

## Learning and Change within Person-centred Therapy: Views of Expert Therapists

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### Published version

MACASKILL, Ann, RENGER, Susan and NAYLOR, Bill (2020). Learning and  
Change within Person-centred Therapy: Views of Expert Therapists. *Counselling and  
Psychotherapy Research*.

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# **Learning and Change within Person-centred Therapy:**

## **Views of Expert Therapists**

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## **Abstract**

### **Aims**

Traditionally in Person-centred Therapy (PCT) clients are counselled for as long as required. It is a non-directive process. Recently, financial constraints have introduced time limits for therapy in health care, so it seemed appropriate to revisit the practice of PCT in the current UK context. The aim was to explore the concepts of learning and change within PCT and whether learning is facilitated.

### **Method**

Five experienced person-centred therapists, who were involved in educating therapists, participated in semi-structured interviews. Questions explored their views on learning and change in therapy, whether learning processes can be facilitated in PCT - both philosophically and practically, and the outcomes of PCT. Therapists were not specifically asked about time pressure but rather it was left to see if it emerged as an issue.

### **Results**

Ten major themes emerged; learning and change, goals, learning process, PCT process, issues on non-directivity, questioning, outcomes, assessment and diagnosis, and other methods used. The issue of time pressure permeated many of these themes. Views were often contradictory reflecting the inconclusive views in the literature, particularly in relation to how clients learn and the relationship between change and learning.

### **Discussion**

The issue of directivity seemed to cause cognitive dissonance, with participants wanting to be directive to deal with time pressures, but not wanting to be disloyal to Rogers' PCT principles. Processes of learning and change were acknowledged as important, but little clarity was obtained on their current application.

**Keywords:** Person-centred, therapy, learning, change, process, time pressure

## **1 INTRODUCTION**

### **1.1 Background**

Rogerian Person-centred Therapy (PCT) is defined by its non-directive and client led foundations. Rogers' intention was that it would take as long as the client required to reach a point that was satisfactory for them. The financial constraints in health care in recent years have introduced strict time limits for therapy which arguably must impact on PCT processes and outcomes. Given this context and the seminal work that Rogers produced on self-directed learning it seemed pertinent to explore the concept of learning within therapy with Rogerian trained therapists, to establish whether there may be potential for learning theory to enable a more time efficient/focused person-centred approach.

The traditional perception of change within a person-centred therapeutic relationship is based on Rogers' notion of the actualising tendency. He believed that humans are "exquisitely rational, moving with subtle and ordered complexity towards the goals his organism is endeavouring to achieve" (Kirschenbaum & Henderson, 1997, p.406). Therefore, therapeutic change meant being "constantly in process," "without a fixed and permanent essence" (Woolfe, 2010, p.137). He said "to be what one is, is to enter fully into being a process" (Rogers, 2004, p.176). This was in contrast to Maslow (1943), whose self-actualised person could, in theory exist. According to Rogers, the actualising tendency is linked closely to our own organismic valuing process - our natural tendency to decide what is good for us. Rogers believed that like potatoes whose roots struggle to reach light, we have an innate tendency to

move in the direction of the best condition for us. This theory suggests a directional and selective tendency towards positive growth and fulfilment. Further, the person centred approach suggests that psychological difficulties are caused by blockages to the actualising tendency which need addressing. Rogers concept of the self suggests that the disintegrated parts of the self which result in a dysfunctional state are usually the 'self-concept' and the 'ideal self', and it is the process of integration which defines therapeutic change. This facilitates movement from fixity to flowingness, from rigidity towards being 'in-motion' along a continuum of personality change (Rogers, 2004). Further, according to Rogers, there are seven stages which define this process of change with various characteristics such as an increased differentiation of feelings, an increased ownership of self-feelings and an increasing acceptance of self-responsibility.

McMillan (2004) comments on the inherent difficulties in addressing the issue of change in a person-centred context. In order to establish whether an individual has in fact changed for the better aligns the process to that of the medical model whereby a change is clearly measurable. Assessing change in deeper structures, which can be perceived differently by different clients and at different points in the therapy process, makes the definition of change very difficult. Rogers agrees (2004), however he also suggests that if the therapy experience is significant, where learning brings about change, then these changes should be amenable to research investigation. And in order to demonstrate this concrete therapeutic process, Rogers (2004) and his team conducted a study which demonstrated therapeutic gains in areas such as

being submissive, not trusting emotions and being afraid of what other people think.

Griffiths and Griffiths (2013) recommend the use of the Unconditional Positive Self-Regard (UPSR) scale for evaluating therapeutic change for client-centred practitioners. It requires ratings of statements such as “I really value my- self” and “Whether other people criticize me or praise me makes no difference to the way I feel about myself”, enabling the practitioner to establish the degree to which a change in the client’s unconditional positive self-regard has been made. However, this measure confines itself to only one aspect of potential humanistic outcomes. There appears to be little to explain change in PCT other than Rogers’ original writings.

Literature on learning is usually found within the academic disciplines of psychology and in its applied form in Education. Therapy, although often situated within psychology or education, is seen as a distinct discipline. However, early on, Combs (1954) asserted that learning is the essence of therapy, with clients learning to interact better with themselves and their surrounding world. Learning theorists have described, over the years, various ways in which humans solve problems, change and grow. Typically, this has resulted in an array of methods designed to teach individuals. More recently the idea of Mathetics puts the focus for learning on the individual and assigns a peripheral role to the teacher (Fino, 2017). This focus on the individual learner is largely as a result of the pioneering work of Rogers and Freiberg (1969) and Knowles (1978).

Rogers, whilst being known for Client-centred Therapy (2003), is less well known for his equally ground-breaking ideas on education. Frustrated by the behaviourist approaches of the day, Rogers wrote extensively on what he called *client-focused* learning (Rogers & Freiberg, 1969). This relies on the self-directed nature of the individual to define and pursue their own learning processes rather than being taught. He concluded that the only significant learning is that which is self-discovered and self-appropriated. He explained that core therapeutic conditions provided the foundation for learning, but to enable the learning process, the facilitator provided the learning resources. This was not a 'teaching' process, but a facility available to the self-directed individual to make use of as they saw fit. His students were not only encouraged to set their own goals, but to define their own curriculum, plan learning activities and then to assess their own work.

Subsequently, adult education has been influenced by Knowles' theory of Andragogy which was based on Rogers' views on the actualising tendency and the importance of the relationship between teacher and learner in facilitating learning (Knowles, 1978). The core assumptions of this approach are that adults need to know why they need to learn before they will learn, and the adult learner's self-concept needs to be acknowledged as being self-directed. This mathetic perspective has developed over time and still provides a foundation for current educational approaches.

Rogers saw clear benefits in applying his therapeutic principles within the classroom, but he did not link the principles of self-directed learning to PCT. These strands of his work have remained distinct. Separately, work on



embedding learning within therapy has progressed with approaches such as Cognitive Behaviour Therapy (CBT) using teaching and learning methodologies. Even so, retention of therapeutic learning is often poor even in CBT (Gumport, Dong, Lee, & Harvey, 2018), which is a significant problem when long term learning and change is the aim. Learning has also been addressed to some extent in other schools of therapy. For example, Gestalt principles explain insight; cognitive schemata explain individual perceptions of the world; and behaviourist principles are applied to facilitate behaviour change. However, generally, any learning which is enabled in current practice is often done from the perspective of teaching. Thus, a CBT practitioner can teach a client to view a threatening situation in a different way, or a psychoanalyst may explain the relationship between a client's current view of their world and their childhood experiences.

The view of therapist as learning facilitator, tasked with initiating, crystallising, and enabling the transfer of learning, is to date, not considered. Neither is there an aim to focus on learning *about* therapeutic processes and to embed that learning for clients to use at a later date. Further, the purposeful and complete integration of therapy and learning theory with the specific intent of improving the efficacy of therapy has yet to be addressed. Thus, the questions remain; how does change occur in PCT, is there a learning process involved, and what part does the therapist play in these change processes? On the basis of this information, it then becomes possible to hypothesise about the potential to utilise learning theory as a driver for person-centred change in therapy as it is used in the classroom.

## **1.2 Aims and Objectives**

The aims for this study were therefore to establish from Person-centred therapists::

- Whether they were aware of clients being actively engaged in any learning processes during therapy
- Whether they purposely implement any learning processes with their clients
- Whether learning facilitation is appropriate in a person-centred context, given its directive potential
- What a person-centred 'curriculum' may consist of in terms of ideal therapy outcomes

While part of the stimulus for the study was the economic limitations placed on the number of therapy sessions that services can deliver, this was not specifically mentioned as this topic could have dominated the sessions. Rather, it was allowed to emerge or not as the interviews progressed.

## **1.3 Methodology**

The dominant research paradigm for this study was critical realism. CR is explained in the early work of Bhaskar (2015), who combined the concepts of transcendental realism and critical naturalism. In summary, this theory provides the useful perspective of a realist ontology combined with epistemological relativism, which forms an objectivist, but fallibilist, theory of knowledge. It separates ontology and epistemology, with a bias towards an understanding of what exists over what we are able to know about it. Thus, a stratified ontology

was utilised, defined by overlapping domains of reality; specifically the 'empirical', the 'actual' and the 'real', or in this case, the interviewees narrative, what they may actually have meant and their underlying drivers.

## **2 METHOD**

### **2.1 Participants**

Defining expertise can be contentious (Flyvbjerg, 2006). After discussion, the authors concluded that experienced practitioners who were trained as and identified themselves as client-centred therapists, who are involved in educating the next generation of therapists, and possibly contributing to the published literature could be defined as experts. Their views were sought for this study. Five individuals, all experienced PCT practitioners involved in educating therapists, agreed to be interviewed. Two of the participants clearly typified the top end of the expertise continuum, as they are well known leading practitioners in the field of both PCT and education and are much published. All the participants were white, British professionals living in the North of England. Three were middle aged and two were near to retirement. There were three males and two females.

### **2.2 Procedure**

The information sheet given to participants described the study as being about learning in a therapeutic context and listed the topics to be addressed. The intention was to keep the subject areas fluid to allow for useful insights to emerge. Purposive sampling was used to identify participants that met the expert criteria specified earlier. Prospective participants were identified on the internet using 'Person-centred courses' as a search term. They were then

approached with a speculative email and follow-up phone call if they expressed interest in the study. One contact known to one of the researchers was also approached.

Semi-structured interviews were conducted by one of the authors in the participant's own work premises, lasted for around 45mins, and were audio recorded. The interviews addressed the following topics:

1. Do clients learn through person-centred therapy, or do they 'just' change?
2. If they do learn, what and how do they learn?
3. Are there any particular theories of learning which you have used in therapy? What was the outcome?
4. Do you think there is room for the therapist to 'facilitate' learning? If so, how?
5. What do you consider to be likely humanistic / learning outcomes for your clients?

In the event, follow-up questions such as “Do you think it is possible to look at person-centred therapy from a learning perspective?” and “In your experience, does the actualising tendency actually work?” were also addressed. The interviews were audio recorded and then transcribed. All utterances were documented in the transcript, including pauses, emphases, questions and words such as ‘er’, ‘hmm’ and ‘um’. The complete Jefferson transcription style was not considered necessary since what was explained was more important than how it was said.

Due consideration was given to any potential ethical issues arising as a result of the research process. In the event the only significant issue that arose was initiated by one particular participant who considered that one specific view would make him easily identifiable. This point was not included. Care was taken to ensure the anonymity of all participants, and specific attention was paid to identifying information where theories in use ran counter to espoused theories, since there was no intention to challenge or embarrass participants. All participants provided written informed consent. Ethical approval for the study was given by Sheffield Hallam University Research Ethics Committee.

### **2.3 Reflexivity**

In terms of personal and interpersonal reflexivity all the authors are trained in PCT and the questions were influenced by this knowledge. The first author interviewed all the participants to ensure continuity of experience and her existing knowledge and practice in PCT was felt to have influenced the interview process and the relationship generated with the interviewee in positive ways. She brought a bias towards the subject of learning to the research process, feeling that facilitating learning could be a useful addition to PCT. The other two authors had a more neutral stance, hence providing balance.

### **2.4 Data analysis**

Data analysis followed the guidelines for Thematic Analysis (Braun & Clarke, 2013). Given that one expression could often seem to have multiple meanings, coding and recoding the data was implemented, resulting in statements being coded into different categories. Consideration was also given to the fact that this analytical process was based on questions which were established by the

researchers, analysed with a specific purpose in mind, and interpreted with the researchers' mind sets. This hermeneutic perspective is, however, in terms of Thematic Analysis, considered to be an advantage (Braun & Clarke, 2013). Using Excel, the data corpus was coded in its entirety rather than coded selectively so that all comments had a code, with the exception of statements of clarification. Analysis and coding were based on a Critical Realist retroductive and abductive process, resulting in themes that were strongly linked to the data themselves rather than utilising a pre-existing template. A combination of semantic and latent codes was used. Some comments were taken at a semantic level since they seemed to require no interpretation, for example, 'Sometimes I recommend books to them'. Others had underlying meanings requiring assumptions to be made and connotations teased out, for example; 'My role is not to direct, my role is to meet'. Coded statements were then checked for a fit within their respective category. What was produced was an entirely bottom-up analysis which could then be summarised into a set of overarching themes. An 'active' basis was used in coding the data, which involved creating patterns rather than discovering them. Checks for misinterpretation or bias were carried out independently at this stage by the two other authors and any issues resolved by discussion.

### **3 RESULTS AND DISCUSSION**

A total of 578 data items were analysed and coded. From this 10 main themes emerged with a range of sub-themes. These are summarised in Table 1.

-Table 1-

Each participant was identified by a letter of the alphabet and the numbers in the brackets (below) refer to the location of the quote in their transcript.

### **3.1 Learning and change**

Most participants considered that client's learning did play a role in therapy saying for example 'it's not good enough... just to say that people get better' (K2.1). It was almost taken as read, 'of course people learn!' (K2.1). It was also accepted that the question of whether clients learn is, '...a different question to 'do therapists teach?' (P2.1) and although this is a simple statement, this consideration is at the heart of this study. When pressed further on whether their clients *changed* in therapy, participants considered that it was likely, suggesting that the two could be different: 'Change can be an outward activity such as bringing a different attitude or awareness. That isn't necessarily learning' (P12.1). Further, 'change is something a bit more organic, so it's something I'm becoming' (C8.1). This is a process of change occurring naturally as Rogers suggested in his stages of change theory (2004). There was a perception here that change does not necessarily require or result from learning, or as another participant suggested, 'it is not always a conscious process' (P8).

It was felt that both learning *and* change happen. For example, one participant said '... change happens as they choose to respond to what they learn' (R2).

Whether change comes as a result of learning, or learning as a result of change, the participants in the study generally agreed that the two outcomes were linked, suggesting that they go together 'like carriages on a train' ( R4.1). It was also noted, that sometimes change and learning does not happen, '... and

there'd be multiple factors in that, about how invested the client is in staying the same' (K4.2). Woolfe (2010) also noted client's resistance to the possibility of being different.

It was clear from this initial question in the interview that the participants reflected the literature available, in that no clear consensus emerged. Learning seemed to be an issue that was not ordinarily addressed in their thinking about therapy and answers did not come easily. 'I don't know' was repeated regularly in this section of the transcripts.

### **3. 2 Goals**

It is important to establish whether therapists or clients work towards goals in therapy since the idea of goal setting forms the basis of a facilitated learning approach. Specifically defined goals are not however, ordinarily part of the person-centred therapeutic process. Some respondents considered goals to be better defined as, 'desires or longings the person may have' (R66.1) which they would not attempt to define further. Even those participants who were willing to consider firm goals for their clients considered that they should honour their clients' autonomy in establishing or not establishing goals. This aligns with the views of Scholl, Ray, & Brady-Amoon (2014) who stressed the importance of client autonomy in the PCT process.

Despite mostly representing a very person-centred perspective, some participants suggested that, 'we absolutely *are* goal oriented' (K16.2). Further, they suggested that goals enable progress in a short period of time or enable 'people to have a sense of choice in their lives' (K66.1). These were not necessarily client generated goals but goals assumed on behalf of the client.



These clients' personal goals were then useful in providing a framework for the therapist to work with. One participant said, 'it's me piecing together the bits and pieces I've thought' (R26.1). Perceived goals were established and utilised to aid the process of therapy from the therapist's perspective, but not necessarily generated in dialogue with the client. In fact, the therapists purposely did not engage goal-directed behaviour in the clients through a discussion of client aims.

Authors such as Knowles (1978) and Egan (2014) have all advocated directivity through the use of goal setting in therapy. Indeed, Levitt, Butler, & Hill (2006) reported that clients wanted an agenda particularly if they felt stuck. The responses indicated a conflict between the need to be seen to do something, but not to be directive. As one participant suggested, 'We can't go in as a blank canvas, can we?' (H41.1) and 'of course I've got an agenda!' (H22.4).

Participants seemed to need to 'do' something, to fulfil their agenda. At the very least, there was consensus that goals or a sense of direction form a part of the therapeutic process, operating often subconsciously.

### **3.3 Learning and the process of facilitation**

Participants commented at length on how their clients learned through the process of therapy. The majority felt that, 'it was a natural process of growth, often unconscious (H63.1), 'sometimes through insight' (P4.21), and occasionally 'through osmosis' (P10.1). Person-centred learning seemed to be summed up by the client going back 'to that organismic place which knows exactly what it wants' H16.2). Participants were adopting a clear Rogerian perspective here. Rogers (1975) believed firmly that learning could be facilitated

through psychotherapy, resulting in the client seeing him/herself differently, becoming more mature and accepting of others for example, and that it was empathy which largely caused this learning. Further, he considered that the experience of allowing the organism to take its own course without the constraints of conditions of worth facilitates a learning and growth process. Similarly, at the heart of Knowles' (1978) work on Andragogy is a process of self-directed development, guided by unconscious drivers.

In considering the question of retaining learning over time, most considered that, 'experience is carried unconsciously in the body and it is that which constitutes learning' (P99.2). 'In that sense, you can't 'unknow' what you have learned about yourself' (H69.2). This echoes the work of Salo (1993) and Glasman, Finlay, & Brock (2004), who underline the importance of retained learning, and define mechanisms to encourage it. So metacognition, engagement and insight into change processes become issues for scrutiny as well as therapy outcomes. Although these processes were considered less relevant by our participants, it may be that in the absence of such processes, learning will fail to be embedded, demonstrated in a comment by one participant who suggested that sometimes we don't know what we've learned until years after (C10.1). This then, may be a failure on the part of the therapist to enable that identification process to occur.

Although participants readily acknowledged learning processes in therapy, some were less ready to accept responsibility for them saying for example that in wanting to facilitate learning, 'I wouldn't be person-centred' (P54.1). Another suggested that understandably, 'my proactivity depended on the client, since

some just needed to express emotion or be heard' (C48.1). Most, however, commented that they did facilitate learning in some way. One described the process of, 'Enabling the client to tell their story (H48.2), and another explained that, 'It is about challenging people's perception of themselves, or challenging the client's conditions of worth' (K26.1). The most common reason for facilitating a learning process was due to time pressures. When the need to challenge perceptions surfaced, time was short, or clients' need to develop emerged, participants seemed to adopt Rogers' educational perspective; namely that the facilitation of some kind of learning experience was not in opposition to being person-centred. One participant suggested directly asking questions; 'so that they can begin to challenge their own perception of themselves' (K36.1) or, 'to challenge their conditions of worth' (K28.1), while another sought an opportunity, 'to allow them to think differently' (R72.21). Further suggestions were, 'to try to get them to think in terms of the bigger picture' (R16.2), or 'to encourage interactive learning that might cause the client to change his stance' (R18.1). Most said they did facilitate learning in some way mainly due to time pressures. One participant suggested that, 'clients need to want to learn, and be ready to hear feedback' (H63.2). Assuming the client had been open to learning and insight had emerged, it was considered that there is still a choice of whether to 'accept whatever it is you've discovered and find a way of assimilating and integrating that' (C66.1). Clearly participants had met with clients who were comfortable with the status quo, seeing no need to change, suggesting that, 'Clients may not like what they learned which created

defence mechanisms (H63.3), and that, 'growth can be a very painful process' (P78.4).

### **3.4 Person-centred process**

While all the participants had a strong commitment to person-centredness, some regarded themselves as 'pure' Person-centred practitioners saying, 'Everything is delivered in a Person-centred way' (C44.1), and 'I respect the core conditions' (R64.1). Participants were also generally clear that, as one put it, 'there's no formula here'. Participants did acknowledge that person-centredness could lead to learning, one commenting that, 'Being real and vulnerable...offers the client that they can... dare to be that vulnerable too and that real ... that's the person learning about themselves' (H16.1). This echoes Rogers' (1975) views on the importance of empathy in bringing about change, although there are arguments about whether it is sufficient (Tudor & Worrall, 2006).

### **3.5 Issues of non-directivity or directivity**

Some of the conflicting views expressed both between and within client statements are explained when therapist directivity is discussed. To begin with, based on the philosophical foundation of Person-centred theory, all participants had strong views about the need to be non-directive with their clients, and facilitating learning did not fit within this paradigm. A common view was, 'my role is not to direct, my role is to meet' (P32.1). One participant explained, 'If I ask questions, it's out of interest rather than to direct' (H74.1), and another said that, 'Even if the client was exhibiting signs of being stuck, direction would still

not be appropriate' (P40.1). This position is common in the literature, (e.g. Schmid, 2005).

Although most participants ascribed to the non-directive nature of PCT, they also recognised that directivity was inevitable if not sometimes intended, which seemed to contradict earlier statements. One participant said, 'I don't set out with the intent of directing, however, every time I open my mouth or smile, or interact within the dynamic, within the process, that impacts on the client at some level' (P324.2). Another stated, 'I think everything is directive ... I think everything I say has an intention. I am directing a process by which you will learn about yourself, through me' (K 78.4). These comments reflect Rogers' view that therapy is built predominantly on the persuasive powers of the counsellor (Rogers & Carmichael, 1942). Indeed Levitt et al. (2006) reported that clients sought teaching, challenges and other directive practices. This lack of consistent thinking seemed to reflect a need to be respectful of the core conditions although going beyond them at times.

When asked whether they 'teach' clients, one explained 'I think it's congruent for me to be sharing ...this is how we might understand this experience that you've just had in therapy' (K70.1). Other methods of teaching were mentioned, such as explaining the process of grief to a client, explaining the transference or countertransference, asking about the physical manifestation of feelings, and using anecdotal stories, examples and illustrations to give context in an attempt to enable insight. Despite being philosophically against the idea of directivity, participants articulated a range of directive methodologies to enable insight and

learning. The most common reason given for being directive was time pressures, 'I think it's really useful when it (therapy) is time limited' (H34.1).

### **3.6. Questioning**

In discussing directive techniques used by therapists, one particular approach mentioned often was the use of questions, although one participant commented on, 'The inappropriately intrusive and directive nature of questioning in PCT' (R30.4). The style of questioning reflected the need to be non-judgemental and without any intent to guide the client, but it was acknowledged that questions inevitably resulted in direction of a sort. The commonest reason for using questions was, 'to enable the client to explore and understand themselves' (K36.1), and 'To enable the client to begin to challenge their own perception of themselves' (K36.1). Rowland, Godfrey, & Perren (2009), researching long term outcomes of therapy, found questioning to be beneficial, suggesting that it facilitates a process of naming and understanding emotions, actions, and their consequences. This is an area that would benefit from further research.

### **3.7 Outcomes**

Most participants had clear ideas on preferred outcomes, mirroring their understanding of Rogers' actualizing tendency. The aim was for, 'a more fully functioning person' (H16.3), defined commonly as being more open to experiencing, dissolving conditions of worth and developing congruence, explained by one participant as, 'The alignment of my experience and how I think about it and think about myself' (K16.3).

The learning outcomes identified by Burnett and Van Dorssen's (2000) study of therapeutic outcomes were identified. Participants identified that,

'Clients begin to understand why they behave in a certain way. How to get back in touch with their feelings' (H55.1); 'to tolerate themselves' (K116.2), and, 'Gain a greater awareness which enables choice' (P70.1). Further common themes included changing their attitudes to life, learning how to be discerning, changing their attitudes to life, becoming more aware of how they relate in the world, tolerating anxiety better, tolerating others more and gaining confidence, self-acceptance, and changes in internal processing. One final common theme was that of learning how to be in relationship with others and an increased sense of mutuality expressed as, 'It's about 're-learning how to be a relational person' (K108.2), but also about knowing that, 'I don't need to ask other people how I need to live my life' (C8.4). These comments were quite specific in nature, rather than describing in a general sense that the client seemed to be better or happier. These views suggest that goal setting based on these defined outcomes may be helpful especially when there are time constraints. Connolly and Strupp (1996) report that specific outcomes relating to the self are rarely assessed. For these participants, however, they were important outcomes, defined in quite specific terms.

### **3.8. Long term learning**

When asked about longer term retention of learning, most participants agreed that it was possible and desirable, one commenting that, 'Once you are on a journey of self-discovery, then it will be maintained naturally' (H69.2).

Loewenthal, Greenwood and Rose (2005) embrace this notion that learning potential continues throughout life, while Salo (1993) comments on the lack of differentiation between learning and life in general.

Probing further on the issue of how long-term learning may be facilitated by the therapist, the subject of 'being your own therapist' was discussed (Bohart & Tallman, 2010). Self-therapy was considered to be reliant on, 'Being able to challenge or be curious about yourself outside of therapy (C46.1), or, 'to use relationships to get help' (K10.6), but was thought to be, 'A process of accessing the therapy experience and reframed perceptions of the self either consciously or unconsciously post therapy' (P99.28). Several participants considered that, 'Unless the underlying work on conditions of worth have been done, strategies to cope will not endure' (H77). Bowles (2012) suggests that it has not been established whether client-centred therapy provides clients with the knowledge and skills to deal with the recurrence of problems post therapy, although others have considered this to be an important therapeutic outcome (Burnett & Van Dorssen, 2000). This warrants further investigation in PCT.

### **3.9 Assessment and diagnosis**

Gibbard and Hanley (2008) suggest that PCT is a unique encounter between two people affecting the client's subjective processing (and the therapist) in ways that cannot necessarily be explained or quantified. Hence, it was considered important to establish whether therapists felt it was appropriate or indeed possible to assess where a client stood in relation to a set of diagnostic criteria. Most participants did claim to assess their clients to some degree, despite it being contrary to the Person-centred approach. A typical comment suggested that, 'Diagnostic criteria were very helpful, to help frame the experience of people and assess their mental health' (K82.3). Another comment was that, 'The therapist's assessment of the client's perception of



themselves in the world was essential to the process and would feed into process decisions made by the therapist' (H2.5). In support of these views, Binder, Nielsen, & Holgersen (2010) recommend that therapeutic change should be assessed with a broad range of outcome criteria including changes in self-understanding and relationships to self and others and should be humanistic in nature. Further, the 1,430 outcome measures identified by Froyd (1996) would indicate that there is value to be gained from measurement of progress.

### **3.10 Other methods**

It was acknowledged from the start that Person-centred practitioners may find the idea of directing a learning facilitation process philosophically problematic. All participants however, despite some regarding themselves as 'purist', claimed to use other therapeutic approaches or techniques occasionally. CBT techniques such as cognitive restructuring or exposure therapy, recommending books or reading poems, attachment theory, and even psychodynamic theory were all suggested. Brief solution-focused therapy was mentioned by two participants, the Skilled Helper Model (Egan, 2014) was mentioned by another, and phenomenological approaches were also considered appropriate. Different reasons were given for using alternate approaches such as, 'pragmatism' (R60.1), to 'Provide process awareness for the client' (K88.1), or to 'Deepen the work' (C44.2) and 'To facilitate learning' (C51.1). It seemed that, for this sample of therapists, while there was resistance philosophically to the notion of directive approaches, in practice they were adding to the therapist's integrative toolkit.

### **3.11 Issues of Time**

All participants mentioned the short time frames for psychotherapy and that PCT is not particularly compatible with this. It was noted that Rogers was not restricted by time-limited work, and that sometimes clients need longer timeframes to address their issues. A comment which sums up the response to budgetary pressure to conclude in 6-8 sessions was, 'It needed more than the sessions I had, and I couldn't go there in depth within that, so I had to find a way to facilitate something' (C36.2). As a result, techniques such as role play, and other directive approaches were often cited as being useful. The need to facilitate something came from several participants and reflected the pressures therapists felt in the current funding models. These therapists wanted to maintain their person-centred ethos but needed to get faster results, and so were incorporating more directive approaches.

#### **4 Quality and limitations**

Quality criteria outlined by Smith (2015) were followed. Rigour was achieved with the definition of and recruitment of an expert sample to interview and in that there were a range of perspectives within the sample. The procedures used for the analysis were clearly outlined and transparent. Labelling was used consistently and checked independently. While this detailed analysis contributed to the validity of the data, it was accepted that validity can only be a property of inferences and not of method. Where inferences were made, these were highlighted and further checked for validity with all the authors. However, inferences ratified or otherwise will always be subject to an element of bias. Generalisability is problematic with such a small sample; however, the notion of 'naturalistic' generalisation is more relevant to this qualitative study in that

reflections on the participants' views can be made by the reader, and thus any potential for generalisation judged individually. In terms of methodological reflexivity, the semi-structured questions frequently led participants to explain their views on learning in therapy rather than question whether learning occurred. Follow-up questions were used to try to address this but were not always successful.

## **5 CONCLUSION**

Current understanding of the role of learning in person-centred therapy as evidenced in the literature is complex, often contradictory and incomplete. The data derived from the interviews echoed this with contradictions and uncertainty apparent in therapists' expressed views. Their views of whether clients learn or change, how they learn or change, and whether or how learning and changing are related were not conclusive. Participants viewed goals variously as inappropriate, a useful process tool in their own armoury or useful to aid clients on the road to self-actualisation. The cognitive dissonance demonstrated in therapist's need to do something but not be directive was also evident. The learning process was described in different ways: organically, through osmosis, unconsciously, stemming from the therapist and as part of a facilitated process. It was clear that all participants regarded themselves as at least 'mostly person-centred' if not 'pure', with the clients' needs driving the process. In contrast, other methodologies were described which therapists were integrating into a person-centred philosophy to allow them to meet short time frames or manage client processes. As a result, their fundamental views on non-directivity were juxtaposed with views about the inevitability of therapist control, if not the desire

to steer the client towards positive outcomes. Finally, techniques such as questioning, although considered inappropriate, were conversely acknowledged as helpful.

There was however, greater agreement between participants and the literature on some issues. For example, participants were able to outline a range of outcomes for successful therapy. There was also a more consistent response to the question of long-term learning, with participants agreeing that not only was it important, but that they should play a role in assisting clients to become 'their own therapist'. Further, most participants agreed that the assessment of clients was a positive part of therapy, assisting them in managing therapeutic processes and the client to develop their self-perception. Learning was considered to be a part of the person-centred therapeutic process. However, the participants considered that aiming for learning outcomes within a person-centred framework would have to be achieved without any overt sense of directivity.

In summary, the most important finding that emerged from this study was that current budgetary time pressures appear to be changing the nature of PCT as it is practised. These experts were less willing to accept that their philosophical basis for therapy had changed, but in practise there seemed to be many strategies in place to focus their approach in shorter time frames, although not necessarily based on learning theory. There are therefore implications which arise from these findings, the most evident of which are the questions: "Should we not be clearer on how our clients change or learn through therapy" and further, "If we (and our clients) are not clear on what success looks like, and as

PCT practitioners we don't see a role for ourselves in directing that process, how can we enable significant change in a time constrained process? Also, "As therapists, are we as non-directive as we say we are?" Further, Rogers' description of the actualising person in a state of 'flowingness' provides a rather esoteric description of success, suggesting that research on a clearer picture of ideal humanistic outcomes may be of value. Finally, the person-centred practitioner's espoused way of *being* implies that any directive intent is inappropriate, but to facilitate a learning process, the therapist cannot just *be*. Further research may establish whether Rogers' person-centred learning principles can be integrated into therapy in order to make the process more efficient or effective.

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**Table 1 Themes and Subthemes emerging from the Interviews**

Theme	Description	Sub themes
1 Learning and Change	Whether clients learn, change, or do both	<ul style="list-style-type: none"> <li>Yes clients learn</li> <li>Yes clients change</li> <li>Sometimes they don't change</li> <li>Learning and change are the same</li> <li>Change is a process</li> </ul>
2 Goals	Who has goals and how they are used	<ul style="list-style-type: none"> <li>I have specific goals</li> <li>I don't have goals</li> <li>Views on goals</li> <li>How I use goals</li> <li>Clients have their own unique goals</li> <li>Clients have specific goals</li> <li>Use of client goals</li> <li>I have an overview of the clients process</li> <li>Therapists should know what's going on for their clients</li> <li>Using process knowledge with the client</li> <li>I have specific goals</li> </ul>
3 Learning Process	How the learning process occurs in therapy	<ul style="list-style-type: none"> <li>The clients role in the learning process</li> <li>Necessary conditions for client learning</li> <li>Regression can be growth</li> <li>Learning can be a negative process for the client</li> <li>Some people will retain negative outcomes</li> <li>How does the learning process work?</li> <li>What does the learning process look like?</li> <li>When does learning occur?</li> <li>The therapists role in the learning process</li> </ul>

		Being person-centred contributes to the learning The therapists responsibility in the learning process Other ways that the therapist facilitates learning How therapists facilitate learning, specifically I don't facilitate Why I facilitate
4 PCT Process	How the person-centred process works	The therapists person-centred process The client's person-centred process The client's history is important The therapists beliefs about the nature of the person You can't unknow what you know
5 Issues of Non-directivity	Being 'in relationship' and not directing	Being directive is wrong We should stay with the client The relationship is important
6 Directivity	Using directive methods; when and how	Directivity is useful The purpose of directivity Teaching
7 Questioning	Questioning and challenging the client	The use of questions Challenging
8 Outcomes	Typical learning outcomes	Learning outcomes Long term learning Negative outcomes
9 Assessment and diagnosis	The appropriateness of assessment tools	
10 Other methods	The integration of other methods for efficiency	Use of other methods Issues of time

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## **Biographies**

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