he said

at the end of the day... therapists have to be like plasticine (John, CBT, 12:R19)

A little later, crossing over with issues around identity discussed in the previous section, John described how he needed to be flexible because of the variety of roles that he had as a therapist:

there's this thing I call myself a 'CBTer', okay but, say, in very real terms if I'm working at a GP practice I'll be referred to as 'the counsellor'. Okay, so it's like saying, 'How do you swim and ensure you don't get wet?' It's not possible [John laughs] – if I'm going to do therapy I'm going to be doing therapy under a fairly large umbrella because some people, even before I get into the room, will see me, and the GPs that I work quite closely with sometimes don't even recognise me – not even as a therapist, they don't even see me as a therapist or a CBTer, they see me as a counsellor... it's like impossible to delineate me as a CBTer apart – as opposed to all these other bits and bobs – that doesn't mean that I feel that my practice encompasses all and that I can be all things to all people because I clearly cannot and – but I say you are... all kinds of bits – if I was to try and single me down to this very, very tight and narrow description of CBT whatever it quite is – does that mean I would be cleaving off mindfulness, for example? And saying, 'Well, that's not really quite CBT' or EMDR... I think to try and cleave yourself – to cleave off all these other bits and say, 'Well, I am just CBT', for example, is, one, very difficult and two, it's actually a bit of a naïveté to say – or an uncertainty with your practice that I've gotta stick so narrowly to these (John, CBT, 12:R11)

Sometimes, however, single approaches can be experienced as 'rigid and inflexible' (Joanne, PCA/SFBT, 2:R9), and Joanne found this 'kind of rigidity uncomfortable' (ibid.), although she had 'initially found it quite comforting and reassuring' (ibid.). Over time she has developed a more

flexible practice and comparing that with her earlier, more rigid practice she reported that

the sense of [flexibility] being freeing, not feeling too bound up in a particular way of doing things... I think it... enables me to be more of myself... it allows me to bring myself into the room a little bit more than when I felt slightly constrained into a particular way of being (Joanne, PCA/SFBT, 2:R22)

In contrast, Peter's view of the PCA was that it is

quite separate in its commitment to what it offers and its belief in people, it's based solely on the relationship... it's like a real belief... it feels quite separate to how the other approaches work (Peter, PCA, 9:R15)

For Peter, bringing in other approaches/techniques is not possible if the therapist has a proper understanding and commitment to the PCA. He illustrated his point with the example of the common practice of some therapists who offer person-centred and CBT therapies simultaneously:

I suppose my struggle is around when it's almost like, 'Well, I offer person-centred counselling but I'll throw CBT in' and it's like, 'Okay, well, how does that work? How can that be possible if there is a real understanding and commitment to the person-centred approach? How congruent, exactly... is that practice with your actual beliefs?' (Peter, PCA, 9:R15).

Peter was not against the idea that 'different clients need different things'; rather, he was against the idea that a person-centred therapist should offer 'different things' if they claim to understand and be committed to the PCA. Other participants were more enthusiastic about offering 'different things', whether they identified their practice as guided by a single or by a mixed approach. All twelve participants – whether they offered different things within their own practice, or whether they referred clients on when they felt they could not offer the client what they needed – were of the view that different clients do need different things.

A common thread running through the participants' discussion of this issue was that empirical context determined theoretical approach. For instance, Susan reported that

I just work with whatever's in the room and use whatever theory I think fits (Susan, Integrative, 7:R9)

The theoretical and/or technical approach is not conceptualised until she understands what particular issues are of concern for a particular client:

so if I'm working with somebody who's bereaved then I'm more than likely gonna be working fairly person-centred in terms of staying with their process and reflecting how they feel; but if I've got somebody with anxiety sat in the room I'm probably pulling out my CBT techniques and actually starting to challenge some of their fears and their negative underpinnings -- so that is really how I work – I work with, 'This is the client, these are the issues, what have we got in the toolbox that might be able to help them?'... if I've got someone with a clear attachment issue sitting in the room then I will talk about attachment theory and if there's somebody that is clearly a psychodynamic theme and you can see a parallel process going back to childhood then I'll work with that (Susan, Integrative, 7:R4, R9)

This easy-going, 'eclectic' attitude was not shared by some participants. For instance, when Joanne first started adding techniques to her PCA practice, she was concerned about the implications of doing so:

does that mean that I'm practising ethically and does it mean that I'm practising with an awareness of the meaning... of the theories that I'm drawing on? (Joanne, PCA/SFBT, 2:R8)

Paul referred to the advantages of staying within one approach as offering

security... ease... the way it can make me feel therapeutically relaxed and able to work (Paul, PCA, 1:R41)

Joanne expressed a similar view of staying within one approach:

it's reassuring to have that kind of certainty that 'This is – what I'm doing is right'... a lot of that came from... a colleague... I found her boundaries and certainty about the approach comforting (Joanne, PCA/SFBT, 2:R9).

Conversely, referring to her private practice, which is reliant on short-term work, Susan challenged the idea that therapists could work with a single model in brief therapy:

I think anyone who works in private practice and offers to work short-term is probably not working to their pure model cos it doesn't fit (Susan, Integrative, 7:R26)

She argued that short-term work requires a more 'boundaried', 'tight', 'directive' approach not offered by pure approaches (Susan, Integrative,

7:R28). She also theorised that more experienced practitioners would be less pure:

I would suggest that the more newly-qualified would probably identify themselves as more pure compared to us old-timers who've been doing it a long time (Susan, Integrative, 7:R52)

Demonstrating the potential strength of feeling against single-model approaches, Amanda asserted that she thought

every practitioner who is not eclectic is not doing justice to themselves and their clients because whatever your client needs you use that tool (Amanda, TA, 4:R10)

Debora did not understand how therapists can stay within one approach:

sticking to one school of thought – I just can't see how you could do it really, I can't quite get my head round it really, that you would be like that with all clients (Debora, Humanistic-Integrative, 6:R44)

Overall, there were mixed feelings and views around single-approach practitioners, with some participants arguing that a purist practice limits the ability to work with clients (Amanda, Lisa, Debora and Susan) whilst simultaneously expressing respect and understanding of purist practitioners (Lisa, Debora and Robert).

All the participants were aware of pluralistic approaches to therapy, in general, and Cooper and McLeod's (2011a) framework for a pluralistic therapy in particular. Some participants liked the pluralistic perspective (Paul, Joanne, Nicola, Lisa, Debora and Peter): Paul, Joanne and Lisa liked the sense of pluralism's inclusivity having the potential to move the therapy profession from division to unification, and thus allow the profession to

present a bigger, more united front to offer therapy to people rather than bickering (Paul, PCA, 1:R41)

Paul, Lisa and Debora were hopeful that the profession would move towards a more pluralistic perspective and practice:

I personally think there will be more pluralists in the world (Lisa, Pluralistic, 5:R28)

I thoroughly support pluralistic – way forward really (Debora, Humanistic-Integrative, 6:R54)

so therapeutically, in terms of models, that's where I'd like us to go; so if someone wants to call themselves a person-centred or a psychodynamic practitioner, fine, as long as they're open to other ways of working and happy to be in dialogue and to learn from each other and to share information... and... be open to ways of working which embrace all sorts of ideas (Paul, PCA, 1:R47)

Joanne, however, was more wary of the pluralistic approach, concerned that its eclectic nature could be dangerous:

the danger of that approach is that potentially people could be eclectic in a way that's not really thought through, that actually could be... slightly damaging... if the therapist's approach isn't thought through and doesn't have a basis or that doesn't really make sense, then how can that be effective practice...? (Joanne, PCA/SFBT, 2:R20)

IAPT itself has backed the idea that there should be a choice of therapies, at least those with an 'evidence base'. Using data from the National Audit of Psychological Therapies (NAPT) (Royal College of Psychiatrists, 2013), the BACP has recently explored the extent of 'choice of therapy within the IAPT programme' (Perfect et al., 2016, p. 3). They found that even within the narrow confines of 'NICE-recommended interventions' (CBT, counselling, IPT, couples therapy, psychodynamic psychotherapy), 'only one of the 114 IAPT services included in [the NAPT] offered all five therapies' (ibid.). Therefore they suggest that the 'IAPT programme has so far failed in its intention to provide a choice' (ibid.).

It is well-known amongst therapy professionals that CBT has come to dominate provision because of its support by NICE and IAPT, yet it is questionable, with evidence to support other approaches and interventions, as to why CBT should be provided twice as much as what is generically called 'counselling' by NICE. The shoe-horning in of various approaches into one term 'counselling' in itself seems to illustrate a lack of basic understandings of how 'counsellors' actually practise: most will identify with one or more approaches, so how 'counselling', as one generic 'thing', has been effectively compared to 'CBT' is problematic (Barkham et al., 2017).

The participants, even if they preferred a more purist approach to therapy in terms of individual practice, all supported a more pluralistic

provision of therapy at the organisational level. The DH also supports 'addressing patient choice by increasing information on treatment options and ensuring that treatment plans are agreed by both patient and therapist' (ibid., p. 6). This seems to reflect what Cooper and McLeod suggest for a pluralistic practice, so the pluralistic agenda does seem to be making some impact on policy decisions at the level of 'talk' but not 'walk' (e.g. Loewenthal, 2016). Similarly, Perfect et al. (2016) emphasise that the NAPT (Royal College of Psychiatrists, 2013) recommends that service managers offer choice on various dimensions, including type of therapy, and again, this advice does not seem to be making much impact at a practical level.

Instead, as practitioners (and the public to some extent) are all too aware, CBT has come to dominate therapy provision in the NHS. The participants reflected on this in various ways. Even the CBT practitioner summed up his view of the present dominance of CBT as perhaps temporal and undeserved (John, CBT, 12:R30). The dominance of CBT as the 'treatment of choice' (e.g. Watts, 2016) is like the 'elephant in the room' in relation to pluralistic therapy. If there is to be a challenge to that dominance in major providers like the NHS then there needs to be an inside challenge to it operating within the accepted and respected research methodologies.

Pluralistic therapy seems to be, on one level, a pragmatic move to get other therapies and therefore 'choice' back into services like the NHS. In this sense, in my view, there is something almost disingenuous about it. The aims, whilst they have philosophical underpinnings, also seem to be quite superficial and pragmatic – an emergency procedure, as it were, to keep more relational therapies (a characteristic of humanistic and psychodynamic therapies) alive in the NHS and mainstream providers. Some of the participants (e.g. Amanda) also had a slightly cynical view of the pluralistic agenda as one driven by a desire for more political and economic power. There are various reasons for the success of CBT but a central reason is its apparent success in RCTs, the research methodology favoured by NICE. There can be a sense of helplessness in practitioners in the face of these seemingly vast evidence bases that go against their own experience and 'professional knowledge' (e.g. McLeod, 2016), and this was reflected in some of the participants' responses.

In the early days of IAPT, in 2007, the dominance of CBT was accepted and acceptable. Later, in 2012, IAPT itself 'challenged [Clinical Commissioning Groups] to commission provision of an additional four therapy interventions recognised by NICE' (Nuttall, 2016; IAPT, 2012). Nevertheless, despite this call the dominance of CBT and a 'one size fits all' attitude, recognised in existing literature and by the participants, still prevails some years later, as demonstrated convincingly by Perfect et al. (2016).

Pluralistic perspectives and practices have as a central concern the danger of therapy practice becoming inflexible: 'Practicing [sic] pluralistically means accepting each client, negotiating ways of working with them and rejecting the notion that one size fits all' (Thompson & Cooper, 2012, p. 65). There is supporting evidence that flexible ways of working (rather than strict adherence to particular protocols) improves outcomes (e.g. Owen & Hilsenroth, 2014).

One belief, which lends itself to a more flexible attitude to practice, is that 'it's the relationship' which is the most important component of effective therapeutic practice. The relationship, on this view, potentially trumps all other components of therapeutic efficacy; therefore as long as the relationship is working then 'whatever works' within the relationship, whether that be a different approach or technique, is for the good. The importance to the participants of the relationship in therapeutic practice forms the basis of the exploration of the next identified theme.

5.2.3 It's the relationship

This theme includes two sub-themes within the main theme of *it's the relationship*. Most of the participants (Paul, Joanne, Amanda, Lisa, Debora, Susan, Robert and Peter) emphasised that *it's the client-therapist relationship* that is central to therapy; but at a more philosophical level this idea was taken further by some participants to highlight the importance of *being versus doing*.

Most participants made direct statements about how they viewed 'the relationship' as centrally important:

I think the relationship, having a healthy relationship, having a relationship where you feel safe and not judged and understood empathically, is an effective tool in helping us to reorganise ourselves so I think it's as fundamental as that... it's as simple as that (Paul, PCA, 1:R26)

I do believe it's the relationship that heals (Nicola, Humanistic, 3:R9)

all the research shows is that what heals is the relationship (Amanda, TA, 4:R17)

I believe myself to be a relationship-based counsellor (Lisa, Pluralistic, 5:R11)

the research shows it's the relationship that makes the difference (Debora, Humanistic-Integrative, 6:R15)

it's gotta be the relationship... I do think it is, it's what it comes back to time and time again... it's all about the relationship... what makes therapy effective is not the techniques we use, it's actually about what's going on between the two of us (Susan, Integrative, 7:R17)

it comes down to... that interpersonal relationship (Robert, PCA, 8:R5)

it's about the relationship (Peter, PCA, 9:R10)

therapy is about a human connection – you can't be working by the book strictly – I mean obviously there are rules that – and there are techniques, and I have an obligation as a professionally-trained counsellor but it would – this is a person there, you can't really try and fit the person into rules... when you come to the bottom of it I think [connection]'s what it's all about... it's the relationship that is the factor (Christine, Psychodynamic, 11:R14/11:R15/11:R37)

CBT is often accused of being an 'instrumental' therapy as opposed to a 'relational' one, but even John, the CBT practitioner, stated that:

professional is the ability to connect (John, CBT, 12:R14)

Participants were aware of research that backs up this claim (e.g. Amanda and Debora). Debora also suggested that perhaps the controversial 'dodo verdict' about therapeutic approaches has been reached *because* 'it's the relationship' (Debora, Humanistic-Integrative, 6:R15) (see also Bohart, 2000; Gilbert & Orlans, 2011). She seemed to be suggesting that this verdict exists because it is not approaches that make any significant difference. If it is the relationship that differentiates therapeutic effectiveness, then that

effectiveness is more likely to be caused by client factors, therapist factors and relationship factors in the interplay between clients and therapists: the dodo verdict exists because so many researchers have their eye on the wrong variable. This is a common theme in the literature about therapy research but, as a few of the participants pointed out, although this is well-known and commonly discussed, most researchers and most commissioning bodies still insist on comparing therapeutic approaches over other variables. The dominance of this approach-based research, when other research seems to demonstrate that it is misplaced (see Cooper, 2008), is a cause of anger for therapists and fuel for debates about pluralism and therapy.

Participants suggested that what made their practice effective were 'relationship factors' (e.g. Norcross & Goldfried, 1992):

I think showing clients warmth is really important: building up a rapport and being kind and gentle with people is a really important part of who I am as a therapist, and I think it works (Joanne, PCA/SFBT, 2:R24)

Joanne saw the 'role-modelling' of a 'healthy relationship' as important, perhaps specifically in her context of working with adolescents who might be survivors of abusive relationships. Other relationship factors mentioned by participants included trust (Lisa); listening (Nicola, Susan, and Robert); and interaction, engagement and dialogue (Robert).

Within the therapist–client relationship clients themselves were seen as important for therapeutic effectiveness in terms of being able to communicate with the therapist (Paul) and, moreover, in doing a lot of the therapeutic work themselves (Nicola) (see also Gilbert & Orlans, 2011; Tallman & Bohart, 2005).

The uniqueness of clients was also cited as an argument against 'evidence-based' interventions:

each person is so individual... you can't say '... they've just got depression and self-esteem issues so therefore I'm going to use x of my methods' (Debora, Humanistic-Integrative, 6:R24)

Susan argued that 'hearing' clients' stories was the essential therapeutic part of the relationship:

for me a lot of it's about them being heard.... I often find that to actually sit and listen to the story or how they're feeling is the

thing that's really powerful for the client because very few people will just sit and listen to whatever it is they need to talk about and I think that's [what] the key part of the relationship is – just being able to give them the respect to let them tell their story (Susan, Integrative, 7:R36)

Robert suggested that it was active listening to clients that could form the basis of sessions:

so often I think there's a key phrase or word that comes through, and that key phrase and word is the one that actually allows you to develop the session, maybe even develop or be the basis of a series of sessions based on that (Robert, PCA, 8:R7)

In any given session he saw his practice as

just listening and reflecting, listening and reflecting and let each reflection take another step, another step, another step (Robert, PCA, 8:R52)

Also, Heidi, a psychodynamic practitioner, when asked what she thought made her practice effective, summed it up in just three words:

listening to people (Heidi, Psychodynamic, 10:R16)

Simultaneously, however, as well as hearing/listening, the full dialogical engagement of the therapist was seen as important in establishing a good relationship. Robert reported:

I'm working with another guy at the moment – his opening statement to me was, 'Look, I don't want you sitting there just nodding your head, I want you to give me some interaction' (Robert, PCA, 8:R33)

He perceived that the basis of the effectiveness of his practice was by

engaging with [clients] in a very human way, in a way that actually respects what they're struggling with (Robert, PCA, 8:R34)

This emphasis on the importance of the qualities of the therapist as a person was echoed by other participants:

I think, 'Well, counselling is about who you are as a person and the personal qualities that you bring'... it's your personal values, your personal beliefs (Nicola, Humanistic, 3:R13)

Paul was aware that whatever he offered clients there was always the possibility that

I might not be what they want so there's that in the mix as well (Paul, PCA, 1:R32)

Debora pointed to her genuine liking of people as a factor in the effectiveness of her practice:

I think I help people like themselves – I think I like most people [laughs]. I really like most people and I see the good in people, and I think so often people come into therapy and they know that I like them, and that makes them like themselves a bit better and that makes them – helps them make changes because they think, 'Yeah, I do deserve' (Debora, Humanistic-Integrative, 6:R31)

Lisa and Debora both mentioned the importance of therapist confidence in their practice:

I need to be confident in the work that I'm doing, I think that makes a huge difference (Lisa, Pluralistic, 5:R18)

I think people want to come to somebody that is quite confident really that this – we will find a way to help you move on (Debora, Humanistic-Integrative, 6:R28)

Perhaps related to the self-confidence of the therapist is the perceived need for personal development:

high levels of self-awareness are really important for me... making sure I'm not stagnating or becoming complacent... that's pretty crucial (Joanne, PCA/SFBT, 2:R24).

The uniqueness of clients and the uniqueness of therapists creating successions of unique experiential moments were seen as being one basis of variance of delivery:

it's not only different people, it might be how I am in the day, where my energy is, and how I'm feeling that day (Paul, PCA, 1:R40)

A strong relationship might also facilitate flexibility, as discussed in the previous section. In reference to a client, Lisa reported:

I felt [the relationship] was sound enough, even though she's suicidal, to try out a different method that I'd never tried before (Lisa, Pluralistic, 5:R19)

The belief that 'it's the relationship' was for some participants rooted in a more philosophical position of putting 'being' with clients above 'doing' to

clients. For instance Paul had these reservations about Cooper and McLeod's pluralistic therapy:

the tasky stuff around pluralism... it felt to me like it was becoming a bit about a collaborative 'doing' to someone rather than a being with someone, and I guess I pull away from that a bit – about people bringing things that you do things to. It should be do things with (Paul, PCA, 1:R48)

Nicola objected to the word 'toolkit' that some therapists use (including the participants in these interviews) to describe drawing on different techniques:

perhaps it's just words, but 'toolkit' to me suggests something where they feel that – where they think they can tinker with somebody or it's something that they do – I think... that from what I've read and understood, counselling is who you are (Nicola, Humanistic, 3:R13)

Further, she identified the dominance of the 'big four' approaches (i.e. psychodynamic, humanistic, integrative and cognitive-behavioural – see, for example, Dryden, 1999) as leading to the idea of therapy as

something that we do instead of making room for focussing on who we are as people (Nicola, Humanistic, 3:R46)

This is an important point, since the taken-for-granted assumptions behind conceptions of therapy practice as fitting into labels perhaps inevitably takes the focus away from the personal and individual 'being' of therapists towards the depersonalised and organisational 'doing' of therapies.

Other participants felt more comfortable about the 'doing' aspect of therapy, whether that was 'treatment plans and... structure' (Lisa, Pluralistic, 5:R7), 'assessment' (ibid., 5:R22) or particular 'techniques' (ibid., 5:R10). Robert, using the 'tool' metaphor, said:

if you've got the tools to engage in something why not hand it over? It's – to me – it worries me when people just sit there knowingly nodding (Robert, PCA, 8:R22);

and he particularly favoured the technique of journal-keeping:

it's an amazingly powerful tool (Robert, PCA, 8:R30)

Lisa reported that

I've got now a huge wodge of different techniques, it's quite a nice feeling actually – in control but out of control, if you see

*what I mean, because there's so much to choose from now
(Lisa, Pluralistic, 5:R14)*

She was easily the most enthusiastic participant about the techniques she had learnt, specifically in relation to trauma work:

*by using these different techniques I really feel like we're
moving through it, it's seriously moving through it... the way
that I'm working now is better (Lisa, Pluralistic, 5:R16)*

However, the use of forms to monitor progress was experienced by this same participant as embarrassing and problematic (Lisa, Pluralistic, 5:R14).

All but one of the participants referred to a common belief of therapists that it is the relationship – rather than techniques – which is the most important factor in therapeutic effectiveness; unconditional positive regard, for example, has been found to be more important than any technique (e.g. Farber & Doolin, 2011). There is quite substantial theoretical support (e.g. Middleton, 2015; Norcross, 2011; Pilgrim et al., 2009) and empirical data behind the assumption of the therapeutic relationship as central to the beneficial processes and outcomes of all therapies (e.g. Norcross & Goldfried, 1992; Norcross & Lambert, 2011a; Norcross & Lambert, 2011b). Two participants explicitly referred to research as backing up their claim, and it might be inferred that the other participants were aware of this kind of research because it is so widely known and talked about within the therapy profession.

From a person-centred perspective the main factors that enable the therapist to co-create a therapeutic relationship are unconditional positive regard, empathy and genuineness, the latter sometimes called congruence. Most therapeutic approaches would encourage these qualities even if they do not use the person-centred terminology. Since most of the participants identified with approaches under a broad humanistic umbrella, it is perhaps unsurprising that there was a lot of emphasis on the importance of the relationship, and this relational basis to humanistic therapies is also encouraged in pluralistic therapy. There is a great deal of overlap between humanistic therapies and pluralistic therapy – so much so that some might argue that it is easier for humanistic therapists to identify with pluralistic principles. However, in this research, the two psychodynamic practitioners

and one CBT practitioner were also sympathetic to pluralism, and emphasised the importance of the relationship. Whether the humanistic emphasis on relational factors differs significantly from other approaches is an area that perhaps warrants further exploration.

However, this belief in the primacy of the relationship is not shared by all: narrative therapists, for instance, emphasise the distressed person's relationships in everyday life, as opposed to the constructed view of the therapist–client relationship as central (Sundet & McLeod, 2016). Research also suggests that although the relationship has a greater effect on outcome than treatment method it is still far less than 'patient contribution' (e.g. Norcross & Lambert, 2011a; Norcross & Lambert 2011b). It has been suggested that clients contribute to positive outcomes, for example, by helping to build and maintain a therapeutic alliance and sustaining a belief that therapy will be helpful (e.g. Bohart & Tallman, 2009; Sparks & Duncan, 2016). Significantly, in relation to pluralism it is suggested that, amongst other factors, it is 'the client's preferences for intervention that drive therapy' (Sparks & Duncan, 2016, p. 72).

The emphasis on the importance of the relationship connects to the belief of participants that generic personal factors – such as warmth, rapport, being kind, being gentle and listening – are at the core of effective therapy rather than any particular approach. As previously mentioned, it was striking to me that when I asked participants to describe their practice and what made it effective, all of them, bar two participants, described their practice in generic terms. Only two participants described their practice with identifying labels and described how they felt their theoretical approaches were central to their practice. If on the whole, then, therapists themselves do not conceptualise different approaches as that central to effectiveness, it is no wonder that they might be frustrated by the dubious basis of research that insists on attempting to compare approaches, rather than the qualities of the therapists delivering those approaches. This is another important issue in the debates around pluralism and purism: it is not just that respect for a variety of approaches is being called for, but it is also suggested that to focus on the title or label of a particular approach fundamentally misses what

might be important about those approaches in terms of their underlying processes (e.g. Gilbert & Orlans, 2011; Norcross, 2002).

An aspect of the relationship which was viewed as very important by some participants was the presence of the therapist and just 'being' with clients, as opposed to 'doing' something to them. This emphasis on the 'being' as well as the 'doing' of therapy has been especially articulated in the literature coming out of humanistic therapy (e.g. Rowan, 2016). Yalom has also referred to the importance of 'presence' and how therapists, through anxiety and restlessness, can be easily distracted by trying to 'do' therapy rather than paying full attention to the client in a 'being' mode (e.g. Yalom, 2015). The notion of 'presence' is intangible and elusive so it is difficult to measure or monitor; however, its importance in the literature and for the participants is central to the therapeutic enterprise. The incommensurability between what might be important about therapy and what can realistically be researched problematises not just research about therapy but also, arguably, pluralistic therapy which seems to want to measure and monitor at every turn.

The common catchphrase by therapists that 'it's the relationship', whilst having substantial support from the research, simultaneously suffers from a seeming vagueness which allows therapists and therapies that seem to 'do' more to gain advantage. It is easier for commissioners of services to understand and support therapies that pursue an instrumental rather than a relational approach. Practitioners like my participants have a grasp of 'the relationship' being an essential aspect of therapy, but the elusive nature of what this actually means leads to technique-based therapies being more favoured. This seems to be another example of gaps between the personal yet empirical evidence of an individual's practice in particular, and generalised evidence from the whole.

At this point I have explored how the participants have discussed the contentious issues (Identity and Approach; The Flexibility–Rigidity Continuum; It's the Relationship) which fuel the debates and conflicts about pluralistic approaches to therapy. In the following section I will explore how the participants discussed these debates directly.

5.3 Debates about Pluralistic Approaches to Therapy

Most participants were aware of debates within the profession about approaches, in general, and notions of pluralism and purism, in particular. Within this general theme (an overarching theme and theme) I have also identified two sub-themes: *therapist attitudes to theories* and *commercial/professional implications*.

In relation to these conflicts within the profession, Paul, referring to the perennial letters in *Therapy Today* arguing for the superior status of CBT, the PCA or psychodynamic therapy, depending on the orientation of the letter-writer, stated:

it just felt like it was warfare or a family bickering (Paul, PCA, 1:R41)

It was this statement that, initially, led me to name this theme 'Therapy Wars', as this term seemed to encapsulate conflicts within the profession which are, arguably, one basis for the manifestation of pluralistic therapy as a potential pathway to resolution. The use of this phrase to describe the factionalism within the therapy professions has also been articulated by others up to the present day (e.g. Burkeman, 2016; Saltzman & Norcross, 1990). However, there is a multitude of issues that cause conflicts in the therapeutic professions, so ultimately I decided to use the phrase 'debates about pluralistic approaches to therapy' to clarify the specificity of the conflict which the participants and myself were discussing in the interviews.

Eight of the twelve participants experienced these debates as having defensive and aggressive characteristics, perhaps rooted in fear:

what I hate about it is the defensiveness and the attacking other models and the closed-mindedness (Paul, PCA, 1:R41)

my first experience of those kind of debates is... noticing very much an 'us and them' perspective (Joanne, PCA/SFBT, 2:R33)

it's good to be passionate about counselling but why people get so – when they feel the need to defend – I find that very interesting (Nicola, Humanistic, 3:R47)

the need to be in a box to me is a sign of defending against the fear or the anxiety or whatever it is of not being in that box (Sandra, TA, 4:R25)

my own view is that I think we get a bit hot under the collar about it, to be honest (Susan, Integrative,7:R26)

my experience has been that it's really been very heated (Peter, PCA, 9:R30)

there can be a defensive mentality which excludes open-mindedness, which I dislike (Heidi, Psychodynamic,10:R29)

when I was training we had to do some lectures in common with the humanistic group and there's huge hostility from all of them to the psychodynamic group but... there are other situations when it goes back the other way (Heidi, Psychodynamic,10:R29)

people need to feel secure in their model... they're not that secure in themselves so they hang on to the model (Heidi, Psychodynamic,10:R44)

why do they feel so strongly in defence of their own approaches? What are they feeling a bit unsecure about? (Christine, Psychodynamic, 11:R31)

Christine also expressed her perception of the aggressiveness against different approaches in the following way:

it just seems like an assault against diversity in terms of therapeutic approaches – why would you be different than I am, what makes – how would that make me feel? Cos I am aware of the stigma of psychoanalysis... I'm not a psychoanalyst but I'm trained in this analytical tradition, I respect it as such but I don't need to – when I go to somebody and they say 'Oh, he's psychodynamic' and it's like immediately there's a division there, you can – it's palpable and I don't like that... why the segregation?... I feel... this certain anxiety connected with diversity (Christine, Psychodynamic,11:R33)

Christine made parallels between the aggressiveness towards particular approaches identified as different to one's own and her own personal experience of being Eastern European in the UK as a kind of 'othering' taking place in the therapeutic professions around approaches:

I had personally a hard time, Eastern European, second language English, 'What you doing here?'; I had previous experience of that, this is all stigmas that you have to battle against (Christine, Psychodynamic,11:R34)

She preferred therapists to identify as therapists in a generic sense rather than with particular approaches:

I think I just catch myself being slightly hostile against this sort of divisions 'I'm CBT' 'I'm psychodynamic', 'I'm-' – 'No, you're all therapists' (Christine, Psychodynamic, 11:R28)

Simultaneously, despite this aggressiveness, defensiveness and fear, seven participants also reported thinking that these debates are positive for the profession (Paul, Nicola, Lisa, Robert, Peter, Heidi and Christine). For instance Robert, Heidi and Christine respectively stated:

I think 'Let them argue' – whatever comes out of the argument... at least there is a debate (Robert, PCA, 8:R59)

I think that anything that encourages a debate about what works in therapy is useful (Heidi, Psychodynamic, 10:R29)

competition can be healthy, you know, you never know what would come out of this... conflict (Christine, Psychodynamic, 11:R44)

One implicit difference between therapists who engage more passionately in these debates and others who are more cynical and disconnected from them is different *therapist attitudes to theories*. Most of the participants (Paul, Joanne, Nicola, Amanda, Debora, Susan and Robert) reported varying degrees of ambivalence towards theories as a basis for practice. I would argue that this ambivalence might make it more difficult for them to engage with debates that are often highly theoretical, and dominated by voices which assume the importance of coherent theoretical underpinnings for therapeutic practice. For instance, Paul remembered a psychodynamic practitioner with whom he had therapy whose attachment to theory he experienced as therapeutically counter-productive:

and sometimes I think [theories] can really get in the way.... I guess some of that comes back to the experience I had with that psychodynamic counsellor who would just give me interpretations and basically tell me what was going on with me. He was full of his own theories and full of his own power and importance and his own wisdom. He was like some archetypal father-figure for me and often that just spun me off into all sorts of confusion that I then had to go away and unpick (Paul, PCA, 1:R48)

Therapy, I would suggest, is first and foremost a shared experience which theories influence and develop to some degree, but which is difficult to theorise comprehensively. Therapists are sometimes confronted with this potential conflict between the direct experiences of *doing therapy* versus *thinking about doing therapy*:

it was a bit of a struggle to match what I was experiencing in the room with what I had previously thought about counselling (Joanne, PCA/SFBT, 2:R8)

and that was really scary because I knew I'd run out of ideas and it really was then listening to what the client... brought, and going with that... it made me realise that I do have ideas and so perhaps I'm not quite listening to the client as much as I should be (Nicola, Humanistic, 3:R41)

Robert suggested that the world of therapy is 'too theoretical', and because of that it is not 'looking at the essentials' (Robert, PCA, 8:R26).

Some participants supported their view that emphasis on theories is misplaced by referring to research. For instance, Amanda stated:

all the meta-analyses show theoretical approach has very little influence in the effectiveness of therapy (Amanda, TA, 4:R18)

However, this ambivalence towards theories also included acknowledgment that theoretical concepts could be useful for the practice of therapy:

so the theories are fun, they're nice ways to try and work out what we're doing (Paul, PCA, 1:R48)

sometimes it's useful to bring some theory in... talking about transference as a concept was transformational [for a client] (Susan, Integrative, 7:R13)

The bases for these debates, however, do not just come from such relatively benign causes as fighting for ideological and pragmatic perceptions of what makes therapists and therapy effective and worthwhile; they also come from more mundane motives (which have *commercial/professional implications*) to achieve political and economic ascendancy or supremacy. Arguing for institutional validation of some approaches but not others has 'real-world' implications for the success and failure of therapies and therapists. The practice of therapy – especially with so many practitioners operating in the private sector (e.g. BACP, 2017b) – is

a highly competitive commercial enterprise (e.g. Clark, 2002) and the participants were even on a casual level aware of their need to 'sell' their services:

I feel like if they don't want to buy what I've got to sell then there's no point (Paul, PCA, 1:R21)

Lisa reported that she trained in a particular approach specifically to gain referrals:

she said that she would refer people if we did ACT [Acceptance and Commitment Therapy] training so I went off and did ACT training (Lisa, Pluralistic, 5:R10)

Christine was tempted to train in CBT for similar reasons:

I contemplated going into a CBT training.... I decided not to, although I recognise that might have helped me in terms of getting more clients and just establishing myself much more smoothly – CBT's the hit of the day, apparently (Christine, Psychodynamic, 11:R3)

John, a CBT practitioner, recognised the cynicism of his perception of practitioners emphasising differences between approaches when there might not, in fact, be any. He saw the debates about pluralism as arguments about 'refranchising' and 'repackaging':

CBT will probably be replaced by something else [John and Jay laugh slightly] and then something else will replace that – mindfulness is incredibly 'in' at the moment – mindfulness is the hot practice at the moment but it's a – I think it's a question of reinventing the wheel constantly – in a sense, we all just keep stealing ideas off each other, reframing it, really just refranchising different bits... and then calling it something new and it's gone on for ever, and it'll continue, and that's a fairly cynical and nihilistic view of it [John laughs slightly] but I really do think that – I think that we just constantly repackage and all the time it's a question of professional role-casting or politics rather than just getting on and doing the job, I think it will just go on and on and on (John, CBT, 12:R30)

Paul also reported that Cooper and McLeod's promotion of pluralistic therapy had been dismissed by other therapists he talked to 'as a re-branding' (Paul, PCA, 1:R41). In other words, the idealistic vision of a more tolerant and open-minded profession, articulated by those sympathetic to conceptions of pluralistic theory and practice, is perceived by some

therapists as being just as motivated by commercial and professional concerns. The commercial and professional implications of debates about pluralism and therapy were expressed by all the participants bar two (Paul, Joanne, Amanda, Lisa, Debora, Susan, Robert, Peter, Christine and John). Nicola, who did not mention the commercial/professional implications, was the least experienced of the participants, being only one year post-qualification, which might be one factor in her not mentioning this issue.

Research was also focussed upon by a few participants (Amanda, Lisa, and Debora) as a powerful tool in promoting commercial and professional interests. For instance Debora stated:

that's one of the things... about... different approaches... the CBT therapists... did really well to get all this data whereas counsellors seem to be [in a slightly mocking tone] 'Well, we can't measure what we do' and I think you just have to these days, you have to prove what you're doing, otherwise companies aren't gonna pay and the NHS won't pay – the CBTs have proved themselves so the NHS do that (Debora, Humanistic-Integrative, 6:R11)

The reference to CBT and the dominance of CBT in comparison to their own chosen approaches (only one of the participants, John, was a CBT practitioner) was also a concern shared by most of the participants. This seems to be one major factor in the debates about therapeutic approaches, and the related perception that CBT is 'winning' because they have seized the power of research to drive commercial interests. However, the acceptance that CBT has indisputably won the research battle was not accepted by all the participants, and, indeed, research continues to support this position (e.g. Barkham et al., 2017; Pybis et al., 2017). A few participants felt that research has shown, amongst other things, that 'it's the relationship' (discussed previously) rather than particular approaches which is the most effective 'ingredient' in therapy. Some participants directly challenged the perception that research supports the idea of CBT being superior to other approaches:

I think the current debate is with CBT and counselling per se – that CBT is superior in some way when the research says that 'Actually it's not' (Susan, Integrative, 7:R34)

Amanda, one of the older participants, who 'started... when the training school was somebody's front room' (Amanda, TA, 4:R50), despaired of the

cutting of currants into halves and quarters in the therapeutic world that 'only this is acceptable' and 'only that kind of training' (Amanda, TA, 4:R50).

This element of cynicism was also expressed by other participants. For instance, Susan reported:

so, yeah, I read [articles] and I scoff, I guess (Susan, Integrative, 7:R26)

And Paul, distancing himself with biting humour from a more purist person-centred position, stated:

it's like 'Well that gives me more freedom than "Oh, I can't do that because I haven't seen a video of Carl Rogers doing it"' (Paul, PCA, 1:R11).

There seemed to be a perception by most of the participants of the debates about pluralism and therapy as power struggles that they did not want to 'get drawn into' (Susan, Integrative, 7:R45). Susan expressed frustration at these struggles that fuel the debates thus:

I just think, 'Oh, for goodness sake, live and let live, let's just have our different opinions and be okay with it; stop trying to impose your opinions on him and you stop imposing your opinions on him – let's just all... make our own choices (Susan, Integrative, 7:R45)

Similarly, Christine thought that there was no need for different approaches to lead to divisiveness in the profession:

I think [pluralistic therapy]'s a very positive things [sic] because you can't really have the hegemony or the monopolism [sic] of one therapy, even the psychoanalytic which is the basis; it had to evolve and it had branched out in so many different directions, and each and every one of these approaches is meaningful and has something to bring to the table, and I don't understand why the separation and the division and the attitudes 'I'm holier-than-thou' and all of that – I don't agree with that (Christine, Psychodynamic, 11:R28)

In terms of the conflict between more purist and more pluralistic positions, Susan was further sceptical that self-identified purist practitioners are actually purist:

I don't think there's very many pure practitioners out there; I think that we all are affected by the others and that we all are a bit flexible... I don't think I've met anybody that I would describe as a 'pure' person-centred or a 'pure' Gestalt or 'pure' psychodynamic – I think they're all a little bit integrative... when you talk to them I don't know that they are as extreme as they think they are (Susan, Integrative, 7:R26)

In terms of how well arguments for pluralistic frameworks (including the framework initiated by Cooper and McLeod) for therapeutic practice are being transmitted and received, it seems as if therapists are, on the whole, informed and enthusiastic. All of the participants knew about pluralistic approaches to therapy and most of them had positive feelings towards it. Some doubted that it was possible, in fact, to practise in any other way, particularly in brief therapy, with adolescents and for particular issues such as trauma. Only one participant held the view that his approach should be practised purely, without the addition of another approach, to claim itself as being that approach and not suffer the effects of adulteration. Even this participant welcomed a pluralistic perspective, in which clients could be referred on to different practitioners, when it seemed clients were not being served well by whatever approach they were currently being offered. It does need to be noted that most of the participants, broadly speaking, were practising under a humanistic umbrella, and humanistic practitioners might be expected to be sympathetic to pluralism. However, the two psychodynamic practitioners and one CBT practitioner whom I interviewed were also generally in favour of pluralistic approaches to therapy; so whether different approaches are more or less sympathetic to pluralism seems to be an open question and one worthy of further research.

It is important to recognise, as does the participant referred to above, that there are two different levels of pluralism in therapy, one of practice and one of perspective. These two levels need to be distinguished for a full understanding of the pluralistic implications for practice and provision of practice (e.g. Cooper & McLeod, 2011a). Pluralistic practitioners draw upon different approaches and techniques, either for different clients or for the same client. They do not perceive pragmatic, ethical or philosophical problems with this approach. Other practitioners do perceive those kinds of

problems which is why they are more hesitant to embrace pluralistic ideas for an individual's practice.

On another level, there is the possibility of holding a vision for therapy in which practitioners are not pluralistic in their own individual practice, but from a pluralistic perspective welcome the prospect of clients being able to choose from an array of therapies, and appreciate the value of most therapeutic approaches for different clients at different times. At this level the issue of whether pluralistic therapy in itself is beneficial for clients is not of concern, but rather whether clients should or should not be allowed easier access to, and movement between, different approaches, and be encouraged in that by therapists and therapy providers. This would reflect the view that different therapies are actually better for different levels of personal development and development within the therapy process (e.g. Marquis, 2008; Wilber, 2000). This view also suggests that attempting to practise with a particular therapeutic approach with a client whose level of development does not match the level at which the therapy is aimed can be counter-therapeutic or ineffective. This might be one explanation for the high drop-out rates in the IAPT programme (e.g. Kelly & Moloney, 2018).

The complexity of the theoretical arguments behind these assertions do not lend themselves to simplistic brand x versus brand y research, yet if there are indeed foundations to these arguments, then clients are being let down by research methodologies which do not respond to the subtleties and intricacies of therapeutic processes (e.g. Wampold & Imel, 2015). Overall, what needs to be borne in mind when exploring the debates about pluralistic approaches to therapy is that it is possible for practitioners to have unfavourable views of pluralistic practice but favourable views of a pluralistic perspective. In other words, it might be easier to gain support from the profession for pluralistic provision of therapies, even if individual pluralistic practice proves too controversial to gain traction.

It might be argued that what distinguishes pluralism from integrationism has – to a certain extent – been lost over time, in attempts to communicate a specific way of practising which emphasises collaboration. In more recent years Cooper et al. (e.g. Cooper & Dryden, 2016a) have described their vision for pluralistic practice as 'collaborative integration',

which supports the view that, in effect, the proponents of pluralistic practice are re-packaging a version of integrative therapy. This development might be seen as devaluing the meaning of pluralism as a philosophical position that values difference, and wants to preserve difference, rather than accelerate 'premature integration' (e.g. Kazdin, 1984).

Nonetheless, a key basis of the approach emphasises that 'different clients need different things at different points in time', which reflects its philosophical roots in pluralism, as opposed to integrationism, which potentially might not concur with such a view. Therefore, in terms of this research and the implications of pluralism for practitioners, clients and practice, the meaning of the object 'pluralism', which was being discussed with the participants, was sufficiently clear to be understood as something distinct. Pluralistic therapy attempts to differentiate itself from integrationism, even if there are arguments to be made that the distinction is perhaps tenuous. The bases for the participants' views of debates about pluralism were also most likely to be filtered through Cooper and McLeod (2011a) either directly, or through the dissemination of their ideas into contemporary discourses about therapy.

A major factor in the development of a 'pluralistic framework for counselling and psychotherapy', also the title of Cooper and McLeod's first published paper on the subject (Cooper & McLeod, 2007), was to develop a model for practice which, they argued, lent itself more easily to research than integrationism or eclecticism. Hence the first paper they wrote sets out the framework in terms of its usefulness for research. In this paper there is no data on how therapists respond to this agenda – it is like a first call to the therapy profession to take note of a new approach.

Yet even at this stage, they were already using language which might lose the sympathy of some practitioners, particularly their use of the terms 'goals', 'tasks' and 'methods' (p. 135). Rowan, the late statesman of humanistic psychology and psychotherapy, both in published literature (e.g. Rowan, 2018; 2016) and in personal correspondence (Rowan, 2015), emphasises his cynicism about the usefulness of goals for clients, arguing that they put unnecessary limits on the therapeutic process, might be rooted in a client's distress, and makes the assumption that the client is consciously

aware of what they might want from therapy. Similarly, Paul articulated this kind of discomfort when he said that Cooper and McLeod began to 'lose him' when they started talking about 'tasky stuff'.

Most of the participants were, broadly speaking, practising under the humanistic umbrella; however, the two psychodynamic practitioners and one CBT practitioner seemed to be as supportive of pluralistic therapy as the other participants. My sense is that therapists do vary in their sympathies to pluralistic therapy but that variance is not determined by approach. Further research on this, either quantitative or qualitative, could determine more convincingly whether there is more or less resistance to pluralistic therapy within particular therapeutic identities.

Cooper and McLeod (2011a, pp. 154–159) summarise many of the critical points to be made about pluralistic counselling. How some of these points were responded to by my participants, and how they have been responded to in the existing literature, will be explored in the following paragraphs.

A common criticism of pluralistic therapy is that there are too many therapies to learn. Cooper and McLeod suggest that it is possible to have a pluralistic perspective whilst practising within a singular approach. This position was implicit in the interviews with Peter, Christine and John. They resonated strongly with the philosophies and practices of a single approach whilst also valuing other approaches.

It is also worth noting that several participants made a distinction between how they practised long-term and short-term therapy. Some claimed that being more pluralistic – implying flexibility – was essential for short-term work, although they might practise less pluralistically, or within a single model, for long-term work. This illustrates the point that the practice of pluralistic therapy – by practitioners who do not necessarily name it as such – varies not just between practitioners but also *within* a practitioner's practice. The suitability of pluralistic practice for short-term versus long-term work would also make for interesting further research.

Another argument Cooper and McLeod make in response to the criticism that there are too many therapies to learn is that therapists need to

be aware of their limitations and be willing to refer on; this was emphasised by a few participants, such as John.

Nicola echoed the criticism that clients do not understand therapy enough for collaboration to be useful and, some might add, interferes with a 'relational' approach that emphasises 'being with' over 'doing to' – a suspicion of techniques as potentially undermining the relationship. Most participants, however, recognised that clients varied from a minimal understanding of therapeutic process to significant understanding and, in a pluralistic spirit, would vary the amount and type of collaboration depending on the client.

The point is also made that sometimes clients want therapists to take the lead, so metacommunication is not suitable for these kinds of clients. Debora used a metaphor of therapy being, for at least some clients, like getting a car fixed, where the customer does not want to know all the technicalities of how it was done, they just want it done. Cooper and McLeod suggest being sensitive to these kinds of clients and 'adjusting accordingly' (ibid., p. 155).

There is some resistance in the literature to putting the client first, in terms of control of therapeutic direction (e.g. Dryden, 2012). Dryden (2012) also insists that the choices presented to clients should be driven by 'evidence' for their particular conditions, which leaves assumptions about the medical model and research methodologies unchallenged. Most of the participants appeared to support collaborative processes, in a general sense, even if that was within a specific model, such as John, the CBT practitioner.

Cooper and McLeod also acknowledge that it appears as if the pluralistic terminology of 'goals', 'tasks' and 'methods' seems to downplay just *being with* clients, as pointed out by Rowan and others. Cooper and McLeod (2011a) argue that these terms are also meant to include 'more subtle, non-conscious and organismic processes' (p. 156). This argument was not recognised by Paul, and other participants did not seem to be aware of the protocols for pluralistic practice that Cooper and McLeod have set out in their book. It is important to note that whilst all the participants were aware of Cooper and McLeod's version of pluralistic therapy, most were responding

to their ideas for it in a more general sense. The protocols for practice have not seeped into the professional consciousness as deeply as the more general ideas behind those particulars. Perhaps this is for the better because it is possibly too paradoxical to prescribe and proscribe how to practise pluralistically.

The main criticism of pluralistic therapy made by Peter was his perception that the philosophies of the PCA and CBT were mutually exclusive, and therefore could not be combined. John, the CBT practitioner, held an opposite view that the PCA could be contained within CBT, and that to argue otherwise reflected an unsophisticated understanding of CBT. Cooper and McLeod respond to this particular argument by suggesting that the pragmatic use of these underlying philosophies of therapeutic practice for clients is what should be prioritised. They emphasise that there is little evidence to suggest that these philosophies are definitively 'true' and that therefore the 'ethical stance to take' is 'holding them in [a] light way' (p. 157). This view reflects Amanda's opinion that therapists who are not eclectic are potentially practising unethically since, in her view, if you are not doing all that you can with all that you know, whether that is a part of your approach or not, then that is unethical practice.

One of the criticisms that is perhaps more difficult to defend is that effectively, most therapists are practising pluralistically anyway. This was reflected by Debora's assumption that 'counsellors', by definition, practise pluralistically. Perhaps this was because she worked mostly for the NHS, where it seems that, institutionally, an understanding of 'counselling' as a generic phenomenon has developed, rather than understanding it as a panoply of approaches, just like 'psychotherapy', in which counsellors can be just as enamoured of a particular approach as any psychotherapist. This perhaps reflected an institutionalised acceptance by the participant of psychotherapy as something different to counselling, at least within the NHS, which is by no means universally accepted – for instance, the BACP itself does not recognise a difference (e.g. BACP, 2009). Retrospectively, this might have been an interesting line to follow in that interview, the beginnings of a social construction of counselling as pluralistic. Certainly, this seems part of John McLeod's agenda for 'counselling', which he wants to ultimately

construct as something different to 'psychotherapy' (e.g. McLeod, John, 2013a).

Research by Thoma and Cicero (2009) gives support to the idea that most therapists are pluralistic. They surveyed 209 therapists and found that therapists actually used more techniques from outside their identified approach than from within it. Further, Norcross (2005) has suggested that an 'integrative or eclectic stance is currently the most common orientation of English-speaking psychotherapists' (Cooper & McLeod, 2011a, p. 5). Therefore, it could be argued that Cooper and McLeod are not offering anything new; and this cynicism that therapy often only pretends at innovation, where there is in reality none, was especially articulated by Robert, and is also reflected in the literature (e.g. Miller et al., 1997).

This aspect of the debates around pluralism connects to the sub-theme I identified as 'different names for the same thing', mentioned by most of the participants. Cooper and McLeod concede that 'many therapists already think, and practise, in a way that is consistent with the pluralistic approach' (Cooper & McLeod, 2011a, p. 157), but insist that theirs is the first comprehensive articulation of how many therapists have been practising. They also perceive their pluralistic practice as 'uniquely inclusive and collaborative' (ibid.). Importantly, they emphasise how their 'framework' enables research to be carried out in ways that previous articulations of this kind of practice have not. This response might be seen as a weak defence against the charge, but the apparent gap between how therapists practise and therapy research *that is taken seriously by those with financial and political power* seems to be so far apart that it would support the idea that pluralistic practice needed a re-articulation since it has not been understood by the commissioners of research thus far, or certainly not by the consumers of research who use research to make decisions about provision.

Cooper and McLeod have therefore presented practitioners and researchers with a framework that fits in with 'evidence base' and 'audit' cultures. For some this is seen as an intelligent and pragmatic move for the benefit of the profession, whilst it is seen by others as a submission to dominant methodologies and discourses about therapy and therapy research (e.g. Loewenthal, 2016).

A significant proportion of the debates about pluralism have been conducted in professional (rather than academic- or research-based) journals, at conferences, and between therapists in informal ways. Thus I have framed the conversations therapists are having about pluralism as having qualities associated with SI. Certainly, the conversations I had with my participants can be interpreted as symbolic interactions about pluralism and pluralistic therapy.

At an academic/research level these debates were first given sustained attention in the *European Journal of Psychotherapy*, March 2012 issue. Its tone is relatively 'intellectual', engaging with pluralism at the theoretical level, repeating criticisms that I have already discussed, and which Cooper and McLeod have already defended in their 2011 book. However, there are some research-based articles which, to an extent, support the view that engaging with client preferences improves outcomes (McLeod, John 2012), the suitability of a pluralistic approach for HIV clients (Miller & Willing, 2012) and therapists' experiences of using forms designed to monitor a pluralistic practice (Bowens & Cooper, 2012). These studies are the first to respond to Cooper and McLeod's call for pluralism to be researched, and they show a preference for process and outcome-based research.

Within this issue, however, there is a paper that uses IPA to explore '[t]herapists' experiences of pluralistic practice' (Thompson & Cooper, 2012). However, the focus is only on therapists who already describe themselves as working pluralistically, so it does not explore how therapists in general may or may not work pluralistically, and how therapists in general make sense of pluralistic perspectives and practices. The authors 'identified two main themes... *Personal philosophy and the ability to work pluralistically*, and *Experiences of putting the pluralistic approach into practice*' (ibid., p. 67). The first theme resonates with some of the concerns of my own participants, especially Peter, a person-centred practitioner. However, Peter was an example of someone whose philosophy made it difficult, if not impossible, for him to work pluralistically. Conversely, the participants in the Thompson and Cooper study all identified with the pluralistic perspective, so perhaps unsurprisingly, all 'reported that the pluralistic approach directly

appealed to them' (ibid.), and their philosophical positions supported a pluralistic perspective and practice.

There are similarities between this piece of research and my own. Both studies focus on how therapists experience pluralism as an idea and in how they practise therapy. However, in my own research the therapists report greater and lesser degrees of pluralistic practice, and pluralism is an idea and practice to which they are not explicitly signed up, as the therapists explicitly are in the Thompson and Cooper study. Therefore, the participants in my research more comprehensively reflect attitudes and experiences of pluralism that belong to the therapy profession as a whole. This research examines how pluralism as a perspective and a practice is being received and taken up (or not) by practitioners. The success or failure of pluralism depends on practitioners themselves wanting to promote the cause; therefore this research illustrates how some therapists understand and make sense of pluralism, and how much they believe pluralism offers solutions or causes problems for the profession.

Another piece of research which is similar to my own is Tilley et al.'s (2015) 'An exploratory qualitative study of values issues associated with training and practice in pluralistic counselling'. However, Tilley et al.'s research, like other research in the pluralistic field, only focusses on therapists who identify as pluralistic. This is an unnecessary constraint, as pluralism is an idea about which most therapists have constructed views and practices in relation to therapy, as my research suggests. Tilley et al. themselves recommend that further research would benefit from a wider range of identified approaches. Their research, like mine, had twelve participants, with a wide spread of experience, from 'recently qualified to more than 25 years post-qualification' (ibid., p. 181), and used semi-structured interviews analysed by the method of thematic analysis.

The methodology and paradigm behind the thematic analysis in Tilley et al.'s research is unclear and implicit, whereas my research has an explicit SI perspective and an II methodology. The themes that the researchers identified were: (1) The importance of connection, (2) 'There is no one right way to be' (3) Equality (not taking an expert role), (4) Honesty, and (5) Willingness to make use of research evidence. Theme 1 is similar to my third

theme of 'It's the Relationship'; Theme 2 is similar to my second theme of 'The Flexibility–Rigidity Continuum'; Theme 3 is reflected in elements of my fifth theme, 'The Uncertainty–Understanding Continuum'; and Theme 4 is reflected as one aspect of my third theme, 'It's the Relationship'. Regarding Theme 5, Tilley et al. report that their participants 'highlighted the importance of research in relation to their practice' (ibid., p. 184).

My participants varied from enthusiastic to dismissive in their views about research evidence, noticeably more varied than those of Tilley et al.'s participants. They report that 'a few participants believed that practising without a research base could be considered unethical' (ibid.), a view not articulated by any of my interviewees. Tilley et al.'s participants seemed unified – in a way that mine were not – around a consensual construction of research as necessarily a good thing. Issues around research were not interpreted as an overarching theme from my interview data; rather, they were interpreted as 'ground' to the 'figure' of all the themes.

Most importantly, Tilley et al.'s research does not refer to debates about pluralism and therapy so, in a research sense, pluralism as a 'problem' is not confronted. This is the main difference between their research and mine. The focus on 'values' is also relatively narrow compared to my research - how the therapists practised, and made sense of their practice, in relation to pluralism as a whole, rather than regarding one particular aspect, is not explored.

I would suggest that pluralism in therapy is best viewed as a variable that manifests in all therapeutic approaches, therapeutic processes and therapists. Therefore, in my research, how therapists practised pluralistically, and how they made sense of pluralism as a constructed concept within therapy, are interpreted as a complex interplay of practices and identifications which do not lend themselves to a binary and static pluralistic/non-pluralistic practitioner divide. Even in 2015, eight years after Cooper and McLeod's initial paper articulating a new pluralistic framework, Tilley et al. state that '[a]t the present time, there exists only a small network of pluralistic counsellors, who tend to be known to each other' (ibid., p. 185).

The use of the term 'pluralistic' to describe practice has not been taken up widely, even if many therapists arguably practise in a pluralistic

way. It seems as if pluralistic therapy, as constructed by Cooper and McLeod as a practice, has had less impact on the field than pluralism as a unifying concept that practitioners can apply to their own differently identified approaches. Overall, it seems as if the protocols and practices articulated by Cooper and others for 'pluralistic therapy' have, to a certain extent, functioned well to instigate the beginnings of research, and particularly process and outcome research, but have not yet convinced practitioners that it is a label with which they wish directly to identify. Perhaps this is because the presentation of it as a therapy packaged with a view to being researched, with forms and questionnaires already devised, imparts a clinical emphasis that feels a bit cold and utilitarian to many practitioners.

Cooper and McLeod (2011a) support this emphasis by referring to evidence that backs the effectiveness of therapy that is monitored via feedback forms, suggesting that it can help to facilitate a pluralistic practice that puts client–therapist collaboration at its centre. The use of these forms is unapologetically encouraged, yet therapists continue to be suspicious, rightly or wrongly, of this kind of 'auditing' of therapeutic processes and outcomes. Practitioners more sympathetic to instrumental, positivistic and quantitative approaches might perceive implementing the suggested protocols into practice as a win–win situation in which therapeutic process and research are both well served. Other practitioners resist the research-driven agenda and do not want to interrupt the flow of a 'conversation' (e.g. Szasz, 1988) with clients in an attempt to attain expediency-driven pseudo-scientific credibility.

The agenda that Cooper and McLeod have for pluralistic therapy – to become an evidence-based therapy via 'evidence' that influential bodies recognise – is demonstrated by Cooper et al. (2015) in their research study into 'pluralistic therapy for depression' (PfD). They used a treatment manual, and suggested that further research would benefit from the development of an 'adherence scale for PfD' (*ibid.*, p. 17). The suggestion that a pluralistic therapist needs to adhere to a particular way of practising is paradoxical if not contradictory and incoherent, and demonstrates the difficulty of trying to fit research about pluralism into the currently dominant research methodologies, particularly the so-called 'gold standard' RCT where the

attempted flattening out of variables goes against the pluralistic wish to increase variation. Pluralistic practices are by their very nature difficult to pin down; it might even be argued that a pluralistic practice that can be pinned down is not much of a pluralistic practice at all.

Thus, the outcome-focussed research by Cooper and others, whilst honourable in its intentions, is perhaps fatally flawed in its attempts to pragmatically follow established research methodologies that cannot adequately answer the questions that pluralism asks of therapy and research. Scott and Hanley (2012), who explore the experience of one therapist attempting to work pluralistically, conclude that practitioners, to effectively understand the implications and possibilities of pluralism for their own practices, perhaps need to understand pluralism more as a 'philosophy' than as a 'framework'. Scott found that he was able to resonate with the philosophical basis but not with the specifics of 'goals, tasks and methods'. A recognisable model of practice might be necessary to establish an 'evidence base' for potential providers, but the attempt to provide one seems contradictory as well as alienating for some practitioners.

Cantwell's (2016, May) research which used Conversation Analysis (CA) to explore actual sessions with therapists seems to offer a more useful approach in terms of articulating practice-based knowledge about the opportunities and difficulties for therapists in practising pluralistically, albeit without the ability to measure effectiveness quantitatively.

There are many aspects, controversies and conflicts in the debates about pluralistic approaches to therapy, some of which I have highlighted in this section. In the following sections I will discuss how participants spoke about issues I have interpreted as 'diplomatic attempts at resolution', which include 'the practice of metacommunication', 'the uncertainty-understanding continuum' and 'common factors'.

5.4 Diplomatic Attempts at Resolution

Although divisions between various schools do lead to some 'winners' – for instance, the current dominance of CBT in the NHS – overall, the splits

between different factions of therapeutic practitioners does not bode well for the therapy profession. Those professions which present a more united front, such as counselling psychologists, clinical psychologists and psychiatrists, appear to be a coherent unitary force, communicating in ways that providers can understand. This presentation of unity may be misleading, but it is effective. In Goffman's terms they are putting on a much better performance (e.g. Scott, 2015).

There are various reasons as to why therapists might want to create a more united profession, not least for the benefit of clients (e.g. Cooper & Dryden, 2016a), but one major reason is so that the professional status and presence of therapists can be maintained in large organisations such as the NHS. I would suggest that a major long-term aim of the pluralistic agenda is to re-incorporate therapists and therapies – which emphasise the importance of relational factors (both humanistic and psychodynamic approaches) – into the NHS by re-translating these kinds of factors into instrumental language that can be measured and understood by the gatekeepers of provision. This agenda and project is perceived by some professionals as urgent (e.g. Ingersoll, 2008; Loewenthal, 2016) if 'traditional' therapies are to survive.

In that sense and spirit, pluralism in therapy can be seen to support 'diplomatic attempts at resolution' not just for the interest of clients, but for the sake of mere survival 'in the therapeutic marketplace... driven by economic agendas' (Ingersoll, 2008, p. ix).

My participants appeared to back three ways of doing this that are also supported by pluralistic approaches to therapy. First, the practice of 'metacommunication' with clients (e.g. Cooper & McLeod, 2011a) with the implication that if clients themselves are given a voice in how they would like their therapy to be, then they might choose other therapies than those which have been approved by an 'evidence base'. If more power is given to clients in choosing what therapies are provided, then therapists, researchers and providers need to listen to them as well as, or instead of, relying on evidence from RCTs. MIND, the well-known mental health charity, is openly advocating for clients to be able to choose from a 'full range of psychological therapies' (Private Practice, 2014, p. 8).

Secondly, the context in which RCTs become so privileged is one in which ‘certainty’ and ‘understanding’ are over-valued in relation to an activity like therapy which is, by its nature, constantly grappling with the uncertainties and confusions of being human. What may be true yesterday might not be true today, especially when it comes to the vicissitudes of human experience. In other words, to deliver the best therapy effectively to clients, it could be argued that flexibility rather than adherence, and comfort with ‘not knowing’ rather than attachment to knowing, are temperamental qualities associated with effectiveness (another area worth researching further). Tolerating uncertainty as well as searching for understanding in the ‘uncertainty–understanding continuum’ is one path to supporting a pluralistic ‘peace’ between approaches.

Thirdly, the recognition that ‘common factors’ might be more important than the idiosyncrasies of different approaches, with its roots in early integrative thinking (e.g. Frank, 1961), is supported by the proponents of pluralism and by some researchers (e.g. Wampold & Imel, 2015), as well as by the participants in this research.

5.4.1 The practice of metacommunication

It could be argued that the ‘pluralistic framework’ articulated by Cooper and McLeod (2011a) is merely theorising and providing terminology for what many therapists have been doing in practice ever since the profession’s beginnings. One important concept within the framework is ‘metacommunication’ (e.g. Cooper & McLeod, 2011a), or ‘talking about talking’. More recently (e.g. Cooper et al., 2016) they have also referred to the practice of ‘meta-therapeutic communication’, which notion perhaps more accurately reflects its more precise meaning of talking about therapy and therapies with clients.

One purpose of metacommunication is to devolve power away from therapists and towards clients. This is arguably good for the therapeutic process in itself but also, if taken up collectively, could be a path to peace and reconciliation in the profession more widely. If clients are allowed to decide what kind of therapy they want with what kind of therapists, then at

least in theory, the need for therapists and other stakeholders to argue about the efficacy of and place for various therapies dissolves. 'Why not ask clients what they want and give it to them?' seems to be the rhetorical question that lies behind the call for metacommunication at the political level. This open and informative communication about therapeutic choices does not just occur at the beginning of therapy, for example in assessment, but throughout, so that clients can choose how therapy can be tailored for them individually, either with one therapist/therapy or a series of therapists/therapies. This idea is not without controversy, however, so in this section I discuss how the participants viewed this issue.

A majority of the participants (Paul, Lisa, Debora, Susan, Robert, Peter and John) reported that they communicated with clients about therapy either in the first session or before sessions have started:

I like in the very first session to be really clear, or try to be clear, about how I work (Paul, PCA, 1:R17)

most of them have a description of the type of therapy we're meant to be providing, that's always given to my clients before I see them... in the room I'll always still verbally check out... what they understand about counselling, if they've had any previous experience of counselling; if they have, what type and their experience of it, so whether they liked it or not, so what worked for them, what didn't work for them really – if they've had no experience, then I will try and explain to them my way of working (Lisa, Pluralistic, 5:R14)

when people first come I ask them if they've had counselling before, and they tell me about their experiences of counselling and I ask whether it's been helpful and what sort of issue they came with before... then I say about the type of therapy it is, that I'm hoping to be supportive and that the counselling is about what they want to talk about, it's client-led... that it is up to them what we do in the session and to give me feedback about what's helpful and not helpful (Debora, Humanistic-Integrative, 6:R21)

my first session is always an explanation of what I'm doing, the contract bit, make sure they understand what's going on (Robert, PCA, 8:R29)

I suppose I will lay it out at the beginning.... I suppose I get an idea from just talking to the client originally about if it's the approach that's attracted them or they just want to speak to someone, and during the contractual process I'll set out a... brief explanation of the approach -- the idea of being non-

directive, the idea of them being in the driving-seat; so that's how I tend to communicate it, and then after, at the end of the first session I'll usually just check out with them, 'Has this felt like what you're looking for? Do you think it's the right thing for you?' So it's really explaining it and then checking out if the approach fits with what they want (Peter, PCA, 9:R9)

it's pragmatic to involve the client straightaway and make joint decisions because [otherwise] you won't keep them on board, they're off (John, CBT, 12:R21)

Some participants (e.g., Paul, Lisa and John) reported that they used metacommunication regularly and throughout sessions:

it's always about ongoing metacommunication... so the client knows what I'm trying to set up and what I'm trying to maintain – it's all about so they can understand their position in it (Paul, PCA, 1:R17)

at the end of every session I'll ask them how they felt it went, if there's anything they'd like me to do differently and at the next session also again say, 'You've had a week to reflect on that... would you like to change it in any way?' (Lisa, Pluralistic, 5:R14)

every decision we make is a joint decision.... I will give my two-penny worth in and let them give their two-penny worth in, and I accept the fact that most people will go with your lead if they trust you... collaborative is... kind of fundamental, and it's not through any particular philosophical stance I've got (John, CBT, 12:R21)

Additionally, Robert and Peter reported that they brought metacommunication into 'review' sessions.

A few participants (Paul, Joanne and Robert) expressed how they felt metacommunication was empowering for clients:

it's about empowering the client. I don't want to be the one pulling the strings... so it feels really important to me to have that metacommunication (Paul, PCA, 1:R18)

[metacommunication] really helps with the power dynamics, with the equalising of the relationship... to know that it's okay to say 'I'd like to talk about this. I feel we've been focussing on that too much' or allowing them a bit of space to notice the process, their own process and how they do therapy (Joanne, PCA/SFBT, 2:R19)

it goes back to respect and individual participation – 'You're an equal partner in this exercise in how we're doing it' (Robert, PCA, 8:R29)

Similarly, Joanne expressed how she felt metacommunication was particularly suitable for young people:

I think I used to... not really explain what I was doing, but these days I think I'm much more explicit about what I'm doing and why I'm doing it... and that's very much informed, I think, by the work with young people because they don't get it... counselling is like a really weird and scary thing, and it really helps to explain what it is, what it's for, why some people think it works and why it might not be suitable for everyone -- but let's give it a go and see what happens (Joanne, PCA/SFBT, 2:R17)

An important aspect of metacommunication, which is also emphasised in Cooper and McLeod's version of pluralistic therapy (2011a), is that it is a collaborative process, seen as a central and distinctive quality of pluralistic practice. Most participants (e.g. Joanne, Lisa, Debora and Susan) also discussed the collaborative aspects of metacommunication:

it can feel quite important... with some clients to have that collaborative working... to know that they can... have a say in the process... that they can be given the opportunity to explore what's working for them and what isn't (Joanne, PCA/SFBT, 2:R19)

Joanne was aware that Cooper and McLeod's suggestions for a pluralistic practice formalise this collaborative process, and reported that she did not do this formally, but rather:

I build that in, in a slightly less structured way, but always making space for a really thorough and proper review of the work (Joanne, PCA/SFBT, 2:R30)

Susan related how she might involve a client in collaborating about the therapeutic process:

in assessment we're setting the goals of 'This is what I want to achieve' and I continue as I'm working with them to check out that they're working towards that so the client is quite involved with what's going on, or if I think we're stalling or we're getting stuck then [Joanne laughs slightly] I'm gonna bring that into the room and check it out with the client that 'My sense is we're not really moving forward here. What's your sense and what can we be doing differently? How can I help you to get over this?' So it's a two-way process (Susan, Integrative, 7:R23)

Lisa felt that the transparency of open collaboration with clients lent support to a more pluralistic as opposed to puristic practice:

I feel just as consistent as somebody that's pure person-centred or psychodynamic pure because I'm being transparent about what we're going to be doing (Lisa, Pluralistic, 5:R16)

Debora seemed less convinced and a bit more cynical about the importance of metacommunication to and for clients:

I think people just trust the counsellor and don't really question if you change to doing different types of therapy, I don't think they would question it really, and I don't think people think about 'Oh, yes, look, she's using psychodynamic technique now' or 'she's being person-centred now' – I don't think they think like that really; and after working in it for 14 years I don't think I think that much about it, I just do what I do, what I think is the best at the time (Debora, Humanistic-Integrative, 6:R24)

Expanding on this view later in the interview, Debora compared metacommunication with clients to taking a car to the garage:

we don't specifically want to know it's the starter motor gone... we don't want to know how they're doing it or what other parts they're doing or how long it's going to take even... just want it done (Debora, Humanistic-Integrative, 6:R35)

Similarly, Paul was

aware when some clients aren't interested in [metacommunication]' (Paul, PCA, 1:R18)

Christine also suggested that clients do not

care too much about what therapeutic approach I'm using [Christine laughs slightly] as long as it works for them and they find a relief (Christine, Psychodynamic, 11:R14)

On the whole these participants seemed to resonate with the idea of metacommunication and collaboration being important. These qualities can facilitate the therapeutic process within one approach, or allow movement between approaches with one therapist, or signal that a client might perhaps be better off with another therapist – either because the therapist does not want to work in ways the client wants to, or because the therapist does not feel they have the competence or skills to do so. Debora voiced a more cynical take on metacommunication, which is also shared by some therapists and researchers, and will be discussed further in this section.

'Metacommunication' as a term related to therapy can be traced back to Rennie's (1994) paper on 'clients' deference'. This research paper

suggested that often clients defer to the therapist not because they want to, but out of politeness, lack of metacommunication or ineffective metacommunication when it occurs. One implication of the paper is that more effective communication with clients, especially via metacommunication about the therapeutic process, would benefit them. The pluralistic emphasis on collaboration and metacommunication could be seen as a response to the therapeutic problems highlighted in Rennie's paper. The most central and distinctive feature of pluralistic therapy is its emphasis on 'metacommunication' that in 2012 Cooper and others renamed 'meta-therapeutic communication' (MTC) (Cooper & McLeod, 2012). This practice is foundational for the pluralistic valuing of therapist–client collaboration.

The implications of this practice, if taken up more widely, could be a devolving of power away from the 'expertise' of professional bodies, researchers and providers to clients themselves and their own unique, contextual positioning which often challenges attempts to categorise and define. In this sense, the practice of MTC holds promise not just for empowering clients, but for empowering therapists whose approaches have not been 'approved' by research; it has the potential to be 'political' as well as 'personal'.

However, there is a parallel to MTC within healthcare called 'shared decision-making'. In defining it, Coulter and Collins (2011) say that 'it involves the provision of evidence-based information about options, outcomes and uncertainties' (p. vii.). If therapists and clients are similarly constrained within a narrow evidence base, then the potential for flexibility and open choices will be decreased. Ultimately, how MTC manifests and decisions are arrived at, if operated within constraining paradigms, might offer more or less empowerment for therapists and clients.

Pluralistic theoreticians seem to be unsure as to how therapists should use evidence to influence their collaborative choices with clients. For instance, Cooper et al. (2016) assert that 'therapists should familiarise themselves with the evidence on what works in therapy: both at the intervention level and the level of different methods' (p. 50). Yet in a different chapter in the same book, McLeod and Sundet (2016) characterise pluralistic therapy 'as a form of radical eclecticism' (p. 160) which 'means...

to pick and choose without these choices being dictated or constrained by demands for logical and theoretical coherence' (p. 161). The latter approach is bounded by working with the clients' preferences, but it nevertheless seems to have less of an emphasis on evidence gained outside of actually working with a particular client. The 'evidence' is only gathered from particular experiences of particular clients from particular sessions, a so-called 'client-directed outcome-informed' therapy (e.g. Duncan & Miller, 2000). This approach to evidence and practice is more pluralistic in spirit, as it values the particular to inform the whole, rather than accepting that generalised evidence is necessarily of use to any particular individual.

Most of the participants in this research practised metacommunication with clients. For some this was only before or at a first session; others practised metacommunication throughout sessions. A few of the participants expressed support for the idea that the practice of metacommunication is empowering for clients, and one participant felt it was particularly suitable for young people, whom she experienced as potentially more fearful and suspicious of therapy. The latter view is to some extent supported by research demonstrating that young people value shared decision-making (e.g. Simmons et al., 2011; Wolpert et al., 2014). Open explanation by the therapist about 'what [therapy] is, what it's for, why some people think it works, and why it might not be suitable for everyone but let's give it a go and see what happens' (Joanne, PCA/SFBT, 2:R17) helps to allay fears about taking up therapy.

Most participants also talked about the importance of collaboration with clients, often perceived as a central aspect of pluralistic practice. In general, this supports Cooper and McLeod's emphasis on collaboration. However, Joanne talked about integrating this into her practice in a 'less structured way', which might support the general sense I felt from the interviews and from analysing the interviews, that whilst therapists seem to be quite comfortable with the general principles of pluralism, they are less comfortable with specific directions of how to apply them.

As previously discussed, only Debora was cynical about the practice of metacommunication and the emphasis on collaboration, believing that clients 'trust the counsellor' (Debora, Humanistic-Integrative, 6:R24).

Similarly, Paul was aware that some clients were not interested in metacommunication about process. Cooper et al. (2016) also discuss this variance of enthusiasm towards MTC, citing research that reflects the mixed feelings that the participants had about it (Health Foundation, 2012).

The evidence base for the value of MTC is ambiguous, with some research suggesting that the impact on outcomes is small (e.g. Duncan et al., 2010), whilst other research suggests that clients value it, and especially value receiving their 'preferred intervention' (Cooper et al., 2016, p. 45; Swift et al., 2011, p. 307).

The perceived need for MTC depends on various factors, but one factor is where practitioners position themselves on the flexibility--rigidity continuum: the more flexible a practitioner, the more approaches and techniques that practitioner might use, and therefore, arguably, the more there is a need for MTC and collaboration. In turn, how comfortable both therapists and clients are with flexibility and MTC depends on their relationship to and tolerance of uncertainty and understanding. Differences of opinion about how flexible therapists should be is one aspect in the debates about pluralism; and respect for uncertainty, as well as understanding, might be seen as one 'diplomatic attempt' to resolve this issue. The participants' views and experiences about what I have termed *the uncertainty--understanding continuum* form the basis of the next theme to be discussed.

5.4.2 The uncertainty–understanding continuum

I propose that there is an *uncertainty–understanding continuum* that exists in and between clients and therapists. How the participants discussed the continuum of uncertainty–understanding *between* clients and therapists, and in matrices of other personal and professional relationships at social and organisational levels, will be explored in this section. When it can be seen that uncertainty–understanding belongs to either the therapist or the client, I have conceptualised two important sub-themes: first, *the continuum of client uncertainty–understanding*, and secondly, *the continuum of therapist uncertainty–understanding*.

Half the participants (Paul, Nicola, Debora, Susan, Robert and Peter) reported varying degrees of professional uncertainty about their practice in particular, and about therapy in general. The most uncertainty was likely to be experienced before or during training:

I didn't really know what therapy was, I suppose. Although I'd been a client I didn't really have much of a sense of what being a therapist entailed (Paul, PCA, 1:R2)

when I started, my certificate was person-centred, I didn't know that, I just signed up for a certificate in counselling; at the time I had no idea what modalities were (Susan, Integrative, 7:R4)

I had a supervisor and some of the papers I submitted and he came out and he says 'Are you a Rogerian aren't you?'... I didn't know what Rogerian meant at the time (Robert, PCA, 8:R4)

Even after training there can still be a lot of uncertainty about what to do or how to be a therapist:

I feel like when I came away from my original training I literally didn't have a clue what to do. I felt like I got my diploma, you know I'd done my placement and I'd passed all the assignments and I had this qualification, and I felt like all I needed to do was pick up all the books I'd started out with and read them and try to work out what the hell I was supposed to be doing, because in a way I don't necessarily feel like the training told me what to do in a room with a client. You know, it told me about theory, it taught me about philosophy, it taught me about ethics, and we were assessed in how to use skills, but I didn't necessarily feel like I knew how to be a counsellor (Paul, PCA, 1:R8)

Nicola, who was only one year post-qualification, echoed this kind of confusion in the novice:

you see... I'm still quite new and counselling obviously is experiential but... theory is also important so I know certain things that I don't like but I'm not too sure what I do like (Nicola, Humanistic, 3:R13)

Other more experienced practitioners also expressed uncertainty about theoretical approaches:

about two or three years ago [I] did my senior accreditation and I had to name my modality and then do a case study showing how that backed up how I say I work, and that shocked me because I wrote the 'This is how I work' first and then did the case study, and actually then had to re-write how I work [Susan

laughs] *because I understood that actually I'm far more Gestalt at my core than I realised I was – I thought I knew how I worked, but actually when I was doing the case study it proved that... actually maybe you're not working that way... so... that was a bit of a shock to me (Susan, Integrative, 7:R7)*

Peter, in explaining his practice in adhering quite strictly to one approach, said that it was because he does not 'have enough knowledge' to 'feel comfortable practising... any other way' (Peter, PCA, 9:R26). Earlier in the interview he also expressed how

my understanding [of the PCA] when I'd first qualified wasn't very good at all, even though it was the focus in our training;

and

the more I've... taught myself and read about it, the more I felt I've had an understanding and the more able I am to stay with that core and for it to feel enough (Peter, PCA, 9:R6)

Peter is implying that increased understanding of this approach leads to an acceptance of the approach as enough in itself, as well as merely not having enough knowledge of other approaches to practise them. This also relates to his view that the PCA, properly understood, precludes the use of other approaches as discussed in section 5.2.2. This participant illustrates the possibility that there is a parallel link between certainty/rigidity and uncertainty/flexibility.

In contrast, Robert, who also identified as 'person-centred', interpreted the PCA as being rooted in uncertainty:

to actually be able to respect that [uncertainty] as your starting-point which I think is the Rogerian principle, isn't it? (Robert, PCA, 8:R23)

However, this uncertainty, one potential cause of his non-purist approach, did lead to some doubts about his practice:

if I were to go back into training now I'd probably be very critical of what I'm doing because it's not purist... I'd think all the time that maybe 'Where are you on that?' and maybe that's something... if I was staying on [in practice] I think I probably would actually go back and actually do some critical examination of what I'm doing (Robert, PCA, 8:R15)

According to many of the participants, clients are also likely to bring uncertainty and 'not knowing' to therapeutic encounters:

sometimes clients don't know what they want to get... anything you say about how you're going to do it I can see sometimes just washes over people because they're just glad to have a therapist and they think it's going to help (Paul, PCA, 1:R26)

I sometimes do talk about being based in the person-centred approach, but not always. That's interesting. I wonder why that is? I think some people want to know, and some people – it doesn't make any difference to them (Joanne, PCA/SFBT, 2:R18)

there's a huge amount of trust that clients come in, in the unknown unknown, with the hope that something will help them. A lot of the people that come certainly have no idea what they're coming to at all. You're going to tell them what to do or let their GP know that they need to be on medication (Lisa, Pluralistic, 5:R20)

I don't know how much [clients] understand therapy per se... most clients come to me in a state of crisis of some sort and they just wanna feel better and I guess they just trust that I can help them get to feeling better... so I don't know that they've got an awful lot of understanding about the process at all (Susan, Integrative, 7:R19)

my experience is that 95 per cent of clients don't have a real, true grasp of maybe what is being offered at the start, right from the beginning. It certainly improves as the work goes on but I think generally, yeah, there's a real misunderstanding of what's happening... I think the understanding is very small (Peter, PCA, 9:R25)

Most – almost all clients or patients or whatever – people you see will have no idea of the difference between a psychologist, a psychotherapist, a psychiatrist, counsellor, they have no ideas [sic]... (John, CBT, 12:R20)

In the view of these therapists, what brings some clients to therapy is not a diagnosis per se, and what they want is not so much a 'treatment', or any particular therapeutic approach, but more 'somebody else's input' (Susan, Integrative, 7:R20). This experience and view of therapy and clients by therapists directly challenges the dominance of the medical model, and the related understanding of different types of therapy as different types of treatment. It suggests that a symptom–treatment–cure reductionist model of therapy misinterprets what at least some clients want from therapy, and what at least some therapists want to provide. These clients and therapists are excluded from the real consequences of research (what is provided and to

whom) which defines the purpose of therapy in narrow and medicalised terms. More fully expressed, this is how Susan related her view of how some of her clients understood therapy:

they need help... they've got a dilemma or a crisis... sometimes it's not that dramatic, sometimes it's somebody who's really depressed and they just don't wanna feel like this anymore... they get to a point where their own resources in trying to solve it are not working anymore and they want somebody else's input – that's how I experience those clients – is they've just got to that tipping-point of 'This is just not working out for me anymore by myself, I need somebody else's input' (Susan, Integrative, 7:R20)

A general view of some participants was that how much clients understand therapy depends on the client (Paul, Joanne, Amanda and Robert). They described their experiences of working with a wide spectrum of clients, some with hardly any understanding of therapy, and some with quite sophisticated understanding:

some clients turn up and they're quite well trained – they've had therapy before or they've done loads of work on themselves or something, so they're in a place where they can get it; and other clients... come and they're full of vulnerability and full of pain and they just want therapy and they don't really know what it is; and I think the thing about how well clients understand therapy is significant as well because they may understand the different models. They may understand their needs in the way different models fit their needs, so there's different levels to it. Some clients turn up and they'll sit down and although they're just a client... they've not done any therapy training – they've not done anything to indoctrinate them into all the schools and things – they'll sit there and say, 'I've looked at your website, I've done some reading. Actually what I want is the person-centred relationship you're offering because it sounds like it's what I need'. Some of them will come and they'll be quite prepared, and others will just come and bleed everywhere and just want some therapy (Paul, PCA, 1:R31)

Some clients come with a really high level of emotional awareness and functioning, and some clients really don't, so on two extremes, like a client who is a therapist and who's been practising for many years and is very au fait with the whole process, or a 14 year old client with learning difficulties who's experienced severe childhood trauma – those two clients are going to have completely different ideas about what therapy is and what it's for, and so therefore the therapy... might look quite different (Joanne, PCA/SFBT, 2:R27)

I'll work with a working-class electrician who doesn't want that information in his head so I keep it very concrete and I'll talk in very experiential, phenomenological, visible ways; but if I'm working with somebody who's been a counsellor for ten years I can talk at a much more nuanced level in a transpersonal way (Amanda, TA, 4:R35)

some will come with previous knowledge about therapy so they have some understanding, some others not a clue – just they've maybe thought it was a good thing or somebody's recommended that maybe it would be a good thing (Robert, PCA, 8:R35)

Joanne pointed out that her particular client group, young people, was unlikely to understand therapy:

they don't get it – really, a lot of teenagers – counselling is like a really weird and scary thing (Joanne, PCA/SFBT, 2:R17)

This lack of understanding also relates to her valuing of metacommunication as discussed in section 5.4.1.

Peter related lack of client understanding with outcomes and access to therapies:

I think [lack of client understanding of therapy] must have a huge impact on the outcomes... of therapy and what people can access (Peter, PCA, 9:R25)

The implication of that statement seems to be that if clients are randomly allocated to particular therapeutic approaches – which effectively, outside the private sector, they are – then this lack of understanding is bound to skew outcomes. Similarly, if clients do not understand what therapies are available, or even have no idea that there are different therapies other than the ones they are offered, then other therapies are less likely to be provided.

Peter further suggested that the PCA approach is

something that almost needs to be experienced (Peter, PCA, 9:R9)

In that sense Peter's view was:

that's the best type of understanding so the majority of people after one session, they have a kind of idea of how the process works, and then they can decide from there (ibid.)

Nicola suggested that clients could be more informed about therapy:

I think we could do a lot more there to help clients understand exactly what therapy is – how to empower the clients to be able

to use therapies... understand the therapeutic process, and how to process outside the therapy room... we could help clients a lot more [to] understand how to use therapy effectively (Nicola, Humanistic, 3:R32)

Conversely, Debora thought that

[clients] don't want a long-winded explanation, I don't think; they just want to know the basics and what's gonna happen to them in the therapy (Debora, Humanistic-Integrative, 6:R16)

In this context, Debora felt that pluralism, with its agenda of wanting clients to be informed about therapy and therefore therapeutic choice, was problematic:

you're bombarding them with a bit much information, going, 'Well, I work – I do a bit of CBT, I'm doing person-centred and a bit of psychodynamic and brief solution-focussed', and it just sounds – they don't want that sort of explanation (Debora, Humanistic-Integrative, 6:R16)

It was interesting that Debora sometimes conflated pluralistic approaches to therapy with 'counselling', as opposed to 'CBT' or 'psychotherapy'. Her implicit view in our dialogue was that counsellors were 'pluralistic' so, for her, the problem for pluralism of explaining therapies was also a problem for counselling:

but then what do we say 'We're doing counselling and we're using... these skills to' – Mm (ibid.)

There are many practitioners who support the idea that therapeutic practice needs to accept 'ambiguity, not knowing, the intuitive and the mysterious' (House, 2016, p. 149). Yet the 'literature suggests that trainees have a need for certainty in the early stages of a career in order to reduce anxiety as the therapist moves from training towards professional individuation and expertise' (Thompson & Cooper, 2012, p. 65). Thompson and Cooper further add that by following a pluralistic approach 'there is less certainty about the way that one should work with a client; instead there must be an acceptance of the underlying philosophical values of pluralism and a commitment to working without certainty' (ibid.).

Many of my participants reflected this understanding of therapists. Some talked about how staying close to a particular model allayed fears around practice, uncertainty during training or the early post-qualification

period, but others talked about uncertainty manifesting in various ways, even when quite experienced.

However, in Cooper and McLeod's pluralistic therapy, their tolerance of uncertainty seems to be diluted with an undue emphasis on suggested protocols and the encouragement of routine monitoring of sessions by therapists. It is almost as if the very uncertainty, which from a pluralistic perspective is welcome, is only acceptable if therapists and clients keep a keen eye on it, as if it is in some way inherently dangerous.

Cooper and his colleagues are heavily invested in proving efficacy of therapeutic processes and outcomes. A sentiment such as Samuels's which 'proposes the psychotherapist as the archetypal trickster, who has no coherent psychological project, but may end up doing good by accident' (Proctor, 2016) and which, from a pluralistic perspective, is a view worthy of consideration, is quite far from the paradigm of research and practice that Cooper's pluralistic therapy encourages. The spirit of pragmatism and rationalism – there is little doubt of his good intentions in ensuring the provision of therapy for as many people as possible – supersedes the possibility of tolerating therapy as a socially constructed activity that cannot be reduced from idiosyncratic encounters between human beings, and which is inherently uncertain and unpredictable – almost the quintessence of what science cannot capture, the multitudinous variables of a human relationship.

The tolerance of uncertainty is a feature of psychodynamic therapy that has been compared to John Keats's "negative capability", the capacity to be "in Mysteries, uncertainties and doubts, without any irritable reaching after facts and reason" (Spurling, 2016, p. 126). Spurling suggests that trying 'to understand what [is] happening in therapy' (ibid.) stops therapists from listening to their clients. A similar sentiment was expressed by Nicola when she said she realised that having 'ideas' in a session meant that she was not listening as closely to her clients as she might (Nicola, *Humanistic*, 3:R41). The importance of embracing uncertainty from a psychodynamic point of view is emphasised by Spurling (2016) using a quotation from Bion (1970): '[t]he capacity to forget, the ability to eschew desire and understanding, must be regarded as essential discipline for the psychoanalyst' (pp. 51–52). This specific quotation was referred to by Christine

(11:R20) as a rationale for her non-directivity in allowing clients 'their space' and the privileging of 'whatever they have on their minds' (11:R20). Conscious uncertainty on the part of the therapist, or as a basis for a theoretical approach, implies privileging the client as knowing more about themselves than the therapist. This parallels pluralistic acceptance of uncertainty in therapeutic practice.

The majority of the participants accepted uncertainty as a part of practice. This is not reflected in how therapy is conceived of by providers such as the NHS, who subscribe to an 'audit-driven, calculation-obsessed worldview' (House, 2016, p. 149). House states that 'one of the first casualties of this ideology will be any approach to therapy that sees as central the embracing of ambiguity and dialectical thinking in its practice, and which does not conform to any linear, predictable and controllable process or monolithic logic' (ibid.).

All the participants in this research arguably reflect a way of making sense of practice that seems outside of how the most influential research (in terms of research that informs policies) makes sense of practice. If, as previously mentioned, a therapist's development is one of individuation (e.g. Thompson & Cooper, 2012) then one might expect that the more experienced therapists become, the less standardised they become. Therefore the standardisation of therapy within services becomes a constraint that inhibits how therapists can practise and how therapy can be provided for clients. This is powered by an agenda that has permeated the culture, one seeking to monitor and predict certainty about professional practices. The way my participants answered questions about how they practise illustrates some of the difficulties of conceptualising practice as an easily monitored and predictable activity.

Both therapists and clients have difficulties in understanding therapy as being mostly about different approaches/techniques. The jury still appears to be out on whether transparency about different techniques/approaches is that helpful for clients, or even that relevant to practitioners. In a different vein, some practitioners and researchers call for an understanding of therapy that does not seek to understand what differentiates therapists and therapies from each other but, rather, what

common factors lead to different therapists and therapies being effective. This view of therapy suggests that an ideal therapeutic world might be one in which therapy evolves to become one practice informed by the effective common factors of all therapies. This might be imagined as a potential diplomatic resolution to the debates about pluralism and therapy; or, perhaps, an unnecessary homogenisation of creative differences. The next section focusses on participants' views and understandings of 'common factors'.

5.4.3 Common factors

As well as *recognising common factors*, some participants (Nicola, Amanda, Lisa, Debora and Robert) spoke about different therapies often having *different names for the same thing*. This is an important sub-theme that points towards a significant question with regard to the purism--pluralism continuum and debate: Are different approaches to therapy really *that* different, or are they just socially constructed to be different in order to stake out political/economic territories?

Paul understood different therapeutic perspectives as being like different languages. He imagined a client wanting to engage with him using a 'psychodynamic' perspective/language:

if a client... want[s] to talk about their experience from a more psychodynamic perspective, then we'll talk more about that stuff in that language; then if I don't have that language or that access to it then that's not for us (Paul, PCA, 1:R43)

On this view, the issue is not so much about the client or the therapist, but the language they use to symbolise their perspectives on reality in their interaction (in their *symbolic interaction*). This contrasts with the experience of adhering to a particular approach to therapy because of a deep connection to personal values, and suggests instead that different therapies operate much like different languages that can be pragmatically *used*, much like a human being can speak a language whilst not necessarily having any deep connection to the culture that produced it. Similarly, Amanda saw her approach as forming a linguistic way of understanding:

when I do my self-supervision I always put it back into Transactional Analysis because that's... how it makes sense to me (Amanda, TA, 4:R11)

If different therapies are experienced as being more like different languages, rather than truly inhabiting any significantly different processual realities, then it follows that some therapists will view what some practitioners defend as being different phenomena as actually being only different word/name symbolisations for the same phenomena:

to me it seems like they've all got different names for the same thing. If we all looked at it honestly I think a lot of these words are interchangeable because they're describing the same thing but coming from, I suppose, from a different point of view (Nicola, Humanistic, 3:R16)

Maria Gilbert says that TA was the original narrative therapy, that White and Epstein with their concept of narrative therapy is all very well and good but what is script but narrative therapy?... Bradshaw's pinched TA's concept of Child ego state, called it 'inner child' (Amanda, TA, 4:R5)

the Charlotte Sills–Helena Hargarden model... looking at object relations but it was always there in Transactional Analysis, you didn't have to do more than choose, in the Gestalt sense, to make it ground and figure, it's... where you put your attention (Amanda, TA, 4:R10)

when I've been on CBT training courses with the CBT therapists in the NHS... and the trainer said to me 'Oh, have you done...' – oh, what did she call it? – '...empathy training?'; and I went 'Oo, no', and she said 'It's like where you put yourself in the other person's shoes'. I went, 'Oh yeah, we do that all the time in counselling!' [Debora laughs]... they give everything a label! Whereas counsellors – we tend to go, 'Well, we do counselling' but we haven't labelled all these... things that we do... there's loads of things that they do that we do, but they've labelled them and said, 'We've done training in empathy!' (Debora, Humanistic-Integrative, 6:R18)

Debora's story illustrates the power of language, and having 'names' for things that can be identified and measured. As mentioned in section 5.4 it can be argued that Cooper and McLeod's version of pluralistic therapy is an attempt to build a vocabulary more than an approach, to enable the concepts, embedded in the vocabulary, to be valid enough to undergo 'scientific' testing.

In terms of *recognising common factors*, some participants spoke specifically about the importance of the 'core conditions':

I'd wanted to train; I phoned a couple of counsellors to ask for some advice about training and one of them said... 'Whatever

you do I'd say do your first-level training in person-centred stuff because the core conditions are at the heart of most therapies, so you do that then you can build on it' (Paul, PCA, 1:R1)

as long as you've got the core conditions, as long as you're empathic and the positive regard and all those core things, I think as long as you've got those conditions in place then, yeah, as long as you're giving your client that (Susan, Integrative, 7:R36)

Other participants (Debora, Susan, Robert and Peter) talked about various qualities of a more generic, descriptive nature that they felt were important for therapeutic encounters with clients. For instance, Debora, in discussing working with a particular client group ('people with substance misuse issues'), said that she thought it was important 'just to be really friendly and build up their trust' (Debora, Humanistic-Integrative, 6:R3). Her view was that the PCA 'builds up quick trust and people feel very supported by that' (Debora, Humanistic-Integrative, 6:R24); but it is significant that, in this context, she would use the approach not from any inherent philosophical position, but rather to foster a generic quality in the client–therapist relationship. Robert similarly valued the quality of trust, but he was unsure whether that trust was 'in the method or me as an individual' (Robert, PCA, 8:R35). Nevertheless, for him, the quality of trust, between therapist and client, is what directs the therapy:

[for] the client to be able to say 'I'm gonna trust this person to not be dishonest with me, to be honest with me in what we're doing' and that honesty is the way that we actually work (Robert, PCA, 8:R69)

When asked what she thought made her therapeutic practice effective, Debora replied:

Being able to get on with people really, most people – not all people by any stretch – find me okay to be with, they feel comfortable, they open up pretty quickly, I'd say (Debora, Humanistic-Integrative, 6:R28)

This simple 'getting on with people' is not something that belongs to any particular approach. Another quality that she thought was important, referred to in section 5.2.3, was 'confidence'.

Robert also emphasised the central aspects of his practice as 'listening and reflecting', and 'respect' for the 'individual' (Robert, PCA,

8:R52, R57, R66), also referred to in section 5.2.3. Regarding the latter, his view was:

'whatever works' is important for the client, if you hold to the belief that you respect that individual for the courage of coming in to look at this stuff, I think that has to be a starting-point and whatever you bring into play, whatever developments take place over time if it works and it's to the benefit of the client, let's give it a shot (Robert, PCA, 8:R57)

In that sense, what might be viewed as a person-centred position of 'listening and reflecting', combined with respect for the individual, leads to a position which wants to include anything and everything that might be effective.

Peter argued that clients who liked the PCA valued its non-directivity as a 'real relief to just go wherever you want' (Peter, PCA, 9:R23).

Other generic terms that the participants used to describe their practice included: 'goal-focussed' (Debra, Humanistic-Integrative, 6:R6); 'relational' and 'here-and-now' (Susan, Integrative, 7:R25).

The participants' discussion of their practice in the interviews suggests that, for some, their practices have affinities to a 'common-factors' view of therapy. Practising in this way is less about adhering to an approach, and more about trying to create generic qualities of practice that might apply to any approach. The responses of these therapists to issues around pluralism suggest that many therapists do think and practise in ways that support the 'common-factors' agenda, even if they are not aware that is the case. It seems as if therapists are more integrative in practice than their identifying approach-labels would suggest.

Norcross and Salzman (1990) recognise '*common-factor approaches*' as one of a few attempts contributing towards 'the contemporary movement to integrate the psychotherapies' (p. 3; italics in original). Most of the participants spoke about their sense of therapy having these common factors and this providing some support for a pluralistic approach to therapy. There does seem to be some confusion about similarities and differences between integrative and pluralistic approaches, both in the participants and, I would argue, from researchers and theoreticians themselves. In the literature, Cooper and McLeod (e.g. 2011a) have attempted to differentiate

pluralistic approaches to therapy, and have more recently referred to their framework as being a 'meta-model of therapy integration' (McLeod & Sundet, 2016, p. 160). However, more generally, there does seem to be a fudging of the distinction between pluralism and integration, which avoids real and profound philosophical and political differences between integrationism and pluralism.

Referring to McLennan (1995), the boundary of pluralism might be considered to be integration: pluralism celebrates difference and wants to retain diversity, whereas integration wishes to homogenise multiplicity into unity. It could be argued that the ideal of the integrationists, particularly the 'common-factors' integrationists, is to create a therapy that is called one thing, whether that be 'counselling', 'therapy', 'psychotherapy' or 'psychological therapy', and within that one thing practitioners would use the common factors of many therapies that, perhaps, have all in some way been based in 'evidence'. A pluralistic attitude would defend the separate identities of different therapies as holistic, irreducible processes in which the need to identify and 'prove' the efficiency of sub-processual elements is possible but unnecessary.

It is unclear from the literature whether Cooper and McLeod support a more integrationist perspective. If they do they could be seen to have abandoned the deeper philosophical basis of their pragmatic pluralistic project and, indeed, are proposing nothing more than integrationism with new terminologies.

This idea of 'different names for the same thing' was an important sub-theme within the 'common-factors' theme. Around half of the participants spoke about different therapies having different names for the same thing, and expressed a cynical view of the repackaging of therapies for political and economic purposes. Cooper and McLeod's pluralistic therapy itself illustrates this tendency within therapy to keep on 'reinventing the wheel', as John described it.

Two participants saw different therapies as akin to different languages. Different languages all attempt to communicate about the same or similar things. In that sense, one language is not better than another, but

therapists and clients engage best when they are 'speaking the same language'.

The idea of different therapies being like different languages has also been recognised in the literature, most notably in Miller, Duncan and Hubble's *Escape from Babel* which sought to create a 'unifying language for psychotherapy practice' (Miller et al., 1997). The authors illustrate how therapeutic orientations sometimes struggle to distinguish themselves from each other yet still insist on doing so for political and economic reasons. However, the authors claim that 'words are practically all that separates the models from each other' (p. 11).

More recently, Goodman (2016) also suggests that different therapeutic orientations are 'actually different languages that human beings have for understanding their suffering, meaning, identity, and healing' (p. 80). He warns that the limited availability of different types of therapy, particularly for those on lower incomes, could lead to "therapy deserts" comparable to "food deserts" (p. 86), in which individuals can only access '*processed psychotherapies*' (italics in original) which only have '[miniscule] language variations' (ibid.). He suggests that this has arisen because of the 'McDonaldization of Society' (e.g. Ritzer, 2015) in which the values of '*predictability, control, calculability, and efficiency*' (Goodman, 2016, p. 89; italics in original) uncritically dominate decision-making.

Overall, the common-factors perspective offers a hopeful ground in which pluralistic therapy might flourish. Research evidence supports the notion that what makes therapy effective is not particular approaches but common factors (e.g. Wampold & Imel, 2015). A practice based on the application and acknowledgment of common factors offers a 'non-denominational' route for those who do not want to identify with particular approaches, but rather want to engage with effective therapeutic practices from various approaches.

If common-factors research were to be more fully acknowledged and respected, the rationale for comparing the effectiveness of approaches against each other would soon collapse (ibid.). Research would have to focus on more relevant factors of therapeutic effectiveness, such as the processual elements of clients, therapists and their relationships.

However, the medical model insists on the idea of ‘treatments’ that have an effect beyond ‘placebo’, and many therapy researchers comply with this imposition of a medical model on what is, arguably, not a treatment but a dialogue based on rhetoric (e.g. Szasz, 1988). Research into therapy process has actually decreased, probably because, although more useful for therapists and clients, the culture of ESTs has no need for it (e.g. Wampold & Imel, 2015). Therapists and the bodies that represent them need to push for non-medicalised ways of researching therapy in order to reflect the views and experiences of therapists, such as the participants of this research, who assume the importance of common factors, even if they are not aware of this term that names their professional knowledge. However, this does not mean that the recognition of common factors needs to lead to generic forms of therapy, subservient to ‘evidence-based’ approaches or even evidence-based micro-processual ‘interventions’. The recognition of common factors that simultaneously allows for a multiplicity of approaches to flourish would more accurately reflect a pluralistic position.

The potential for common factors to influence policy and provision is under threat as there are moves to suggest that practitioners who choose not to use empirically validated treatments are practising unethically (e.g. Bryceland & Stam, 2018; Goodman, 2016). Historical and contemporary understandings by my participants and by therapists more generally, of therapy as more rooted in similarities than differences, need to be protected and promoted.

5.5 Conclusions

In this chapter I have described, interpreted and discussed the interview data with twelve therapists, about their practices and how they make sense of those practices in relation to pluralism, therapy in general, and pluralistic therapy in particular.

I identified seven themes which the participants discussed in relation to their own experience and knowledge of therapy. The central theme concerned ‘debates about pluralistic approaches to therapy’. In this context,

the theoretical and practical manifestations of such approaches might be seen as an attempted diplomatic means towards 'peace'. Three themes focussed on contentious issues suggested as causes of the debates about pluralistic approaches to therapy – namely, 'identity and approach', 'flexibility–rigidity' and differences of opinion about the importance of 'the relationship'. Three themes focussed on potential ways to resolve issues around the difficulties of having multiple therapeutic approaches, which I have characterised as 'diplomatic attempts at resolution', including the 'practice of metacommunication', specifically associated with Cooper and McLeod's version of pluralistic practice; the tolerance of 'uncertainty' as well as aiming for 'understanding'; and the recognition of 'common factors' at play in all approaches.

The impetus for doing this research came from a sense that pluralism encapsulated values that I felt were missing from the therapy 'subculture' as I have experienced it. From the beginning of my training, when I began to meet other practitioners in a pre-professional way, and since qualification over 20 years ago, I have witnessed the manifestation of 'therapy wars' in my social and professional interactions (personal and intellectual), especially as they relate to approach, but also political struggles around titles, professionalisation and regulation. Over the years I have been uncomfortable with practitioners whom I perceived as feeling superior to others because they have trained in particular approaches or they have assumed particular titles after training (e.g. 'psychotherapists' often feeling more qualified than 'counsellors', even if the 'counsellors' have decades of experience and additional trainings). I have felt especially uncomfortable with practitioners who seem to 'believe' in particular therapies in what seemed to me to be a 'religious' way. As someone who values non-religious ways of exploring and finding personal and ethical meanings -- without any need for pre-ordained tenets – the 'schoolism' of therapy seems to reflect the intolerance of diversity that is also a central cause of troubles in other contexts. Christine also viewed orthodox approaches to therapy as reflecting a wider, cultural resistance to intolerance of diversity.

Simultaneously, I despaired at the gradual marginalisation of humanistic, psychodynamic and other therapeutic approaches in the NHS

and elsewhere. Admittedly, this would have been from a personally and professionally interested position, in that I saw that my particular trainings were less favoured, so I had potentially less 'career opportunities' than, say, my CBT-trained colleagues. However, it was also out of concern for clients. My own therapy, over many years and before I even considered training, had been of a more relational and humanistic kind, and it appeared to me unfair that others might not be offered this kind of therapy 'free at the point of delivery' (NHS, 2016). To add to my despair it seemed these developments were based on evidence that did not seem to resonate with my own experience, both as a client and a therapist.

So when I came across Cooper and McLeod's vision for a pluralistic therapy it seemed to resonate with my own personal sense of therapy as it is and as it might be, and I was glad that this vision was being articulated by two central and influential figures within the therapy profession. As discussed previously, the publication of *Pluralistic Counselling and Psychotherapy* (Cooper & McLeod, 2011a) provoked a lot of debates within the profession. These events also coincided with the beginning of my studies for a Ph.D., and this topic inspired me as sufficiently important and interesting to be the focus of my attention in subsequent years.

Pluralism, as a philosophy and a perspective, and pluralistic therapy, as that philosophy and perspective might be applied in therapeutic practice is, however, complex and problematic. My understanding of the literature was that it did differentiate itself sufficiently from integrationism and eclecticism. Yet in conversation with other therapists, most did not seem to recognise a difference, and there was usually confusion about what pluralism and pluralistic therapy actually meant. It is an idea and a practice that is difficult to understand. Therefore the confusion and lack of clarity about pluralism, and what it has to offer therapy and therapists, seemed to be a topic worth exploring with therapists, since if the pluralistic agenda is to gain influence within the profession, therapists themselves have to be able to make sense of it, be convinced of its utility and integrity, and be willing to push for its acceptance in the contexts in which they work.

In the course of this research I have found that pluralism and therapy have become more problematic for me. Overall, I still feel quite aligned with

the 'gist' of the position that voices associated with pluralistic therapy are articulating. However, in terms of theory, research and implications for practice/practitioners, the literature that has been produced in support of pluralism has the potential to solve some problems, but also has the potential to create others along the way. I have referred to these problems, such as the tendency to conform to, rather than challenge, the disputable hegemony of favoured research methodologies.

I hold contradictory biases about pluralism and therapy; on one hand I understand the deeper and conscientious motives behind the call for pluralism, and on the other I understand more cynical views of it as a pragmatic, political move with quite shallow ambitions of getting different therapies back into mainstream delivery. I trust that being able to hold these contradictory biases has led to a research study that has been able to step back and make sense of the phenomenon of pluralism within the context of therapy, with reference to socio-historical aspects, the extant literature, and the participants' views and experiences about the subject in relation to professional discourses about it and their own individual practices.

This research is a useful and significant addition to the literature, as it explores how therapists who are not already aligned with a pluralistic perspective make sense of pluralism. There have been a few qualitative studies that focus on therapists' experiences of pluralism, and those are significantly extended by this research. The participants were on the whole supportive of pluralism, yet there were some difficulties with pluralistic therapy as a practice rather than a perspective. This issue has not been articulated as clearly in previous research although Scott and Hanley (2012) touched upon this issue in their research paper.

Overall, this research has provided an in-depth exploration of how therapists make sense of pluralistic approaches to therapy, which will be useful in understanding some of the difficulties and obstacles that face the agenda of pluralists in the therapy profession. Perhaps the research tried to cover too much, in the sense of trying to include both the therapist's own practice in relation to pluralism and pluralism as a perspective. Future research might find it beneficial to separate out those two strands for increased clarity about those two levels. In this vein, perhaps further

research might ask therapists themselves how they would like pluralism to be articulated for the benefit of the profession. Currently, it seems as if it is 'owned' by relatively few practitioners; it would benefit the pluralistic agenda if practitioners as a whole felt more of a sense of belonging to the project.

The actors supporting pluralistic therapy (theory, practice and research) unfortunately seem to exemplify the problematic gap between researchers and practitioners, reflected by most of the participants whose actual practices reflect pluralistic principles but who are not part of the conversations about research into – and provision of – therapy. Quantitative research with a large, generalisable sample might further clarify how much support (or not) pluralistic therapy has within the profession as a whole. If there is any respect for 'professional knowledge' (e.g. McLeod, 2016), then this could encourage the acceptance of different ways of evaluating therapeutic approaches and practices than existing infrastructures allow. This could positively benefit influences on how therapy is provided.

It is also noticeable that there were only two psychodynamic practitioners and one CBT practitioner in this research. In the interviews with these practitioners they did not seem to vary substantially in their understanding of, and general support for, a pluralistic perspective and, indeed, practice. This was perhaps a surprising result, as in an informal conversation with a psychodynamic practitioner it was suggested to me that non-humanistic practitioners might be less sympathetic to pluralistic ideas. This sense of psychodynamic practitioners being suspicious of pluralism has some support in the literature (e.g. Milton, 2001; Spurling, 2016). However, this suspicion in the psychodynamic community could not be said to be universal, and how widespread it is remains an open question, perhaps one worthy of further research.

There is also the complication of potential differences between how therapists say they practise and how they actually do practise. In the psychodynamic field recent research has demonstrated that '[psychodynamic therapists]' practice is more pluralistic than they think it is' (Spurling, 2016, p. 124). This is supported, to some extent, by my own research, because the descriptions of practice by most of the participants were pluralistic to greater and lesser degrees, even though most of the

practitioners identified themselves as following a single model, and only one participant identified as pluralistic. This led me to suggest that pluralism is perhaps not so much a separate approach but a dimension that runs through all therapies and therapists. This dimension is sometimes absent, sometimes present, sometimes overt, sometimes covert, sometimes consciously applied or integrated into an individual's practice in a way that the practitioner feels no need to name it as such; an automatic, learned-from-experience approach which some of the participants talked about as not that special, just how they work with the client who 'comes in'. They bring everything they have to work with the client and that will inevitably be pluralistic because they have learnt from a diverse array of sources.

In Bakhtinian terms, I recognise the unfinalisability of the dialogues around pluralism and therapy (e.g. Bakhtin, 1973). Ultimately, this research is one more 'utterance' in ongoing dialogues between practitioners, researchers and providers that will add useful knowledge in how to make therapeutic decisions at individual, dyadic, group and organisational levels.

In the following Conclusions chapter I will summarise the main implications of points raised in this chapter in relation to the previous chapters, and to this research, both as a disparate project and in relation to previous literature and research.

6: Conclusions

6.1 Outline of the Chapter

In section 6.2 I restate the aim of the research and summarise the findings, with particular reference to the importance of the identified themes and the issues raised by pluralism for therapy. The existing literature and the sociohistorical context in relation to these issues is also emphasised in this section and throughout.

In section 6.3 I contextualise the issues raised by the research in relation to regulation, professionalisation and the difficult relationship that sometimes exists between therapists and a pervasive, dominating 'audit culture'.

In section 6.4 I re-emphasise the difference between modern and postmodern sensibilities and argue that therapists often practise from a postmodern perspective whether they would articulate it as that or not. The postmodern perspective is sympathetic to uncertainty and flexibility, and finds itself at odds with cultures insisting on certainty and rigidity. Pluralistic therapy is explicitly postmodern in its outlook so it will inevitably struggle to explain and prove itself within modern paradigms.

In section 6.5 I offer some concluding thoughts about the research methodology, and how further research about pluralistic therapy might benefit from similar qualitative approaches.

In section 6.6 I outline some limitations of this research and suggest further research based on them. I also suggest further research that might be undertaken around issues and questions that have been raised.

In section 6.7 I explore the impact of the research on me both personally and professionally.

Although reasons for this research to be viewed as an original contribution to knowledge are articulated throughout this chapter, in section 6.8 I summarise them in a final statement.

6.2 Aim of the Research, Findings, and Implications

The aim of this research was to explore how therapists make sense of pluralistic approaches to therapy and how therapists think and feel in relation to their perceptions and experiences of pluralism.

There has been a drive in the provision of therapy to privilege therapies that have an evidence base and the therapists that provide them. As a consequence many therapies and therapists have been marginalised by large-scale providers such as the NHS. Cooper and McLeod's articulation of 'pluralistic therapy' can be seen as a research-friendly framework which might act as a basis for reintroducing these marginalised therapies back into mainstream provision. The rationale for their approach was that different clients need different approaches at different times, and the best way to determine what and when was by open collaboration with the client. Their proposals for research and practice, however, were not welcomed by all therapists and became the focus for heated debates in the profession. In my research, in-depth interviews with twelve therapists provided rich data that built upon and added to the existing literature by exploring with them how pluralistic perspectives and practices related to them personally and in terms of their therapeutic practice. The sociohistorical development of the therapeutic professions also sheds light on why pluralistic therapy became prominent in the mid-2000s, particularly in the UK, as discussed in the Sociohistorical Context chapter.

Whether the call for having a more pluralistic attitude to the provision and practice of therapy is heeded or not is of the utmost importance. If it is not heeded it seems likely that the amount of choice for clients will continue to be severely limited by current policies in the NHS, via what NICE recommends and the delivery of the IAPT programme. Some bodies, such as MIND and the BACP, are drawing attention to this lack of choice for clients, but the hope for a more pluralistic provision of therapy will be slight without the support of therapists themselves. My research illustrates – in more depth and breadth than previous research – how therapists resonate and do not resonate with the implications of pluralism for therapy, and

thereby allows for a deeper understanding of where arguments are yet to be won and where theoretical and practical obstacles still exist.

Some might suggest that it is only right that 'old' therapies and 'old' therapists are being marginalised, and regarded as unimportant and ineffective. But if the 'direction of travel' privileging some therapies over others is misguided then it is clients themselves who might suffer unnecessarily. The 'languages' of the old therapies cannot or will not be understood by the present gatekeepers of provision (e.g. Goodman, 2016). Marginalised therapies have found themselves like foreign language-speakers unable to speak the language of medicalised and evidence-based discourses. They have other words and different meanings, some of which are almost beyond translation. The imbalance of power is such that in order to be heard, they have to learn the medical and favoured research languages whilst little reciprocal effort is made to try and understand their language and the meanings they are trying to convey. The clash of paradigms could be interpreted as suggesting that these problems might be merely of theoretical and intellectual interest. Unfortunately, however, the issue has potentially severe consequences. Someone might feel helped and understood by being offered the right therapist practising the right therapy at the right time, sensitive to their unique contextual circumstances (the basic pluralistic position). Such provision could be enough to encourage hope, rather than submit to despair, and if such provision is not offered, then within the current NHS system, the NHS is failing its patients. In that sense the stakes could not be higher for the 'real world'. For this reason, I believe that the aim of my research, which is to understand how therapists are making sense of this highly important issue, is of profound importance.

The research focussed on how therapists make sense of pluralistic approaches to therapy via thematic analysis of semi-structured interviews. The analysis revealed that in various ways most participants had experienced, in their practice and professional life, three major issues of contention that centred around (1) identity and approach, (2) how flexible or rigid one should be in one's practice and (3) the belief, based on experience, that it is the relationship that is more important than approach or other factors. These contentious issues are what feed the debates about pluralism

and therapy. Potential diplomatic solutions to these debates were discussed by the participants and included: (1) the practice of MTC, associated with pluralistic therapy; (2) the toleration of uncertainty and valuing it as important as understanding; and (3) the articulation of 'common factors' as a way of viewing their practice, without referencing the literature – in other words, it was not clear if they were consciously aware of a literature that supports their views, or whether they were speaking solely from their own experience and 'tacit knowledge' (e.g. Polanyi, 1964). These were the themes that I identified in the Findings and Discussion chapter.

I will briefly summarise the importance of the implications of these themes for practice and policy. Some participants held tightly to a particular approach, and holding on to this approach was inextricably linked to their sense of identity. For instance, one participant said that he did not feel that he was so much practising an approach as expressing a philosophy. When a professional practice can be experienced as so deeply part of a person's sense of identity as a human being, not just a professional, then the demands of an 'evidence-based' world seriously challenge practitioners who may not want to be put into evidence-based boxes. One participant went so far as to say that she believed that therapy was not so much what you do as who you are. This kind of perspective on therapy does not easily fit into a system in which therapeutic procedures need to be codified and manualised for the sake of validating particular approaches.

Therefore, the strong feelings this issue engenders were reflected by some of the participants in their responses, and can be seen as a contributing factor to the debates about pluralism and therapy. For some participants the pluralistic attitude offered hope that their identity and approach might be valued, whilst for others it seemed as if pluralism might efface legitimate and valuable differences between approaches, and discount the importance of understanding and responding to philosophical positions underlying single-model approaches. Most of the participants reported that it was on initial trainings that they developed a more rigid identification with particular approaches. The first challenges to these identifications were experienced in various situations including supervision groups and agencies dealing with specialised issues and/or particular client

groups. Some of the participants reported that group supervision was where their approach had been most challenged and that they had difficulties in harmonising the views developed during their training with the views of a pluralistic group (in the sense that several approaches might be represented in the group). This struck me as quite an important discovery which I had not thought about before. It seems important that therapists are exposed to different points of view about practice, and supervision groups offer a site for challenge, debate and critical thinking. The potential for exploring how multi-approach supervision groups support or challenge pluralistic therapy and the impact of these groups on therapists would offer a fruitful avenue for further research.

Whether therapists become exposed to different approaches via supervision or other means, these experiences lead to identifications that are more or less pluralistic or monistic. Not long into the exploration of the interview data it became apparent that when the participants spoke about pluralism, either theoretically or in terms of their own practice, the notion that one was either pluralistic or not pluralistic was a false dichotomy. As referred to in the Literature Review, therapists often identify as integrative, and most are open to drawing on other approaches other than their own even if they do not identify as integrative (or pluralistic). Research also demonstrates that therapists often do not practise in accordance with the principles of their identified approach. This tendency was illustrated by one of the participants who, in the process of gaining her accreditation, came to the realisation that she did not actually practise the way she had previously thought.

Thus, there are a multitude of paradoxes, contradictions and misunderstandings in how therapists identify with approaches which problematises research based on comparing them: the notion of therapists adhering to a given approach is, at best, slippery. When asked to describe their practice most of the therapists did not name an approach but, rather, described it in generic terms such as 'warm', 'friendly', and 'compassionate'. Again, this was a surprise for me, as I expected the participants to be rather more enthusiastic about singular models, but in fact found that most, with two exceptions, were more concerned with relational factors, no matter what their identified theoretical approach.

Nevertheless, despite this commonality, research that is taken seriously usually conforms to the protocol of comparing one approach against another, or proving the effectiveness of an apparently consistently delivered unitary approach. This is despite a great deal of research which demonstrates that theoretical approach is a relatively unimportant aspect of therapeutic effectiveness. Some of the participants, aware of this and angry about it, demonstrated that part of what feeds into the debates about pluralism and therapy is the disconnect between therapists' awareness of what the research supports, and the persistent continuation of research that appears to be researching therapeutic effectiveness with the wrong questions addressed in the wrong ways. One participant summed up this kind of perception by exasperatingly suggesting that the research community is not taking notice of its own results.

The favouring of large-scale quantitative research (e.g. RCTs) by bodies such as NICE and IAPT has ultimately led to a 'one-size-fits-all' culture in which clients have little choice within a narrow band of evidence-based therapies. Most of the participants, even if they stated that they adhered to a single approach, believed that different things worked for different clients at different times, and two participants viewed a pluralistic approach as reflective of a common-sense 'horses for courses' attitude. There were various views as to how flexible or rigid therapists should be in practice, and this is one area in which a pluralistic approach faces a certain amount of challenge. The participants were most concerned about the dangers of therapists operating beyond their abilities, but overall were quite sympathetic to the pluralistic approach and the flexibility of practice that such an approach implies.

A limitation of the research is that because of the snowball sampling method, most of my participants practised approaches that, broadly speaking, come under the humanistic umbrella. Therefore, it is perhaps unsurprising that most of the therapists emphasised a more 'relational' practice. Yet, the two psychodynamic practitioners and the CBT practitioner also emphasised the importance of the relationship, and offered varying degrees of flexibility within their practices. This illustrates a further problem in that researchers (including those nominally sympathetic to – and within – the

profession) continue to push for 'technical' knowledge about practice, conforming to the demand of the medical model that not only should specific approaches be identified for specific disorders, but specific interventions and processes should be identified for best practice within sessions, whilst practitioners themselves often emphasise the relational aspects of therapy above the technical. It seems as if the disconnect between the practice of research and the empirical understanding of practitioners is widening. This has huge political implications in terms of the power dynamics within the profession. Some participants seemed palpably annoyed by the consequences of the status quo on therapy provision. This research has to a certain extent covered such issues in relation to pluralistic therapy. However, how therapists have been affected by the politics of provision on the frontlines in the NHS might be worthy of further research as a topic in itself. Interviews with researchers, providers, clients and therapists could provide the basis for a dialogical examination of how well these different groups are communicating with each other about what they want and what they do not want. Such research might facilitate the negotiation of positions that could serve the interests of all these stakeholders interested in the provision of therapy.

The debates about pluralism and therapy, of which all the participants were aware, demonstrate that pluralism allows therapists a way of understanding the variety of therapeutic approaches, even if they take an anti-pluralistic stance with regards to practice and provision. Pluralism encapsulates a way of perceiving therapeutic practices which has important commercial and professional implications. The assumption that some approaches are better than others inevitably leads to 'winners' and 'losers'. For the winners, such as CBT – as an approach and CBT practitioners as a group – to support the principles of pluralism could threaten their current advantage in the field. On that basis alone, resistance to pluralism can be anticipated. Most of the non-CBT participants were aware of their disadvantaged position in the current climate, but even the CBT practitioner saw the possibility of change, remarking that CBT was perhaps only 'flavour of the month'.

The perceived monopolisation by CBT in the NHS was pointed out by several participants, and pluralistic therapy could be seen as a valiant attempt to create an evidence base for non-CBT therapies. A few of the participants spoke about the need to compete -- in terms of research -- with CBT, and the interview data make it clear that the dominance of CBT was a major concern for them. Cooper has said that 'to some extent' pluralistic practice is a political move against the dominance of CBT, but that it is more of a 'move against the dominance and dogma of any one therapy' (Cooper, 2017). Ultimately his position is that CBT is 'neither "the answer" or [sic] "the problem"' (ibid.).

One of the main ways in which pluralistic therapy aims to transcend 'schoolism' and, in my interpretation, offer a 'diplomatic attempt at resolution' to the conflicts between therapeutic approaches, is via the practice of 'metatherapeutic communication' (MTC). MTC forms one foundation of its attempt to practise 'collaborative integration'. Most of the participants practised MTC, even if only at the initial session or at review sessions. For some participants, if it was clear that they could not help the client within their approach they would refer on. Other participants, however, were flexible and felt comfortable using different techniques or approaches, depending on the client. This aspect of pluralistic therapy, which has been emphasised as a particular strength, might therefore be seen as not really that innovative, and something that most practitioners do anyway. This has been noted and rebuffed by Cooper and McLeod – but the argument still remains. Whilst the participants were overall in favour of MTC, there was some doubt that it is useful for all clients all of the time.

Cooper and McLeod have also encouraged the formalisation of MTC in therapy practice via the use of Likert scale forms. There has been research about the use of their forms with encouraging results, and they also cite research in the USA that demonstrates better outcomes via the use of ongoing monitoring of sessions with forms.

One participant described the use of forms as 'embarrassing', and on the whole I avoid the use of them in my own practice (sometimes I am compelled to use forms by EAPs and insurance companies, however). But as an experiment I used the Cooper and McLeod forms with a client who

wanted to change therapeutic direction. She was a psychological professional and was therefore more accustomed to the rationale for using such instruments. We talked about the experience of using them, and agreed that whilst they were of some benefit there was nothing we accomplished that might not have been achieved just as well by more informal dialogue. The Bowens and Cooper study (2012) about the use of these forms found their therapists were positive about them. However, there was no research into how their clients felt about using them. I asked another client, who had previously been an NHS client, in our last session, what he had found positive about our therapy. He reported that he was relieved not to have had to fill in so many forms. It seems to me that the use of forms, for pluralistic therapy and other approaches, is a topic that could definitely benefit from further careful research, especially from the client's point of view, and with particular reference to how formal versus informal 'monitoring' feels for therapists and clients. The impact on therapy of using forms for monitoring and evaluation purposes is one that seems to me to be in quite urgent need of further assessment, and it would make a valuable research contribution. In a pluralistic spirit, perhaps they are useful at the right time with the right person, but when, and with whom, remain unanswered questions.

The main challenge of MTC for pluralistic therapy, however, is whether clients might be trusted enough, and empowered enough, to make up their own minds about what kind of therapist and therapeutic approach they want. In the NHS the current assumption is that expert researchers need to evaluate different therapies for the benefit of clients with particular symptoms. Perhaps it might be easier, cheaper and more effective to ask clients of sufficient capacity and knowledge what they would prefer. This is an idea that, as far as I am aware, has not been proposed, let alone entertained, despite the patient-centred rhetoric of the NHS.

One of my participants suggested that NHS clients should be allowed to access a directory and actually choose not just their own therapeutic approach but the individual therapist. When I was in the midst of the interview I have to admit that I thought this was a really off-the-wall idea that would never be accepted by providers like the NHS. One rationale provided

by the participant for this idea was that otherwise, therapy remains a class-ridden enterprise where only financially advantaged people can access therapies not provided in the NHS. This is an argument similar to that made, at a later date, by Goodman (2016). Samuels (2016) argued along similar lines when he suggested that the NHS is providing what he calls 'state therapy' rather than the usually qualitatively and quantitatively different experience provided by practitioners in the private sector.

In the midst of re-reading this participant's interview transcript during the analysis stage of the research it suddenly occurred to me, as someone who works for Bupa, that what the participant was suggesting is effectively what Bupa does for its insurance-holders. They have access to a directory of Bupa-approved therapists (who do not have to be a CBT practitioner) and contact the individual therapist who most appeals to them after seeing their photo, qualifications and professional interests. So why not an NHS-approved list of therapists from which NHS patients can choose their therapist just like a Bupa patient? This could make for interesting research – a trial of patients who can choose from an online directory versus Treatment As Usual (TAU). If the evidence backed up this approach, the NHS could transform itself from being a top-down, choice-restricting therapy provider into a bottom-up, choice-enabling one. This would allow a pluralistic perspective for therapy, in terms of individuals being able to access the right therapy at the right time, to exist in the public sector as well as in the privileged private sector. The potential for some interesting -- although expensive – research seems to be opened up by what I initially considered to be 'off-the-wall'. Some critics suggest that emphasising choice for patients and clients panders to a wider, problematic consumer-focussed culture. Perhaps; but within the frame of choice being seen as a good thing, it would be hard to envision a way of offering patients more.

Another argument used against giving clients greater choice is that their understanding is not sophisticated enough to be able to choose wisely, or that they do not want to know, that they just want it 'done', as one participant put it. Yet, the need for certainty can in itself be criticised as part of a 'phallogocentric' culture which is attached to the ideal that it can neatly categorise symptoms, treatments and outcomes, and that everyone is

completely sure that they know exactly what they are doing (e.g. Spinelli, 1996). Rizq (2016) criticises this attitude as exemplifying the fear of the messier, disordered aspects of caring in more 'feminine' ways. The participants spoke about understanding, but also varying degrees of uncertainty concerning their practices and that this dynamic is also manifest in clients. They spoke about how the tolerance of uncertainty is, in some ways, foundational to effective practice. This theme, which I named the Uncertainty–Understanding Continuum, is another important aspect of the findings and could lead to further research.

Most therapy research is, perhaps unsurprisingly, directed towards ascertaining certainty about therapeutic processes and outcomes. In Goffmanian terms one could say that the therapy professions, and the research projects behind them, are endeavouring to create a good performance for allied professionals and providers, so that the profession can survive as a profession. Therefore, focussing on the aspects of therapy that are intangible and uncertain – and therapist feelings of not being able to explain and not really knowing – are a hidden/shadow side of practice shunned by researchers who consciously grasp for certainty. There has been some research about uncertainty: for example, Leite and Kuiper (2008) who suggest, amongst other things, that 'uncertainty pervades the entire psychotherapeutic process' (p. 55); but overall, it is an under-researched and under-theorised area. Some practitioners (e.g. Yalom, 2015) argue that a different therapy must be provided for each and every client. If that is the case, then nothing can be certain in how to practise. This kind of thinking, whilst popular amongst many practitioners, challenges the very foundation of research which assumes best practice can be predicted by what has come before. Critics might counter that these therapists and the problems they pose to research methodologies, accepted fairly easily by other health professionals, perhaps demonstrate a profession not willing and able to come up to the standards imposed on others. However, a profession that is based on two human beings encountering one another, which is simultaneously a special and an ordinary phenomenon cannot perhaps be so easily analysed as other professions regarding what impedes or facilitates its effectiveness. The ability and willingness of therapists, clients

and providers to tolerate uncertainty as well as understanding is arguably another area worthy of more research.

A theme discussed by most of the participants was how different therapeutic approaches often seem to have 'different names for the same thing'. This perception parallels views in the literature (e.g. Miller et al., 1997) which led to the rise of the 'common-factors' integrative approach. Most of the participants talked about common factors in their practice, which supports the notion that researchers might be better off identifying these generic aspects of therapy rather than generating more research based on differentiating and comparing approaches. Indeed, there has been a substantial amount of common-factors research which has built up quite an evidence base for its view that 'what works' in whatever therapy is more important than any particular therapy on its own. Although Duncan and Miller (e.g. Duncan et al., 2004) in the USA have had some success validating Feedback Informed Treatment (FIT), influenced by the common-factors approach, the impact of common factors on the research and the provision of therapy in the UK has been minimal.

6.3 Professionalisation and Regulation

The themes identified in the interviews sit within broader contexts. One of those contexts is that of professionalisation and regulation of the psychological therapies. The vast array of approaches, ideas and professional titles in the psychological therapies make them difficult professions to regulate, even if it is assumed that aiming for professionalisation and regulation is an unproblematic ideal. Exemplifying this problem, and one factor amongst many that derailed attempts at SR in 2010/2011, was the dispute between counsellors and psychotherapists about what, if anything, constituted the differences between their practices. It has been argued that professionalisation and regulation encourage therapists to stay in their box (Morgan-Ayrs, 2016). Pluralism has the potential to free therapeutic practice from box-containing and box-ticking

cultures. The appeal of practising in a 'box without walls', as one of my participants put it, is that it would allow practice to be flexible, a pre-requisite of any pluralistic practice. Over-regulation of therapeutic practices could lead to (if it has not already) unnecessary demarcation of approaches and practices akin to over-zealous demarcation of job roles. There is also the danger, which has already begun to manifest, that therapists who do not choose to use ESTs or EBP will be accused of being 'unethical' (e.g. see Goodman, 2016, p. 79).

The more standards and rules are emphasised, the more of a felt need exists for the auditing of practitioners to check that they are staying in the boxes that have been created, purportedly for their benefit and the benefit of clients. Cooper and McLeod, nevertheless, have formulated a pluralistic practice that would be regulation-friendly. They also seem to have responded enthusiastically to ideas proposed by researchers such as Norcross (2015, May) that processes, even ones like 'the relationship', need to be monitored in formal and bureaucratic ways, throughout therapy, in order to improve outcomes. They value these practices as additions to practice that make therapy more effective, and implicitly more professional. Yet these practices run the risk of tangling up practitioners who do not wish to monitor in such instrumental ways – a kind of micro-regulation that could engender more problems than even the more 'meta' regulation envisioned by professional bodies such as the BACP.

6.4 Modernism and Postmodernism

Another context within which the practice of therapy sits is contradictory modern and postmodern conceptualisations of reality and truth. The positivistic paradigm for determining the 'truth' about therapy practice has led to the wholesale ditching of therapies which have not (yet) been able to prove their worth within that paradigm. The motivation for practitioners, with more postmodern sensibilities (whether they recognise them as such or not), to prove themselves within that paradigm may or may not be forthcoming. Another gap exists, not just between practitioners and researchers but also

between educators/trainers and providers. Academic institutions providing the training do not on the whole provide trained practitioners in the NHS's favoured models. The nuanced and subtle postmodern critiques of 'truth games' (Lyotard, 1984/1979) and so forth, which postgraduate trainees are familiar with, have not reached the managerial power brokers.

Perhaps the dominance of CBT and the marginalisation of psychodynamic, humanistic and other therapies within bodies such as the NHS reflects a split between modern ways of conceptualising truth and 'best practice' versus postmodern views of uncertainty and practice as contextual rather than generalisable and universal. Some of the participants spoke about this, but not all. The postmodern assumptions seem to be 'ground' (in a Gestalt sense) and not necessarily articulated or understood as such. I only became aware of how central this modern/postmodern divide is to difficulties in the profession as I developed my analysis. This theme is one that is ripe for further research. Is it possible that these two different world-views might be able to dialogue with each other so that trainers, practitioners and providers can begin to understand each other? Is there any way the deep differences between modern and postmodern views of the world can be reconciled? How can postmodern therapies and therapists survive in modern healthcare systems? Do they accept that they will not and cannot be understood, and so must retreat to private practice where only economically privileged clients can seek their benefits?

6.5 Some Concluding Thoughts about the Research Methodology

Most studies about pluralism to date have been quantitative in nature. My research was qualitative, and that in itself has allowed a deeper analysis of the issues and themes that inhabit and surround pluralistic therapy. There have been some qualitative studies but only of therapists who self-identify as pluralistic. To the best of my knowledge, this research is the first qualitative study that has explored these issues with therapists as a whole. Also, it has emphasised therapists' views and experiences rather than the usual

emphasis on processes and outcomes, which are explored to some extent, but from within the therapists' own experiences and perceptions.

The interviews were set up using a snowballing procedure: in the first instance I contacted therapists I knew, who then contacted other therapists who they thought might also be interested in participating. The topic was an interesting one for therapists, so it did not take me very long to find twelve willing participants. I asked them about how they practised, basing the questions on the principles of pluralistic practice (such as collaboration, MTC and flexibility) as described by Cooper and McLeod (2011a). This procedure enabled the participants to reveal how their practice aligned or did not align with pluralistic principles. They spoke about the thoughts and feelings behind how they chose to practise. These included abstract and theoretical rationales as well as unique narratives about particular clients. The narratives they related about their own professional experiences illustrated how they had developed particular ways of perceiving therapeutic practice.

By discussing practice, without directly mentioning pluralism, I discovered that most of the participants practised pluralistically even if they did not identify as pluralistic per se. From this I gained an understanding of pluralism in relation to therapy, as being more of a continuum or dimension of therapy rather than something that therapists are or are not. On one end of the continuum is 'extreme' purism to which only a few therapists might subscribe and on the other is 'extreme' pluralism, with most therapists moving up and down the continuum over time in between those two extremes.

The notion that therapists can actually be 'pure' was challenged by one participant, who suggested that purist therapists are less purist than they think they are. Similarly, even the most open-minded therapist will have their favoured approaches and be prejudiced against others. This was illustrated by some participants in their antipathy towards specific approaches such as CBT or psychodynamic therapy. For instance, one participant spoke jokingly, but revealingly, of psychodynamic therapy as the 'dark side'.

One part of the semi-structured interviews concerned itself directly with pluralistic therapy and the debates it has inspired. These sections

allowed me to explore how pluralistic therapy manifests to greater and lesser extents in the participants' practices. I saw it manifesting on two levels: at a 'micro' level (conscious use of different techniques and approaches, for instance) and at a 'macro' level (how the theoretical articulation for a pluralistic therapy had affected them as practitioners, in terms of their support, or otherwise, for it).

Some literature has already explored the mismatch between how practitioners say they practise and how they actually do practise. There could be further research to explore how practitioners of different approaches may or may not practise with varying degrees of pluralism. If what I found with my participants is transferable to therapists as a whole then the actual fuzziness of how therapists practise might fundamentally challenge the idealised perception of therapists practising particular approaches. This could encourage more nuanced research for the benefit of the profession and the clients it serves.

6.6 Limitations of the Research and Potential for Further Research

Although the research demonstrates that, for these participants, there are unresolved issues around pluralistic therapy, particularly as a protocol for practice rather than as a perspective, overall there was support for pluralism in therapy. Feelings of disconnection and conflicts between therapists might be less severe than between therapists and the organisational structures surrounding them. All the participants seemed to be conscientious and hard-working practitioners with the necessary reflexivity to have achieved high standards of practice, and capable of continuing to develop higher standards in the future.

Other practitioners, such as Gillian Proctor (e.g. Proctor, 2015), have spoken of the devaluation of experienced therapists in the NHS, and this devaluation was also mentioned by the participants. The situation for (non-CBT) therapists, at this historical juncture, is highly precarious. Some resistance is beginning to grow, with the recent foundation of organisations like the Psychotherapists and Counsellors Union (PCU), founded in 2016,

and Counsellors Together (resisting the culture of low-paid and unpaid work for therapists), founded in 2017. The BACP continue to get embroiled in matters of professionalisation and regulation, for instance a recent, disastrous online questionnaire (see e.g. Alliance for Counselling & Psychotherapy, 2017) that severely misjudged the mood of its members. If therapists are to retain and improve their status in the NHS and with other large employers, perhaps the BACP is only attempting to set its members on a course that must be travelled, however controversial and difficult it is for them. But it must be noted that the reason the questionnaire received such a backlash was because there was no open, mood-assessing discussion about the issues with their membership before the document was published.

On one level, my research could be seen as a small-scale consultation, which could certainly be 'upgraded' to enable more generalisability. There has not been enough consultation with practitioners on a whole range of issues about how to research, professionalise and regulate the profession. As in other fields, the therapy profession has become victim to top-down thinking and hierarchical directives from institutions which misjudge or dismiss what therapists perceive to be the most important elements of practice. One dimension of therapy is to facilitate a sense of empowerment for their clients. This is perhaps one reason why such directives face more resistance from psychotherapeutic professionals than other groups. Therapists owe it to their clients, and to the political implications of therapy, to fight attempts to disempower practitioners in how they practise. The articulation of definitions of standards, ethics and other issues must be co-created by the 'community of practice' (Wenger, 1997). I would argue that this research points the way to further research, conducted with and by practitioners themselves, to co-create guidelines for the future developments of therapeutic practice. Organisations such as the BACP could innovate more democratic and dialogical methods of policy-making and representation, rather than acting in ways that mirror the same anxieties which are prone to befall other professional organisations. Pluralism has offered a framework by which practitioners might find a way to empower themselves with research and provision structures, as they exist now; but it does not challenge the assumptions of those structures in themselves.

A critical theory approach to issues in and around pluralistic therapy might also serve as a complementary basis for important research. Political, cultural, economic, ethnic and gender issues related to pluralism could all form points of departure for critical exploration. For instance, the masculinised orientation and delivery of privileged research methodologies might benefit from feminist research that explores how gender influences or fails to influence research, policy and provision.

Pluralism itself is often associated not with different therapeutic approaches but with the pluralities of races, religions and other multicultural manifestations in different societies. This aspect of pluralism has only been partly addressed by this research and the interview data. Issues around race and class were only discussed in a few interviews. It might be that these issues are not that prominent for therapists. Indeed, therapists' lack of interest in politics reminds me of my Masters research in which I asked the participants if there were political reasons attached to wanting to become a therapist. I was surprised to discover that this factor was one of the least important in my sample. Although some therapists are committed to political causes in the widest sense in terms of initiating social change, social justice and working towards equal opportunity, and perceive therapy as part of these wider processes (see, for example, the organisation Psychotherapists and Counsellors for Social Responsibility, or PCSR), for the most part I wonder about the extent to which the majority of therapists are politically disengaged. Perhaps not feeling a need to unite as a movement to protect and develop their own political interests is one reason they have become so easily disempowered; although the PCU, mentioned previously, perhaps points to the possibility of an emerging movement towards solidarity.

The practice of therapy, in the UK, still seems to be a mostly female, white and middle-class occupation. Pluralism is not just about type of therapy: it is also about type of client and type of therapist, and how different types of people might need different types of therapy. The profession could do more to address how to make therapy a practice engaged with a multitude of different personal and cultural identities that do not necessarily conform to standardised Western conceptions of therapy practice. There has been some research concerned with how to tailor therapeutic practice for

specific groups (e.g. McLeod, John, 2013b), but there could be a focus on how different voices are empowered or marginalised in the structures that currently have the most influence on the provision of therapy.

Another limitation of my research was that although a few of the practitioners practised or had experience of practice within the NHS, the majority were private practitioners, or had left the NHS to practise privately or for other agencies. There is more freedom within the private sector to practise more pluralistically than in the NHS, even though, as previously discussed, how practitioners say they practise and how they actually do practise does not often align at all closely. A study similar to my own could be conducted with NHS practitioners, within or outside the IAPT programme. Interesting questions to ask might be: How are therapists with a more pluralistic perspective experiencing and making sense of the IAPT/NHS culture? One of my participants who worked for the NHS, for example, had experience of being negatively evaluated in comparison to her CBT colleagues. She spoke about a felt distinction between the latter and 'counsellors'. In that kind of setting it would also be possible to explore the practice of therapy as a 'community of practice' in the more microsocial way that Wenger (1997) applied to his company of claims processors.

A comparison between the practices of NHS therapists and the practices of private therapists might support my sense that pluralistic therapy is de facto available in the private sector, because clients are free to choose in the first place, and also because more pluralistically-inclined therapists are being forced into the private sector because of lack of opportunity and respect within the NHS. This would support the view of Samuels (2016) that there are two types of therapy: state and private. Further research might illuminate whether there is any data to support or refute these kinds of views about therapy provision.

A further limitation to this research is that I could have had a wider spread of different types of therapists. I used a snowballing sampling method which did not manage to reach many non-humanistic practitioners. I did interview two psychodynamic practitioners and one CBT practitioner; however, since CBT turned out to be such a central issue it would have been interesting to hear from more CBT practitioners. The bias towards

humanistic-existential approaches also exists in Cooper and McLeod's (2007) theory and research with an assumption that they are of 'universal relevance' to therapeutic practice. This bias has been pointed out by others such as Dryden (2012) and Ross (2012).

I have made other recommendations for further research in previous sections of this chapter and also in previous chapters which I will concisely reiterate here: viz. (1) issues about pluralism and pluralistic therapy in relation to other types of psychological practitioners, (2) comparisons of integrative and pluralistic therapies in the USA and the UK (3) the use of forms in pluralistic therapy and in general, (4) the relationship between individual and group supervision and pluralistic approaches to therapy, (5) the relationship of different approaches to pluralistic approaches to therapy, (6) the use of pluralistic approaches in short-term versus long-term therapy, (7) flexibility versus adherence in relation to effectiveness, (8) asking therapists how they would like pluralistic ideas to be articulated for the therapy profession, (9) quantitative research to determine how much support pluralism/pluralistic therapy has within the profession (the amount of support could also be gauged in other groups such as NHS patients, user groups etc.), (10) comparison of clients who are allowed to choose their therapist from a directory (just like private clients can) versus TAU, (11) dialogical research between researchers, providers, clients and therapists about therapy, (12) the relationship between tolerance of uncertainty and effective practice, (13) the modern/postmodern divide in therapy and the wider culture, and (14) research to examine how therapists *actually* practise versus how they say they practice and implications for pluralistic practices and perspectives.

6.7 Concluding Personal Statement

Overall, my experience of the interviews made me value the work that therapists do more than I did before. All my participants were seriously engaged and deeply reflective about their practices. A subtextual message of the intense debates and drives for regulation and professionalisation,

often in the name of protecting clients, is that therapists are not professional enough, even dangerous. Whilst it is true, as in any profession, that some practitioners may lack conscientiousness and/or skills, on the whole, interviewing these practitioners I was taken aback by how much thought and energy goes into individual practices and the amount of continuous learning practitioners are willing to undertake for the benefit of clients. Whilst supervision, case studies and similar methods of professional development may not produce the evidence required for the provision of therapy in 'managed-care' contexts, perhaps they do provide the best forms of learning for therapists -- learning which in turn provides the best therapeutic experiences for clients.

Whether therapists practise from within a single model or collaborate with clients from a pluralistic standpoint, the interviews showed me the seriousness with which they all undertake the enterprise of therapy. Perhaps the appeal of pluralistic therapy, as it was for some of the participants, is that it offers a hope for valuing, re-valuing and ultimately re-evaluating the potential of therapies to which most people might otherwise lose access.

In this sense I believe the best way forward for pluralism in therapy is for it to re-vision itself as a political movement for change in the commissioning and provision of therapies. The independent/private sector is *de facto* pluralistic in the sense that pluralistic/integrative/eclectic practitioners can be easily identified and accessed and clients are also free to choose from a huge array of therapists and therapies. So, at present, the private sector is effectively the refuge for clients and therapists who believe in pluralistic therapy as a perspective and practice. The sectors in which pressure needs to be applied are the public sector (the NHS and IAPT) in which all types of counselling and psychotherapy are being marginalised by other professionals and paraprofessionals and the third sector which can fall prey to mirroring the policies and procedures of the public sector.

When I first came across Cooper and McLeod's (2011a) book at the very beginning of my doctoral studies I perceived it as articulating a version of therapy that was very close to my perception of my practice. I read the book in a very positive and uncritical way. As the debates about purism versus pluralism raged I resonated with the pluralistic voices over the purist

voices. This seemed to me to be a crucial issue and a crucial battle that needed to be fought in the various therapy wars.

In the process of researching and writing up this thesis I have come to different positions and views. In the first instance although I am still quite sympathetic to the overall positioning of pluralistic therapy as articulated by Cooper and McLeod there are issues that leave me feeling less comfortable with it than I did at the end of 2011.

These issues include a discomfort with the apparent 'ownership' of 'pluralistic therapy' by Cooper and McLeod. This ownership was perhaps inevitable as they have produced the most theory and research about the possibility of 'pluralistic therapy'. However pluralistic therapy is not something that by its nature can be owned or have protocols -- pluralistic therapists to be pluralistic will have a tendency to be suspicious of preordained systems. A pluralistic attitude, in my view, might be summarised in the famous Blake quotation (spoken by Los in *Jerusalem*) which states "I must Create a System or be enslav'd by another Man's"./ "I will not Reason & Compare: my business is to Create." (Blake in Keynes, 1957, p. 629, capitalisation in original).

The protocols for the practice of pluralistic therapy have evolved, in my view, from disconnecting with the philosophy of pluralism and a misunderstanding of pluralism as equivalent to integrationism. Referring back to the Literature Review McLennan's view -- that the 'conceptual opposite' of pluralism is 'a sense of unity and integration' (McLennan, 1995, p. x) -- makes the conflation of pluralistic therapy with integrative therapy problematic. Cooper, McLeod and those connected with them still seem confused about this issue -- sometimes trying to differentiate pluralistic therapy as something different to integrative therapy and sometimes quite casually stating that pluralistic therapy is an integrative therapy. The distinct philosophical positions of pluralism and integrationism could lead to very different political outcomes. For instance an integrationist stance could ultimately lead to the validation of a generic 'therapy' informed by 'evidence-based' interventions whereas a pluralistic stance would always celebrate and value having a multiplicity of approaches.

Pluralism is first and foremost a philosophy that has been applied to therapy on two levels. The first level is that of practice: whilst I understand the pragmatic attempts to explain and codify a 'pluralistic therapy' this runs the danger of creating yet another monistic way of practising. For instance the literature and trainings about pluralistic practice seem to have led to implicit 'rules'. When I attended the 1st International Conference on Pluralistic Counselling and Psychotherapy most of the delegates seemed to assume that pluralistic therapy is grounded in the idea of 'goals, tasks and methods' -- a kind of 'Holy Trinity' for pluralistic therapy. This is one way of conceptualising it but open to legitimate critique and, as discussed in previous chapters, the language does not sit easily with some practitioners. The second level on which pluralism is applied to therapy is as a perspective: this makes more sense to practitioners such as my participants. That perspective, I would argue, is what practitioners and researchers would be better focussed on in order to build a political movement in support of patient and client choice. A new webpage by XenZone called *A Thousand Ways to Therapy: The Importance of Choice* (thousandtherapies.xenzone.com) with contributions by Dr Lynne Green, Miranda Wolpert, Terry Hanley and Mick Cooper takes a more overtly political stance than demonstrated in most of the literature and research about pluralistic therapy. A politicisation of pluralism / pluralistic therapy as well as helping clients is also vital to stem the tide of redundancies, underemployment and unemployment of therapists which is reaching crisis proportions and urgently needs to be addressed: for instance, the exploitation of qualified volunteers has been embedded into the public and third sectors and needs at least some reforms.

I am sympathetic towards a pluralistic perspective to inform practice and a political position but Cooper and McLeod's particular version of 'pluralistic therapy' as a practice seems to me to be problematic. That does not mean that I am against potential alternative articulations. As I have argued previously, writers such as Wilber also articulate pluralistic perspectives about therapy without using the label 'pluralistic therapy'. In my view, it is most useful to think of 'pluralism' as a dimension of therapy and therapists rather than as a distinct approach. Over the course of my research

I have moved to seeing the concept of pluralism as most useful for metatheoretical explorations (rather than trying to be a self-contained theory) and as a potential focal point to encourage political solidarity amongst therapists.

6.8 Concluding Summary Statement of How This Research Makes an Original Contribution to Knowledge

This research has explored how therapists make sense of pluralistic approaches to therapy. Since the experience of therapists in general, as opposed to pluralistic practitioners, has not previously been researched, new knowledge has been generated in this thesis about how some therapists practise and orientate themselves in relation to pluralism. Their experiences of pluralism, as an important and controversial issue for the field, add important data to the debates about it because the research reveals, in considerable depth, their attitudes to the phenomenon of pluralistic therapy.

Although some qualitative research has explored therapists' experiences of pluralistic therapy, no previous research has yet addressed how pluralistic therapy has impacted therapists who do not themselves identify as pluralistic. My research was able to contextualise the impact of pluralism on therapists as a whole rather than for any particular faction or 'tribe'. The thematic analysis supported the conceptualisation of pluralistic therapy as not just reflecting a wish to propose a new theory but also a wish to resolve controversies within the field. How pluralistic theory and practice resonated (or not) with the participants provided rich data on how they have responded to the development of pluralistic practices and perspectives within the field, and the impact of these practices/perspectives on the wider culture of therapy in the UK.

Problems remain in convincing therapists themselves that pluralistic therapy offers a solution or solutions. The extensive discussion centred on these issues in this research will enable researchers and practitioners to

understand more thoroughly how therapists actually practise, how they articulate that practice, and how they might be more or less comfortable with different representations of and prescriptions for practice. Ultimately, this is important for understanding how to represent therapists and use their own knowledge about therapy for the benefit of clients and the improvement of policies for therapy provision.

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Appendix A: Email Texts

For previously interested participants

Dear (name),

Firstly thank you for your patience waiting for the information sheet and consent form to arrive. Ethical approval has now been granted and interviews for my research project can take place.

I really appreciate your informal wish to take part. Now the project is at a stage where this wish can be formalised if you still want to take part in this research.

I realise that once you have read the information sheet and consent form and have a fuller idea of what the research is about and entails you may not want to take part and if you want to change your mind for any reason whatsoever that is absolutely fine with me.

If you do not want to take part but you know someone who might be interested please ask them to contact me by phone or email and I will send them the information sheet and consent form.

Best,

Jay (Beichman) MA(Couns) MBACP(SnrAccred)

For newly interested participants

Dear (name),

Thanks for contacting me about my research.

Please find an information sheet and consent form attached.

Please contact me if you want to take part and/or want to discuss the research further with me.

Many Thanks,

Jay Beichman MA(Couns) MBACP(SnrAccred)

Appendix B: Notice for Participants

Pluralism? What's that ?

What do therapists make of pluralistic approaches to counselling and psychotherapy? An answer to factionalism? Or are some approaches just incompatible with others? What's the difference between integrative and pluralistic approaches anyway? What's your experience and understanding of pluralism in your own practice? These are the types of questions I intend to explore in my research in dialogue with therapists of different theoretical persuasions.

I am undertaking a PhD in counselling and psychotherapy at the University of Brighton. I am seeking therapists, members of either BACP or UKCP, to explore their experience and understandings about pluralistic approaches to therapy, their thoughts, feelings, views and experiences of it in their own life and practice

The research will entail the recording of one interview lasting approximately one hour.

Would you like to take part in this research? For you, taking part will facilitate reflections of how you situate your own practice in the wider professional context and count as very meaningful continuing professional development.

If you are interested in further information and/or information sheets please contact me.

For further details contact:

Jay Beichman MA(Couns) MBACP(SnrAccred)

Tel. 01273 672140 / 07817 404562

jay.beichman@gmail.com / www.counsellinginbrighton.co.uk

Appendix C: Information Sheet

Participant Information Sheet

What the research is about

Firstly, thank you for your interest in this research. The working question for this research is 'How do counsellors and psychotherapists experience and understand pluralistic approaches to therapy?' Henceforward I will refer to both counselling and psychotherapy as 'therapy' and counsellors and psychotherapists as 'therapists'.

What is pluralistic therapy?

There's not a definitive answer to this question and what pluralistic therapy means or we perceive it to mean will probably be part of our dialogue in our interview. But as a guideline and starting point pluralistic therapy is a new framework and approach for therapy theory, practice and research. It is an attempt to influence practitioners and policy-makers to de-emphasise the mainstream discourse concerned with attempting to prove superiority and inferiority of different therapeutic orientations. The main argument is that there is not a 'better' or 'right' way of practicing therapy, rather that different clients need different kinds of interventions at different times. So a therapist sympathetic to a pluralistic approach to therapy would have a flexible framework and attitude towards practice rooted in an awareness of the client's needs and their own skills and competence to make different kinds of interventions. It might also be seen as a political attempt to destabilise the privileging of 'evidence-based' therapies. If you want further information about meanings and ideas associated with pluralistic therapy please refer to Cooper & McLeod (2011) and/or the website www.pluralistictherapy.com.

The purpose of the research is to look at how you experience and understand pluralistic approaches to therapy. We will discuss, amongst other things, your own experience and understanding of pluralism and therapy. We will be able to explore many issues both theoretical and directly related to your own practice. Implications of the research might include how different understandings of therapy inform therapists at theoretical, practical and pragmatic levels. These different understandings might also implicitly support, challenge or show indifference to pluralistic approaches proposed by some as a future course for therapy's evolution.

What your part in the research will be

For the research you will be asked to allow one audio recording of one interview. The recording of the interview will take place in a location convenient for you.

The interview will be semi-structured. What this means is that although we will be free to follow tangents and allow an open dialogue I will also have some topics and/or questions that will be the same for all interviewees. This will support my ability to compare and contrast similarities and differences of themes we cover. So

although the research has a particular focus it is also 'open', in the sense that I want to us to be free to talk in any way that seems useful or interesting. In this research I see you as a co-investigator.

Important issues to consider before agreeing to participate

It is unlikely but possible that the interview might become distressing. Either of us has the right to terminate the interview if you become too distressed. If anything has been difficult or uncomfortable for you I can initially support you and then make sure that you have someone to talk to after the interview and, if you want, you can also contact a therapist. My role is definitively and solely as a researcher so while I can offer initial support I cannot offer therapy. If any disclosures are made in the interview that raise ethical concerns I will consult with my research supervisors and suggest that any issues are raised in your next supervision session and/or with the BACP or UKCP.

Consent

I will seek consent for your participation with the 'Consent Form'.

The research is voluntary and you can withdraw at any time

It is important that you know that participating in this research is completely voluntary and you have the right to withdraw at any time without having to give any reason whatsoever. You can also ask that any data you have given in the interview recording and any related transcriptions can be withdrawn and destroyed. You do not have to answer any questions you don't want to and you can ask any questions you want in response to this information sheet and my initial contact with you. If you agree to have an interview I will meet with you shortly before the interview to gain written consent and to discuss any remaining concerns.

You can also withdraw your consent

I will also check with you that you still consent to being part of the research after the interview recording has been made and before using any of your dialogue in any written materials. Any details that might identify you personally will be changed or cut out.

So that your consent and confidentiality can be ensured I will need to contact you when this data has been analysed and written up. This will allow you to continue or discontinue your consent and confirm for yourself that any of your contributions have been changed enough to ensure confidentiality and are an accurate representation of the interview. It will also allow you to get an update on the progress of the research in which you have been a co-investigator as well as a participant. You can also contact me at any point to ask questions about the progress of the research or any concerns you might have about it. You will only be contacted by me when necessary for the purposes of this research.

Confidentiality and some limits of confidentiality

The interview recording and transcript will be treated as confidential. The only exception to this is if disclosures are made that suggest there may be imminent harm to self or others. Then I may become legally or ethically obligated to break confidentiality by referring the matter to an appropriate agency. My research supervisors might also see anonymised and transcribed data for the purposes of the research. Otherwise all documents and data will be stored safely and securely on a password-protected memory stick while the research is being written up. All data (recordings, transcriptions, and documents) will be destroyed within five years of the time of recording the interview, or whenever the data is no longer required, whichever comes sooner. The data will be disposed of sensitively and securely. The memory sticks will be destroyed and any documents will be shredded.

It is my intention that any excerpts will be sufficiently changed so that any personal details would not be recognised by anyone. So I anticipate that any written documents will not have any effect on you. You will be given the opportunity to read any elements of the thesis in which you feature. You may suggest any further changes that you think are necessary to ensure anonymity.

How the research will be used

The interview recordings and transcripts will be used as supporting material for the award of a Doctor of Philosophy (PhD) by the School of Applied Social Sciences (SASS) at the University of Brighton. It is also possible that as part of this I might want to use some material in respected and relevant academic journals and in presentations to other academics.

This proposed research has been approved by the Faculty Research Ethics and Governance Committee (FREGC) of the University of Brighton.

Financial reimbursement

Any travel expenses to take part in the research will be reimbursed.

Contact details

If you are interested in participating in this research study please contact me by email or phone.

Jay Beichman MA(Couns) MBACP(Snr Accred)

01273-672140 / 07817-404562

jay.beichman@gmail.com

If you wish to make a complaint about any aspect of the research please contact my professional organisation which is the BACP (01455-883300).

If you wish to receive a copy of the PhD once it has been accepted please let me know and I can send you a copy by email.

References

Cooper, M. & McLeod, J. (2011). *Pluralistic Counselling and Psychotherapy*. London: Sage.

Appendix D: Consent Form

(The signature boxes from the original Word document that was used with participants was not able to be copied into this document)

Jay Beichman MA(Couns)
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01273-672140

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CONSENT FORM

How counsellors and psychotherapists experience and understand pluralistic approaches to therapy.

Name of Researcher: Jay Beichman

Please initial all boxes

1. I have read and understood the attached information sheet dated 18/08/14, version 12, giving details of the above research. I have had the opportunity to consider the information, to ask the researcher any questions and have had these answered satisfactorily. I understand my role in the project and my involvement in it.
2. I agree to allow the recording of one interview with myself about the above topics.
3. My decision to consent is entirely voluntary and I understand that I am free to withdraw at any time without giving a reason.
4. I understand that the researcher reserves the right to terminate the research if I become too distressed.
5. I understand the data gathered for this research may become part of a thesis and other forms of publications and presentations.
6. I understand that my name will not be used in any report, publication or presentation, and that every effort will be made to protect my anonymity and the confidentiality of the research. However, there are exceptions to confidentiality,

namely if information is disclosed that suggests there is risk of harm to self or others, legal and ethical exceptions, and disclosure of serious crime.

7. I understand that if any disclosure is made that appears to breach the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy or the UKCP Ethical Principles and Code of Professional Conduct the researcher will consult with his research supervisors and advise that the issue be discussed in a supervision session and/or with the British Association for Counselling and Psychotherapy (BACP) or United Kingdom Council for Psychotherapy (UKCP).

8. I agree to take part in the above study.

Participant's signature:

Date:

Participant's name (in CAPITALS)

Researcher's signature:

Date:

Researcher's name (in CAPITALS)

Appendix E: Interview Schedule

Interview schedule for research exploring therapists' experiences and understandings of pluralistic approaches to counselling and psychotherapy.

Overarching research question = How do counsellors and psychotherapists experience and understand pluralistic approaches to therapy?

Before any questions I will introduce myself, explain the purpose of the interview, assure confidentiality, ask for permission to tape, and make time for both of us to sign the consent form. Perhaps I will also ask the client to fill in a very basic demographic questionnaire for information about gender, age, ethnicity etc. There will also be a little time for general chit-chat before going into the questions/topics directly relevant to the research (Robson, 2011).

Questions 1-4 = 'first topics' – designed to help the participant relax into the interview. They will also give me the story/background of the therapist to some extent.

1. How did you become interested in therapy? [personal experience leading to professional experience]
2. How did you train to become a therapist? [initial training]
3. How have subsequent trainings or therapeutic experiences affected you? [other trainings]
4. How would you describe your practice? [maybe this question will identify an approach but it's open enough that it does not have to]

Questions 5-15 = the main schedule of questions / [topics]

5. How have different approaches to therapy affected you and your practice? [different approaches]
6. How closely is your practice based on your original training? [training]
7. How do you communicate with your clients about what you are doing and what's happening in therapy? [communication with clients]
8. In your experience how do you think using different therapeutic approaches with different clients at different times affects therapy? [the basic pluralistic therapy position]
9. What do you think makes your therapeutic practice effective? [common or particular factors? approach?]
10. How much do you think clients understand therapy? [trust in client's ability for collaboration]
11. How much do you involve clients in decisions about therapeutic direction or approach? [client involvement with therapeutic process]

12. How do you help clients determine what it is they want from therapy? [collaboration?]
13. How much do you vary the way that you work with different clients? [degree of fixedness/flexibility]
14. What has been your experience of past and current debates about different approaches to therapy and calls for a more pluralistic attitude in the therapy profession? [personal experience of professional debates]
15. How do you see the profession of therapy developing in the future? [open question that may or may not elicit issues around approaches/pluralism]

Questions 16 > = 'cool out' questions

We're getting near to the end of this interview so...

16. Anything you want to ask me? Anything you think we've missed that you want to say something about now? Or anything at all you would like to add before we close the interview?

Reference

Robson, C. (2011). *Real World Research (3rd edn): A Resource for Users of Social Research Methods in Applied Settings*. Chichester: John Wiley & Sons Ltd.

Appendix F: Interview with R1 (Paul [original pseudonym = Dan]), Complete Transcript with ‘Initial Ideas’

Notes about the transcription

For ease of reading most ums and uhs have been removed as well as some immediately repeated words and some repetitive phrases such as ‘sort of’ and ‘you know’ (sometimes it seemed to me better to leave them in for sense and rhythm).

When either the interviewer or the respondent* has spoken briefly or made some kind of noise within a speech sequence of the other this is shown within the speech sequence in italics within italicised square brackets e.g. [*hmm*]. Most of these brief verbal and paraverbal interventions have been noted but not all.

When words have been particularly emphasised this is indicated by the word being italicised.

When some explanation of what can be heard but not easily read is helpful I have indicated this in italicised brackets and words (e.g., (*shows surprised interest in the question*)).

Most names and places have been changed in order to ensure anonymity and confidentiality.

In ‘initial ideas’ the term ‘therapist’ and ‘therapy’ are used to refer to both counsellors and psychotherapists and counselling and psychotherapy.

*I prefer the term ‘interviewee’ to ‘respondent’ but to distinguish one I from another I in the transcript I use R for respondent.

<u>I/R</u>	<u>Transcript</u>	<u>Initial Ideas</u>
I1	Yeah, so I’m just going to start with some general questions [<i>okay</i>] before I move into more specific things I’m interested in [<i>cool</i>] - but yeah, basically in the first place I’m just wondering how you became interested in therapy?	[00:35] The encouraging ‘okay’ and ‘cool’ perhaps demonstrating the ‘active’ [see pp in Gubrium et al.] participation of the interviewee in attempting to put me at ease in what he knows is my first interview for this project.
R1	Hmm (<i>shows surprised interest in the question</i>) – I think it’s just because of I - it’s a – I think I wasn’t interested in therapy at all, I didn’t have any interest in it and all the images I had of therapists were quite kind of	

<p>negative sort of you know Woody Allen psychoanalysis type stuff and then I met some people who had had therapy and so I ended up having some and found it helpful. And then I – yeah somewhere through that and through getting involved in shamanism and stuff I just got involved in listening and helping stuff but it wasn't an intention to become a therapist or anything, and in that, I don't know, I guess somehow I just started listening to people and then my niece - just having a phonecall with my niece - she was in her twenties and she was going through a bad relationship and she just said that she thought I'd make a good counsellor and it was a time when I was looking for something to do, you know, looking for something to train in, looking for - because I was - I didn't - I was just doing bar-work and odds and sods and I was looking for something meaningful to do so when Harriet said she thought I'd make a good counsellor I just thought I'd try an introduction to counselling and actually this is probably really relevant because I went on a ten week introduction to counselling course just to feel my way in to see what it was like <i>[hmm]</i> and what resonated with me straight away was when the tutor started talking about person-centred ideas <i>[hmm hmm]</i> - and that - there's two reasons for that, one was because I'd wanted to train I phoned a couple of counsellors to ask for some advice about training and one of them said 'Whatever you do' – you know because I</p>	<p>Representations of therapists in the media.</p> <p>A related but different practice.</p> <p>The respondent aware we are having a conversation in which his answers will be more or less relevant for the institutional goals of the conversation [i.e. 'this is probably really relevant'].</p>
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	<p>knew there was all the different models [yeah] - one of them said 'Whatever you do I'd say do your first level training in person-centred stuff because the core conditions are at the heart of most therapies so if you do that then you can build on it' and then on the introduction course when the lecturer started talking about how it's - from a person-centred perspective - it's about not being an expert I just suddenly felt 'Oh brilliant I'm not going to have to have loads of knowledge and take loads of responsibility for making decisions about people's lives' [right] - so for me that - the idea of a model - arose right at the beginning [and] of getting into therapy - [and the values of the model] - yeah, they're kind of a person-centred -</p>	<p>Again, with awareness of the main topic of the interview. Awareness of the diversity of models from the start and implications for favouring one over the other. The respondent before his PGDip training hears from a qualified therapist that the 'core conditions are at the heart of most therapies': an early-career moment when the respondent hears the articulation of a 'common factor' idea.</p>
I2	<p>- it's more about the values then maybe techniques as such -</p>	
R2	<p>- yeah, absolutely – and the sense of it fitting with my sense of who I was – that [hmm] – starting - thinking I'm starting on a professional training to be a therapist, I guess I thought I was going to end up like a social – because I didn't really know what therapy was I suppose. Although I'd been a client I didn't really have much of a sense of what being a therapist entailed so I think some of it was probably 'At some point I'm going to have to learn interventions and the right thing to do at the right time and I'm going to have to learn and hold lots of information and be responsible for making clinical decisions' [yeah] so when this woman just said 'Actually it's - the client's the</p>	<p>In a sense like a <i>tabula rosa</i> – some trainees will be like this and others won't. Also notice a kind of guessing at what 'being a therapist' could be...being-a-therapist...</p>

	<p>best expert in their own experience and it's about you just helping them to understand that' - <i>[hmm]</i> – 'their perspective' – it just felt like – she said it much simpler than that – <i>[yeah]</i> but it just felt like 'Yeah, brilliant I think I can do that, it doesn't feel too hard' (<i>laughs</i>).</p>	
I3	<p>Yeah, okay. So how did you train to become a therapist?</p>	
R3	<p>So, yeah, so I did the - I did the introduction and the certificate and the certificate was a person-centred certificate at LC [abbreviated for anonymity – anonymous enough?] and then I was, when I finished my certificate I wanted to do a diploma because by then I was like 'Yeah, this is working for me' because I found I was interested enough and found I could study so I was developing a sense of myself as someone who could do stuff in the world, someone who could learn, someone who could grow and so I applied for two courses, I applied for the diploma at LC in person-centred counselling and one at BC [abbreviated and changed for anonymity – again, enough?] and I interviewed for both of them and the reason I chose the BC one was because part of what I was doing in therapy was - I mean in the training – was discovering about how academic I could be so it was all like - I could do a HND or I could do something that if it works out I could maybe go on to do a Masters <i>[hmm]</i> and I had no idea what a Masters was but it sounded like it really meant something and it kind of had some value for me so I thought 'Okay, I'll go for the one that's more academic because it's got</p>	<p>Something we've both done so this 'hmm' a kind of positive 'marker' from me to him. The aspect of therapy that's 'academic' – another controversial theme cf. recent Therapy Today with Nick Totton saying none of these courses actually teach you how to be a therapist and, in his view, the irrelevance of being able to write an</p>

	<p>the other bit too' – yeah, so – [yeah, so more] - yeah – [possibly more to do] – and more for your CV – [more what sorry?] – and more for your CV as well [ah, okay, yeah] - so, yeah, I did the diploma then at BC then did the postgrad diploma, then did the MA and when I finished that I never really wanted to work for anyone. I'd obviously done placements during my training and done a few placements but all I ever really ever wanted to do was set myself up in practice so once I finished the diploma I decided to start up private practice [hmm] and that was it really.</p>	<p>essay etc.</p> <p>The desire of trained therapists to be in private practice. I really want to find an estimate of how many private versus NHS therapists there are but have so far been unsuccessful in finding that stat.</p>
I3	<p>Okay, so outside of that kind of, if you like, that kind of core path [hmm] of introductory certificate, postgraduate diploma [hmm], MA and I know now of course that you're doing a PhD but [hmm hmm] outside of that, if you like, that central core path, I'm wondering if you've had any other trainings or any other kind of therapeutic experiences that have affected you and your practice?</p>	<p>We know each other and are on a similar PhD path – this commonality – advantages and disadvantages re: the research??</p>
R3	<p>Umm (as if he's taking a think about it). Well I guess when I - my first counsellor was a psychosynthesis practitioner - so I think that was around at the beginning [hmm hmm] and as I've said I was interested in the shamanic stuff so something about kind of experience and different levels of experience, different ways of experiencing the world [hmm hmm] so something about counselling being one way of doing psychological healing – I guess that was in there –</p>	<p>Here, Dan states that counselling is only 'one way' of doing psychological healing – pluralism also has implications for all the different kinds</p>

	<p>obviously we did the Gestalt and the TA on the diploma [hmm hmm] – my, the counsellor I had when I was doing my diploma was person-centred, I had a psychodynamic counsellor for a while after I'd finished my diploma [hmm hmm] – which I didn't have a very good experience of because I didn't enjoy any of his interpretations I thought they were all bullshit to be honest, and some of them were quite damaging [yeah] but other than that I think because of the teaching, because I teach as well [yeah] - I've had to read quite widely for my teaching [yeah] - so I can give students a critical edge about stuff so I haven't done any other training [hmm] other than in the core stuff but I have read widely and I do try to - psychodynamic supervisors – I've been in supervision groups with people of all sorts of different models [yeah] - so more about absorbing different ways of working [yeah] rather than kind of learning about them -</p>	<p>of professionals offering therapy or therapy-like services e.g. psychiatrists, clinical psychologists, counselling psychologists, psychotherapists, counsellors and I think in the US social workers who offer counselling and psychotherapy as a kind of subset of their overall social worker identity. All these identities/professions are confusing within these professions and for the public.</p> <p>Some therapists do have experiences of other identifiable approaches and therapists who identify with these approaches which may have been negatively experienced. In that sense, sometimes it can be quite difficult to hold onto a respectful appreciation of the 'other' and maybe want to 'choose a side'. My first 'yeah' might have been an agreement – I, too, had a psychodynamic therapist who I didn't find damaging but whose 'classical' blank screen style I found ineffective and alienating. The second 'yeah' is because I know he teaches.</p> <p>In this sequence there also seems to be some discomfort around not having done different kinds of trainings, perhaps because of the perceived agenda of the interview and a desire to emphasise the breadth of reading (as opposed to training). I am wondering about the whole experiential versus intellectual debate in the therapy world that is maybe implicit in this sequence but not articulated.</p> <p>Then he mentions that he has been in supervision groups with supervisees of different modalities. This had not occurred to me as a 'site' for experiences of pluralism and I am excited by this 'discovery'.</p>
I4	<p>- yeah – but I'm wondering if you think it's affected your practice in any way? [Which, what, the?] These other ideas outside of your core training.</p>	<p>So have these experiences affected his practice? This question remains unanswered and I think it's important. He is confused by the question and I attempt to clarify.</p>
R4	<p>Yeah well yeah they have and it hasn't always been helpful I don't think [hmm] because at times I can remember when I was in a</p>	<p>Then he says that they have affected his practice and goes into a more detailed narrative that illustrates quite vividly some of the difficulties therapists experience around</p>

<p>super- when I was doing telephone counselling I was in a team with people with all sorts of different modalities and we used to have group supervision (<i>coughs</i>) and the supervisor was quite psychodynamic and my experiences in that was often feeling that coming from a person-centred place I often felt like I had to defend my way of working because I'd just be falling back on Rogers' conditions and trying to have a therapeutic relationship and I felt like everyone else in the group from their different models was on some level saying 'Well, that's all very well but at some point you need to do something' (<i>slight laugh</i>) and trying to kind of get me to do things so I felt like in supervision there I could be quite defensive and at times I would take other people's ideas on and I think something about the process of me taking them on that very rarely turned out to be helpful and I think it was because I didn't feel like I knew enough about them, sometimes I felt like I was doing things because I felt I <i>should</i>, because I'd been told to in supervision or because people had been talking about it – things like on the phone counselling we used to do quite a lot of work with people who'd been through trauma so we did a little bit of work in supervision on how to work with trauma and how to debrief so I did some phone work with that which kind of worked a little bit and then so I tried it in a face-to-face situation with a client and it was just completely different and just didn't work and I felt like I'm picking these ideas</p>	<p>pressures to take up or conform to different approaches and techniques in therapy.</p> <p>The sense of having to defend one's approach with a therapist of another approach.</p> <p>A common perception of person-centred therapy somehow not being 'enough' and the pressures he experienced in this group to 'do' more.[e.g. a classic training essay is along the lines of 'The core conditions are necessary and sufficient – discuss'.]</p> <p>A fear some have about pluralistic approaches: that practitioners will attempt to practice with ideas 'before [they] know enough about them".</p> <p>A criticism of pluralism is that it's</p>
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	<p>up before I know enough about them <i>[right]</i>. So in a way it's - in an odd way it's made me get closer to working in a person-centred way <i>[right]</i> because of almost a kind of fear you know like doing – you know someone talking about a really traumatic incident they had and me thinking 'Oh, we can do this stuff' – there's suggesting it, there's doing it and then realising that in a fifteen – you know because we only had fifteen minutes booked - actually I didn't have the space to hold it because when I'd done it on the phone it was open-ended and you'd be on the phone for a couple of hours <i>[right]</i> sometimes so suddenly having to contain this process – which - so not having the experience, not having the knowledge or the experience to use some of the tools that I felt I was absorbing <i>[right]</i> – left me feeling like, yeah, some of those things they just feel like they just get in the way and they can be dangerous <i>[okay]</i> – yeah?</p>	<p>Better to be master of one 'trade'?</p> <p>He seems to be remembering a specific incident on which he's basing the view that it was unhelpful being pressured to use these other ideas. I'm curious now about why face-to-face consultations were so brief and the phone ones much longer. Was his bad experience of trying to use this other technique more to do with the shortness of the session than his ability to implement it??</p> <p>Unclear if he means they can be dangerous in themselves or just dangerous if the therapist is not practiced in them or dangerous in face-to-face sessions that are only 15 minutes!! – but in any case the overall point is that he felt safer coming from a particular therapeutic position without venturing into techniques that came from a different model/approach.</p>
I5	So, how would you describe your practice now?	
R5	I'd describe it as classically person-centred and informed by existential ideas <i>[right, okay]</i> .	
I6	I think you've talked about different approaches to	

	<p>therapy and how they've affected you and your practice but, I mean, is there anything more you want to say about that?</p>	
R6	<p>Well, just that - it's just like I feel that therapy's really complicated (<i>slight laugh</i>) and I can say 'I'm classically person-centred and informed by existential ideas' which means that, well, I'm tracking the client and trying to communicate empathy and unconditional positive regard. I'm also sometimes aware of existential issues around, you know, if a client's talking about, I don't know, death or choices or something, some of those existential givens are around and I'm happy to go into them if a client seems, they seem to be being present for a client. But I feel like I'm probably different with every client inasmuch as for me being, working in a person-centred way means offering the core conditions but doesn't really prescribe how to do it so it's as long as I feel like I'm being empathic [<i>hmm</i>] and not judging the client then anything goes in a way [<i>yeah, okay</i>] so that might mean talking about homework, that might mean bringing in stuff from TA to talk about the Drama Triangle or [<i>yeah</i>] Parent-Adult-Child or scripts or something. It comes from a place that's informed by Rogers' conditions - but I don't necessarily feel tied to it as long as I understand what I'm doing enough to feel [<i>yeah</i>] confident to do it – does that make sense?</p>	<p>Cf. Yalom who says I think in the Gift of Therapy that there should be a brand new therapy for each and every client. How would this idea be researched by the 'brand' model of therapy? And the key note at a conference this year, is it BACP Research one? Is titled 'A different therapy for every client?' or something like that.</p> <p>The problem too that even named therapies are not uniformly generic – e.g. Pete Sanders' The Tribes of the Person-Centred Nation, all the different ideas in psychodynamic practice, 'humanistic' as an umbrella term for a whole variety of approaches/ideas, the contradictory CBT approaches of is it 'second wave'? which emphasises changing your thoughts, feelings and behaviours versus 'third wave' which emphasises a more detached 'acceptance' e.g. mindfulness – two very different ways of viewing 'problems' within the same approach, purportedly.</p> <p>Here Dan articulates his person-</p>

		centred position as focussing on the core conditions and as long as they are in place 'anything goes'. In that technical sense there is nothing to stop a person-centred practitioner being pluralistic. It is the philosophical and ideological position that the therapist must not be directive and must not interfere with the client's process and must not attempt to be any kind of 'expert' that contradicts a potentially pluralistic potential for some person-centred therapists but the core conditions in themselves do not contradict a potential for a more pluralistic position in person-centred therapy.
17	It does make sense. But, I'd say that takes you out of what might be described as a 'purist' position because <i>[yeah]</i> certainly some person-centred practitioners if they heard you say that you sometimes bring in TA might put up their hands in horror.	Of course I'm going to agree because I hold a pluralistic position. I get a sense that Dan knows he is articulating such a position and maybe is struggling with it a bit because of his overall identification as 'person-centred' and 'classically person-centred' which might be seen as less flexible than non-classical practitioners. I bring this theme into the dialogue and name it as purism as a kind of counterpoint to pluralism. I don't see these positions as black and white, rather I see these positions as operating along a continuum.
R7	Absolutely, yeah, and I'm very aware of that and it's almost like if I was doing a skills session for a person-centred course I think often I'd fail but I feel like I'm being person-centred (<i>some laughter</i>) but I'm not going outside the conditions <i>[yeah]</i> because I don't feel like I'm being judgmental and I always check that and for me that comes from wanting to have an equal relationship with the client and not wanting to disempower them and not wanting to become an expert and someone they rely on but to become someone who they can work through stuff with <i>[yeah]</i> . So yeah, absolutely <i>[okay]</i> .	So one question is does bringing in an idea or a technique really make the client more dependent and cause 'expert' projections or, if it does, does the potential helpfulness of such an

		idea/technique outweigh, at least temporarily, the arguably counter-therapeutic nature of dependence, projections, or disempowerment.
I8	Okay, well I mean, so following on from that how closely do you think your practice <i>is</i> based on your original training?	
R8	<p>[Slight laugh] I - that's a tricky question because I feel like when I came away from my original training [yeah] I literally didn't have a clue what to do [right]. I felt like I got my diploma, you know I'd done my placement and I'd passed all the assignments and I had this qualification and I felt like all I needed to do was pick up all the books I'd started out with and read them and try to work out what the hell I was supposed to be doing because in a way I don't necessarily feel like the training told me what to do in a room with a client. You know, it told me about theory, it taught me about philosophy, it taught me about ethics and we were assessed in how to use skills but I didn't necessarily feel like I knew how to be a counsellor so it's almost like the - I had to then - I think that's why I did the Masters was to try to spend a bit of time working out what I'd learnt on the Diploma [right]. Yeah? So it's almost like the training asked questions and gave me ideas and then I feel like the MA was something else, it gave me a chance to consolidate them but that was about me going off on my own and coming back with my own consolidation [yeah] and so I guess if the question is 'Have I strayed far from where I ended up at the end of all of that process?' I don't think I have</p>	<p>Interesting that a training can leave a practitioner feeling like this.</p> <p>Cf. the Petruska Clarkson quote at that SC seminar when she said that psychotherapists don't like to admit that they don't actually quite know what exactly it is they're doing - and that got quite knowing laughter from the audience.</p> <p>And also, cf. Totton, the training not necessarily that useful for the actual <i>practice</i> of therapy.</p>

	<p><i>[yeah]</i>. I've wandered away and then come back and come back to it in different ways and come back to it on another level because the existential ideas and some philosophical ideas about the core conditions, if you like, have come along later <i>[yeah]</i> and shifted my understanding of it <i>[yeah]</i>. Does that make sense? <i>[Yes, yeah]</i>. So rather than I have to use the conditions because they're the be-all and end-all but they're an expression of fundamentally phenomenological ideas. So I feel like I'm expressing a meaningful philosophy rather than doing an approach to therapy.</p>	<p>This is a very interesting point – in terms of researching therapy, therapy is usually framed in terms as coming from a pragmatic position with pragmatic techniques – the embodiment of a philosophical view, or a 'way of being' (whether that's person-centred or Freudian or Kleinian) that actually informs and infiltrates a therapist's whole life and which the understanding and embracing of by the therapist may actually activate the effectiveness or not of a therapeutic process falls outside the paradigm of how research into therapy is usually conducted.</p>
19	<p>You're expressing a meaningful philosophy rather than doing an approach to therapy? <i>[Yeah]</i>. But by that do you mean you're expressing a meaningful philosophy when you're practising as a therapist? <i>[Yeah, absolutely]</i>. How you're practicing is, if you like, you're practicing from a kind of embodied philosophical position <i>[yeah]</i> as opposed to doing person-centred techniques.</p>	
R9	<p>Yeah, so therefore if the question is 'How would you describe your practice?' the easiest way I can describe</p>	<p>The difficulty in describing practice and what it is that therapists do.</p>

	<p>what it is I do is by saying 'It fits Rogers' conditions' [yeah], it's person-centred. So I feel like I got into the approach and then got deeper into some of the philosophy around it [yeah] and then ended up with feeling really comfortable with that and then coming back through the approach [yeah] yeah, because it's - it just feels like it's, yeah, expressing [yeah] phenomenological ideas about the uniqueness of experience and trying to understand someone else's experience and about bracketing [hmm] and all that stuff [yeah] and the easiest way to describe that to someone else who's a therapist is to say 'I work in a person-centred way'.</p>	<p>We are both aware that we know a certain amount about phenomenology and have had conversations about it in different contexts. This is bound to affect our dialogue at this point.</p> <p>The need for this label being identified as a need to be able to have a shorthand for other therapists. The use of the label for non-therapists?</p>
I10	<p>Right, okay, but in some ways you're suggesting it's a kind of shorthand [yeah!] (<i>enthusiastic agreement</i>). It doesn't necessarily sum it up.</p>	
R11	<p>Yeah, absolutely and I think that sense of a person-centred purist would throw their hands up in horror [yeah] is because coming from that position, coming from a meta-position or a [yeah] - it's like 'Well that gives me more freedom than "Oh, I can't do that because I haven't seen a video of Carl Rogers doing it" [yeah]. His intention was to express something about the way we should be together therapeutically so if I'm expressing that intention from my understanding of what it means to be human [yeah] then it's an expression of a meaningful philosophy that's a useful vehicle, it's a way to describe what I'm doing [yeah, or being]. Yeah, being,</p>	<p>Dan, borrowing the phrase I used earlier [number]</p> <p>Actually Dan brings in the term 'meta-position', not me – I think initially I thought I did but that was probably because of conversations we'd had before the interview so I thought of this word as 'my' word. Freedom/restriction I think could be a potentially important theme.</p>

	absolutely.	
I12	I mean in that sense the person-centred thing can be more about a way of being than a way of doing.	
R12	And the thing about doing it differently then <i>[yeah]</i> is because different clients need different things from you <i>[yeah]</i> . You know some clients are very aware and are just happy to be with me in a way that feels like me just <i>being [yeah]</i> and other clients whether it's they want to work in a more cognitive way or whatever but it's, like I say, as long as I feel I'm expressing what I want to express <i>[yeah]</i> in the doing because the doing is less important and more idiosyncratic for each relationship <i>[yeah, yes, okay]</i> . Yeah?	Treading onto 'pluralistic' ground...
I13	Right, yeah, so I understand that <i>[hmm hmm]</i> and I think there's some interesting issues around <i>[hmm]</i> what does person-centred mean <i>[yeah, absolutely]</i> when you say that's how you practise being person-centred <i>[yeah]</i> . And I kind of understand that you're saying that your practice is still quite based on your original training it just seems to be at deeper levels <i>[yeah]</i> than you may have understood <i>[yeah]</i> after you were holding your Postgraduate Diploma <i>[yeah]</i> proudly in your hand <i>[yeah]</i> but I'm still a bit confused about how closely you think your practice is actually based on your original training <i>[well]</i> and by your original training I mean the diploma level <i>[yeah]</i> – you know, obviously at Masters and PhD it all <i>[yeah]</i> gets a bit more philosophical -	

<p>R13</p>	<p>- and that's what I mean is it's tricky because when I did finish the training I felt like I didn't know what to do [yeah] so to say 'Was it based on my training?' I just feel like well I guess it is because the training asked a load of questions and left me with a load of stuff to resolve which I resolved by going back to the original books, by going back to [yeah] <i>On Becoming a Person, Person-Centred Counselling in Action</i> [hmm], by going back to the books that were at the heart of the course [yeah] I guess I got a clearer sense of it so in that sense I suppose it is close to the course and <i>maybe</i> closer to person-centred than the course was because sometimes I feel like the course was a bit confused because of all the systemic stuff, all the TA stuff that had come in [yeah] and the psychodynamic stuff in terms of looking at developmental psychology and the Gestalt stuff [hmm] from the skills tutors and things that are actually – it was more like a therapy course [yeah] that hung itself in a humanistic corner [hmm hmm] and introduced loads of other ideas because I guess it was Masters level so it was about critical thinking and awareness and stuff but I don't feel like it did much person-centred, I don't feel - because I'm sure it was called 'person-centred', I can't even remember now, I'm sure it was called 'Person-Centred Diploma' [hmm] or 'Postgraduate Diploma in Person-Centred Counselling' but I don't feel like it did much this-is-how-you-be-person-centred [hmm].</p>	<p>Dan repeats what he's said earlier – this repetition points to the importance of this for Dan.</p> <p>Books as codes of practice for different therapeutic positions.</p> <p>I agree because I went on the same course but in previous years to those Dan attended.</p>
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I14	Right, so it wasn't – okay, so from your original training it wasn't like you felt they've told me how to be <i>[yeah]</i> a counsellor and how to practice <i>[yeah]</i> and still confused about that so -	
R14	<p>- but I didn't come away feeling like <i>[hmm]</i> this is how you do or be person-centred <i>[yeah]</i>. I felt like I came away with loads of input from loads of different tutors about how to do skills and how to – and about theory <i>[yeah]</i> and also loads of different input from different supervisors <i>[yeah]</i> because I worked in a drug and alcohol agency so there was Motivational Interviewing which is person-centred but also almost kind of bits of CBT in it and I worked in a school with a psychodynamic supervisor and she focussed heavily on boundaries and holding the frame and developmental issues and I worked – and I'd done some work for Cruse <i>[right]</i> which is the grief model although quite person-centred and I'd worked in a drug and alcohol rehab <i>[hmm]</i> where we could just work in our own way but that was heavily influenced by contracts in the house and limits on confidentiality and was actually quite critical <i>[yeah]</i>, the environment was quite critical so I feel like all of those, the experiences in placement and loads of different experiences in placement, none of them purely person-centred and the kind of, the mix of stuff, the confusion in the training meant by the end I felt that sense of I've qualified to be a counsellor and I know I've passed all the stuff but I'm not quite sure what I'm meant to be doing. <i>[Yeah]</i>. Does that make sense?</p>	<p>I think this would be quite a common 'pluralistic' experience for trainees – the modality of their training versus the modalities of their placement supervisors, co-supervisees etc.</p>

I15	<p>It sounds as if you were left confused [<i>yeah, absolutely</i>] and maybe I'm a little bit confused on whether that confusion left you unsure of how to practice and how you identified yourself [<i>yeah</i>] or whether you were, as it were, quite certain that you were person-centred or that you were person-centred [<i>well, yeah</i>] even if you didn't understand it too well.</p>	
R15	<p>I felt like I was person-centred and that went right back to the introductory course and whatever that sentence that woman said that made me think 'Oh, that's a relief, that feels like me,' [<i>yeah</i>] 'that feels like something I can do' and so a lot of the books - I used to - in my training were person-centred books so I kind of stayed close to that [<i>yeah</i>] and I guess I didn't feel like I got much specific input on how to be person-centred and that's the whole thing about being and doing [<i>yeah</i>]. Maybe what I was left with was the right place where actually I had loads of ideas and what I had to do was consolidate them into my own person [<i>yeah</i>], into my own way of expressing them. Maybe it's just that, maybe it's kind of like a birth, you know you just kind of come out and you have to learn how to be human [<i>yeah, right, so okay</i>]. Maybe it is actually quite congruent in a way because it's not about 'Well this is how you do it', it's 'Here's all the ideas, you work out how you're going to be it' [<i>right</i>]. Does that make sense?</p>	<p>Great metaphor, the newly qualified counsellor like a new-born!</p> <p>There seems to be another I-position coming in here – one that appreciates the not being told how to do it versus the previously held position that seems to be criticising the course for not telling him how to do it.</p>
I16	<p>That does. Yeah. And a lot of – although you have the qualification, it seems as if the real qualification just</p>	

	comes from experience [yeah] which of course you have in the training like you said on your placements [yeah]-	
R16	- and in that I've just realised something else really significant was in that place of getting bits of TA, bits of Gestalt, bits of systemic stuff, bits of psychodynamic stuff, bits of a kind of person-centred thread through it and all those placements and all those supervisors one thing I did was I took on a purely person-centred supervisor [hmm] to supervise all my supervision because I had a psychodynamic supervisor, I had a TA supervisor, I had a Cruse supervisor who was a bit - I'm not sure what they were doing – so I went and got another supervisor so at one point I had four supervisors and I would just take my supervision to this person-centred supervisor who I knew was a person-centred lecturer so I knew was an authority on the model that I'd identified with to help me understand it all so there was a kind of a commitment on my behalf to sticking with that model that had resonated with me all the way through [yeah] and a lot of the learning actually took place in that supervision [yeah, okay].	<p>Again, significant to what he knows the topic is – the interviewee is 'active' in 'accomplishing' the interview.</p> <p>This is very interesting – the pluralistic spirit of the course and the pluralistic nature of his placements and supervisory structures pushes him into finding a more 'purist' overseer of all these different positions. Kind of like a meta-view but from a particular position.</p> <p>Direct reference to 'identification' with a model.</p>
I17	Alright, yeah, okay, that's interesting. A sort of master key. [Yeah, absolutely]. Okay, so I'm wondering when you see clients I'm wondering how you communicate with clients about what you're doing and what's happening in therapy.	
R17	Yeah, okay, so like at the very beginning? [Any time]. Okay, well I like in the very	

	<p>first session to be really clear or try to be clear about how I work and try to express it in terms of not being an expert, not being someone who's necessarily going to have answers, something about just helping them to understand themselves more deeply and trusting that out of that they'll find some direction or whatever they're looking for. I don't feel like that's coming out very coherently now but with clients I can say it in a way in those first sessions that's clear and I – it's I guess it's therefore around in the ways I am with clients – it's always about following them and also an ongoing metacommunication because if anything happens when I feel like I'm stepping out of that role then I'll talk about that, that'll be part of the <i>[right]</i> process with the client – me checking it and trying to involve that in the conversation <i>[right, so]</i> so the client knows what I'm trying to set up and what I'm trying to maintain – it's all about so they can understand their position in it.</p>	
I18	<p>Right, so you're fairly open <i>[yeah, absolutely]</i> – yeah, you're fairly open about what you're doing <i>[yeah]</i> and the process. Basically you can have what some people call a 'meta-conversation' about the conversation <i>[yeah, absolutely]</i>, conversation about the conversation <i>[conversation, yeah]</i> and you don't mind doing that? <i>[No]</i>. Yeah, because some approaches think that that's not a good idea <i>[yeah]</i> to talk about therapy -</p>	<p>I'm aware Cooper & McLeod call it this there might be others too. Dan has actually referred to metacommunication in R17 so he's already mentioned it in a way. I need to check up on who brings it in because it becomes a central theme of this interview.</p>
R18	<p>- yeah, but from my perspective I think it is because it's about</p>	<p>So the metaconversations</p>

	empowering the client <i>[yeah]</i> . I don't want to be the one pulling the strings <i>[yeah]</i> . I don't want to be - anything hidden - so it feels really important to me to have that metacommunication <i>[yeah]</i> and I'm aware when some clients aren't interested in it.	encouraged by a pluralistic perspective/practice align with person-centred notions of client empowerment. Cf interview with GP whose basic spirit was she thought most clients aren't bothered about what you're doing as long as you're providing a supportive relationship and seem confident about what you're doing whatever you're doing [cf. instillation of hope literature as a indicator of positive therapy outcomes]
I19	Right, so that's a kind of personal judgment in the moment.	
R19	Yeah. But even if they're not interested I will still try to express it because what's important to me in it is we're having this - a real relationship as possible so they - I'm at least trying to let them know what I'm doing even if I'm not sure they're getting it because I don't want them to be giving me a role that doesn't - that isn't what I'm trying to give them <i>[right]</i> . Does that make any sense?	
I20	I think - are you talking about the tendency that clients sometimes have to try and keep you in a position of power <i>[yeah, absolutely]</i> and expertise and then you need to basically say 'I'm not about that' <i>[yeah]</i> as part of a metaconversation <i>[yeah]</i> .	
R20	Yeah, so even if it's just in the simple one of you reflect something back in a session and it's just reflecting back exactly what the client said and they come back to you next week and you and they say 'You know when you told me to do so-and-so' - <i>[yeah!]</i>	

	(<i>excited recognition of my own similar experiences</i>) it's like 'Hold on' - in some way - ' well actually what I was doing, that was exactly as you said, I was just giving you back your words' so trying to unpick that all the time.	
I21	Yeah, okay, alright. So for you having a conversation about the conversation's fine. [<i>Yeah, absolutely</i>]. Okay. So I'm just wondering in your experience and from what you're saying maybe you don't have the direct experience but maybe you know other people who have had different experiences but I'm just wondering how you think using different therapeutic approaches with different clients at different times affects therapy?	
R21	Well, I think it affects therapy in the way that different people need different things at different times [<i>right</i>] so if you're not giving your client what they need it's not therapeutic [<i>yeah</i>] so if a client comes to me and they need something other than what I feel I've got, what I'm equipped with, what feels like me being the therapy to me then that's going to be part of our metacommunication [<i>hmm</i>] because I feel like if they don't want to buy what I've got to sell then there's no point and because people need different things at different times then I think it's really important to have an awareness of the limits of what you're doing [<i>right</i>].	<p>This is the pluralistic perspective on therapy.</p> <p>Direct reference to therapy as a 'product' in the 'market'.</p> <p>An important aspect that having a pluralistic perspective/practice does not mean delivering therapy incompetently (in whatever way that is perceived or judged).</p>

I22	How comfortable are you about offering different therapeutic approaches with different clients at different times?	
R22	<p>If they're within my understanding, if they're within the things that fit the way I – even if it's things I've read or things I feel an affinity with, an understanding and fit my way I want to be therapeutic then I'm quite happy to do it. For instance I'm working with a guy now who I've been working with for a long time and he's just been talking about problems he's having – he's trying to make a decision about a relationship he's in and I suddenly realised that some of the stuff from MI, from addictions work about making decisions about change was really relevant so I was quite happy because I feel that's something I'm familiar and comfortable with. I was quite happy to bring it in and to bring it in as part of the metacommunication as well as in 'I know this is not what I would normally do but what you're talking about reminds me of and I'm wondering if this process might help you' <i>[right and what did he say, yes?]</i> Yeah, absolutely and we, so we used some MI ideas for a session and he found it really helpful <i>[right]</i>. And it feels like what's interesting in the next session after that we went back to our more familiar place <i>[yeah]</i> so it's – because of the metacommunication and the relationship he and I have it's easy to bring something in and because it felt like it fitted in a way and I understood it so I'm happy to do that, I'm happy to, like I</p>	<p>Narrative illustration.</p> <p>Mixing in MI with person-centred.</p>

	<p>say, bring in ideas from TA if it seems appropriate <i>[right]</i> so, yeah, I'm more than happy if I feel like I understand it and therefore it's safe <i>[yeah]</i> and therapeutic then absolutely <i>[happy to bring it in]</i> – happy to bring it in - because it still feels person-centred <i>[yeah]</i> because I'm hearing in him, he's communicating a need for something and I'm sitting here with something that might meet the need so to say 'Let's talk about this', that feels like it's me meeting him <i>[yeah, okay]</i>. Yeah? It doesn't feel like I'm judging him, it doesn't feel like I'm being unempathic.</p>	<p>Understanding of other things therapists bring in very important.</p> <p>'feel' an operative word here, bringing in an intuitive sense of practicing within a particular model rather than a codified [is that the word?] one – certainly, the opposite of 'manualised'...</p>
I23	<p>Yeah, okay, so that, in a way, fits within your way of doing therapy?</p>	
R23	<p>Yeah, and that's quite important because in a way I've always got a, like a metaquestion, hovering over everything I do which has got two aspects and one is 'Is this empathic?'[sic] and the other is 'Is it judgmental?' <i>[hmm]</i> and if it's either of those then I'm very, very wary of doing it <i>[yeah]</i> but if it feels empathic and is non-judgmental then it's passed the test <i>[right, okay]</i> so it's in the room.</p>	<p>Empathy and being non-judgmental the two 'criteria' [the word I use to describe it in I24] of Dan's therapeutic approach.</p>
I24	<p>So those are the two criteria <i>[yeah, absolutely]</i> and, if you like, other approaches can fit underneath that criteria <i>[yeah, absolutely]</i>. There's a sense in which if you lose the label <i>[yeah]</i> just momentarily <i>[yeah]</i> and you actually think 'Well, these are the two criteria,' <i>[hmm]</i> 'that are important to me' <i>[yeah]</i> 'empathy and non-judgmentalness' <i>[yeah]</i> anything can fit underneath those two words <i>[yeah]</i> in a</p>	<p>Losing the label. I like that phrase.</p>

	way -	
R24	- yeah, and so the next question is <i>[hmm]</i> 'And do I know what I'm talking about?' <i>(slight laugh)</i>	
I25	And do I know what I'm – yeah, okay - with enough knowledge <i>[yeah, absolutely]</i> and experience <i>[yeah]</i> . So, in more general terms I suppose what do you think makes your therapeutic practice effective?	
R25	Oh blimey. <i>(He's initially a bit stumped by this question.) [Sorry, tough question]</i> Yeah, it is! It's a massive question.	
I26	What do you think makes your therapeutic practice effective? Just in general or specific terms.	I try and open up the question.
R26	I think it's – crikey – yeah, okay, on one level I think it's upfront having that metaconversation, being very clear upfront 'This is what I offer', making sure the client understands it, and making sure that's what the client wants. I think the first thing that makes it effective is that the client knows what they're getting and that it's what they want to get which is sometimes tricky because sometimes clients don't know what they want to get and they - anything you say about how you're going to do it I can see sometimes just washes over people because they're just glad to have a therapist and they think it's going to help so I think from what I can control I feel like some of what makes it effective is setting the scene out, setting the stall out clearly and being consistent about it and well, just because I think the relationship, having a healthy relationship, having a relationship where you feel	<p>This transparency of what's on offer and collaborating with the client that's what they want a key pluralistic principle.</p> <p>Cf. what GP was saying in her interview.</p>

	safe and not judged and understood empathically is an effective tool in helping us to reorganise ourselves <i>[right]</i> so I think it's as fundamental as that <i>[yeah]</i> . You know, it's as simple as that. <i>[Yeah]</i> . What we need is a loving relationship <i>[right]</i> so therefore if we give that to someone and that's what they want and we've said 'This is what we're going to give' and they say 'Brilliant, bring it on' then I think it's going to help.	
I27	Yeah, okay <i>[yeah?]</i> . So the loving relationship is the central aspect of therapeutic practice that <i>[yeah, I think so]</i> you think makes it effective.	
R27	Yeah, and within that there's always that the client wants it.	
I28	What do you mean by that?	
R28	Well, just I had a client a few years ago who turned up and sat there and they said 'I'm suffering with really bad panic attacks and anxiety and I want some help with it, I need some exercises, I need someone who can help me to work through, who can give me homework, who can give me breathing exercises and I said 'Basically what I offer is <i>this [hmm]</i> but I don't do that so if that's what you need and you're definite then the best I can do is help you find someone who offers that' <i>[right, okay]</i> . So as effective as I think it is it's only effective for people <i>[yeah, with people who want to -]</i> - who think it's going to be effective <i>[yeah, okay]</i> .	<p>He is pointing out that the client was sitting where I am sitting in this interview.</p> <p>'Hope' as a factor – and papers that support one factor of effective therapy being the client's hope in the effectiveness of the therapy</p>

		encouraged by the therapist's belief in their approach.
I29	Because if they don't think it's going to be effective then you can't -	
R29	- yeah, there's absolutely no point and it's - another avenue on that is that the constant self-supervision is that even if I feel like that although a client's sat there and said 'Yes' at the beginning if I feel like through the process it's not helping them <i>[yeah]</i> then that's part of the metaconversation.	This 'metaconversation' word that I brought into this interview keeps on coming up. I'm not sure how much this occurs in subsequent interviews – talking about it does but I don't think the word comes up. [But Dan brought in metacommunication I think earlier but I need to double-check].
I30	Yeah, you might say 'I'm not sure if this is helping'.	
R30	Yeah, and 'Let's talk about it.'	
I31	And either you might be able to offer them something like Motivational Interviewing <i>[yeah]</i> or <i>[or]</i> you might, say, refer them on <i>[yeah, absolutely]</i> . Yeah, okay, this kind of relates to a little bit where you were before in terms of setting out your stall <i>[yeah, absolutely]</i> and saying 'This is what I offer'. How much do you think clients understand therapy?	
R31	Not much, I don't think. It's tricky isn't it? Because some clients turn up and they're quite well trained <i>[hmm]</i> , they've had therapy before or they've done loads of work on themselves or something so they're in a place where they can get it and other clients - are just - come and they're full of vulnerability and full of pain and they just want therapy and they don't	

	<p>really know what it is and I think the thing about how well clients understand therapy is significant as well because they may understand the different models. They may understand their needs in the way different models fit their needs so there's different levels to it [yeah]. Some clients turn up and they'll sit down and although they're just a client – you know, they've not done any therapy training [yeah] –they've not done anything to indoctrinate them into all the schools and things they'll sit there and say 'I've looked at your website, I've done some reading. Actually what I want is the person-centred relationship you're offering because it sounds like it's what I need'. [Yeah]. Some of them will come and they'll be quite prepared and others will just come and bleed everywhere and just want some therapy.</p>	<p>The point that it's not just therapists' and professional bodies' understandings of what therapy is that's important but also clients! In this social construction or 'symbolic interaction' we are all 'players' in what therapy becomes or does not become – what dies and what lives – an image of 'neuroplasticity' and the pruning of neural pathways etc comes to mind.</p> <p>I like this metaphor and the ease with which Dan utters it.</p>
132	<p>Right, so that's not, that wouldn't be a point at which you're necessarily going to have metaconversations [no]. You're just going to have a conversation. But I'm wondering how able in terms of talking with clients about therapy, how able you think clients are to actually engage in those metaconversations [yeah, okay]. Do you think they really have the ability? We might take it for granted that they understand all this stuff because we've been immersed in therapy for twenty-plus years [yeah] but someone who's just looked you up on the internet and found you and 'Well, it could work this way, it could work that way' or et cetera [yeah] – how able do you think clients are actually able to engage in</p>	<p>Conversations as a way of describing therapy of Szasz.</p> <p>I generally think they do have the ability but this is contended by some [e.g. Dryden] so remains a relevant question and I wonder what Dan thinks about this issue.</p>

	these kinds of metaconversations?	
R32	<p>I think it's a continuum. Some are very able [yeah]. Some are – some have done the research, maybe seen other counsellors [hmm], maybe done some reading and have turned up saying 'This is exactly what I want' and even then it might not be right because it might be what they want but I might not be what they want so there's that in the mix as well [yeah] and the other end of the scale [yeah] is people who turn up and have no idea – they just 'Someone said counselling might help' [yeah] so they come along and they've got no idea and even then some of them are able to hear it and able to understand and others aren't and I think then for those who aren't part of the process of therapy in the early days is helping them to work out what they need just by being with them and having that ongoing metacommunication while they establish their needs and it might be that they come along because – I was working with a client a little while ago – he'd turned up and he was a bit of a meditator, a bit of a self-philosopher – he'd done some reading, he hadn't done any therapy but he'd heard about – he looked at my website and saw a bit in there about the person-centred stuff that seemed to fit his philosophy so he came and sat in the chair and after a few weeks what came out was what he needed was some CBT to help with his anxiety and he ended up doing a mindfulness course so -</p>	<p>The person of the therapist, not just the approach, as important for clients.</p> <p>Dan illustrates what he means with a narrative example.</p> <p>Websites and the internet as a taken-for-granted place for marketing ourselves as private practitioners now.</p> <p>Just noticing how Dan is very aware that clients sit in chairs and uses that as a way of describing a client coming to therapy – I just get a sense of 'the chair' as a situated place of change...</p>

I33	- right – but you pushed him away a bit rather than doing that yourself because you maybe can't -	A little bit strong and probably in response to my own experience of therapists saying I didn't need therapy when I felt I did.
R33	- well, it was a conversation we had. We'd spent a while talking about it. I don't feel it was a push, [okay] I feel it was something we evolved between us [right]. Okay, so maybe there was a bit of a push as in sometimes 'I wonder how this is working for you because it seems like you're still stuck', having that conversation and then him getting into it and then him going to his GP and talked to them about CBT and then just chancing across some mindfulness. No, I suggested the mindfulness course. That's right [yeah], I suggested the mindfulness course because he'd been talking about thinking about getting into meditation [right] so it was like the referral evolved through us both doing bits of research [yeah] and then he found a route that fitted both [okay, yeah]. Does that make sense? [Yeah].	Mindfulness – all over the place at the moment but also talk of 'McMindfulness' and some critical discussion of it in various papers / newspapers / online etc. In general terms I am also aware of the McDonaldisation of therapy – cf. the academic who has been talking about that in more general terms recently – I think he spoke at Brighton Uni – in other words the wish for therapy to be the 'same' – like a McDonalds hamburger is the same all over the world and it may not be that good but it's filling and you know exactly what you're going to get...
I34	And being able to actually have that collaborative conversation, yeah? [Yeah, absolutely, you know, that's it, it is all about collaboration] And then in some ways you were involving your client there [yeah] in the decision about therapeutic direction [yeah, absolutely] so I was wondering in <i>general</i> – that's a specific example but in general how much do you involve clients in decisions about therapeutic direction or approach?	The issue of collaboration as a central pillar to pluralistic practice/perspective.
R34	All the time I think. [All the time?] Yeah, because of the	

	<p>– yeah, I think so, because right at the beginning it's there as in 'Let's talk openly about what I can offer and what you want' [yeah] 'so let's collaborate in what we can do' and it's quite simple, at the beginning it's 'Let's have this conversation to decide whether we're going to work together' [yeah, okay] and about sharing that decision [yeah] and then as an ongoing thing having a metaconversation about the process and reflecting on it to always be collaborating about therapeutic direction because this whole thing coming back to my philosophy [yeah] I don't feel like I have any privileged information about what the therapeutic direction is [right] so how can I, why would I hold anything [yeah] or make any decisions because I honestly don't believe that I know any more about life than anyone else does [right] and I certainly don't know any more about your life than you do. I may have an understanding of a useful therapeutic process [yeah] but not necessarily about what you need for the right therapeutic process [yeah] for your life, a therapeutic process.</p>	<p>'metaconversation' looks like it will probably be one theme</p>
I35	<p>Right, but the only way of finding out what the client thinks about it is to ask them [yeah, absolutely] so it sounds like you do ask.</p>	
R35	<p>Yeah, so whether that's right at the beginning by having transparent information so the people will turn up and are a bit informed, then having a conversation when they're here and having an ongoing conversation that evolves through time just to keep checking it out - [yeah,</p>	

	<p><i>thanks a lot, no, carry on] (I thought he'd finished but he wanted to add some more thoughts) - and that kind of fits with my sense of therapy which is about empowering people, about them living their own lives - so therefore for me it's a therapeutic success if someone sits there after a few weeks and says 'I've realised this isn't what I want' and it's 'Brilliant, fantastic, well done'. This has worked.</i></p>	
I36	<p>Excellent, yeah, okay. Because they're aware [<i>yeah</i>] that there are other options [<i>yeah</i>] and you can help them either explore the options within the relationship you've already established or point them to some other relationship [<i>yeah</i>]. So how do you help clients determine what it is they want from therapy?</p>	<p>I suppose me judging his responses in such a positive way might be seen as a way in which my bias is co-constructing the dialogue.</p>
R36	<p>Well, part of it is trying to keep myself up to date with what's available so that I can at least talk about different options and some of it is just about trying to get us both doing research. And if someone is particularly lost and vulnerable then I won't volunteer to do some research for them but I'm always offering them options, not 'This is the one'. These are some things you can try and try to help them find their choice.</p>	<p>I wonder if the use of the word 'research' all the way through reflects that we are both researchers and this interview is part of a research project – the elevation of the status of 'research'.</p> <p>'not "This is the one"' – cf standard therapy research whose aim often seems to be to find 'the one'.</p>
I37	<p>So there's finding out information [<i>yeah</i>] and get them to find out their own information if you feel they're strong enough to do that [<i>yeah</i>] or you don't mind maybe printing something off for them [<i>yeah</i>] if they seem more helpless than that -</p>	<p>I misheard R36 and he doesn't contradict me but my sense is he meant he wouldn't print something off for them – that would be too directive and disempowering?</p>

R37	- get together and talk about it again and if I don't feel they're strong enough it's as simple as 'How do you feel about doing some research about this?' and if they say 'I'm not sure' I say 'What do you want me to do then?' because it's not making a decision for them about whether they're strong enough [yeah]. Even that's part of the discussion.	
I38	Right, okay, nothing taken for granted or assumed [yeah] or as little as possible anyway. So how much do you think you vary the way that you work with different clients?	
R38	Very much. Yeah, I think I'm, like I say, I've got those two check questions [two what?], those two questions about 'Is it?' – [oh, yeah] – and otherwise I vary but it's not necessarily conscious, it's more about meeting someone else [right] so I guess if there was someone else in this room we'd be having a very different conversation and if you were someone else asking me these questions we'd be having a different conversation – it's not strategic.	When therapy is such a situated, embodied and unique experience it's very difficult to generalise about therapeutic process in exactly the same way as it's difficult to generalise about interview process – Dan is pointing this out via our here-and-now situation.
I39	It necessarily varies just because you're talking to a different person [yeah]. Sorry about the -	
R39	- I'm just wondering about if there's an inconsistency in there because I think it might be a bit too easy to just say it varies for different people because it – 'Yeah, I am different because different people bring out different things in me' [yeah] - and also there's part of that evolving thing between us where [yeah] if as well as bringing out something	Cf Dialogical Self Theory (DST) here – seeing a therapist or a client as

	<p>different, bringing out different aspects of my personality and also as if someone seems to be talking, say, in a very physical, embodied way about their experience [yeah] then I will on some level make a choice of okay – ‘Let’s, okay, that’s their language’ [yeah], ‘let’s work with that’ [yeah], so there is a bit of conscious stuff going on as well, it isn’t just that I’m different with different people [right, okay]. There is an awareness thing as well. If it’s quite cognitive so ‘Let’s do that and let’s make sure we don’t get lost in thinking and also have an awareness of other parts of our experience’ and likewise if someone seems to be all feeling then I’m happy to go there so it’s about meeting them where they are, how they see the world, how they experience the world.</p>	<p>unified things in themselves is a flaw in how most therapy research is conducted.</p>
I40	<p>Yeah, okay. Yalom said that you had to do a different type of therapy for every single client [yeah, absolutely] which is one way of looking at it but I suppose what’s sort of behind the question really is some therapists might identify with a way of working so much that they’re sort of trying to present the same thing to every single client [yeah] and think that that is, if you like, the correct way to proceed, that you actually have a certain philosophy, a certain creed, a certain way of doing things that must be delivered the same no matter who’s in front of you because that’s effective but it’s – I suppose it’s asking the question ‘Are you doing that?’ really.</p>	<p>I bring in Yalom – a figure in part of our social construction of therapy?</p>
R40	<p>So the first level is ‘Yes, I’ve got a philosophy stroke</p>	

	<p>creed' but how I deliver it, it's not only different people, it might be how I am in the day [<i>yeah</i>], where my energy is, and how I'm feeling that day so it's dynamic in that way.</p>	
I41	<p>Yeah, you're spontaneous to a certain extent. I mean this is quite a difficult question in a way but I'm going to ask it anyway (<i>slight laugh from Dan</i>). What's been your experience of – there's a lot of debates about different approaches in the therapy world and more recently there has been calls for a more pluralistic attitude in the therapy profession - I was wondering what has been your experience of past and current debates about different approaches to therapy and this call for a more pluralistic attitude? Any experiences of that?</p>	
R41	<p>Yeah, absolutely. You could almost do like a time line of it [<i>yeah</i>]. When I finished my training it seemed like every copy of <i>Therapy Today</i> would have a letter from someone saying about how the person-centred approach was the only way to do it and everyone else was a charlatan and then the next week you'd have a response to that from a CBT practitioner saying 'Well, this is nonsense, the only way to do it is CBT' and then there'd be a psychodynamic practitioner and it was just - it was like there – it just felt like it was warfare or a family bickering and it just used to really, really piss me off, I would just feel like well, actually, I would read the person-centred stuff and I would think yeah, there's so much in there I understand and that makes sense to me and what I hate about it is the</p>	<p>The BACP magazine for practitioners. I don't know the circulation but I imagine a lot more than most therapy magazines in the UK, if not the most, by perhaps some way. It would be good to get the readership numbers and compare.</p> <p>That was how I have and do experience it. I have referred to it as 'therapy wars' – I'm not sure if that phrase has been used by others or not.</p> <p>Anger and hatred – these ideas aren't just theoretical – they stir up strong emotions in therapists both for and against pluralism, purism etc.</p>

<p>defensiveness and the attacking other models and the closed-mindedness so all of that I found really uncomfortable – and, as I say, being in supervision groups around that time and feeling like everyone had to defend their way of working and the people were quite defensive of it and in that – and I found myself being defensive of the person-centred way of working because I felt diminished and attacked and so there was – that was horrible. So when I first became aware of the pluralistic stuff I was really excited because I thought ‘Yeah, brilliant, this could be a move away from this stuff which is just actually dividing us when what we should be doing is – we’re all trying to do the same things so let’s just get on and do it and then we can present a bigger, more united front to offer therapy to people rather than bickering’ so pluralism I thought was really exciting. So I read the first paper I found – I can’t remember, Cooper and someone, well, anyway I read the first pluralism paper which I thought was wonderful because I just liked the fact that, for a start, right at the beginning it said - which I thought was funny - was essentially pluralistic therapy is humanistic because it relies on a collaboration and therefore trusts the other person and puts them in the driving-seat as much as you, so I thought ‘Well, that’s great because that fits with all my values and I can wear that quite nicely’ and the idea of being open to different ways of working and not feeling like you have to stick</p>	<p>Closed-mindedness</p> <p>Quite strong emotional reactions to the inter-school competitiveness</p> <p>This theme of inter-school conflict lessening the potential power of counsellors/psychotherapists also in the GP interview if I remember rightly. And ‘bickering’ quite a dismissive word of what some might wish to call a ‘debate’ or ‘issue’.</p> <p>There is a certain amount of crossover and confusion with these terms that I have seen in recent papers and goes back to James: ‘Even non-philosophers have begun to take an interest in a controversy over what is known as pluralism or humanism’ (in the very first para of ‘The Pluralistic Universe’ – this is a dimension I need to clarify).</p>
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<p>within a model and you couldn't move outside of it and all the attacking and defending and stuff I thought was a fantastic idea and then so I got the pluralism book and I read the pluralism book and the first couple of chapters I loved and then when I got more into the how-to-do-it and more into the stuff about therapeutic tasks and all of that it just started to lose me because it then started to get into all that stuff – again, right back to the introduction 'Oh God, I'm going to have to think about tasks and "What's the difference between a task and a whatever, an activity or whatever?"' and it's like suddenly it became all the stuff I didn't want to do so then that - in a way I sort of disconnected from being a pluralistic therapy – because for a while I wanted to be a pluralistic therapy because I was so excited about the end of the war and this sense of something that's broadly humanistic but isn't restrictive. I thought 'Fantastic. If we can all come together in that then we can have useful supervision sessions where we're talking about clients more rather than trying to undermine each other's models' (<i>slight laugh</i>) and so I thought – so then 'I don't know if I do want to be a pluralistic therapist because I – it's just starting to get too task-orientated' and, for me, there's something about where I connected with those words, where I thought 'Now, this is becoming too manualised', you know <i>too</i> manualised as in going away from my much looser, more idiosyncratic way of working so I then felt</p>	<p>He's referring to Cooper & McLeod (2011) – there are other books on pluralism but this is by far the most well-known to therapists.</p> <p>I have heard John Rowan criticise Cooper & McLeod about the focus on tasks and goals as well – I can probably get Rowan to put something in an email if that seems like a good idea.</p> <p>And at this point the critique is of pluralistic practice as opposed to perspective – and practice as suggested by Cooper & McLeod – it can only be their version because by definition it cannot be a 'monistic' thing – Cooper etc grapple with this themselves and again I could get Cooper to email me something about this issue. The paradox of trying to prescribe a pluralistic practice. Is there any point to that? Is it at all possible or necessary?</p> <p>The metaphors of wars, family bickering etc very important.</p> <p>The manualisation of therapy – a huge theme and probably why C & M did try and formulate it a bit so it can</p>
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<p>a reaction away from it but then I got to that point of well, actually I'm happy to call myself pluralistic in attitude because I think there's no one way of being therapeutic and they all work and for some people that will mean a therapist who actually has access to a load of different ideas, tools and tasks and who can work collaboratively with the client, for others that will be people like me who maybe have a more restrictive, in an odd way, restrictive but idiosyncratic toolbox (<i>slight laugh</i>) and an awareness of what other things might help so I don't try to hang onto clients and make them work my way. I know the limitations of what I can offer and where it can cross over into other things and live within a world in which where actually – yeah - hang onto my way of working because of the security, the ease, the way it can make me feel therapeutically relaxed and able to work but also a sense of 'I know that's not going to work for everyone so the first thing to do is to collaborate with them about what they want. If I can do it great, if not then collaborate on helping them to find someone else in this pluralistic therapy world who can help, so for me I think it's a really positive thing and it's also been interesting in how other people I've spoken to respond to it. Some people have responded to it on the same level I did about the tasks and things, 'This is just rubbish' or 'This is just whatever' and lost sight of the philosophy behind it [<i>right</i>] and dismissed it as a re-branding or as a something rather than it</p>	<p>be compared in trials ultimately but the whole point is that pluralistic practitioners won't be the same. Not that purist or single-model practitioners are the same either but that is the pretense/assumption that underlies comparison trials. Dan picks up on the pluralistic attitude versus practice differentiation.</p> <p>'Toolbox', another word (theme?) that comes up in some of the interviews</p> <p>The relationship between security and sticking to one model I think quite an important theme and one I discuss with JM.</p> <p>We are already in a pluralistic therapy world? Yes, in a way, because there are lots of different therapies and therapists on offer and clients can pick and choose. So how are we not? : the agenda of research which pushes for the idea of particular therapies as monistic entities to be favoured over other therapies as monistic therapies. But how many therapists actually practice this way or think of therapy in this way? Yes, a</p>
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	<p>being what I see as a political move, an ideology [<i>yeah</i>], a useful ideology.</p>	<p>few, who do feel that their therapy is 'better' and that they are consequently a 'better therapist'. I need to think this one out a bit more... Two themes that come up here that are important: (1) the 're-branding' theme – what are the differences between pluralism, integrationism and eclecticism? How easy it is for people, therapists, clients, policy-makers to really understand what is being communicated as important? And (2) pluralism as a 'political move'...which Alec Grant is so keen to identify – perhaps a chat with Alec Grant about what he sees wrong with this whole political move might bear some fruit? Worth recording?</p>
I42	<p>Right, okay. I think what Mick Cooper and John McLeod refer to, they try to distinguish between a pluralistic perspective and a pluralistic practice [<i>yeah, yeah</i>]. It sounds like you're on board with the pluralistic perspective [<i>absolutely, yeah</i>] but have quite a lot of question marks around the pluralistic practice.</p>	<p>This distinction is a crucial one and I am just checking that Dan understands it and his position on it. And cf. Rowan and his position on the practice as Cooper & McLeod describe it which is not favourable for very similar reasons to Dan. I could get Rowan to elaborate in an email?</p>
R42	<p>Yeah, and the question mark's, in a way, about the pluralistic practice - the question mark's about <i>me</i> [<i>yeah</i>] because I don't feel like I've got the time or the energy or the motivation to engage with learning about those bits of being a pluralistic therapist so they're more question marks about 'Am I willing to engage with it that much?' [<i>Yeah</i>]. Because for some people <i>fantastic</i> [<i>yeah</i>]. I'm not writing it off, it's just 'Not for me' – and it might even be 'Not for me right now'. It might be at some point, it could be something I want to get into [<i>yeah</i>] but right now, it's just felt like 'No, it's too much work' [<i>yeah</i>]. Do you know what I mean? It'd take me somewhere I haven't got the</p>	

	time or the energy for at the minute <i>[yeah]</i> .	
I43	It sounds like you feel like you've found your home <i>[yeah, exactly]</i> . If you – the way that I'm thinking about this kind of stuff at the moment is there's different ways of <i>being</i> – I quite like that Carl Rogers word 'being' – so - but as well as there being a person-centred way of being maybe there's a psychodynamic way of being <i>[absolutely, yeah]</i> and so forth and if you found a way of being that suits you why would you want or need to jump ship to another way of being if it doesn't really interest you?	
R43	Yeah, and that for me ultimately is both person-centred and pluralistic <i>[yeah]</i> because it's assuming that you find your own way, your own personhood, as being a therapist and it's like 'Okay, well, that's my congruent expression of me', to use loads of person-centred words and that has to fit within a world where that's not the only way so that's therefore the only way anybody can be therapeutic, that's the way that everyone should be therapeutic and the way the client should work. Because if a client turns up in front of me and they blatantly want something else, even if it's just something not as obvious as 'I need help with my anxiety' – they just want to relate in a different way, they want to talk about their experience from a more psychodynamic perspective then we'll talk more about that stuff in that language then if I don't have that language or that access to it then that's not for us.	A definite statement that he is identifying as person-centred and pluralistic – but this is not where he started out from in this interview – his perception of my position perhaps influencing this statement? Or a change of mind via the interview process? The literature that supports both interviewer and interviewee being changed by the process of the interview. I like this 'language' metaphor.

I44	Yeah, so it seems to me, I'm just going to check that I've got this right is that overall you identify as person-centred [<i>yep</i>], at least in terms of the non-judgmental bits and empathy being absolutely central to your practice [<i>yeah</i>], that you can identify with the pluralistic perspective [<i>yeah</i>] but have problems with how pluralistic practice so far has been articulated -	Checking within the interview as recommended by Kvale & Brinkmann etc.
R44	- yeah, but only as in problems for <i>me</i> , not that I think it's wrong but it doesn't fit for me.	Re-emphasising that he is okay with pluralistic practice in itself just it's not for him for reasons he's previously articulated.
I45	It doesn't fit for you. Okay. I'm wondering how you see the profession of therapy developing in the future? Where are we going from here?	
R45	(<i>pause</i>) Oh, blimey.	
I46	That's a very wide question and it could refer to so many things. It could refer to third sector, NHS, private practice, philosophies, it's a really wide open question but obviously you haven't got time to answer all those areas it could apply to but just any thoughts on that?	
R46	It's tricky because they're - with all of that there's two ways for answering that and one is where I'd like it to go [<i>yeah</i>] and the other is where I think it's going.	
I47	Can you answer those questions?	
R47	Well, where I would like it to go is to move into a more open and dialogic place where everyone's glad to be an individual, where there's no one way of being human, there's no one way of being a therapist so therefore we don't all become pluralistic therapists if that's not what	An implicit fear here is that 'pluralism' potentially could become another 'cbt'

<p>we are <i>[yeah]</i> but we live in a pluralistic world, we live in a multicultural world, so therefore it's alright for me to be me, I don't have to absorb parts of other cultures that don't feel like mine. I can be aware of them, I can respect them, I can value them, I can enjoy conversations with them but I haven't got to lose what feels like my sense of self so therapeutically, in terms of models, that's where I'd like us to go so if someone wants to call themselves a person-centred or a psychodynamic practitioner, fine, as long as they're open to other ways of working and happy to be in dialogue and to learn from each other and to share information and share clients (<i>very slight laugh</i>) and also be open to ways of working which embrace all sorts of ideas. So that's fine because that fits with the way I see the world, so, in terms of models, that's where I'd like it to be. I would like it to be more accessible and I'd like it to - there's something about private practice because I think in our world there's - a lot of the work is done by trainees and in private practice and a lot of the research is done about school counselling, university counselling, counselling with different client groups but we don't know enough about private practice but - I can't remember the stat - there's a really large proportion of therapists identify as being in private practice but not much is known about private practice and I'd also like to do something about the fact that the majority of counsellors work for free <i>[yeah]</i>. Actually what they do</p>	<p>i.e. in the same way therapists feel marginalised by cbt if pluralism was successful in its bid to be influential in NHS policy etc then therapists who wanted to identify with particular models etc could become equally marginalised - in my view an unlikely scenario but there is that potential danger...</p> <p>Exploration of multiculturalism which is another area where ideas about pluralism are important. Refer to that 2014 lecture I went to which was about pluralism of religions/cultures and has parallels to debates/issues in the therapy world.</p> <p>Relationship between multiculturalism/pluralism.</p> <p>This sounds more like Bott & Howard's 'cross-modality' stuff which Bott insists is very different to pluralism and Bott is someone else who seems to have a problem with pluralism as articulated by Cooper & McLeod - might be worth an email and/or interview to clarify what he sees as the differences and what his critique of pluralism consists of.</p> <p>'our world' - I think Dan is referring to me and him - our private practice therapy world - insider statement. All the interviewees are private practitioners.</p> <p>JM told me that BACP did a survey in which the split was 70% private practice 30% NHS - so my hunch that private practice is where the vast majority of therapy takes place seems to be correct - but I need the reference for that. That also only refers to counsellors and</p>
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<p>isn't valued and that therefore private sector stuff, NHS, all that, where's the funding coming from? Who's supporting the people that are supporting the people? <i>[Hmm]</i>. So that is a big thing that I think needs resolving or addressing. Having the majority of the most vulnerable clients being seen by trainees who aren't getting paid, it seems absolutely potty to me <i>[yeah]</i>. So, yeah. So that idea we have to change and how I think it's – I've no idea how I think it's - I feel at the minute there's loads of work being done in terms of - there's loads of research being done, loads of – well, there's some political stuff being done but I really don't know where it's going. Are we going to get regulated? What effect is that going to have on us? I don't feel like there's a clear direction <i>[yeah]</i>. I feel like there's loads of questions that aren't being addressed like the ones I've just said <i>[yeah]</i> and loads of work that is being done and it's all being driven by who can give the funding <i>[yeah]</i> so there's always - yeah, so I've no idea <i>[yeah]</i>, I feel like therapy's kind of stumbling along, I don't really know where it's going but I hope – I read something ages ago, it was in the pluralistic debate and someone suggested that therapy right now is where medicine was about 100 years ago or something when there were loads of different schools in medicine but no sense of medicine as a thing <i>[yeah]</i> and actually that we could be moving towards a place where therapy is a thing and all the different schools are valued but - so</p>	<p>psychotherapists. The further complication of psychiatrists, clinical psychologists, counselling psychologists, graduate mental health practitioners etc engaging in counselling/psychotherapy-like activities which they may even call counselling and psychotherapy complicates or 'problematise' (?) even that stat...I am not sure about Dan's statement that the majority of counsellors work for free – need to check that one – but maybe that's something that could be changed – a minimum wage or something...the system has got to the stage where people's labour is being exploited undoubtedly – that's not to say there's no room for voluntary work but maybe there could be an opt-in or opt-out of something like they're going to do for zero hours so that people who find zero hours to their advantage can opt out of enforced employee status...</p> <p>Regulation – another big issue – also brought up by JM. Relates to pluralism in that regulation may be more or less favourable to pluralistic approaches to therapy.</p> <p>Yes, I'm familiar with this idea too but need a reference or two. And also see the reference at the beginning of my SFT book about development of theories/practices and 'schoolism' as an intermediate</p>
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	we could be just on a growth, on a developmental path but -	developmental phase.
I48	- but you're not sure about that [no]. So, basically, we're getting near the end of this interview so I'm just wondering, finally really, if there's anything you want to ask me or anything you think we've missed that you want to say something about now or anything at all you'd like to add before we close the interview down?	
R48	(long pause) Well, the only thing I guess I think I would say is that - and this is something that goes in a way back to my relationship with the person-centred model [hmm] - is the way I always think about it is it's all about the relationship with someone and about that caring, loving, non-possessive relationship so someone can find their feet again and find their feet for the first time and about how, in a way, in the person-centred approach, going back to Rogers trying to work out what the therapeutic factors were but it's about getting broken down into terms - you've got to be empathic, you've got to be non-judgmental, and how it gets broken down into <i>things</i> and actually that's the same with therapy getting broken down into schools [hmm] and even into techniques and actually it's about the relationship, it's about two people having a meaningful relationship that's focussed on one person's healing and all the other stuff is just ways to understand that and sometimes they can be helpful and sometimes I think they can really get in the way because all the theories and I	Relationship – this is also a common theme – as the essential factor articulated by JM etc. In individual counselling – and these interviews are implicitly about that (versus couples or family) – the therapists don't really talk about couples or family work.

	<p>guess some of that comes back to the experience I had with that psychodynamic counsellor who would just give me interpretations and basically tell me what was going on with me. He was full of his own theories and full of his own power and importance and his own wisdom. He was like some archetypal father-figure for me and often that just spun me off into all sorts of confusion that I then had to go away and unpick but actually what matters to me is having relationships with people [yeah]. So the theories are fun, they're nice ways to try and work out what we're doing and maybe to help us look for ways we might be unhelpful but they're just theories [yeah]. It's that old maps and territories thing [yes, yeah]. The territories are these special sort of relationships [yeah] and in a way I guess maybe this is a bit of my response to the tasky stuff around pluralism [yeah] was then that it becomes, it <i>felt</i> to me like it was becoming a bit about a collaborative 'doing' to someone [yeah] rather than a being with someone [right] and I guess I pull away from that a bit [yeah] - about people bringing things that you do things to. It should be do things with.</p>	<p>Cf. Wilber etc. – a good metaphor to use though.</p>
I49	<p>Yeah, even if you're doing collaboration [yeah, exactly] it feels like you might be imposing some kind of value.</p>	
R49	<p>Yeah, or, okay, some of that's about effectiveness and back to your question about effectiveness it's yeah, okay, as a professional, as a practitioner, someone who's offering hopefully a healing encounter, yeah, of course</p>	

	<p>we've got to know it's effective but something about the value judgments - [<i>Yeah, it's quite outcome-based</i>] – yeah, it's outcome-based, absolutely [<i>yeah</i>] so, <i>that</i> I totally understand why we need to be - because I need to know that what I'm doing is actually helping people and I totally understand that and it's almost like an expression of the IAPT stuff about it's not about helping people it's about helping people be more productive [<i>yes, yeah</i>]. Do you know what I mean? It's that kind of reducing us into output [<i>employability</i>] whether it's as clients or therapists.</p>	<p>A criticism of Cooper not just re: pluralism but he seems to play into the agenda of bodies who maybe don't understand the values of many kinds of therapy who do not want to buy into symptom-based, medical model therapy – how do these therapies get noticed without buying into that model? Cooper is very pragmatic and says if they want RCTs give them RCTs – others object to this capitulation.</p> <p>Clients and therapists both being measured – the 'audit culture' (where does that phrase come from?)</p>
I50	<p>There is, I just want to add something to that because I think it's talking about what you're talking about in that you're saying 'Of course I want to help people, of course I want to be effective', whereas in some ways, I'm not saying it's the same, but in some ways that's almost medical model assuming that there's something wrong that needs to be <i>fixed</i> [<i>yeah, exactly</i>] and some therapists might have the attitude where therapy actually isn't about things being wrong [<i>yeah</i>], things needing to be fixed, it's actually more of a philosophical investigation of a life story [<i>yeah</i>] and there doesn't have to be any problems as such.</p>	
R50	<p>And it's really odd the way we've had this conversation [<i>yeah</i>], the way this has come out because when I say 'person-centred informed by existential ideas' that's at the heart of it [<i>yeah</i>] because life is hard and we will</p>	

	<p>struggle and actually sometimes therapy is just about being with someone in their struggle [yeah] and it's not - if the outcome is that someone goes away feeling like they've shared their struggle for fifty minutes - and that's fine. Maybe, because you can't change the world [yeah]. Outcomes aren't always possible.</p>	
I51	<p>Yeah, and also is it necessarily a bad thing that sometimes we feel sad, bad or mad?</p>	
R51	<p>Yeah, absolutely, it's just part of human experience [yeah]. Yeah so that's - I'm really glad you said that because that's at the heart of the outcome thing for me (<i>slight laugh</i>) is - because when I say 'Of course I want to make people, help people get better', whatever that is, there is a little bit of me just now thinking 'Yeah, how much of that is that therapeutic super-ego?' saying 'Oh, you can't call yourself a therapist unless you're determined to make people better'. Well, actually, no, I might be determined just to be with people. If people are happy - if people get something out of that being with me in the way that I can be then in a way that's therapy for me [yes, and is it that measurable?] Yes, and trying to measure it, trying to reduce it to effectiveness and outcomes - but then, okay, then there's therapy which just becomes philosophical debate, and if so, why not? If that's what someone needs [yeah] then that's what - yeah, so that's a whole thing about productivity and outcomes that is also rumbling along in the background (<i>laughs as he</i></p>	<p>Yes, how much are therapists conforming to internal and external harsh superegos or -CP in trying to gain acceptability in institutional structures. And in-the-moment change of mind via the interview process/dialogue.</p>

	<i>speaks the words from 'rumbling along' and after)</i>	
I52	Yeah, and certainly the way Cooper and McLeod talk about it – a pluralistic practice as opposed to perspective - they are implicitly and I think at times explicitly quite concerned about outcomes [<i>yeah, absolutely</i>].	
R52	Yeah, because there is a little bit of me that will relax and smile if I say to a client 'What do you want to get out of therapy?' in the first session and they say 'I just want to talk about life' - fantastic (<i>laughs</i>). 'Let's do that then' and in there I know that's going to be therapeutic [<i>yeah</i>] – do you know what I mean?	
I53	Absolutely, I'm thinking that might be a good place to stop.	
R53	Yeah. (<i>laughs</i>)	1:12:53

Appendix G: Sample of Coded Interview

Notes about the coding:

1. The words 'therapy' and 'therapist' are used to denote counselling, psychotherapy, counsellors and psychotherapists in the codes.
2. All 'initial ideas' have been deleted but still can be read in the 'initial ideas' documents. To see how themes may have been developed it is perhaps necessary to cross-reference the coding documents with the initial ideas documents.

Interview 1 – Coding 1

<u>I/R</u>	<u>Transcript</u>	<u>Codes</u>
I1	Yeah, so I'm just going to start with some general questions [okay] before I move into more specific things I'm interested in [cool] - but yeah, basically in the first place I'm just wondering how you became interested in therapy?	[00:35]
R1	<p>Hmm (<i>shows surprised interest in the question</i>) – I think it's just because of I - it's a – I think I wasn't interested in therapy at all, I didn't have any interest in it and all the images I had of therapists were quite kind of negative sort of you know Woody Allen psychoanalysis type stuff and then I met some people who had had therapy and so I ended up having some and found it helpful. And then I – yeah somewhere through that and through getting involved in shamanism and stuff I just got involved in listening and helping stuff but it wasn't an intention to become a therapist or anything, and in that, I don't know, I guess somehow I just started listening to people and then my niece - just having a phonecall with my niece - she was in her twenties and she was going through a bad relationship and she just said that she thought I'd make a good counsellor and it was a time when I was looking for something to do, you know, looking for something to train in, looking for - because I was - I didn't -</p>	<p>No interest in therapy Personal images of therapists as negative Media images of therapy Influence of others Positive experience of therapy Experience of different approaches / similar activities to therapy No intention to become a therapist Listening to people</p>

	<p>I was just doing bar-work and odds and sods and I was looking for something meaningful to do so when Harriet said she thought I'd make a good counsellor I just thought I'd try an introduction to counselling and actually this is probably really relevant because I went on a ten week introduction to counselling course just to feel my way in to see what it was like [hmm] and what resonated with me straight away was when the tutor started talking about person-centred ideas [hmm] - and that - there's two reasons for that, one was because I'd wanted to train I phoned a couple of counsellors to ask for some advice about training and one of them said 'Whatever you do' - you know because I knew there was all the different models [yeah] - one of them said 'Whatever you do I'd say do your first level training in person-centred stuff because the core conditions are at the heart of most therapies so if you do that then you can build on it' and then on the introduction course when the lecturer started talking about how it's - from a person-centred perspective - it's about not being an expert I just suddenly felt 'Oh brilliant I'm not going to have to have loads of knowledge and take loads of responsibility for making decisions about people's lives' [right] - so for me that - the idea of a model - arose right at the beginning [and] of getting into therapy - [and the values of the model] - yeah, they're kind of a person-centred -</p>	<p>Influence of others Looking for something to do Influence of others The influence and processing of training Influence of others Knowing different models Influence of others The core conditions at the heart of a variety of therapies Person-centred is not about being an expert The arising of the idea of a model</p>
I2	<p>- it's more about the values than maybe techniques as such -</p>	
R2	<p>- yeah, absolutely - and the sense of it fitting with my sense of who I was - that [hmm] - starting - thinking I'm starting on a professional training to be a therapist, I guess I thought I was going to end up like a social - because I didn't really know what therapy was I suppose. Although I'd been a client I didn't really have much of a sense of what being a therapist entailed so I think some of it was probably 'At some point I'm going to have to learn interventions and the right thing to do at the right time and I'm going to have to learn and hold lots of information and be responsible for making clinical decisions' [yeah] so when this woman just said 'Actually</p>	<p>Identifying with an approach Not knowing what therapy is Person-centred is not about being an expert</p>

	it's - the client's the best expert in their own experience and it's about you just helping them to understand that' - <i>[hmm]</i> - 'their perspective' - it just felt like - she said it much simpler than that - <i>[yeah]</i> but it just felt like 'Yeah, brilliant I think I can do that, it doesn't feel too hard' <i>(laughs)</i> .	
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Appendix H: Samples of Searching For, Reviewing, Defining, Refining and Naming Themes

Collecting the Codes and Creating Candidate Themes

I see the need for a second draft of this initial 'collecting the codes' document – I agree with Graham Stew that the amount of meanings identified points to these really being meaning units I have collected that point to the codes that are in purple, only some of which might become themes. These will be collected in a re-draft of the collecting the codes document 2. So for re-drafts of both documents see collectingthecodes12 which will be the second draft of this document and collectingthecodes22 which will be the second draft of the main codes to be used to find themes (10/02/16)

This colour = potential ('candidate') themes

Experience of different approaches / similar activities to therapy [1], and Experience of therapists with different approaches [1] and Previous experience of related professions [5] [6] [8] merge into: Experience of similar activities to therapy [1] [5] [8] and Experience of different approaches [1]

Reading as a gateway to learning about different approaches [1]

New code/theme?: Personal experience of different approaches

(15/01/16)

The importance of being aware of one's own limits [1]

Happy to offer other therapeutic approaches within his understanding [1]

Finding other modalities helpful [2] – I think I just want one word ‘approaches’ as much as possible – and will maybe change – but modality is also a good word – unsure which word to use at the moment but will try to keep it consistent in the end (19/01/16)

Tired of therapies experienced as a client as too analytical, diagnostic, objectifying and disempowering [3]

Seeing an approach as a hybrid of two approaches [4] and Identifying a ‘hybrid’ practice [6] merge into: **Hybridisation** [4] [6]

Candidate theme: Knowing about different approaches (15/01/16) [1]
[2] [3] [4] [5] [6] [8]

[The] Influence and process of training on approach [1] – think I should take out ‘The’ (15/01/16) so **Influence and process of training on approach [1] [2] [3]** [5] [6], Variety of training [1], Training seen as not embracing many approaches [3], Additional training in other approaches merge into Training in different approaches [7], Experiencing training as a site of purism [7], Feeling powerless in placement [7], Feeling angry and unsupported in placement [7], The influence of training institutions on fostering a sense of superiority [7], Experiencing training as a place of being exposed to different approaches [8], Doing a training in CBT [9] all subsumed into **Influence and process of training on approach** (15/01/16) [1]
[2] [3] [5] [6] [7] [8] [9]

Training is like learning to drive a car [5]

Trainees need to tick boxes [5]

Questioning the power dynamics in training [2]

Influence of peers [7] merges into: **Influence of others [on approach]**

[1] [7] [9] – on approach added 15/01/16

Supervision groups and placements as a gateway to learning about different approaches [1], Supervision as a gateway into learning about different approaches [1] [3] [5], The influence of supervisors [8] Supervision as a commitment to a model

Collecting the Codes and Creating Candidate Themes

This version is a 'tidied up' version of collectingthecodes – the 'working out' and dates of ideas and process are all in collecting the codes – this is a simplified version in which the main codes/candidate themes can be seen without too much complicating detail. (19/01/16)

After discussion with my supervisor Graham Stew it was agreed that these 'candidate themes' are really more like 'codes'. Once I have revised the codes I will then revise candidate themes. Once I have done that I will put the candidate themes in a new document to include a concept map. (29/01/16)

This document in itself after collecting all the 'meaning units', only some of which might become 'codes' in this document, of which only some might become 'themes', means that I want a tidier version of this document – this will be collectingthecodes22. (10/02/16)

This colour = potential ('candidate') themes

New code/theme? : Images of therapy and therapists

New code/theme?: Personal experience of different approaches

Candidate theme: Knowing about different approaches

New code/theme?: Therapy's not the only way

Influence and process of training on approach [1]

Influence of others on approach [1]

Influence and process of supervision on approach [1]

Candidate theme: Influences on approach

Candidate theme: Recognising common factors

Candidate theme: Different names for the same thing

Candidate theme: Professional uncertainty

Candidate theme: Pressures to conform

Candidate theme: The flexibility-rigidity continuum

Candidate theme: Person-centred values and pluralism merging into this Candidate theme: Therapist identity and approach (29/01/16)

Candidate theme: Horses for courses: Different clients need different things Horses for courses added 01/02/16)

Candidate theme: Being versus doing

Candidate theme: The practice of metacommunication

Collecting the Codes and Creating Candidate

Themes

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This colour = potential ('candidate') themes

Candidate theme: Influences on approach

Candidate theme: Recognising common factors

Candidate theme: Different names for the same thing

Candidate theme: Therapist identity and approach

Candidate theme: Professional uncertainty

Candidate theme: The continuum of client uncertainty-understanding

Candidate theme: The flexibility-rigidity continuum

Candidate theme: Horses for courses: Different clients need different things

Candidate theme: Being versus doing

Candidate theme: The practice of metacommunication

Candidate theme: It's the client-therapist relationship

Candidate theme: Therapy wars

Candidate theme: Therapist attitudes to pluralism

Candidate theme: One size fits all: Therapist attitudes to single-model
practice

Candidate theme: Therapist attitudes to theories

Candidate theme: Commercial/professional implications

Candidate theme: Experience leading to discovery and practice of
other approaches/techniques

Photo of 17 candidate themes before final refinement into 7 themes

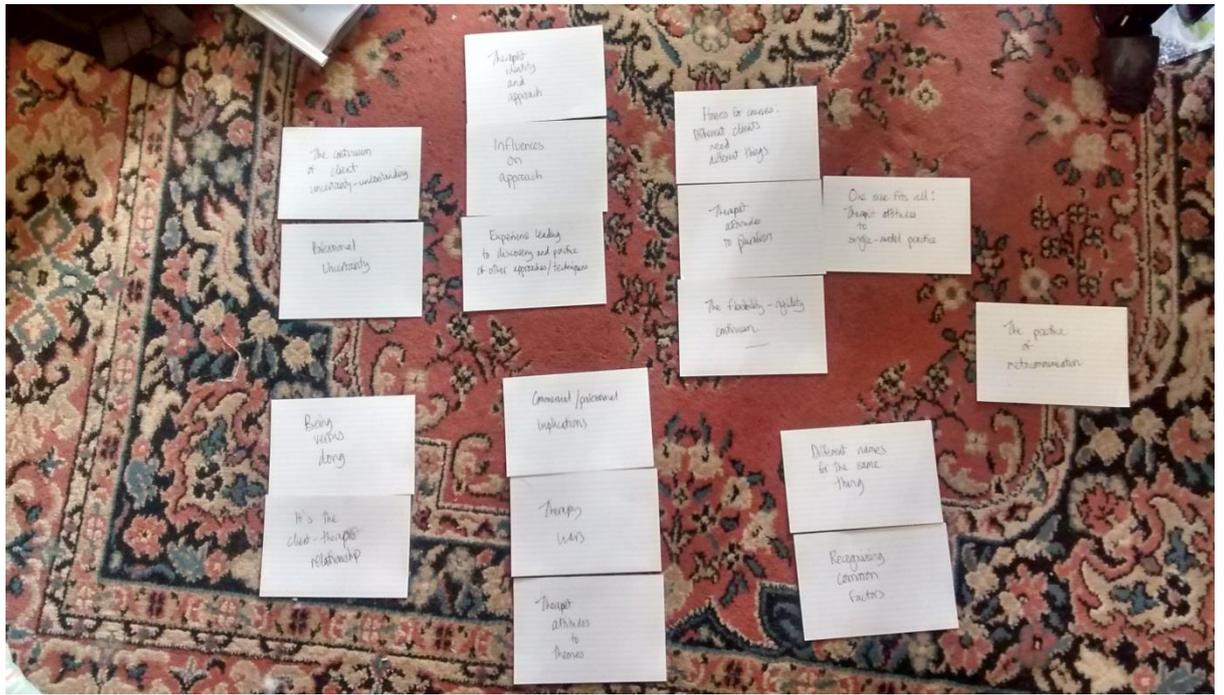


Photo of refining down the 17 themes into 7 themes

