

Developing Pluralistic Practice in Counselling and Psychotherapy: Using What the Client Knows

John McLeod^{*a}

[a] Department of Psychology, University of Oslo, Oslo, Norway.

Abstract

The concept of pluralism is increasingly used to indicate the rich diversity of theory and practice in the field of counselling and psychotherapy. A version of pluralism is described that takes account of the range of ideas about health and healing that exist within contemporary culture, and the expression of these positions in the personal knowledge and preferences held by clients in respect of different therapy formats and techniques. A review of recent research is used to provide a basis for discussion of some of the practical manifestations of client knowledge, and the ways in which practitioners can work with these factors.

Keywords: client experience, knowledge, pluralism, preferences, research

The European Journal of Counselling Psychology, 2013, Vol. 2(1), 51–64, doi:10.5964/ejcop.v2i1.5

Received: 2011-04-20. Accepted: 2012-04-11. Published: 2013-03-28.

*Corresponding author at: Department of Psychology, University of Oslo, Oslo 0317, Norway. E-mail: j.mcleod@abertay.ac.uk



This is an open access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/3.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

One of the most striking aspects of current theory and practice in counselling, counselling psychology and psychotherapy, is the wide range of ideas in circulation around the nature of psychological problems, and the change processes through which these problems might be addressed. Within the therapy literature, there are quite different ideas and practices associated with mainstream therapy approaches such as cognitive-behavioural therapy, psychodynamic therapy, experiential/humanistic therapy, narrative therapy, and systemic/family therapy. In addition, there is also a diversity of ideas about healing and well-being that arise from different cultural worldviews. The existence of this spectrum of therapeutic possibilities has presented a major challenge for the professional community. One response to this challenge has been to seek to use research to identify a single model of change that is most effective. Another response has been to identify “common factors”, such as instillation of hope, or involvement in a therapeutic relationship, that represent underlying change mechanisms that operate even in therapy approaches that on the surface might appear to be radically different from each other. A third response has been to find ways to integrate different ideas and practices within one over-arching approach. At a philosophical or conceptual level, each of these responses to the diversity ideas about what is therapeutic represents a *monistic* strategy, which assumes that there is one right answer that can be found – a single truth. An alternative to monism, which is receiving increased attention within the counselling and psychotherapy community, is to adopt a *pluralistic* stance in relation to knowledge and practice. The concept of pluralism was first suggested as a basis for psychological theory and practice by William James, one of the founders of modern psychology (Slife & Wendt, 2009; Woody & Viney, 2009). Pluralism refers to the idea that there are many valid responses or answers to any significant questions about the nature of reality (Rescher, 1993).

In recent years, the concept of pluralism has been applied within the field of counselling, counselling psychology and psychotherapy in three ways. First, it has been used as a basis for arguing, at an organisational or societal level, that all approaches to therapy have a value, and that attempts to use evidence-based practice policies to restrict the range of therapies available to the public are misguided (Samuels, 1989). Second, an implicit pluralism has informed research that has sought to demonstrate and document the multiplicity of change processes that occur in therapy. For example, reviews of research into client and therapist experiences of significant change events in therapy (Timulak, 2007, 2010) have shown that each of the following types of helpful event are frequently described by clients: awareness/insight/self-understanding; behavioural change/problem solution, exploring feelings/emotional experiencing, empowerment, relief, feeling understood, client involvement, reassurance/support/safety, personal contact. Other lines of research, for instance into client preferences for different kinds of therapeutic activities, has similarly found that clients identify a plurality of ideas. Third, pluralism has had an impact on contemporary therapy practice through the work of various writers who have suggested ways in which the practice of therapy might be informed by a pluralistic stance (Gergen, 2000; McAteer, 2010; Polkinghorne, 1992; Snyder, 1999; Snyder & Mitchell, 2008). Within the group of therapy theorists who have actively embraced pluralism as a cornerstone of their practice, perhaps the most fully articulated account of how a pluralistic approach to therapy might look like in action, can be found in the work of Mick Cooper and myself (Cooper & McLeod, 2007, 2011a, 2011b). Our pluralistic framework for practice suggests that both client and therapist draw not only on ideas and methods that are available within the counselling and psychotherapy literature, but also make use of therapeutic possibilities that exist within the wider culture within which they live. Effective therapy involves collaboration between therapist and client to identify and then implement the ideas and methods that are acceptable and make sense to the client and that make a practical difference in relation to the resolution of the client's difficulties. A key aspect of pluralistic counselling and psychotherapy is therefore the facilitation of conversations between client and therapist that allow various therapeutic possibilities to be explored. These conversations need to focus on four main questions: What does the client want from therapy – what are his or her goals? What are the step-by-step tasks that need to be pursued in order to accomplish these goals? What are the practical strategies and methods that can be used to allow specific tasks to be carried out? What ideas contribute to the development of an understanding of what has happened in the client's life and how the he or she can move forward?

A more detailed presentation of the principles and practice of pluralistic counselling, and their application in therapy, training, supervision and research, can be found in Cooper and McLeod (2011a). The aim of the present paper is to explore one particular aspect of pluralistic theory and practice, which is the role of the client's knowledge about what is helpful. This issue is examined in relation to the concept of client knowledge, a discussion of some research studies of what clients know, and some examples of how the client's knowledge plays a role in the process of therapy.

The Concept of Client Knowledge

It is obvious to any therapist that clients are not passive recipients of treatment. Over the years, the client's contribution to therapy has been conceptualised in different ways, for example through studies of cognitive structures such as client attitudes, beliefs, expectations, preferences and "ideas of cure", and research into personality patterns that lead to clients possessing an "aptitude" for certain interventions and a tendency to respond less well to other interventions (see Cooper, 2008, for further discussion of this area of research). These models and research studies have made an important contribution to the understanding of therapy. However, the limitation of these perspectives is that they conceptualise what is happening in terms of static, unchanging structures. As a result,

these ways of understanding do not encourage reflection around how a person's views about therapy might change over the course of time, for example as he or she gains more experience of what is involved in participating in therapy. An alternative conceptualisation is available in the form of the "active client" theory that has been developed by Bohart and Tallman (1996, 1999). In this model, the client is regarded as making choices around how to make use of what their therapist offers them, and learn new coping strategies, guided by a basic human capacity for "self-healing". The "active client" perspective is valuable, in terms of acknowledging that client intentionality and agency are essential elements of the process of therapy. But it focuses predominantly on the process of therapy, and does not suggest how we might make sense of what it is that makes such activity possible for a client – the underlying maps or ideas that guide his or her self-healing efforts.

The concept of *knowledge* provides a means of thinking about what the client brings to therapy that has the potential to overcome these limitations. "Knowledge" is a broad concept that readily incorporates all forms of cognitive organisation of information, such as attitudes, expectations and preferences. The idea of "knowledge" encompasses both a sense of "knowing" as something that involves possessing information ("knowing *that*") and a sense of active doing ("knowing *how*" or "*know-how*"). There exists a rich history of philosophical analysis of the concept of knowledge, which includes Bruner's (1986) distinction between *paradigmatic* or abstract ways of knowing, and *narrative* ways of knowing (conveying understanding through storytelling), as well as Polanyi's (1958) analysis of the role of implicit or tacit knowing. Finally, and of huge significance to the use of this concept within the field of psychotherapy, the narrative therapy community have developed the notion of *indigenous* or *insider* knowledge (White & Epston, 1990) to refer to knowledge about life, and about how to cope with problems in living, that is possessed by a person by virtue of being a member of a particular culture or community. The concept of indigenous knowledge has powerful implications for the practice of therapy. It draws attention to the power imbalance between therapist and client. The former is defined as being in possession of specialist professional knowledge, which is then applied in treatment of the client. The latter, by contrast, is regarded as holding knowledge that is of less value. The idea of indigenous knowledge also directs attention to structures of knowledge within cultures and communities that White (2004) characterised as "folk psychology", and invites therapists and their clients to take account of the relevance of these resources. It is clear that knowledge can be acquired, and also may be lost or forgotten. Finally, the idea of knowledge brings with it the notion that there exists a special type of knowledge, which is *wisdom*. The concept of knowledge therefore makes a space for consideration of the role of wisdom in therapy.

Research Into the Role of Client Knowledge in Therapy

There has been a great deal of research into various aspects of clients' knowledge around what might help them to deal with their problems. This research has made use of both quantitative and qualitative methodologies. A large number of studies have been based on questionnaire measures of expectations, beliefs and preferences in relation to therapy. One of the most consistent findings within this literature is that preferences exist: people differ in terms of the kinds of intervention and treatment that they believe to be credible and effective for conditions such as anxiety, depression and trauma (Bakker, Spinhoven, van Balkom, Vleugel, & van Dyck, 2000; Bragesjö, Clinton, & Sandell, 2004; Hemmings, 2000; Lang, 2005; McLeod & Sweeting, 2010; Sobel, 1979; Tarrier, Liversidge, & Gregg, 2006). Some studies have explored preferences for psychotherapy in contrast to drug treatments (Kocsis et al., 2009; Kwan, Dimidjian, & Rizvi, 2010; Lin et al., 2005; van Schaik et al., 2004) and have found support for both types of intervention in research participants. There is also evidence for differences in attitudes and preferences associated with gender, age, ethnicity and previous experience of therapy (e.g., Bragesjö et al.,

2004; Nadeem, Lange, & Miranda, 2008). In one UK study of counselling in primary care, depressed patients were given the option of choosing between non-directive counselling and CBT (King et al., 2000). Of those patients who specifically opted to choose one of these two therapies, around 40 percent opted for non-directive counselling, while 60 percent chose CBT. In Sweden, Bragesjö et al. (2004) examined the opinions of a random sample of the public on the credibility of three different models of psychological therapy: psychodynamic, cognitive, and cognitive-behavioural therapy. Bragesjö et al. (2004) found strong preferences for each of these approaches in different sub-groups of the population included in their survey.

One of the key issues that arises when considering clients' knowledge of therapy is the question of the extent to which preferences and attitudes make a difference to the degree to which clients benefit from the therapy that they receive. There is strong evidence that pre-existing preferences have a substantial effect on the extent to which clients benefit from psychotherapy and drug treatment. In a study conducted by Kocsis et al. (2009), depressed clients in primary care were randomly allocated to receive psychotherapy or anti-depressant medication. Preferences for each treatment were assessed prior to allocation to each intervention. Kocsis et al. (2009) found that preference had a massive influence on eventual outcome, with clients who had received their preferred treatment doing on average twice as well as those who had been allocated to the non-preferred option. The relationship between preference for types of psychotherapy, and eventual outcome, is complex (van Schaik et al., 2004). Overall, the balance of evidence suggests that clients who enter a preferred therapy report better alliances with their therapists at an early stage in therapy (Constantino et al., 2007; Goates-Jones & Hill, 2008; Iacoviello et al., 2007; Patterson, Uhlin, & Anderson, 2008). On the basis of a systematic review of research into client preferences, Swift and Callahan (2009) concluded that clients who received a preferred therapy gained had better outcomes than those who did not, and were less likely to drop out of therapy.

There are a number of methodological challenges involved in examining the impact of preference for type of therapy on outcome at the end of therapy. First, from a client perspective, different types of therapy may come across as being in fact fairly similar, in that they all involve talking to a therapist once a week. Second, good therapists are responsive to clients, and may adapt their approach, as far as they are able, to correspond to the preferred style of each client. Third, while some clients may have quite fixed and definite preferences, other clients may be less clear about what they prefer, and are therefore open to following wherever their therapist might lead them. Finally, there are methodological difficulties in explaining or describing types of therapy to clients who take part in these studies (Coursol & Sipps, 1986). For example, can a brief written statement or video vignette actually convey sufficient information to enable client preference ratings to be based on a genuine knowledge of what CBT or psychodynamic therapy is like, in reality? Each of these factors is likely to attenuate the link between preference and outcome. The consistent finding that fulfilment of preference is associated with better outcome can therefore be viewed as a potentially robust finding that transcends the methodological limitations of the studies that have been carried out.

Some quantitatively based studies have examined the relationship between client preferences for particular types of therapeutic activity, and outcome. A key study on this issue was carried out by Levy Berg, Sandahl, and Clinton (2008), who asked clients to complete a questionnaire before they entered therapy, around what kind of in-therapy activities and processes they believed would be most helpful for them. Examples of questionnaire items include "sharing bottled-up emotions", "getting good advice", "training in practical problem-solving", and "learning to forget painful memories". Clients in this study were then randomly allocated to either of two forms of therapy. At the end of therapy, clients were asked to complete the preferences questionnaire again, to indicate the extent to which

each activity had been present in the therapy they had received. The results showed that fulfilment of preferences was strongly predictive of good outcome. The kind of therapy the client had received was of limited significance – what was important, in terms of eventual outcome, was whether the therapy provided experiences that matched the client's view of what would help. If replicated in further research, the findings reported by [Levy Berg et al. \(2008\)](#) are potentially highly important for therapy practice, because they suggest that the models of therapy that have been developed by the professional community do not necessarily map on to what clients want. Clients' beliefs about what is most helpful for them appears to range across therapy approaches, rather than being limited to single approaches. Compared to studies of client perceptions of broad therapy approaches, the research into client preferences for specific interventions is methodologically more robust, because it enables the researcher to ask the client to comment on concrete, easily-described activities, and also because the client can then report at the end of therapy whether these activities actually occurred in the therapy that he or she received.

An alternative strategy for investigating clients' knowledge about their sense of what would be helpful for them in therapy has been to make use of qualitative methods, typically involving interviews conducted at the start of therapy, at the end, or at both time-points. One of the themes that has emerged from several qualitative studies is that over the course of therapy, some clients become aware that what they are being offered is not right for them, and reach the end of therapy with a feeling of disappointment or "something was missing". For example, [Nilsson, Svensson, Sandell, and Clinton \(2007\)](#) found that some clients were disappointed with the CBT therapy they had received because what they felt they had needed was to just talk about their difficulties and make sense of their relationships, whereas disappointed clients who had received psychodynamic therapy reported that they wanted more practical advice and ideas about how to cope.

An important set of qualitative studies has investigated client knowledge through exploring "ideas of cure" in clients receiving psychoanalytic psychotherapy ([Lilliengren & Werbart, 2005](#); [Philips, Werbart, Wennberg, & Schubert, 2007](#)). In one study, young adults who were referred for psychoanalytic psychotherapy were invited to take part in pre-therapy interviews around their ideas of how therapy might help them ([Philips, Werbart, et al., 2007](#)). A continuum of ideas of cure was identified. At one end of this dimension, were clients who believed that what would be helpful would be to approach or face up to their problems by talking, and by processing and understanding their feelings. At the other end of the dimension were clients who preferred to find strategies for avoiding their difficulties, or placing the solution on to others. In a further study, [Philips, Wennberg, and Werbart \(2007\)](#) were able to show that premature termination of psychodynamic therapy was more likely to occur in clients whose beliefs were located at the "avoidance" or distancing end of the dimension. However, in this study there was no relationship between ideas of cure and the quality of the therapeutic relationship, or outcome at the end of therapy. What seems to have happened was that most "avoidance" clients (whose beliefs were different from those held by their therapists, who were committed to the value of approaching and working through difficult experiences) decided early on that this kind of therapy was not for them, and quit. However, if a client who believed in the value of "avoidant" coping strategies stayed in therapy long enough, what seemed to happen was that the therapist and the client were eventually able to find ways in which they could work collaboratively and effectively, even though each of them was operating from a different set of basic assumptions about what was helpful. Nevertheless, despite the resourcefulness of their therapists in being able to form a bridge between their contrasting knowledge bases, at least some of these clients reached the end of therapy with a sense that "something had been missing" ([Lilliengren & Werbart, 2005](#)), even though the therapy as a whole had been beneficial.

The programme of research conducted by [Lilliengren and Werbart \(2005\)](#) and [Philips, Werbart, et al. \(2007\)](#) has begun the task of mapping the contours of client knowledge about therapy, and the ways in which client knowledge can have an impact on the course of therapy. However, their research does not address the question of whether clients whose ideas about what is helpful are different from the ideas held by their therapists, eventually come to adopt their therapists' beliefs, or whether successful outcomes are due to the capacity of the therapist to implement a flexible approach that accommodates these differences. This question has been examined in two qualitative studies, conducted by [Kühnlein \(1999\)](#) and [Valkonen, Hanninen, and Lindfors \(2011\)](#). The findings of these studies suggest that the majority of clients do not shift from their pre-existing preferences or ideas of cure over the course of therapy, and in fact evaluate the effectiveness of therapy in terms of the extent to which it corresponds to these beliefs. The study by [Valkonen et al. \(2011\)](#) represents a particularly thorough investigation of this topic. They interviewed clients before therapy, and at follow-up. Clients were participants in a controlled randomised trial of therapy for depression, in which they were randomly allocated to brief solution-focused therapy or long-term psychodynamic psychotherapy. [Valkonen et al. \(2011\)](#) categorised the pre-existing knowledge of clients about how to understand their problems, into three categories: (i) life historical: the client believed that early childhood experiences were the source of their problems; (ii) situational: the problem was attributed to a lack of skills and strategies to deal with current sources of stress, and (iii) moral: the client believed that their difficulties arose from not knowing what they wanted from life, or a lack of meaning in their lives. The design of this study meant that some clients with "life historical" beliefs were allocated to a "situational" therapy (solution-focused) while other clients with "situational beliefs" were allocated to a "life historical" therapy (psychodynamic). Also, all clients with "moral" ideas found themselves receiving a form of therapy that did not correspond to their assumptions about what was helpful for them. At the follow-up interviews, [Valkonen et al. \(2011\)](#) found that most of the clients who had been allocated to a therapy that was discrepant with their pre-existing beliefs, reported that the therapy had not been helpful. This result was particularly striking for the "life historical" clients who received solution-focused therapy. At the same time, a small number of "situational" and "moral" clients benefited from psychodynamic therapy, and reported at the end of therapy that their ideas about how to deal with life problems had shifted. These clients described how the process of therapy had been difficult for them, and that they had needed to learn a new way to think about life. These findings are consistent with the conclusion reached by [Kühnlein \(1999\)](#), that the majority of clients are seeking "biographical continuity" in their therapy. In other words, clients tend to benefit from ways of working in therapy that allow them to make sense of current problems in terms of their pre-existing life stories.

Some other qualitative studies have approached the issue of client therapeutic knowledge from a different direction. These are studies in which researchers have interviewed people who have overcome, recovered from, or are living with serious emotional and interpersonal problems, in an attempt to identify the practical knowledge or "wisdom" that these individuals have acquired in relation to that struggle. The rich and diverse literature in this area includes studies by [Grossman, Sorsoli, and Kia-Keating \(2006\)](#), [Higginson and Mansell \(2008\)](#), [Kinnier, Hofsess, Pongratz, and Lambert \(2009\)](#), [Murray et al. \(2011\)](#), [Peglidou \(2010\)](#), [Reynolds and Shepherd \(2011\)](#) and [Ridge and Ziebland \(2006\)](#). Findings reported by these studies range from instances of simple yet helpful affirmatory statements such as "I am not 'crazy' and I will not go crazy", "the power to heal myself is within me. I can do it" and "my problem is very common – many people live with it – I am not alone" ([Kinnier et al., 2009](#)), to complex sequences of interpersonal and self-management strategies. What clearly emerges from this body of research is that there exists a wide range of activities that individuals have found to be helpful when overcoming problems, and that these activities reach far beyond the scope of most current forms of psychotherapy. In addition,

those who are engaged in trying to deal with problems seem to be able to differentiate between different strategies that are most helpful at particular times for particular problems.

Why do different clients express different ideas about what kind of therapy would be most useful to them? There has been little research that has sought to go beyond the documentation and measurement of preferences and attitudes, to examine the sources of these positions. Some studies have found that previous experience of therapy tends to shape a person's ideas around what kind of therapy they would like to receive next time (e.g., [Bragesjö et al., 2004](#)). A theme that runs through much of the research is the notion that broad contextual factors such as culture and gender play important roles in shaping therapeutic knowledge ([Cabassa, Lester, & Zayas, 2007](#); [Farsimadan, Khan, & Draghi-Lorenz, 2011](#); [Nadeem et al., 2008](#); [Peglidou, 2010](#)). There are also tangible practical factors that contribute to client preferences, such as the difficulty of combining childcare responsibilities with the commitment of attending therapy on a weekly basis ([Mohr et al., 2006](#); [Snape, Perren, Jones, & Rowland, 2003](#)). Taken as a whole, research into everyday knowledge of what is "therapeutic" suggests that the ideas that clients hold and the decisions they make, reflect a set of multiple layers of influence. At the deepest level, a person's ideas about how to cope with problems in living are shaped by the fact of having grown up as a man or woman, and as a member of a particular cultural community. At the level of individual life history, specific encounters with healing activities, whether within the context of formal psychotherapy or elsewhere, contribute to a sense of what feels "right" or "scary" or "weird" in relation to various therapy methods. Finally, there are practical factors that also come into play, for instance "I know that I cannot afford the time to attend therapy every week, so maybe it would be better to start by trying antidepressant medication".

A final area of research that is relevant to an understanding of the role of client knowledge in therapy, comprises studies of what happens when a therapist seeks to impose his or her knowledge on the client, and does not listen to or accept the validity of feedback from the client that these ideas are not helpful. There have not been many studies of this phenomenon. Perhaps the most vivid examples can be found in a classic study by [Chesler \(1972\)](#) which documented instances when therapists believed that it would be helpful for their clients to enter into a sexual relationship with them. Case accounts collected by [Bates \(2006\)](#) reinforce the finding that clients may experience any situation in which their therapist perseveres with a line of action that they know is wrong for them, as abusive and harmful. Similar results are reported in an interview study by [Dale, Allen, and Measor \(1998\)](#). These studies are important because they suggest that clients who know that the direction of their therapy is not right for them, do not necessarily quit therapy – the authority, interpersonal skills and persuasiveness of their therapist may result in on-going exposure to therapeutic activities that are dissonant with their core beliefs and values.

For reasons of space, the discussion of research into clients' knowledge of what is helpful or unhelpful for them in therapy, cannot claim to comprise a comprehensive review of this topic. There are many other studies that might have been included. Rather than offer a systematic and comprehensive review, the aim has been to provide a "practice-friendly" review, that focuses on implications for practice. Taken as a whole, the research that has been carried out reinforces the significance of client knowledge as an active ingredient in effective therapy. However, it is also clear that more research is required, to fill in some of the gaps within the current literature. For example, there is little research evidence around the ways in which therapists handle (or fail to handle) situations in which their client's ideas of how to proceed radically differs from their own professional judgement.

Promoting Dialogue Around Client and Therapist Knowledge: The Case of Andrew

The intention of this section is to move beyond consideration of research evidence around client expectations, attitudes and preferences for different types of therapeutic experience, in order to look at how an appreciation of the importance of client knowledge can be used to inform practice. The discussion that follows is based on my own practice, rather than on any attempt to survey what other therapists approach these issues. My practice consists of open-ended individual and couple therapy usually on a weekly basis, with clients with moderate levels of difficulty around issues such as depression, anxiety, trauma, relationship difficulties, life choices and bereavement.

My assumption, when a client makes an appointment to see me, is that somewhere in his or her awareness are questions such as “is this going to help?” and “is this counsellor the right person to help me?” I am also aware that similar questions are present in my own awareness: “is it likely that therapy will be useful for this person?”, “to what extent are my own knowledge, experience and skills sufficient for this person’s needs?” and “what does this person already know, about how to live with and to transcend his or her current difficulties”

In my work with clients, I attempt to build a scaffolding of shared understanding, within which collaborative dialogue might take place, from the beginning. The written information that the client receives in advance of our first meeting conveys key messages around the importance that we should work together, and that the counsellor will be flexible in trying to find the best way to address the client’s problems. In first meetings with clients, or assessment/intake sessions, I ask questions such as, “what do you know about counselling?”, “can you tell me what counselling means to you?”, “how can I help you?” and “how do you think that counselling might help?”. I have no great expectation that the client will be able to answer these questions in any detail at that moment, although what he or she might say is of course valuable. Instead, what I am trying to do is to convey my curiosity and respect around the client’s knowledge about how different types of conversation, and ways of working together, might make a difference to whatever it is that is troubling him or her (or them). At around the same time, within such an initial meeting, I offer to talk about my own knowledge of how therapy might work. My aim is to create the conditions for dialogue and mutual learning. I want to be guided by the client in terms of how to approach his or her problem. In addition, I want to be open about the reality that I possess a certain amount of knowledge and experience, some of which might represent new possibilities for the client. My assumption is that it is very unlikely that we will engage in dialogue around these issues until we have got to know each other a bit better. My experience has been that, at the start of therapy, most clients do not have a clear idea of what they are looking for from a therapist. However, they probably have a vague sense of what would be helpful or unhelpful for them, and part of my job is to create the conditions under which this sense can be turned into something more specific and concrete, in terms of a shared understanding of how to move forward together.

As therapy continues, regular review conversations, incorporation of metacommunicative sequences within the process of counselling, and use of client feedback instruments, function as ways of reinforcing the core idea that the client’s ideas about what is most helpful, are precious and important. Further information on these strategies can be found in [Cooper and McLeod \(2011a\)](#).

An illustration of how the client’s knowledge can play a part in therapy is represented by the case of Andrew, a 35 year old man who attended client for 12 sessions of counselling following the sudden and unexpected death of a close family member. Andrew had no previous experience of counselling or psychotherapy. His cultural background, as a child who grew up in a tough inner-city community, followed by time in the armed forces and

then a job as a manager in a competitive business environment, had taught him to handle things on his own, and to use alcohol as a means of blunting painful feelings. At the same time, he was someone who was caring, and had a hidden artistic side. At our first meeting, I reiterated the ideas about collaborative working that he had already encountered in the leaflet he had been sent, asked him what he thought might be helpful or unhelpful for him in counselling (he did not know), and emphasised the importance for our work together of providing feedback to me, in terms of what I did that was useful or hindering for him. I asked him to identify his goals for therapy (he wished to overcome his loss). I then told him that I thought that it would help me to understand him better, and the situation in which he found himself, if he could take some time to just talk to me about what had happened, and how he felt. I explained that once this information was out in the open, we would both be in a better position to decide how to proceed. Andrew then talked for two sessions. At various points I reflected back what he had said, invited him to tell me more about some aspects of what had happened, and made some suggestions for ways to allow me to get closer to his world (for example, by bringing in a photograph of the person who had died). Throughout this process I regularly checked out with Andrew whether what we were doing was helpful for him, or whether there were other directions or activities he felt might be better ways to proceed. As Andrew talked, I was listening not only for the content of his story, but also for what I could learn about his “know-how” around coping with painful emotions and losses. I was also listening for my own response to Andrew, in terms of my own knowledge of these matters.

Toward the start of the fourth session, I asked Andrew if it would be all right for me to talk for a bit, to share my understanding of what he had said. I then tentatively mapped out (on a large piece of paper) a preliminary formulation of his therapeutic goals, the step-by-step tasks that might need to be accomplished in order to attain these goals, and some ideas about the methods or practical activities that we might use to complete each task. During this conversation, I took every opportunity to add his own words and suggestions to our “map”. By the end of the session, we had agreed on a rough order of priority – which issues we might work on first. After the session, I sent him an email that summarised the main points of our discussion, and repeated the invitation to him to adapt, or add to, the map as he saw fit.

Among the tasks that we worked on were: undoing his self-criticism at not being able to prevent the death; being able to seek and accept emotional support from his wife; experiencing his feelings and the meanings that they held for him; and adjusting to his new role within his extended family. There were three points during the course of therapy where Andrew’s personal knowledge of what was helpful for him had a major impact on our work. First, on several occasions he asked me to be more challenging of him, if I suspected that he might be holding back from talking about difficult issues, or was contradicting himself. My style of relating is mainly empathic and “soft”, and Andrew’s feedback enabled me to shift in the direction of a style of interaction that was more familiar to him, and which he knew how to use. The second area in which Andrew’s personal knowledge played a key role in therapy was that he began to remember how helpful writing had been to him in his adolescence, as a way of dealing with some of the pressures he had felt at that time. During the period of counselling, he began to write poems, as a means of giving expression to his feelings about the person who had died, and also to write sections of an autobiography, as a way of making sense of larger themes in his own life. The third area in which Andrew’s knowledge took centre stage in therapy was toward the end of our work, when he talked about visiting a spirit medium in order to make contact with his deceased family member. This practice was well outside of my own knowledge base and belief system, and I had to be willing to learn from him, and be lead by him, in appreciating the value of this activity. In turn, I was able to make bridges between his experience of visiting a spiritual guide, and other themes within the counselling, such as finding meaning, and accepting support.

My work with Andrew is not offered as an example of an unusual or gifted piece of therapy. Instead, it is intended to illustrate some of the ordinary ways in which a client can be encouraged to share and use what he or she knows, and engage in dialogue with what his or her therapist knows. My belief is that Andrew was more open to learning from me, because I was open to learning from him.

Conclusion

At the present time, the implications of a pluralistic stance for counselling, counselling psychology, and psychotherapy theory, research, practice and training are only just beginning to be explored. As a construct that originates from philosophy and political theory, the concept of pluralism offers a meta-perspective from which psychological and psychotherapeutic ideas and practices can be viewed in a different light. One of the aspects of therapy that is brought vividly into focus from a pluralistic perspective is that client knowledge needs to be taken seriously. For most of the history of counselling and psychotherapy, huge amounts of attention and energy have been devoted to articulating the knowledge of the therapist. However, putting a pluralistic ethic into action requires being open to, and engaging in dialogue with, the knowledge of the client. The question of how to find ways of integrating professional and indigenous knowledge, in the service of effective care, has long been recognised within medicine (Kiesler, McFadden, & Belliard, 2006; Stevenson, Britten, Barry, Bradley, & Barber, 2003). Given the many competing discourses of mental health and healing that exist within contemporary society, this is an issue that is perhaps even more critical for practitioners of psychological therapies. While there are research studies that have begun to examine aspects of this topic, and there are some ideas about how to facilitate such dialogue between therapists and clients, it is also clear that there are many unanswered questions and possibilities for creative ways of working, that await future investigation and discovery.

References

- Bakker, A., Spinhoven, P., van Balkom, A. J. L. M., Vleugel, L., & van Dyck, R. (2000). Cognitive therapy by allocation versus cognitive therapy by preference in the treatment of panic disorder. *Psychotherapy and Psychosomatics*, 69, 240-243. doi:10.1159/000012402
- Bates, Y. (Ed.). (2006). *Shouldn't I be feeling better by now? Client views of therapy*. London: Palgrave Macmillan.
- Bohart, A., & Tallman, K. (1996). The active client: Therapy as self-help. *Journal of Humanistic Psychology*, 36, 7-30. doi:10.1177/00221678960363002
- Bohart, A., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington DC: American Psychological Association.
- Bragesjö, M., Clinton, D., & Sandell, R. (2004). The credibility of psychodynamic, cognitive and cognitive-behavioural psychotherapy in a randomly selected sample of the general public. *Psychology and Psychotherapy*, 77, 297-307. doi:10.1348/1476083041839358
- Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.
- Cabassa, L. J., Lester, R., & Zayas, L. H. (2007). "It's like being in a labyrinth:" Hispanic immigrants' perceptions of depression and attitudes toward treatments. *Journal of Immigrant and Minority Health*, 9, 1-16. doi:10.1007/s10903-006-9010-1
- Chesler, P. (1972). *Women and madness*. New York: Doubleday.

- Constantino, M. J., Manber, R., Ong, J., Kuo, T. F., Huang, J., & Arnow, B. A. (2007). Patient expectations and therapeutic alliance as predictors of outcome in group cognitive-behavioral therapy for insomnia. *Behavioral Sleep Medicine*, 5, 210-228. doi:[10.1080/15402000701263932](https://doi.org/10.1080/15402000701263932)
- Cooper, M. (2008). *Essential research findings in counselling and psychotherapy: The facts are friendly*. London: SAGE.
- Cooper, M., & McLeod, J. (2007). A pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling & Psychotherapy Research*, 7, 135-143. doi:[10.1080/14733140701566282](https://doi.org/10.1080/14733140701566282)
- Cooper, M., & McLeod, J. (2011a). *Pluralistic counselling and psychotherapy*. London: SAGE.
- Cooper, M., & McLeod, J. (2011b). Person-centered therapy: A pluralistic perspective. *Person-Centered and Experiential Psychotherapies*, 10, 210-223. doi:[10.1080/14779757.2011.599517](https://doi.org/10.1080/14779757.2011.599517)
- Coursol, A., & Sipps, G. J. (1986). Examination of the unintentional effect of stimulus medium and context on preference for psychotherapy. *Journal of Clinical Psychology*, 42, 280-286. doi:[10.1002/1097-4679\(198603\)42:2<280::AID-JCLP2270420209>3.0.CO;2-I](https://doi.org/10.1002/1097-4679(198603)42:2<280::AID-JCLP2270420209>3.0.CO;2-I)
- Dale, P., Allen, J., & Measor, L. (1998). Counselling adults who were abused as children: Clients' perceptions of efficacy, client-counsellor communication, and dissatisfaction. *British Journal of Guidance & Counselling*, 26, 141-157.
- Farsimadan, F., Khan, A., & Draghi-Lorenz, R. (2011). On ethnic matching: A review of the research and considerations for practice, training and policy. In C. Lago (Ed.), *The handbook of transcultural counselling and psychotherapy* (pp. 65-80). Maidenhead: Open University Press.
- Gergen, K. J. (2000). The coming of creative confluence in therapeutic practice. *Psychotherapy*, 37, 364-369. doi:[10.1037/0033-3204.37.4.364](https://doi.org/10.1037/0033-3204.37.4.364)
- Goates-Jones, M., & Hill, C. E. (2008). Treatment preference, treatment-preference match, and psychotherapist credibility: Influence on session outcome and preference shift. *Psychotherapy (Chicago, Ill.)*, 45, 61-74. doi:[10.1037/0033-3204.45.1.61](https://doi.org/10.1037/0033-3204.45.1.61)
- Grossman, F. K., Sorsoli, L., & Kia-Keating, M. (2006). A gale force wind: Meaning making by male survivors of childhood sexual abuse. *The American Journal of Orthopsychiatry*, 76, 434-443. doi:[10.1037/0002-9432.76.4.434](https://doi.org/10.1037/0002-9432.76.4.434)
- Hemmings, A. (2000). A systematic review of the effectiveness of brief psychological therapies in primary health care. *Families, Systems & Health*, 18, 279-313. doi:[10.1037/h0091857](https://doi.org/10.1037/h0091857)
- Higginson, S., & Mansell, W. (2008). What is the mechanism of psychological change? A qualitative analysis of six individuals who experienced personal change and recovery. *Psychology and Psychotherapy*, 81, 309-328. doi:[10.1348/147608308X320125](https://doi.org/10.1348/147608308X320125)
- Iacoviello, B. M., McCarthy, K. S., Barrett, M. S., Rynn, M., Gallop, R., & Barber, J. P. (2007). Treatment preferences affect the therapeutic alliance: Implications for randomized controlled trials. *Journal of Consulting and Clinical Psychology*, 75, 194-198. doi:[10.1037/0022-006X.75.1.194](https://doi.org/10.1037/0022-006X.75.1.194)
- Kiesser, M., McFadden, J., & Belliard, J. C. (2006). An interdisciplinary view of medical pluralism among Mexican-Americans. *Journal of Interprofessional Care*, 20, 223-234. doi:[10.1080/13561820600718055](https://doi.org/10.1080/13561820600718055)

- King, M., Sibbald, B., Ward, E., Bower, P., Lloyd, M., Gabbay, M., & Byford, S. (2000). Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy and usual general practitioner care in the management of depression as well as mixed anxiety and depression in primary care. *Health Technology Assessment*, 4, 1-83.
- Kinnier, R. T., Hofsess, C., Pongratz, R., & Lambert, C. (2009). Attributions and affirmations for overcoming anxiety and depression. *Psychology and Psychotherapy*, 82, 153-169. doi:[10.1348/147608308X389418](https://doi.org/10.1348/147608308X389418)
- Kocsis, J. H., Leon, A. C., Markowitz, J. C., Manber, R., Arnow, B., Klein, D. N., & Thase, M. E. (2009). Patient preference as a moderator of outcome for chronic forms of major depressive disorder treated with Nefazodone, cognitive behavioral analysis system of psychotherapy, or their combination. *The Journal of Clinical Psychiatry*, 70, 354-361. doi:[10.4088/JCP.08m04371](https://doi.org/10.4088/JCP.08m04371)
- Kühnlein, I. (1999). Psychotherapy as a process of transformation: Analysis of posttherapeutic autobiographical narrations. *Psychotherapy Research*, 9, 274-287. doi:[10.1093/ptr/9.3.274](https://doi.org/10.1093/ptr/9.3.274)
- Kwan, B. M., Dimidjian, S., & Rizvi, S. L. (2010). Treatment preference, engagement, and clinical improvement in pharmacotherapy versus psychotherapy for depression. *Behaviour Research and Therapy*, 48, 799-804. doi:[10.1016/j.brat.2010.04.003](https://doi.org/10.1016/j.brat.2010.04.003)
- Lang, A. J. (2005). Mental health treatment preferences of primary care patients. *Journal of Behavioral Medicine*, 28, 581-586. doi:[10.1007/s10865-005-9019-2](https://doi.org/10.1007/s10865-005-9019-2)
- Levy Berg, A., Sandahl, C., & Clinton, D. (2008). The relationship of treatment preferences and experiences to outcome in Generalized Anxiety Disorder (GAD). *Psychology and Psychotherapy*, 81, 247-259. doi:[10.1348/147608308X297113](https://doi.org/10.1348/147608308X297113)
- Lilliengren, P., & Werbart, A. (2005). A model of therapeutic action grounded in the patients' view of curative and hindering factors in psychoanalytic psychotherapy. *Psychotherapy (Chicago, Ill.)*, 3, 324-399.
- Lin, P., Campbell, D. G., Chaney, E. F., Liu, C. F., Heagerty, P., Felker, B. L., & Hedrick, S. C. (2005). The influence of patient preference on depression treatment in primary care. *Annals of Behavioral Medicine*, 30, 164-173. doi:[10.1207/s15324796abm3002_9](https://doi.org/10.1207/s15324796abm3002_9)
- McAteer, D. (2010). Philosophical pluralism: Navigating the sea of diversity in psychotherapeutic and counselling psychology practice. In M. Milton (Ed.), *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 5-20). Chichester: Wiley-Blackwell.
- McLeod, J., & Sweeting, A. (2010). Public perceptions of the usefulness of CBT, psychodynamic therapy and counselling. *Counselling in Scotland*, 12, 41-43.
- Mohr, D. C., Hart, S. L., Howard, I., Julian, L., Vella, L., Catledge, C., & Feldman, M. D. (2006). Barriers to psychotherapy among depressed and nondepressed primary care patients. *Annals of Behavioral Medicine*, 32, 254-258. doi:[10.1207/s15324796abm3203_12](https://doi.org/10.1207/s15324796abm3203_12)
- Murray, G., Suto, M., Hole, R., Hale, S., Amari, E., & Michalak, E. E. (2011). Self-management strategies used by 'high functioning' individuals with bipolar disorder: From research to clinical practice. *Clinical Psychology & Psychotherapy*, 18, 95-109. doi:[10.1002/cpp.710](https://doi.org/10.1002/cpp.710)
- Nadeem, E., Lange, J. M., & Miranda, J. (2008). Mental health care preferences among low-income and minority women. *Archives of Women's Mental Health*, 11, 93-102. doi:[10.1007/s00737-008-0002-0](https://doi.org/10.1007/s00737-008-0002-0)

- Nilsson, T., Svensson, M., Sandell, R., & Clinton, D. (2007). Patients' experiences of change on cognitive-behavioral therapy and psychodynamic therapy: A qualitative comparative study. *Psychotherapy Research*, 17, 553-566. doi:[10.1080/10503300601139988](https://doi.org/10.1080/10503300601139988)
- Patterson, C. L., Uhlin, B., & Anderson, T. (2008). Clients' pretreatment counseling expectations as predictors of the working alliance. *Journal of Counseling Psychology*, 55, 528-534. doi:[10.1037/a0013289](https://doi.org/10.1037/a0013289)
- Peglidou, A. (2010). Therapeutic itineraries of 'depressed' women in Greece: Power relationships and agency in therapeutic pluralism. *Anthropology & Medicine*, 17, 41-57. doi:[10.1080/13648471003600404](https://doi.org/10.1080/13648471003600404)
- Philips, B., Wennberg, P., & Werbart, A. (2007). Ideas of cure as a predictor of premature termination, early alliance, and outcome in psychoanalytic psychotherapy. *Psychology and Psychotherapy*, 80, 229-245. doi:[10.1348/147608306X128266](https://doi.org/10.1348/147608306X128266)
- Philips, B., Werbart, A., Wennberg, P., & Schubert, J. (2007). Young adults' ideas of cure prior to psychoanalytic psychotherapy. *Journal of Clinical Psychology*, 63, 213-232. doi:[10.1002/jclp.20342](https://doi.org/10.1002/jclp.20342)
- Polanyi, M. (1958). *Personal knowledge*. London: Routledge.
- Polkinghorne, D. E. (1992). Postmodern epistemology of practice. In S. Kvale (Ed.), *Psychology and postmodernism* (pp. 124-146). London: SAGE.
- Rescher, N. (1993). *Pluralism: Against the demand for consensus*. Oxford: Oxford University Press.
- Reynolds, F., & Shepherd, C. (2011). Young women's accounts of intimate partner violence during adolescence and subsequent recovery processes: An interpretative phenomenological analysis. *Psychology and Psychotherapy*, 84, 314-334. doi:[10.1111/j.2044-8341.2010.02001.x](https://doi.org/10.1111/j.2044-8341.2010.02001.x)
- Ridge, D., & Ziebland, S. (2006). "The old me could never have done that": How people give meaning to recovery following depression. *Qualitative Health Research*, 16, 1038-1053. doi:[10.1177/1049732306292132](https://doi.org/10.1177/1049732306292132)
- Samuels, A. (1989). Analysis and pluralism: The politics of the psyche. *The Journal of Analytical Psychology*, 34, 33-51. doi:[10.1111/j.1465-5922.1989.00033.x](https://doi.org/10.1111/j.1465-5922.1989.00033.x)
- Slife, B. D., & Wendt, D. C. (2009). Editors' introduction: The modern legacy of William James' 'A pluralistic universe'. *Journal of Mind and Behavior*, 30, 103-106.
- Snape, C., Perren, S., Jones, L., & Rowland, N. (2003). Counselling – Why not? A qualitative study of people's accounts of not taking up counselling appointments. *Counselling & Psychotherapy Research*, 3, 239-245. doi:[10.1080/14733140312331384412](https://doi.org/10.1080/14733140312331384412)
- Snyder, D. K. (1999). Affective reconstruction in the context of a pluralistic approach to couple therapy. *Clinical Psychology*, 6, 348-365. doi:[10.1093/clipsy.6.4.348](https://doi.org/10.1093/clipsy.6.4.348)
- Snyder, D. K., & Mitchell, A. E. (2008). Affective-reconstructive couple therapy: A pluralistic, developmental approach. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 151-179). New York: Guilford Press.
- Sobel, H. J. (1979). Preferences for behavioural, analytic and Gestalt psychotherapy. *The British Journal of Medical Psychology*, 52, 263-269. doi:[10.1111/j.2044-8341.1979.tb02524.x](https://doi.org/10.1111/j.2044-8341.1979.tb02524.x)

- Stevenson, F. A., Britten, N., Barry, C. A., Bradley, C. P., & Barber, N. (2003). Self-treatment and its discussion in medical consultations: How is medical pluralism managed in practice? *Social Science & Medicine*, 57, 513-527. doi:[10.1016/S0277-9536\(02\)00377-5](https://doi.org/10.1016/S0277-9536(02)00377-5)
- Swift, J. K., & Callahan, J. L. (2009). The impact of client treatment preferences on outcome: A meta-analysis. *Journal of Clinical Psychology*, 65, 368-381. doi:[10.1002/jclp.20553](https://doi.org/10.1002/jclp.20553)
- Tarrier, N., Liversidge, T., & Gregg, L. (2006). The acceptability and preference for the psychological treatment of PTSD. *Behaviour Research and Therapy*, 44, 1643-1656. doi:[10.1016/j.brat.2005.11.012](https://doi.org/10.1016/j.brat.2005.11.012)
- Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative meta-analysis. *Psychotherapy Research*, 17, 305-314. doi:[10.1080/10503300600608116](https://doi.org/10.1080/10503300600608116)
- Timulak, L. (2010). Significant events in psychotherapy: An update of research findings. *Psychology and Psychotherapy*, 83, 421-447. doi:[10.1348/147608310X499404](https://doi.org/10.1348/147608310X499404)
- Valkonen, J., Hanninen, V., & Lindfors, O. (2011). Outcomes of psychotherapy from the perspective of the users. *Psychotherapy Research*, 21, 227-240. doi:[10.1080/10503307.2010.548346](https://doi.org/10.1080/10503307.2010.548346)
- van Schaik, D. J. F., Klijn, A. F. J., van Hout, H. P. J., van Marwijk, H. W. J., Beekman, A. T. F., de Haan, M., & van Dyck, R. (2004). Patients' preferences in the treatment of depressive disorder in primary care. *General Hospital Psychiatry*, 26, 184-189. doi:[10.1016/j.genhosppsych.2003.12.001](https://doi.org/10.1016/j.genhosppsych.2003.12.001)
- White, M. (2004). Folk psychology. In L. A. Angus & J. McLeod (Eds.), *Handbook of narrative and psychotherapy* (pp. 22-57). Thousand Oaks: SAGE.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.
- Woody, W. D., & Viney, W. (2009). A pluralistic universe: An overview and implications for psychology. *Journal of Mind and Behavior*, 30, 107-120.