CORE
Metadata, citation and similar papers at core.ac.uk
Provided by Roehampton University Research Repository

Development of a Therapists' Self-Report Measure of Pluralistic Thought and Practice: The Therapy Pluralism Inventory

Allison Thompson
University of Strathclyde and Glasgow Caledonian University

Mick Cooper
University of Strathclyde

Regina Pauli
University of Roehampton

Published as:
Thompson, A., Cooper, M., & Pauli, R. (2017). Development of a therapists' self-report measure of pluralistic thought and practice: the Therapy Pluralism Inventory. *British Journal of Guidance & Counselling*, 1-11. doi: 10.1080/03069885.2017.1373745

Author Note

Allison Thompson, NHS Lanarkshire, 19 Douglas St, Hamilton, ML3 0BP, UK, +44 (0) 1698 368742, allison.thompson@lanarkshire.scot.nhs.uk; Mick Cooper, Department of Psychology, University of Roehampton, London SW15 4JD, UK; +44 (0) 20 8392 3741, mick.cooper@roehampton.ac.uk; Regina Pauli, Department of Psychology, University of Roehampton, London SW15 4JD, UK; +44 (0) 20 8392 3545, r.pauli@roehampton.ac.uk

Acknowledgments: Thanks to John McLeod; trainees on the third year of the Doctorate in Counselling Psychology (2011-12) at Glasgow Caledonian University/University of Strathclyde; and the participants, from across the globe, who showed interest and took part in the study.

Correspondence concerning this article should be addressed to Mick Cooper.

Development of a Therapists' Self-Report Measure of Pluralistic Thought and Practice: The Therapy Pluralism Inventory

Abstract

This study aimed to develop a self-report measure of pluralistic thought and practice. Following pilot development, a 23-item inventory was placed on an online survey site, and 474 participants satisfactorily completed the measure. Respondents were trainee or qualified therapists, predominantly female, based in the UK, and of a humanistic or integrative/eclectic orientation. A principal components analysis resulted in two scales, Pluralistic Philosophy and Pluralistic Practice, which had good internal consistency (Cronbach's $\alpha = .72$ and .80, respectively). Confirmatory factor analysis showed good model fit for this two factor solution. The Therapy Pluralism Inventory (TPI) has potential for use in training and research, although additional validity and normative data are needed.

Keywords: therapeutic relationship, counselling training, pluralistic therapy, measure development, integrative psychotherapy.

Over the last decade, a *pluralistic* approach to counselling and psychotherapy has been developed, primarily within the UK (Cooper & Dryden, 2016; Cooper & McLeod, 2007, 2010, 2011a, 2011b, 2012; McLeod, McLeod, Cooper and Dryden, 2014; Thompson & Cooper, 2012). This approach draws from pluralistic epistemology and ethic (e.g., Berlin, 1958, 2003; James, 1909/1996; McLellan, 1995), which holds that 'any substantial question admits of a variety of plausible but mutually conflicting responses' (Rescher, 1993, p. 79). Three principal 'pillars' of pluralistic counselling and psychotherapy have been proposed (Cooper & Dryden, 2016). First, *pluralism across orientations*: that clients may be helped by a wide variety of different therapeutic ideas and practices. Second, *pluralism across clients*: that each episode of therapy should be tailored to the unique, individual client. Third, *pluralism across perspectives*: that clients, as well as therapists, should be involved in determining the nature of the therapeutic work.

Within the pluralistic literature, a pluralistic *perspective* on counselling and psychotherapy has been distinguished from a pluralistic *practice* (Cooper & McLeod, 2011a). The former has been defined as the general belief, or 'sensibility', that there is no one, best set of therapeutic methods: that different clients may benefit from different understandings and strategies at different points in time. The latter, by contrast, has been defined as a specific form of therapeutic practice that draws on understandings and methods from two or more therapeutic orientations, and in which there is a high degree of shared decision making.

There is considerable overlap between the pluralistic approach and integrative and eclectic forms of therapy, in that both are open to understandings and methods from two or more therapeutic orientation (Hollanders, 2014; Norcross, 2005). However, there are three principal ways in which a pluralistic approach is distinctive. First, while an integrative or eclectic approach, by definition, refers to a multi-orientation form of practice; the pluralistic approach, as indicated above, can refer to a more general sensibility towards the therapeutic field as a whole, which may be inclusive of single orientation practices. Second, closely related to this, while an integrative or eclectic approach may exist as a specific combination of understandings and methods (e.g., Cognitive Analytic Therapy, Ryle, 1990); a pluralistic approach—either as a perspective or a practice—is, by definition, open to a wide variety of different ideas and methods. Third, pluralistic therapy puts particular emphasis on shared decision making, or 'metatherapeutic communication', as the orienting point for combining different therapeutic understandings and methods. While such practices are also common in integrative and eclectic therapies (e.g., Lazarus, 2005), they are not intrinsic to it.

In terms of its evidence base, an open-label trial of pluralistic therapy with 39 clients meeting criteria for depression found acceptable levels of retention and outcomes, with over 90% of clients engaging for two sessions or more, and an effect size of 1.83 on the primary outcome measure (Cooper et al., 2015). Pluralistic practice is supported by several further lines of evidence. First, meta-analyses indicate that clients show small improvements in outcomes, and large reductions in dropout, when the therapeutic approach matches their individual preferences (Lindhiem, Bennett, Trentacosta, & McLear, 2014; Swift, Callahan, & Vollmer, 2011). Second, alliance research suggests that client-therapist agreement on the tasks of therapy, as well as the goals, are amongst the strongest predictors of therapeutic outcomes (Horvath, Del Re, Fluckinger, & Symonds, 2012; Tryon & Winograd, 2011). Third, qualitative research indicates that clients find it helpful when therapists are flexible and responsive to their individual needs (Antoniou, Cooper, Tempier, & Holliday, 2017; Perren, Godfrey, & Rowland, 2009).

The aim of this study is to develop a self-report measure of pluralistic thought and practice. Such a tool may support research in the field: for instance, by helping to examine the relationship between levels of self-reported pluralism and psychotherapy outcomes. It may also be a useful tool for training pluralistic therapists, as well as evaluating their work.

Such a measure has not yet been developed in the field; indeed, reliable measures of integrative or eclectic practice do not currently exist. To date, measures of theoretical orientation have not included an integrative or eclectic stance, focusing instead on the single orientations to which therapists adhere (e.g., Therapist Orientation Questionnaire, Sundland & Barker, 1962; Theoretical Orientation Survey, Coan, 1979; Counsellor Theoretical Position Scale, Poznanski & McLennan, 1999; Theoretical Evaluation Self Test, Coleman, 2004). The one exception to this is the Development of Psychotherapists Common Core Questionnaire (DPCCQ, Orlinsky and Rønnestad, 2005). However, even here, there is no specific 'integrative' or 'eclectic' item to endorse. Rather, therapists were defined as *broad-spectrum* if they endorsed three or more orientations at a level of 4 or more on a 0 (not influenced at all) to 5 (influenced very greatly) scale.

Method

Overview of Design

Items were developed for the measure through an analysis of the pluralistic literature. The measure was then piloted with a small group of participants and revised. In the principal part of the study, the revised version of the measure was posted on an online survey site, and data were analysed using an exploratory principal components analysis. The emerging model was then subjected to confirmatory factor analysis and tests of criterion validity.

Participants

There were 474 respondents who completed the online survey. The majority were female (n = 341, 72%), with 128 males (27%), and five (1%) who did not disclose their gender. Of these participants, 255 (53.8%) currently practiced within the UK, 55 in other European countries (11.6%), 104 in North America (21.9%), and 60 in other countries (12.7%). The majority of the respondents identified as counsellors (n = 185, 39%), with 118 (24.9%) psychotherapists, 91 counselling psychologists (19.2%), 65 (13.7%) clinical psychologists, and 60 (12.9%) identifying as allied helping professionals who were working therapeutically (total percentage is greater than 100 as participants could indicate more than one principal professional grouping). Of the 474 participants, 98 (20.7%) were still in training. The median and modal years of experience of qualified practitioners was 7-15 years: less than 1.5 years, n = 65 (13.7%); 1.5-3.5 years, n = 65 (13.7%); 3.5-7 years, n = 56 (11.8%); 7-15 years, n = 88 (18.6%), 15-25 years, n = 58 (12.2%); 25+ years, n = 47 (9.9%). In terms of orientation, the majority of participants indicated that they were greatly influenced by a humanistic approach (n = 200, 42.2%), followed by integrative/eclectic (n = 157, 33.1%), cognitive-behavioural (n = 92, 19.4%), analytic/dynamic (n = 75, 15.8%), systemic (n = 40, 8.4%), and other (n = 128, 27%) (total percentage is greater than 100 as participants could indicate they were greatly influenced by more than one orientation). The high proportion of humanistic and integrative/eclectic therapists in this sample is consistent with the distribution of counsellors and psychotherapists in the UK (British Association for Counselling and Psychotherapy, 2015). No data were collected on participants' ethnicity or social class.

Procedure and Materials

As indicated above, the pluralistic approach distinguishes between—and is inclusive of—both a perspectival dimension and a practice dimension. To develop items for our measure, therefore, two original pluralistic texts were scrutinised (Cooper & McLeod, 2007, 2011), and concepts related to both a pluralistic perspective and a pluralistic practice were extracted. With respect to the former, for instance, the basic pluralistic principle that 'Lots of different things can be helpful to clients' (Cooper & Mcleod, 2011b, p.6) was operationalised as 'I believe that lots of different therapeutic approaches have much to offer.' With respect to the latter, the pluralistic emphasis on monitoring clients' goal progress (pp. 72-73, Cooper & McLeod, 2011b) was operationalised as, 'I talk to my clients about whether or not we are

progressing towards their therapeutic goals.' In total, 21 items were generated, and were then assessed by 26 individuals were known to the first two authors for (a) fidelity to construct, (b) clarity, and (c) readability. Feedback from colleagues led to the deletion of two items and the addition of four further items.

The second draft of the measure consisted of 23 items. Participants were asked to rate how strongly they agreed or disagreed with 23 statements using a 5-point scale: Strongly disagree, Disagree, Neither agree or disagree, Agree, and Strongly agree. Of these items, nine items were intended to evaluate the extent to which the respondents held a pluralistic perspective. Examples of this were: 'I do not believe that there is any one, "best" therapeutic orientation' and 'I think there is one approach that suits most clients' (reversed scoring). The other 14 items were intended to evaluate the extent to which the respondents specifically practiced in a pluralistic way. Examples of this were: 'I tailor the way that I work to each individual client', and 'My practice is drawn from a wide variety of therapeutic approaches'.

The measure was then posted on an online survey site for participants to complete electronically, using checkboxes for each item. The measure was preceded by an information sheet titled 'Therapeutic orientation questionnaire', and participants were required to check an informed consent box before being able to proceed with participation. If participants did so, they were then asked a series of demographic questions, adapted from Orlinsky and Rønnestad (2005). This inquired about the participant's principal professional identity, gender, the country in which they currently practiced, and career level. Participants were also asked to indicate the extent to which their current practice was influenced by a range of orientations, and they were asked to check a box on a 6-point scale ranging from *Not at all influenced* to *Greatly influenced.*

A variety of methods were used to recruit respondents to the site. Contact was made with a range of psychotherapy, counselling and psychology organizations, primarily in the UK, inviting interested practitioners to take part in a survey of 'therapeutic orientation and attitudes toward practice'. A recruiting notice was also posted on the UK British Psychological Society's Division of Counselling Psychology website, and was added to online networking sites such as LinkedIn; with targeted posts on group pages that had large numbers of counsellors, psychotherapists or psychologists. All recruiting information included a link to the online survey site.

We aimed for 500 respondents to our survey, and closed it when we had 521. Responses were then checked for missing items and we excluded any respondent who had missed three or more questions. This led to the removal of 47 (9%) of the respondents, resulting in the 474 completed questionnaires that were taken forward for analysis.

Analysis and Coding

All analyses were conducted using SPSS v.19. Data for geographical location were coded as United Kingdom, North America, Europe (excepting UK), and rest of world. With respect to theoretical orientation, cognitive, behavioural, and cognitive-behavioural approaches were all coded under cognitive-behavioural; and integrative and eclectic approaches were combined as integrative/eclectic. Participants were coded as identifying with an orientation if they had indicated that they were *greatly influenced* by it. A response of *Strongly Disagree* on the 23 items was scored as 0, through to 4 for *Strongly Agree*, with scorings inverted for reverse items.

Results

Data preparation

In order to facilitate exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) the sample was split at random into two separate data sets. For the EFA a random subset of 40% of the original data set was utilized (sample 1, $n = 192$), the remaining cases were allocated to a separate data set for CFA (sample 2, $n = 282$). The size of the

random subsets were determined by requirements of minimum sample sizes for achieving statistical precision and factor stability in EFA ($100 < N < 200$) and CFA ($N > 200$) respectively. Cases with missing values were deleted listwise in the smaller subsample, and replaced with the scale mean in the larger subsample. There was less than 1% missing values across the whole sample. The two subsamples were compared in terms of equivalence on demographic variables. There were no significant differences between the random subsets in terms of gender ($\chi^2(1) = .023$, $p = .88$), professional identification ($\chi^2(4) = 4.2$, $p = .39$) or professional experience ($\chi^2(6) = 3.9$, $p = .68$).

Exploratory Factor Analysis

Although, as discussed above, the pluralistic approach assumes a distinction between perspectival and practical dimensions—and we had developed items on this basis—we had no empirical evidence to substantiate this distinction. We also wanted to remain open to a range of other dimensions that could, potentially, underlie a pluralistic approach. For this reason, we decided to first conduct an exploratory factor analysis, before going on to test our factorial structure through CFA.

The factorability of the correlation matrix for our EFA sample was assessed with Bartlett's test of sphericity and the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy. This indicated that the correlation matrix was significantly different from an identity matrix (χ^2 (231) = 1285.78, $p < .0005$) and that there was good sampling adequacy (KMO = .8). Principal components analysis with an oblique rotation (oblimin) was conducted on the 23 item scale as factors were expected to be correlated. The scree plot and initial statistics indicated possible solutions of up to five factors. Two, three, four and five factor solutions were therefore examined. However, only the two factor solution yielded a clearly interpretable structure. The two factor solution was retained based on eigenvalues > 2, parsimony, theoretical considerations and conceptual clarity of the extracted factors. This solution accounted for 37% of the variance.

Three items were excluded from further analysis due to low discrimination, i.e. the large majority of participants agreed with these items leading to highly skewed item means. Only items with factor loadings > .5 were retained leading to the exclusion of a further four items which failed to load sufficiently on either factor. One item was excluded because it was complex, cross-loading equally on both factors. One further item was removed because of high collinearity with another item ($r > .55$). Inspection of the two items indicated that they were semantically closely related, therefore only one of these was retained. Twelve items formed the final scale.

The factor structure, item loadings and communalities for the two-factor solution are shown in Table 1. The first factor was labelled *Pluralistic Practice* and consisted of seven items. All items loading on this factor measure the degree to which therapists adopt a personally tailored approach with clients. This includes involving clients in conversations about the therapeutic process, ensuring that the therapeutic approach is suitable from the client's perspective, and tailoring therapy to the individual. The second factor represents therapists' *Pluralistic Philosophy* tapping into beliefs and attitudes underlying their practice. Five items loaded on this subscale. The two factors were only marginally correlated ($r = .19$) indicating that two relatively independent latent factors contribute to a pluralistic approach. The two subscales showed good reliability ($\alpha > .7$). The reliability coefficient for the overall scale was .81. This indicates that the scale represents a measure of pluralism overall, with subscales representing subscription to the underlying philosophy, on the one hand, and the practice of pluralism in therapy on the other.

Confirmatory Factor Analysis

Confirmatory factor analysis (CFA) was conducted to test the stability of scores in terms of the correlated two factor model of the Therapy Pluralism Inventory (TPI) in the

second random subset of data using AMOS Graphics v21. Table 2 shows the fit indices computed for three alternative models. As the hypothesized two factor model identified in the exploratory factor analysis were only marginally correlated we compared this with a two uncorrelated factors model as well as an alternative one factor model, in which all twelve items of the TPI are indicators of one underlying latent variable. Evaluation of the fit indices shows that the two correlated factors model has the best fit overall, and it is the only model for which all fit indices are in the acceptable range for a an adequately fitting model. This provides support for the factor structure identified and interpreted in the exploratory factor analysis above.

Validity

There were no gender differences in *Total Pluralism* (combined scores on the Pluralistic Practice and Pluralistic Philosophy subscales), or subscales scores (all t (467) < .1.9, $p > .05$). Length of professional experience correlated marginally with Pluralistic Practice (r_s (473) = .11, $p = .018$) but was uncorrelated with Pluralistic Philosophy and Total Pluralism.

The criterion validity of the TPI was examined in relation to the total number of different therapeutic orientations that participants endorsed. Further analysis examined whether they had endorsed integrative and eclectic orientations or not in relation to identified professional group (clinical psychologist, counselling psychologist, counsellor, psychotherapist, other) and geographical location of practice (North America, UK, other European, rest of the world).

The total number of orientations which participants endorsed showed moderate correlations with Pluralistic Practice, r_s (367) = .25, $p < .0005$; Pluralistic Philosophy r_s (367) = .30, $p < .0005$; and Total Pluralism, r_s (367) = .32, $p < .0005$.

Table 3 shows means and standard deviations on the subscales and total scale scores by self-identified professional group and whether participants had endorsed integrative/eclectic orientations or not. Two-way ANOVA revealed a significant main effect for endorsement of integrative/eclectic orientation for Total Pluralism, $F(1, 421) = 39.52$, $p < .0005$); Pluralistic Practice, $F(1, 421) = 17.19$, $p < .0005$; and Pluralistic Philosophy, $F(1,421) = 35.84$, $p < .0005$. There was no main effect for professional group, but there was a significant interaction for Pluralistic Philosophy, $F(3, 421) = 3.78$, $p = .011$. Post hoc analysis indicates that Pluralistic Philosophy scores tended to be relatively similar for counselling psychologists and clinical psychologists whether or not they endorsed an integrative/eclectic orientation, whereas there were more marked differences for counsellors and psychotherapists.

Table 4 shows the means and standard deviations for the location of practice split into those who endorsed integrative/eclectic orientations and those who did not. In addition to the main effects for integrative/eclectic orientation, which replicate those of the previous analysis, two-way ANOVA revealed small main effects for geographical location for Pluralistic Practice, $F(3, 466) = 2.81$, $p = .039$, and for Total Pluralism, $F(3, 466) = 2.58$, $p = .05$. Posthoc tests with Bonferroni correction indicated that the observed difference on Pluralistic Practice was due to significantly higher scores in North America compared to European locations excluding the UK ($p = .005$). The location main effect for Total Pluralism can be attributed to significantly lower scores in European locations compared to both UK ($p = .034$) and North American locations ($p = .008$). There were no significant interactions.

Discussion

Through EFA, we developed a 12 item inventory of self-reported pluralism in psychotherapy that consisted of two, relatively independent scales: Pluralistic Philosophy and Pluralistic Practice. Both scales, and the inventory overall, had good levels of internal consistency, and this two factor solution was supported by a CFA.

Consistent with the pluralistic literature (Cooper & McLeod, 2011), our study found that a pluralistic perspective, and a pluralistic practice, are distinctive dimensions. In other words, the extent to which therapists appreciate multiple therapeutic orientations is only weakly predictive of the extent to which they tailor their therapy to the particular needs of their clients. To our knowledge, this is the first time such a distinction has been empirically demonstrated; and suggests that single item, or single dimensions, measures of therapeutic breadth, such as the DPCCQ, may not capture the different elements of multi-orientation thought and practice.

Criterion validity for the TPI and its subscales was supported by evidence of significantly higher scores for respondents who endorsed an integrative/eclectic orientation. However, this was not true for counselling and clinical psychologists on the Pluralistic Philosophy subscale. In addition, correlations with breadth of orientation, as indicated by the DPCCQ items, were not large. This latter finding may have arisen because being influenced by multiple orientations may be distinct from working flexibly with individual clients, as well as believing that many different therapies have much to offer. A psychotherapist, for instance, may utilise a specific combination of humanistic, dynamic and systemic methods; but deliver this in a relatively inflexible way, and not believe that other therapeutic orientations are of value.

The significant correlation between TPI scores and breadth of orientations, as well as its significant association with endorsement of an integrative/eclectic orientation, indicates that pluralism and integration/eclecticism are related constructs. However, the moderate size of these associations (point biserial correlations with endorsement of an integrative/eclectic orientation: Total Pluralism = .31, Pluralistic Practice = .21, Pluralistic Philosophy = .32) indicate that pluralism and integration/eclecticism are not synonymous. This lends supports to the assertion that pluralism—both as a perspective and as a practice—makes a distinctive contribution to the therapeutic field.

In terms of developing an understanding of the pluralistic approach, it should be noted that the two dimensions that emerged from our EFA were not entirely consistent with prior definitions of pluralistic perspective and pluralistic practice (Cooper & McLeod, 2011). Previously, a pluralistic perspective was defined as the beliefs that different clients would benefit from different methods and that therapists should work collaboratively with them to achieve their goals. Our Pluralistic Philosophy scale reflects only the former component, and not the latter. Similarly, while our Pluralistic Practice scale reflects self-perceptions of tailoring therapeutic work and using metatherapeutic communication, it does not reflect therapists' self-perceptions of the extent to which they draw on different orientations in their practice. These emerging dimensions justify the use of an EFA as the first step in our analysis, and suggest that any further dimension of self-reported pluralistic—or integrative or eclectic—practice will need to be developed and tested to a highly nuanced degree. A principal limitation of this study was our opportunity sampling procedure. Hence, our participants (and particularly the large numbers of humanistic therapists) do not accurately represent the wider, international population of counsellors, psychotherapists and psychologists. In addition, our test of criterion validity was relatively weak, and we did not evaluate the test-retest reliability of the measure or its discriminant validity. The latter would be particularly important to show that our Pluralistic Practice scale is not simply a measure of self-reported alliance formation, but a more distinctive feature of pluralistic therapy. We also did not test the measure against a social desirability scale, such that the dimensions represented here might reflect therapists' desire to present themselves in more or less positive ways. Closely related to this, as with all self-report measures, what is being assessed here is participants' perceptions of how they behave and think, rather than what they actually do.

Our claims for the measure, therefore, must remain relatively modest at the present time. In terms of future research, a particular priority is to test further the criterion validity of the measure, and particularly against actual clinical practice. Do scores on the TPI, for instance, correlate against observer-rated measures of shared decision making in practice, or against clients' ratings of their therapists' degree of pluralism? As indicated above, it would also be useful to develop subscales for an expanded Therapy Pluralism Inventory, which assessed other dimensions of pluralistic, or integrative and eclectic, practice, particularly the use of multiple orientations in practice. If these scales prove valid, they could then be used in both process and process-outcome psychotherapy research. For instance, Orlinsky & Rønnestad (2005) found that breadth of theoretical influence was associated with higher levels of 'healing involvement' in psychotherapeutic work. Research could examine whether the same would be found for levels of Pluralistic Philosophy or Pluralistic Practice. In terms of developing and potentially validating integrative approaches to psychotherapy, it would also be very useful to study the relationship between clinical outcomes and self-, client- or observer-rated levels of therapist pluralism.

Conclusion

The Therapy Pluralism Inventory is freely available for use (see Appendix for final measure and scoring instructions), and is the first self-report measure to provide a means whereby trainee and practicing therapists can assess their levels of pluralistic thought and practice. The measure has a coherent and reliable component structure, and can be used in both self-reflection and further empirical work. Although our study is limited by the representativeness of its respondents, this is a valuable first step towards the development of tools that can articulate, audit and assess a pluralistic approach.

References

Antoniou, P., Cooper, M., Tempier, A., & Holliday, C. (2017). Helpful aspects of pluralistic therapy for depression. *Counselling and Psychotherapy Research, 17*(2), 137-147. doi: 10.1002/capr.12116

Berlin, I. (1958). Two concepts of liberty. In H. Hardy (Ed.), *Liberty* (pp. 166-217). Oxford: Oxford University.

Berlin, I. (2003). The pursuit of the ideal. In H. Hardy (Ed.), *The crooked timber of humanity: Chapters in the history of ideas* (pp. 1-19). London: Random House.

Bowen, M. & Cooper, M. (2012) Development of a client feedback tool: a qualitative study of therapists' experiences of using the therapy Personalisation Forms. *European Journal of Psychotherapy and Counselling, 14*, 47–62. http://dx.doi.org/10.1080/13642537.2012.652392

British Association for Counselling and Psychotherapy. (2015). Members age gender ethnicity June 2015 [Unpublished dataset]. Lutterworth: BACP.

Coan, R.W. (1979) *Psychologists: Personal and theoretical pathways.* New York: Irvington.

Coleman, D. (2004). The theoretical evaluation self test (TEST): A preliminary validation study. *Social Work Research, 28*, 117-128. http://dx.doi.org/10.1093/swr/28.2.117

Cooper, M., & Dryden, W. (2016). Introduction to pluralistic counselling and psychotherapy. In M. Cooper & W. Dryden (Eds.), *Handbook of pluralistic counselling and psychotherapy*. London: Sage.

Cooper, M., & Dryden, W. (Eds.). (2016). *Handbook of pluralistic counselling and psychotherapy*. London: Sage.

Cooper, M., Dryden, W., Martin, K., & Papayianni, F. (2016). Metatherapeutic communication and shared decision-making. In M. Cooper & W. Dryden (Eds.), *Handbook of pluralistic counselling and psychotherapy*. London: Sage.

Cooper, M., & McLeod, J. (2007). A pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling and Psychotherapy Research, 7*(3), 135-143.

Cooper, M., & McLeod, J. (2010). Pluralism: Towards a new paradigm for therapy. *Therapy Today, 21*(9), 10-14.

Cooper, M., & McLeod, J. (2011a). Person-centered therapy: A pluralistic perspective. *Person- Centered and Experiential Psychotherapies,* 10(3), 210-223. http://dx.doi.org/10.1080/14779757.2011.599517

Cooper, M., & McLeod, J. (2011b). Pluralistic counselling and psychotherapy. London: Sage.

Cooper, M. & McLeod, J. (2012). From either/or to both/and: Developing a pluralistic approach to counselling and psychotherapy. *European Journal of Psychotherapy & Counselling*, 14 (1), 5-17. http://dx.doi.org/10.1080/13642537.2012.652389

Cooper, M., Wild, C., van Rijn, B., Ward, T., McLeod, J., Cassar, S., . . . Sreenath, S. (2015). Pluralistic therapy for depression: Acceptability, outcomes and helpful aspects in a multisite study. *Counselling Psychology Review, 30*(1), 6-20.

Edwards, A. and Elwyn, G. (Eds) (2009) Shared decision-making in health care: achieving evidence-based patient choice. In: *Shared Decision-Making in Health Care : Achieving Evidence-Based Patient Choice* (2nd ed., pp. 3-10). Oxford: Oxford University Press.

Hollanders, H. (2014). Integrative therapy. In W. Dryden & A. Reeves (Eds.), *The handbook of individual therapy* (6th ed., pp. 519-545). London: Sage.

Horvath, A. O., Del Re, A. C., Fluckinger, C., & Symonds, D. (2012). Alliance in individual psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work: Evidence-based responsiveness* (pp. 25-69). New York: Oxford University Press.

James, W. (1909/1996). *A pluralistic universe*. London: University of Nebraska.

Lazarus, A. A. (2005). Multimodal therapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 105-120). New York: Oxford University.

Lindhiem, O., Bennett, C. B., Trentacosta, C. J., & McLear, C. (2014). Client preferences affect treatment satisfaction, completion, and clinical outcome: A meta-analysis. *Clinical psychology review, 34*(6), 506-517. doi: 10.1016/j.cpr.2014.06.002

McLellan, G. (1995). *Pluralism*. Buckingham: Open University.

McLeod, J., McLeod, J., Cooper, M., & Dryden, W. (2014). Pluralistic therapy. In A. Reeves & W. Dryden (Eds.), *Handbook of individual therapy* (6th ed., pp. 547-573). London: Sage.

Norcross, J. C. (2005). A primer on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 3-23). New York: Oxford University.

Norcross, J. C., & Goldfried, M. R. (Eds.). (2005). *Handbook of psychotherapy integration*. New York: Oxford University.

Nuttall, J. (2008). The integrative attitude - a personal journey. *European Journal of Psychotherapy and Counselling,* 10(1), 19-38. http://dx.doi.org/10.1080/13642530701869326

Orlinsky, D. E., & Rønnestad, M. H. (Eds.). (2005). *How Psychotherapists Develop: A Study of Therapeutic Work and Professional Growth*. Washington, DC: APA.

Perren, S., Godfrey, M., & Rowland, N. (2009). The long-term effects of counselling: The process and mechanisms that contribute to ongoing change from a user perspective. *Counselling and Psychotherapy Research*, *9*(4), 241 - 249.

Poznanski, J.J. & McLennan, J (1999) Measuring counsellor theoretical orientation *Counselling Psychology Quarterly*, 12(4), 327-334. http://dx.doi.org/10.1080/09515079908254103

Rescher, N. (1993). *Pluralism: Against the Demand for Consensus*. Oxford: Oxford University.

Ryle, A. (1990). *Cognitive analytic therapy: Active participation in change*. Chichester: Wiley.

Stevens, J.P. (2002). *Applied multivariate statistics for the social sciences* (4th Ed.). Hillsdale, NJ: Erlbaum.

Sundland, M. & Barker, E.N. (1962) Orientation of psychotherapists. *Journal* of *Consulting Psychology*, 26, 201-212. http://dx.doi.org/10.1037/h0045682

Swift, J. K., Callahan, J. L., & Vollmer, B. M. (2011). Preferences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed., pp. 301-315). NY: Oxford University.

Thompson, A. & Cooper, M. (2012) Therapists' experiences of pluralistic practice, *European Journal of Psychotherapy & Counselling*, 14 (1), 63-75. http://dx.doi.org/10.1080/13642537.2012.652393

Tryon, G. S., & Winograd, G. (2011). Goal consensus and collaboration. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work: Evidence-based responsiveness* (2nd ed., pp. 153-167). New York: Oxford University Press.

Appendix

Therapy Pluralism Inventory

For each of the statements below, please tick a response that matches how strongly you agree or disagree with them. The word “approach” has been used throughout this scale to refer to a specific therapeutic orientation, such as CBT, Humanistic or Psychodynamic.

Strongly Disagree = SD, Disagree = D, Neither agree nor disagree = N, Agree = A and Strongly agree = SA

1. I would be open to training in a wide variety of approaches	SD	D	N	A	SA
2. I talk to my clients about whether or not we are progressing towards their therapeutic goals	SD	D	N	A	SA
3. I do not believe that there is any one, ‘best’ therapeutic approach	SD	D	N	A	SA
4. I work collaboratively with my clients to agree the direction for therapy	SD	D	N	A	SA
5. I think that different clients benefit from different therapeutic approaches at different times	SD	D	N	A	SA
6. I talk to my clients about what I feel I can offer them	SD	D	N	A	SA
7. I tailor the way that I work to each individual client	SD	D	N	A	SA
8. I believe that lots of different therapeutic approaches have much to offer	SD	D	N	A	SA
9. I explore with my clients the various ways we could work toward their goals	SD	D	N	A	SA
10. I think that there is one approach that suits most clients	SD	D	N	A	SA
11. I talk to my clients about the process of therapy and how it might be improved for them	SD	D	N	A	SA
12. I ask clients for feedback about the therapeutic process throughout our work together	SD	D	N	A	SA

Therapy Pluralism Inventory: Scoring

ALL ITEMS (EXCEPT ITEM 10)
Strongly Agree = 4
Agree = 3
Neither agree nor disagree = 2
Disagree = 1
Strongly disagree = 0

ITEM 10
Strongly Agree = 0
Agree = 1
Neither agree nor disagree = 2
Disagree = 3
Strongly disagree = 4

Pluralistic practice
Add items 2, 4, 6, 7, 9, 11, 12

Pluralistic philosophy
Add items 1, 3, 5, 8, 10

Table 1: Rotated factor pattern, factor loadings, communalities and reliability coefficients for the Therapy Pluralism Inventory (TPI) items

	Factor 1	Factor 2	communalities	alpha
Pluralistic Practice				.80
I explore with my clients the various ways we could work toward their goals	.737		.56	
I ask clients for feedback about the therapeutic process throughout our work together	.688		.46	
I work collaboratively with my clients to agree the direction for therapy	.679		.45	
I talk to my clients about whether or not we are progressing towards their therapeutic goals	.647		.53	
I tailor the way that I work to each individual client	.627		.42	
I talk to my clients about the process of therapy and how it might be improved for them	.621		.39	
I talk to my clients about what I feel I can offer them	.605		.36	
Pluralistic Philosophy				.72
I do not believe that there is any one, 'best' therapeutic orientation		.700	.50	
I would be open to training in a wide variety of models/approaches		.561	.39	
I think there is one approach that suits most clients (reverse scored)		.552	.33	
I believe that lots of different therapeutic approaches have much to offer		.530	.38	
I think that different clients benefit from different therapeutic approaches at different times		.529	.37	
Variance accounted for	24.44%	12.49%		

All secondary loadings <.250

Table 2: Confirmatory Factor Analysis: Summary of fit indices for alternative models

Model	χ^2	df	χ^2/df	CFI	TFI	RMSEA	RMSEA (90% CI)	AIC
Two correlated factors	118.18*	53	2.23	.92	.90	.066	(.050-.082)	168.18
Two uncorrelated factors	163.48*	54	3.03	.87	.84	.085	(.070-.100)	211.48
One factor	277.22*	54	5.13	.72	.66	.121	(.107-.136)	325.22

Note. CFI = comparative fit index; TFI = Tucker-Lewis Index (non-normed fit index); RMSEA = root mean square error of approximation; AIC = Akaike Information Criterion; * p<.01

Table 3: Means and standard deviations by profession and influence by integrative/eclectic orientation

	Integrative / eclectic orientation	Clinical psychologist (n = 65)	Counselling psychologist (n = 90)	Counsellor (n = 167)	Psychotherapist (n = 107)	Total
Pluralistic Practice	yes	3.28	3.34	3.24	3.16	3.26
		.40	.48	.46	.51	.46
	no	3.05	3.08	3.01	2.97	3.02
		.41	.52	.47	.62	.52
Pluralistic Philosophy	yes	3.20	3.27	3.42	3.46	3.36
		.65	.47	.47	.51	.51
	no	2.98	3.16	2.96	2.84	2.96
		.65	.52	.45	.66	.57
Total Pluralism	yes	3.24	3.31	3.33	3.31	3.31
		.39	.40	.38	.44	.40
	no	3.01	3.12	2.98	2.90	2.99
		.45	.44	.35	.51	.44

Note. For the purposes of our ANOVA, each participant was identified with just one professional identity. Where they had indicated more than one profession (n = 29), we identified them with their "highest status" profession in the following order: clinical psychologist > counselling psychologist > psychotherapist > counsellor.

Table 4: Means and standard deviations by geographical location of practice and influence by integrative/eclectic orientation

	Integrative/ eclectic orientation	UK (n = 255)	North America (n = 104)	Other European (n = 55)	Rest of the world (n = 60)	Total
Pluralistic	yes	3.26	3.30	3.04	3.27	3.26
Practice		.48	.47	.43	.46	.46
	no	3.01	3.14	2.88	2.97	3.02
		.50	.46	.62	.41	.52
Pluralistic	yes	3.41	3.37	3.25	3.20	3.36
Philosophy		.45	.62	.43	.56	.51
	no	2.99	2.97	2.82	2.96	2.96
		.55	.67	.62	.43	.57
Total	yes	3.34	3.34	3.15	3.24	3.30
Pluralism		.40	.44	.31	.44	.41
	no	3.00	3.05	2.85	2.97	2.99
		.39	.51	.53	.35	.44