Collaboration, Metacommunication and Pluralistic Therapy

The following thoughts about collaboration and metacommunication (later called ‘metatherapeutic communication’ by pluralistic therapy theorists) as central aspects of pluralistic therapy are drawn from my thesis *How Counsellors and Psychotherapists Make Sense of Pluralistic Approaches to Therapy* (2018). In that thesis, I interviewed 12 therapists identifying with different approaches. From those interviews I created a qualitative thematic analysis identifying seven themes. Firstly, under an umbrella of ‘Contentious Issues’ I identified ‘The Flexibility-Rigidity Continuum’, ‘Identity and Approach’ and ‘It’s the Relationship’. All these feed into ‘Debates about Pluralistic Approaches to Therapy’. From these debates flow three ‘Diplomatic Attempts at Resolution’ which are ‘The Uncertainty-Understanding Continuum’, ‘Common Factors’ and ‘The Practice of Metacommunication’. The latter is central to Cooper and McLeod’s articulation of pluralistic therapy (Cooper & McLeod, 2011). The focus of this article is on that theme with some reference to what the interviewees said about it. I also write this in anticipation of the 5th Pluralistic Therapy Conference, taking place online in June of this year, whose headline is: ‘Collaborative Relationships: Working Together to Rebuild Lives and Communities’.

The Pluralistic Dimension

One of the conclusions of my thesis is that pluralism is better thought of as a dimension which runs through different therapies and therapists to greater and lesser extents. In that sense I do not think that there can be one solitary ‘pluralistic therapy’. That is why I deliberately titled my thesis with the phrase ‘pluralistic approaches’ rather than with a singular ‘pluralistic approach’. However,

for the sake of clarity, unless stated otherwise, the use of the term ‘pluralistic therapy’ throughout this text refers to Cooper and McLeod’s version (ibid.). Also, the therapists I interviewed are referred to throughout as ‘interviewees’.

Collaboration, Choice, Integrationism and Pluralism

What therapies are offered to whom, and how much choice and/or collaboration clients are allowed is one of the most important aspects of the pluralistic agenda for therapy. If choice and collaboration are valued -- which they might not be (for various reasons) -- then the pluralistic agenda is centrally important to how therapy is provided in the future. If the pluralistic agenda is to take hold, practitioners will need to support it. Without this support, pluralistic therapy will not solve problems that it implicitly, and sometimes explicitly, sets out to solve. Yet, pluralistic therapy, as a perspective and practice, has instigated division amongst practitioners, with some embracing it, some more neutral, and others who reject it. There is work to do in convincing therapists that the pluralistic agenda will serve the profession well.

In terms of differentiating integrationism from pluralism, as well as pluralistic therapy having a philosophical base, the main distinguishing feature is the emphasis on collaboration with the client. But at least some integrative therapists would also articulate integrative therapy as having a philosophical base and valuing collaboration (e.g. Gilbert & Orlans, 2011; Miller et al., 2005). Therefore, it is perhaps not surprising that there is an admission that ‘[p]luralistic therapy is an integrative approach’ (Cooper & McLeod, 2011, p. 6). In later publications pluralistic therapy is described as a ‘“collaborative integrative” way of working’ (Cooper, 2015, p. 4), a ‘meta-integrative framework’ (McLeod & Sundet, 2016, p.

158) and a ‘radical eclectic approach’ (ibid., p. 167) – phrases that seem to struggle to encapsulate substantial differences to integrative and eclectic approaches.

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

The valuing of both client and therapist perspectives is central to Cooper and McLeod’s pluralistic practice, and leads to their particular emphasis for it to have a ‘collaborative relationship’ at its ‘heart’ (Cooper & McLeod, 2007, p. 139). In

this regard, pluralistic practice seems to be an attempt to maximise the benefit of the 'working alliance' and the 'therapeutic relationship' (Clarkson, 1995), which is seen by many researchers and practitioners as a key factor in therapeutic effectiveness (e.g. Fluckiger et al., 2018; Horvath & Greenberg, 1994). Cooper and McLeod (2007) cite further research evidence (e.g. Addis & Jacobson, 2000) to support their view that the collaborative qualities they associate with pluralistic therapy improve outcomes.

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

The humanistic-existential philosophical basis for their pluralistic approach might alienate practitioners who do not come from that philosophical position. Cooper and McLeod (2011) anticipate that resistance, and attempt to make their humanistic position inclusive of all practitioners by framing it as one which is a general 'ethic', rather than any kind of specific therapeutic practice – one that might apply to any kind of therapy, including CBT. They argue that collaboration is what makes any kind of therapy humanistic, so that even person-centred therapy, if it is delivered without client involvement, could be non-humanistic. This is a valiant attempt to bridge divides; nevertheless, it does come across as trying to claim humanistic values as more universally accepted than is perhaps the case. It might also be seen as wishful thinking that their values have the potential to be trans-theoretical when perhaps that potential is actually problematic and limited. Interestingly, in a book about counselling skills it seems as if McLeod and McLeod (2011) are to some extent distancing themselves from a labelled pluralistic approach by describing pluralistic ways of working in chapters about 'goals, tasks and methods' (pp. 68--86) and another about 'working collaboratively' (pp. 125--150), but downplay its relation to a pluralistic framework.

The assertion that pluralistic therapy is 'uniquely inclusive and collaborative' (Cooper & McLeod, 2011, p. 157) is extremely arguable, as various integrative therapists have argued for similarly inclusive and collaborative approaches to therapy (e.g. Gilbert & Orlans, 2011), before and since Cooper and McLeod first articulated their version of pluralistic therapy. Their framework is also not as original as they claim it to be, and it might be argued that Wilber offered a much more comprehensive and comprehensible 'pluralistic framework' as far back as

1977 (for example see Wilber, 1977) more fully developed by 2000 (see Wilber, 2000).

In 2018 John McLeod published a book entitled *Pluralistic Therapy: Distinctive Features* (McLeod, 2018). This book is part of a series called 'Psychotherapy and Counselling Distinctive Features' edited by Windy Dryden. McLeod clearly accepts the categorisation of pluralistic therapy as an integrative approach, if 'integrative' is defined as 'combin[ing] ideas and methods from several (or all) purist approaches' (p. 21). However, whilst he admits and elaborates on what the similarities between pluralistic and integrative therapy are, he also insists that there are differences. It could be argued that the 'pluralistic framework' articulated by Cooper and McLeod (2011) is merely theorising and providing terminology for what many therapists have been doing in practice ever since the profession's beginnings.

It might be that what distinguishes pluralism from integrationism has – to a certain extent – been lost over time, in attempts to communicate a specific way of practising which emphasises collaboration. In more recent years Cooper et al. (e.g. Cooper & Dryden, 2016) have described their vision for pluralistic practice as 'collaborative integration', which supports the view that, in effect, the proponents of pluralistic practice are re-packaging a version of integrative therapy. This development might be seen as devaluing the meaning of pluralism as a philosophical position that values difference, and wants to preserve difference, rather than accelerate 'premature integration' (e.g. Kazdin, 1984).

Cooper and McLeod (2011), in trying to articulate how their pluralistic therapy is different to integrative therapies which have come before, emphasise how their

‘framework’ enables research to be carried out in ways that previous articulations of this kind of practice have not. This response might be seen as a weak defence against the charge that pluralistic therapy is just integrative therapy. But the apparent gap -- between how therapists practise and therapy research that is taken seriously by those with financial and political power -- seems to be so far apart that it would support the idea that pluralistic practice needed a re-articulation: pluralistic values in therapy have not been understood by research commissioners, thus far, or certainly not by the consumers of research who use research to make decisions about provision.

Metacommunication and Collaboration

One purpose of metacommunication is to devolve power away from therapists and towards clients. This is arguably good for the therapeutic process in itself but also, if taken up collectively, could be a path to peace and reconciliation in the profession more widely. If clients are allowed to decide what kind of therapy they want with what kind of therapists, then at least in theory, the need for therapists and other stakeholders to argue about the efficacy of and place for various therapies dissolves. ‘Why not ask clients what they want and give it to them?’ seems to be the rhetorical question that lies behind the call for metacommunication at the political level. This open and informative communication about therapeutic choices does not just occur at the beginning of therapy, for example in assessment, but throughout, so that clients can choose how therapy can be tailored for them individually, either with one therapist/therapy or a series of therapists/therapies.

From interviews I conducted with therapists, Paul, a person-centred therapist, had reservations about pluralistic therapy's version of collaboration:

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

Another interviewee, Nicola, echoed a common critique of pluralistic therapy that clients do not understand therapy enough for collaboration to be useful and, some might add, interferes with a 'relational' approach that emphasises 'being with' over 'doing to' – a suspicion of techniques as potentially undermining the relationship. Most interviewees, however, recognised that clients varied from a minimal understanding of therapeutic process to significant understanding and, in a pluralistic spirit, would vary the amount and type of collaboration depending on the client.

There is some resistance in the literature to putting the client first, in terms of control of therapeutic direction (e.g. Dryden, 2012). Dryden (2012) also insists that the choices presented to clients should be driven by 'evidence' for their particular conditions, which leaves assumptions about the medical model and research methodologies unchallenged. Most interviewees appeared to support collaborative processes, in a general sense, even if that was within a specific model, including a CBT therapist.

Cooper and McLeod (2011) support the emphasis on research by referring to evidence that backs the effectiveness of therapy that is monitored via feedback forms, suggesting that it can help to facilitate a pluralistic practice that puts client–

therapist collaboration at its centre. The use of these forms is unapologetically encouraged, yet therapists continue to be suspicious, rightly or wrongly, of this kind of 'auditing' of therapeutic processes and outcomes. Practitioners more sympathetic to instrumental, positivistic and quantitative approaches might perceive implementing the suggested protocols into practice as a win–win situation in which therapeutic process and research are both well served. Other practitioners resist the research-driven agenda and do not want to interrupt the flow of a 'conversation' with clients (e.g. Szasz, 1988) in what might be seen as an attempt to attain expediency-driven 'scientific' credibility.

A majority of the interviewees reported that they communicated with clients about therapy either in the first session or before sessions have started. Paul, the person-centred therapist, said:

I like in the very first session to be really clear, or try to be clear, about how I work

Lisa, a pluralistic therapist, said:

most of them have a description of the type of therapy we're meant to be providing, that's always given to my clients before I see them… in the room I'll always still verbally check out… what they understand about counselling, if they've had any previous experience of counselling; if they have, what type and their experience of it, so whether they liked it or not, so what worked for them, what didn't work for them really – if they've had no experience, then I will try and explain to them my way of working

Debora, a humanistic-integrative therapist, said:

`when people first come I ask them if they've had counselling before, and they tell me about their experiences of counselling and I ask whether it's been helpful and what sort of issue they came with before… then I say about the type of therapy it is, that I'm hoping to be supportive and that the counselling is about what they want to talk about, it's client-led… that it is up to them what we do in the session and to give me feedback about what's helpful and not helpful

Robert, a person-centred therapist, said:

my first session is always an explanation of what I'm doing, the contract bit, make sure they understand what's going on

Peter, a person-centred therapist, said:

I suppose I will lay it out at the beginning…. I suppose I get an idea from just talking to the client originally about if it's the approach that's attracted them or they just want to speak to someone, and during the contractual process I'll set out a… brief explanation of the approach -- the idea of being non-directive, the idea of them being in the driving-seat; so that's how I tend to communicate it, and then after, at the end of the first session I'll usually just check out with them, 'Has this felt like what you're looking for? Do you think it's the right thing for you?' So it's really explaining it and then checking out if the approach fits with what they want

John, a CBT therapist, said:

it's pragmatic to involve the client straightaway and make joint decisions because [otherwise] *you won't keep them on board, they're off*

A few of the interviewees reported that they used metacommunication regularly and throughout sessions. Paul, a person-centred therapist, said:

it's always about ongoing metacommunication… so the client knows what I'm trying to set up and what I'm trying to maintain – it's all about so they can understand their position in it

Lisa, a pluralistic therapist, said:

at the end of every session I'll ask them how they felt it went, if there's anything they'd like me to do differently and at the next session also again say, 'You've had a week to reflect on that… would you like to change it in any way?'

John, a CBT therapist said:

every decision we make is a joint decision…. I will give my two-penny worth in and let them give their two-penny worth in, and I accept the fact that most people will go with your lead if they trust you… collaborative is… kind of fundamental, and it's not through any particular philosophical stance I've got

Other therapists reported that they brought metacommunication into 'review' sessions.

A few interviewees expressed how they felt metacommunication was empowering for clients:

it's about empowering the client. I don't want to be the one pulling the strings… so it feels really important to me to have that metacommunication (Paul)

[metacommunication] really helps with the power dynamics, with the equalising of the relationship… to know that it's okay to say 'I'd like to talk about this. I feel we've been focussing on that too much' or allowing them a bit of space to notice the process, their own process and how they do therapy (Joanne)

it goes back to respect and individual participation – 'You're an equal partner in this exercise in how we're doing it' (Robert)

Similarly, Joanne,a person-centred/solution-focussed therapist, expressed how she felt metacommunication was particularly suitable for young people:

I think I used to… not really explain what I was doing, but these days I think I'm much more explicit about what I'm doing and why I'm doing it… and that's very much informed, I think, by the work with young people because they don't get it… counselling is like a really weird and scary thing, and it really helps to explain what it is, what it's for, why some people think it works and why it might not be suitable for everyone -- but let's give it a go and see what happens

An important aspect of metacommunication, which is also emphasised in pluralistic therapy, is that it is a collaborative process, seen as a central and distinctive quality of pluralistic practice. Most interviewees also discussed the collaborative aspects of metacommunication. For instance, Joanne said:

it can feel quite important… with some clients to have that collaborative working… to know that they can… have a say in the process… that they can be given the opportunity to explore what's working for them and what isn't

Joanne was aware that Cooper and McLeod's suggestions for a pluralistic practice formalise this collaborative process, but reported that she did not do this formally, but rather:

I build that in, in a slightly less structured way, but always making space for a really thorough and proper review of the work

Susan, an integrative therapist, related how she might involve a client in collaborating about the therapeutic process:

in assessment we're setting the goals of 'This is what I want to achieve' and I continue as I'm working with them to check out that they're working towards that so the client is quite involved with what's going on, or if I think we're stalling or we're getting stuck then [Susan laughs slightly] *I'm gonna bring that into the room and check it out with the client that 'My sense is we're not really moving forward here. What's your sense and what can we be doing differently? How can I help you to get over this?' So it's a two-way process*

Lisa, the pluralistic therapist, felt that the transparency of open collaboration with clients lent support to a more pluralistic as opposed to puristic practice:

I feel just as consistent as somebody that's pure person-centred or psychodynamic pure because I'm being transparent about what we're going to be doing

Debora, the humanistic-integrative therapist, seemed less convinced and a bit more cynical about the importance of metacommunication to and for clients:

I think people just trust the counsellor and don't really question if you change to doing different types of therapy, I don't think they would question it really, and I don't think people think about 'Oh, yes, look, she's using psychodynamic technique now' or 'she's being person-centred now' – I don't think they think like that really; and after working in it for 14 years I don't think I think that much about it, I just do what I do, what I think is the best at the time

Expanding on this view later in the interview, Debora compared metacommunication with clients to taking a car to the garage:

we don't specifically want to know it's the starter motor gone… we don't want to know how they're doing it or what other parts they're doing or how long it's going to take even… just want it done

Similarly, Paul, a person-centred therapist, was

aware when some clients aren't interested in [metacommunication]*'*

Christine, the psychodynamic therapist, also suggested that clients do not

care too much about what therapeutic approach I'm using [Christine laughs slightly] *as long as it works for them and they find a relief*

On the whole the interviewees seemed to resonate with the idea of metacommunication and collaboration being important. These qualities can facilitate the therapeutic process within one approach, or allow movement between approaches with one therapist, or signal that a client might perhaps be better off with another therapist – either because the therapist does not want to work in ways the client wants to, or because the therapist does not feel they have the competence or skills to do so. Debora, the humanistic-integrative therapist, voiced a more cynical take on metacommunication, which is also shared by some therapists and researchers, and will be discussed subsequently.

'Metacommunication' as a term related to therapy can be traced back to Rennie's (1994) paper on 'clients' deference'. This research paper suggested that often clients defer to the therapist not because they want to, but out of politeness, lack of metacommunication or ineffective metacommunication when it occurs. One

implication of the paper is that more effective communication with clients, especially via metacommunication about the therapeutic process, would benefit them. The pluralistic emphasis on collaboration and metacommunication could be seen as a response to the therapeutic problems highlighted in Rennie's paper (1994). The most central and distinctive feature of pluralistic therapy is its emphasis on 'metacommunication' that in 2012 Cooper and others renamed 'meta-therapeutic communication' (MTC) (Cooper & McLeod, 2012). This practice is foundational for the pluralistic valuing of therapist–client collaboration.

The implications of this practice, if taken up more widely, could be a devolving of power away from the 'expertise' of professional bodies, researchers and providers to clients themselves and their own unique, contextual positioning, which often challenges attempts to categorise and define. In this sense, the practice of MTC holds promise not just for empowering clients, but for empowering therapists whose approaches have not been 'approved' by research; it has the potential to be 'political' as well as 'personal'.

There is a parallel to MTC within healthcare called 'shared decision-making'. In defining it, Coulter and Collins (2011) say that 'it involves the provision of evidence-based information about options, outcomes and uncertainties' (p. vii.). If therapists and clients are similarly constrained within a narrow evidence base, then the potential for flexibility and open choices will be decreased. Ultimately, how MTC manifests and decisions are arrived at, if operated within constraining paradigms, might offer more or less empowerment for therapists and clients.

Pluralistic theoreticians seem to be unsure as to how therapists should use evidence to influence their collaborative choices with clients. For instance, Cooper et al. (2016) assert that 'therapists should familiarise themselves with the evidence on what works in therapy: both at the intervention level and the level of different methods' (p. 50). Yet in a different chapter in the same book, McLeod and Sundet (2016) characterise pluralistic therapy 'as a form of radical eclecticism' (p. 160) which 'means… to pick and choose without these choices being dictated or constrained by demands for logical and theoretical coherence' (p. 161). The latter approach is bounded by working with the clients' preferences, but it nevertheless seems to have less of an emphasis on evidence gained outside of actually working with a particular client. The 'evidence' is only gathered from particular experiences of particular clients from particular sessions, a so-called 'client-directed outcome-informed' therapy (e.g. Duncan & Miller, 2000). This approach to evidence and practice is more pluralistic in spirit, as it values the particular to inform the whole, rather than accepting that generalised evidence is necessarily of use to any particular individual.

Most of the interviewees practised metacommunication with clients. For some this was only before or at a first session; others practised metacommunication throughout sessions. A few of the interviewees expressed support for the idea that the practice of metacommunication is empowering for clients, and one interviewee felt it was particularly suitable for young people, whom she experienced as potentially more fearful and suspicious of therapy. The latter view is to some extent supported by research demonstrating that young people value shared decision-making (e.g. Simmons et al., 2011; Wolpert et al., 2014). Open explanation by the therapist about 'what [therapy] is, what it's for, why some

people think it works, and why it might not be suitable for everyone but let's give it a go and see what happens' (Joanne – person-centred/SFBT therapist) helps to allay fears about taking up therapy.

Most interviewees talked about the importance of collaboration with clients, often perceived as a central aspect of pluralistic practice. In general, this supports pluralistic therapy's emphasis on collaboration. However, Joanne, talked about integrating this into her practice in a 'less structured way', which might support the general sense I felt from the interviews and from analysing the interviews, that whilst therapists seem to be quite comfortable with the general principles of pluralism, such as collaboration and metacommunication, they are less comfortable with specific directions of how to apply them.

As previously discussed, only Debora, the humanistic-integrative therapist, was cynical about the practice of metacommunication and the emphasis on collaboration, believing that clients 'trust the counsellor'. Similarly, Paul, the person-centred therapist, was aware that some clients were not interested in metacommunication about process. Cooper et al. (2016) also discuss this variance of enthusiasm towards MTC, citing research that reflects the mixed feelings that interviewees had about it (Health Foundation, 2012).

The evidence base for the value of MTC is ambiguous, with some research suggesting that the impact on outcomes is small (e.g. Duncan et al., 2010), whilst other research suggests that clients value it, and especially value receiving their 'preferred intervention' (Cooper et al., 2016, p. 45; Swift et al., 2011, p. 307).

The perceived need for MTC depends on various factors, but one factor is where practitioners position themselves on what I call the 'flexibility--rigidity continuum':

the more flexible a practitioner, the more approaches and techniques that practitioner might use, and therefore, arguably, the more there is a need for MTC and collaboration. In turn, how comfortable both therapists and clients are with flexibility and MTC depends on their relationship to and tolerance of uncertainty and understanding. Differences of opinion about how flexible therapists should be is one aspect in the debates about pluralism; and respect for uncertainty, as well as understanding, might be seen as one 'diplomatic attempt' to resolve this issue.

There has been a drive in the provision of therapy to privilege therapies that have an evidence base and the therapists that provide them. As a consequence many therapies and therapists have been marginalised by large-scale providers such as the NHS. Pluralistic therapy can be seen as a research-friendly framework which might act as a basis for reintroducing these marginalised therapies back into mainstream provision. The rationale for pluralistic therapy is that different clients need different approaches at different times, and the best way to determine what and when is by open collaboration with the client.

One of the main ways in which pluralistic therapy aims to transcend 'schoolism' and, in my interpretation, offer a 'diplomatic attempt at resolution' to the conflicts between therapeutic approaches, is via the practice of metacommunication. Metacommunication forms one foundation of its attempt to practise 'collaborative integration'. Most of the interviewees practised metacommunication, even if only at the initial session or at review sessions. For some interviewees, if it was clear that if they could not help the client within their approach they would refer on. Other interviewees, however, were flexible and felt comfortable using different techniques or approaches, depending on the client. This aspect of pluralistic therapy, which has been emphasised as a particular strength, might therefore be

seen as not really that innovative, and something that most practitioners do anyway. This has been noted and rebuffed by Cooper and McLeod – but the argument still remains. Whilst the interviewees were overall in favour of metacommunication, there was some doubt that it is useful for all clients all of the time.

Cooper and McLeod have also encouraged the formalisation of metacommunication in therapy practice via the use of Likert scale forms. There has been research about the use of their forms with encouraging results, and they also cite research in the USA that demonstrates better outcomes via the use of on-going monitoring of sessions with forms.

The main challenge of metacommunication for pluralistic therapy, however, is whether clients might be trusted enough, and empowered enough, to make up their own minds about what kind of therapist and therapeutic approach they want. In the NHS the current assumption is that expert researchers need to evaluate different therapies for the benefit of clients with particular symptoms. Perhaps it might be easier, cheaper and more effective to ask clients of sufficient capacity and knowledge what they would prefer. This is an idea that, as far as I am aware, has not been proposed, let alone entertained, despite the patient-centred rhetoric of the NHS.

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