The effectiveness of pluralistic counselling in a primary counselling setting: A pilot study

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PLURALISTIC PRACTICE

RESEARCH ARTICLE

Abstract

Pluralistic therapy is a relatively new form of psychotherapy where counsellors and clients work together to achieve clients' goals through collaboration and preference accommodation, drawing on a range of therapy methods (Cooper & McLeod, 2011). This pilot study looks at data collected from a counselling research centre to investigate the effectiveness of pluralistic therapy in reducing clinical symptoms for well-being in a primary care setting, with the aim to support the establishment of processes for evaluation of pluralistic therapy.

Pre- and post-counselling CORE-OM, GAD-7, and PHQ-9 outcome measurement scores were compared for 45 clients. In the absence of a control group, results were benchmarked against studies with similar participant groups (Armstrong, 2010; Mullin et al., 2006; Barkham et al., 2013; Cooper et al., 2015).

Of those with a CORE score above clinical level at intake, 62.1% of clients showed either reliable improvement or recovery. 70.8% of clients' GAD-7 scores and 65.5% of clients' PHQ-9 scores showed either reliable improvement or recovery. Client CORE, GAD-7, and PHQ-9 scores decreased significantly over time, from pre- to post-intervention.

CORE improvement-only rates were higher, while recovery rates were lower compared to benchmarks. GAD-7 and PHQ-9 score reductions were similar to those found in a comparable study looking at pluralistic therapy for depression (Cooper et al., 2015). These findings are a helpful starting point from which to develop research on the effectiveness of pluralistic therapy.

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INTRODUCTION

A pluralistic approach to therapy, as defined by Cooper & McLeod (2011), is a stance based on the premise that different people can be helped by different therapeutic activities at different times. The framework for pluralistic practice defines effective ways to enact this. Pluralistic therapy in practice emphasises building a strong collaborative relationship between counsellor and client and allowing the client to exercise agency and active decision-making in the ongoing co-creation of an effective therapeutic model. The emphasis in practice is on the elucidation of client goals, needs and preferences, and on developing relevant therapeutic practice by drawing on a range of potentially helpful methods and techniques.

Pluralism is a contemporary approach to undertaking therapy and is, in quantitative terms, relatively untested. Routine outcome measures have been used in two studies (Joyce et al., 2022; Cooper et al., 2015). In an early pilot study, Cooper et al. (2015) looked at the working alliance, helpful aspects, and effectiveness of pluralistic therapy for depression. The measures indicated that 71.8% of participants' symptoms of anxiety and depression improving on GAD-7 (Spitzer *et al*., 2006) and PHQ-9 (Kroenke et al., 2001). These results are comparable to those found in the Improving Access to Psychological Therapies Programme (Gyani *et al*., 2013), leading authors to propose that pluralistic therapy could be as effective for counselling with depression as existing NICE-approved approaches.

A more recent pilot randomised control trial (Joyce et al., 2022) compared pluralistic counselling with counselling-as-usual treatment for young people (12-25 years) presenting with addiction issues. The authors discovered no difference in client outcomes for the two intervention groups, as measured using Young Person's CORE (Twigg et al., 2010) or the Strengths and Difficulties Questionnaires, but concluded that this could be due to low statistical power (n=31 for the pluralistic counselling and n=33 for those receiving counselling as usual), and crossover effects between the types of therapy offered to clients. In the study, the therapists and context were the same in both conditions, with the use of a therapy preferences scale in the pluralistic condition. The outcomes of this study and lack of difference between the conditions could, therefore, be due to the therapists delivering very similar styles of relationship and intervention, with the tool use potentially not impacting the actual therapy being undertaken.

Some qualitative research has focussed on the processes and outcomes of pluralistic therapy. McLeod (2013) investigated pluralistic Transactional Analysis for long-term health conditions. Clients reported that the therapy was helpful, and the author concluded that this was due to the "flexible, integrative approach" (ibid. p. 40). Similarly, Thurston et al. (2013) found pluralistic counselling for sight loss to be beneficial for the client, identifying specific helpful aspects for clients, such as 'feeling understood', 'finding a new identity', and 'exploring the possibility of a positive future without sight'. Specific helpful aspects of pluralistic therapy for depression have also been identified (Antoniou et al., 2017), including the client's contribution to the decision-making process and the therapists' responsiveness to the client's needs. In another study using pluralistic therapy, the development of a shared understanding for men with HIV (Miller & Willig, 2012) was found to be key.

More recently, research on pluralistic therapy has focussed on aspects of goal negotiation (Lloyd & Antoniou, 2022), meta-communication (Papayianni & Cooper, 2018); shared decision-making (di Malta et al., 2019; Gibson et al., 2020); preference work (Cooper, et al., 2023); training (McLeod, 2022; McLeod et al., 2021); helpful factors in pluralistic therapy (Antoniou et al., 2017), and pluralistic responses to range of client presentations (e.g. Mills, 2023; Omylinska-Thurston et al., 2021).

While pluralistic therapy has been examined in terms of its characteristics and impact on the client, there is to date only one study presenting empirical evidence to evaluate its efficacy, and one which examines its effectiveness relative to other modalities of therapy. In terms of the broader context of the validation and commissioning of therapy practices, outcome research is needed to validate this emerging approach in ways which speak to practitioners, service-funders, and service-users.

While the evaluation of client process and outcomes can be undertaken in a range of ways, the outcomes of an approach at a group level usually involves the use of qualitative client reported outcomes. One of the most common standardised self-report outcome measures for counselling is the Clinical Outcomes in Routine Evaluation (CORE), which has been used in numerous outcome studies and have shown high reliability and validity when used to judge levels of psychosocial aspects of function, distress, and risk in counselling (e.g., Barkham et al. 2006). The Generalised Anxiety Disorder Scale (GAD-7) has been used to detect anxiety levels of clients in primary care settings (e.g., Kroenke et al., 2007; Ruiz et al., 2011) and is shown to be a reliable and valid self-report measure, with a high correlation with other self-report questionnaires (Löwe et al., 2008), and high sensitivity, i.e. it is able to detect well-being with a high level of accuracy (Spitzer et al., 2006). The validity and reliability of the Patient Health Questionnaire (PHQ-9) measure has been shown on several occasions (e.g., Kroenke et al., 2001; Cannon et al., 2007). It has also been used as a measure of improvement for depressive symptoms (Löwe et al., 2004; McMillan et al., 2010), and as a screening method for depression in primary care settings (Arroll et al., 2010).

This study explored whether well-being, and symptoms of depression and anxiety (judged by using the CORE-OM or CORE-10, PHQ-9 and GAD-7 respectively) improve over time in the context of pluralistic counselling, conducted in a naturalistic clinic setting. In contrast to the Cooper et al. (2015) study, the aim was to examine these factors in a service offering pluralistic therapy to the general population independent of presenting issue and include an evaluation of the CORE-OM and CORE-10 measures. This emphasis on a naturalistic setting will allow an exploration of the effectiveness of pluralistic therapy in context, and the potential for its use in community services and help address the limited evidence base for effective outcomes for the approach.

To establish the outcome effect of any therapeutic intervention, it is common to compare routine measures across interventions and populations, e.g. through the establishment of a randomised controlled trial (Green, 2006). Because the data used in this pilot study was obtained from a counselling setting delivering pluralistic therapy, there was no 'in practice' data available from therapists using interventions not aligned to the pluralistic approach. As a result, in the current

study we aimed to establish the effectiveness of pluralistic counselling to improve client well-being compared to published studies to establish equivalence. The results from this study were compared to those of three other similar studies to evaluate the relative effectiveness of pluralistic counselling versus other modalities (Armstrong, 2010; Mellor-Clark et al., 2001; Mullin et al., 2006). These studies were chosen because they represented similar community settings and reported on the same measures used. Armstrong (2010) examined outcomes in a community setting for minimally trained and volunteer counsellors working with solution-focussed and common factors approaches; Mellor-Clarke et al. (2001) reported on NHS primary care therapists working with a range of therapies including person-centred, cognitive-behavioural, and integrative approaches, while Mullin et al. (2006) did not report their therapists' approaches but strived to set their own benchmarks for outcomes of therapy.

METHODOLOGY

DESIGN

This is a non-randomised effectiveness study, investigating the impact of pluralistic counselling on client CORE-OM or CORE-10, GAD-7, and PHQ-9 scores.

SETTING

The data was collected from a counselling research centre affiliated to Abertay University. This facility, Tayside Centre for Counselling (TCC), provides free counselling for adults for up to twenty sessions. Clients self-referred to the centre on the basis that they felt they might benefit from counselling. All the counsellors aligned to, or were training in, pluralistic counselling, as defined by Cooper & McLeod (2011).

Ethical approval for this study was obtained from the Research Ethics panel at Abertay University, Scotland.

PARTICIPANTS

Clients

Inclusion criteria were that the clients had to be over 17 years old, had received at least two sessions and had completed their therapy. This reflects the requirement for the clinic to see only adult clients, and that pre- and post-data had been collected on the measures of interest.

The data held by the clinic indicated that 99 client data sets were available for consideration. Out of a possible 99 clients, 45 were eligible for the study. Nineteen cases were ongoing, and fifteen people who had been assigned a client code did not receive any counselling. Seven clients had not given research consent, four were deemed 'unsuitable' for counselling due to health and personal circumstances. Four were referred on to specialist services, two had only one session, and three clients' files were unavailable for administrative reasons (Table 1). Of the resulting 45 clients, 25 clients were female, which reflected a larger number of males compared to that seen in most primary care settings (Rzepnicka,

et al., 2022). The age range was between 17 and 72 with a mean age of 39. The ethnic mix of the clients was limited: one client's ethnicity was stated as Polish, one Irish, one Mexican, one American, one British Italian, one mixed, and the rest were White British. Eight clients declared a disability, again differing somewhat to that of a normal UK population of mental health service users (Rzepnicka, et al., 2022) (Table 2). This ethnic mix may be reflective of the geographic location of the clinic in Dundee, Scotland.

Table 1.

Exclusions from study

Clients entering therapy service		99
Exclusions	Ongoing clients	19
	No counselling received	15
	No research consent	7
	Assessed as unsuitable on entry to service	4
	Referred to other services	4
	Only one session attended	2
	Data file unavailable	3
Total clients included in analysis		45

Table 2.

Client demographics

Female	25
Male	20
Age range	17-72 (mean 39)
Identify as white British	39
Disability (self-declared)	8

The presenting issues articulated by clients on entry to the service represented a mix of experiences, with 22% of clients reported depression, 20% anxiety, and 9% depression and anxiety. 20% presented with relationship/interpersonal issues, 9% bereavement issues, 7% anger issues, 7% self-esteem problems and 4% classed as 'other'. There is no information about presenting issue for one included participant.

The number of sessions attended ranged from 3-39 (including Initial Assessment), with a mean of 15 sessions. Two clients with non-standard data sets were included in the analysis: one client received twenty sessions but there was only information for the first seventeen, while another client followed their counsellor

to another agency after 24 sessions and did not complete their counselling at the clinic.

Counsellors

The 45 clients were seen by eleven different counsellors. All counsellors had gained a Graduate Certificate in Counselling, or an equivalent, three had a higher counselling qualification while still being in training on the MSc Counselling (pluralistic): one had not trained in pluralistic therapy but had ten years of experience with an Alcohol Focus Scotland Accreditation, and the other two already held a Postgraduate Diploma in Counselling. Therefore, of the eleven therapists at the clinic, nine were still in training as pluralistic practitioners.

The three therapists who already had a professional qualification and some experience before joining TCC saw most clients in this study, each with six, seven and eight clients. Of the trainees, two had five clients, four had three clients, and two had one client in this study.

Table 3.

Therapists by training and experience

Therapist	Qualification	Years in practice	Number of clients
1	Addictions counselling	>10	6
2	PGDip Counselling	>4	7
3	PGDip Counselling	>4	8
4	Training on MSc Pluralistic Counselling	<2	5
5	Training on MSc Pluralistic Counselling	<2	5
6	Training on MSc Pluralistic Counselling	<2	3
7	Training on MSc Pluralistic Counselling	<2	3
8	Training on MSc Pluralistic Counselling	<2	3
9	Training on MSc Pluralistic Counselling	<2	3
10	Training on MSc Pluralistic Counselling	<2	1
11	Training on MSc Pluralistic Counselling	<2	1

Pluralistic adherence

At the time this study was carried out, there was no validated pluralistic adherence scale that could be used to guarantee each counsellor's close adherence to the pluralistic approach. However, all counsellors were expected to work within the pluralistic framework (Cooper & McLeod, 2011; McLeod, 2017; Cooper and Dryden, 2016; Smith and de la Prida, 2021). All counsellors self-reported an alignment to the approach, pluralistic group supervision was given to all at TCC, and counsellors frequently used goal and feedback forms.

MEASURES

CORE Outcome Measure and CORE-10

Both the CORE-OM (Barkham *et al.*, 2006) and the CORE-10 (Barkham *et al.*, 2013) were used in this study. Both are client self-report measures, which assess

subjective wellbeing, problems/symptoms, functioning, and risk. The mean scores are calculated and multiplied by ten to gain a clinical score of between 0 and 40. Most clients used the CORE-OM, but some chose to use the CORE-10 for accessibility as it is shorter, with ten questions, while CORE-OM has 34. In practice and research, CORE-OM allows for granular domain scoring, while CORE-10 does not provide separate domain scores due to its brevity, the use of both measures was considered appropriate as only the sum total of scores and not the domains were used in this analysis. CORE-10 has been shown to have a 0.9 reliability, has a large correlation between it and both the CORE-OM and the Beck Depression Inventory (Barkham et al., 2013). It has also been used alongside the CORE-OM within the same study to good effect (Andrews et al., 2011). Clients completed the CORE at initial assessment, and at each session (usually weekly). In this study, only the clients' scores at intake and final session were compared to allow an analysis of recovery and change across their therapeutic engagement. Pre- and post-counselling scores were collated and converted into a clinical score of between 0 and 40.

GAD-7 and PHQ-9

The Generalised Anxiety Disorder screener (GAD-7; Löwe et al., 2008) and Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) were also used in this study. Like the CORE measures, clients completed these forms at initial assessment and each session. Initial assessment and final session scores were compared to establish overall change over the therapeutic engagement. Spitzer and colleagues (2006) provide an anxiety severity scale for use with the GAD-7 between 0 and 21, while Kroenke et al. (2001) provide a depression severity scale with the PHQ-9 of between 0 and 27.

Benchmarking procedure

As this study contains relatively few participants, and there was no control group, it was decided that the measure outcomes should be compared to those from similar published, peer-reviewed empirical studies which were publicly available. The CORE system can be used to verify whether a client has recovered, improved, or has not changed (Mullin et al., 2006). The Reliable Change Index (RCI) indicates improvement if the final CORE-OM score is five points lower than their score at intake, or six for the CORE-10 (Barkham et al., 2013). Under this paradigm, clients are considered to have recovered if their clinical CORE score has reliably and clinically significantly improved (RCSI), as demonstrated by their final score decreasing by at least five for the CORE-OM and six for the CORE-10 and below the clinical cut-off score of ten for CORE-OM and eleven for CORE-10 (Barkham et al., 2013).

Three comparator studies for CORE were chosen: Armstrong (2010), Mellor-Clark et al., (2001), and Mullin et al., (2006) (Table 1 and Box 1). The Armstrong (2010) study is used for a comparison, due to its focus on the effectiveness of volunteer counsellors with minimal training. Mellor-Clark et al. (2001) was chosen because it tested counselling efficacy and the feasibility of using the CORE system of counselling in primary care settings. Mullin et al. (2006) examine the average recovery and improvement benchmarks for counselling in primary care.

The findings from the GAD-7 and PHQ-9 for clients in this study were compared to results of the Cooper et al. (2015) Pluralism for Depression study (Table 4 and Box 1). This comparison allowed GAD-7 and PHQ-9 data on the clinical cut off (point at which the scale considers the person to be experiencing distress at a clinical level) and "reliable change" index (RI or RD - change in the score which represents a reliable and sustained difference in mental well-being) to be used (Gyani et al., 2013, p.3). For the GAD-7, the clinical cut-off is eight, and a change of 3.53 points or more is indicative of a reliable change. For PHQ-9, the clinical cut-off score is ten, and a change in score of 5.20 points or more suggests a reliable change.

Pre- and post-counselling scores of 45 participants' CORE-OM or CORE-10, GAD-7 and PHQ-9 self-report questionnaires were used to calculate 1. Clinical severity of distress on entry into the clinic, 2. Reliable change in well-being as a result of therapy and 3. Reliable change and clinical change (see Table 3). In the results section, these criteria are examined first in terms of the current sample, and then in terms of their comparison to other studies. Analysis of the outcomes data was carried out IBM SPSS Statistics (Version 27) statistical software.

Table 4.
Clinical terms used for CORE, GAD-7, and PHQ-9 measures

Term use	Meaning
CORE clinical severity	Core scores are given categories of meaning which relate to the severity of the experience of clients when compared to the general population. A score of 10 or more on the CORE indicates a clinical severity above that of the general population. • **0-9**: Healthy/low level of problems • **10-14**: Mild psychological distress • **15-19**: Moderate psychological distress • **20-24**: Moderate-to-severe psychological distress • **25 and above**: Severe psychological distress
CORE reliable change index (RCI or RI/RD)	The change in CORE score for a client, whereby at the end of therapy they have a score which has reduced by 5 points, or more is considered to be an improvement (RI) as a result of therapy. If the score increases by 5 points or more, this is considered reliable deterioration (RD) as a result of therapy.
CORE clinically significant improvement	Clinically significant improvement involves a reduction from a CORE score above 10 to a score below 10.

GAD-7 clinical severity	A score of 8 or more on the GAD-7 indicates clinical severity above that of the general population. • **0-4**: Minimal anxiety • **5-9**: Mild anxiety • **10-14**: Moderate anxiety • **15-21:** Severe anxiety
GAD-7 reliable improvement	A reduction in GAD-7 score of 3.53 or more indicates that the improvement is reliable (RI) and may be due to therapy
GAD-7 clinically significant improvement	A reduction in the GAD-7 score which brings the client from a clinical (above 8) to a non-clinical range (below 8)
PHQ-9 clinical severity	A score of 10 or more on the PHQ-9 indicates clinical severity above that of the general population. • **0-4**: None or minimal depression • **5-9**: Mild depression • **10-14**: Moderate depression • **15-19**: Moderately severe depression • **20-27:** Severe depression
PHQ-9 reliable improvement	A reduction in PHQ-9 score of 5.20 or more indicates that the improvement is reliable (RI)
PHQ-9 clinically significant improvement	A reduction in the PHQ-9 score which brings the client from a clinical (above 10) to a non-clinical range (below 10)
Reliable and clinically significant improvement (RCSI)	Defined on each measure as the client meeting the criteria for both reliable improvement and clinically significant improvement This is often termed 'Recovery'
Reliable change	The use of expected decreases (RI) or increases (RD) in scores means that the change indicated is not a result of variability occurring when clients respond over time to the measure questions without a change in the symptoms.
Deterioration	Both reliable and clinically significant deterioration (RCSD) are indicated by the increase in scores with the criteria matching those of 'reliable change', 'clinically significant change', and 'reliable and clinically significant change' e.g. a CORE score rising 5 points over time indicates deterioration, and if the increase brings the client from the non-clinical (under 10) category to the clinical (over 10) category this is consider reliable and clinically significant deterioration.

Effect size	Effect sizes help us understand how important a result might be in 'real life'. In statistical analysis a change can be significant without it indicating whether the change is 'small', 'medium' or 'large'. So, an effect size can be included in the analysis. The size of the change allows us to consider whether it might be important. For example, a statistically significant change with a *small effect* such as a mean of 1 point on the CORE scores across a group, indicates that the therapy, while it may have made a difference, doesn't really impact that much on the clients, whereas a *large effect* such as mean of 8 points on the CORE might indicate that the impact of therapy is more obvious for the client group. The calculations proposed by Cohen (1977) are used to calculate effect size, and these are generally accepted across disciplines.

RESULTS

In this section the rating scales are considered independently, in terms of symptom severity and clinical significance, and change according to the criteria indicated in Table 3. The standard practice for reporting group outcomes on these measures is to evaluate the proportion of clients who meet the criteria for pre- and post-therapy 'clinical severity', 'reliable change', 'clinical change', and 'reliable and clinically significant change'.

CORE outcome data

For the 45 clients included in this study, the pre-counselling CORE scores showed a range of presentation symptom severity. At the initial assessment, two (4%)

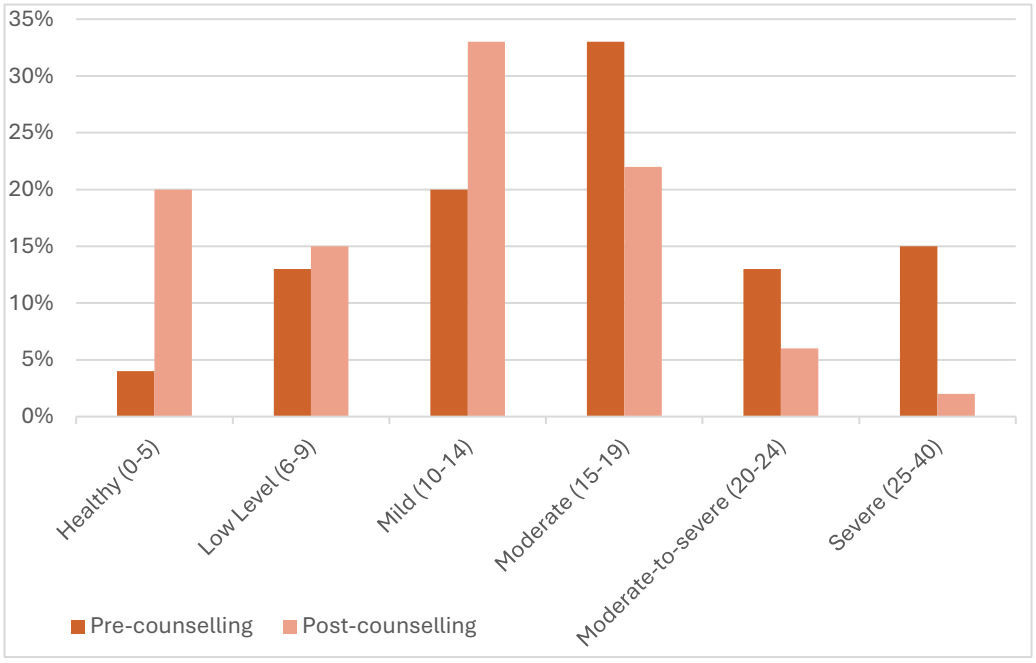

Figure 1.

Symptom severity change pre- to post-counselling (CORE scores)

participants were in the healthy range, six (13%) in the low-level range, 9 (20%) the mild range, 15 (33%) were moderate, 6 (13%) moderate-to-severe, and seven (16%) in the severe range. Of the 45 participants in this study, 37 (82%) had a CORE score of ten or above and therefore held the potential for CORE-defined 'clinically significant' improvement and 'reliable and clinically significant change' or 'recovery' (see Table 3). Within the group, symptom severity decreased after pluralistic counselling, with nine (20%) of the sample population in the healthy range, seven (15%) in the low-level range, 15 (33%) the mild range, 10 (22%) moderate, three (6%) in the moderate-to-severe range, and one (2%) in the severe range (*see Figure 1*).

CORE analysis involves establishing the degree to which the clients within the data set have reliably improved, and reliability improved with clinical significance. Prior to doing this, it is helpful to establish the degree of overall change occurring within the group. Pre- and post-counselling clinical CORE-OM and CORE-10 scores were compared to explore the extent to which changes were statically significant across the sample population. CORE scores at intake and at final session were compared using a repeated measures t-test (t1-t2), so the change for each individual client was compared to the overall pattern of change within the group. Results revealed a significant decrease in CORE score for the group, $t(44)=6.241$, $p<.000$, with a medium effect size d=0.75 (Cohen, 1977). For this client group, the mean CORE score decreased from 17.0 (S.D. 6.7) pre-counselling to 11.9 (S.D. 6.9) post-counselling.

Turning to the evaluation of clinical and reliable improvements of the 45 clients, 37 (82.2%) had a CORE clinical score of ten or above at intake, and this indicated that reliable clinical improvement was possible in these 37 clients, as it relies on an initial clinical severity score of greater than ten (see Table 3). Reliable improvement (a decrease in CORE score of 5 or more) which was not clinically significant was demonstrated in 15 (40.5%) of these clients' scores. Eight (21.6%) of clients' scores showed a reliable and clinically significant improvement (a decrease from above the clinical cut-off of 10 to below 10 and a decrease of five or more). In terms of deterioration, none of the 45 participants' scores reliably increased by five points or more, however 14 (37.8%) of clients showed no reliable change in their scores (the CORE post-therapy did not vary more than 5 from the pre-therapy score).

GAD-7 outcome data

A similar analysis was carried out for the GAD-7 scores pre- to post-counselling, where there were 36 client datasets out of the 45 clients in the study due to non-completion of forms during therapy.

Symptom severity at intake and according to the GAD-7 criteria ranged from minimal to severe: four (11.1%) were in the 'minimal' category, 15 (41.7%) mild, five (13.9%) moderate, and 12 (33.3%) severe. This changed after pluralistic counselling to 12 (33.3%) at the minimal level, 15 (41.1%) mild, eight (22.2.%) moderate and two (5.6%) severe (*see Figure 2*).

As with the CORE, the client pre- and post-counselling GAD-7 scores were compared using a within-subjects t-test examining individual changes on the GAD-7 before and after counselling and further comparing these changes to the overall seen in the sample. The decrease in GAD-7 anxiety ratings were also found to be

statistically significant, with $t(35)=4.924$, $p<.000$ d=0.79, a medium effect size (Cohen, 1977). For the 36 clients included in this analysis, the GAD-7 scores reduced significantly, with mean scores dropping from 10.8 (SD 5.9) to 6.5 (SD 4.9) as a result of therapy.

Twenty-four of the possible 36 clients were at or above the clinical cut-off level of eight on the GAD-7 at intake. Of these 24 clients, eleven (45.8%) reliably and clinically significantly improved, and six (25%) reliably improved only, six (25%) showed no reliable change, and one person (4.2%) reliably deteriorated. The twelve who were not above the clinical cut off were not examined for reliable improvement in alignment with the GAD-7 criteria (Löwe et al., 2008).

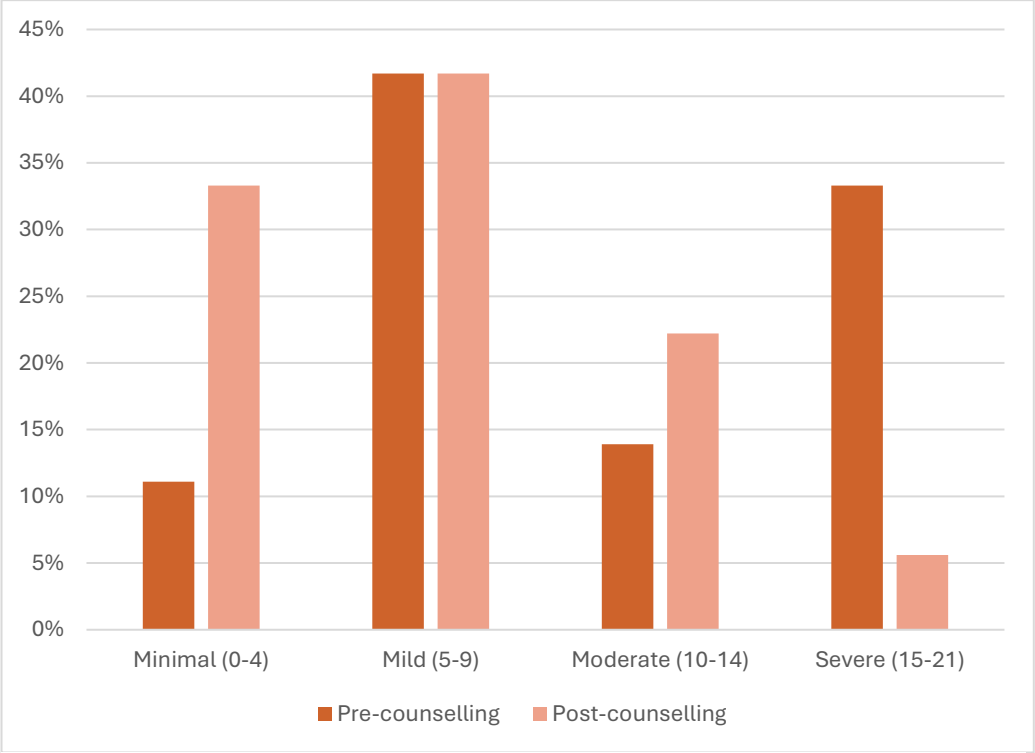

Figure 2.

Difference in GAD-7 scores Pre- to Post-Counselling

PHQ-9 outcome data

The clients' PHQ-9 questionnaire scores from before and after counselling were compared. There were 37 clients with pre- post- PHQ-9 questionnaires available of the possible 45 total, due to non-completion of the forms during therapy.

For the 37 clients, symptom severity ranged from minimal to severe at entry to the clinic, with two (5.4%) clients in the minimal range, six (16.2%) mild, 15 (40.5%) moderate, six (16.2%) moderately severe, and eight (21.6%) were severe. After counselling, the overall severity had reduced with 11 (29.7%) clients in the minimal range, 13 (35.1%) the mild range, seven (18.9%) moderate, six (16.2%) moderately severe, and none were in the severe range (*see Figure 3*).

A within-subjects t-test was performed examining the individual client changes within the context of the mean overall change in PHQ-9 scores. The scores significantly improved pre- to post-counselling, with $t(36)=5.507$, $p<.000$, d=1.08,

a large effect size (Cohen, 1977). Clients scores improved, with mean pre-counselling score of 13.8 (S.D. 5.8) decreasing to a post-counselling score of 7.5 (S.D. 5.8).

Twenty-nine participants had PHQ-9 scores which were at or above the clinical cut-off level of 10 at first contact. Of these 17 (58.6%), reliably and clinically significantly improved (recovered), and two (6.9%) reliably improved only and ten (34.5%) showed no reliable change and none showed reliable deterioration.

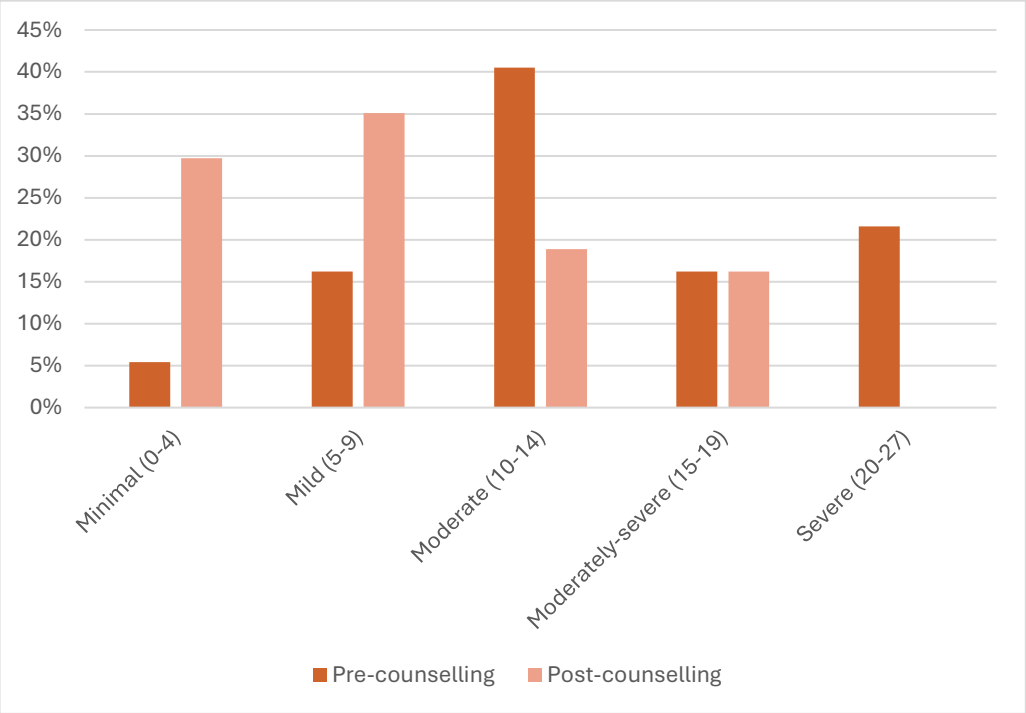

Figure 3.

Difference in PHQ-9 scores Pre- to Post-counselling

Benchmarking

The results show positive changes to client well-being as a result of engaging in pluralistic therapy, with mean client CORE-OM and CORE-10, GAD-7 and PHQ-9 scores significantly decreased over time, from pre- to post-intervention, deterioration was seen in only one client and on one measure, indicating that for this person deterioration was related only to the GAD-7 levels of anxiety. To explore the data and establish the relevance of these outcomes a benchmarking process was carried out to contextualise the results. This narrative benchmarking aimed to compare and contrast the results from the current study CORE results with three empirical papers: Armstrong (2010); Mellor-Clark et al. (2001), and Mullin et al. (2006), none of which examined pluralistic therapy, and further comparison to the work on pluralistic therapy carried out by Cooper et al. (2015) to explore Gad-7 and PHQ-9 results.

A brief overview of these studies is provided in Box 1.

Box 1.

Comparision studies, a brief overview

Armstrong (2010) This naturalistic study gathered data from community settings to explore the CORE-OM outcomes for volunteer and minimally trained counsellors. Twelve counsellors and 118 client pre- and post- measures were benchmarked against similar studies (including Mullins et al., 2006, below). The reliable improvement and reliable and clinically significant improvement of clients was below that of the benchmarked studies, and the author concluded that qualified practitioners were significantly more effective in therapy.

Cooper et al. (2015) This mixed-methods evaluation is the first study examining the quantitative effectiveness of pluralistic therapy focussing on the process and outcome of pluralistic therapy in a multi-site study. The outcome measures used were the PHQ-9 and GAD-7, and for the 39 clients included in the analysis, reliable improvement and recovery (reliable and clinically significant improvement) were assessed.

Mellor-Clarke et al. (2001) This is a large multi-site study examining both the feasibility and utility of the use of CORE-OM outcome measures in general practice. The results indicate that counselling interventions are effective in alleviating distress and psychosocial difficulties seen in primary care. The study included nearly 150 trained counsellors, working in established for at least one year. The therapies provided included person-centred, CBT, and integrative approaches. The analysis of data is comprehensive, and the recommendations of the paper have influenced how counselling is deployed and monitored within the NHS.

Mullin et al. (2006) This paper was designed to establish practice benchmarks for practitioners and within counselling services. Focussing on categories of reliable improvement, reliable and clinically significant improvement, no change, and deterioration, data from >11,000 clients in 32 different primary care services, the benchmarks determine the % of clients at entry to services and on completion of therapy who are considered high, above average, below average, and low levels of distress on the CORE-OM. The categorical benchmarks from this study are referred to in the results.

Table 1.

Benchmarking studies, CORE data

Study	Clients (n)	Type of counselling	Setting	Recovered (RSCI) (%)	Reliably Improved only (%)	Total Reliably improved	Reliably deteriorated (%)	No reliable change (%)	Change in CORE score	Mean intake CORE (SD)
Armstrong (2010)	118	Solution-focussed, common factors	One site, voluntary organisation, trainee therapists	30.5%	17.8%	48.3%	7.6%	44.0%	- 4.70	18.19 (6.65)
Mellor-Clark et al. (2001)	1087	PCT, CBT, Integrative	Nine NHS counselling sites	59%	17%	76%	2%	23%	- 9.6	17.6 (6.3)
Mullin et al. (2006)	11953	Information not given	32 NHS services	53.8%	18.4%	72.2%	1.8%	26.1%	- 9	17.5 (6.3)
Murphie & Smith (2024)	45	Pluralistic therapy	One university-based training clinic	21.6%	40.5%	62.7%	0%	36.8%	- 5.1	17.0 (6.7)

On the main counselling-oriented measure, the CORE-OM, reliable improvement (RI) was seen in eighteen clients (40.5%) indicating that a much higher reduction in symptoms without clinical improvement was present for pluralistic therapy compared to that shown in the three comparison studies. Armstrong (2010) and Mellor-Clark et al. (2001) both reported a symptom improvement rate of only 17.8%, while Mullin et al. (2006) state that any RI over 20% is considered high. However, the number of clients considered to be 'recovered' (RCSI), i.e. have reliable reductions in CORE, while also moving from a 'clinical' above 10 score to a 'non-clinical' below 10 score in the measure, was low in this study (21.6%) compared to the other studies, with Armstrong (2010) reporting a rate of 30.5% and Mellor-Clark et al. (2001) reported 58%. Mullin et al. (2006) report that 49% recovery rate is considered low, while anything over 58% is considered high. So, when considering this evaluation of clinical and reliable improvements, of 45 TCC clients, 37 (82.2%) had a CORE clinical score of ten or above at intake, which is slightly lower than the average of 89% according to Mullin et al. (2006), this also means that clinical reliable improvement (RCSI) was only measurable in these 37 clients.

While the data indicate that recovery as a result of undertaking pluralistic therapy is low, there was a higher number of clients that showed reliable improvement (a decrease in the CORE score of five or more), so the number of clients who had either recovered (RCSI) or improved (RI) was 62.1%, despite the low number who clinically improved. This reliable improvement was higher than that found in the Armstrong (2010) study (48.3%) for minimally trained therapists, but lower than that found in Mellor-Clark et al. (2001) (75%), which evaluated the work of NHS therapists. According to Mullin et al. (2006), a 67% overall reliable improvement rate is low, and 78% is considered high, and therefore this indicates that the outcomes for pluralistic therapy clients on the CORE measure in this study is lower than the benchmarked expectations.

With regards to reliable deterioration (RD) on the CORE, no-one in the present study deteriorated by five points or more. This category is also low in the other studies, with a percentage of 7.6% in Armstrong (2010) and 2% in Mellor-Clark et al. (2001). Mullin et al. (2006) report the average as 1.8%, and so the current study has a lower-than-average number of clients who reliably deteriorated, but only minimally so and this may be a reflection of the small sample size.

Overall, therefore the recovery rates (RCSI) in the current study were low, in comparison to the benchmark studies, the improvement rates (RI) were higher, but overall improvement on the CORE was lower than expected by benchmarking processes (Mullin, et al., 2006). The recovery rates (RCSI) can be examined in the light of the client population in terms of two things: the first is that the sample contains sufficient clients above the clinical cut-off at the start of the therapy, and the second is that they are realistically able to decrease their scores on the CORE in the time available. There were fewer participants in this pilot study compared Mellor-Clark and colleagues (2001) with 1087 participants; Armstrong (2010) with 118 participants, and Mullin et al. (2006) with 11,953 clients over 32 services. The larger studies used for comparison therefore may have the advantage of having a greater chance of representing the population and demonstrating these effects and future studies with more participants could provide more comprehensive

results. At intake, there were fewer clients with a clinical cut off score above ten than average (Mullin et al., 2006), which could mean that it would be more difficult to establish evidence of change. For example, if a client presents in the lower ranges (healthy/low level) at intake, then it would be more difficult for the post-therapy score to be at least five points lower. In addition, it was not possible for them to 'recover' as defined by the CORE-OM (e.g. Mellor-Clark et al., 2001). Mullin et al. (2006) state that any number under 86% of clients at intake with a score lower than the cut-off as low, with the average stated as 89%. These factors could potentially explain the relatively low recovery and no reliable change for the clients in this study.

Overall, these results indicate a mid-range improvement when compared to NHS clients (Barkham et al., 2001; Mullins et al., 2006) while being slightly above the improvements seen in the minimally trained study from Armstrong (2010).

With regards to pluralistic therapy specifically, the current study had similar findings to those in the pluralism for depression study by Cooper *et al*. (2015), which while not reporting CORE outcome data, used GAD-7 and PHQ-9 to explore pluralistic therapy in community clinic settings. In the Cooper et al. (2015) study, 65.7% of clients reliably improved on their GAD-7 scores, while in this study, the comparable number included clients who either 'improved' or 'recovered' which comprised a slightly higher proportion of 70.8%. In the current study 25% of clients did not show reliable improvement, which is almost identical to Cooper and colleagues' (2015) findings of 24%. In terms of the PHQ-9, one person (4.2%) did show a reliable deterioration, as did four (10.3%) of the 39 participants in the Cooper et al. (2015) analysis. The percentage of those who either recovered or improved with regards to the PHQ-9 in this study was 65.5%, in line with Cooper et al. (2015), who found that 66.6% showed improvement. The percentage of those who showed no reliable change in the current analysis was 34.5%, which was again very similar to Cooper et al. (2015), who found 33.4%.

Table 5.

Outcomes on PHQ-9 and GAD-7

Study		Clients (n)	Type of counselling	Setting	Recovered (RSCI) (%)	Reliable Improved (RI) (%)	Clinical improvement (CI) (%)	Reliably deteriorated (RD) (%)	No reliable change (%)	Mean intake measure	Mean endpoint measure
Cooper, et al.,[1] (2015)	PHQ-9	39	Pluralistic therapy	Multiple community clinics	RSCI not reported	66.6%	46.2%	0%	Not reported	18.4 (SD 4.3)	10.6 (SD 7.1)
Murphie & Smith (2024)	PHQ-9	45	Pluralistic therapy	One university-based training clinic	58.6%	65.5% (6.9% RI only)	Not reported	0%	34.6%	13.8 (SD 5.8)	7.5 (SD 5.8)
Cooper, et al., (2015)	GAD-7	39	Pluralistic therapy	Multiple community clinics	RSCI not reported	65.7%	40%	10.3%	Not reported	14.5 (SD 4.7)	9.1 (SD 6.1)
Murphie & Smith (2024)	GAD-7	45	Pluralistic therapy	One university-based training clinic	45.8%	70.8% (25% RI only)	Not reported	4.2%	25%	10.8 (SD 5.9)	6.5 (SD 4.9)

[1] Cooper, et al. (2015, p. 13) used a combined measure of improvement following Gyani et al. (2013)

We can conclude that the similarity in findings between the present study and Cooper et al. (2015) indicate that in terms of the GAD-7 anxiety and PHQ-9 depression inventories, the effectiveness in pluralistic therapy is consistent. Both findings taken together, along with the evidence of improvement in CORE scores, suggest that pluralistic therapy is an effective form of treatment, however the below-benchmarked outcomes on CORE requires further examination. One factor that might explain these results is that the services in Barkham et al.'s (2001) and Mullins et al.'s (2006) papers were well established and the practitioners within them were trained professionals, while around half of the clients in the current study were seen by trainees, and this is reflected in the work by Armstrong (2010) where the results for minimally trained volunteers was below those seen in the current study. Work on the relative effectiveness of trainee therapists compared to qualified practitioners in terms of outcomes for clients is sparse, and there are indications that there are a range of capacities and competencies with might impact on effectiveness (Banham & Schweitzer, 2016). Alongside this training in the use of outcome measures are a common requirement for the two larger benchmarking studies (Barkham et al., 2001; Mullin et al., 2006), while it could not be established that this had been undertaken by the counsellors in this study. Aspects of service provision, supervision, and management are also factors which impact on the outcomes of therapy beyond the core training, such as practice protocols and quality assurance methods, and while supervision groups were a feature of the clinic, no conclusions can be drawn from the effectiveness or otherwise of this for the practitioners involved.

In addition to this, the current study aimed to explore effectiveness of pluralistic therapy, and there remains some uncertainty around the therapeutic competencies and application of this approach within the clinic. Recently, an increasing conceptual delineation has developed between those therapists who hold a pluralistic stance and those who undertake pluralistic practice (Smith & de la Prida, 2021; Thomson et al., 2017), and the practitioners may have been undertaking their work in alignment with the former and not the latter. The assumption that the improvements reported are a result of service effectiveness and therapy or a specific result of pluralistic therapy is therefore inconclusive because pluralistic practice has been assumed rather than established.

This pilot study has added to the evidence base for the use of pluralistic therapy in that the outcomes match those of Cooper and colleagues (2015). The results demonstrate a positive mental health impact on clients in alignment with other therapeutic approaches, but in some respects with lower effectiveness than NHS services. In order to explore this further and establish effectiveness as a feature of pluralistic therapy specifically, a comprehensive study using the principles of well-being measure use, the active deployment of measures within the collaborative relationship, and importantly an effective way of evaluating the use of pluralistic practice.

LIMITATIONS AND FUTURE STUDIES

The largest limitations of this study are the pragmatic data collection, based on available client records within the clinic, the small sample size, and the absence of a randomised-controlled design. Additionally, some data was unavailable for analysis as was the rate of planned completion compared to drop-out.

We cannot, without controlled conditions, conclude that pluralistic therapy was the primary cause of the decrease in client CORE, GAD-7, and PHQ-9 scores, and this is a limitation of the study. Comparing scores between studies shows the relative effectiveness, of pluralistic therapy but there are risks to over-interpretation of the results. One of the key problems is the evaluation of whether the practitioners in this study were indeed using pluralistic practice, considering that half of the therapists were in training, while other more experienced therapists had trained in other modalities prior to working at the pluralistic clinic. Like the Joyce et al. (2022) study, adherence to the model was not evaluated. The absence of a pluralistic adherence scale or competencies framework which can be used to support and assess practice it is difficult to draw conclusions on the effectiveness of pluralistic counselling, as without it, we cannot ensure that counsellors were adhering to the model. A validated pluralistic adherence scale, which is currently being developed, will allow research to be carried out on the effectiveness of pluralistic therapy.

In addition, as this was a pilot study, the sample size was small, and, as a result of being from a single site, most participants were white British nationals, meaning that it is not representative of a UK population of counselling clients. A larger sample size with increased diversity would help to make these findings more applicable to a wider context.

CONCLUSIONS

In this study, symptoms of well-being and distress for a sample of 45 community clinic clients, as measured by CORE, GAD-7, and PHQ-9 data all significantly decreased over time, from pre- to post-counselling. The CORE data indicated that 62.7% of clients showed either a reliable improvement, or recovery, with trainee and qualified counsellors working within a pluralistic framework. 70.8% of clients' anxiety levels either improved or recovered, as measured by the GAD-7. 65.5% of clients' depressive symptoms either improved or recovered, as measured by the PHQ-9. The recovery and improvement rates are comparable to other therapies, as measured using these clinical tools. These positive findings are a helpful starting point from which to develop larger and more thorough quantitative and qualitative studies looking at the effectiveness, and potential improvements, to pluralistic therapy.

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COMPETING INTERESTS

The author has no competing interests to declare.

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