Research Paper

Pluralistic therapy for depression: Acceptability, outcomes and helpful aspects in a multisite study

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Objectives: *The aim of this study was to assess the outcomes, acceptability and helpful aspects of a pluralistic therapeutic intervention for depression.*

Design: *The study adopted a multisite, non-randomised, pre-/post-intervention design.*

Methods: *Participants experiencing moderate or more severe levels of depression (as assessed by a score of 10 or greater on the Patient Health Questionnaire depression scale, PHQ-9) were offered up to 24 weeks of pluralistic therapy for depression. This is a collaborative integrative practice oriented around shared decision making on the goals and methods of therapy. Of the 42 participants assessed, 39 (92.9 per cent) completed two or more sessions. Participants were predominantly female (N=28, 71.8 per cent) and white (N=30, 76.9 per cent), with a mean age of 30.9. The principal outcome indicator was improvement and recovery on the PHQ-9 and Generalised Anxiety Disorder 7-item (GAD-7) scale.*

Results: *Of the completer sample, 71.8 per cent of clients (N=28) showed reliable improvement and 43.6 per cent (N=17) showed reliable recovery. Effect sizes (Cohen's d) from baseline to endpoint were 1.83 for the PHQ-9 and 1.16 for the GAD-7. On average, the clients found the PfD sessions helpful and valued the flexibility and collaborative approach of their therapists. Clients felt that change had been brought about by their own active engagement in therapy and through the therapists relational qualities, as well as their use of techniques.*

Conclusions: *Initial indications suggest that pluralistic therapy for depression has acceptable outcomes, retention rates, and user satisfaction. Refinement and further testing of the approach is recommended.*

Keywords: *integrative psychotherapy; depression; pluralism; therapeutic outcomes.*

DEPRESSION refers to a wide range of mental health problems characterised by the absence of a positive affect and low mood (National Collaborating Centre for Mental Health, 2010). Diagnostic criteria for a major depressive disorder from the *DSM-5* include low mood, decreased interest or pleasure, fatigue or loss of energy, feelings of guilt and worthlessness, and suicidality. It is the most common mental disorder in community settings (National Collaborating Centre for Mental Health, 2010) and the fourth most common cause of disability-adjusted life years (World Health Organization, 2001). It is estimated that between four and 10 per cent of adults are likely to experience major depression in their lifetime (National Collaborating Centre for Mental Health, 2010).

For people with moderate or severe depression, evidence-based guidelines from the UK's National Institute of Health and Clinical Excellence (NICE) recommend a combination of antidepressants and a high intensity intervention, comprising either cognitive behavioural therapy (CBT) or interpersonal therapy (IPT) (National Collaborating Centre for Mental Health,

2010). If these treatments are declined, it is recommended that counselling or short-term psychodynamic psychotherapy should be considered.

NICE guidelines also recommend a *person-centred* approach, in which 'Treatment and care should take into account patients' needs and preferences. People with depression should have the opportunity to make informed decisions and their care and treatment, in partnership with their practitioners' (National Institute for Health and Clinical Excellence, 2009, p.90). However, there is an absence of guidance on how these preferences can be identified, or how they should inform the clinical decision-making process. Within NICE recommendations, choice is also limited to macro-level decisions about treatment programmes, with no role for patient choice at the micro-level of particular treatment component.

Pluralistic therapy is a collaborative integrative model of psychological therapy that attempts to address some of the limitations of an empirically-supported treatments paradigm. Articulated by Cooper and McLeod (2007, 2011), it has evoked considerable interest, debate and research in the British counselling psychology fields (e.g. Hanley, Williams & Sefi, 2012; Milton, 2010; Scott, 2014). The basic assumptions of the pluralistic approach are that a wide range of different treatment methods and strategies that can be helpful for different clients, and that therapists should work closely with their clients to help them identify the treatment approach that most suits their therapeutic goals and preferences. Therapist client collaborative action is facilitated both through formal feedback tools (e.g. the Therapy Personalisation Form; Bowen & Cooper, 2012), and through ongoing *meta-therapeutic dialogue* (Cooper & McLeod, 2012) regarding the goals and methods of therapy. A preliminary open-label trial of pluralistic therapy at a university research clinic found acceptable levels of clinical and/or reliable improvement (76.9 per cent); with one client (six per cent) showing clinical and reliable deterioration (Cooper, 2014). All clients engaged for at least three sessions of therapy, and 78 per cent had a planned ending.

A pluralistic approach to therapy is supported by several further strands of evidence in the psychotherapy research field. First, clients' preferences for treatment have been identified as a 'demonstrably effective' factor in determining their clinical outcomes (Swift, Callahan & Vollmer, 2011). Clients who receive a preferred intervention are 'between a half and a third less likely to drop out of therapy prematurely compared with clients who did not receive their preferred therapy conditions' (Swift et al., 2011, p.307); and also show a small but significant increase in outcomes (d=0.31). 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 et al., 2012; Tryon & Winograd, 2012). Third, there is research to suggest that flexible practice, tailored the needs of individual clients, can lead to improved outcomes and greater engagement with therapy (Chu & Kendall, 2009; Ghaderi, 2006; Jacobson et al., 1989). This is supported by qualitative interview evidence which suggests that clients experience therapist flexibility as helpful and important to the relationship (Perren, Godfrey & Rowland, 2009). Fourth, randomised controlled studies indicate that the use of systematic client feedback can significantly enhance therapeutic outcomes (Lambert & Shimokawa, 2011; Schuman et al., 2014), with feedback-informed treatment recognised as an evidence-based programme by the US Government's Substance Abuse and Mental Health Services Administration (SAMHSA).

As a pluralistic intervention for depressed clients has yet to be tested, the aims of the present study were to evaluate the outcomes of this therapy, its acceptability to clients, and the pathways by which it might bring about therapeutic change.

Method

Design

An open-label, non-randomised trial design was adopted, in which all participants were offered up to 24 weeks of pluralistic therapy for depression. Clinical outcomes were assessed by comparing scores on psychological measures at baseline and endpoint. Process measures were used to assess the acceptability of the intervention, and qualitative data was used to identify the helpful aspects of the therapy. Ethical approval was obtained from the first author's University Ethics Committee prior to the commencement of data collection.

Participants

Participants were accepted into the study if they scored 10 or more on the Patient Health Questionnaire-9 (PHQ-9) at assessment, indicating moderate or more severe levels of depression. Participants were excluded if their primary presenting problem was assessed as being psychosis, personality disorder(s), or drug use.

In total, 48 individuals were assessed for participation in the study: 16 at Site A, 13 at Site B, ten at Site C, and nine at Site D. Of these, four (8.3 per cent) were excluded from the study because they scored nine or less on the PHQ-9. No demographic data were retained on these participants. A further two participants were accepted into the study, but their data were subsequently excluded as they had been wrongly accepted into the study with a PHQ-9 score of 9. Three participants (7.1 per cent of those correctly accepted into the study) dropped out after the assessment session, all at site D. As no endpoint data were available for these participants, they were dropped from further analysis.

Of the 39 participants who engaged in the intervention and for whom outcome data were available ('treatment sample'), 24 had planned endings (61.5 per cent) and 15 had unplanned endings (38.5 per cent). The mean number of sessions was 14.4 (*SD*=7.7, 562 sessions in total), with a range of three to 25 sessions (one client was inadvertently offered an additional session), and a median of 13 sessions. Ten of the participants (25.7 per cent) took the maximum number of sessions available.

The mean age of the 39 participants in the treatment sample was 30.9 (*SD*=11.8), with a range of 18 to 58 (see Table 1). The sample was predominantly female (*N*=28, 71.8 per cent), of a white European ethnic origin (*N*=30, 76.9 per cent), and non-disabled (*N*=35, 89.7 per cent). Approximately half of the participants were in full-time education (*N*=20, 51.3 per cent) and half were not (*N*=19, 48.7 per cent). Almost half of the sample (46.1 per cent) met PHQ-9 criteria for severe depression at baseline (PHQ-9 score ≥20), with a mean score of 18.4 (*SD*=4.3). Similarly, approximately half of the participants (48.7 per cent) met GAD-7 criteria for severe anxiety (GAD-7 score ≥15), and 35 (89.7 per cent) were above the clinical cut off for an anxiety disorder (GAD-7 ≥8), with a mean score of 14.5 (*SD*=4.7).

All participants were invited to take part in an end of therapy *Change Interview*, and 18 consented to do so (42.9 per cent of the full sample). The participants who were interviewed did not differ significantly from non-interviewees by gender, ethnicity, disability status or baseline levels of distress; but were more likely to be older (F=7.7, p=.001) and less likely to be in full-time education (χ^2=5.0, p=.03). In addition, they had a significantly greater number of sessions (Mean interviewees=20.1, Mean non-interviewees=9.5) and were more likely to have had a planned treatment ending (χ^2=15.3, p<.001).

Analysis of data from the Helpful Aspects of Therapy (HAT) form was conducted for 22 participants at two of the four sites: B and C. These participants did not differ significantly from the non-HAT participants by gender, ethnicity, disability status, levels of baseline distress, number of sessions, or planned/unplanned ending. However, they were significantly younger (t=4.5, p<.001),

Table 1: Participant characteristics at baseline (treatment sample, N=39).

Age (years), mean ± SD	30.9 ± 11.8
Gender, N (%)	
Female	28 (71.8%)
Male	11 (28.2%)
Ethnicity	
BME	9 (23.1%)
White European	30 (76.9%)
Disability	
Disabled	4 (10.3%)
Non-disabled	35 (89.7%)
Student	
In full-time education	20 (51.3%)
Not in full-time education	19 (48.7%)
Depression[a]	
Moderate depression	11 (28.2%)
Moderately severe depression	10 (25.6%)
Severe depression	18 (46.1%)
Anxiety[b]	
Minimal anxiety	0 (0%)
Mild anxiety	8 (20.5%)
Moderate anxiety	12 (30.8%)
Severe anxiety	19 (48.7%)

[a] Based on PHQ-9 scoring: 10–14=Moderate depression, 15–19=Moderately severe depression, 20–27=Severe depression.

[b] Based on GAD-7 scoring: 0–4=Minimal anxiety, 5–9=Mild anxiety, 10–14=Moderate anxiety, 15–21=Severe anxiety.

and more likely to be in full-time education (χ^2=28.6, p>.001). In total, data from 253 HAT forms were analysed.

Materials

Demographics Form

A simple Demographic Form recorded participant gender, age, occupation, ethnicity (open response format), and presence of a disability.

Patient Health Questionnaire Depression (PHQ-9) Scale

The PHQ-9 is a brief self-report measure for detecting severity of depression symptoms in a general population. Respondents are asked to rate how bothered they have been by a range of problems over the last two weeks, such as 'Feeling down, depressed, or hopeless.' There are nine items, and responses are given on a four-point Likert scale from *Not at all* (0) to *Nearly every day* (3). Scores are totalled, and severity of depression is rated as none (0 to 4), mild (5 to 9), moderately severe (15 to 19) or severe (20 to 27). The PHQ-9 has high internal consistency (Cronbach's α=0.89), good test-retest reliability (r=.84) (Kroenke, Spitzer & Williams, 2001), and good convergent validity when correlated with the SF-20 mental health subscale (r=.73).

Generalised Anxiety Disorder 7-item (GAD-7) Scale

The GAD-7 is a brief self-report measure to assess symptom severity of general anxiety disorder. As with the PHQ-9, respondents are asked to rate how bothered they have been by a range of problems over the last two weeks, such as 'Feeling nervous, anxious or on edge.' There are seven items and, as with the PHQ-9, responses are on a four-point Likert scale from *Not at all* (0) to *Nearly every day* (3). The scale has high internal consistency (Cronbach's α=.92), high test-restest reliability (r=.83), and good convergent validity against the Beck Anxiety Inventory (r=.72) (Spitzer et al., 2006).

Goals Form

The Goals Form is an individualised outcome measure used to assess attainment of personal objectives for therapy. It was developed for an initial open-label trial of pluralistic therapy for depression (Cooper, 2014), and showed good inter-item reliability (α=.93), and convergent validity (r=–.61) with the CORE-OM (Barkham et al., 2001) (Michael & Cooper, 2014).

The Goals Form invites clients, in collaboration with their therapist, to identify up to seven goals for therapy – typically at a first assessment session – and then to rate them on a seven-point Likert scale, with 1 being *Not at all achieved* and 7 being *Completely achieved* (Cooper, 2012). The agreed goals are then typed onto a digital copy of the form and printed off, such that the client is able to rate the same goals at regular intervals. Procedures for the form allow for the addition, modification or deletion of goals.

Session Effectiveness Scale (SES)

The SES is a four item measure of session effectiveness (Elliott, 2000). Clients are asked to rate on a seven-point Likert scale how they feel about the session just completed (*Perfect* to *Very poor*), how much progress they feel they are making (*A great deal* to *My problems have gotten worse*), whether something shifted (*Not at all* to *Very much*); and on a nine-point Likert scale how helpful or hindering the session was overall (*Extremely hindering* to *Extremely helpful*). Inter-item reliability in the current sample was acceptable (Cronbach's α=.76).

Helpful Aspects of Therapy (HAT) Form

The HAT Form is a post-session self-report instrument developed by Llewelyn (1988) that gathers information about the client's perception of helpful and hindering events in psychotherapy. The form contains seven questions, though only data from the first two questions were analysed for the present study. These were, 'Of the events which occurred in this session, which one do you feel was the most helpful of important for you personally? (By event we mean something that happened in the session. It might be something you said or did, or something your therapist said or did);' and 'Please describe what made this event helpful/important and what you got out of it'. Participants were also asked to rate how helpful or hindering the particular event was on a nine-point Likert scale with 1 being *Extremely hindering* and 9 being *Extremely helpful*.

Change Interview

The Change Interview is a semi-structured qualitative instrument, developed by Elliott, Slatick and Urman (2001) with the aim of eliciting the clients' personal overview and evaluation of their therapeutic experience. For the purposes of the present study, a modified form of the Change Interview was implemented. This consisted of 10 questions and was focused on clients' descriptions regarding: (a) any changes during treatment; (b) the possible reasons behind them; and (c) aspects of therapy that may have helped or hindered these change processes. In addition, clients were asked to rate how helpful they have found each of the outcome and process measured used in the study on a five-point Likert scale, where 1 is *Very unhelpful* and 5 is *Very helpful*. Interview lasted for approximately 30 to 90 minutes.

Session Rating Scale

The Session Rating Scale (SRS) is an ultra-brief post-session measure of the therapeutic alliance (Duncan et al., 2003). Clients are asked to indicate on four lines the extent to which they feel their therapists understand them, are working towards similar goals, are a good fit, and the quality of the session overall. Scoring ranges from 0 to 10 on each item giving a maximum of 40. The measure has adequate inter-item consistency (Cronbach's α=.88), test-retest reliability (r=.63), and concurrent validity against the revised Helpful Alliance Questionnaire (HAQ-II, r=.48, p<0.01).

Working Alliance Inventory – Short Form (WAI S)

The client-completed version of the WAI S is a 12-item measure of the quality of the therapeutic alliance (Tracey & Kokotovic, 1989). Items, such as 'We agree on what is important for me to work on', are rated by clients on a 1 (*Never*) to 7 (*Always*) scale, giving a total score that ranges from 12 to 84. The WAI-S is a widely used measure and has high levels of internal consistency (Hanson, Curry & Bandalos, 2002).

Alliance Negotiation Scale (ANS)

The client-completed version of the ANS is a 12-item measure of the extent to which clients feel that they can constructively negotiate disagreements about tasks and goals with their therapists (Doran et al., 2012). As with the WAI-S, clients are asked to rate items such as 'My therapist encourages me to express any concerns I have with our progress' on a 1 (*Never*) to 7 (*Always*) scale, with scores on half of the items reversed to give a total alliance negotiation score from 12 to 84. The measure has adequate inter-item consistency (Cronbach's α=.84) and convergent validity against the WAI (r=.75, p<.001).

Procedure

Recruitment

At sites A and D, participants were recruited through information distributed at local public health centres. At site B, participants were recruited through an internet notice and through the University's established counselling service. At Site C, participants on the waiting list for the established University counselling service were contacted, and asked if they would like to participate in the trial.

Assessment

Participants who expressed an interest in the study were sent an information sheet. If they subsequently contacted the site to indicate that they were interested in participating, they were invited to an assessment interview. Participants were sent copies of the PHQ-9, GAD-7 and the Demographics Form and asked to bring them completed to the assessment.

The assessment interviews were conducted by the therapists in the trial. At the commencement of the assessment session, the assessor went over the information sheet, answered any questions, and then invited the prospective participant to sign the consent form. They were then asked to submit, or complete if they had not already done so, the PHQ-9, GAD-7, Demographics Form, and a brief client identity form to record their personal contact details. If participants' PHQ-9 scores were nine or less, they were informed that, unfortunately, they were ineligible for participation in the trial, and alternative sources of support were discussed with them.

If participants' PHQ-9 scores were 10 or greater, the assessor went on to explore with them their reasons for seeking therapy, their background and history, and the personal goals that they were hoping to achieve in therapy. Once wording for these goals were agreed, these were recorded, and scored, on the Goals Form.

Participants were then invited to complete the Therapy Personalisation Form Assessment (TPF-A). This is a tool developed within the pluralistic paradigm to help personalise therapy to the individual client's particular preferences (Bowen & Cooper,

2012). Clients are asked to indicate how they would like their therapist to be on 20, 11-point dimension: for instance, *Be challenging – Be gentle*. This is then used as the basis for meta-therapeutic dialogue on the clients' particular therapeutic wants.

Sessions

Participants were offered up to 24 weekly sessions of pluralistic therapy for depression. This was conducted by the therapist that had conducted their assessment. At the start of each session, participants were invited to complete the PHQ-9, GAD-7 and their personalised Goals Form. At the end of each session, they were invited to complete the HAT form and the SRS. All sessions were electronically recorded.

Review sessions

A review of the therapeutic work was conducted at approximately session four and session 10. Participants were asked to complete the TPF, WAI and ANS, and their experience of the therapeutic work was discussed. They were also asked to review their goals and, where appropriate, the Goals Form was modified.

Follow-up interview

At the end of therapy, participants were invited back to meet with an independent researcher to take part in the Change Interview. They were also asked to complete an endpoint PHQ-9, GAD-7 and GAF.

Therapists

The 39 completer participants were seen by 12 therapists (mean=3.3 participants per therapist, range=1 to 8 participants per therapist). Five of the therapists were male (41.7 per cent) and seven were female (58.3 per cent). Two of the practitioners (13.3 per cent) were qualified counselling psychologists with a mean of approximately 20 years' experience as clinicians. Ten of the practitioners (86.7 per cent) were trainees on a three year doctorate in counselling psychology programme, in the final or penultimate year of their studies. All practitioners had received training in person-centred/humanistic practice, along with varying levels of training in cognitive-behavioural and psychodynamic therapy. In addition, all participants had received input or training on a pluralistic approach to therapy, and were committed to working in a pluralistic way for the purposes of the trial.

Pluralistic therapy for depression

Pluralistic therapy was delivered in accordance with a treatment manual (McLeod & Cooper, 2012b) that specified four general phases of therapy. Phase one consisted of developing a collaborative relationship, eliciting the client's story, identifying client strengths and resources, and agreeing a set of therapeutic goals. Phase two involved establishing a collaborative case formulation and a plan of work. Phase three consisted of engaging in activities that client and therapist have identified as likely to facilitate change in the direction of the client's goals. Phase four consisted of bringing the therapy to an end: reviewing and consolidating progress, and anticipating and preventing relapse. Within each session, on-going meta-therapeutic communication and discussion of client process and outcome ratings were used to ensure collaborative alignment with client goals and tasks.

Therapists were encouraged to draw on, from within their competencies, a wide range of change processes of potential relevance to the efforts of the client to overcome depression. These included:

1. cognitive interventions (e.g. challenging irrational thoughts);
2. working with feelings (e.g. helping clients express and be aware of feelings and emotions);
3. helping clients develop a coherent narrative/explanatory model that makes links between current difficulties, underlying reasons, and possibilities for change;
4. exploring and initiating change within patterns of interpersonal relating;
5. planned behaviour change (e.g. home-

work tasks to enable various forms of behavioural activation);
6. use of self-help reading;
7. information-giving (e.g. explaining relevant psychological concepts);
8. identifying client strengths and how they can be applied;
9. identifying cultural resources (e.g. friendships);
10. enabling clients to understand the significance of their family system;
11. enabling clients to appreciate the significance of cultural-political factors in their lives (e.g. racism, domestic violence);
12. expressive art-making;
13. coming to terms with circumstances that stifled hope (e.g. physical illness);
14. identifying and making use of physical interventions to alleviate depression (e.g. antidepressant medication, herbal remedies).

Adherence

All therapists received monthly individual supervision from one of the founders of the pluralistic approach to therapy. This supervisor checked the practitioners' adherence to protocol using a pilot version of a pluralistic therapy adherence scale (McLeod & Cooper, 2012c). All therapists who contributed completed cases to the study were deemed to have been practising according to the pluralistic therapy for depression guidelines. One therapist whose practice was not in accordance with the protocol withdrew from the study on health grounds following six sessions of their first case. This case was transferred to another therapist, who completed work with the client. Therapists' also self-assessed their adherence to pluralistic practice using a structured note form, completed after the end of each session of therapy.

Analysis

Baseline scores were taken from measures completed at initial assessment. Endpoint scores were taken from measures completed at post-therapy change interview or, where not attended, the last completed measure.

To assess rates of clinical improvement, we used the formulae provided by Gyani et al. (2013) in their analysis of IAPT data. Clients were deemed to have *reliably recovered* if they showed reliable improvement during treatment (improvement on PHQ-9 >5.2, improvement on GAD-7 >3.53, Gyani et al., 2013), and scored below the clinical cut-offs on both the PHQ-9 (<10) and the GAD-7 (<8) at endpoint. Clients were deemed to have *reliably improved* if their PHQ-9 or GAD-7 showed reliable improvement and their score for the other measure did not reliably deteriorate. Clients were deemed to have *reliably deteriorated* if their PHQ-9 or GAD-7 score worsened to a reliable extent, and the score for the other measure did not reliably improve.

To calculate baseline-to-endpoint effect sizes on the PHQ-9, GAD-7 and Goals Form, we used the formulae for Cohen's *d* adopted by Stiles et al. (2008): the mean baseline to endpoint difference divided by the baseline standard deviation.

We used ANOVA tests to evaluate whether the amount of change on the PHQ-9 and GAD-7 was related to site, gender, ethnicity, student status and disability status; and correlational tests to evaluate whether it was associated with number of sessions and age. To adjust for the possibility of type II errors, we used a Bonferroni-corrected alpha of .007 (α=.05 for seven tests).

For the Goals Form, we compared the mean first ratings of clients on their goals against their mean last rating. As goals may have been added or deleted during the course of therapy, these first and last ratings did not necessarily correspond to ratings at baseline and endpoint sessions. Modified goals were treated as new goals. Participants were only included in this analysis if they had at least one goal that was present for three sessions or more.

Data from the Change Interviews and HAT forms were analysed independently, using thematic analysis (Braun & Clarke,

2006). Text relating to helpful factors was organised into themes and sub-themes, and then organised into three *a priori* domains: client activities, therapist activities, and helpful outcomes. Text selections in both studies could be coded into more than one theme/sub-theme, where appropriate. For the HAT data, we counted the number of helpful events that had been coded into each theme or subtheme, and the mean rating of helpfulness for events within that theme or subtheme. For the Change Interviews, we counted the number of participants who had one or more selection of text coded within that theme or subtheme.

For the Session Effectiveness Scale, we calculated a standardised mean score of helpfulness for each session that could range from 1 (*extremely unhelpful*) to 10 (*extremely helpful*). To achieve this, we reversed scored items 2 and 3, divided all scores by the scale length, averaged the scores, and then multiplied by 10.

Results

Reliable and clinical change

Based on combined data from the PHQ-9 and GAD-7, 28 participants showed reliable improvement (71.8 per cent of completers, 66.6 per cent of all assessed), 17 showed reliable recovery (43.6 per cent of completers, 40.4 per cent of all assessed), four showed reliable deterioration (10.3 per cent of completers, 9.5 per cent of all assessed), and seven (17.9 per cent of completers, 16.7 per cent of all assessed) showed no change in their clinical status.

Depression

The mean PHQ-9 score for the 39 completer participants at endpoint was 10.6 (*SD*=7.1) (Table 2). This indicates a mean reduction of 7.8 points (range=–4 to 22): an effect size (Cohen's *d*) from baseline to endpoint of 1.81. By endpoint, 18 participants (46.2 per cent) showed clinical improvement on the depression measure, 29 (66.6 per cent) showed reliable improvement, and none showed reliable deterioration. Change from baseline to endpoint on the PHQ-9 was not significantly related to any of the predictor variables.

Anxiety

The mean GAD-7 score for the 39 participants at endpoint was 9.1 (*SD*=6.1). This indicates a mean reduction of 5.4 points (range=–10 to 17): an effect size (Cohen's *d*) from baseline to endpoint of 1.14. Of the 35 participants who met criteria for an anxiety disorder at assessment, 14 (40 per cent) showed clinical improvement and 23 (65.7 per cent) showed reliable improvement. Four of the 39 participants (10.3 per cent) showed reliable deterioration in levels of anxiety. Change from baseline to endpoint on the GAD-7 was not significantly related to any of the predictor variables.

Table 2: Change from baseline to endpoint.

Measure	*N*	Baseline		Endpoint		*d*
		Mean	*SD*	*Mean*	*SD*	
PHQ	39	18.4	4.3	10.6	7.1	1.81
GAD	39	14.5	4.7	9.1	6.1	1.14
Goals Form	31	2.5	1.1	4.2	1.3	1.55

Note: Cohen's *d*=(Baseline Mean–Endpoint Mean)/Baseline SD (Stiles et al., 2006).

Personal goals

Data on the Goals Form was not available for three participants. In addition, for five participants, the procedure for the Goals Forms had not been followed correctly, and clients had been asked to re-set goals at the start of each session.

For the 31 participants for whom appropriate data were available, the mean rating of goal attainment at first measurement was 2.5 (*SD*=1.1), and this increased to 4.2 (*SD*=1.3) at last measurement. This was a significant increase ($p<.001$) of 1.7 points, with an effect size (Cohen's *d*) of 1.55.

Process measures

Ratings of session effectiveness on the SES (range=1 to 10) were available for 527 of the 562 sessions (93.8 per cent). The mean was 7.4 (*SD*=1.5, Table 3). In terms of raw scores, the mean session rating on the first, helpful-hindering item (range=1 to 9) was 7.6 (*SD*=1.3, between *Moderately helpful* and *Greatly helpful*), with a median rating of 8 (*Greatly helpful*). Ratings of the therapeutic relationship on the SRS (range=0 to 40) were available for 524 of the 562 sessions (93.2 per cent), and the mean rating across all sessions was 37.3 (*N*=524 observations, *SD*=4.3), with 43 per cent of sessions given the maximum rating of 40. At session four, the WAI-S (range=12 to 84) had a mean of 67.1 (*SD*=11.4) on the, and at session 10 of 70.1 (*SD*=10.1). The Alliance Negotiation Scale (range=12 to 84) at session four had a mean of 66.4 (SD=12.0) and at session 10 of 70.9 (*SD*=9.6).

Helpful aspects of therapy

In terms of client activities, 11 clients (61.1 per cent of respondents) indicated in the Change Interview that their own *active engagement with therapy* had been a helpful factor. From the post-session HAT forms, the most frequently coded client activity was *exploring/talking about things* (*N*=84, *mean rating of helpfulness*=7.5), including *specific difficulties* (*N*=38, *mean*=7.7), *emotions* (*N*=20, *mean*=7.6), *relationships* (*N*=18, *mean*=7.1), and *past events* (*N*=8, *mean*=7.9). The two other most commonly coded helpful client activities on the HAT forms were *being open and honest* (*N*=16, *mean*=8.1) and *recognising progress* (*N*=10, *mean*=8.3).

In terms of helpful therapist activities, clients in the Change Interviews primarily referred to relational practices. This included *offering positive regard* (*N*=18, 100 per cent), *being empathic* (*N*=17, 94.4 per cent), *helping the client to feel relaxed* (*N*=12, 66.7 per cent), *being challenging* (*N*=10, 55.6 per cent), *empowering* (*N*=10, 55.6 per cent),

Table 3: Ratings of the PfD therapeutic process.

Measure	Mean (SD)	Median (range)	*N*
SES	7.4 (1.5)	7.3 (3.5–10)	527
SRS	37.3 (4.3)	39.3 (17.2–40)	524
WAI-S S4	67.1 (11.4)	68.5 (43–83)	30
WAI-S10	70.1 (10.1)	72 (50–84)	19
ANS S4	66.4 (12.0)	70 (37–84)	31
ANS S10	70.9 (9.6)	69 (50–84)	20

Note: SES=Session Effectiveness Scale, average across all ratings.
SRS=Session Rating Scale, average across all ratings.
WAI-S=Working Alliance Inventory – Short Form,
ANS=Alliance Negotiation Scale. S4=Session 4. S10=Session 10.

and *using techniques* (*N*=8, 44.4 per cent). In addition, clients referred to two therapist activities that were closely related to principles of pluralistic practice. The first of these was *responsiveness to clients' needs* (*N*=12, 66.7 per cent), for instance 'You had a say in what was going on so that I think was great.' The second was therapist *flexibility* (*N*=8, 44.4 per cent), for instance, 'I think one of the reasons that it helped […] we might be working on one thing for the next week but it had to get shelved because there was some disaster that I was not able to cope with.' In contrast to this relational emphasis, clients on the HAT forms primarily emphasised the *use of techniques* (*N*=59, *mean*=7.7), particularly *CBT techniques* (*N*=26, *mean*=7.8) and *psychoeducation* (*N*=15, *mean*=7.3).

In terms of helpful outcomes, clients in the Change Interviews referred to *behavioural change/ problem solving* (*N*=18, 100 per cent) and developing *insight* (*N*=13, 7.2 per cent). The development of *insight* was also the most commonly cited helpful outcome on the HAT forms (*N*=99, *mean*=7.8), as well as the development of *alternative perspectives* (*N*=42, *mean*=7.7). On the HAT forms, participants also described the development of *changed self-images* (*N*=25, *mean*=8.2), *changed emotions* (*N*=24, *mean*=8), and *new coping strategies* (*N*=23, *mean*=7.4).

Ratings of measures

Clients' rated the Goals Form as the most helpful measure (*mean*=4.2, *SD*=1.2), followed by the HAT Form (*mean*=3.9, *SD*=1.2), and the TPF-A (*mean*=3.8, *SD*=1.2) (Table 4). The modal rating for each of these three forms was 5 (*very helpful*). The form that was rated as least helpful was the WAI-S, with a mean rating of 3.1 (*SD*=1.0) and a modal and median score of 3 (*neither helpful or unhelpful*).

Discussion

The findings from this study suggest that the majority of clients in pluralistic therapy for depression experienced improvements: with reduced levels of anxiety and depression and greater attainment of personal goals. Changes in mental well-being for clients who engaged with therapy were consistent with outcomes for the Improving Access to Psychological Therapies Pro-gramme (Gyani et al., 2013): for reliable recovery, PfD=43.6 per cent, IAPT=40.3 per cent; for reliable improvement, PfD=71.8 per cent, IAPT=63.7 per cent; and for reliable deterioration: PfD=10.3 per cent, IAPT=6.7 per cent.

Levels of engagement in PfD were relatively high. Just three of the 42 participants did not engage with therapy following assessment (7.1 per cent), and this is at the lowest end of the range identified by Wierzbicki and Pekarik (1993) of 7 per cent to 36 per cent. This can also be compared against the IAPT data, where 24.5 per cent of all participants assessed went on to engage with therapy and have two or more sessions. Although many of these clients may have been referred elsewhere, Callan and Fry (2012) argue that this indicates that the actual recovery rates for IAPT services is 14 per cent to 17 per cent of all clients assessed, which compares against 40.4 per cent in the present study. Drop out in the present study was also at acceptable levels, with 38.5 per cent having unplanned endings, compared against average unplanned ending rates reported in recent reviews of 46.86 per cent on average (Wierzbicki & Pekarik, 1993), 35 per cent (Roos & Werbart, 2013) and 20 per cent (Swift & Greenberg, 2012) . This finding is consistent with previous research suggesting that clients are more likely to stay in therapy if they feel they are receiving the intervention that they want (Swift et al., 2011).

Process measure ratings indicated that, on average, the clients found the PfD sessions helpful. Ratings on alliance and negotiation measures indicated that the intervention was generally acceptable to clients.

In terms of helpful processes, the factors identified by clients in pluralistic therapy were relatively consistent with those found more broadly across the therapeutic spectrum (e.g. Timulak, 2007). Clients felt that

Table 4: Clients' ratings of helpfulness of systematic feedback measures.

Measure	Mean (SD)	Median	Mode	N
PHQ-9	3.7 (1.0)	4	4	17
GAD-7	3.7 (1.1)	4	4	18
Goals Form	4.2 (1.2)	5	5	17
HAT	3.9 (1.2)	4	5	18
SRS	3.7 (1.1)	4	4	18
WAI-SF	3.1 (1.0)	3	3	17
ANS	3.6 (0.9)	4	4	17
TPF-A	3.8 (1.2)	4	5	18
TPF	3.5 (1.0)	4	4	17

Note: PHQ-9=Patient Health Questionnaire depression 9 item scale; GAD-7=Generalised Anxiety Disorder 7 item scale; HAT=Helpful Aspects of Therapy form (including Post-session Satisfaction Scale); SRS=Session Rating Scale; WAI=Working Alliance Inventory – Short Form; ANS=Alliance Negotiation Scale; TPF-A=Therapy Personalisation Form – Assessment; TPF=Therapy Personalisation Form. Measure ratings: 1=*very unhelpful*, 2=*unhelpful*, 3=*neither*, 4=*helpful*, 5=*very helpful*.

they had brought about change by actively engaging with therapy and talking about their problems, feelings and relationships. This had been facilitated by therapists who were accepting and empathic; but who were also challenging and used a range of techniques, particularly CBT methods and psychoeducation. This led to the development of insight, and changes in behaviours. Consistent with a pluralistic approach, clients found *both* relational and technical therapist factors helpful, though it was interesting to note that the Change Interview and the HAT forms brought out different emphases. The Change Interviews also indicated that clients tended to find the specifically pluralistic elements of the therapy helpful: the therapists' responsiveness to their needs and their flexibility. In addition, the ratings of the measures indicated that clients tended to value the specifically pluralistic tools, in particular the Goals Form. However, two participants in the Change Interviews indicated that, at times, they would have liked more guidance from their therapists on the particular method of treatment.

Limitations of the study were that the sample was relatively small and select, with a large proportion of university students. Therapists had a limited amount of training in the pluralistic approach and were relatively inexperienced, with the majority being trainees. Adherence to the pluralistic approach was not formally audited. As the trial was uncontrolled, inferences cannot be made about the effectiveness of the approach, and comparison with IAPT data can provide only the most approximate indicators of relative effectiveness. Change Interview data came from an unrepresentative selection of participants: those who were in therapy for longer and were more likely to have planned endings. It is probable, therefore, that it comprises an overly-positive representation of PfD. In addition, we did not report on unhelpful factors, though these were mentioned only infrequently, and the only factor reported three or more times was an insufficient number of sessions. Around seven per cent of the data on the session-by-session process measures were also missing.

Despite these limitations, the findings of this study provide preliminary evidence that a pluralistic therapy for depression is acceptable to clients and produces outcomes which are within the range of other psychological interventions. This is particularly encouraging given that many of the clients in the present study had longstanding, complex problems and had previously been in therapy or psychiatric care. Further research is needed, however, to develop and refine this pluralistic approach. Case studies and further analyses of the qualitative data are required to identify specific pathways of change that clients with depression might go through; and there is also a need to examine heterogeneity of change processes across clients. Another area for further research work is the development and validation of an adequate adherence scale for PfD. Ultimately, PfD will need to be trialled against a comparative therapy, such as CBT for depression or Counselling for Depression (CfD; Sanders & Hill, 2014), to see whether this pluralistic approach gives added value to outcomes, or to other factors such as engagement rates or client satisfaction.

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