1 Introducing the Pluralistic Approach

This chapter discusses:

- The rationale for the development of a pluralistic approach to counselling and psychotherapy.
- The development of 'schoolism' in the counselling and psychotherapy field and its limitations.
- The development of integrative and eclectic approaches.
- The basic assumptions and framework underpinning the pluralistic approach.

From Schools to Schoolism

Since the first days of psychoanalysis, the psychotherapy and counselling world has been characterised by the emergence of divergent schools of thought and practice. 'Over the years', write Duncan, Miller, and Sparks (2004: 31), 'new schools of therapy arrived with the regularity of the Book-of-the-Month Club's main selection.' Today, it is estimated that there are more than 400 different types of therapy (Norcross, 2005), offering a vast array of practices, techniques, and understandings of mental distress.

Within the United Kingdom, most practitioners adhere to one or other of these schools, and single orientation approaches remain the predominant way of practising, commissioning and thinking about the therapeutic field. In the British Association for Counselling and Psychotherapy (BACP), for instance, less than 25% of therapists are trained in an integrative approach (Couchman, 2006, personal communication), and the UK Council for Psychotherapy (UKCP) has recently restructured along orientation-specific lines. An orientation-based conceptualisation of counselling and psychotherapy is also evident in recent moves – both within the UK and internationally – towards 'evidence-based practices', in which highly specific, manualised forms of therapeutic intervention are recommended for specific psychological 'disorders' (e.g., Department of Health, 2001). As a consequence of this, trainings for such initiatives as the Improving Access to Psychological Therapies programme in the UK are almost entirely orientation-based, with trainees schooled in very specific manualised treatments for specific psychological problems.

Exercise 1.1: Therapeutic attitudes

For each of the following therapies, write down a number from 1 to 7 in the box after it indicating how much you like or dislike it. Try to respond with your immediate gut feeling and try and to be as honest as you can – don't think too much about it. If you haven't heard of the orientation, just leave the box blank. Scoring is as follows:

1 = Strongly dislike, 2 = Moderately dislike, 3 = Slightly dislike, 4 = Neither like or dislike, 5 = Slightly like, 6 = Moderately like, 7 = Strongly like

Psychodynamic therapy ☐
Person-centred therapy ☐
Cognitive-behavioural therapy ☐
Gestalt therapy ☐
Integrative therapy ☐
Hypnotherapy ☐
Arts therapy ☐
Classical/Freudian psychoanalysis ☐
Pharmacological/drug therapies ☐

Please write down any other therapies that you have a gut feeling of like towards:

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Please write down any other therapies that you have a gut feeling of dislike towards:

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If there are any therapies that you have given a score of 3 or less to, or stated that you dislike, spend some time (maybe 10 minutes) thinking why you have come to feel that way towards them. Is it something to do, for instance, with your personal experiences of that therapy, the practitioners of that therapy you have met, or what you have come to associate that therapy with?

Now take some time (maybe 10 minutes) thinking about why you like the therapies that you do.

Finally, ask yourself the following questions (maybe 10 minutes):

- Can you think of ways in which the therapies that you *dislike* may be *helpful* to some people?
- Can you think of ways in which the therapies that you *like* may be *unhelpful* to some people?

Without doubt, the emergence of specific schools within the psychotherapy and counselling field has done much to foster growth and creativity within the field (see Samuels, 1997). We are now in a position where clients have a vast diversity of practices to choose from, and where forms of therapy are constantly developed and refined to be of as much benefit as possible to clients. And yet, there is also the danger that the existence of schools can tip over into an unproductive 'schoolism': 'characterized by binary thinking (i.e. "This", against "That"),' where, 'those immersed in schoolistic attitudes are likely to defend passionately the "truth" of their own school and attack with vigour the "error" of rival schools' (Hollanders, 2003: 277–278). In other words, rather than practitioners of different orientations respecting and valuing the others' work – as a heart surgeon might do to a paediatrician – a tribalism emerges that is more akin to rivalries between supporters of different football teams.

Such schoolism can be highly destructive, and this is for a number of reasons. First, such a 'battle of the brands' (Duncan et al., 2004: 31) makes it difficult for adherents of any one orientation to learn from, and develop their practice in response to, adherents of other orientations. Second, schoolism can degrade further into an 'ideological cold war', with 'Mutual antipathy and exchange of puerile insults between adherents of rival orientations' (Norcross, 2005: 3). This can then create a professional environment that is experienced as hostile, unsafe and unproductive by all. Third, and perhaps most importantly, schoolism can lead practitioners to be 'blind to alternative conceptualizations and potentially superior interventions' (Norcross, 2005: 3), such that they can end up imposing upon clients less helpful – or actively unhelpful – practices. Ultimately, then, it is clients who are most likely to lose out as a result of schoolism – people who, as the research shows, do not tend to be particularly interested in the therapist's 'brand' (Binder, Holgersen & Nielsen, 2009). As the philosopher William James writes (1996: 219), 'It is but an old story, of a useful practice first becoming a method, then a habit, and finally a tyranny that defeats the end it was used for.'

Box 1.1: Pathways to schoolism

Why is it that schools of therapy can, so easily, deteriorate into schoolisms? Interestingly, perhaps, many of the theories developed in these schools, themselves, can help us to understand this transition. For instance, in person-centred theory (Rogers, 1951, 1959), it is hypothesised that people tend to form, and then defend, fixed concepts of self (e.g., 'I am a person-centred therapist'), out of a desire to maintain self-consistency, and out of a fear of how they might be judged by themselves and those around them if they relinquished that identity. Similarly, at the core of CBT is the belief that people tend towards absolutist, black-or-white thinking (Beck, John, Shaw & Emery, 1979), in which all experiences are placed in one of two opposite categories – e.g., 'This therapy is effective', 'That therapy is ineffective' – rather than

(Continued)

acknowledging 'the complexity, variability and diversity of human experiences and behavior' (Beck et al., 1979: 15). This emphasis on the tendency to split between 'good' and 'bad' 'objects' is also evident in the psychodynamic theory of Klein (Cooper, 1996). Another way of thinking about the emergence of schoolism comes from an existential perspective, which holds that one of our most fundamental needs is to feel that our lives are of meaning (Frankl, 1986). From this stance, it might be argued that we need to feel that our approach is 'better' than others to give ourselves a sense of significance and purpose in the work that we do. To face the possibility that other therapists' work may actually be more valuable and helpful might be decidedly anxiety-evoking.

Social psychological theories can also be very valuable in helping us understand this shift from schools to schoolism. 'Social identity theory', for instance, highlights the way that we instinctively tend to favour our in-group because, by feeling positive about a group we are part of, we feel better about ourselves (Tajfel & Turner, 1979). Research around 'cognitive dissonance' (e.g., Festinger, 1957) has also highlighted the fact that, once we make a choice (for instance, to train in a particular orientation), we then tend to feel more positive towards that standpoint, as a means of justifying to ourselves why we made that choice in the first place.

What may also fuel schoolism is a desire – perhaps a basic human one – to have simple, neat, definitive answers to complex questions. In other words, it may be much more satisfying and reassuring for people to believe that the answer to the question: 'What is of help to people?' is 'X' rather than 'X and Y and a bit of Z… though for some people it is U and P and possibly Z… but we are not sure…' As William James (1996: 45) states, this latter, pluralistic worldview – the belief in a 'messy universe' – is by no means appealing: 'It is a turbid, muddled, gothic sort of affair, without a sweeping outline and with little pictorial nobility.'

In discussing this tendency towards schoolism, it is probably important to emphasise also that we are not just talking about cognitive processes here, but about deeply affective and emotional ones. 'When your faith is disturbed your being is rattled,' writes Connolly (2005: 93). 'You react bodily through the roiling [churning] of your gut, the hunching of your shoulders, the pursing of your lips, and the tightening of your skin.'

At the heart of many of these issues, however, may be the fact that the field of psychotherapy and counselling is, in essence, still in a 'pre-paradigmatic' state (Kuhn, 1970; Norcross, 2005). The philosopher Thomas Kuhn uses this term to refer to a period in the development of a scientific discipline in which a shared understanding has yet to be reached, and is characterised by 'competing schools of thought' that 'possess differing procedures, theories, even metaphysical presuppositions' (Bird, 2009). Here, in the absence of any agreed-upon evidence, dogmas are likely to flourish. Moreover, without such certainty, psychotherapists and counsellors may be more likely to experience anxiety and defensiveness in the face of alternative viewpoints and practices.

Integrative and Eclectic Approaches

Since the 1930s, psychotherapists and counsellors have attempted to overcome the problems associated with single orientation therapies by developing more integrative and eclectic approaches (Goldfried, Pachanakis, & Bell, 2005). Growth in this field has been particularly marked from the 1970s onwards (Nuttall, 2008), such that it can now be claimed that an integrative or eclectic stance is currently the most common theoretical orientation of English-speaking psychotherapists (Norcross, 2005), with around 25–50% of American clinicians identifying in this way (Norcross, 2005; Orlinsky & Rønnestad, 2005d). Furthermore, research indicates that many practitioners identified with specific orientations, in reality, tend to integrate into their practice methods from other orientations (see Box 6.1 on page 99). For instance, psychodynamic therapists, on average, have been found to strongly endorse the CBT practice of challenging maladaptive beliefs, while cognitive-behavioural therapists have been found to prioritise the person-centred stance of empathy (Thoma & Cecero, 2009).

Recommended reading

McLeod, J. (2009). *An Introduction to Counselling* (4th edn). Maidenhead: Open University Press (Chapter 13). An overview of current ideas about therapy integration.

Norcross, J. C., & Goldfried, M. R. (Eds.). (2005). *Handbook of Psychotherapy Integration*. New York: Oxford University Press. An invaluable, US-based compendium of chapters on all aspects of integrative and eclectic practice.

It is possible to distinguish between four contrasting modes of therapy integration. First, there is 'theoretical integration', in which aspects of two or more approaches are synthesised together into a new therapy, such as cognitive analytic therapy (Ryle, 1990). Second, there is 'assimilative integration', in which therapists gradually introduce new techniques and ideas into their pre-existing approach, over the course of their career (Messer, 1992). Third, there are common factors approaches, which involve attempts to identify active ingredients across a range of therapies (see, for instance, Hubble, Duncan, & Miller, 1999). Finally, there is technical eclecticism, such as Lazarus's multimodal therapy, in which the therapist makes an initial assessment of the client, and then draws on an extensive range of methods from a variety of orientations (see, for instance, Palmer, 2000) to address the client's problems.

In contrast to a schoolist perspective, integrative and eclectic therapists tend to hold that no one school has all the answers (Lazarus, 2005; Pinsof, 2005), and that different methods may be of help to different clients. Arnold Lazarus, for instance, founder of multimodal therapy, writes that the multimodal therapist asks '*Who or what is best for this particular individual?*', and he describes his approach as both 'personalistic' and 'individualistic', flexibly tailoring the therapeutic method and style of relating to

the individual client. However, as Downing (2004) points out, there can be a tendency for many of these attempts to transcend singular models of theory and practice to end up replicating something quite similar, albeit with elements synthesised from a variety of sources. Ryle's (1990) cognitive analytic therapy, for instance, outlines a very specific model of personality functioning, while Egan's (1994) problem management approach advocates a highly specified set of procedures for helping clients overcome their difficulties. Even multimodal therapy (Lazarus, 1981, 2005) locates itself within a specific theoretical framework, and has a highly specified form of assessment. Lazarus (2005: 107, italics added) writes, for instance, that 'the multimodal therapist *does not embrace divergent theories* but remains consistently within social-cognitive learning theory'. And he goes on to state that, 'The polar opposite of the multimodal approach is the Rogerian or Person-Centered orientation, which is entirely conversational'. While integrative and eclectic approaches, then, tend to be less tied down to specific methods and specific theories than their single orientation predecessors, there can still be a tendency to promote certain practices and understandings above others.

Pluralistic therapy is an integrative approach that seeks to build on the ideas of existing models of therapy integration (see McLeod, 2009b), while avoiding their tendency to end up with the privileging yet another single orientation school of practice. The pluralistic approach accomplishes this intention through the use of two key strategies. First, it is organised around a philosophical construct (pluralism) rather than psychological constructs, and so is not identified with any particular psychological model. Second, it commits the practitioner to sustained engagement with the client's view of what will be helpful for them. This commitment inevitably requires the therapist to accommodate ideas and practices that are outside their existing assumptions about therapeutic concepts and methods.

Introduction to a Pluralistic Approach

The aim of the present book is to develop a way of practising, researching and thinking about therapy which can embrace, as fully as possible, the whole range of therapeutic methods and concepts. This is an approach which starts from the assumption that different things are likely to help different people at different points in time, such that it is meaningless to argue over which is the 'best' way of practising therapy, *per se*. It can be summed up as a 'both/and' standpoint (Gergen, 2000) – that CBT can be helpful, *and* person-centred therapy can be helpful, *and* psychodynamic therapy can be helpful… – in contrast to an 'either/or' one (Castonguay & Beutler, 2006b). As a corollary of this, the approach introduced in this book also starts from the assumption that it is not just therapists who should decide on the focus and course of therapy. Rather, therapists should work closely with their clients to decide on how the work should proceed. The two basic principles underlying this approach, therefore, can be summarised as follows:

1. Lots of different things can be helpful to clients (see Box 1.2 on page 7).
2. If we want to know what is most likely to help clients, we should talk to them about it.

Box 1.2: Ashok: Many ways to health

Below are some of the things that Ashok, a young man experiencing depression and isolation, described as helpful in his 40 weeks of therapy:

- Just talking.
- Focusing on practical solutions to problems.
- Looking at each relationship with a man in the past and seeing what attracted me to him.
- Realising that I am loved.
- Deciding to look forward and turn a corner.
- Reading a letter from my father and getting the therapist's take on it.
- Just being allowed to go off tangent.

As can be seen here, for Ashok, as for many clients (see Chapter 2), there are many different things that were helpful, and these cannot be reduced down to one, orientation-specific 'super-factor.' Rather, both within one individual client, and across clients, there would seem to be 'many ways to health' (Lambert, Bergin, & Garfield, 2004: 809).

We have come to describe this approach to therapy as 'pluralistic', as the term seems to describe, very fittingly, these two core principles. 'Pluralism' is a word used in a variety of fields (see Chapter 2), and refers to the belief that 'any substantial question admits of a variety of plausible but mutually conflicting responses' (Rescher, 1993: 79). It is a viewpoint that has becoming increasingly prevalent in the field of philosophy (see, for instance, Berlin, 1958; Connolly, 2005), and which has had a major role in debates within political science and sociology as well as in psychology and psychotherapy (see Chapter 2). Pluralism can be contrasted with 'monism', the belief that every question has a single and definitive answer. In other words, a pluralist holds that there can be many 'right' answers to scientific, moral or psychological questions which are not reducible down to any one, single truth. Central to this standpoint is also the belief that there is no one, privileged perspective from which the 'truth' can be known. That is, neither scientists, philosophers, psychotherapists nor any other kinds of people can claim to have a better vantage point on reality. Each of us has our own quite special and unique understanding of what is there.

In developing this pluralistic approach to psychotherapy and counselling, we have come to find it useful to distinguish between pluralism as a *perspective* on psychotherapy and counselling and pluralism as a particular form of therapeutic *practice* (see Figure 1.1 on page 8).

A pluralistic 'perspective', 'viewpoint', or 'sensibility' refers simply to the *belief* that there is no, one best set of therapeutic methods. It can be defined as *the assumption that different clients are likely to benefit from different therapeutic methods at different points in time, and that therapists should work collaboratively with clients*

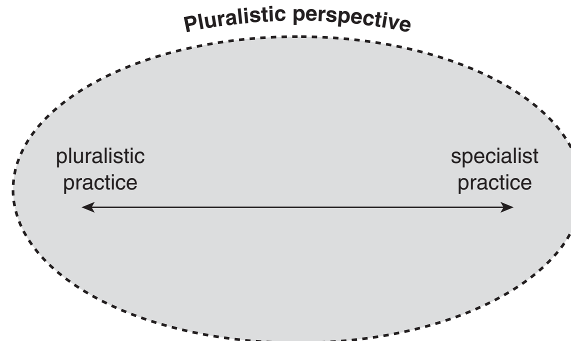

Figure 1.1: Pluralism as a perspective on therapy and as a particular practice

to help them identify what they want from therapy and how they might achieve it. This is a general definition, which does not make any specific recommendations about *how* a therapist might go about implementing a pluralistic perspective in their own practice.

By contrast, 'pluralistic practice' or 'pluralistic therapy' refers to a specific form of therapeutic *practice* which draws on methods from a range of orientation, and which is characterised by dialogue and negotiation over the goals, tasks and methods of therapy. Making this distinction is important because, although pluralistic practice is rooted in a pluralistic viewpoint, it is also quite possible for therapists to hold a pluralistic viewpoint while working in a non-pluralistic, single orientation way (see Box 1.3 below). It is also quite possible for single orientation therapists to draw on a range of pluralistic practices while remaining within a single therapeutic orientation. For example, '*working collaboratively with clients to help them identify what they want from therapy and how they might achieve it*' describes an approach to practice that is consistent with any therapeutic orientation, whether person-centred, psychodynamic or CBT. In addition, most well-established therapy orientations encompass a diversity of ideas and methods, which provide scope for therapist responsiveness and flexibility.

Box 1.3: Single orientation practices within a pluralistic framework: 'Schoolism' versus 'specialism'

While a pluralistic standpoint fundamentally challenges the assumption that any one form of therapy is superior ('schoolism'), it does not, in any way, question the value of single orientation therapeutic practices (which we describe here as 'specialisms'). From a pluralistic standpoint, different clients will want and need different things, such that specialists in approaches such as CBT, classical person-centred therapy

or psychoanalysis are all essential resources within the therapeutic community. Moreover, the existence and development of specialisms in the counselling and psychotherapy fields ensures that the rich heritage and diversity of psychotherapeutic theory and practice is maintained and that a healthy flow of innovative new therapies continues to emerge. Ultimately, then, a pluralistic approach can be strengthened and enhanced through the development of specialised theories and practices.

Undoubtedly, there is considerable overlap between the pluralistic approach introduced here and much integrative and eclectic thought, practice and vision – particularly technical eclecticism (e.g., Lazarus, 2005). Indeed, when eclectic therapists are asked to define and explain their approach, the most common answer is in relation to fitting their practice to the individual client (Thoma & Cecero, 2009). In this respect, as John (McLeod, 2009b: 382) has written, 'collaborative pluralism can be regarded as an adaptation and elaboration of central themes found in other strategies for therapy integration'. Even within single orientation specialists, as we have seen above, there is a considerable degree of overlap in the actual methods used, with many (if not most) striving to flexibly tailor their practice to the individual client's needs (Thoma & Cecero, 2009). However, there are several elements of the pluralistic approach that, we think, give it a distinctive flavour, and distinguish it from much integrative and eclectic writing – if not practice. A lot of this flows from the fact that, in contrast to most (if not all) integrative and eclectic therapies, the present pluralistic approach is rooted in a particular set of humanistic, progressive values (see Chapter 2). These differences can be summarised as follows:

- The pluralistic approach is not just a form of therapeutic *practice* but, as indicated above, is also a particular outlook on, or sensibility towards, therapy as a whole (which means that non-integrative or non-eclectic specialisms can also be embraced within this perspective).
- A pluralistic perspective, and pluralistic practice, is not just confined to one particular combination of methods or theories (as many integrative and even eclectic therapies are) but has the potential to embrace an *infinite* variety of theories, practices and change mechanisms – including those in such domains as politics, physiology and economics.
- In contrast to many 'standardised' integrative therapies, the pluralistic approach puts particular emphasis on tailoring each episode of therapy to the individual client.
- In contrast to some integrative and eclectic therapies, the pluralistic approach puts particular emphasis on the formation and maintenance of a collaborative therapeutic alliance, emphasising dialogue around the goals, tasks and methods of therapy.
- In contrast to common factors approaches, the pluralistic approach does not hold that any one set of factors – whether the quality of the therapeutic alliance or instilling hope – are the key determinants of therapeutic change for *all* clients.
- In contrast to most eclectic and integrative therapies, the pluralistic approach puts particular emphasis on the client as an active agent of change.
- The pluralistic approach introduces a particular framework for thinking about, researching and practising therapy, introduced on the next page.

A Pluralistic Framework

If a pluralistic approach strives to embrace an infinite diversity of therapies, how does it avoid an anything goes 'syncretism': the haphazard, uncritical and unsystematic combination of theories and practices (Hollanders, 2003)? Clearly, there needs to be some kind of structure, some focal point for thinking about therapy and what might be effective. Coming from a pluralistic philosophical standpoint with its commitment to prioritising the perspective of the client (Cooper, 2007; Duncan, et al., 2004), what we will suggest in this book is that the focal point for therapy should be, ultimately, what the client *wants* from it (see Chapter 4). That is, not the client's diagnosis, their assessment, or the therapist's personal beliefs about what is effective in therapy, but the clients' own *goals* for the therapeutic process. This then sets the basis for what the client and therapist see as the *tasks* of therapy (i.e., the different foci, or strategy, of the therapeutic work) and, from this, the specific *methods* (i.e., the concrete activities that they will undertake). (Note that we have used the term 'tasks' in a slightly different way from how it is sometimes adopted in the therapeutic literature (see, in particular, Bordin, 1979). We use it to refer to more macro-level therapeutic strategies, while the term 'methods' defines the actual, concrete-level, moment-by-moment activities.)

Box 1.4: Therapy as a journey

A useful way of remembering the key ideas of the pluralistic framework, which was suggested to us by qualitative researcher Nicky Forsythe, is the metaphor of therapy as a journey that the client and therapist undertake together. From this perspective:

- the goal is the destination – where you're trying to get to;
- tasks are like routes – the roads you take to change – motorway or B road, winding or straight, scenic or boring, stages in the journey, etc.;
- methods are the vehicles that you use to travel on a particular route – bus, plane, walking, swimming, flying.

Taken together, all this constitutes a route map or road map to change that needs to be continually reviewed and renegotiated by client and therapist, in the light of climate conditions, energy levels, and other factors.

These overlapping domains of goals, tasks and methods (and sub-domains of life goals/therapy goals (see Chapter 4), and client activity/therapist activity (see Chapter 6)) can be mapped out as a basic framework for therapy (see Figure 1.2). What this

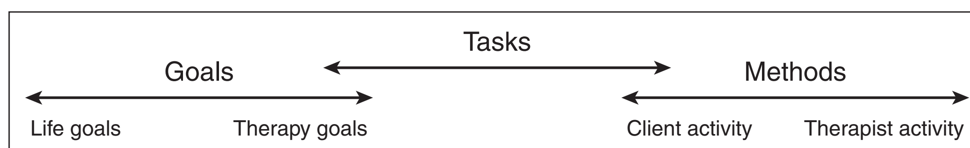

Figure 1.2: A pluralistic framework for conceptualising the therapeutic process

framework offers is a basis for collaborative dialogue around what will happen in therapy. Each key concept within the framework (goals, tasks, methods) provides a topic for discussion, reflection and collaborative choice-making by both client an therapist. For instance, Dave came to therapy with an overall desire to be happier in his life and less anxious ('life goal'). More specifically, he wanted to look at ways in which he could have better relationships with other people ('therapy goal'). In discussing this with his therapist, it became apparent that one thing that he might helpfully do is to look at ways of changing his behaviour ('task') so that he might make himself more available for close friendships. To achieve this, Dave and his therapist talked about the ways that Dave behaved in social situations and what he might do differently ('method'). Dave reflected on how he might come across to others ('client activity'), and his therapist gave him feedback on how he perceived him ('therapist activity').

For us, the value of this pluralistic framework lies in the fact that, while it provides some structure for thinking about, researching and practising therapy, it does not, in any way, circumscribe the particular goals, methods and tasks that may be conceptualised or endorsed, nor the relationships between them. So, for instance, the framework allows for the possibility that the same client may have a range of goals, or that different clients may have very different goals, or that the same goal may be reached in very different ways by different clients, or even by the same client. While Dave, for instance, might achieve his therapeutic goal of getting on better with people by focusing on changing his behaviour (a task associated with CBT), it might also be that he could achieve this goal by trying to make sense of his early relationships with his parents (a task associated with psychodynamic therapy, see Figure 1.3 on page 12). And while these might be the most helpful tasks for Dave to pursue, it might be that a different client finds it much more useful to focus on their here-and-now feelings of anxiety with their therapist (a more humanistically-orientated task). In this respect, then, the pluralistic framework provides a 'space' in which methods and theories from the whole pantheon of therapeutic orientations can be brought together and articulated. Like an 'open source' repository of information (cf. Lopez & Kerr, 2006) – for instance, Wikipedia or the operating software Linux – it does not try to define content (i.e., how people should practise), but a set of structures by which an infinite variety of pathways can be articulated.

In Chapters 4, 5 and 6, we will look much more specifically at these three domains of goals, tasks and methods, and how therapists can use them in practice. Chapter 7 then looks at how research might be used to populate this framework.

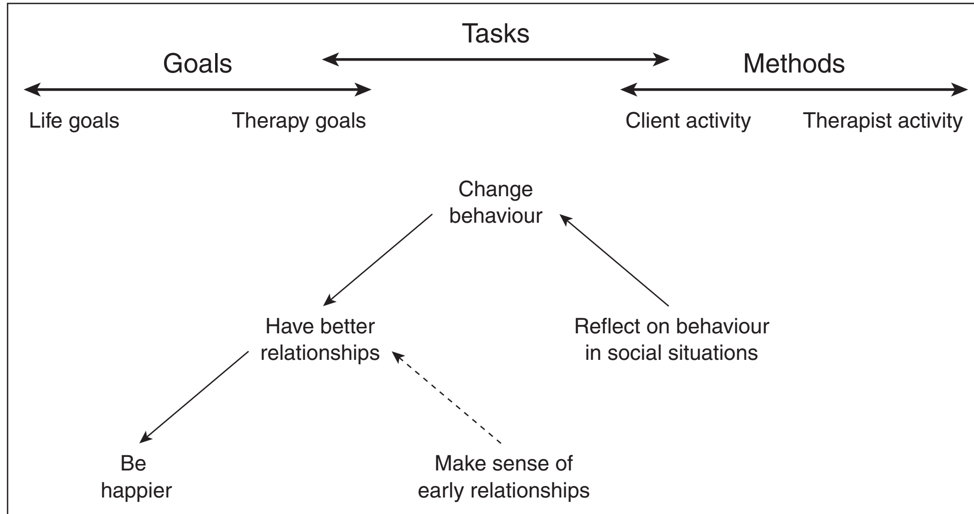

Figure 1.3: Dave's goals, tasks and methods

Box 1.5: Key terms

Pluralism: The standpoint that any substantial question admits a variety of plausible but mutually conflicting responses (Rescher, 1993).

Pluralistic perspective: The belief that different clients are likely to benefit from different things at different points in time, and that therapists should work closely with clients to help them identify what they want from therapy and how they might get it.

Pluralistic practice: A form of therapy, based on a pluralistic perspective, which draws on methods from a multiplicity of therapeutic orientations, and is characterised by dialogue and negotiation over the goals, tasks and methods of therapy.

Pluralistic framework: A conceptual structure for thinking about the therapeutic process, consisting of the three overlapping domains of goals, tasks and methods.

Goals: What clients want from life ('life goals') and from therapy ('therapeutic goals').

Tasks: The macro-level strategies by which clients can achieve their goals.

Methods: The specific, micro-level activities that clients ('client activities') and therapists ('therapist activities') can undertake to accomplish tasks and achieve their goals.

Summary

Single orientation schools of therapy have made enormous contributions to the field of psychotherapy and counselling. But there is always a danger that schools can lead to 'schoolisms', generating conflict and closed-mindedness within the field. In an attempt to overcome this, many counsellors and psychotherapists have moved towards integrative and eclectic perspectives. However, in some cases, these also tend to offer relatively limited prescriptions of how effective therapy can be conducted. In an attempt to offer a broader and more inclusive perspective, a 'pluralistic' approach to counselling and psychotherapy is introduced. The essence of this approach is the assumption that different clients may want different things from counselling and psychotherapy at different points in time, and that if we want to know what is best for clients, we should start by asking them. To provide a focal point for thinking about, researching and practising therapy, the pluralistic approach suggests a framework of three overlapping domains: goals, tasks and methods.

Questions for reflection and discussion

1. What is your initial 'gut' response to the pluralistic approach, as introduced in this chapter?
2. What do you consider are:
   (a) The advantages/strengths of a pluralistic approach over a schoolist approach?
   (b) The disadvantages/limitations of a pluralistic approach over a schoolist approach?
3. What would you consider are the principal differences, if any, between the pluralistic perspective outlined in this chapter and previous integrative/eclectic approaches?