Can Person-centred Learning Facilitation be Integrated into Counselling?

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Abstract

Enabling a learning process for counselling clients is regarded as a useful aim for therapists, and has been addressed by integrative therapeutic models such as CBT for example. In a humanistic setting, however, how clients learn is not so clear cut, nor is it necessarily addressed by person-centred therapists for fear of being directive. The research presented here therefore seeks to discover whether learning processes *can* be facilitated in a humanistic person-centred counselling relationship - both philosophically and practically. Carl Rogers had much to say on the subject of person-centred learning facilitation in the context of the classroom, but did not apply these principles to his Client-centred therapeutic approach. Whether Rogers' learning facilitation principles can be beneficially integrated into a person-centred, humanistic counselling relationship provides the foundation to this research.

In a mixed methods approach, firstly five established educationalists (who are also Person-centred therapists), were interviewed about their views on learning facilitation in therapy. It was concluded that whilst these therapists acknowledge that learning plays a key part in therapeutic change, learning facilitation was not systematically addressed.

Since goal-setting helps individuals to define learning outcomes, the second study, using a Delphi approach, sought to gain consensus from 35 humanistic therapists on what characterises a 'fully-functioning' client. The resulting list of 71 items was then developed into a questionnaire and card sort goal-setting exercise.

Study 3, in the form of a quasi-experiment, involved 9 humanistic therapists and 23 of their clients in establishing whether the 'fully-functioning' learning outcomes could aid therapy through setting learning goals. Therapists who were most happy with being directive found the instruments useful in enabling client progress.

Finally, a case study of one client in therapy (with the researcher) tested the use of person-centred learning facilitation techniques. A list of useful generic learning processes emerged including establishing client learning goals, enabling the client to understand her own learning style and processes, and planning for her own long term learning.

In summary, it was established that facilitated learning processes based on person-centred principles *can* provide a philosophically and practically acceptable focus for humanistic therapy. Further, using an instrument to set learning goals was perceived to be useful by more directive humanistic practitioners. Given that the final case study tested only nine learning theories, there are now the foundations in place to develop further a 'therapeutic learning' methodology or meta-framework, and to research resulting benefits.

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Chapter One: Background

1.1 The Context

The researcher has a background in both learning facilitation and Person-centred Counselling - in separate qualifications and job roles, and this study stemmed from an interest in finding out if it were possible to integrate the two disciplines. The researcher's experience (and MSc) in training was based on Carl Rogers' work on person-centred learning facilitation, and was gained whilst as a Training Manager at British Airways and then Head of L&D at Courtaulds Plc. The researcher then trained as a Person-centred Counsellor (also through an MSc), with the specific intent to then study the possibility of combining learning facilitation and person-centred counselling from an academic perspective.

The field of learning - usually to be found under the umbrella of Education, and the field of counselling - usually contained within the discipline of Psychology, are generally seen as distinct disciplines. School children are taught and employees trained or coached, whilst those with mental health issues receive counselling, psychotherapy or psychiatric care. Combs suggests, however, that:

> *There can be little doubt that counselling is, in essence, a learning process. When counselling is successful, the client learns a new and better relationship between himself and the world in which he lives. Counselling… should be a situation expressly designed to assist the client to learn more effectively and efficiently than is possible in most other life experiences. If not, counsellors had better close up shop,* (1954, p.31).

It is evident that work on combining the fields of learning and counselling has already progressed to a degree, since approaches to counselling such as CBT for example, use teaching and learning methodologies in part. Even so, retention of

therapeutic learning is often poor. For example, a study by Gumport and colleagues (2018), reports that although more than half of patients reported thinking about their therapy following their session each week, half of these thoughts were inaccurate, and less than half of the applications were accurate - a significant problem if long term learning and change is the aim. The question of whether a greater focus on learning in therapy may increase the efficiency, effectiveness, or longevity of the outcomes is therefore also a pertinent one.

The purposeful and complete integration of counselling and learning theory with the specific intent to impact the efficacy of counselling has yet to be addressed. So for example, Gestalt principles explain insight, cognitive schemata explain individual perceptions of the world and behaviourist principles can assist in behaviour change. Despite this, there is no *overall aim* to enable the client specifically to learn and to embed that learning over the longer term. Further, any learning which is targeted 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* is much less prevalent.

1.2 Using Person-centred Therapy as a Start Point

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. From the instruction of religious doctrine and Greek philosophy (Compayré, 2015), to the publication of Paulo Freire's *Pedagogy of the Oppressed* in 1971 (Freire, 2018) didactic methods have dominated. More recently, however, this approach has been superseded by the postmodern, feminist, poststructuralist perspectives and critical discourses of today's educators (Carlson, 2018). Critical pedagogies of engagement have emerged (Zepke, 2017) and modern day 'mathetic' methodologies implemented. (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 two key figures, Carl Rogers and Malcolm Knowles.

Rogers, whilst being known for Client-centred Therapy (2003), is less well known for his equally ground-breaking ideas on education and it was these that influenced the progress of pedagogy over the latter part of the 20th century. Frustrated by the behaviourist approaches of the day, Rogers wrote extensively on the topic of *client-focused* learning (Rogers & Freiberg, 1969), which relies on the self-directed nature of the individual to define and pursue their own learning processes rather than being taught. Over time, 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 to learning, but to enable the learning process the facilitator provides learning resources (Kirschenbaum & Henderson, 1997). 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 assess their own work. Further, Rogers suggested that the facilitator was responsible for: setting the mood for the experience; helping to elicit and clarify the purposes of the individual; organising learning resources; becoming a participant learner; sharing his feelings and thoughts; and being alert to deep or strong feelings (Kirschenbaum & Henderson, 1997, p.164).

Adult education has also been influenced by Knowles' theory of Andragogy (Knowles, Holton, & Swanson, 2011) which was based on Rogers' views on the

actualising tendency and the "central importance of the quality of the relationship between teacher and learner in effecting learning" (Knowles, 1978, p.16). His andragogical assumptions include: 1. adults need to know why they need to learn before they will learn, and 2. the adult's self-concept needs to be acknowledged as being self-directed (Knowles, 1978, p.12). This mathetic perspective has developed over time and still provides a foundation for current educational approaches. Recent education theory, for example (Watkins, 2017), suggests that learners should; plan, monitor and review their own learning; view themselves as driving the learning; and learn about and experiment with their learning

This research considers the application of a learner-centred approach to education, (such as that recommended by Rogers and Knowles), to the counselling setting. For Rogers, self-directed learning and Person-Centred Therapy (PCT) share a philosophical foundation. For that reason, these theories are the start-point for this study. His core conditions of empathy, unconditional positive regard (UPR) and congruence (Rogers, 2004) provide the foundations to both learning and therapy, and his 'actualising tendency' is seen to drive development in both learner and counsellee. Rogers saw clear benefits in applying his therapeutic principles within the classroom. Therefore, and conversely, this study seeks to explore ways in which principles of self-directed learning can be utilised in person-centred therapy.

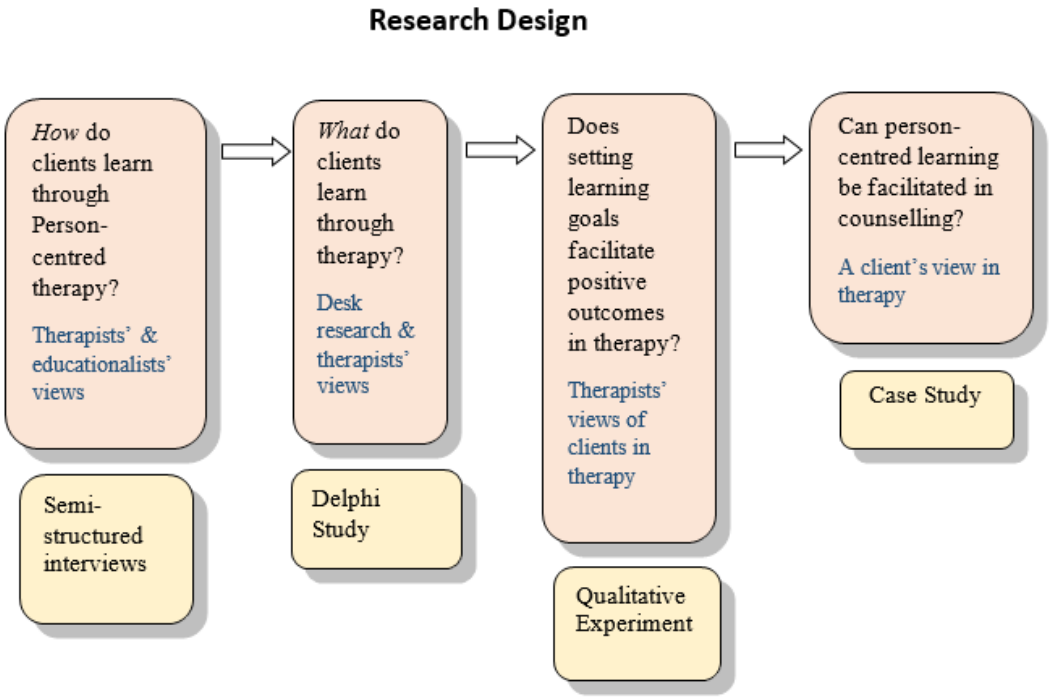
1.3 Overview of the Study

Firstly, a literature review presents the person-centred foundations to the study before establishing in theory, whether counselling based on person-centred principles of learning would be philosophically viable. Then a review of therapeutic

approaches and theories which already utilise learning theory are presented. Next, further models and theories of learning which are applicable to therapy are offered. Since effectiveness of therapy is an area of focus, key issues in the application of learning facilitation to therapy, such as learning transfer and life-long learning, are then included.

The desk research outlined above provided the foundation to the practical studies which, in summary, sought to understand how learning is viewed currently in the context of therapy, and then to experiment with a defined set of learning theories in therapeutic practice, (particularly goal setting which is a key feature of learning facilitation). The research was separated into four individual practical studies, integrated within a mixed methods approach:

Diagram 1: Research Design Overview



- Firstly, semi-structured interviews with a group of educationalists (who were also therapists) aimed to establish their views on how clients might learn in the context of person-centred therapy, and whether they engaged consciously in learning facilitation with their clients.
- Secondly, a Delphi study sought to define a common understanding of successful learning outcomes from therapy, or what a 'fully-functioning' person might look like. This list was then developed into a learning tool for use in therapy, in the form of a card sort exercise and a questionnaire.
- Thirdly, the setting of learning goals was tested in therapeutic practice. (Assuming that working on agreed learning goals is fundamental to a learning facilitation process, it was considered that a trial of the learning tools which enabled goal setting would provide a suitable initial study before testing a broader range of theories.) Therefore this study sought to ask:
    - Can a defined set of learning outcomes enable the client to set learning goals for therapy?
    - Can setting learning goals aid the process of therapy?
- Fourthly, a case study of one client engaged in therapy with the researcher, gave the opportunity to attempt to integrate a limited set of learning facilitation techniques into therapy based on person-centred principles.

Additionally, a point is made about writing format. Current reporting standards for qualitative research recommended by the APA (Levitt, et. al., 2018) suggest that;

> *... qualitative researchers often combine Results and Discussion sections, as they may see both as intertwined and therefore [it is] not*

> *possible to separate a given finding from its interpreted meaning within the broader frame of the analysis...*

They suggest that mandating that manuscripts be segmented into the same sections and subsections as quantitative research is not necessary. Two of the studies therefore combine Results and Discussion sections to facilitate a more coherent flow of the material.

Learning theory is a vast topic and as such it was considered necessary to limit the scope of investigation here to that which could be described as *self-directed* learning, particularly due to the clear links with Rogers' work. Further, the final study was limited to testing a small number of self-directed learning facilitation techniques from a broad range of possible choices. Clarity here is also suggested between the use of Person-centred Therapy (large P), and person-centred practice (small p). Whilst the inspiration for this research project lies in Rogers' Person-centred Therapy (PCT) and the associated core conditions, much of the work focuses on person-centred practice which often provides the foundation to other therapeutic approaches. Therefore, since Rogers' theories are humanistic in origin and humanistic therapists are usually (although not always) person-centred, there is a resulting focus on humanistic therapists.

It is offered that the following aspects of the study may be considered a new contribution to knowledge in the field of counselling:

- Emerging therapeutic praxis contradictions are explored, as person-centred therapists explain a desire to enable learning and change, but retain a non-directive stance.

- The fundamental question of what successful humanistic therapeutic learning outcomes look like is addressed in this study. It defines in detail the ultimate ideal of therapy in terms of fully actualised personal states and traits. This information could be used by therapists to inform their ongoing practice whether they employ a therapeutic learning model or not.

- A practical method to support learning facilitation is also presented through the use of two specific therapeutic 'instruments', namely a card sort exercise and a questionnaire. The instruments could be used by any therapeutic practitioner, although integrative therapists may derive the most benefit from them. Equally, individuals wishing to engage in their own personal reflection in the absence of therapy could put them to good use.

- Finally, a therapeutic approach based systematically on *learning facilitation* is unavailable to counsellors and clients at present. This study considers the theoretical foundations for such an approach and tests the implementation of initial principles. There is the possibility, therefore, that self-directed learning principles may result in greater efficiencies, effectiveness or long term retention of positive outcomes for counsellees, but further research would be necessary to validate these possibilities.

Chapter Two: Literature Review

2.1 Pure Person-centred Therapy as a Foundation for Integration

Client-centred Therapy (Rogers, 2003), introduced in the middle of the 20th century as an alternative to the dominant psychoanalytic school of thought at the time, sought to use the innate wisdom of the individual to enable self-actualisation. Using a set of core conditions embodied in the therapist, the individual was enabled to 'become their potential'. Rogers also translated this approach into his work with university students, resulting in an approach from which modern day adult learning techniques are derived. Since this research seeks to understand whether those principles of learning can be translated back into a therapeutic setting, it is important to outline their origin. Included here therefore, is an outline of Rogers principles of Client-centred Therapy.

A year before he died, Rogers described what is now generally known as the 'pure' or 'classical' Person-centred approach:

> *It is that the individual has within himself or herself, vast resources for self-understanding, for altering his or her self-concept, attitudes, and self-directed behaviour – and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided* (Kirschenbaum & Henderson, 1997, p.135).

Rogers believed that for therapeutic change to occur, six conditions or psychological attitudes were necessary in the relationship between therapist and client, and further, he believed that "…the conditions… apply to *any* situation in which constructive personality change occurs", whether psychoanalysis or Adlerian psychotherapy or in the classroom (Kirschenbaum & Henderson 1997, p.230).

These conditions are now most often referred to as simply 'unconditional positive regard', 'empathy' and 'congruence', and provide the cornerstone of Rogers' theory of therapy and education. Generally speaking, learning processes in the context of PCT would need to be based on these fundamental principles, facilitating the self-directed nature of the individual to change understanding and attitudes.

Rogers believed that 'warm acceptance' (1957, p.98) of the client was necessary. 'Prizing' and valuing the person without judgement, facilitated by a non-possessive bond constituted the attitude necessary for trust to be developed between client and therapist. Trust would then lead to a change in self-concept on the part of the client. For Rogers, and the researcher, this condition is equally important in the facilitation of a learning process (Rogers, Lyon, & Tausch, 2014).

For Rogers "…a high degree of empathy in a relationship is possibly *the* most potent and certainly one of the most potent factors in bringing about change and learning" (Rogers, 1975, p.3). It is about getting close to the experiencing of the client, 'as if' part of the client's world. "It means entering the private perceptual world of the other and becoming thoroughly at home in it" (Rogers, 1975, p.4). Later in his life, Rogers added to his idea of empathy, citing Gendlin's view of "…empathy as pointing sensitively to the 'felt meaning' which the client is experiencing in this particular moment…" (Rogers, 1975, p.3). He goes on to talk of a 'psych-physiological flow' within the individual to be used as a referent, indicating his belief that empathy is a process rather than a state (Rogers, 1975, p.4). Some current theorists have developed Rogers idea of empathy, most notably Mearns, Thorne and McLeod (2013, p.59). They have produced an Empathy Scale which

suggests “an understanding of the client beyond the level of the client’s present expression”. This is working on the ‘edge of the client’s awareness’ (Gendlin, 2012), as is Stage 8 of Truax’s Accurate Empathy Scale, where the therapist may be “voicing meanings in the client’s experience of which the client is scarcely aware” (Rogers, 1975, p.4). Rogers was clear that this condition was fundamental to the learning process (2014), and the researcher also considers that, to be able to facilitate the self-direction of the client, one must be engaged in, and knowledgeable about, where that client is coming from.

Given that humanistic therapy, on the whole, aims for the integration of ‘the self’ or even Mair’s ‘community of selves’ (Bannister, 1977), ‘congruence’ is the aim. In PCT the disintegrated parts of the self which result in a dysfunctional state are usually the ‘self-concept’ and the ‘ideal self’ (outlined below) and it is the process of integration which is therapeutic. For Rogers, this congruence also needed to be present and demonstrable in the therapist whilst in relationship with the client. Therefore a trust in the deeper felt sense, and its expression on the part of the therapist was felt to be not only therapeutic, but of value as a role model for the client. Spinelli (1995) felt that it was this role modelling that was at the heart of congruence and, as such, is a subject which is discussed in more detail later as a learning process to be utilised.

Rogers’ theory of personality seemed to develop from his own life experiences, and being largely existential and phenomenological in nature, also seems to draw on the philosophy of Dewey (Rennie, 2004, p.184). Further, Dolliver (1995, p.137) suggests that Rogers’ theory of personality grew “directly from his

theory of therapy". In summary, Rogers based his theory on the nature of the self, modified by conditions of worth, and the idea of the fully functioning person driven by the actualising tendency linked to the organismic valuing process. It is interesting to note the positive, trustworthy, growthful aspects of personhood that are assumptions upon which his theories are based. The relevance of this particular perspective becomes clear when seen in the context of recent research on the Human Genome Project (James, 2016), which suggests that DNA counts for little in terms of our personalities, most of which results from a process of learning. For the researcher however, this positive, growthful person may need facilitated engagement in the process of actualisation, since it is not always automatic.

Rogers 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). So, with the "interaction of the actualizing tendency with rationality, the possibilities for personality change become even more pronounced" (Ziegler, 2002, p.86). This goal oriented perspective has particular relevance to self-directed learning, and becomes a force to be harnessed and used. Therefore, this research tests learning processes which enable engagement in the positive development of the client's innate abilities and desires, modified by the rationality that comes through therapeutic dialogue.

Rogers did not subscribe to a fixed view of personhood. For him, it 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). In contrast to Maslow (1943), whose self-actualised person

could, in theory exist, Rogers believed in growth as a fluid concept; a process, not an end state. It was only when psychological defences came into play that a state of 'stuckness' was experienced as particular emotions were denied to awareness. Therapy then fulfilled the function of 'walking alongside' the client in an attempt to navigate this rough terrain and resume a course of personal growth. In the view of the researcher, some elements of the persona achieve an actualised state, and others continually develop. For example, I may achieve a state of being content with who I am, but continue to engage in spiritual discovery. Any attempt therefore, at defining therapeutic learning processes would take into account both fixed goals and a process of continual learning.

Key to Rogers' theory of personality is his concept of 'self' which emerges from the individual's perception of his own being. This 'awareness of being, of functioning' is developed from the 'total perceptual field' (Rogers, 2003, p.497). A further modification to the notion of the self is that of the 'ideal self'. Defined by Tudor and Worrall as "the self-concept + added value" (2006, p.108), it is the self that is purposely striven for, the self that is imagined in the day to day definition of personal goals. As such, it is the difference in understanding between the self and the ideal self that defines a 'learning gap', and further uncovering that which is on the edge of awareness becomes the role of the learning facilitator.

Rogers believed in an evolutionary drive towards an individual's greatest potential, towards being 'fully functioning' (2004). As an individual is increasingly open to their experiences without defensiveness, increasingly concerned with the existential aspects of living and has an increasing trust in his organism, the process

of functioning develops more fully. “This ultimate hypothetical person would be synonymous with ‘the goal of social evolution” (Kirschenbaum & Henderson 1997, p.250). This state, although seemingly difficult to define, is what provides the foundation to the learning framework outlined later in this study, and it is a precise definition which is sought through the Delphi study. Whether it is appropriate to reduce the emerging, transpersonal being to a list of descriptors is questionable, but without such a start point, a purposeful journey cannot begin.

According to Rogers, it is the actualising tendency which facilitates movement towards being fully functioning, which in turn, 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, so “all the productions of nature have an innate tendency in the direction of the best condition of which they are capable” (Tudor & Worrall, 2006, p.70). This theory suggests a directional and selective tendency towards positive growth and fulfilment. Further, according to Nelson-Jones, “the person centred approach posits a unitary diagnosis that all psychological difficulties are caused by blockages to this actualising tendency and, consequently, the task of counselling is to release further this fundamentally good motivating drive” (1982, p.18). There is an interesting dichotomy established in consideration of this principle here. ‘Teaching’ is often quite specifically designed to change thought processes, change attitudes, or correct behaviour based on an existing inability or lack of understanding. Learning therapeutically through the engagement of the actualising tendency, however, would involve the facilitation of that which is naturally developing rather than steering clients based on the therapist’s knowledge or skills. There is a fundamental

difference between ‘self-directed learning facilitation’ and ‘teaching’: The clients own learning processes are enabled, rather than a process of teaching applied, enabling the approach to sit comfortably within a person-centred framework. In an ‘expert’ position, however, it is hard for a therapist focused on learning not to enable the client to acquire an understanding or skill which they can see are helpful, but the client is as yet, unaware of.

For the sake of clarity, Rogers differentiated over time between the notion of the ‘actualising tendency’ and ‘self-actualisation’. For him, the actualising tendency was largely an *unconscious* process, whilst self-actualisation was striving for self-regulation away from any control by external forces (Rogers, 2004). It was a *conscious* or purposeful drive towards the satisfaction of internal needs and personal growth. For the researcher, however, the positive movement of the individual is driven by the need to avoid fear and insecurity, and positive growth is a bi-product of this. Running counter to both of these views was Freud’s psychological model at the time, which suggested that the organism preferred to be in an unstimulated condition, to have an ‘easy’ life (1991). For Rogers, congruency results when the organism attempts to self-actualise in the direction of the actualising tendency, but when the organism attempts to actualise in the direction of the ideal self-concept- socially mediated to meet the needs of others, internal conflicts can arise. Therefore, in the process of identifying learning goals, care must be taken to enable the client to work in harmony with the actualising tendency rather than towards a potentially destructive picture of the ideal self: As incongruences emerge new goals can be defined through dialogue which meet the needs of internal drivers. Rather than being a directive process, this is learning that is enabled through facilitation.

Further, these are good examples of theories which, once understood by the client can become a focus for further self-development outside therapy.

For a final definition of terms, if 'conditions of worth' feature significantly for a client, Rogers suggests that this client is likely to have an *external* locus of evaluation, a need to know from others what is 'right'. Preferably, "instead of searching for guidance from outside or experiencing an internal confusion or blankness, the fully functioning person holds their source of wisdom deep within…" (Mearns, et al., 2013, p.12). In this state, the client is said to have an *internal* locus of evaluation and is able to stay true to their organismic valuing process and actualising tendency. The process of therapy can facilitate a shift in this locus and this is often when significant movement is made with the client. As mentioned above, care would need to be taken to enable the locus of evaluation to reside internally and that a process of learning facilitation does not become a source of external control. In learning situations, the internal wisdom of the client is often disregarded in favour of teaching the right answer, so unsurprisingly, outcomes are limited.

Much is made of what the therapist actually *does* in most therapeutic models, although for person-centred practitioners this is an entirely inappropriate question. The therapist doesn't necessarily *do* anything – it is more about *being,* what they *are.* It is an attitude rather than a technique. To put it in as near concrete terms as possible, Merry suggests that "the spirit of Carl Rogers had much to do with caring for each other and creating conditions for each other in which we all grow to our fullest potential" (2000, p.101). The assertion that the core conditions of empathy,

positive regard and congruence are attitudes rather than techniques gives rise to the criticism that the therapist's role is a passive one, although "very far from being a passive, merely reactive process on the therapist's part, it involves attentiveness, highly active listening and direct interest", according to Barrett-Lennard (1998, p.89). Even so, this lack of directivity does give rise to a significant dilemma when learning facilitation is considered. Therefore, any attempt to facilitate learning based on Rogers' person-centred principles, would quite clearly contradict the basic tenet of only actively listening and showing interest. There would in fact be a great deal to 'do'. As result, it may be that those (such as the researcher) who have emerged from Person-centred therapy wondering what the point was, more specific outcomes may be facilitated.

Over time, a variety of person-centred therapeutic approaches have emerged, which seek to define more specifically what the therapist should focus on (Cain, 1993). The diverse nature of these PCT therapeutic models or 'tribes' (Sanders, 2012) is seen as a positive quality to be prized (Cooper & McLeod, 2012). Developments over time have included Gendlin's Focusing (1969, 2012); Perceptual-Experiential Therapy (Combs, 1993); PCT at relational depth (Mearns & Cooper, 2005, 2013); Dialogical Person-centered Psychotherapy (Schmid, 2006); Process-Experiential/Emotion-Focused Therapy (Elliot & Greenberg 2007; Greenberg, 2011); a Pluralistic Perspective by Cooper and McLeod (2011); Pre-therapy (Sanders, 2012); Counselling for Depression (Sanders & Hill, 2014) and most recently, existentially Informed PCT (Cooper, 2016). Even Rogers' daughter Natalie developed her own approach in the form of Expressive Arts Therapy (Rogers, Tudor, Embleton-Tudor, & Keemar, 2012), which Rogers himself was

involved in tutoring. What each of these approaches share is a specific focus, and therefore potentially increased directivity, on the part of the therapist. Indeed Bazzano (2016) sees these recent developments in PCT as consistent with the current master narrative of neo-liberalism in which it is assumed that therapy can measure, apprehend and even control human experience. To a degree, this is the perspective from which this study emerges, one which seeks to define humanistic experiencing in such a way that it can be addressed and developed.

As person-centred models become more focused, the intentions and activities of the therapist are more defined, which raises the contentious issue of being directive within a non-directive therapeutic paradigm. PCT is a well-established approach that has endured since the 1950s with a group of writers arguing for it to stay that way. The philosophical and methodological integrity of the classical approach has been advocated by many, most recently for example by Cornelius-White (2015), Moon and Rice (2012), Farber (2007), Mearns (2003), Brodley and Moon (2011), Bozarth (2002), Levitt (2005), Merry (2000), Barrett-Lennard (1998) and Wilkins (2002). Strong support for Rogers' approach is to be found in these references, and a good deal more psychotherapy literature, often with unnecessary fervour.

Despite these views, Rogers and Koch (1959) expressed a warning, saying: "...at the time a theory is constructed, some precautions should be taken to prevent it from becoming dogma" (p.190) and there have been criticisms levelled at 'pure' PCT over time. Thorne (1944) suggested right from the start that the classical PC approach amounted to 'scientious summarising' and was 'monotonous'. More

recently Sachse accused Person-centred practitioners of developing into a ‘sect’ on the basis of their ethical stance, shut off from new developments (2003). Kahn agrees, suggesting that ‘purists’, although non-judgemental of the client are highly judgemental of any flexibility or ‘naturalness’ in using the approach (2002). From the researcher’s perspective pure PCT can be a laborious process, often making limited progress. The researcher therefore concurs with Cooper and McLeod’s pluralistic view (2012), “that each individual is distinct, and that the role of the therapist should be to facilitate the actualization of the client’s unique potential in the way that best suits the individual client” (p.213).

The main question of PCT theory is whether Rogers’ conditions of therapeutic personality change (1957) are in fact necessary and/or sufficient at all (Hill, 2007). Lazarus considered it a rare and privileged pleasure to find a client only in need of empathic reflection (1969), and over time, more criticisms of this nature have emerged; discussed for example by Parloff, Waskow and Wolfe (1978), Patterson (1980), and Tudor and Worrall (2006). The main argument here is that for some clients, something more than empathic reflection is needed. For example, a fear of flying may be better addressed with behavioural therapy than empathy. Notably, for Patterson like Lazarus, there are some clients for whom new skills, knowledge and therefore teaching are also necessary (1980, p.661). And from the researcher’s point of view, it is often very difficult to sit with a client’s own processes when progress could be expedited in some cases through a more directive approach. Sometimes empathy, congruence and unconditional positive regard seem to be simply not enough.

Further attacks on Rogers' most basic philosophical assumptions are also readily available. An individualistic nature, unaffected by either surroundings or social context is called into question by many, for example Patterson (1969) and Ryan (1995). As Kensit (2000) explains, an individual is not driven entirely by their genes, nor able to achieve their best in isolation. Neither is the client driven wholly by their environment and social context, but a mix of the two. The implication therefore is that the client *within their context* is the focus for therapy rather than the client's innate tendency to 'become'. It rings true for the researcher that clients need to discuss their issues in the context of personal relationships or their environment. Clients are unlikely to disregard issues of context bringing only intra-personal issues for debate.

More criticisms of Rogers' belief in self-actualisation include its lack of detail on individual differences, suggesting that client's progress similarly in a positive direction towards the universal goal of being fully-functioning. Bordin (1969) argues that focusing on the integration of the 'self' and 'ideal self' concepts, which is a main focus of PCT, ignores the richness and complexity of the human personality. As a result, it may be that, as Quinn suggests, this overly optimistic practise of relying on the actualising tendency and organismic valuing process has led to 'Pollyannish optimism' and passivity on the part of the therapist (1993). The researcher agrees that human development may be entirely more complex than Rogers would lead us to believe and therefore, a rich dialogue which uncovers the individual needs of the client through a process of learning facilitation may be appropriate.

One of the most contentious areas for debate in PCT is the extent to which the therapist is or should be non-directive, (particularly since the approach was originally known as a Non-directive Therapy). Views are highly polarised, with critics of the approach suggesting that directivity in PCT, far from being inappropriate, is in fact inevitable. Sachse (2004), for example, is adamant that therapists *are* directive, and further, Wood (2008) is of the view that client-centred therapists 'play a role', practising in a mechanistic way. Indeed the researcher's perspective supports the inevitability of directivity to some degree in any helping relationship.

Other writers on PCT consider that directivity on the part of the therapist is, if not inevitable, at least acceptable. Wachtel (2007) suggests, (and the researcher has experienced), that sometimes advice or direction is precisely what the client yearns for. Bohart (2012) agrees, commenting that there is a need to find ways to direct in a collaborative way whilst also respecting the client's autonomy. Takens and Lietaer (2004) suggest that Rogers' core conditions imply task-oriented, or directive ways of responding anyway. They suggest a subtle balance between steering and following, in which there remains plenty of room for the 'self-propelling' process of the client. In fact, Holdstock and Rogers (1983), claim that the PC approach does not exclude the use of techniques as long as they are not forced on the client, a view regularly referenced in the name of directivity in PCT. It seems that these views would seemingly support the notion of 'facilitation' at least, if not actual teaching.

Further, critics of PCT consider that non-directivity is quite specifically not enough, a view readily supported by the researcher. Kahn (2012) suggests that merely providing an empathic understanding limits the creative and intellectual potential of the therapist. Hill (2007) also suggests that therapist techniques are able to influence PC outcomes. Sachse is even more forthright in his view, suggesting that a vital element of the therapeutic process are interventions that deliberately steer the clients' clarification processes (2004). For these commentators, directivity is not only acceptable, but necessary. The views on directivity outlined here, in the writer's opinion, provide enough critical support for the purposeful facilitation of learning in person-centred therapy.

Rogers considered that "there was the possibility of describing the process of therapy in terms of learning theory" (2004, p.127-8), understanding well the works of Skinner and the behaviourists (Rogers, 2004, ch.20). Further, he considered that in therapy "it is learning which makes a difference – in the individual's behaviour, in the course of action he chooses in the future, in his attitudes and in his personality" (2004, p.280). He goes on to outline specific learning that takes place; for example, the client "becomes more confident and self-directing" (p.280). Rogers always regarded empathy as possibly the most important element in bringing about learning and change (1975, p.3) and concluded that "…my long experience as a therapist convinces me that significant learning is facilitated in psychotherapy, and occurs in that relationship" (2004, p.280). As Bordin concludes, "the effort to establish a discontinuity between teaching and psychotherapy seems futile. Of all theorists, Rogers has, in fact, been most loathe to separate them" (1969, p.44). Any argument

that person-centred therapy is not about enabling a learning process would therefore seem inappropriate.

In summarising the heated debates outlined above, the researcher is drawn to the following quotation by Bohart:

What I have minded in our community is the contentious and dismissing tone that has characterized some of the debate over (PCT). This has happened on both ''sides'' – those who are convinced that anything but traditional, classical nondirective ways of practicing are destructive distortions; and those who believe that if we do not add techniques and other things onto traditional person-centered practice we are being unscientific, irresponsible, and stubborn stick-in-the-muds… On the one hand, my ''heart'' is with the traditional nondirective approach. On the other hand, my experience of doing therapy has led me to believe that I had to be open to a wide variety of ''tools'' to help my clients. Furthermore, I became philosophically and theoretically convinced that there was nothing incompatible about incorporating techniques and procedures into person-centered therapy (Bohart, 2012, p3).

It is considered on the basis of the arguments above therefore, that enabling a learning process, which still remains self-directed by the client, is not pushing the boundaries of PCT too far.

2.2 Talking Therapies Which Have a Learning Element

Learning has not historically been a specific focus for psychotherapy, except that Martin (1972) clearly considered the issue of learning significant enough to write a book entitled 'Learning-Based Client-Centred Therapy'. (Reflecting the time of writing of his book, however, the focus was very much on behaviourism and therefore leaves scope for further development of the material.) More recent integrative approaches do, in some cases, make a learning intent explicit - as an adjunct to therapeutic change, but none regard their overall aim as a learning one.

The following therapeutic approaches are considered to have an explicit learning element:

Cognitive Behavioural Therapy (CBT) for example, is a therapeutic approach with an emphasis on homework, and teaching new ways of thinking and behaving (Beck, 2011). CBT is "based on the assumption that prior learning is currently having maladaptive consequences, and the purpose of therapy is to reduce distress or unwanted behaviour by undoing this learning or by providing new, more adaptive learning experiences" (Brewin, 1996). CBT has its foundations in the integration of behaviour therapy and cognitive therapy; behaviourism being defined quite specifically on principles of learning (Eaglen 1978). Exposure therapy for example, is a behavioural technique based on inhibitory learning theory (Craske, et al., 2014) and is used within CBT. Beck's cognitive element of the therapy focuses on identifying automatic thoughts which lead to unhelpful behaviours, and the evaluation of these thoughts is a skill which is learned in collaboration with the therapist. Homework assignments are designed to reinforce this learning. Experiential learning is also encouraged as clients test out new approaches to problem solving. Clients are then encouraged to engage in self-therapy sessions in which they develop skills in assessing problematic situations and assessing which skill would best meet the need (Beck, 2011, p.326). The therapist is encouraged to focus on the clients' learning by ensuring they understand the necessity of certain tools and skills and using them regularly. Further, they are encouraged to consolidate the clients' learning by ensuring they will remember key elements of the therapy session and are motivated to read their notes daily (p.355). Although the subject of learning is addressed in CBT, it is from the perspective of teaching, as

clients are encouraged to learn the tools and skills necessary to manage their unhelpful automatic thoughts, behaviours and feelings.

For Gestaltists, "learning is a complex process of interrelationships which occur as a result of engaging with a new problem in the light of previous experiences" (Armitage, 2012, p.78). It is a process of the perception of 'wholes' rather than parts, and their integration, which leads to a sense of closure and insight. (Insight is defined as "the clear and sudden understanding of how to solve a problem" (Bowden, et al., 2005, p.322)). This learning process, often experiential, and building upon previous learning and growth, is identified as a significant element of Gestalt therapy (Perls 1992; Philippson, 2018). The 'gestalt experiment' for example, is designed to heighten awareness of the present and how that might be shaped by past experience (Mann, 2010). The journey that the client takes gives the opportunity to experience a profound learning through the wisdom of the organism, so directivity in the form of rescuing the client is therefore seen as inappropriate. Thus, learning theory is integrated, to a limited extent, into this approach, in the form of experiential learning and learning based on prior experience.

The Skilled Helper approach to therapy is a client-centred approach which explicitly utilises elements of learning theory (Egan 2014). It is based on a problem-solving model which helps clients to manage problem situations and develop unused opportunities through effective decision making and a preference for prevention of further problems. And, if "a problem-solving action is not successful, then the counsellor helps the client learn from it" (p.176). There is a CBT element to the approach in that distorted thinking, emotional expression and behaviour is

challenged, and the client is helped to identify, develop and use resources that will make them more effective agents of change. Although the main aim of the approach is to help the client to solve problems and utilise opportunities, one of the mechanisms by which this is achieved is identified as learning. For example; learning how to help oneself is defined as the second main goal for the client in therapy; learning transfer is also discussed; and mutual learning by the therapist about their client and the client about their problem is highlighted. However, the therapist is still identified as a helper, a coach or a consultant and the approach is largely directive, following a very clearly defined process. The learning is defined by an understanding and implementation of a successful problem-solving model, a process which begins with the therapist and not in fact with the client.

Solution-focused Therapy, attributed to De Shazer (1982, 2012), in summary, is a client-centred approach based on un-conditional positive regard and works towards well-formed goals, which are concrete, achievable, measurable and realistic. It is also non-pathologizing and assumes that the client is competent in making their own decisions about their life. The client is considered to have both resources and strengths which can be identified, and which then take on a level of importance in finding solutions. Only the client can know what is best for them, so therapists are therefore experts in the "process of solution-building" (Nelson & Thomas, 2007, p.12), but not experts in the life of the client. The therapist does, however, engage in "persistent questioning driven by the therapist's interest in client experiences and meanings" (p.5). It is a questioning process that 'identifies and amplifies' possibilities and the 'miracle' question may assist in that process by enabling insight into the future. This approach is not built on any particular model, but has been

pragmatically derived from empirical observations of therapeutic dialogue. Learning principles are not referred to specifically, but elements of the approach are aligned to learning processes. For example; detailed goals are elicited and framed positively to enable clients to work towards a solution, and clients are encouraged to design their own homework rather than follow a defined process. Therapists, however, are not entirely facilitative in that they lead the session from 'one step behind' (De Shazer, 2012, p.4).

Multi-modal Therapy is built on a trimodal base of cognition, affect and behaviour, in a similar way to CBT, but Lazarus contends that "equal weight should be given to imagery, sensations, interpersonal relationships, and biological considerations thus operating from a seven-point multimodal perspective (behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biological factors)" (Lazarus, 2015, p.72). Multimodal therapy is an approach which is explicitly built on social - cognitive learning theory using techniques such as modelling, observational learning, the acquisition of expectancies, operant and respondent conditioning, and various self-regulatory mechanisms (p.73). Learning theory is at the heart of the approach since its roots are in behaviourism. The addition of cognitive-social learning theory, coupled with a focus on the individual modality preference of the client make it a facilitated learning experience in part. Indeed Lazarus suggests that "it is a multimodal maxim that the more someone learns in therapy, the less likely he or she is to relapse" (p.72). It is however, a directive and prescriptive approach, designed to enable an expert therapist to define the most suitable *technical strategies* to employ (rather than any combination of

theoretical perspectives). As such Lazarus considered that the multimodal approach is the polar opposite Rogers Person-centred therapy.

There are clearly many other approaches to therapy which utilise learning theory such as; behaviourally rooted approaches like Rational Emotive Behaviour Therapy (Ellis 2013); cognitive perspectives such as Personal Construct theory (Kelly, 2003); existential therapies such as Psychosynthesis (Assagioli, 2000); and the psychodynamic stable of approaches, to name a few. The theories reviewed above have identified learning theory explicitly as part of their approach in some way, but that is not to say that other approaches do not also enable their clients to learn either explicitly or incidentally. In summary, psychotherapy seeks to enable a limited number of learning processes in various ways, but learning is not the main aim.

2.3 Existing Theories Which Link Learning and Therapy

Attempts to consider the links between learning theory and psychotherapy have been made by a number of theorists and clinicians over time, although these theories have not necessarily been used as part of a psychotherapeutic approach. None focus specifically on self-directed learning facilitation, but all have implications for this study. Gerber, suggests "that all counselling interventions work because they exist in the context of a learning theory". He proposes that all that is really needed is an understanding of each of these basic learning theories: "association, reinforcement, cognition-perceptual, and cognition-rational/linguistic", within these contexts: "developmental, social, and spiritual" (2001, p.282). By being a seemingly complex solution to an equally complex problem, this model has

limitations for its use in a practical setting. Marton and colleagues conclude through a phenomenological study, albeit in an educational setting, that learning is ultimately "changing as a person" (in Salo 1993, p.283). They suggest that learning is hierarchical and includes an existential aspect. They go on to say that "by developing insights into …the phenomena dealt with in the learning material, one develops a new way of seeing those phenomena, and seeing the world differently means that you change as a person" (p.292). Personal change is a useful perspective for therapy, presenting learning as more than the acquisition of new knowledge and skills. It suggests that permanent change occurs, which would seem entirely logical as a definition of learning. In a specific examination of learning in counselling, Griggs also suggests that "counselling is fundamentally a learning process that, if successful, involves positive changes in the attitudes and behaviour of the counsellee. Further, Griggs suggests that individuals have learning style preferences, which, if attended to, will facilitate the learning process" (1991, p.46). Amongst others she discusses Kolb's Learning Style model in which 'divergers, convergers, assimilators and accommodators' are identified (p.24). Learning styles, are a subject worthy of discussion with trainees, so the same approach could usefully be applied to a counsellee. Once a client is aware of their own preferred way of learning, time is not lost, for example, in providing unhelpful homework, or explaining a model from the perspective of the therapist.

Burnett is one of a small number of current figures with an interest in learning *outcomes* applied to psychotherapy with a fundamental belief that "all theories of psychological change are fundamentally theories of learning" (Burnett & Meacham 2002, p.411). In a study, completed with Van Dorssen in 2000, in which

learning outcomes in therapy were captured, they consider that their "taxonomies offer a promising and exciting way to view the impact of counselling within a learning framework" (p.241). Burnett and Van Dorssen's study was a key inspiration for this project, since it addressed the outcome of therapy purely from the point of view of what had been learned, rather than the usual measures of success such as decreased symptomatology. This learning perspective would provide the start point for a learning focused methodology, since if learning outcomes were clarified, then learning goals could be set and an individual 'curriculum' identified.

In 2005, Loewenthal and colleagues considered the topic of 'Counselling as a Form of Learning' and further as "a reparative discourse that facilitates a return to learning from experience" (2005, p.441). Here, progress is made by relearning or filling in the gaps where childhood learning experiences were deficient or absent. Experiential learning provides the foundation to experiential therapeutic approaches, but unless the client is aware of the process in which they are involved, they cannot replicate it. Experiential learning in therapy demonstrates the difference between a therapeutic approach and learning facilitation well – for example, a client may change as they experience therapist UPR, or better still, learn that acceptance is a need that they have, and identify sources other than the therapist.

Donald Scaturo (2010) has produced a tripartite, heuristic model for training and clinical practice encompassing three domains of learning that occur in psychotherapy. These are the emotional elements of the therapeutic alliance, the cognitive aspects of technical interventions taken by the therapist, and the behavioural relearning that occurs post-therapy. Scaturo sees learning as a 'unifying

metatheory', bringing together "a wide range of diverse theoretical perspectives" (p.21). The fact that Scaturo sees learning as a unifying metatheory is particularly relevant here, since the various psychotherapeutic approaches often compete for proof of greatest efficacy which entrenches opposing theoretical positions. Learning outcomes could provide a unifying raison d'être for the field.

Only a small number of writers have addressed the issue of learning in the context of therapy specifically, but the majority of findings are summed up well in the following quotation:

> *Psychotherapy typically involves learning (unlearning, relearning, new learning), which may take many different forms; and it proceeds by a diversity of methods that may have divergent outcomes. The outcomes may manifest themselves as changes in cognitions, feelings or behaviour (or some combination of these)* (Strupp, 1986, p.124).

More specifically, it is considered that Person-centred Therapy is, as Dryden suggests, "…a process which is in many ways an education for living" (2007, p.164).

2.4 Theories of Learning Applicable to Person-centred Therapy

A variety of behaviourist, cognitivist, emotion-based and neurological learning theories, when consolidated together, could provide the basis for a person-centred therapy defined entirely by its intent to enable clients to manage their own learning process and resulting therapeutic development. A limited sample of applicable theories are offered below, starting from the beginning of the 20th century through to modern day neurological theories, and are summarised from a broader knowledge base. The theories presented are referenced using their original writers and sources, although all are still used in a variety of learning contexts today.

2.4.1 Behaviourism.

Behaviourism is a deterministic science, in that the behaviour of individuals, and the choices which lead to those behaviours, conscious or subconscious, are said to be *caused*. Further, person-centred therapists accept that they direct the process, even to a small extent (Kahn, 1999), for example in the questions that they ask (Renger, 2014, unpublished). Therefore, there are behaviourist concepts which may be relevant to person-centred therapy, and which can be utilised to facilitate self-directed learning.

Pavlov's ground-breaking work with salivating dogs (1960) gave us the stimulus-response (S-R) theory which suggested that reflex actions can be externally stimulated. In the same way, as Rogers suggests, the life process of the healthy organism relies on "the capacity for receiving feedback information which enables the organism continually to adjust its behaviour and reactions so as to achieve the maximum possible self-enhancement" (Rogers, 1969, p.251). Therefore, feedback given in the context of the therapeutic relationship and based on the core conditions, is able to facilitate change. What this feedback is, and how much it is directed by the therapist, is an important question to consider.

Building on Pavlov's ideas of stimulus and response, Skinner considered that responses could be conditioned. On the surface, the stimulus-response theory of the behaviourists would seem to be more applicable to CBT than person-centred therapy, although consideration of the term core 'conditions' may suggest otherwise. Surely if a set of conditions exist, the client is subject to some kind of 'conditioning'?

Clients are conditioned by language (Bandura, 1961), and in a 'way of being' by mere exposure to the process and the therapist (Rogers, 2004). Client's behaviour or dialogue is rewarded in the minutest facial expressions demonstrating approval or disinterest. In this way, behaviour can be influenced subconsciously by the therapist, or consciously towards defined humanistic outcomes.

Skinner also believed that learning involved a stimulus, the response, and a reinforcement occurring together, and that "teaching…is a process of managing the contiguous relationship of the three contingent events" (Gerber, 2001, p.285). Therefore learning facilitation becomes a process of ensuring that the right reinforcers occur at the right time for the client. As radical behaviourism developed, Skinner included emotions in his equation (which he also saw as a type of behaviour), suggesting that the aim for the individual "is to change how they act and thus, incidentally how they feel" (Skinner 1974, p.175). CBT seeks to explain this relationship between emotions, thinking and acting. There may therefore be potential for the therapist to provide a feedback loop (Argyris, 2000) to support this process of integration by providing systematic stimulus and reinforcement.

Another behaviourist concept suggests that "when a given act is almost always reinforced, a person is said to have a feeling of confidence" (Skinner, 1974, p.58). Confidence building within the context of person-centred therapy would not normally be a given aim, but should a client receive a positive reaction, when they reflect on and make progress on important emotional factors, progress is encouraged and confidence may develop over time. Further, Dijksterhuis and Van Knippenberg's notion of 'priming' (1998, p.865) suggests that a client's frame of thinking can be

subtly directed towards positive growth. Bargh and Fergusson's idea of 'behaviour mimicry' (2000) also occurs, often without the conscious awareness of the individual, as may be seen in children who watch violent videos behaving in a violent way to classmates. Thus a congruent therapist, able to demonstrate confidence in her own organismic experiencing, provides a model which, over time, can engender those same qualities in the client. In theory then, this would also be possible for traits such as confidence, assertiveness, calmness, respect and so on - whatever would be most beneficial.

2.4.2 Cognitivism.

Skinner considered that between stimulus and action was room for thought processes, and that these internal processes were behaviours in themselves (1974, p.225). Analysis of these behaviours also has potential in the process of therapy. What is particularly relevant in this context is his view that "a person who has been 'made aware of himself' by the questions he has been asked is in a better position to predict and control his own behaviour" (1974, p.31). 'Self-management' is therefore an important part of an on-going process of learning and growth, and the prediction and control of behaviour by the individual is key to that process. The use of questions within person-centred therapy facilitates a process of self-awareness whether it is in a directive sense, or in the 'here and now' experiencing within the relationship. What questions to use, when, and for what purpose, are therefore key considerations for the therapist focusing on learning and development.

One of the fundamental features of a self-directed learning process is that of goal setting. As Knowles suggested, facilitating a learning process without some

idea of the purpose is very difficult, and as Bandura notes, "goal setting … provides a major cognitive mechanism of motivation and self-directedness," (1999, p.28). Conscious goals can be derived, developed and firmly established in a facilitated learning process. For example, Motschnig-Pitrik and colleagues (2008, p.10-11) characterize learner-centered learning goals as being derived and co-determined in dialogue and co-assessed by the learner and facilitator. This framework applies to an educational setting, but the idea of goal setting is also appropriate to the therapeutic setting and has been addressed in Bordin's notion of 'goals, tasks and bond' elements (1979). And goal-directedness is foundational for the researcher, both in a personal sense and as a trainer/counsellor.

Goals, contracts and learning plans do not generally feature in PCT unless requested by the client. Even so, Rogers' theory of personality and behaviour suggests that behaviour is "basically the goal-oriented attempt of the organism to satisfy his or her needs as experienced, in the field, as perceived" (2003). Rogers' organism strives both consciously and unconsciously towards often competing goals and it is the rationalisation and integration of these goals through therapeutic dialogue that facilitates growth towards self-fulfilment. Most recently, Cooper and McLeod suggest that "therapists should specifically orientate their work toward clients' goals, and enhance their levels of dialogue and metacommunication with clients regarding the goals, tasks and methods of therapy" (2011, p.210). Given this support from the person-centred community, goal-setting features strongly in Study 3 of this project as the approach is tested in a clinical setting.

Gerber (2001) has included the idea of *decision-making* within stimulus-response theory, suggesting that stage 1 is stimulus *and perception*, stage 2 is decision and action. In Person-centred Therapy there is no requirement to question the client on the thought processes which brought about any change in their perception; hence Bowles' concern (2012, p.259) that clients may lack the 'scaffolding' to transfer their learning. The potential therefore, is for the therapist to facilitate a process of decision making linked to perceptions. So, for example, a client may experience a new sense of acceptance, and then benefit from dialogue on how that may be consolidated into positive life changes and growth.

Tolman (1925, p.39) also believed in something occurring between stimulus and response, which he regarded as a sense of 'purpose'. He felt that it was necessary to be going *to* or *from* something, and also that the route to a goal could be learned. Therefore, if self-actualisation is a conscious drive, the facilitation of the engagement of this inner drive and of the resulting personal growth can be a legitimate aim for the therapist. Aarts and Dijksterhuis (cited in Bargh & Ferguson 2000, p.933), have suggested that behaviours are automatically linked to higher order goals, so, if a goal is activated, the plan or the habitual behaviour is automatically engaged. As Bandura notes, "the capacity to exercise self-influence by personal challenge through goal setting, and evaluative reaction to one's own performances, provides a major cognitive mechanism of motivation and self-directedness" (1999, p.28). Goal setting in therapy is most often associated with the alleviation of specific problems, for example, 'to stop being anxious' or to 'deal with a difficult relationship'. Humanistic outcomes such as 'to experience self-compassion' are equally valid goals and can be defined and constructed in a way which makes sense

to the individual. Thus a learning process is initiated as the goals are defined and automatic habits formed which drive towards their attainment.

The cognitivists brought a new perspective to the idea of learning in the mid 1900's, focusing on the inputs, processes and outputs of the mind, conscious or otherwise. Knowledge, memory, mental maps and decision making became the focus of scientific study, providing useful concepts for defining how therapeutic learning may be facilitated. Piaget, although focusing mainly on child development, contributed the ideas of accommodation, assimilation and schemata to the field of learning (Piaget, Gruber, & Voneche, 1977), all of which have relevance to person-centred counselling. As the individual assimilates new knowledge into existing internal mental maps, or accommodates new information that initially does not have a place, so the world view, or self-concept develops. Facilitating this process of 'adaption' enables the client to move towards a sense of equilibrium, a state whereby most new information can be dealt with on the basis of assimilation. In a therapeutic sense, "…unassimilated experiences may be described as obscured, warded-off, denied or repressed…. After being assimilated, however, the formerly problematic experience is part of the schema; thus, a schema, comes to consist partly of the personal insights achieved during therapy" (Stiles, et al., 1990, p.412). Further, this process can allow for the integration of a community of voices, allowing over time, the contradictions of the ideal self and conditions of worth to be amalgamated. Facilitation of this process through the use of questions or reflections by the therapist, typically focusing on areas of incongruence, frustration and anxiety, would enable accommodation and assimilation to occur.

Constructivism grew from the work of Piaget, and was considered to be "basically a metaphor for learning, likening the acquisition of knowledge to a process of building or construction" (Fox, 2001, p.23). The application of constructivist theory to psychotherapy has been considered extensively in Kelly's Personal Construct Theory (Kelly, 2003) and in Polkinghorne's notion of 'narrative' (2010), in which lives are represented and acted out as constructed stories. Within person-centred therapy, there is also the possibility to facilitate a dialogue which demonstrates that a client's experiencing may be a personal construct rather than an objective 'truth'. A move towards an inner locus of control requires a shift in thinking from external conditions of worth towards a personal phenomenological framework. Consideration of the social context within which information is constructed and assimilated can be discussed, and the resulting 'voices' or 'selves' which give rise to internal conflicts identified.

Bruner's notion of discovery learning (1961) grew out of the constructivist idea of mental maps and their development based on experience. Discovery learning, useful for problem-solving, allows the individual to discover his own way of viewing the world and can therefore be a powerful tool for learning. Because connections are built upon the individual's prior knowledge, "they are already more meaningful than an artificially imposed connection" (Svinicki, 1998, p.6). This process of discovery could be facilitated through dialogue in person-centred therapy, so insights are experienced as 'aha moments', when conflicting ideas about the ideal and conditioned self-concepts become integrated. The role of the therapist therefore "involves confronting the learner with a problem and allowing them to explore the problem and try out solutions on the basis of inquiry and previous learning"

(Armitage, 2012, p.80). Learning is generalised into knowledge that can be applied in the longer term and contributes to an ongoing process of growth towards self-actualisation.

One theory of learning suggests that the post-modern self is created in communion with others through the personal phenomena of experience. It is also suggested that "…all experience is the 'raw material' of learning" (Loewenthal, et al., 2005, p.446). Practically speaking, that involves "the process of transforming experience …into knowledge, skills, attitudes, values, senses, emotions, and so forth" (Jarvis and cited in Loewenthal, et al., 2005, p.447), by revising or creating new interpretations of that experience. And further, they suggest that being open to current experiencing allows for reflection to be consolidated into learning and transferred to other similar situations (p.451). There is here, an important learning process of continual reflection and discovery through experience. That consolidation then allows for learning transfer to new situations, a process which could be facilitated in a therapeutic setting.

Kolb's 'experiential learning' theory (Kolb & Kolb, 2009) managed to successfully combine cognitive processing, with environmental influences and emotional experiencing, and was inspired by the work of Rogers. Their experiential learning cycle includes concrete experience, reflective observation, abstract conceptualization and active experimentation, where "everything begins and ends in the continuous flux and flow of experience" (Kolb & Kolb, 2009, p.300). Kolb presents a useful process to be aware of for therapy since it could provide a cyclical model through which to monitor or facilitate a client's progress. Kolb's Learning

Style Inventory is based on this model and suggests that our learning preferences can include experiencing, reflecting, thinking and acting, diverging, assimilating, converging, accommodating and balancing (Kolb & Kolb, 2009, p.315). Understanding the client's learning preferences would be vital to a person-centred therapy based on learning theory, in order to facilitate appropriate learning processes. Finally, Kolb's idea of a 'learning self-identity' (Kolb & Kolb, 2009) could also be facilitated through therapy. A personal belief in the potential to grow through experiencing, rather than accepting the limitations of a 'fixed-identity', requires trust in the experiential process, and equally could be facilitated.

Vygotsky (2012) was writing around the time of Piaget, and focused on social development theory which stressed the importance of social interaction on the learning process. His view that social learning preceded development in children resulted in his idea of the 'zone of proximal development' (ZPD), explained as the learning potential for the individual gained through dialogue with a more knowledgeable other. Vygotsky's idea was based on the premise that "the state of development is never defined only by what has matured, but that which is in the state of maturing" (Vygotskii, Rieber, & Carton, 1987, p.208). Further, development in this context occurs mainly through imitation, although it is considered to be limited by the potential of the individual. In applying Vygotsky's ideas to therapy, Carkhuff notes that:

> *The helping relationship is critical because it is the vehicle by which the counsellor becomes both agent and model for the client. An effective relationship enables a low-level functioning client to function at higher levels in critical areas of functioning* (1971, p.129).

Therefore in practice, the modelling of problem solving or self-efficacy for example, may enable the same in the client. Holzman (2009, p.35) also suggests an 'emotional ZPD' emerging in the process of therapy. In this way, dialogue focused on the 'felt sense' or emotional experiencing (of the therapist's process in addition to the client's own process) can facilitate emotional growth. The key here is acknowledging the role that the therapists' skills, abilities, attitudes and emotional experiences can have in developing the same in the client.

2.4.3 Client Autonomy.

If learning is to be facilitated as a self-directed process, consideration must be given to the likelihood of the client taking on that responsibility for themselves, and not to rely on the therapist to direct the process for them. Holdsworth and colleagues (2014) suggest that client engagement has been associated with positive psychotherapeutic outcomes, however, they acknowledge that much therapeutic progress is lost as clients disengage with the therapeutic process. Since, in their view, "…inconsistent definitions and assessments have generated confusion as to the precise scope and nature of the engagement process" (p.24), there is clearly room to develop this body of knowledge further. Although often considered to be linked to the therapeutic alliance (Thompson et al., 2007), engagement for the writer is a function of; motivation; personal goals; the confidence to commit to a process; the lack of external barriers; and sufficient learning resources available - and, in the absence of a good therapeutic alliance, a self-directed learner will find a way to engage or change their therapist. Tools and techniques for client engagement are offered by O'Donohue and colleagues (2017), such as 'meeting patients where they

are at' or through mindfulness, but it is considered that the following theories would best support the notion of a self-directed learner:

The autonomous nature of the individual is driven in part by their motivation to achieve. In the 1970's, Ryan and Deci (2011) put forward a humanistic theory of motivation known as Self Determination Theory (SDT), which emphasised the active involvement of the individual rather than the drive of the unconscious. They saw the interplay between the organism and the social context as the basis for growth, giving clear implications for the role that the therapist plays in engaging that drive to learn. More specifically, SDT suggests that three fundamental psychological needs drive personality integration: (a) the need to feel in control of personal goals and behaviour; (b) competence; (c) relatedness to others (Ryan, et al., 2011, p.230). These natural development tendencies require social support and it is the role of a therapist to enable their progress. Although the writer would suggest that therapeutic learning could occur in the absence of a sense of relatedness, a sense of competence and control would need to be attained before long term change could be effected. According to Ryan and Deci (2000, p.59) this is achieved by positive performance feedback; so it is a process of feedback which is fundamental to learning facilitation. Feedback on successes enables the client to feel in control of personal goals and develop in competence, rather than accept stagnation.

Bandura believed that individuals based their behaviours on judgemental self-reactions which were themselves based on personal standards rooted in a social context (Grusec, 1992, p.782). 'Self-efficacy' is a concept based on social learning theory and refers to people's expectations of themselves. Bandura notes that "...this

belief system is the foundation of human agency. Unless people believe that they can produce desired effects by their actions they have little incentive to act or to persevere in the face of difficulties" (Bandura, 1999, p.28). He suggests that personal successes and failures, vicarious experience, persuasion and emotional or physiological states affect self-efficacy (Bandura, 1997, p.79), as does the individual's beliefs about likely outcomes (Bandura 1999, p.28). There are implications for therapy here. Egan, in the Skilled Helper Model for example (2010), advocates the development of self-belief through feedback, identifying role-models and the development of necessary client skills (p.346). In terms of person-centred therapy, beginning with a climate of positive belief in success is relevant, for which unconditional positive regard is clearly the foundation. Vicarious experiences which influence self-efficacy may be considered in the form of self-disclosure on the part of the therapist, or by modelling self-belief. Focusing on positive cognitive scenarios rather than dwelling on risk, in addition to enabling the internal locus of control to develop, may also be fruitful. In summary, in order to facilitate learning, "the task of the therapist therefore, becomes one of manipulating expectancies and reinforcement so as to bring about new values" (Price & Archbold 1995, p.1265).

The Theory of Planned Behaviour (Ajzen, 1991) (TPB) is also a theory of motivation. It grew out of the Theory of Reasoned Action and its latest formulation - The Integrative Model of behavioural prediction (Fishbein, 2008). It attempts to explain the connection between attitudes and action. The TPB suggests that the enactment of a behaviour is driven by a) the individual's attitude; b) the subjective norm – or the pressure perceived from others; and c) their perceived behavioural control – or the degree of difficulty envisaged by the individual. The constructs are

dependent on the individual's behavioural beliefs; the beliefs of others - or normative beliefs; and beliefs about the ability to control the behaviour. The attitudes or beliefs are further described as learned dispositions. So for example, the individual's attitude may be demonstrated in choosing not to return to therapy after a previously unsuccessful attempt. Normative beliefs and the pressure to comply may also drive behaviour, for example, family members have had success in therapy, so it is considered the norm to do so. Perceived behavioural control is the additional construct which separates the Theory of Reasoned Action from the Theory of Planned Behaviour and has links to Bandura's theory of self-efficacy (Ajzen, 2002). Control is defined as either internal, i.e. there is confidence that the individual can succeed, or external, i.e. that there are no barriers to success, or an opportunity to succeed. So for example, a client may choose to discontinue therapy as their internal confidence grows, or to make use of the external unconditional positive regard offered by the therapist to enable progress.

Critics of the theory argue that unconscious drivers are not considered in the model, a view countered by Ajzen (2011), who suggests that unconscious drivers lead to conscious decision making. For the writer, unconscious drivers can be made explicit through the therapeutic dialogue and the theory of TPB explained and made use of. The perception of the level of control over learning outcomes experienced by the individual is key and is something that can be worked on explicitly.

The self-directed or autonomous individual learner must be more than just motivated, but be able to harness the necessary resources to succeed. This individually focused perspective is encompassed in the 'self-directed' and

'autonomous' learner models , which have different origins, in Andragogy and Betts and Kercher's Autonomous Learner Model respectively (Betts, 1985). Armitage defines this idea as a process where adults set their own criteria for achievement, knowing where and how to find necessary resources, and measure their own success (2012, p.89). Although Armitage presents a cognitive/behavioural perspective, Ben-Eliyahu and Linnenbrink-Garcia add that self-regulated *emotional* strategies are also important (2013, p.558), a relevant addition for the person-centred approach - also to be found in Goleman's Emotional Intelligence theory (2006).

The notion of client autonomy or self-directedness is entirely compatible with a person-centred philosophy. In fact Rogers believed that the fully functioning person would be "confident and self-directing" (Rogers, 2004, p.280); and although clients could in theory be 'trained to manage their own therapy' as Carkhuff suggested (1971), at least a sense of volition and self-efficacy could be the aim if not. For Nelson-Jones, for example, this would be by encouraging clients "to confront their own problems and assume responsibility for finding their own warmth and happiness rather than seeking it from therapists" (2006, p.318). On a practical level, it may be in the behaviour modelling of the therapist, demonstrating self-acceptance, self-efficacy, belief in the potential for change and confidence in finding the support for it. It is an explicit assumption that the client will be able to manage their own process of healing, defined and presented to the client in such a way that the responsibility is understood and accepted.

2.4.4 Emotions and Learning Theory.

Emotional experiencing is a driver of the actualising tendency, core to understanding the self, and as such, has long been fundamental to person-centred therapy. Emotional experiencing has been seen more recently as a complex interplay between feelings, cognitions and actions (LeDoux, 1998), and further, "much learning and problem-solving occurs using implicit, non-conscious, emotion-driven brain systems" (Carter, 2003, p.238). Thus, if emotional experiencing drives thoughts and actions in the context of becoming fully functioning, understanding the workings of the mind from a holistic perspective becomes more relevant in that context.

Emotions can be considered in one sense to be a subconscious facilitator of learning, for example to enable a more efficient cognitive process (Carter, 2003, p.236) or to create concern for the individual self and initiate a problem solving process (Motschnig- Pitrik & Lux 2008, p.292). Bechara, Damasio, and Damasio (2000, p.301), consider that if emotional arousal is too intense learning is impaired, and Ben-Eliyahu suggests that emotions need to be of a positive nature to facilitate learning (2013, p.559). So, as the researcher has experienced with clients, if they are consumed by anxiety, or grief for example, little is possible in terms of a rational learning process. The role of a facilitator could be therefore to stay with the client in the emotional arousal but also to work towards enabling those emotions to be translated into problem-solving processes. In this sense, learning "results in the establishment of internal states that influence the individual's choices of personal action" (Gagne, 1985, p.219), and it is the understanding of those states which can be facilitated by the therapist. For example, a client may be enabled to recognise a state

of ongoing internal anger and frustration which may have been referenced as 'everybody else's fault'.

Neuroscience has contributed significantly to the debate on learning theory, largely due to advances in imaging technology. Gerber, for example, is clear that "learning either causes or results from changes in the central nervous system" (2001, p.284). Further, the organism is now seen to be an interwoven mesh of body, brain and mind, whereas before, they were seen as separate parts (Damasio, 2001, p.102). It is even questioned whether emotion and cognition can be distinguished at all due to the "…increasing understanding of the pervasive influence of emotions on all forms of psychological processing" (Pessoa in Dalgleish, Dunn, & Mobbs, 2009, p.363). Bloom's classic distinction between cognition, affect and motor-skills may therefore be no longer useful (Bloom, 1956; Krathwol, Bloom, & Masia, 1964).

Emotional processing as viewed by the neuroscientists has particular application to person-centred therapy: Damasio's 'Somatic Marker Hypothesis' (Damasio & Bechara, 2005), is an interesting neuroscientific theory of learning which deals with the interplay between cognition and emotion. In summary, this theory suggests that emotional information retained in the amygdala can consciously or unconsciously drive cognition and action: For example, a 'gut feel' which comes from learning through a previous experience is stimulated, possibly without the individual being conscious of it, when a similar situation occurs. (This is a theory which the researcher has particular experience of through a relative with a brain injury in the orbito-frontal cortex who is unable to experience this process at all.) Motschnig-Pitrik and Lux note that "it is interesting that Damasio's concepts and

findings appear to match and thus to confirm the visionary theories of personality and behaviour of Carl Rogers" (2008, p.288). For example, the organismic sensing of the client, or emotional learning retained in the amygdala, drives both the actualising tendency and modified self-concept based on conditions of worth. Therefore, "the therapist's empathic understanding helps the client to label and thus symbolize his/her emotional experiences" (Lux, 2010, p.282), then enabling a judgement about the value of those emotions.

Finally there is the idea of 'becoming' or as Jarvis has suggested,

> *...as long as I continue to learn, I remain an unfinished person ...I am always becoming. Being and becoming are inextricably intertwined, and human learning is one of the phenomena that unite them, for it is fundamental to life itself* (Knud, 2009a, p.32).

Heidegger saw 'becoming' as a learning process, and Rogers' self-actualising individual is in the process of 'becoming'. For Rogers it is seen as a natural tendency, and for the learning facilitator it is a process which could be enabled. Trusting in the innate tendency of the individual to become what they truly are may well be appropriate for long term therapeutic endeavour, but for a more efficient process, learning facilitation may be necessary.

2.5 Key Issues in Learning

One of the key questions to address in the application of learning theory to therapy is 'do clients learn or do they just change?' since if they 'just change', facilitating learning is a pointless exercise. Views are generally inconsistent: Gerber suggests that, "all client change comes as the result of learning" (2001, p.283). Marton, Dall Alba and Beaty, however, see it the other way around, believing that

"in order for a change to be called learning it has to endure..." (in Salo 1993, p.297), whilst in a study by Carey and colleagues, clients "described change occurring both as a gradual process and at an identifiable and memorable moment" (2007, p182). For Feltham and Horton, more specifically, therapeutic change comes from the client's ability to rediscover a trust in themselves (2006). The picture is confused, with little clarity on when, in what order, and over what period of time learning and change occur.

A number of general change models are available and variously shed light or confusion on the subject of the interplay between learning and change. Norcross and colleagues have identified 8-10 different processes of change across 400 different psychotherapies in their Transtheoretical Change Model (2011, p.144). The Transtheoretical model is clearly defined and includes direction for the therapist in that they may engage in Socratic teaching, coaching and consulting in order to enable their client to move through stages of change from 'pre-contemplation' to 'maintenance'. It does however, apply more readily to directive methodologies in its recommendations for interventions. Bowles' Adaptive Change Model (2006), is more appropriate for a person-centred approach, identifying stages of change such as 'openness to opportunity' and 'closure'. Factors supporting the process of change, such as 'inner drive', are also more applicable to the Rogers' conception of the person. Stiles and colleagues (1990, p.411) present an "integrative model of a central aspect of change in psychotherapy". Their assimilation model focuses on the integration of problematic experiences from a cognitive frame of reference, and as such is limited in scope, but does focus on experiential learning. The Phase Model of Psychotherapeutic Outcome put forward by Howard, Lueger, Maling and

Martinovich (1993) defines a therapeutic process, which "entails progressive improvement of subjectively experienced well-being, reduction in symptomatology, and enhancement of life-functioning" (p.678). In a similar stage to that of 'maintenance' in the Transtheoretical model, Howard and colleagues make reference to 'rehabilitation' which refers to the maintenance of gains and the prevention of deterioration – concepts associated with learning transfer.

Learning transfer is a subject addressed by a number of change models. For example, the concept of *treatment fidelity* (Rew, et al., 2018) which ensures consistent and robust interventions, includes reference to learning transfer. (The training of therapists is important in this regard, and is considered later in this thesis.) Two stages of change within the idea of treatment fidelity are referred to as 'receipt' and 'enactment' (Bellg, 2004). Regardless of the fidelity of the approach to its theoretical model, change only occurs if the intervention is actively *received* and *acted upon*. For example if the intervention is designed to define the learning style of the client, receipt is confirmed if the client can explain the results and their implications. Then the next phase, for example in applying the knowledge to a real life setting would confirm that it could be enacted effectively.

There is a wealth of contradictory data on the subject of client change in therapeutic approaches, and a clear strategy to enable client change through *learning* is not a subject which has been addressed. Models such as these often provide little in the way of implications for therapeutic intervention, but merely seek to describe a process. Those that do, find problems in meeting the needs of a variety of

therapeutic perspectives. Neither do they focus on the issue of learning; whether learning causes change, or results from it.

The process of change occurs in PCT according to Rogers (in an untested theory), in specific stages (2004). Alternatively, change for the client in a person-centred context has been described by Gillon as "a capacity to take responsibility for much of his experiencing" and to "engage in moment-by-moment experiencing" (2007, p.69). Thorne, suggests 3 distinct phases of change (2000, p.42), in which change is experienced in the relationship with the therapist. These theories do not describe *facilitated* change, but natural client processes. The implication is therefore that the client does indeed 'just change' rather than participate in a process of engaged learning. There is also considerable debate about the likelihood that the core conditions alone are in fact able to facilitate lasting change at all. Further, despite Rogers' evidence to suggest that change was evident eighteen months post therapy, Bowles for example suggests that "Person centred therapy alone… does not allow the client to recall and use the factors of change strategically to manage the recurrence of the problem in future" Bowles (2012, p.268). He comments further that the principles of PCT limit possible responses that would allow the therapist to facilitate client change. There is a considerable lack of clarity on the issue of change in PCT, particularly since Rogers' view of change in therapy was that it was a process which occurred naturally, but that in an educational context, it needed nurturing and developing in order to be identified as 'learning'. It is helpful to note that today, schools and universities are concerned with pedagogies of engagement where students are viewed as partners in that change process. Notions such as the 'flipped' classroom, where learning from a real-world perspective is more authentic

and holistic, and the environment is one of deep respect and nurturing (Tucker, 2012), reflect well Rogers' approach to learning and change. This thesis seeks to apply these self-directed change processes to a person-centred therapeutic context.

If one of the benefits in integrating person-centred learning facilitation into counselling may be to enable learning to be retained in the longer term, then the subjects of transferring learning out of the therapy session, and retaining the need to learn on an ongoing basis, are important issues. Long term learning depends to a degree on the ability that the client has to transfer their learning to new situations, and 'to become able' (Marton, et al., in Salo, 1993, p.283). Originally a behaviourist concept, Knud, for example, has suggested more recently that there are four types of learning transfer, summarised as: (a) new learning which transfers only to a similar situation; (b) assimilative learning to be recalled in a similar field of experience; (c) the reconstruction of schema which can be applied to different contexts; (d) permanent personality changes (2009, p.141). These ideas are simple and helpful conceptualisations, implying the aim for the facilitator would be for the client's learning to move through each of these stages towards a permanent change in personality.

Attempts to address the concept of learning transfer have been made in the field of psychotherapy. Psycho-education is a commonly used technique in therapy to facilitate learning transfer and has "been proven to increase the client's capacity to deal with the recurrence of the issues dealt with in therapy" (Bowles, 2012, p.260). Alternatively, Knud (2009b, p.145) regards learning by *problem solving* as most relevant to learning transfer, both of which fit well into a learning facilitation model.

Alternatively, Rowland, Godfrey and Perren suggest a 'toolkit' for learning transfer, saying "one of the most powerful tools in the kit was the metaphor" (2009, p.245) – a very specific technique, but nonetheless useful. With reference to timing, Prochaska and colleagues (cited in Norcross, et al., 2011, p.144) regard their final stage of change as "the stage in which people work to prevent relapse and consolidate the gains attained during action". They regard a time frame of 6 months of application of new knowledge to be critical for long-term gains. Person-centred theory, however, does not deal specifically with the idea of learning transfer. Possibly transcendent learning would be the most appropriate perspective from which to view learning transfer in this context, but at least reflection would bring new schemas and transferable insights. What could be considered important is that learning transfer should not be left to chance, but purposefully initiated.

Learning transfer is explained as 'becoming able' (Salo 1993), or achieving permanent personality change (Knud, 2009a) and this can be facilitated through 'generalisation' (Day and Goldstone, 2012), which develops flexible thinking. From a Gestaltist perspective, generalisation stems from an understanding of the underlying nature of the problem (Olson & Hergenhahn, 2009, p.269) and for Kolb it is a process of critical reflection. Alternatively, according to Rogers and Horrocks, the process starts with abstract conceptualisation, from which evolves critical reflection, leading to new generalisations being made (2010, p.121). It does, however, seem that these theories are saying much the same thing, and further it was considered that "for many years transfer research was a study in frustration: Many studies failed to provide evidence that transfer occurs at all" (Schliemann and Carraher, 2002, p.3). It may well be therefore, that learning facilitation can tackle

this particular problem head on by settling on a clear conceptualisation of 'generalisation' and aiming to enable it.

Lifelong learning is a concept closely entwined with the idea of learning transfer, since little can be expected to change in the longer term if learning is not embedded. James, in 1980, suggested that "consciousness of one's learning process can be used to intentionally improve learning" and "my experience is what I agree to attend to" (Kolb & Kolb, 2009, p.301). Today this may be labelled as 'metacognition' (Flavell, 1979), described as 'thinking about thinking'. Mindfulness and Metacognitive Therapy (Wells, 2002) utilise a process of monitoring one's own thoughts, as does journal writing. It is the researcher's view that this monitoring and control of thought processes is fundamental to the idea of continuous learning. Similar, but conceptually different to metacognition, are cognitive strategies which "are goal directed, intentionally invoked, effortful and… situation specific" (Cornford, 2002, p.359), such as the planning, conscious attention and memory necessary to reach a long term goal. Cognitive strategies such as these could be addressed as part of a process of learning facilitation. Levels of engagement are also considered to affect lifelong learning, and are defined by Wang and Degol as "the effort directed toward completing a task, or the action or energy component of motivation" (2014, p.137). Employee engagement, customer engagement and student engagement are all the focus of activity currently, and client engagement is equally important to lifelong change. Combined together, all these concepts contribute to learning as a lifetime's activity.

Lifelong learning has, however, had implementation problems over time. Ohsako (2000, p.108) notes the low levels of commitment to personal growth in society generally, and Burnett (1999, p.579) found that his clients were failing to integrate knowledge gained in the context of counselling. This failing is often due to learning blocks where a form of 'unlearning', is required according to Loewenthal and colleagues (2005, p.446); for example, a client may have been told as a child that they would always be a failure. The resulting negative self-concept would need to be unlearned for progress to be made. In contrast, a number of studies have concluded that these lifelong learning processes are indeed adopted by clients post therapy. As a result of therapy, clients often change their way of seeing things and the understanding of that process itself becomes the learning outcome (Salo, 1993, Glasman, et al., 2004). Glasman and colleagues also found that clients saw themselves as becoming 'self-therapists' with an appreciation that on-going self-management of their situation was possible or necessary.

An important issue for this thesis is that Rogers believed that lifelong learning or 'learning how to learn' was vital (Kirschenbaum & Henderson, 1997, p.304). The researcher also supports the notion that there is no distinction to be made between learning and life in general (Salo 1993), particularly viewed from a therapeutic perspective. In a person-centred therapeutic approach, a congruent therapist who models life-long learning would be a start point, but there is no reason why helpful metacognitive strategies cannot be identified from the basis of here and now experiencing. In addition, the long term planning, attention to goals and motivation to engage can be part of person-centred dialogue. For this to work in practice a degree of directiveness may be necessary by the therapist, albeit subtle,

and in the form of questions rather than directions. Lifelong learning for Rogers was part of his theory of education, not his theory of personality, and as such, may require some initiation and support.

A final point to note however, is that of Bjork and Bjork, whose New Theory of Disuse proposes that regardless of how well learned items of information are, eventually, with disuse, they will be unable to be recalled (Lang, Craske, & Bjork, 1999), which is also the experience of the researcher. 'Refresher courses' are common place in training, for example in First Aid; maybe this idea could be applied to therapy.

Chapter Three: Methodology

3.1 Paradigms

This chapter reviews the methodological issues associated with this study, such as the philosophical paradigms within which it is situated, and the overall methodological approach adopted. It presents broad sampling and analytical strategies, and outlines the different research methods used in each of the series of four studies. Critical Realism (CR) provides the dominant philosophical foundation to the approach, and a mixed methods framework for the research design is offered, combining quantitative and qualitative data gathering techniques. The studies include interviews and a Delphi study, followed by the pilot testing of therapeutic interventions by therapists with their counselling clients.

3.1.1 Critical Realism.

The concept of research *paradigms*, introduced by Kuhn (1996), and described as personal models acquired through education and exposure to literature, has provided the context within which to debate issues of ontology and epistemology for researchers. Morgan (2007) has further described research paradigms as "systems of beliefs and practices that influence how researchers select both the questions they study and methods that they use to study them". As a consequence of the researcher's education and experience, it is considered that Critical Realism describes best the dominant research paradigm for this study. 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.

Statements about structures, power and agency provide the foundations for Critical Realist knowledge, rather than propositions about events or phenomena (Gorski 2013). These elements are contained in a stratified ontology defined by overlapping domains of reality; specifically the 'empirical', the 'actual' and the 'real', or in this case, *observable* learning experiences; what learning *actually* occurs; and *how* it occurs. Further, these levels in conjunction, are considered to have the potential to produce new phenomena, which themselves are irreducible to their constituent parts (Bhaskar, 2008). A particularly useful Critical Realist perspective for this study is the notion that the existence of unobservable entities can be made by reference to observable effects (Bhaskar, 2008). Therefore, for example, inferences about unobservable learning processes such as rationalization, or critical analysis were hypothesised from observable outputs such as dialogue or observed behaviour.

'Mechanisms' are considered to provide the foundation to a Critical Realist perspective, and are explained as regularly occurring, obvious patterns, which explain phenomena (but do not to predict them). Experiments in this context therefore reveal 'laws', but these laws describe tendencies rather than regularities. Laws are therefore statements about structures or mechanisms rather than events, (Gorski 2013). Critical Realism is also based on the key concept of 'emergence' (Archer, 2009), where mechanisms are derived, developed further, re-considered and

re-researched in a process of on-going discovery. Thus, the search in these studies was for emerging causal explanations which may define learning processes, and therefore provide concepts for further investigation post PhD.

There is an argument that the Critical Realist perspective reflects Rogers' own scientific approach and that of his theories. Rogers described his need for rigorous objectivity as a scientist, whilst accepting a 'double life' in his appreciation of subjectivity (2004). For him, this created a theoretical foundation which was based on a realist ontological concept of therapeutic outcomes, for example the 'fully-functioning person', countered by a relativist epistemology in the therapeutic encounter. In fact, it is the researcher's contention that Rogers' views on scientific endeavour are not that far from Bhaskar's Critical Realism. Over time, Rogers came to the conclusion that science exists only in people (2004). He describes a process of hypothesis identification in which the scientist becomes completely immersed in their field, and produces a question based on their own values and understanding. He accepts that logical positivism has its place to check that hunches conform to reality, although all of the choices as to method and analysis are subjectively derived. Findings are then a basis for further investigation. So no objective truth is uncovered, but instead, confirmation or otherwise that a scientist's subjective views are evident in reality. There are only subjective beliefs existing tentatively in different persons. In summary, Rogers argues for an integration of positivist and experientialist research. He is curious about the exquisite orderliness of the universe observed by the hunches that grow out of the experience of living. Therefore, Critical Realism provides a contextually appropriate paradigm from which to approach this study and it is from this perspective that this methodology grows.

3.1.2 Pragmatism.

It is considered that multiple paradigms within one study are feasible (Tashakkori and Teddlie, 2010, p.9). The idea of 'pragmatism' is therefore offered as an additional influence on this study, recognising the researcher's personal philosophy which is based on personal history (Tashakkori and Teddlie, 2010, p.285). There is currently considerable debate concerning the definition of pragmatism as a research paradigm between those who see it as a philosophical paradigm and those who regard it is a means for the selection of research methods. For example, theoretical assumptions, methodological traditions, personal understandings and values (Greene, 2007) based on a need to produce results for a specific purpose, are considered to constitute a *philosophical* pragmatic paradigm. Johnson and Onwuegbuzie (2004, p.17), however, suggest more simply that pragmatism represents a 'needs-based' approach in which "research methods should *follow* research questions in a way that offers the best chance to obtain useful answers". Thus the most appropriate methods are the focus.

It is the traditional perspective of methodological pragmatism (Morgan, 2014) which has been utilised here. Methodological pragmatism evolves from the belief that whatever methods produce the optimum results should be considered. It negates the quantitative/qualitative dichotomy, settling on a mixture and combination of these approaches to best suit the research question. As McEvoy and Richards (2006) suggest, although usually considered as separate approaches, quantitative or qualitative methods alone may not produce the desired outcome; so a combination of the two may be necessary. Biesta refers to this as 'everyday pragmatism' (in

Tashakkori and Teddlie, 2010), an approach which, according to Morgan (2007), argues for the use of mixed and multiple methods. Methodological pragmatism "is based on action, and leads iteratively, to further action and the elimination of doubt" (Johnson & Onwuegbuzie, 2004, p.17). It is this notion of action which underpins the choice of methods in this study, an iterative process which builds towards a viable output.

It is important also to note that, as Zachariadis, Scott, and Barrett (2013) suggest, Critical Realism endorses a variety of quantitative and qualitative research methods, the choice being dependent on the capability of different methods to convey different kinds of knowledge about generative mechanisms. McEvoy and Richards (2006) also suggest that a combination of quantitative and qualitative methods should be dictated by the nature of the research problem for Critical Realists. There seems therefore to be no clear contradiction between the Critical Realist perspective and a pragmatic approach.

3.2 Research Design

Mixed methods research (MMR), combines meaning and quantity in the same project (Tashakkori and Teddlie, 2010) and therefore supports both a pragmatic and Critical Realist perspective. By way of further explanation, four core characteristics of mixed methods research are defined by Johnson, Teddlie, and Tashakkori (2012), including 'shameless' eclecticism and an iterative, cyclical approach which moves from grounded data to general inferences, to tentative predictions or hypotheses, to results. Further, they define 'signature' research designs, of which one is a 'sequential mixed design', which is also of relevance here.

Of course, it is argued by some that combining both quantitative and qualitative approaches in one study may destroy the epistemological foundations of each approach, although it is considered possible to subscribe to the philosophy of one paradigm whilst employing the methods of the other, (Steckler, Mcleroy, Goodman, Bird, & McCormick, 1992). Alternatively, Teddlie and Tashakkori (2009) contend that 'pure' qualitative and quantitative approaches do not actually exist. It may be that "…the various paradigms are beginning to 'interbreed' such that two theorists previously thought to be in irreconcilable conflict, may now appear, under a different theoretical rubric, to be informing one another's arguments" (Denzin & Lincoln, 2011, p.97). Riggin (1997), also regards this combination as inevitable. Kidder and Fine (1987), consider the call for a synthesis between qualitative and quantitative methods. They suggest a distinction between 'large Q' and 'small q' methodologies; traditional qualitative approaches being used within or along-side more quantitative methods. No clear distinctions were drawn in this overall research strategy between quantitative and qualitative studies, and it seemed that a combination of the two would provide the most pragmatic output.

Reasons for considering a mixed methods approach for this study include, as Axinn and Pearce suggest (2006), the ability to address variance along continua of different dimensions, not simply summarised by the qualitative/quantitative dichotomy. In addition, the opportunity to vary potential biases characteristic of each method was useful. Mixed methods further allows for the statement of research questions as well as hypotheses, (Teddlie and Tashakkori, 2009); in this case, 'how do clients learn' and 'learning can be facilitated', respectively. In addition, Johnson

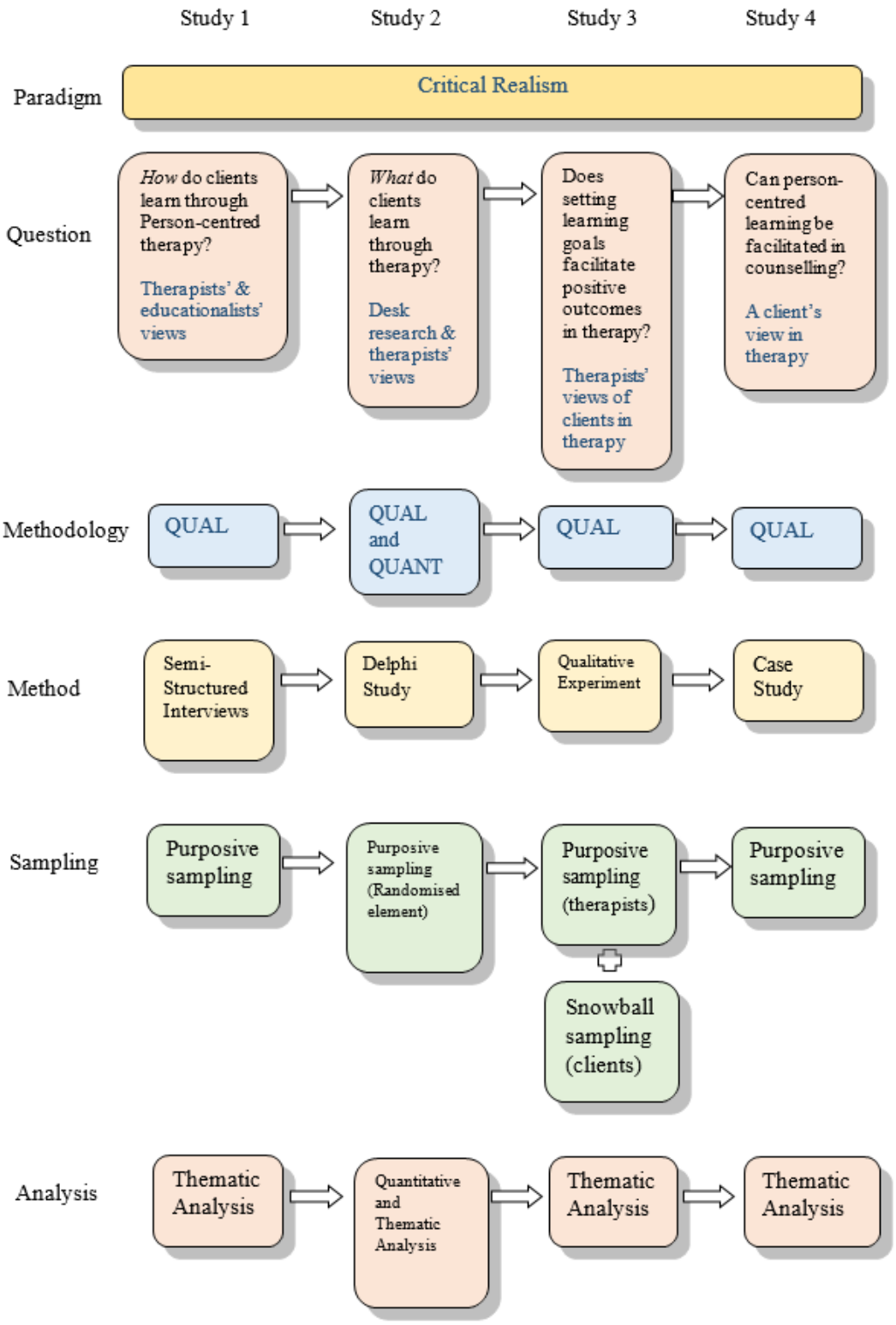
and Onwuegbuzie (2004, p.22), consider that two of the purposes in conducting mixed methods research are the elements of ‘complementarity’, described as “seeking elaboration, enhancement, illustration, and clarification of the results from one method with results from the other method”; and ‘development’, or “using the findings from one method to help inform the other method”; both of which are relevant to this study.

Various types of mixed methods design are defined by various authors, most of which give scope for further development and enhancement. A number of them were considered before finalising an approach which seemed to be appropriate for the research question here. Designs relevant were firstly, an 'exploratory sequential design', generating qualitative results which are used in a subsequent quantitative data collection (Creswell & Plano Clark, 2011). They further define an 'instrument development variant' in which the qualitative phase plays a secondary role and supports the development of a quantitative instrument, which was also used here. Further, the design can be considered a ‘sequential embedded design’ which is suggested by Creswell, Plano Clark, and Garrett (in Bergman, 2008, ch.50). The design is ‘embedded’ in the sense that data sets are complemented by using different methods. Finally, each stage was connected in that outcome data fed into the design of the next stage. Also, qualitative data was used to help recruit further participants and to select clients for an intervention.

The specific methodologies for each study are discussed in detail later in this thesis, but in summary: Study 1 comprises interviews with a small group of experts in the fields of learning and counselling. Study 2 uses the Delphi technique with a

larger group of humanist therapists to establish an agreed list of learning outcomes, followed by the informal testing of the resulting card sort and questionnaire instruments. Study 3 is a qualitative experiment in which the resulting therapeutic instruments are trialled by therapists with their clients. Finally, Study 4 is a case study which seeks to demonstrate learning theory applied to therapy. Graphically, this mixed methods research design would be represented as in Diagram 2:

Diagram 2: Field Research Design



3.3 General Approach to Data Analysis

Data analysis can be relatively simple in a sequential design compared for example, to a concurrent design (Creswell & Plano Clark, 2011). In the sequence of studies used here however, since data from one study fed into and supported questions, theories or methods in subsequent studies, elements of data integration were necessary. Caracelli and Greene (1993) have identified various methods of integrating data analysis in mixed methods research: An example is 'typology development' which is identified as the generation of substantive categories which are then incorporated into the analysis of a contrasting data type, a method appropriate for stage 1 of the study, as learning outcomes were identified, categorised, and incorporated into stage 2. Secondly, the 'transformation' of one data type into the other to allow for statistical or thematic analysis was used for data analysis within the Delphi study. Finally, data 'consolidation or merging' was achieved through the joint use of both data types to create new data sets, a method appropriate for the conclusion of the Delphi study, as both qualitative and quantitative data were combined in the final analysis.

The research strategy most often associated with Critical Realism is that of retroductive reasoning (Blaikie, 2007), although an argument is put forward by Meyer and Lunnay (2013) who suggest that a combination of both retroductive and abductive reasoning is most useful within a Critical Realist perspective, and it is this viewpoint that is adopted in this study. Briefly, retroductive inference (Danermark 2002) seeks to produce an explanation to account for an observed set of circumstances, or in the context of Critical Realism, a hypothesis drawn from inferences about causal mechanisms (Easton, 2010). Unlike abductive inference,

assumptions are brought to the research. Abductive enquiry on the other hand, seeks to analyse data which may fall outside the theory or framework and which in turn may produce new theories and concepts, or to hypothesise from incomplete data. Meyer and Lunnay (2013) argue that these reasoning processes are complimentary tools and provide a rigorous methodology capable of distinguishing between the actual and the real, or what people do and why they do it. On this basis, both retroductive and abductive reasoning were used in the process of data analysis in this study.

Various views exist on the appropriateness of using theoretical frameworks to inform qualitative research. Best and Kahn (2014) recommend against it, whilst Lincoln and Guba (1985) are advocates assuming that theories relate to the research paradigm and methodology. Mitchell and Cody (1993), on the other hand, state that all knowledge is theory-laden and methods are theory-driven. It is the assumption of the researcher, like Lincoln and Guba, that the process is approached with a considered perspective on learning which in turn presents a set of questions to be answered. Indeed, a hypothesis is tested as a result. Further, as (Bradbury-Jones, Taylor, & Herber, 2014) recommend, the aim is that theory is consistently applied throughout the entire research process. Consequently, the researcher's views (or theoretical framework) on the possibilities of learning facilitation and the ideas on practical application are systematically applied to the process of this participant research.

The *quantitative* analytical procedure associated with some of the data in the Delphi study is outlined in detail in Chapter Six, following as closely as possible

guidelines offered by writers such as Linstone and Turoff (1975, 2011), Powell (2002) and Delbecq (1975). The majority of the analysis within each of the studies has been of a *qualitative* nature. In considering the most appropriate qualitative analytical methodology, it was decided firstly, that consistency would be necessary since in that way, data could be combined and compared more easily. Secondly, flexibility would be the key since a number of different methods, samples, data types and questions were involved.

It was considered that although Thematic Analysis has over time struggled to be accepted as a genuine research methodology, it would provide the most appropriate approach for this study due to its flexibility. Despite the fact that there seem to be "no universally accepted guidelines" (Howitt & Cramer, 2008, p.334), Braun and Clarke have defined the process in their production of a considered set of procedures (2006, 2014). In simple terms, "thematic analysis produces knowledge that takes the form of themes, built up from descriptive codes, which capture and make sense of the meanings which characterise the phenomenon under investigation" (Willig, 2013, p.65).

Through the process of Thematic Analysis, a researcher is able to scrutinise affective in-depth experiencing and phenomenological expression, in addition to aspects of dialogue which lend themselves to a more positivistic analysis. The considerable flexibility provided by this approach to the analysis of cognitive and affective elements, whether constructivist or reductionist, made it an ideal tool for addressing the complex issue of learning in therapy. Typically, the wide-ranging data obtained from open-ended questions with semi-structured interviews had

potential for problems in generalising data into consistent themes. The flexible nature of Thematic Analysis allowed for the manipulation of data in relatively subjective ways, facilitating the researcher's interpretation of the wide range of opinions. (This subjective process is seen as a positive advantage in the context of Thematic Analysis rather than a negative source of bias.)

Researcher subjectivity is also considered useful by Klein and Elliot who gave credence "…to the use of the researcher-derived domains, especially for their utility in analysing a large set of data". Further, they consider that open-coding categories provide a rich understanding of data, and "categories could be differentiated further into subcategories and even sub-sub-categories" (2006, p.100). This analysis therefore used an open-coding procedure, coupled with a high degree of 'semantic analysis' (Braun & Clarke, 2006, p.83). Clearly, much of the data was able to be scrutinised at a purely semantic level, although other comments necessitated much more interpretation. As such, it was considered that in terms of the data analysis approach, Willig's notion of 'empathic interpretation' (2013, p.43), fitted both the researcher's epistemological view point and the type of data that had been collected. The idea of seeing comments from the point of view of the respondent in an empathic way is at the heart of empathic interpretation, rather than applying purely a personal perspective to the analysis.

Additionally, the notion of 'suspicious' interpretation (Willig 2013, p.43) fitted with a Critical Realist perspective. Giving consideration to potential subconscious processes contained within the data, although not necessarily obvious, was necessary. For example, the fact that one question was misinterpreted

consistently indicated a common issue with the subject matter. Different philosophical standpoints, approaches to therapy and communication styles were all contained within the dialogue and gave great potential for a variety of interpretations. In this sense, data analysis at times could not be a passive process designed to list themes only on a semantic basis, but an active engagement aimed at the identification of unique patterns of meaning (Braun and Clarke 2006, p.80).

In summary, the mixed methodology for this study is supported by the researcher's Critical Realist perspective on the issues of ontology and epistemology. Fundamental to this perspective is the notion of emergent mechanisms which reveal laws or tendencies. As learning processes are applied systematically to the therapeutic context, these patterns, outcomes or processes are identified and categorised. The depth of this process further allows for unknown processes to emerge and to provide causal mechanisms and enabling structures. Given the complex nature of the overall objective for this study, it was considered that a mixed methods approach facilitated the collation of a combination of different types of data derived from a variety of sources addressing a set of interrelated questions and hypotheses.

3.4 General Issues of Quality, Reflexivity and Ethics

Any claim that this largely qualitative research process and its outcomes can be regarded as being 'quality' research, requires consideration based on the philosophical framework within which it resides (Willig, 2013), and the emergent nature of the subject in question (Seale, 1999, p.52). Maxwell (2015) notes the Critical Realist perspective which asks the question 'what is happening', in reference

to "participant's meanings, intentions, beliefs and perspectives", from which interpretive claims are made (p.93). Claims about this 'evidence' need to be assessed in terms of the methods used to obtain them and evidence considered in the context of other claims relevant to that research. Finally, Maxwell discusses what he considers to be an essential component of realist approaches, which is that "there must be some explanatory connection between the fact and the claim" (p.95). Scrutiny of this study therefore focused on claims made about emergent theory in relation to methods chosen and in the context of other research, but was based on the analysis of data at the three different Critical Realist levels.

The rubric of quality considerations contains different measures, and the issue of **generalisation** is a relevant one. Although important in quantitative research, it is a different proposition “in circumstances of imperfect knowledge (where) people use rules of thumb, heuristics, based on the best available information” (Thomas, 2011, p.27). Thomas goes on to suggest that generalisation in a qualitative context is “a simple process of conjectures and refutations, some of which will prove helpful, some not”, a perspective taken by the researcher here.

The notion of **transferability** is also important in judging the quality of research processes and outcomes, a condition which in this context, Braun and Clarke suggest, is judged by the reader as they decide for themselves whether the results are transferable to other situations (2013, p.282). One measure of transferability would be that of **validity**, a measure viewed by Lincoln and Guba (1985) as an issue of credibility facilitated by triangulation, engagement, member checks and progressive subjectivity. Maxwell (2015) discusses the notion that

validity can only be a property of inferences, and not of method. Thus the discussion here focuses on the inferences made which are a function of the method chosen. **Triangulation** is considered appropriate to increase validity, particularly in mixed methods research, since combining methodological practices, empirical materials, perspectives and observers adds rigour, richness, breadth, depth and complexity (Denzin, 2012). Triangulation is particularly addressed in the case study.

Other measures of quality were addressed during the process of this research such as the **comprehensiveness** of the data treatment: "One should not be satisfied until one's generalisation is able to apply to every single gobbet of relevant data you have collected", recommends Silverman (2013, p.292). Further, Yardley suggests that '**rigour**' may be shown in the appropriateness of the sample population to the topic being discussed (in Smith, Larkin, & Flowers, 2009, p.179). Yardley (2000) also suggests that commitment is a significant measure of quality, demonstrated by prolonged engagement in the subject and 'immersion' in this field of research began long before the start of the PhD for the researcher here.

The notion of reliability is "rooted in a realist view of a single external reality knowable through language" (Seale, in Braun & Clarke, 2013, p.279), a perspective that does not sit comfortably in this context. An alternate form of **dependability** is therefore addressed relating to the stability of data over a period of time; i.e. was it logical, traceable and documented? Madill, Jordan and Shirley (2000) discuss in particular the inherently subjective perspective of the Critical Realist in terms of the production of reliable data, concluding that only the naïve and scientific realist epistemologies can evaluate data on the basis of objectivity and reliability. A naïve

perspective was taken in parts of this study and thus reliability measures increased. Reliability in this context can also be judged in terms of **consistency**. Boyatzis suggests that "reliability is consistency of observation, labelling or interpretation" (1998, p.144), which was a consideration attended to throughout. Lincoln and Guba (1985) suggest that a question of **confirmability** is addressed by asking: 'Are findings a product of the researcher's biases, motivations and interests?', and the subject of reflexivity is addressed below.

Recommendations are made in the literature for different quality measures which are applicable to different research processes, although it was considered that, to guard against a "static form of criteriology…. the list should be developed in the engagement itself" (Sparkes & Smith, 2014, p.197). Therefore, a section at the end of each study considers quality measures appropriate for that specific study, designed for that context, that process and those outcomes as they emerged.

Qualitative research is usually undertaken with consideration given to the issue of **reflexivity**, conventionally defined as "that which turns back upon, or takes account of, itself or the person's self" (Holland, 1999, p.2). Being a reflexive researcher involves taking a closer look at issues such as the context in which participants provide their accounts, methodological assumptions made by the researcher, and the attitudes and expectations of both parties (Walsh, 2003, p.52). Further defined by Walsh, reflexivity can be characterised as: *personal*, i.e. that which focuses on the attitudes and expectations of the researcher; *interpersonal*, i.e. that which is concerned with the relationship between researcher and participant; and *contextual*, i.e. focusing on cultural and historical influences. Both Walsh, and

Braun and Clarke (2013) also define *methodological* or *functional* reflexivity. Rennie adds an additional dimension by defining reflexivity as "self-awareness and agency within that self-awareness". Further he differentiates between conscious and unconscious agency (2004, p.183), which at its simplest, means that, as Ahern suggests (1999, p.408), "it is not possible for researchers to set aside things about which they are not aware".

In summary, research is influenced by the assumptions and values of the researcher. Raw data is therefore concept dependent; i.e. information collected is constrained by an understanding of it (Cruickshank, 2003, p.1). Consideration of the expectations, prior experience or assumptions brought by the researcher, can either be restricted or coveted, (Braun & Clarke, 2013); in this case valued and utilised. As Archer (2009) points out, Critical Realist research is "a process of engagement with the natural, practical and social orders of natural reality" (p.78), and humans have a reality status as much as social and cultural norms. The meanings of phenomena, however, are descriptive *and* constative of them (Sayer 2000), and as such contain a hermeneutic or interpretive element. A double hermeneutic results where researcher and participant perspectives are combined. The issues outlined here were considered in more detail as the study progressed, particularly in the qualitative data analysis stages. The most significant consideration was the tacit belief that the researcher brought to the research, that learning theory probably *could* be integrated successfully into therapy, if not 'pure' Person-centred Therapy, which proved to be a difficult assumption to bracket off.

Generally speaking, the subject of **ethics** is "primarily concerned with the evaluation and justification of norms and standards of personal and interpersonal behaviour" (Karhausen, cited in Homan, 1991, p.1). In the context of research, according to Gregory (2003, p.14), ethical considerations come down principally to the integrity of the researcher and the process. In considering the nature of integrity, Homan suggests that "professionals are reminded that truth in reporting is a fundamental aspect of professional integrity" (1991, p.6). So, truth is the aim, although, if the epistemological stance is that there can be no 'truth', but a set of personal constructs which at best can be marshalled into some kind of workable hunch, and if the phenomenological basis of qualitative research suggests that any interpretation can be made as long as it is justified, then a dilemma remains. Thus the ethical standpoint here is that the study represents the researcher's own understanding of truth and therefore integrity, which can only be completely defined and appreciated on a personal level.

On a more practical note, whilst considering the ethical issues relating to this study, the new Ethical Framework for Good Practice in Counselling and Psychotherapy (Bond, 2016), and the Sheffield Hallam University Ethics Committee guidelines have been addressed. Ethical approval for each of the studies was obtained from the Sheffield Hallam University's Faculty Research Ethics Committee, before proceeding to identify participants. Also worth noting from an ethical perspective is one particularly beneficial aspect of the research, which was its lack of accountability to any funding body. The research was entirely self-funded by the researcher, with no agenda other than to enquire into an area of curiosity; thus no

conflict of interest arose. Generally speaking the following procedures were applied to all studies:

Trustworthiness is an important aspect of ethical research. Crisp and colleagues (1997) suggest that the role of the Delphi researcher is seen as an objective one, and it this perspective that was aimed for in all of the studies, with an acknowledgement that objectivity can never be absolute. They suggest that the researcher should be methodologically objective (by not manipulating feedback to obtain desired responses), pragmatically objective, and ethical (to avoid influencing decisions). The reader will note the thorough analysis of data and documentation of decisions made, all available digitally for scrutiny to address these issues.

Confidentiality and Anonymity is an important consideration for the protection of participants. Although Parker (2005) suggests that there is no such thing as confidential research since what is discovered is available for scrutiny, every effort was made to ensure participant privacy through the use of coding and security procedures (explained in the consent documentation in Appendix I). Christians, however, considers that in social research "…watertight confidentiality has proved to be impossible", (in Denzin and Lincoln 2011), suggesting that what appears neutral on paper can often have damaging consequences as others recognise the source of the data. Throughout this research, the most likely source of problems has been in the case study, with the participant revealing considerable personal data. Giving the client the opportunity to read and agree the transcripts was vital, in addition to gaining agreement that the resulting data could be published. The view of the client

was that she was keen to help others and as such was happy for her data to be published.

Guillemin & Gillam (2004), distinguish between procedural ethics and ethics in practice. Ethics *in practise* are more subtle and specific to the client and context. For example, they discuss the Kantian maxim that people should not be used in such a way as to benefit others, or in this case the client benefiting researcher. Blindly following research objectives has the potential to do **harm, particularly to client participants** and there was a real danger here of hijacking therapeutic encounters for the purposes of scientific enquiry (Willig and Stainton Rogers, 2008). The concern about harm applied particularly to studies 3 and 4 where clients in therapy participated in the research. On one hand, the therapeutic needs of the client participants were paramount, but these needs were juxtaposed with a research imperative to test a new therapeutic technique or approach. It was therefore possible that goal setting re-directed the course of therapy for the clients, resulting in something less than would have been achieved otherwise, or an overall learning approach for the case study client may have affected her personal development. The researcher therefore sought to "reduce risk and prevent harm by detecting and removing any negative consequences associated with a study, *to the extent possible*" (Wang, 2015, p.126). What was relied upon was the therapist's ability to monitor client processes with a supervisor and ensure as far as possible that any harm to the participants was limited. Further, Guillemin & Gillam (2004) suggest that tension can be resolved if the research participant takes up the research goals as their own, which did happen in study 4.

Flick (2007) suggests we consider the general disturbance that is created for participants by the study. Time pressure was no doubt an issue for participants in this study as was demonstrated by respondents dropping out of the Delphi study over time, cancelling interviews, and deciding to pull out of the 3rd study without notice. Flick recommends keeping disturbance to a minimum for the sake of ethical researching, but clearly some must be expected in order to maintain the process. Care was taken not to 'harass' participants, but to politely thank them for their input, even when it had been limited or unhelpful.

In terms of **informed consent**, it is acknowledged that "research involving human subjects undertaken without the explicit consent of the researched lacks an adequate moral basis" (Gregory, 2003, p.35), so steps to obtain consent were taken at each stage of this study. This important issue "depends on the fulfilment of three criteria; competence, provision of adequate information and voluntariness" (McLeod 2003). Consent was obtained from each participant to collect their information, analyse and publish it prior to each process, whether interview or questionnaire. Participants were made aware that they could withdraw from the process, or change material up to 2 weeks after the interview. Copies of the consent letter and information sheet are contained in Appendix I and a complete set archived in the Supporting Data File. It is also acknowledged, as Homan says, that "what passes for the informing of consent is often designed more to allay the suspicions and fears of intended subjects and to encourage their participation than to appraise them of hazards and rights" (1991, p.179), which may well have been the case. Each participant was debriefed after the interview, questionnaire completion, or therapeutic intervention to ensure that they understood how their data was to be

transcribed, analysed and published. An opportunity to change comments was available during the coding process as the transcripts and coding was emailed to each participant for checking.

Part of the process of informed consent is the **voluntariness** of the participation. Assent must be given without any implicit coercion, pressure or undue enticement, such as pleasing a likeable therapist or a vulnerable client wanting to be perceived as a 'good client' (Wang, 2015). Control over client recruitment in Study 3 was delegated to the therapist participants, so it was recommended to them that these issues were kept in mind. The case study client also presented an ethical dilemma in this sense. The individual is however, confident, assertive and professional, and is unlikely to take something on board which she did not consider helpful, which, of course, may not be the case if future studies involve less emotionally stable existing clients. Wang (2015) suggests that as researchers we seek to avoid improper and potentially harmful dual relationships, but that the task of assessing risk potential "is often subjective, ambiguous, and involves an estimation of probabilities… In short, assessing risk is difficult, if not impossible, to quantify" (p.126).

Chapter Four: A Literature Review and Consolidation of Taxonomies of Therapy Outcomes

If it is accepted that in order to learn, adults must be self-directing, the implication is that they have some idea of *what* they want to learn. If the subject is maths, or pottery, aims can be defined clearly. In therapy, aims may be more difficult to describe – how can a client 'be content' for example. In order to aid that process for the client, a framework of possible therapeutic outcomes was needed – which could be *learned* and would enable them to develop their own 'curriculum'. The aim for this stage of the project was therefore to produce a list of items which would describe a 'fully-functioning' client based on Rogers conception of the term (2004), and which would then be ratified in later studies.

4.1 Background

Rogers' book 'On Becoming a Person' (2004) outlines a picture of the fully functioning person. It is a summary of 'the good life' or the picture of the person who would emerge if therapy were completely successful. For Rogers, it was not a fixed state of being, but a process or a direction. He regarded the characteristics to include "an increasing openness to experience: The ability to experience feeling which the client has not hitherto been able to 'own'. It is a movement away from defensiveness towards the freedom to live feelings subjectively" (p.187). Further, he considered that an individual will experience increasingly existential living: "Living fully in each moment allowing the self to emerge *from* experience rather than

twisting it to fit a pre-conceived structure" (p.188). He saw the individual engaged in organismic experiencing with an absence of rigidity, based on an adaptable, flowing and changing self. He also explained an increasing trust in the organism where instead of relying on others, the individual defines a direction based on 'what feels right'. These are complex ideas, not all of which can be operationalised or measured. Indeed some are not outcomes at all, but processes. Further, progress towards 'organismic experiencing' would require the client to have a good understanding of Rogers' academic work. As a result, some alternative guidance as to the definition of humanistic learning outcomes was considered necessary and was therefore sought from the literature. A nebulous concept such as 'fully functioning' could then be operationalised.

A review of existing humanist therapy outcome studies was considered appropriate in order to amalgamate conclusions and produce a complete list of outcomes. Levitt and colleagues (2005) have already presented their findings on this issue in a study in which they assessed a broad range of existing outcome studies derived from humanistic psychotherapy literature. Their database, however, was limited to material between 1970 and 2003, which leaves a further 15 years' worth of research material to bring the study up to date. The search covered 9 measures that were used 4 or more times in the studies, which in the main were not intended to address humanistic change, and therefore the results would only ever prove their hypothesis, that no such humanistic measure was available. The other 107 measures were not addressed because they were only used once in the studies, but may have yielded useful results. Even so, a list of humanistic understandings or constructs of change was generated, ordered into 10 discrete categories including 'personal

growth', 'client agency in self-definition', and 'global functioning'. For each category, they outline which measures address the construct and which are deficient, although no well-used humanistic measure was used to act as a criterion reference. Thus their concern for example, that sexual desire is not addressed is irrelevant unless sexual desire is accepted to be a humanistic outcome. What transpired, in their view, was the complete inappropriateness of these outcome measures to be applied to humanistic therapy. They concluded that none of the outcomes were open ended to allow for idiosyncratic responses, and questions were about change within specific symptoms rather than holistic change. Thus they suggest that the measures available "may not be appropriate for the purpose of evaluating the success of humanistic therapies" (p.124). Whilst this would seem to be true from their study, they do produce a list of potential humanistic aims from their content analysis, so this issue may be more one of consolidation of existing measures than creation of a new measure. One specific area of inadequacy however, was that "most did not adequately inquire about important goals of humanistic psychotherapy such as personal growth, …or client agency". These are important elements of self-directed learning and would as such, need to be part of a learning outcomes measure. Also, "none asked about the development of comfort with emotion, the resolution of negative emotion, or emotional expression—central goals of humanistic work (e.g., Rogers, 1959)". Emotional expression defines humanistic work to a degree and is therefore also fundamental to personal learning and growth in this context. This study, whilst limited in its scope, provides a start point from which to address the issue of learning outcomes in a humanistic context. The categories and associated constructs provide a useful foundation for the construction of a humanistic measure,

but more importantly, the assertion that there was no suitable humanistic measure available up to 2003 provides impetus for research further.

4.2 Procedure

In order to update the Levitt study (2005), a literature review from 2003 onwards was undertaken to identify any taxonomies which might form the foundation for a humanistic outcome framework. Material not identified by Levitt and collegues in their study before 2003 was also uncovered. Combinations of the search terms 'humanistic', 'therapy', 'outcome' and 'learning' were used in a search of PsycINFO, Scopus, Proquest, SAGE Journals Online and Web of Science. Duplicates were checked for manually. The criteria for inclusion was that a defined set of descriptors which included at least *some* humanistic outcomes were identified, either being used as a measurement instrument or in a descriptive format - such as Rogers' description of the fully functioning person. Measures based on a medical model which focused mostly on negative symptoms such as the experiencing of anxiety or depression were excluded. The CORE-OM (Barkham, et al., 2001) was included, however, due to its common usage and its use of humanistic outcomes which although negative, could be expressed in a positive way. In addition to Rogers' description, eight documents were identified and outcomes from each one were collated into one spreadsheet. Each paper is now reviewed in turn:

1. What do clients learn from counselling?

A study by Burnett and Van Dorssen (2000) was the only study uncovered through the literature review to address learning outcomes. The researchers asked 35 therapy clients to write a letter to a friend explaining what they had learned through

therapy and those learning outcomes were then categorised into 3 areas: The Self; Relations with Others; and the Process of Learning and Change. This was a small study, and some clients reported back after only 2 sessions, so the results may not be considered rigorous. Further, the counselling was not restricted to humanistic therapies. Clients neither commented that 'they learned' – these statements were added by the authors, and since no instruction was possible whilst the clients wrote their letters, it is likely that the context of learning was lost and clients focused on improved symptomatology rather than humanistic change. Even so, some useful categories of learning emerged, such as 'basic survival and coping', 'self-awareness and self-acceptance', 'personal growth and development' and 'insights into relationships'. Each category was further broken down into outcomes such as 'having a sense of hope for the future', 'understanding of the impact that past and present personal experiences can have on feelings' and 'higher self-esteem'. Despite the lack of rigour in the study, these descriptors seemed to begin to describe the broader themes outlined by Rogers but from a learning perspective, and therefore provided the foundation to a potential list of items.

As a side note, some items such as just 'surviving' did not seem to fit within a paradigm of self-actualisation. Maslow's hierarchy (1943), however, indicates that self actualisation would not be possible without first attending to basic functional needs. Basic life skills was therefore an area which the researcher would have left out had Burnett and Van Dorssen's study not also clarified that 'just coping' was a legitimate part of the learning experienced by some clients. There was also, at the other end of the spectrum, no transpersonal element to Burnett and Van Dorssen's

outcomes, but which emerged in Rogers' later writings and from other outcome measures.

2. The CORE outcome measurement system

The CORE-OM, developed by Barkham and colleagues (2001), is a commonly used measure comprising 34 items within the domains of subjective well-being: symptoms (anxiety, depression, physical problems, trauma); functioning (general functioning, close relationships, social relationships); and risk (risk to self, risk to others), assessed on a 5 point scale (Mothersole, Mullin, Trusler, Grant, & Bewick, 2006 p.35). It was included here since, although it is based on a medical model of pathology, including items such as "I have felt terribly alone and isolated" and "I have thought of hurting myself", there were other more useful outcomes such as "I have felt optimistic about my future" and "I have felt I have someone to turn to for support when needed". Further negative descriptors such as 'feeling blame' could be reversed and described as self-acceptance. The CORE-OM is a commonly used system and is widely accepted as an outcome measure, but it does not allow for humanistic concepts such as self-actualisation, it sees therapy as a means to solve problem issues and it makes no allowance for the idiosyncrasies of client change. Should a client find a relationship in which he/she is unconditionally accepted and as such develops in her own understanding and acceptance of self, this would be lost in this measure.

3. An inventory for the measurement of self-actualisation

Shostrom's Personal Orientation Inventory (1964) sought to meet the needs for a humanistic measure to address self-actualisation in the middle of the last

century. The resulting humanistic outcomes were derived from therapist encounters with clients over a five year period and developed on the basis of theories by Maslow, May and Perls, Rogers and Ellis. The Personal Orientation Inventory (POI) uses 150 paired opposite value judgements under measures such as: inner directed; time competent; self-actualising value; existentiality; feeling reactivity; spontaneity; self-regard; self-acceptance; nature of man; synergy; acceptance of aggression and capacity for intimate contact. What is valuable here, is that 'clinically healthy' patients were included in the research allowing for positive, developmental outcomes. Whilst complex terms are used, and a mixture of broad philosophical criteria such as that of 'existentiality' are combined with specific behaviours such as time management, there were, never the less, useful additions to be gleaned in concepts such as 'the ability to situationally or existentially react without rigid adherence to principles' and 'the ability to be synergistic'. Shostrom's framework also measures the freedom to react spontaneously or to be oneself, an item which was considered unnecessary in Study 2, as was the idea of being 'synergistic', mainly due to a lack of clarity in its meaning. The ability to act 'situationally', although difficult to define satisfactorily, did prove useful in the sense that a client could be 'flexible in different situations'. It was also interesting to note an item relating to 'the constructive view of masculinity and femininity' which suggests a need for some reference to gender issues in a humanistic measure, possibly less dichotomous than indicated here.

4. Cluster analysis of patient reported psychotherapy outcomes

Connolly and Strupp (1996), produced a set of outcomes defined relatively, indicating that they were not absolute outcomes, but dependant on the start point of

the client, a theme which was fundamental to the design of the emerging list of items. Further, their main finding was that a change in self-concept was evidenced, - an outcome often excluded by other measures. They also highlight the importance of measuring change from the perspective of the client, however, they focus only on psychodynamic therapy and their clients were suffering largely from anxiety and depression, giving a limited set of results. Results were assimilated from patient essays on important changes they experienced, which numbered between 1 and 7, giving limited scope for analysis. Detail was available in this measure under headings of fewer symptoms, improved self-understanding, improved self-confidence, greater self-definition (greater independence and better boundaries in relationships), greater self-control and improved psychological symptoms. Items such as these were utilised to clarify broader concepts in the design process. For example, the ability to handle fears (such as flying), to stop smoking, to eat a balanced diet and concentrate came from here. Improved sexual relations was also mentioned in this taxonomy, a subject that proved to be contentious in Study 2. Some interesting outcomes emerged such as being 'certain of physical health', which in the event was translated into 'manages physically', again with some consideration, but being "less hostile towards men" was considered unhelpful due to being politically incorrect. Some of the more pathologically based outcomes were discounted such as "decreased fear of insanity" and "less obsessed with depression" since this was intended to be a framework defined in the positive rather than the negative. All items were added to the spreadsheet to begin with, but some issues proved more contentious than others as the study progressed.

5. Client accounts of personal change in process-experiential psychotherapy

A study in 2006 by Klein and Elliot researched 40 clients with mood or anxiety disorders, engaged in process-experiential therapy. They employed a thorough pluralistic method combining quantitative and qualitative approaches, and also collected data at 6 and 18 months post-therapy, giving a high level of validity to their results. The number of reported client changes was up to 18, giving a broad range of data to code through content analysis. Further, their final interpretive approach emphasised the uniqueness of each client using a case study approach, which meets the need of a measure which allows for idiosyncratic tendencies. They concluded that outcomes from process-experiential therapy fell into two broad categories: firstly 'changes within the self', which included affective change, self-improvement and experiential processing; and secondly, 'changes in life situation', including general life functioning and interpersonal relationships. Their notion of 'psychological peace and stability' was an interesting one, giving rise to some consideration as to how that could be expressed as a defined outcome. In the event, stability was taken to be too nebulous a term and the spiritual nature of peace also to be too vague. Their notions of 'energy' within a definition of 'is motivated' proved useful and 'self-care' was particularly appropriate within the person-centred community. Whilst the research process here was robust, and the outcomes significant, the constructs are limited in number and are described in limited terms, giving only a small amount of material to utilise here. Further, it is difficult to equate statements such "I am happier to be alive" into a descriptor for a fully functioning individual.

6. Qualitative meta-analysis of outcomes of person-centred and existential psychotherapies

This meta-analysis, completed by Timulak and Creaner (Cooper, et al., 2012), collated outcome studies in person-centred/experiential therapies. They considered studies which reported a change post-therapy rather than within therapy, which is relevant since *learning* outcomes are being sought implying a long term change. Each study included in the meta-analysis produced a framework based on participant accounts rather than utilising any explicit theoretical framework, which firstly may be an indicator that a framework of this nature is unavailable, but usefully grounds the results in the experiencing of clients. The aggregated results include a range of humanistic items on the issues of experiencing the self, and the self in relation to others, expressed in enough detail for them to be readily applicable to a client outcome framework. Some elements were particularly useful for the formulation of new items; so 'awareness of being old', 'self-acceptance of existential isolation' and 'process of grieving' formed a new category entitled 'accepts the negative'. Their notion and explanation of 'feeling empowered' was also useful, incorporating items such as 'giving self credit for accomplishments', and the final category explaining the outcomes of successful relationships added depth, since Rogers particularly focuses on the individual in isolation rather than in context. One particularly interesting outcome from this study, which was considered at length in these studies, was the notion of being told 'you are a nicer person'. The debate was whether a good therapeutic outcome was to receive good feedback, or *be able* to receive good feedback. In the event, both seemed applicable. Finally, some items such as 'feeling more free and easy, more light and lively' and 'seeing patterns' were not clear enough to be considered useful. Timulak and Creaner's meta-analysis

helpfully researched studies from 1954 to 2009, but again produced a limited range of constructs, focused on describing only a change in emotional experiencing by the client. Further their categorisation is at times open to question as for example, they include ‘day to day coping’ under the heading of ‘feeling empowered’ where a client may only just be coping due to a lack of empowerment. However, the descriptors given for each construct in some categories is detailed, so items such as ‘accepting parents faults’ has been identified, and may otherwise have been missed.

7. Maslow’s hierarchy of needs

Maslow’s model (1943), which deals with physiological, safety, love, esteem, and self-actualization drivers, is considered by Patterson (1969, p.12) in the light of the client-centred relationship. He suggests that normal, healthy, self-actualising people are considered, amongst other things, to be ‘detached from turmoil’ and to be able to ‘rise above misfortunes’ with a ‘philosophical sense of humour’. They should ‘discriminate between means and ends’, be creative and have a ‘democratic character structure’. This process of actualisation is a ‘mystic experience’, involving acceptance of self and others and of nature, with a ‘resistance to enculturation’. Granted, this is not the most useful list, and as Truax points out (1969, p.62), “Maslow’s Hierarchy of needs may well have been left to die a slow death; it’s relevance to psychotherapy is beyond comprehension”. It is worthy of note too, as Patterson (1969, p.3) comments, that Maslow’s hierarchy may not in fact always be hierarchical. He cites the example whereby the psychological need to maintain one’s self esteem may lead to the sacrificing of more basic needs, or even life. Even so, the issue of the order in which outcomes are achieved is an important one, since there may be little point in a client seeking to achieve goals which are

unachievable in the absence of a foundational structure. The items in the list were therefore reordered to reflect a hierarchical structure, enabling clients to benefit from that viewpoint if appropriate.

Helpfully, Lester (1990) has devised a scale to measure the degree of satisfaction of Maslow's basic needs including 50 clear statements relating to Maslow's 5 levels of need. Unfortunately Lester's scale was written for college students and therefore, for example, limits the elements of self-actualisation which Maslow considered to develop in the second half of life. Equally, as is pointed out, there is little reference to cross-cultural application since the items were designed for the typical American. Further the method by which the items was derived has not been published, so the only indication of their origination was that Lester, Hvezda, Sullivan and Plourde 'wrote them'. Nevertheless, the items provide useful ways to describe self-actualisation such as 'I feel I am doing the best I am capable of' and 'I feel that I am growing as a person'. More controversial items are included by Lester such as 'my life is orderly and well-defined'; 'I am religious and consider myself to be a member of a religious group'; and 'I have a satisfactory sex life', topics which were to prove a contentious addition to the list of items initially. Other items were less helpful such as 'in winter, I always feel too cold' and 'there's usually some part of my body that is giving me trouble'. Whilst the researcher could identify with the sentiment, these items were not integrated into the final list of outcomes due to their negativity and specificity. The Delphi Study which follows later was important to ratify these items particularly, since they had no identifiable research base.

8. The adult learner: a neglected species

It has already been discussed that Knowles' theory of Andragogy (Knowles, et al., 2011) has direct links to Rogers' theory of learning, and as such is reviewed throughout the process of this research. Knowles has produced a table which defines life roles such as being a 'self', 'friend' or 'citizen', each of which have related competencies such as the loving, empathising, listening, collaborating, sharing, helping and supporting competencies required to be a friend. It was considered that whilst the attributes were not always entirely applicable to therapeutic outcomes, there were useful items contained within this framework. For example, the ability to compute, read and write were not considered essential for self-fulfilment, but the sense of having a role such as being a friend relates to Maslow's sense of belonging and could be utilised to expand on items which outline the value obtained in being part of a community, being part of a family and having friendships. Not surprisingly there was also a role of 'learner' identified which was incorporated in the list of items as 'has a desire for learning'. It must be noted, however, that there is no clear source or method of production for Knowles Life Roles. They are merely listed and the assumption is therefore that they were derived independently. As for Lester's model above, further consideration of the items through the course of this research was therefore necessary.

Finally, some minor points from further taxonomies such as the 'Feelings, Reactions and Beliefs Survey (Cartwright & Mori, 1988), and material from conversations with various academics were also collated.

The studies outlined above provided a wide range of humanistic outcomes and described Rogers' fully functioning person in detail. With development, they could be expressed in such a way as to be outcomes which could be *learned*. The next stage in this process was therefore to review all 260 items from the vantage point of a single spreadsheet, to collate, analyse and develop them. It was intended that a framework of learning outcomes would emerge, based on this existing research and the researcher's understanding of the field.

4.2.1 Data Analysis.

Firstly, the various texts were broken down into lists of discrete states or traits and then given a category label. At this stage they were also identified as either thinking, feeling or behaving states or traits, and further categorised into issues relating to either 'the self' or 'the self in relationship with others'. For example:

Discrete states or traits	**Category**		
Values caring for others, giving serving	Values interaction	Feeling	Relationships
Values support from others when necessary	Values interaction	Feeling	Relationships
Accepts the need for compromise or personal change may be necessary for a relationship to work	Change	Thinking	Relationships
Does not desire others to change	Change	Thinking	Relationships
Is altruistic, considers the greater good	Treats others	Thinking	Relationships
Can identify dysfunctionality in relationships	Understanding	Thinking	Relationships
Is able to face problems	Deals with -ve	Behaving	Self
Manages the uncontrollable, e.g. physical disability	Deals with -ve	Behaving	Self
Can identify and manage own emotions eg anger, fear, stress, sadness	Manage own emotions	Behaving	Self
Expresses emotion appropriately	Manage own emotions	Behaving	Self

Finally the categories were expanded again to ensure all items in the original lists were included, if not in the main state or trait, at least in a clarification statement going into more detail. Almost all data in the original texts were included and thus, 260 items were reduced to 22 categories and 80 states or traits. Items excluded were those which were problem oriented such as 'I have thought of hurting myself', or ones that were too specific such as 'accepts the birth of a child'. As mentioned previously, others just didn't seem to have a place such as 'less hostile to men', and some were relative such as 'more settled' and therefore were translated to a specific outcome such as 'is emotionally stable'. Some items were vague and more difficult to operationalise, such as Rogers' notion of moving towards 'being complexity'. This item for example was translated into 'awareness of different 'selves' or layers of personality', and separately, 'is authentic/congruent'. Some complex terms were left unchanged such as the 'ability to be synergistic', but later were considered to be unclear and removed. Validity checks were completed at this stage by the researcher's supervisors to ensure assumptions and decisions made were appropriate.

The analysis was completed using Thematic Analysis, explained in Chapter Three. It was approached at the level of 'the actual' from a Critical Realist perspective (Bhaskar, 2008) and a semantic level (Braun & Clarke 2013, p.207), since the task was largely a semantic 'sifting' and ordering' exercise. Interpretation, or analysis at the 'real' or 'mechanistic' level had already been addressed by the authors of the various studies, quite specifically to produce clear outcomes, so a naïve perspective was considered to be appropriate at this stage. Some interpretation of definitions was necessary, such as deciding what 'enlightened' or 'adjusted' was

intended to define, for which a degree of phronesis was necessary. The process was complex, so more easily understood by the reader by reviewing the spreadsheet which details the analytical stages. (The list of items is contained in the data file: Supporting Data\Chapter 4 Outcome Design\Outcome Framework Design.xlsx.)

4.3 Results

22 categories of learning outcomes emerged from this process of analysis, each with a set of associated states and traits, followed by a detailed description of meanings. For example, the first category included the following states/traits and description:

Category	**States or Traits**	**Description**
Understands self	A clear and objective view of self	Able to analyse own thought processes. Is able to be objective about self.
	Understands different facets of self	Aware of different 'selves' or layers of personality. Acknowledges types of self or 'community of voices'.
	Acknowledges weaknesses, but affirms self	Can see own problems or deficiencies (e.g., denial, self-doubt, self-fulfilling prophecies, fears, poor coping strategies.) Affirms self in spite of deficiencies.
	Understands impact of self on others	Is aware of own impact on others
	Acknowledges personal needs	Is aware of own needs. Understands own reactions.
	Understands development of self	Understands self in the context of the past, (e.g. neglect, abuse, or style of nurturing).

The 22 main categories were identified as follows:

- Understands self
- Trusts self
- Positive self view
- Views on growth
- Views about change
- Accepts lack of control
- Accepts the negative
- The maturing self
- A developing world view
- Emotional expression
- Accessing the inner child
- Managing practically
- Managing self
- Deals with the negative
- Manages own emotions
- Change in relationships
- Others viewpoint
- Treats others well
- Values relationships
- Beliefs about others
- Manages inter-personal issues
- Managing own needs within relationships

Initially, 79 state or trait descriptions were included under these headings, each with an explanation for clarification. So, for example, the heading 'managing self' included 'engages with self' as one of 11 states and traits, which was clarified as 'responds to own needs/feelings; communicates with inner self; and engages with self'. In summary, a complete list of therapeutic learning outcomes was produced based on the literature review and the researcher's intuitive approach to the subject.

Given that, according to Levitt and colleagues (2005) no existing outcome measure was suitable for use in a humanistic therapeutic setting, and the only study identified on learning outcomes was limited in scope, the researcher intended to collate a list of concrete, positive outcomes suitable for use in a person-centred, learning oriented, therapeutic encounter. The list would be exhaustive, whilst

acknowledging that any client may wish to tailor the items to their own specific requirements. It is noted however, that this list is presented from a humanistic perspective, based on person-centred theory, from a Western, individualist perspective, devised by a white British researcher. No claim is made that the states and traits outlined would be suitable for all cultures, with different religious beliefs and different life expectations. Nevertheless, the outcome was a comprehensive, if Westernised, list with an emphasis on learning, which the researcher was comfortable would be a good start point from which to address the issue of identifying client aims from therapy. Assumptions made would require testing, so field research was planned first with educationalists and then with therapists direct. The studies are outlined in the next two chapters.

Chapter Five: Study 1: How do Clients Learn through Person-centred Therapy?

Interviews with therapists/educationalists

This first field study was designed to provide a foundation to later studies by researching very broadly, the topics of learning and change in therapy. Interviews were planned with educationalists in psychotherapy and counselling covering their existing knowledge on the combination of learning and counselling theory. Their views on humanistic learning outcomes in the context of therapy were also sought. The participants were, in some cases, leading practitioners in the field of person-centred therapy, so if there was information to be gained on the topic, it was considered that they would be a good source.

5.1 Methodology: The Interview

One to one interviews are a powerful data collection strategy (Teddlie and Tashakkori, 2009) and were considered to be appropriate for this first study since in-depth, qualitative data was needed. An interview approach, based on a seminal text by Merton and Kendal (1946), also gave the opportunity for flexibility in data-gathering. Open-ended interviews, semi-structured in nature (Smith, 2015), were utilised in order to allow for interesting lines of enquiry to be followed during the course of the conversation, whilst maintaining a focus on relevant topics and questions. A small number of interviews were planned (N=5), having given consideration to issues outlined by Baker, Edwards, and Doidge (2012), such as the Critical Realist and mixed methods nature of the research, the complexity of the

subject, practical issues such as the availability of participants, and the 'epistemic community' in which the topic and researcher were located, of which the selected participants formed a part (p.42).

5.2 Method

5.2.1 Participants.

Participants were chosen, based on the judgement of the researcher, to have in-depth knowledge of both learning and Person-centred theory. 5 individuals, including an author on Person-centred Counselling, a Professor responsible for Masters level training in Person-centred Counselling, and Person-centred Counsellors with either a teaching or coaching background agreed to participate. Two of the participants could have been regarded as 'atypical or extreme' cases since they are well known individuals in the field of both Person-centred Therapy and education. Arguably, these two individuals represented 'expert' knowledge of the subject areas, meaning that a much broader sample was unnecessary. All participants were white, British professionals living in the North of England. 3 were middle aged and 2 near to retirement. 3 were male and 2 female.

5.2.2 Recruitment.

Prospective participants were initially identified on the internet through Google using 'Person-centred courses' as a search term. They were then approached with a speculative email and follow-up phone call once they had expressed interest.

5.2.3 Materials.

Each participant was provided with the appropriate forms to ensure informed consent was sought (App. I). (All documents are contained in data file: Supporting Data\Chapter 5 Interviews\Consent Letter and Information sheet.) The overview of the study indicated that the topic was 'learning in a therapeutic context' and would consider the possibilities for 'increased efficiency, and effectiveness of therapy' through learning. The following specific topic guide was also provided:

- Do clients learn through person-centred therapy, or do they 'just' change?
- If they do learn, what and how do they learn?
- Are there any particular theories of learning which you have used in therapy? What was the outcome?
- Do you think there is room for the therapist to 'facilitate' learning? If so, how?
- What do you regard as good humanistic outcomes for therapy?

5.2.4 Procedure.

Semi-structured interviews were conducted in the participant's own work premises, lasted for around 45mins, and were audio recorded. The interviews were centred on the questions provided in the topic guide, although subject areas were purposely fluid, to allow for useful insights to emerge. The interviews were audio recorded and then transcribed. All utterances were documented in the transcript, including pauses, emphases, questions and 'nonsense' words such as 'er', 'hmm' and 'um'. The complete Jefferson (1983) transcription style was not considered necessary since *what* was explained was more important than *how* it was said.

5.2.5 Data Analysis.

The data analysis followed the guidelines for Thematic Analysis (Braun & Clarke, 2013), and immersion in the data was a complex, time-consuming and at times, laborious process. 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 analysis process was based on questions which were established by the researcher, analysed with a specific purpose in mind, and interpreted with the researcher's mind set. This hermeneutic perspective is, however, in terms of Thematic Analysis, considered to be an advantage.

Importantly, 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 was based on the retroductive and abductive process described earlier, resulting in themes that were strongly linked to the data themselves rather than utilising a pre-existing template. Given that the analysis was approached from within a Critical Realist paradigm, a combination of semantic and latent codes was used: Some comments were taken at a sematic level since they seemed to require no interpretation, such as "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". Here, assumptions had to be made about what 'meeting' meant and whether the respondent was attempting to remain true to person-centred ideals rather than expressing what he really did in practice.

Using Excel, initial interpretations were made of each statement and coding then applied. Often more than one code was applied and more than one interpretation derived. 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. Although some items were mentioned only once, they were still included within a theme. A total of 578 data items were analysed and coded. 10 main themes emerged with sub-themes ranging in number from 2 to 17. Checks for misinterpretation or bias were carried out at this stage by the researcher's supervisors. The complete analysis is included in the file: Supporting Data\Chapter 5 Interviews\Analysis.xlsx.

5.3 Results and Discussion

Each of the 10 main themes identified in the process of analysis were derived from a range of comments. The analysis moves through illustrative and descriptive comments, to more interpretive and analytical approaches depending on the content of the theme (Braun & Clarke, 2013, p.252). Braun and Clarke regard it as not good practice to use numbers in reporting results; therefore the discussion is limited to comments such as 'most', and 'very few' participants etc. The quotes from the transcripts are referenced by the participant's initial and appropriate line number, and are to be found in the data file 'Supporting Data\Chapter 5\Individual Transcripts and Coding'. Data analysed from the semi-structured interviews produced the following overall themes:

	Theme	Description	Codes
1	**Learning and Change**	Whether clients learn, change, or do both	Yes clients learn Yes clients change Sometimes they don't change Learning and change are the same Change is a process
2	**Goals**	Who has goals and how they are used	I have specific goals I don't have goals Views on goals How I use goals Clients have their own unique goals Clients have specific goals Use of client goals I have an overview of the clients process Therapists should know what's going on for their clients Using process knowledge with the client I have specific goals
3	**Learning Process**	How the learning process occurs in therapy	The clients role in the learning process Necessary conditions for client learning Regression can be growth Learning can be a negative process for the client Some people will retain negative outcomes How does the learning process work? What does the learning process look like? When does learning occur? The therapists role in the learning process Being person-centred contributes to the learning process 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	**PC 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

Specific comments relating to the themes, and their implications for learning in therapy, are described next.

1. Learning and Change

The initial interview questions intended to provide a backdrop to the rest of the interview and were around the nature of learning and change: whether clients did in fact 'learn' anything at all in therapy; whether they subconsciously changed; whether learning happened as a result of change; and how that process occurred. These were clearly fundamental questions supporting the whole study, since if learning occurs naturally as clients are exposed to Rogers' core conditions, then learning facilitation is unnecessary. 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! It was also accepted that the question of whether clients learn is "…a different question to 'do therapists teach?'" (P2.1), and although 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 also 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, I'm becoming different (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 also considered that both learning *and* change happen (e.g. H2). For example one said "… change happens as they choose to respond to what they learn" (R2). Whether change comes as a result of learning as suggested by Gerber (2001), or learning as a result of change as suggested by Marton, and colleagues (in Salo, 1993), 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). As Binder and colleagues (2010) report from their study, there was agreement that change cannot be separated from insight. One said "learning is demonstrated in change" (R10) and another "I don't see how it's possible to separate those two kinds of concepts" (C6), or more tentatively, "well they can be the same thing, but I would say they allow for differences" (R6). 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.

Some consideration was also given to the issue of whether learning or change could be seen as a *process*. Carey and colleagues (2007) identify both learning processes *and* identifiable moments of learning in therapy, although for Feltham (1999) it is a more specific event rooted in client insight. Some participants also offered views on the process of change, one suggesting that "insight emerges and then people have a choice of what they do with that insight" (P6). Being largely person-centred therapists, the emphasis was on a process of change rather than a

specific outcome, which was often linked to the idea of insight. The fact that a client has the choice of whether to apply insight was also acknowledged.

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. There was, however, a general acknowledgement that personal learning did play a role in therapy and further, that this learning was intertwined with the gaining of personal insights and a degree of unconscious personal change. It is the researcher's hypothesis that although change can occur without necessarily being recorded in the consciousness, further benefit to be gained from the process will require it to be formulated into conscious learning (assuming it is more than a stimulus/response mechanism). Further research into how change is represented in the consciousness and how that learning can be used as a catalyst for further change would therefore be welcomed.

2. Goals

Whether or not therapists or clients work towards goals in therapy is important to establish since the idea of goal setting forms the basis of a facilitated learning approach. One needs only to refer to the National Curriculum (https://www.gov.uk/government/ collections/national-curriculum) for evidence that knowing what is to be achieved is considered essential to define the learning process. Specifically defined goals are not ordinarily part of the person-centred therapeutic process. Some respondents considered goals to be better defined as "desires or

longings the person may have" which they would not attempt to define further (R66.1). This very Person-centred perspective on goals reflects Rogers' views that the organism is oriented towards the integration of competing goals, (which can be an entirely subconscious process), in a process of self-actualisation (2003). Even those participants who were willing to consider firm goals for their clients expressed their views in a similar way to Scholl, Ray, and Brady-Amoon, who suggest that "…humanistic counsellors do not act upon clients; they act with them, honouring client autonomy in establishing or not establishing goals" (2014, p.219).

Despite mostly representing a very person-centred perspective, some participants suggested that "we absolutely *are* goal oriented" (K16.2). Further, they suggested, for example, "the goal is threat reduction, and integration of symbolisation into the self-concept" (K66.1), or to enable progress in a short period of time (H22.2), or to enable "people to have a sense of choice in their lives" (K104.1). Clearly these were not client generated goals, but goals assumed *on behalf* of the client. Goals seemed to be either personal to the therapists who expressed them, or tied into Rogers' ideas on therapeutic process. There seemed to be an acknowledgement here, as Bandura suggested (1999), that goal setting is a significant cognitive mechanism in the process of learning and development.

The most common comments made about clients' personal goals, centred on their usefulness in providing a framework for the therapist to work with. For example one said "it's me piecing together the bits and pieces I've thought, but it isn't collusive or it isn't constructed together because he's not ready to have the big picture" (R26.1). Most considered that this piecing together of the client's narrative

gave them an overview or helicopter view of the process (P36.2), by "making the pieces fit if you like in my head" (H32.1). This process overview did not *necessarily* extend to an accurate understanding of client goals, since one commented: "I can only think I know" (C14.2), and another: "I can't see where they're heading but I understand from my theoretical knowledge what's going on for them" (H12.2). Therefore 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 by the clients through a discussion of client aims.

One question which was of interest particularly was whether participants saw clients as self-actualising in a common direction towards being a 'fully-functioning person' or whether the outcome would be unique to each client. One respondent said "I see everybody as unique" (R48.1) and goals are "constructed from what they bring" (R36.2). These views contrast with the assumption of Rogers which is that clients are all moving in one direction towards being fully-functioning (2004), which may be explained by the following comment; that "some people go for growth…but often people come along because they've got problems… to resolve" (C82.2). Thus if a client wished to deal with a bereavement issue, they may leave feeling less troubled, but little further on the road to being fully functioning than before.

What was most interesting about the responses in this section on goals was the 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). A dichotomy emerges as a result; if process knowledge is being used by the therapist

on the basis that they do not wish to be a blank canvas, then it is likely that they are directing the process in some way. As one respondent put it, "of course I've got an agenda!" (H22.4). Authors such as Knowles (1978), Bandura (1999), Motschnig-Pitrik (2008), Egan (2010) and Bordin (1979), have all advocated directivity through the use of goal setting in therapy, and Sachse suggests that negotiation to establish either a consensus or compromise about the direction of therapy is necessary (2004, p.29). Further, in practice, Levitt and colleagues found that clients generally "wished for more of an agenda when stuck focusing on unimportant issues, and yet were unsure how to redirect the process…" (2006, p.319).

In summary, there seemed to be a need by participants to 'do' something, to fulfil their agenda, and there is support for this view as various writers advocate collaborative goal setting. At the very least, there seemed to be a consensus from participants that goals, or a sense of direction form a part of the therapeutic process, operating often subconsciously. Therapists considered there to be useful process intelligence to be gained through the client's drivers, but were unwilling to talk explicitly about that process with the client. It is possible that a more explicit conversation about the direction of therapy would empower clients and clarify person-centred therapeutic processes even further.

3. Learning and the Process of Facilitation

Participants had much to say on the issue of *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 (P4.2), and occasionally "through osmosis" (P10.1). Specific examples were also cited such as learning from

the therapist being congruent (H2.1), or "applied knowledge" resulting from a 'birds-eye view' (R8.1). 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). Rogers (1975) believed firmly that learning could be facilitated through psychotherapy, resulting in the client seeing himself differently, becoming more mature and accepting of others for example, and it was empathy which largely brought this learning about. He considered further, 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' work on Andragogy is a process of self-directed development, guided by unconscious drivers. This seemed to be the perspective adopted by the participants.

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. So, "…once you're on that open journey of finding out more about yourself… then that is just going to continue" (H69.2). The work of Salo (1993), Flavell (1979) and Glasman and colleagues (2004), not only underlines the importance of retained learning, but defines mechanisms by which that can be encouraged. So metacognition, engagement and insight into change processes, for example, become issues for scrutiny as well as therapy outcomes in isolation: thereby what must not be 'unknown' is identified. So, although this process was considered less relevant by the participants, it may be in the absence of such a process, 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 with the client.

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 "I wouldn't be Person-centred" (P54.1). Another suggested that understandably, their 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 (H45.2), and another explained that it is about challenging people's perception of themselves (K26.1), or challenging the client's conditions of worth (K28.1). The most common reason for facilitating a learning process was due to time pressures (H28.6). Whether the need to challenge perceptions surfaced, time was short, or clients' needs to develop emerged, participants seemed to adopt Rogers' educational perspective (Kirschenbaum & Henderson, 1997), that the facilitation of some kind of a learning experience was not in opposition to being person-centred. This perspective is vital to any learning facilitation methodology and it was concluded by the researcher that as long as the therapist was not 'pure' Person-centred, then the principle may therefore not be rejected outright.

The most common approach to enabling learning was the use of therapist congruence (H2.2), aimed largely at enabling a reconnection with the individual's instinct or actualising tendency (H59.1). In a more directive sense, one suggested asking questions, "so that they can begin to challenge their own perception of themselves" (K36.1), and another sought an opportunity to allow them to think

differently (R72.2). Other specific approaches were also mentioned, such as attachment theory (H41.3), and 'thought work' (C44.2). Further suggestions were, to try to get them to think in terms of the bigger picture (R16.2), or "interactive learning that might cause the client to change his stance" (R18.1). Surprisingly, what emerged was a wide range of techniques employed by the participants which were intended to bring about a specific consequence, often related to learning. Although Rogers' perspective on this was "I have come to feel that the only learning which significantly influences behaviour is self-discovered, self-appropriated learning" (Kirschenbaum & Henderson, 1997), it seemed that these therapists were content to direct the process with more specific intent, almost to teach, or to make a point, which pushed the boundaries of their Person-centred philosophy. It may be then, that a greater understanding of self-directed learning facilitation strategies may allow these therapists to achieve their desire to enable learning without directing the client in a non-person-centred way.

The participants were clear, as Rogers believed, that the core conditions are fundamental to learning. The lightbulb moments created by experiencing deeper empathy (H2.6), and "…daring to be congruent and real in this relationship, and daring to be vulnerable, …is the person learning about themselves" (H16.1). Further it was considered that in the tradition of 'walking alongside the client', "to work with somebody who isn't trying to push you beyond where you are, teaches you how to be you" (C76.4). In this process, "by dissolving conditions of worth, the individual will naturally become a more fully functioning person" (H18.3). This deep empathy, unconditional positive regard and congruence was identified by all participants as part of the learning process, and as Feltham notes (2009), the

resulting trust gained by the client in their own experiences drives significant change. What is at issue is whether this process can be made more explicit, defined and directive, in order to enable that process more quickly or along more focused lines.

One final point worthy of note came from this part of the interviews, with one participant suggesting that the client has a significant part to play in the learning process, in that they need to *want* to learn (H63.2), and be ready to hear feedback (C66.1). Further, 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" (P6.3). Clearly participants had met with clients who were comfortable with the status quo seeing no need to change. Further, in terms of negative outcomes, some felt that clients may not like what they learned which in turn created defence mechanisms (H63.3), and that growth can be a very painful process (P78.4). In fact, one participant suggested that some clients do not naturally self-actualise at all, preferring to return to difficult situations or stay in victim mode (P84.1). Loewenthal and colleagues (2005) and Bohart (2007) both discuss learning blocks and methods for their removal. Learning facilitation techniques to tackle learning blocks, for them, remain fundamental to progress, dealt with most effectively by addressing the issue of drivers at the start of therapy before they are given chance to surface as blocks later in the process.

4. Person-centred Process

All of the participants in the interviews had a strong leaning towards person-centredness with some regarding themselves as 'pure' Person-centred practitioners. So for example, "everything is delivered in a person-centred way" (C44.1) said one, and "I respect the core conditions" (R64.1) said another, which clearly influenced comments they then made about the nature of learning. Participants were also generally clear "that there's no formula here" (R20.1) which seemed to be a comment intended to explain that learning 'facilitation' was not considered appropriate. Participants did, however, 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). Similarly, Rogers' belief in the capability of Person-centred Therapy to bring about new self-knowledge (1975) was explained in his analysis of his own interview with Mrs Oak who expanded her understanding of her own experiencing through his empathic understanding. He was in no doubt that 'being' in a person-centred relationship could bring about learning and change. In fact, no one questioned whether person-centred therapists could bring about change and learning, the question was more related to whether that was a purposeful activity on their part.

Specifically, and consistent with Person-centred philosophy, all respondents felt that the clients' needs drove the therapeutic process (e.g. C6.4 and R46.1) and that it was a collaborative process of 'being' and discovering together (P54.3) in the here and now (H12.4), which enabled learning processes. Therefore:

> *The therapist brings a set of beliefs and attitudes to the environment and creates a safe space, where the client is able to get in touch with whatever they need to get in touch with, and to have that accepted and empathised with and travelled alongside,* (P22.1).

or more specifically for example, "by dissolving conditions of worth, the individual will naturally become a more fully functioning person" (H18.1). Put another way, a therapist "who isn't trying to push you beyond where you are teaches you… how to be you" (C76.4) most often by getting back in touch with feelings (H55.1). The intent of the therapist to stay within the Person-centred philosophy thus gives rise to certain client-centred processes from which learning is derived.

Writers have questioned the sufficiency of the core conditions to bring about change (Parloff, et al., 1978; Patterson, 1980; Tudor & Worrall, 2006). As one participant concurred; "…I don't think all therapy has to be done at relational depth". He considered that a client who is "more cognitive", may need to think things through and to understand rather than feel (P30.2). Patterson (1980), also notes the value of teaching new skills and knowledge in situations where the core conditions are not enough. The mix of views represented by the interviewees reflected well the disparity in views from the literature.

The person-centred process experienced by clients is built upon the beliefs that therapists hold about the nature of the person. Rogers was very clear about the actualising tendency of the individual and nearly all the participants explained their commitment to this philosophy: "We've all got the answers within us" said one (H39.1). This interviewee also explained Rogers' ideas on the development of conditions of worth in childhood (H51.1) and the process of therapy which dissolves

them. Another suggested that "all distress is from disordered relating" (K108.1), which is slightly less Rogerian in that he was often criticised for his lack of emphasis on socially mediating factors (Spinelli, 1995). On the whole, the self-actualising nature of the individual was considered by the participants to be fundamental to learning, despite writers who believe that this is not necessarily the basis of personal development (for example, Patterson, 1969; Ryan, 1995; Kensit, 2000; Bordin, 1969; Truax, 1969; Quinn, 1993). The issue of whether or not an individual self-actualises, however, does not necessarily impinge upon the notion of facilitated learning. Whether a client can be relied upon to chart their own course for personal fulfilment or not, does not negate the possibility of facilitating a learning process which aims towards being 'fully functional'.

5. Issues of non-directivity or directivity

Some of the conflicting views expressed both between and within client statements are well summed up in these next observations on therapist directivity. 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), or I work in the moment, it's not scripted (R54.3), and "I don't think I'm telling people how they should feel… I'm clear about that" (K78.3). One participant explained that if she did ask questions, it was out of interest rather than to direct (H74.1), and even when the client was exhibiting signs of 'stuckness', one individual suggested that direction would still not be appropriate (P40.1). These views reflect those of Embleton-Tudor, Keemar, Tudor, Valentine, and Worrall who suggest that "the nature of the organism is to

actualise, it is trustworthy and does not need to be controlled or directed from the outside" (2004, p.32). Bozarth clarifies the point: it is "not that the therapist should attempt to be nondirective. Rather, the theory of Client-centered Therapy results in the nondirective attitude" (2002, p.81). So, no attempt to control or determine the processes that occur for the client should be made by the therapist (Schmid, 2005). Participants were, in theory, very much in agreement with this perspective.

In an attempt to explain this process of non-directivity, participants commented on the importance of being 'alongside' the client in PCT. This relationship was considered a fundamental premise and most participants commented accordingly: "I'm incredibly mindful …that I don't respond in a way that's possibly too, too far ahead for the client" (H14.1) and "I definitely want to be alongside" (P36.1). The basis of this practice is that the relationship is the catalyst for the healing process and all participants had comments along the lines of "at the end of the day it's the relationship that heals" (H14.4). "We are relational beings" (P24.1) suggested one participant and further, "it's how you do that relationality that will define whether it's purely Person-centred or whether it belongs in the CBT stable, or whatever really" (P58.1). As Merry and Brodley suggest (2002), non-directivity is about being with clients in a mutually influencing relationship, whilst Wilkins suggests that "the liberation that can come from client-centered therapy is accomplished by respecting clients as autonomous beings, not by making them autonomous beings" (Grant, 1990, p.79). There are a wealth of views that, on the surface, negate the need for learning facilitation, equally reinforced by the interviewees.

Although most participants ascribed to the non-directive nature of Person-centred counselling, they also recognised that directivity was inevitable if not in some cases intended, which seemed to contradict much of what they had already said. For example, "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" (P34.2), or simply "I think everything is directive" (K76.1) and further, "I think everything I say has an intention" (K40.1). This view was also explained in this comment: "I am directing a process by which you will learn about yourself, through me" (K78.4). These comments reflect well the views of Kahn (1999), and even Rogers himself, who suggested that "…counselling is built largely on the persuasive powers of the counsellor" (Rogers & Carmichael, 1942, p.118). Further, Levitt and colleagues (2006) have found clients to positively seek help through directive practices such as challenging, teaching and offering new perspectives. From a Critical Realist view, clarity in the *real* views of participants was lost at this point. What they were *actually* saying contradicted previous statements, and could no longer be accepted as real. Underlying mechanisms, such as the need to be respectful of the core conditions, seemed to be driving comments which were not real for the participants.

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 specific methods of perceived teaching were mentioned, such as explaining a concept like the process of grief to a client (H22.4), explaining the transferential or counter-transferential relationship (K92.1), and to bring to awareness how the person relates in the world (K96.1).

Other suggestions involved asking about the physical manifestation of feelings (H55.2), the use of anecdotal stories, examples and illustrations to give context (R68.3), and therapists offering clients what they had heard (H34.1) in an attempt to enable insight. Levitt and colleagues (2006) recommend guided examination of client's emotional, cognitive, relational and expression patterns, and Ellis notes that the counsellor:

> *…often selects one of the client's first statements, channelizes this by very precise, if subtle, 'non-directive' probing, and encourages the client to exhaust this original stream of thought or feeling before he is given the opportunity to go on to something else* (2000, p.250).

Despite being philosophically against the idea of directivity, participants articulated a range of directive methodologies such as these that they considered enabled insight and learning.

When questioned about their reasons for becoming more directive within a therapeutic relationship, one common reason given was "I think it's really useful when it's time limited" (H34.1). This participant explained that "for me, it's about - let's get to this, and find out what the underlying issue is" (H28.2). Another commented on the use of brief-solution-focused principles to get an idea of "what will fix this?" (R72.1). The interesting reflections here on motives address a question within this study - whether the process of therapy can be made more efficient. It seems that one reason for being directive was exactly for this purpose.

6. Questioning

In discussing directive techniques used by therapists, one particular approach mentioned often was the use of questions (e.g. K32.1), although one participant

commented on the inappropriately intrusive and directive nature of questioning in PCT (R64.4). The way in which questions were asked generally reflected the need to be non-judgemental and without any intent to guide the client (R30.4). The point was stressed that questions were not intended to be directive, but inevitably resulted in direction of a sort. One specific question - the 'why question', which could be considered to have judgmental and directive overtones, was regarded as important by one participant. He felt that asking "'Why do you do that?' is an invitation to learn" (K34.1). Although questions were considered on the whole useful but not important by the participants, Haroutunian-Gordon (2007) suggests that it is not actually possible to listen empathically *without* questioning. And, in a study of Person-centred therapists (Renger, 2014), all claimed not to ask questions, but on closer examination, found that in fact questioning formed a significant part of their therapeutic approach.

The most often cited reason for directing the conversation through the use of questions was to enable the client to explore and understand themselves (H6.1), and to enable the client to begin to challenge their own perception of themselves (K36.1). Further reasons for their use included dissolving conditions of worth by asking "what stops you?" (H23.1), defining alternative approaches to achieve goals (R22.3), and another suggested that "there's something about learning how to challenge yourself outside of the therapy room" (C46.1) which is beneficial. Further, Rowland and colleagues, in research on long term outcomes of therapy, report on the benefit of questioning, suggesting that it facilitates a process of naming and understanding emotions, actions and their consequences (2009, p244).

Questioning is a technique used in Knowles' Andragogy (Elias, 1979). It may also be the case therefore, that the use of questions is the key to learning in a therapeutic context, and more specifically that a form of Socratic questioning would enable insight, learning and change (Paraskevas & Wickens, 2003). In fact, gentle challenging through Socratic questioning was considered appropriate by one participant (H34.4). Fairburn (in Kazantzis, et al., 2014) points out that contrary to the gentle approach of the therapist, Socrates was quite ruthless in pinning his opponent down to contradicting himself. Not surprisingly, research conducted by Levitt and colleagues found that clients "…did not want a therapist who felt more strongly about an issue than they did themselves. They described these therapists as pushy, annoying, and judgmental". Confronting clients who were being manipulative within the therapeutic context or were avoiding important aspects of their experience, however, was considered more favourably by clients (2006, p.320). Clearly purpose or intent on the part of the therapist plays a large part in the success of this particular technique and it is an area which would benefit from further research in practice.

7. Outcomes

Moving on from therapeutic processes to outcomes, the participants were all asked about the kind of change which they would either typically see in their clients, or they would like to see, and most had clear ideas on the subject. Given that Rogers' 'fully functioning person' has an increasing openness to experience, is increasingly existential in living and with increasing trust in his organism for example (2004, Ch. 9), participant comments stemmed largely from the therapist's understanding of this actualising tendency. Operating in the world as a much more

fully functioning person (H16.3) was defined as being more open to experiencing (P74.2), dissolving conditions of worth (H18.1) and developing congruence explained as "the alignment of my experience and how I think about it and think about myself" (K16.3).

The learning outcomes identified in Burnett and Van Dorssen's study of therapeutic outcomes (2000) were also identified by participants: Participants identified that clients begin to understand why they behave in a certain way (H53.2), how to get back in touch with their feelings (H55.1), to tolerate themselves (K116.2), and in summary, gain a greater awareness which enables choice (P70.1). A further common theme was that of gaining a wider perspective on and changing attitudes to life (P6.4), learning how to be discerning (C82.4), and becoming more aware of how they relate in the world (K96.1). More specifically, participants cited an ability to tolerate anxiety better (K110.1), and to tolerate others better (P74.2). They also mentioned a gain in confidence (C74.1), self-acceptance (P74.20) and a change in internal processing (P20.2). One final common theme was that of learning how to be in relationship with others and an increased sense of mutuality (C68.1). It's about "re-learning how to be a relational person" (K108.2), but also knowing that "I don't need to ask other people how I need to live my life" (C8.4). Being more discerning of others (K22.1), and being able to articulate their own needs within the context of relationships (H53.1) were also mentioned.

What was interesting about these comments was that they 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. Connolly and Strupp suggest, "although current research on the efficacy of psychotherapy often includes multiple domains of outcome assessed from multiple perspectives, constructs such as self-understanding, self-confidence, and self-definition are rarely assessed as important domains of outcome" (1996, p.39). For these participants, however, they were important outcomes, defined in quite specific terms.

8. Long term learning

When asked about the possibility that learning is retained by clients in the longer term, most participants agreed that it was possible and desirable. Two interviewees commented that in fact, you cannot *not* know what you know, suggesting that change of some sort was more than possible, but inevitable (e.g. H69.1 and P99.1). Another commented that once you are on a journey of self-discovery, then it will be maintained naturally (H69.2). Loewenthal and colleagues also suggest that lifelong learning embraces the notion that learning potential continues throughout life (2005, p.444), while Marton and colleagues discuss the lack of differentiation between learning and life in general (in Salo, 1993, p.285). One may question therefore whether the actualising tendency engages subconsciously and long term learning plays out automatically, or whether lifelong learning is a purposeful activity in which therapy has a role to play.

Probing further then 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, 1999). Self-therapy was considered to be reliant for example, on being able to challenge or be curious about yourself outside of therapy (C46.1), or to

use relationships to get help (K106.1), but was thought to be a process of accessing the therapy experience and reframed perceptions of the self either consciously or unconsciously post therapy (P99.2 and C82.1). In agreement on this point is Glasman who notes that a number of his counsellee study participants, since therapy, had changed the way they related to thinking (Glasman, et al., 2004, p.341). More specific comments were made on this subject, such as "unless I understand what I'm doing, I can't replicate it" (K102.2), reflected in Flavell's ideas on 'thinking about thinking' or 'knowing that we know' (1979). Further it was considered that unless the underlying work on conditions of worth have been done, strategies to cope will not endure (H75.1 and H.77). These and other comments reflected ideas such as the Metacognition of Flavell (1979), the need for engagement (Wang & Degol, 2014, p.137), John Heron's notion of 'living as learning' (in Carter, 2003), and a 'toolkit' for learning transfer (Rowland, et al., 2009).

Bowles suggests that "…it is not yet known whether client-centred therapy leaves the client with the language and cognitive scaffolding to deal with the recurrence of the problem or other problems in the future" (2012, p.259). "The ability to apply change/learning processes… to other life areas and/or problems and in the future" was an important therapeutic outcome for Burnett and Van Dorssen (2000, p.249), and therefore may warrant further investigation in the person-centred context.

9. Assessment and diagnosis

Gibbard and Hanley (2008) suggest that PCT is a unique encounter between two people affecting the client's subjective process or inner experiencing. In that

reciprocal encounter, both are affected in ways that cannot necessarily be explained, quantified and therefore measured at all. Hence, it was considered important to establish whether or not the therapists felt it was appropriate or indeed possible to make an assessment of where the client stood in relation to a set of criteria in a person-centred context. Participant views were particularly relevant since, if learning goals were to be defined by clients, then a process of measurement both before and after could demonstrate success.

Most participants claimed 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 and C26.2). Another comment was that the therapist's assessment of the client's perception of themselves in the world was essential to the process (K84.2). This information would then feed into process decisions made by the therapist. One final comment was that "actually Person-centred counsellors assess all the time in the moment by moment" (H2.5), implying benefits to the therapist such as a process overview derived from knowing where the client is and where they are heading. In support of these views, Binder and colleagues (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.

10. Other methods

It was acknowledged from the start that 'pure' Person-centred practitioners may find the idea of directing a learning facilitation process philosophically problematic. All participants on the other hand, despite in some cases regarding themselves as 'purist', claimed to use other therapeutic approaches or techniques occasionally. For example, CBT techniques such as cognitive restructuring or exposure therapy (C42.2), recommending books or reading poems (R54.1), attachment theory (H41.3), and even psychodynamic theory (K92.1), were all suggested. Brief solution-focused therapy was mentioned by two participants (R72.1 and H22.3), the Skilled Helper Model was mentioned by another (R62.1), and phenomenological approaches were also considered appropriate (R48.4). Different reasons were given for using alternate approaches such as pragmatism (R60.1), to provide process awareness for the client (P64.2 and K88.1), or to deepen the work (C44.2). One participant regarded these alternative approaches as useful for facilitating learning (C14.9 and C51.1). It seemed therefore that, in this sample of therapists, the notion of a more directive approach would not necessarily be met with a philosophical brick wall, but may in fact be welcomed as a useful addition to the therapist's integrative 'toolkit'.

Issues of Time

One final issue which was brought up by all participants was that of short time frames for psychotherapy, but that "Person-centred Therapy isn't particularly compatible with short-term, it takes time" (C6.5). It was noted that Carl Rogers was not restricted by time-limited work (H28.5), and that sometimes clients need longer timeframes to address their issues (H26.2). A comment which sums up the response

to budgetary pressure to conclude in 6-8 sessions was as follows; “it was more than the sessions I had, and I couldn’t go there in depth with that, so I had to find a way to facilitate something” (C36.2). As a result, techniques such as role play (C28.1), and other directive approaches were often cited as useful. This need to ‘facilitate something’ came across in a number of comments (H22.2, R70.1, C36.2), and reflected a real pressure from those responsible for the cost of provision. An important point was uncovered here, since a facilitated learning process could possibly meet the need to shorten timeframes by giving therapists methods by which the person-centred ethos could be adhered to, but the processes condensed.

5.3.1 Quality.

Some reflection on the quality of this research process was appropriate before moving on: Firstly, Yardley (in Smith, et al., 2009, p.179) suggests that ‘rigour’ may be shown in the appropriateness of the sample population to the topic being discussed, and it was considered that the interviewees chosen represented a good spread of both person-centred and learning experience, and that 5 ‘experts’ were sufficient to represent current thinking. Also, Boyatzis (1998, p.144) suggests sub-sets of participants representing different facets of a topic, which was partially adhered to by including one participant who considered PCT to be sacrosanct.

Transparency is achieved, according to Yardley (2000), by the detailed explanation of the data collection and analysis process, and by making such data available for scrutiny by others, so the data collection and analysis is documented in detail in the supporting data file. Further, Boyatzis suggests that “reliability is consistency of observation, labelling or interpretation” (1998, p.144), and therefore

every effort to be consistent was made and documented before being checked by the researcher's supervisors.

The detailed analysis also contributes to a measure of validity of the data. Maxwell (in Denzin and Giardina, 2015) discusses the notion that validity can only be a property of inferences, and not of method. Thus inferences made, which are a function of the method chosen, were highlighted. A further concept relating to the issue of validity, presented by Cho and Trent (in Sparkes & Smith, 2014, p.192), relates to 'catalytic validity', and is particularly relevant to a "critical agenda …that is openly ideological". Catalytic validity measures "the degree to which the research process energised participants and altered their consciousness so that they know reality better". It was considered that on the basis of comments by some of the interviewees, the debate around learning and humanistic outcomes proved to be a minor catalyst for change in their practice. In summary, considerations of validity were made through a clear path of evidence for data and processes of analysis, coupled with clear ideas, concepts and relationships forming the basis of the study (Farquhar, 2012).

Finally, in terms of generalisability, Stake's idea (Sparkes, 2014, p.173) of 'naturalistic' generalisation is more relevant to this qualitative process in that reflections on the participants' experiences can be made by the reader, and thus any claim for generalisation judged individually.

Walsh's notions of *personal* and *interpersonal* reflexivity (2003) were relevant in the context of the interview process here, since the questions and dialogue

developed based on the researcher's existing knowledge and the relationship generated with the interviewee. It is acknowledged that the researcher brought a bias towards the subject of learning to the research process, and some interviews were more positive than others since there was irritation by some that directivity in PCT was even being considered. Further, the issue of methodological reflexivity was thought relevant in that the semi-structured questions led participants to *explain* their views on learning in therapy rather than to *question* whether learning actually occurred. The power imbalance between interviewer and interviewee was also relevant here (Yardley, in Smith, et al., 2009, p.179) but steps were taken to enable genuine responses and to demonstrate that there was no 'wrong answer'.

5.4 Integration of Outcomes into Literature Review Results in Chapter 4

It was the intention to question the experts in this study about their views on learning outcomes in person-centred therapy and then to amalgamate the results with the literature review outlined in the previous chapter. In the event, the participants' suggestions (outlined in theme 7, 'Learning Outcomes' above) reflected the findings already made. Even so, all comments were included in a second analysis phase to bring the desk research up to date with current views. For example, one interviewee had considered particularly the question of learning outcomes and had listed the following attributes for a fully functioning person:

> *…a person of value, self-worth, self-acceptance, gain deeper insight into process, recognise defences, blocks, a greater level of self-acceptance, become more towards fully functioning people, open to experience, more opportunity or to be appropriately authentic, more able to be empathic, develop a greater level of reflexivity, developing a greater internal locus of evaluation.* (P86.1)

Another suggested that "learning is being fully functioning, being open to experience" (H14.5) and that "dissolving conditions of worth enables the individual to be fully functioning" (H18.1). A client that became "more open to experiencing, tolerant, self-accepting" (P74.2) or engaged in "re-learning how to be a relational person" (K108.2) was also thought to be moving towards their potential. All data are detailed in the spreadsheet: Supporting Data\Chapter 4 Outcome Design\Outcome Framework Design.xlsx

5.5 Conclusion

Current understanding of the nature of learning through therapy as evidenced in the literature is complex, often contradictory and incomplete. This first study was intended to clarify some of these issues in order to derive some theoretical foundations to the integration of person-centred therapy and learning theory. The data derived from the interviews also proved to be largely contradictory and it could be argued that a limited amount of clear conclusions emerged. For example, whether clients learn or change, *how* they learn or change and whether or how learning or changing are related was 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 also described in different ways: organically, through osmosis, unconsciously, stemming from the therapist and as part of a facilitated process. Further all participants regarded themselves as at least 'mostly person-centred' if not 'pure', with the client's needs driving the process. In contrast, other methodologies were

described which were integrated into a person-centred philosophy allowing therapists 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 greater agreement between participants and the literature on some issues. For example, participants were able to outline a range of outcomes for successful therapy which concurred with those in Burnett and Van Dorssen's research (2000). Given the general lack of humanistic outcomes available in the literature, these suggestions were helpful in finalising the learning outcomes framework described in Chapter Four. 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 played a role in assisting clients for example 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 understand their own self-perception. Participants also agreed that they integrated other therapeutic methods into their work, albeit based on a person-centred philosophy, with a view to reducing time frames and meeting budgetary constraints.

In summary, it seemed that the notion of defining and aiming towards long term learning outcomes within a person-centred framework may be accepted as part of an integrative approach, although it would have to be a philosophically, if not

demonstrably person-centred process, without any overt sense of directivity. The theory of learning underlying any methodology such as this was less clear, leading to the conclusion that it may emerge more readily 'experientially' in the process of longer term case study research. Given that learning was considered to be at least a part of the person-centred therapeutic process, the next study aimed to establish some of the detailed knowledge which would enable that learning to be facilitated.

Chapter Six: Study 2: What do Clients Learn through Therapy?

The Production of a Learning Outcomes Framework

A literature review, (detailed in Chapter 4 of this thesis), has identified outcome measures which could provide the basis for the definition of a 'fully functioning' person. The results were collated to produce a list of descriptors. The following chapter outlines a Delphi study designed to validate the items on the list and present them in a suitable learning framework for use in therapy.

6.1 Methodology: The Delphi Process

The RAND Corporation saw the introduction of the Delphi technique (Dalkey & Helmer 1963), a method which is now associated most often with Linstone and Turoff (2011). It is a method for structuring a group communication process where the aim is consensus, or where consensus is not forthcoming - stability in responses (Linstone & Turoff, 2011, p.1714). In this case, a consensus on what constitutes being 'fully functioning' was sought. The main Delphi types are usually considered to be 'conventional', 'real-time' and 'policy', but have been added to over time, and now include numerous variations (Crisp, Pelletier, Duffield, Adams, & Nagy, 1997). It was the 'Reactive or Responsive Delphi' (Vernon 2009; McKenna 1994) which was used here, as this process allows for an inventory to be made available for reactions by respondents (such as the list of learning outcomes) rather than beginning with a blank sheet. Despite establishing guidelines for the methodology, Turoff considers that "no hard and fast rules exist to guide the design

of a particular Delphi…success is dependent on the ingenuity of the design team and the background of the respondent group" (Turoff, 1970, p.151).

Although considered a tool for generating consensus, the purposes and outcomes of a Delphi have been debated over time. It is also considered to be a means of generating debate (McKenna, 1994), a means to address what could or should be, rather than what is (Hsu & Sandford, 2007), and a way to establish opinions rather than fact (Powell, 2003). For Hasson, Keeney, and McKenna (2000) it can be used to explore underlying assumptions leading to differing judgements, and for Linstone and Turoff (2011, p.1714), "a bipolar distribution may be a result and a very significant one indeed". In fact Mullen (2003) suggests that failure in a Delphi is often due to not exploring disagreements. What most seem to agree on is that the Delphi is characterised by four features: anonymity, iteration, controlled feedback, and statistical aggregation of group responses (Rowe, Wright, & Bolger, 1991), characteristics which were therefore the foundations of the research approach used here.

For Linstone and Turoff, the Delphi represents a way of supplying 'soft data' in the social sciences (2011). Where a matter of subjective judgement, which does not fit neatly into a precise analytical paradigm is to be researched, as here, a Delphi approach is indicated. Where the participants have a wide range of experience and backgrounds, are geographically spread (Fink, Kosecoff, Chassin, & Brook, 1984), and are in different settings with time constraints, as here, a simple group brainstorming exercise would not be feasible. Finally, larger numbers can be incorporated than could feasibly interact in a meeting, including individuals who

may not contribute in a pressurised environment (Hsu & Sandford, 2007). Further, a Delphi can facilitate controversial responses, and finally, as McKenna suggests, there also may be no definitive answer (1994). For all of these reasons, a Delphi study was considered appropriate.

The Delphi approach also fits well within a mixed methods design since, as for Thematic Analysis, it is a flexible approach to data collection and analysis; useful here in that it can combine both quantitative and qualitative methods. Rankings can be given on set criteria, but the opportunity to add further comments, ideas, or arguments is also available and can be integrated into further 'rounds'.

One of the main pitfalls of the method, according to Linstone and Turoff (1975), is sloppy execution and would include elements such as the poor selection of participants and vague statements supplied for consideration. McKenna (1994) also suggests that there can be poor response rates in later rounds due to fatigue. He goes on to say that although complete anonymity is generally guaranteed for most Delphi surveys, this can lead to a lack of accountability for views, and hasty, ill-considered judgements (1994). Finally, Linstone and Turoff (1975) suggest that a Delphi study can fail if: (a) the structure is over specified, therefore not allowing for other contributions relating to the problem, (b) poor techniques of summarizing data are used, and (c) disagreements are ignored. Further, although the Delphi is a widely used technique, Sackman's scathing attack on its validity and reliability cannot be ignored (1974). Crude questionnaire design, capitalising on forced consensus, based on no serious critical literature are just some of his findings. He urges researchers to work with psychometrically trained social scientists able to apply more rigorous

standards to the approach. As such, the researcher undertook a study of psychometrics before attempting this study. As a result for example, pilot tests of the questionnaire were run each time (Vernon, 2009; Powell, 2003) and a more detailed quantitative data analysis conducted than is usual in Delphi studies. It is suggested therefore that the questionnaire design and analysis could be considered robust. A more detailed reflection on quality issues is presented later in this chapter.

In order to identify participants for the study, some consideration of who would be considered an 'expert' in the field was necessary, a subject which is debated at length in the literature (Hsu & Sandford, 2007). As Vernon notes, a "poor choice of experts can lead to collective ignorance rather than collective wisdom being collated" (2009, p.75) and Linstone and Turoff also warn of 'illusory expertise' (1975, p.566). Therefore, in this case, relevant questions were whether therapists can be considered experts on fulfilment in life, and whether they are able to represent the views of the larger population. The negative answers here clearly affected the ultimate validity of the outcomes. In fact, McKenna notes the benefits of using non-experts (1994, p.1224), suggesting using 'informed individuals' rather than experts. Either way, Vernon suggests that they must be impartial (i.e. not affected by the outcome), as was the case here. Delbecq and Van de Ven (1975) also note that heterogeneous groups with substantially different perspectives on a problem produce higher quality solutions than homogenous groups. In summary, it was considered appropriate to approach a wider base of humanistic therapists rather than pure Person-centred counsellors. A more heterogeneous sample including participants with additional experience in CBT and brief therapy for example were considered to be valid contributors.

Mullen (2003) suggests that the optimum size of the panel is 7- 12 members. Vernon (2009) notes that there is no fixed number since 4-1000 people could be used equally effectively, and Clayton (1997) quotes 15-30 for participants from the same discipline. In this study, a small sample was considered to be manageable in the context of a PhD, although it is acknowledged that a much larger sample would have given more generalisable results.

A final methodological consideration was given to the design of the Delphi response mechanism. Some initial Delphi rounds utilise questionnaires based on an extensive review of the literature (Hsu & Sandford, 2007; Mullen, 2003; Powell, 2003; Fink, et al., 1984) rather than the more common approach of beginning with a question and a blank sheet. The former approach was considered to be appropriate here, utilising the outcome list outlined in Chapter Four as a basis, as it was considered too onerous a task to expect therapists to derive this list from scratch. It could be argued therefore that some 'leading' by the researcher was therefore inevitable (Dalkey & Helmer, 1962). It was considered that the format of the questionnaire would allow for strong disagreements to emerge, or new ideas to be tabled which had not been included.

6.2 Method

6.2.1 Participants.

Fifty therapists agreed to participate in the study, although only 35 participants eventually took part. Their average experience as a therapist was 13 years, which was considered more than adequate. A 'semi-random' sample was

sought, of BACP registered therapists based in the UK, offering humanistic services and/or Person-centred therapy. The sample was semi-random in that not all therapists advertise on the BACP website, not all therapists would receive cold calls, and not all were interested in the study.

6.2.2 Recruitment.

Initially, 20 Person-centred therapists were approached using the BACP website to obtain email contact details. Care was taken to contact only those who had left the 'no canvassing option' unchecked. It was considered after initial feedback from one potential respondent, that 'classical' Person-centred therapists may not be the best source of data, since he considered that defined outcomes ran counter to his Person-centred philosophy. As a result the search base was broadened to include humanistic, integrative therapists. Subsequently, 300 therapists, who also cited PCT as being at least one of their approaches, were invited to participate individually by email. (Copies of the recruitment email and information sheet are included in Appendix II.)

6.2.3 Round 1.

6.2.3.1 Materials

As explained in Chapter Four, a collection of existing outcome measures were entered into a spreadsheet and categorised into themes using Thematic Analysis. The list was then developed further by adding comments from the interviews described in Chapter Five. Each of the major themes were identified and expressed in terms of a series of states or traits with an accompanying explanation. Thus, 260

items were reduced to 22 categories and corresponding 79 states or traits. These statements provided the basis of the questionnaire for this round. A five point Likert scale ranging from strongly disagree to strongly agree was used, allowing for an opt-out middle value labelled 'neither'. Space for comments was also provided which allowed for the collection of qualitative data. By way of instructions, respondents were asked to state how much they agreed that each item represented a 'fully functioning' individual.

Example 1: First Research Questionnaire Design

Questionnaire Round 1

	Category	Client States or Traits	Strongly Disagree	Slightly Disagree	Neither	Slightly Agree	Strongly Agree	Any thoughts, comments?
			Please click **one** box for each statement					
1	Understands self	A clear and objective view of self	- ☐	☐	☐	☒	☐ +	Click here to enter text.
		Understands different facets of self	- ☐	☐	☐	☐	☒ +	Click here to enter text.
		Acknowledges weaknesses, but affirms self	- ☐	☐	☒	☐	☐ +	Click here to enter text.

Accompanying the questionnaire was a document ('Clarification of Statements') which provided a more detailed explanation of each item.

Example 2: Clarification statements

Clarification of Statements Round 1

	Category	Client States or Traits	Explanation
1	Understands self	A clear and objective view of self	Able to analyse own thought processes. Is able to be objective about self. Recognises own defences.
		Understands different facets of self	Aware of different 'selves' or layers of personality. Acknowledges types of self or 'community of voices'.
		Acknowledges weaknesses, but affirms self	Can see own problems or deficiencies (e.g., denial, self-doubt, self-fulfilling prophecies, fears, poor coping strategies.) Affirms self in spite of deficiencies.

(A full copy of the first round Questionnaire and Clarification Statements is in Appendix II.)

6.2.3.2 Procedure

The questionnaire was tested first with 3 therapists for coherence and clarity after which some minor amendments were made to the instructions for completion to make them clearer. It was considered that both an e-Delphi (email version) and a pencil and paper format would be necessary given the respondents involved (since some expressed concerns about using IT). Either a paper questionnaire or an electronic version was then sent to each of the 50 participants.

6.2.3.3 Analysis and Results

Of the 50 questionnaires and clarification statements which were sent out either by post or email, 35 responses were received, (2 of which included comments only, without a completed questionnaire.) The results were analysed both quantitatively and qualitatively.

Quantitative analysis of the results of Delphi questionnaires seeks to establish the level of consensus or stability in responses. A decision had to be made, therefore, on what consensus means, since no hard and fast rules exist. Fink and colleagues (1984) consider that measures should be decided upon before data collection starts. Various recommendations exist ranging from 80% of votes falling within 2 categories on a 7 point scale, to 70% rating 3 or higher on a 4 point Likert-type scale, and the median at 3.25 or higher (Hsu & Sandford, 2007). Alternatively, the stability of responses across successive rounds is considered a more useful measure (Crisp, et al., 1997). Powell (2002) cites agreement levels set as high as 100% and

as low as 55% or simply defined as ‘most’ participants. For this study, it was considered from the outset that items should be rated as ‘slightly’ or ‘strongly’ agree by 75% of the participants to be included in the final list, correlated with other measures outlined below.

In order to feed back the results from each round to participants, descriptive statistics are usually calculated and information usually presented visually. Typically, central tendencies (means, medians and mode) and levels of dispersion (standard deviation and the inter-quartile range) are most usefully presented (Delbecq, 1975; Hasson, et al., 2000). Further, the use of frequency distributions demonstrate patterns of agreement or highlight bimodal distributions and are often key to Delphi feedback (McKenna, 1994; Powell, 2002). Given the data, frequency charts were particularly useful here.

As a side note, there is considerable debate as to whether a Likert scale from strongly disagree to strongly agree constitutes an ordinal or interval scale and whether it is appropriate therefore to calculate descriptive statistics (Witkin, 1984). Calculations such as the mean and interquartile ranges are, however, routinely performed on this type of data and so were considered acceptable.

Initially, it was considered that the most efficient method for progressing this study would be to eliminate those items on which most therapists agreed as rounds progressed, leaving only those where disagreement existed to be debated further. Thus the ultimate aim would be a list of items on which most therapists agreed. After Round 1 for example, items rated as ‘slightly’ or ‘strongly’ agree by 75% of

the participants could be excluded from further debate. (Since the opportunity for changes in wording was given via the comments box, it could have been considered that, having taken their comments into consideration, those who responded 'slightly agree' could then be considered as 'agree'.) It was considered subsequently, however, that a more sophisticated measure to determine which items to exclude from subsequent rounds was needed than that described above, since, for example, some items may have generated a high number of 'slightly agree' options coupled with a number of 'strongly disagree' options (Hsu & Sandford, 2007). A more complex measure which correlated other calculations was therefore utilised:

The analysis was completed on the basis that:

- Strongly disagree = 1
- Slightly disagree = 2
- Neither = 3
- Slightly agree = 4
- Strongly agree = 5

The following calculations were then made:

1. The number of items which had less than 75% of participants rating them 4 or 5
2. Mean (It was considered that a mean of less than 4 would identify items which did not generate agreement on average)
3. Standard Deviation (A STD DEV of 1 or more would indicate a lack of consistency in views)
4. All those items rated 1 or 'strongly disagree'

5. A Median of less than 4
6. Items with a range of more than 3 were also identified
7. A Kendall W score assessing agreement between raters (items less than 36 on a mean ranked basis included)
8. More than 20% of participants giving a score of 3

(The mode was not particularly helpful since only 4% of items had a mode of less than 4.) Items were identified if they met at least half of the 8 criteria outlined above.

A Cronbach Alpha calculation was also made at this point (estimating reliability of averages), which was 0.99 overall. The lowest item-total correlation was 0.4 which is considered high. Thus there was high internal reliability indicating that all items correlated. Some items could be considered redundant by a high item-total correlation, but in reality this was not considered to be the case. Thus, no items were considered inappropriate on this basis.

Firstly, *excluding* scores of 'neither', (i.e. a score of 3), from the total numbers, items ranged from 68%-100% of participants slightly or strongly agreeing. Only 6 items had less than 80% agreement, (constituting 8% of the total list), which indicated a good level of agreement in the first round. There was also consensus on which items were causing difficulties. Undecided scores were valid data to explore further in this context, since they were probably more than just a 'don't know' response. They could also have been "I disagree, but I can't say why in this format".

Secondly, *including* the scores of neither, all items were rated slightly or strongly agree, (or neither), by 73% of the participants. The results indicated a low level of specific disagreements, but since all items were also rated slightly or strongly agree (but not neither) by only 45% of the participants, this indicated that good use was being made of the 'neither' option. Reasons were not often given for this choice. Therefore, it was considered appropriate to reiterate some items for consideration which had a high level of participants opting out, with the intent to encourage explanations or some justification for not answering. All items with more than 20% of participants giving a score of 3 were therefore resubmitted in the second questionnaire.

As explained above, all items were then correlated within the 8 criteria described, (including the scores of 3), to see which items occurred in most criteria. 18 items had a high correlation being present in at least half of the above categories, and were therefore chosen to be resubmitted in Round 2 for reconsideration. All items with under 75% agreement were included as part of this calculation, except one which was added under the 'high number of 3's section and re-rated that way. All of these calculations are detailed in the file: Supporting Data\ Chapter 6 Delphi Study and Chapter 7 Instrument Design \Round1\3.Analysis\ Quantitative Analysis.xlsx.

"Delphi straddles the divide between qualitative and quantitative methodologies" (Mullen, 2003) and so, in addition to quantitative data, qualitative comments relating to each item were invited in Round 1. From a total of 366 comments, all items received at least 1 comment, varying to up to 13 for some. The

comments were analysed using Thematic Analysis as outlined above and ordered into commonly occurring themes. This methodology allowed for consistent themes or comments by 'outliers' to be fed back in Round 2, and individuals to be invited to contribute arguments, justification or support. Due to the potentially high level of data generated through this process, comments were often presented quantitatively in order to facilitate further consideration by participants.

Comments from the questionnaires in Round 1 were collated both into topics and by question. Firstly, commonly occurring themes mentioned in relation to more than one item included the following (numbers of comments are in brackets): 52 comments along the lines of; "it depends on the importance for the client" were made, and further issues such as the maturity (10), and capacity of the client (11), or variables such as their personality (9), their context (7), or relationships were addressed. Statements of agreement were made (27), such as "I think this is important" and some followed up these comments with suggestions on how to improve the explanation of the item (46). Comments on minor word changes (27), such as preferring the word 'respond' rather than 'react', indicated personal preferences rather than substantive changes to meaning. Further, a number of respondents wished to include "tries to be" in front of the statements (8). 25 respondents commented on the idea of having a questionnaire at all or on the design of it, and 7 individuals questioned whether some of the items were even possible. A common theme was that of self-actualisation being a process rather than an endpoint (22), and 9 respondents gave examples of how the wording could be changed to reflect that view, such as "…learnt through exploration and reflection". 20 respondents expressed disagreement, for example by asking specific questions such

as “why inner child?” and 58 cited specific disagreements such as “need to avoid this issue” (relating to emotional stability). Three missing elements: ‘sense of humour’; ‘quality of being’; and ‘self-awareness’ were suggested. And finally, a number of positive reinforcements of the process were given such as “I think your aims are great - a kind of 'holy grail' in the counselling research field.”

Common views on specific questions were also collated in order to be added to the second round questionnaire. The complete set is in Appendix II, but starts for example:

	Item	**Sample comment**
5a	Understands the nature of change	“I think clients don’t need to understand it theoretically, just recognise and integrate it.”

The comments indicated a broad level of agreement with the overall list of items, since most comments dealt with quite specific issues, such as ‘whether one can be assertive *all* the time’. Some broader issues emerged such as whether outcomes could be defined in what is a process oriented engagement. Nevertheless, it was considered appropriate to continue onto a second round, with the intent to narrow down the list to a final consensus by feeding back these opinions and scores from Round 1 for reconsideration.

After further research on the topic of self-actualisation and discussions with other therapists and academics, some minor changes in clarification statements were also made in Round 2 and offered for comment. These items are detailed in red in

the original analysis sheet (Outcome Framework Design.xlsx). The qualitative analysis is detailed in file: Supporting Data\ Chapter 6 Delphi Study and Chapter 7 Instrument Design \Round1\3.Analysis\ Qualitative Analysis.xlsx.

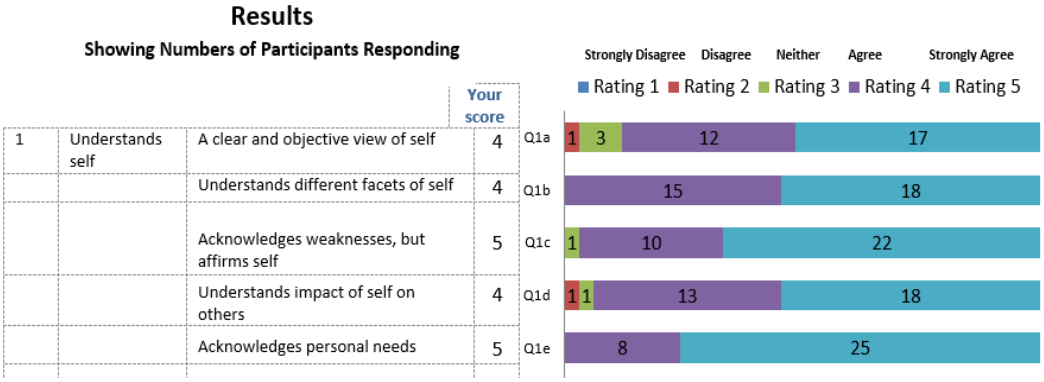
6.2.4 Round 2.

The second round of this Delphi study was designed to give participants the opportunity to reassess their original responses in the light of others' comments.

6.2.4.1 Materials

To accompany the second round questionnaire, the results of Round 1 were presented in the form of a frequency chart, and individual scores added for each participant. Participants would therefore be able to change their mind, or justify their position in the light of feedback (Powell, 2002).

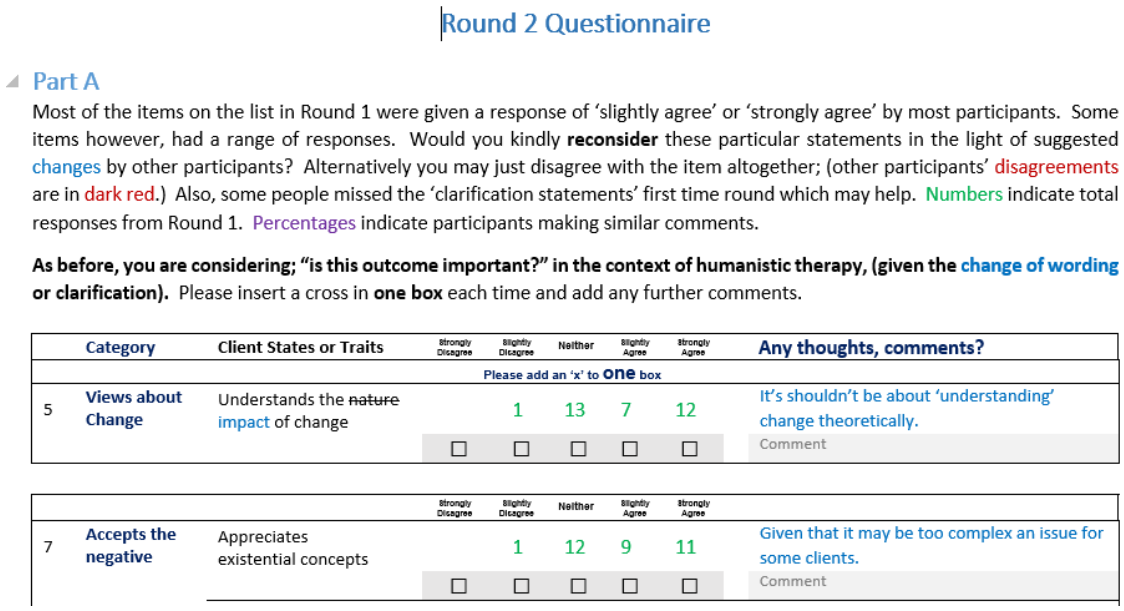
Example 3: Feedback in Round 2



The questionnaire consisted of a repetition of those items with greatest disagreement in Round 1. Reasons for 'outlying' views in Round 1 were also presented in order to allow participants to consider alternative perspectives. Further,

issues not necessarily relating to specific items, but which appeared as consistent themes from the Round 1 Thematic Analysis, were included as separate questions. For example, participants commented that the inclusion of each item 'depends on the client', so a specific question was included in Round 2 on that point. Also, items which had a high score of 'neither' in round 1 were resubmitted and participants asked to explain their scoring. So, in summary, in addition to the 18 items with a higher level of disagreement, 5 common comments were added, 3 further elements considered to be missing by one person were added and finally the 3 items with a high level of 'neither' scores were added, making a manageable questionnaire with 29 items for consideration.

Example 4: Round 2 questionnaire



Round 2 Questionnaire

Part A

Most of the items on the list in Round 1 were given a response of 'slightly agree' or 'strongly agree' by most participants. Some items however, had a range of responses. Would you kindly **reconsider** these particular statements in the light of suggested changes by other participants? Alternatively you may just disagree with the item altogether; (other participants' disagreements are in dark red.) Also, some people missed the 'clarification statements' first time round which may help. Numbers indicate total responses from Round 1. Percentages indicate participants making similar comments.

As before, you are considering; "is this outcome important?" in the context of humanistic therapy, (given the change of wording or clarification). Please insert a cross in **one box** each time and add any further comments.

	Category	Client States or Traits	Strongly Disagree	Slightly Disagree	Neither	Slightly Agree	Strongly Agree	Any thoughts, comments?
			Please add an 'x' to one box					
5	Views about Change	Understands the ~~nature~~ impact of change		1	13	7	12	It's shouldn't be about 'understanding' change theoretically.
			☐	☐	☐	☐	☐	Comment
			Strongly Disagree	Slightly Disagree	Neither	Slightly Agree	Strongly Agree	
7	Accepts the negative	Appreciates existential concepts		1	12	9	11	Given that it may be too complex an issue for some clients.
			☐	☐	☐	☐	☐	Comment

As a side note, Delphi studies often omit infrequently occurring items to keep the resulting list manageable. Hasson believes that this goes against the basic principles of the Delphi technique and that *participants* should judge items in terms

of quality, not the researcher (2000, p.1012). To keep the questionnaire manageable, occasional comments made by only *one* person *were* excluded from Round 2, particularly since participant fatigue was a real possibility. In the event, most comments were included either in the second round questionnaire itself, or a revised version of the clarification statements, which was also sent out in Round 2 for comment. So participants did have the opportunity to feedback on most comments if they wished.

Example 5: Clarification statements sent out in round 2

Clarification Statements Round 2

				Any thoughts, comments?
2	Trusts ~~self~~ themself	Has self confidence	Is secure and comfortable in self. Has self-esteem. Is confident in self. Is secure in own knowledge, (but without arrogance).	
		Relies on own counsel	Trusts self. Can rely on support from within. Is able to rely on own intuition and experience. Relies on personal wisdom. **Also able to seek help, (15%).** Not to the detriment of others.	

(A full copy of the second round Questionnaire and Clarification Statements is in Appendix III.)

6.2.4.2 Procedure

Two therapists tested the format of this questionnaire before it was re-sent to the whole group on paper or via email. (A complete copy is included in Appendix III.)

6.2.4.3 Analysis and Results

27 questionnaires were returned in Round 2, representing 82% of the original participants. Only 4 participants chose to go through the clarification statements in detail. A **quantitative analysis** of the results was conducted in the same way as in Round 1, so that those items with: a) less than 75% agreement, b) a mean less than 4, c) a standard deviation of 1 or more, d) a minimum score of 1, e) a median of 3, f) a range of 4, g) a Kendal mean rank of less than 10, and h) more than 20% of a score of 3, were considered to have retained a level of disagreement. 9 of the 21 resubmitted items were identified in this category, representing 11% of the original list.

Deciding **when to stop a Delphi study** needs consideration. A definition of the number of rounds in a Delphi study can be provided from the start or as part of the process when the responses have reached a required level of consensus. Turoff and Linstone (1975) suggest that there are no firm rules for establishing when consensus is reached, although they consider that more than 3 rounds tends to show very little change and participant fatigue sets in. Rowe and colleagues (1991) suggest that Delphi studies rarely go beyond 1 or 2 iterations. Further, some convergence in opinion is to be expected (Dalkey & Helmer, 1963), although this may only be slight (Powell, 2003). Further, whether participants have been coerced into going with the majority view, or whether this is a constructive process of moulding opinion is a matter of much debate (Greatorex & Dexter, 2000). For a more quantifiable decision, some suggest a statistical approach to deciding on consensus. Scheibe, Skutsch, and Schofer (2002) suggest that a measure of change from the mode remaining under 15% would be sufficient. Although 9 items deviated

by more than 15% from their mode in Round 1, each remained at a score of 4 or 5, indicating agreement. This measure was not therefore considered to be helpful.

What was important to understand at this stage, was whether new disagreements had arisen from different individuals, or whether in fact those disagreeing had maintained their views. If new disagreements had arisen, further data could be sought, but if views were stable, then that would be unnecessary (Scheibe, et al., 2002). Although there is no specific statistical technique generally recommended for this procedure, it was considered that participant's original scores on each item, compared with second scores on the same item would identify a high or low level of correlation, in fact a Kappa value (Holey, Feeley, Dixon, & Whittaker, 2007). Kappa values (by question) were therefore calculated; only 4 items scored under 0.2, indicating broad stability.

On the basis firstly, of the relative stability of the data; that secondly a reduction in 11% of items from the list would be no bad thing given the length of it; and finally, potential participant fatigue, it was considered that the list could now be considered complete, and the Delphi process stopped, providing that 9 items were excluded due to lack of substantive agreement or polarised views. These were:

Table 1: Items with substantial disagreement

	Agreement	
7a	55.6%	Appreciates existential concepts
9b	40.7%	Has a positive view of the world
9d	59.3%	Acknowledges spiritual self
10a	74.1%	Is emotionally stable
11a	66.7%	Can be spontaneous
12c	66.7%	Avoids creating problems
16b	51.9%	Does not demand change in relationships
18b	74.1%	Is altruistic
21b	70.4%	Expresses self sexually

(Further it was planned that a third round would then be possible with the therapists to work on the actual wording of the items before they began to drop out of the process. It was considered that their help with this stage would be more valuable than arguing over the finer detail of some of the items.)

The **commonly occurring themes** in Round 1 which were presented as questions in Round 2: ‘it depends on the client’, ‘I’m against the idea of a questionnaire’ and ‘is some of this really possible?’ generated agreement levels of 59%, 37% and 63% respectively. Although these questions were not integral to the research objective, the implications of the results are discussed below. Further, using the same measure as outlined above, the **3 new items** suggested were not

included in the final list due to a low level of agreement (56%, 63%, and 52% respectively). Finally, the **items re-rated** due to a high number of scores of 3 in the first round had a much higher level of agreement in round 2; 93%, 78% and 96% respectively, so were included. The analysis for this stage of the study is detailed in file: Supporting Data\ Chapter 6 Delphi Study and Chapter 7 Instrument Design \Round 2\3. Analysis\ Quantitative Data.xlsx)

Results were also analysed on a **qualitative basis**. A small number of changes in meaning were made to the items and clarification statements as a result of feedback at this stage. Firstly, 'accept the freedom to adapt/grow sense of self' was added to the explanation of 'has a firm identity' to account for those who felt that identity is not fixed. The item suggesting that individuals 'can be independent' had a change of clarification from "has awareness and acceptance that others do not have the answers" by adding the words "do not *necessarily* have the answers", implying that it is difficult to be completely self-reliant and that help may be sought where necessary. The issue of whether it is appropriate to 'respect' differences in others was mentioned by 3 respondents, one suggesting that 'accepts' may be a better word. Finally it was considered by 96% of participants that finding 'connections' with others read better than finding 'synergy'.

There were also further responses to the common themes which emerged from the previous round which are worthy of note. A key issue expressed by 81% of the respondents was that being fully functioning "entirely depends on client's circumstances, issues and experience". It may therefore be appropriate to explain in the instructions for completion that it should be done based on client requirements

and capabilities. The debate as to whether a questionnaire was even relevant in the context of a person-centred therapeutic encounter continued in this round, with 4 comments *for* its use and one against. Clearly this is a tool which will be used only by those therapists for whom the fundamental premise is philosophically acceptable. 63% of respondents questioned whether some of the outcomes would ever be possible, and it would be helpful to explain to potential counselling clients that it is based on an ideological premise. Setting goals to achieve all of the states or traits would be difficult and dispiriting to say the least. Finally, 93% of people agreed that outcomes would be worked towards rather than being an endpoint. The notion of an ongoing process that ebbs and flows through life was an issue to be addressed in the use rather than the design of the instrument. All of the qualitative analysis is detailed in the file: Supporting Data\ Chapter 6 Delphi Study and Chapter 7 Instrument Design \Round 2\3. Analysis\ Qualitative Data.xlsx).

Whether each item would be included in the final list had already been established on the basis of a statistical procedure (and would therefore have a reasonable level of reliability). Inclusion of the items, and the final wording were kept strictly within the limits of the statistical framework. For example, 'is emotionally stable' had an agreement level of 74.1%, but had to be excluded from the final list since the cut off was 75%. It was not possible, however, to apply the same strict criteria to **the clarification statements**, for the following reasons: A qualitative Delphi study which seeks consensus (in this case on complex psychological concepts) is comparable to a group brainstorm whereby agreement would need to be reached by the majority of 33 participants on every single word in a 2,000 word document. During the process, certain individuals would dominate

with ideas that no one else agreed with; some participants would fail to even read the document properly or at all; some would have drifted off and ceased to care, whilst others would go through each word and comment on all of them. As the equivalent of the meeting Chairperson, the researcher has to ensure everyone has read the document, everyone has had the opportunity to speak, and views are accepted (in this case) on the basis of a 75% majority. Since the Delphi was done remotely, not all participants in Round One read the instructions and therefore were unaware of the clarification documents. Some ticked 'strongly agree' to everything in Round 1, suggesting that they may not have necessarily read each item in detail. Only 4 people actually returned the clarification statement document in Round 2 and some comments demonstrated a lack of understanding of either the item in question or purpose of the exercise. Further, when comments were made, there were often only 3 or 4 made, either each different, or in direct opposition to each other. Comments were also relatively minor: for example, one respondent stated that the item on feedback should read 'is able to receive' and another suggested just 'receives'. Without a week in a conference room together, true consensus on the final clarification statements was therefore always going to be impossible. It was considered therefore that the researcher would be in the best position to make a final decision, as a Chairperson may do in a meeting, given the knowledge of the context of the project, the detailed literature review and having been immersed in the subject as a whole. It is acknowledged therefore, that the clarification statements had to be finalised on the basis of a combination of the participants' views and the researcher's experience, preferences and requirements. Bias in this situation was inevitable, but attempts to mitigate the effects were planned through the implementation of a third round to check further the phraseology and wording of the items.

This stage of the Delphi process, in summary, produced an agreed list of therapeutic learning outcomes, ratified by humanistic therapists (with a person-centred bias). The final list contained 22 items, each with a number of descriptors in the format shown in Table 2.

Table 2: Final List of Items

	Category	Client States or Traits
1	Understands self	A clear and objective view of self
		Understands different facets of self
		Acknowledges weaknesses, but affirms self
		Understands impact of self on others
		Acknowledges personal needs
		Understands development of self
2	Trusts self	Has self confidence
		Relies on own counsel
3	Positive self view	Values self
		Values achievements
		Receives positive feedback
4	Views on growth	Has a desire for learning
		Has a desire for growth
		Accepts help in the process of growth

This was a list written in academic language, and not one which could be presented to clients in its current format. Further work was necessary to simplify the wording. So a further round of data collection was planned with existing participants.

6.2.5 Round 3.

Round 3 of the Delphi process was designed to develop the wording of the items into a more appropriate format. For example, “has an internal locus of evaluation” may be expressed more clearly as; “I am driven by myself rather than others”. Thus the questionnaire would become more user-friendly, particularly as the potential users may come from any educational or cultural background.

6.2.5.1 Materials

User-friendly wording suggestions were generated by the researcher in discussion with colleagues and supervisors for each of the items. The questionnaire sent out for this round is included in file: supporting Data\ Chapter 6 Delphi Study and Chapter 7 Instrument Design \1.Material Sent Out\Item Wording to be Tested by Therapists. A sample is included here.

Example 7: Simplified wording sent out to therapists in Round 3

Personal Inventory

Would this blue column make sense to your clients? *If not...*

		Original Descriptions (for Therapists)		Shortened Descriptions (for Clients)			...any better wording?
Area	**Category**	**States or Traits**	**Clarification Statements**	**Quality**	**Description**	**More Details**	
Understanding Me	1 Understands self	A clear and objective view of self	Able to analyse own thought processes. Is able to be objective about self. Recognises own defences.	I understand me	I know myself well	• I know how I think • I can stand back and look at myself • I know when and why I'm being defensive	
	2	Awareness of different facets of self	Aware of different 'selves' or layers of personality. Acknowledges types of self or 'community of voices'.		I know the different sides to me		
	3	Acknowledges weaknesses, but affirms self	Can see own problems or deficiencies (e.g., denial, self-doubt, self-fulfilling prophecies, fears, poor coping strategies.) Affirms self in spite of deficiencies.		I know what I'm good at and what needs to be worked on	• I know my fears and failings • Even when I fail I can encourage myself	

6.2.5.2 Procedure A

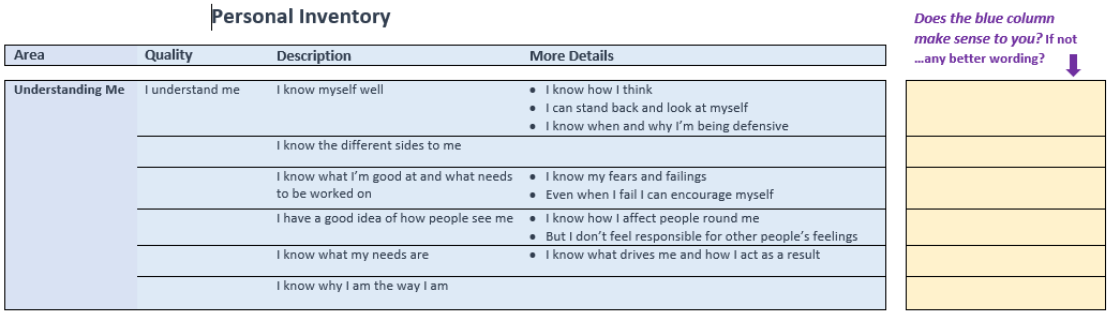
All 27 participants who had responded to Round 2 were sent an updated version of the ’22 item and 71 descriptors’ list with suggestions for clearer wording and were invited to suggest improvements. (For clarity, the items were collated under 7 general headings at this point.) It was considered that the therapists would be able to judge whether the simple wording adequately reflected the more complex academic wording, and if not to suggest improvements.

6.2.5.3 Procedure B

Only 10 responses were received on the wording from the therapists so clearly some fatigue had set in. An extension to the study was therefore planned in order to add to the quality of the output. Although it was important to ascertain the therapist’s perspective on the wording of items, it was also considered important to test the simplified wording with a sample of people who would best represent possible future clients. They would not need to assess the accuracy of the translation of academic language into everyday language, however, but simply to judge whether the wording made sense to them. Therefore a convenience sample of other people of different educational levels, ages, professions/jobs, people with little understanding of therapy, people with English as a second language, with some cultural diversity, and gender differences were also asked to look at the wording. Importantly they were encouraged not to ‘do’ the questionnaire, but just to check the text. It was important not to generate any ethical issues in this process since it was considered unnecessary to gain ethical approval for this process. Nevertheless, counselling support was offered free of charge to all individuals in the unlikely event that it

generated any issues for them. The item list was sent to 18 people, most of whom were known to the researcher either as friends, relatives, colleagues or friends of friends. These included a solicitor, a cleaner, 2 teachers, 2 teenagers, a mountain rescue volunteer, an elderly couple, 1 with poor reading skills, a dental receptionist, an artist, 2 office workers, 1 Polish, 1 Slovakian and 1 Somalian with poor educational attainment.

Example 8: Simplified wording sent out to general public



Personal Inventory

Area	Quality	Description	More Details	*Does the blue column make sense to you?* If not ...any better wording?
Understanding Me	I understand me	I know myself well	• I know how I think • I can stand back and look at myself • I know when and why I'm being defensive	
		I know the different sides to me		
		I know what I'm good at and what needs to be worked on	• I know my fears and failings • Even when I fail I can encourage myself	
		I have a good idea of how people see me	• I know how I affect people round me • But I don't feel responsible for other people's feelings	
		I know what my needs are	• I know what drives me and how I act as a result	
		I know why I am the way I am		

6.2.5.3 Analysis and Results

The two most regularly cited problems with the simplified wording from both therapists and the general public related to the idea of 'flow' and of 'hidden depths'. Thus, for the sake of clarity, "I have experienced deep emotions like 'flow' or passion" was changed to "I can experience deep, intense emotions like joy, passion, or being completely immersed in something" and "I know my 'hidden depths'" was changed to "I understand the more complex and deeper layers of my personality. I am enlightened about myself". The majority of responders found the wording easy to understand, so comments were a matter of taste, such as "I prefer 'understand' to 'know'" or 'myself' to 'self'. Consideration was also given as to whether it should be 'day to day' life, 'the basics of life' or 'everyday life', and other relatively minor

issues. A significant problem for one participant was the idea of being ‘in control of my life’ and so, was changed to “I'm in control of the direction of my life as much as I can be”. By way of further clarification, some extra comments were also added in, such as “I am aware of relationships that damage or erode my sense of self” and accepting “the faults of other ‘key’ influences in my life”. Care was taken to retain the integrity of the items so that they did not deviate from the original statements agreed in Round 2 of the Delphi study. The results of this exercise are contained in Sheet 1 entitled ‘Wording Changes’ in the following file: Supporting Data\ Chapter 6 Delphi Study and Chapter 7 Instrument Design \Feedback on Instrument Designs\Analysis.xlsx.

6.3 Discussion

The purpose of this study was to establish an agreed list of humanistic outcomes which could be used for the purposes of goal setting as part of a therapeutic learning process. A start point for this process had already been developed from the available literature and this study ratified those decisions through a panel of ‘experts’.

There was on the whole, general agreement, not only on the contents of the predefined list presented to the therapists, but also on the intent behind it. There were positive comments such as “Oh wouldn’t it be fabulous to think that we could facilitate all of this!” and another “I think your task is ambitious but I think it’s really worthwhile”. Conversely, once therapists began to analyse the details of the document comments were made on its positivist basis, saying, for example, fully functioning “entirely depends on client’s circumstances, issues and experience”.

Comments on reductionism initiated a change in direction for the research. It began with the intent to outline defined and generalizable outcomes which could be used for predictive purposes with clients. As comments were received, it became evident that this was not a likely outcome, but rather the constructivist nature of the therapeutic encounter would define the way the list would be used.

Some specific issues became the subject of fierce debate, which was particularly interesting from a research perspective. For example, respondents agreed that a fully functioning person would be able to 'express themselves sexually', whilst others firmly believed that it was possible to be fully functioning and *asexual*. Whilst the subject matter in question is important and some debate ensued resulting in the deletion of the item from the final list, what was also important was the underlying premise: if the therapist has life experience that defines success in his/her eyes in a specific way, to what extent is that worldview projected onto the client when collaborating over outcomes? It was no surprise to the researcher for example when strong feelings also emerged around transpersonal items in the list of outcomes. The Feelings, Reactions and Beliefs Survey (Cartwright & Mori, 1988) has attempted to operationalise Rogers' self-actualised person and particularly adds definition to his later thoughts on the transcendental elements. For example, mental powers such as intuition, meditation, bio-feedback, prayer, and fasting are considered important. A belief in the spirit of the person and its eternal nature is therefore considered. Although Rogers' views were not specifically Christian, it is argued that his Christian upbringing was reflected in much of his work. As such, what it means to be fully-functioning as suggested by the Bible was considered. Galatians 5:22 outlines "love, joy, peace, forbearance,

kindness, goodness, faithfulness, gentleness and self-control". As was evident in the debate that ensued in the data gathering exercise, the inclusion of such items was controversial. In fact, a third of the 9 items which were finally excluded related to spirituality: 'appreciates existential concepts (55.6% agreement); 'acknowledges spiritual self (59.3% agreement) and 'is altruistic' (74.1% agreement). Consistent with this post-modern perspective on the fully-functioning person being neither necessarily religious nor even spiritual, issues of diversity contained within the list of items were fully supported. For example the statement "I appreciate differences in people but I also believe in equality and the rights of others" had one of the highest ratings for 'strongly agree'. ("I manage any physical conditions I have" was also included to address issues of disability.) Thompson (2017) promotes the idea of social justice through the tackling of inequality, and stresses the importance of approaching these matters from the perspective of critically reflective practice. This viewpoint was clearly embedded in the responses of the participants.

It is suggested by the researcher however, that confronted with a person expressing a faith as a counsellee the inventory would seem incomplete. Indeed the client in the case study (described in chapter 9) demonstrates this issue very well. It is considered therefore that an optional section be included at the end of the questionnaire and made available to those wishing to deal with existential concepts, including the following reworded items:

Considers the spiritual self:

- Seeks to understand the nature of their existence.
- Acknowledges transpersonal self; is open to explore or re-explore transcendent self.
- Is caring; seeks to help others where appropriate; seeks to avoid harming others; is interested in others.

The most significant limitation in pursuing a list of outcomes, particularly given the holistic foundations of the person-centred philosophy, is that of tending towards reductionism. Linstone and Turoff note that using a reductionist approach on social or behavioural issues may develop 'superficial caricatures' (1975). Further Gorski (2013) outlines the danger of falling short of the epistemic goal of explaining one level of reality in terms of a lower-order one, by disregarding potential 'emergent' entities and properties. Accordingly, some respondents declined to be involved in the survey since the process simply contradicted their underlying holistic person-centred philosophy. Nevertheless, this was the aim of the study, to reduce the holistic, supernatural being to a quantifiable list. In the view of the researcher, efficient learning is directional, namely it seeks to achieve something of benefit, and if that something is not clear, then learning is a random process. As such, an attempt to quantify success is necessary even if potentially problematic. By way of mitigating these concerns, from a Critical Realist perspective, lower-order strata were derived through the literature review and Delphi process. Further, emergent entities and properties are sought in the development of personal aims in the therapeutic context. Thus, as an individual considers the defined outcomes, personal

outcomes ‘emerge’ within a more holistic perspective. In this way, a framework for consideration provides the basis of an analytical dialogue, which should result in a highly idiosyncratic outcome. As Gorski suggests (2013), social science cannot generate specific directives for our lives, but can produce prudential principles. Further, as Seale suggests (1999), scientific reductionism cannot be justifiably dismissed as long as a process of reconstruction is possible, a process which occurs through the therapeutic dialogue.

Theories outlined in the literature review and results from the initial interviews would suggest that learning and change are inextricably linked. In fact, the outcomes agreed by the therapists were often a mixture of both learning and change. For example, No. 34 is ‘I am forgiving’ (i.e. a process), but a description is given which is “I have accepted the faults of my parents”, which is an outcome. Although learning outcomes are relatively easy to measure, if change is considered to be a learning process, then that would need to be addressed on an ongoing basis. Further, if change is a long term process, measurement would not occur solely at the end of therapy. In reality, most of the outcomes are written in the present tense in the sense that “I am doing something” and as such, suggest that this learning and assessment process is ongoing, dynamic and experiential. Rogers was clear that the idea of being fully functioning was a process and not an end state commenting that “life, at its best, is a flowing, changing process in which nothing is fixed” (Kirschenbaum & Henderson 1997, p.28). It is concluded therefore that any Learning Plan would be mostly perceived as a ‘learning tool’, not an assessment process.

6.3.1 Quality.

Sackman (1974) notes the tendency of the Delphi study to fail to follow 'conventional scientific procedures', particularly relating to psychometric validity and general reliability measures. Hasson and colleagues suggest too that there is no evidence of reliability in the Delphi method (2000, p.1012). Flick (2007) discusses the notion of adequacy of method, suggesting rechecking whether the method continues to be suitable as the study progresses. The fact that "Delphi straddles the divide between qualitative and quantitative methodologies" (Mullen, 2003, p.40) in itself makes the analysis of the quality of the research challenging. Supporters of the approach suggest that the knowledge and experience of experts corrects for the lack of conclusive data (Fink, et al., 1984), and in any event the method should not be subject to the same validation criteria as more positivistic methods. Powell (2003) also discusses the notion that rather than creating new knowledge, the Delphi method makes best use of information available which in this case is collective wisdom or 'expert opinion' rather than indisputable fact (Fink, et al., 1984).

There are also epistemological challenges which relate to the quantitative/qualitative divide. "Most Delphi studies lack clarity about the framework in which the findings are to be judged" suggests Powell (2003, p.380). The Critical Realist perspective of the researcher in this context proved to be entirely appropriate for the methodological complexities. The realist perspective which sought quantitatively supported 'facts' was adequately balanced by a critical stance

which allowed for the production of expert wisdom, which is debated, challenged and developed over time.

Some measures of quality such as reliability, validity, and generalisability, in addition to those relating to psychometric testing (Coaley, 2009), were still appropriate to this Delphi study. The reliability of the data was affected by the unwillingness of some of the participants to devote a reasonable amount of time to it and their responses dropped in number as rounds progressed. Positively, the experts were considered mostly to be as 'expert' as was feasible, items were made very specific, response rates were generally good, and the data analysis was thorough, all contributing to the reliability of the data.

It could be argued that the process was over-structured, particularly since a pre-defined list was supplied in Round 1. This structure, however, actually supported a construct validity measure, since this was a process where participants validated their own understanding of a clear construct, on the basis that 'understandability' was the overall aim (Okoli & Pawlowski, 2004, p.16). Further, Hasson and colleagues note that "threats to validity arise principally from pressures for convergence of predictions" (2000, p.1012) where "the 'holdouts'… draw the 'swingers' toward their estimates… through their superior knowledge" (Rowe, et al., 1991 p.248). Pressure not be controversial no doubt affected the results of this Delphi study, as did pressure to 'get it over with'.

As mentioned previously, for Yardley (2000) rigour is demonstrated in the comprehensiveness of the data collection and analysis. The Delphi is a fairly

rigorous process, requiring in depth consideration of a topic by participants over an extended period of time. A reasonable sized sample of participants was involved, although clearly this exercise could be conducted over a much broader base of therapists, ideally involving different styles and approaches to therapy. Further, Vernon notes (2009) that robustness or rigour in the process tends to lie in the justification that the researcher is able to provide for decisions made, rather than in any scientific rationale, so all analysis and calculations are available for assessment.

Finally, generalisability of the resulting theory was considered possible due to the wide range of experience of participants, making it more likely that "resulting theory will hold across multiple contexts and settings" (Okoli & Pawlowski, 2004, p.15).

As Cruickshank notes, information collected can only be analysed based on an understanding of it (2003, p.1), and the researcher brought a great deal of previous experiences, views and biases to the table. The most relevant of these was a belief that learning is goal focused and that the 'fully functioning' person can be defined in terms of measurable outcomes. Both of these perspectives were not necessarily supported by the participants. More positively, it is considered that the researcher was able to bring 30 years of experience in the field of personal development as background wisdom and this bias was 'coveted' (Braun & Clarke 2013), on the basis that it provided a different perspective from which to view therapeutic outcomes.

6.4 Conclusion

Encouraging person-centred therapists to discuss therapy goals had inherent problems, not least of which was their reticence to consider a structured approach to therapy, saying for example: It "felt very conditioned – to create perfection"; and "a lot of counsellors are anti questionnaires". Nevertheless, there were therapists who were very comfortable with the concept saying for example; "Oh wouldn't it be fabulous to think that we could facilitate all of this!" and "This is a very thought-provoking instrument". There seemed to be a fairly clear split between therapists who were very happy to consider the approach and those who just didn't think that way, but the outcome of the Delphi was, even so, an apparently robust list of outcomes which only generated significant debate over one or two issues such as spirituality and sexuality.

So a list of items was now available, but there was still work to be done in order for therapists be able to present the list to their clients and make any use of it. Initially, it was considered that it may be a simple process of adding some form of scale indicating level of agreement to each item and presenting it in the form of a questionnaire. Much more thought was given to format in the end, and that design process is outlined in the next section.

Chapter Seven: Designing a Format for the List of Items

7.1 Design Considerations

Having established a set of humanistic outcomes which could be realised through learning processes, this discussion turns now to how they could be presented in the context of the therapeutic encounter. A document was needed which would allow a client to make use of the 71 identified items to plan their own learning outcomes. The theoretical basis that enabled the design decisions is presented next.

Firstly, two uses for this set of outcomes were considered, either to measure the individual in absolute terms against themselves over time or against a larger population, or to enable the client to use the outcomes as a framework or tool to support their therapeutic change, specifically to set their own learning goals. In terms of the latter, Burnett and Meacham suggest that;

> *If the formal evaluation of the learning acquired by the counselling process is required, Burnett's (1999), Burnett and Van Dorssen's (2000) or Biggs and Collis's (1982) taxonomies can be used to qualitatively measure learning levels. These procedures can be used to facilitate discussion with the client to promote critical reflection. Such enhanced learning competencies are the foundation of meta-cognition, which enables the establishment of world views to inform decisions and outcomes in problematical situations* (2002, p.414).

Here they suggest a qualitative approach using their own taxonomies (discussed earlier), with the aim of facilitating critical reflection, and it is this purpose which was considered to be the most appropriate. This perspective would allow the client to use the instrument as a vehicle to plan their own self-directed, humanistic learning

process rather than use it merely to measure a start and end point such as may be used in measures of pathology.

In terms of measurement against a larger population, it was thought initially that on the basis of quantitative data, the therapist may be able to predict the likely therapeutic change over time and tailor their processes accordingly. The production of an absolute measure, however, would require a much larger study, allowing for data to be generated to enable norm referencing. It was also noted that according to Roth and Fonargy "research data….cannot predict the trajectory of change for an individual patient… it may be more fruitful to use a patients initial response to therapy as an indicator of later benefit, rather than attempting to do this at the stage of pre-therapy assessment", (2006, p.473). And as the study progressed, it became evident that using this data in a predictive sense would not only prove problematic due to the largely qualitative nature of the data, but would not necessarily be helpful to the therapist. There remains the possibility to develop this idea further in future research.

It was decided that the learning outcomes should be used to facilitate critical reflection, coupled with some kind of measure which would enable the client to see their own therapeutic progress. Whether measurement is quantitatively taken against a given standard, or qualitatively derived to inform learning processes, it is achieved through a carefully designed psychological assessment instrument. Psychological assessment is usually used as a diagnostic process administered by the therapist, to "identify therapeutic needs, highlight issues likely to emerge in treatment, recommend forms of intervention, and offer guidance about likely outcomes"

(Meyer, et al., 2001, p.129). Humanistic therapies, however, see assessment from a different perspective. For Tonsager and Finn (2002), "a primary goal of therapeutic assessment is to meet the individual goals/needs of clients" (p.14), rather than to serve as a tool for therapists. For them, "tests are viewed as empathy magnifiers that are useful in helping assessors get in clients' shoes" (p.15). As a result:

> *…by engaging clients in an intense process of self-exploration and using psychological tests to quickly gain empathy for clients' problems in living, we attempt to decrease shame and to assist clients in seeing and testing out new ways of being* (p.18).

Further, Finn suggests that key aspects of this approach include: helping clients generate their own assessment questions; exploring past assessment-based hurts and involving clients in discussing results (cited in Poston & Hanson 2010, p.204).

Assessment was therefore considered to be a client-led, self-exploration process in which the establishment of personal goals would be facilitated on the basis of the suggested framework. This exploratory process would enable the therapist to engage fully with the issues raised by the client and to be involved in the ways that Finn suggests. So, as Finn recommends, the client then takes on a greater role in psychological testing, making, as Poston and Hanson note, psychological testing a relational experience rather than a reductionist practice and "…when combined with personalized, collaborative, and highly involving test feedback", it can have positive, clinically meaningful effects on treatment and treatment processes (2010, p.203). In this context, therapeutic assessment models "view assessment-related processes and procedures as 'interventions' in their own right, as opposed to precursors or adjuncts to treatment" (2010, p.203).

Considering that "…a humanistic therapy might be expected to prize the clients' perspective" (Levitt, et al., 2005, p.120) and no expert diagnostic assessment of the client was intended - it was a personal perspective for use *by* the client - some consideration of whether the therapist should be involved in the completion of the questionnaire at all was necessary. Further reasons to question therapist involvement include the view that reliability of assessments are often called into question when the outcome has potentially negative consequences and, given that individuals taking tests are "likely to answer questionnaire items according to the social desirability of the item statements" (McLeod, 2001, p.216), individuals may score on the basis of the way they would like to be perceived. In summary, there seemed to be no value in having a formal external perspective in the process of evaluation, although informally, clients may wish to seek feedback to assist them in the completion of the questionnaire, whether from friends, relatives or the therapist. Some clarity on this issue would likely emerge from implementing the questionnaire with clients in practice, and obtaining their feedback.

The traditional approach to therapeutic assessment is through the use of self-report questionnaires, although direct behavioural observation or ability tests are also used in certain circumstances. The idea of self-assessment on the basis of questionnaires can be problematic. McLeod, for example, suggests that "…changes in self-report questionnaire scores do not necessarily reflect changes in the client's problems or in his or her life" (2001, p.217). One of the main reasons for this is that "the categories one meets in psychological texts are discursive categories, forms of words, not the things themselves" (Danziger cited in McLeod, 2001, p.217). It is

always, therefore, a perception of a construct under analysis, rather than an objective assessment of observed behaviour or ability.

Another issue with scored questionnaires is that a positive movement in outcome may not necessarily be required. Some clients with denied mental health problems would be regarded as having success in therapy if their depression ratings rose on a self-report questionnaire. Situational factors also have a high impact on self-report questionnaires. A respondent may be in a particular 'mood' while completing it, or affected by the therapist's attitude, distracted by surroundings and so on. The client may be typically apprehensive about disclosing their true feelings, or adopt a response mind set such as always answering around a particular range or the 'don't know' option (Fernandez-Ballesteros, 2004).

There are disadvantages to using questionnaires, although "there is plenty of anecdotal evidence that at least some clients find that filling in questionnaires helps them to reflect usefully on their therapeutic goals" (McLeod 2001, p.218). Notwithstanding the limited reliability and validity of the outcomes of this type of assessment, it gives a useful tool by which to engage the client in a productive debate about their psychological profile at the point of entry to therapy, and their desired learning goals. Although the document would be a questionnaire, the label 'Therapeutic Learning Framework' was considered to have a more positive connotation and describe the personally reflective nature of the instrument. Further, the idea of there being no wrong or right answer, that no comparisons with others could be made, (at this stage), and that responses were expected to be changed over time were considered helpful.

7.2 Design Conclusions

From research into psychological assessment design issues, some of which is outlined above, it was considered in summary, that the design of the document would need to meet the following needs: (a) The process would be seen to be an intervention in its own right by client and therapist. (b) The format would facilitate critical reflection and produce outcomes of a qualitative nature. It would enable clients to develop their perception of the construct under analysis rather than undertake an absolute measure of it. (c) The process would be client led, enabling self-reflection, but would engage both client and therapist in dialogue. (d) Ownership of the material and process would be with the client. (e) Finally, the document would be a tool to engage in productive debate and would imply no right or wrong answer.

An open-ended 'questionnaire' format seemed to be an appropriate start point from which to design a process which would meet the requirements outlined above. So, having first listed the 71 items on the document, the issue of some sort of measurement system which identified a start and end point in the client's journey needed to be addressed. There is an implied hierarchy of operations in being fully functioning, i.e., one can be more or less functioning, and the statement of values, states of mind, preferences and so on, rather than ability, knowledge or skills suggested more of an 'inventory' than a test. Therefore, a score of right or wrong, a percentage correct, or level of achievement was not applicable; rather the notion of a *rating* was more relevant than a score.

Typically, in psychological assessment, a set of items is considered and responded to in the form of a free format answer, a forced choice, or more often than not, a point on a scale. The Likert Scale (Likert, 1934) uses a set of 1-5 or 1-7 responses for example, most typically ranging from strongly disagree to strongly agree, and it was this format which was initially considered worth testing. It was decided that 5 options would be a reasonable start point, with the client being invited to assess at what level they considered themselves to be in relation to each item. Initially the rating ranged from 'strongly disagree' to 'strongly agree'. Further, given that this humanistic profile should also allow for qualitative, open-ended responses (Levitt, et al., 2005), a free-format space at the end of each item was designed into the format, to allow for personal reflections. So, for example, a client may add to an item, "I only need to do this when I'm around my brother" to personalise the goal.

Finally, one particular issue to deal with in the design, was how to reduce such a large number of items to something that was manageable for the client. The instructions were therefore designed to encourage respondents *not* to consider *every* item on the list. (Respondents were asked to pick just one or two of the 7 main areas to work on, then just some items within those main areas, using the colour coding system shown in Example 9.)

7.3 Pilot Testing the Questionnaire Layout and Design

7.3.1 First Pilot Test and Redesign.

Having made some decisions about the format of the list of items, it was considered prudent to pilot test the design with a small sample of people before the study with 'live' clients outlined in the next chapter. This pilot process was not designed to be a study in its own right, but a precursor for the main study that followed. As such, ethical approval was not considered necessary, since it was planned to simply ask a small convenience sample of easily accessible students if the layout of the document made sense to them.

A simple 1st draft was produced which, in summary, added a Likert scale running from 'strongly disagree' to 'strongly agree' to the list of 71 items, coupled with a space to note what the client wanted to work on. Simple instructions for completion were added, encouraging the respondent to focus only on certain sections of the document at a time.

This first draft of the questionnaire was presented to 2 groups of 3rd year counselling students at Sheffield Hallam University with the involvement of one of the researcher's supervisors. They were given a draft copy of the questionnaire and asked to consider the effectiveness of the format, and then to provide brief verbal feedback on the clarity of the instructions, the wording of the items, and general layout of the document. 2 groups of 12 students reviewed the document and informal feedback was obtained afterwards via a round table discussion with each group.

Example 9: Questionnaire piloted with students

Exploring Me and Setting Goals for Therapy

Instructions for Completion (If anything is unclear, please ask your therapist for clarification.)

Part A **Describing You:** This part of the questionnaire takes a measure of where you are now in terms of your self, your relationships and your life.

1. **Green Column**
First, have a look down the **green** column. Tick those categories which you may like to work on in therapy. (One or two categories will probably be enough to start with.)

2. **Pink column**
For **only** the areas you ticked in the green column, do the same in the pink column – tick those that interest you.

3. **Blue column**
For those categories that you have ticked in the pink column, consider the statements in the blue column. For those that you would like to work on, decide how much you agree that it describes you, and tick one of the 5 boxes. (The yellow 'more details' column explains the description further.) Again, one or two descriptions may be enough.

Part B **Setting Goals:** This part of the questionnaire looks at your plans for improvement in therapy.

4. White Column
Think about exactly what you want to achieve in therapy for each description you have considered and add your thoughts in the white column.

This process can be completed alone or with the help of your therapist. However, it would be helpful to your progress if you would discuss the results with your therapist before you start therapy. You may also wish to refer back to the document as your therapy progresses.

Part A						Part B
Area	Quality	Description	(More Details)	- Strongly Disagree / Slightly Disagree / Neither / Slightly Agree / Strongly Agree +		I want to work specifically on...
Understanding Me ☐	I understand me ☐	1 I know myself well	• I know how I think • I can stand back and look at myself • I know when and why I'm being defensive	- ☐ ☐ ☐ ☐ ☐ +		
		2 I know the different sides to me		- ☐ ☐ ☐ ☐ ☐ +		
		3 I know what I'm good at and what needs to be worked on	• I know my fears and failings • Even when I fail I can encourage myself	- ☐ ☐ ☐ ☐ ☐ +		
		4 I have a good idea of	• I know how I affect people	- ☐ ☐ ☐ ☐ ☐ +		

Following an assessment of the questionnaire, the students provided the following general observations: There was a fear that the questionnaire may 'steer' the client into areas which were inappropriate. This point, and others like it, came understandably from the point of view of the Person-centred counsellor training which the students had undergone. Further they suggested that the client may be more anxious if faced with a list of items which they think 'should' be possible but are not within their grasp. They suggested that the questionnaire could be considered at the end of therapy by the therapist in order to validate their own practice, either as a personal feedback mechanism or as part of a wider collation of results. It was suggested that the questionnaire may be better supplied around the middle of the counselling process after some trust and understanding had been established. Further, it was suggested that some clients may not be able to perceive their needs until some way through the counselling process anyway. One student commented on

the unique nature of the client and that they may not conform to this profile, and further that clients may change on a day to day basis. Finally, it was suggested that the whole format would be more appropriate for a more confident, self-actualising client. The instructions on the whole seemed to be reasonably clear, but it was pointed out that colour-blind individuals may have a problem with references to coloured columns.

In addition to the items mentioned above, it was questioned by the students whether the framework should be presented in hierarchical terms. Maslow's idea of a Hierarchy of Needs (1943), outlines progress towards the idea of self-actualisation, given that achieving one's potential relies on having food, shelter and a sense of belonging first. It was worth considering whether a client can realistically consider their 'sense of oneness with the world', before considering their ability to manage their own basic needs. Changing the order did not seem to effect the instrument negatively, so it was considered appropriate to begin with items relating to coping strategies, before progressing to relationship issues, on to those relating to self-esteem, before finally addressing self-actualisation. The reordered items are presented on sheet 2 entitled 'Items Reordered Hierarchically' in file supporting Data\Chapter 6 Delphi Study and Chapter 7 Instrument Feedback\Feedback on Instrument Designs\Analysis.xlsx)

The main feedback from the students centred on the complexity of the questionnaire and its sense of being overwhelming, so it was this problem which required consideration first. Rogers (2003) recommends studying the perception of self-characteristics using the Q-sorting method (developed by William Stephenson),

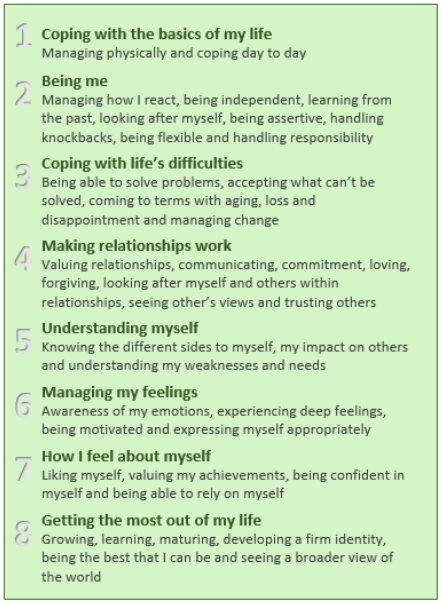
so it was considered that this methodology may be used here. "Q methodological studies involve a group of participants sorting a sample of items into a configuration (the Q sort) that, taken as a Gestalt reflects a relevant subjective dimension (e.g. personal degree of agreement with the items)", (Stenner, Watts, & Worrell, p.216, in Willig & Stainton Rogers, 2008). The items were therefore designed as a sorting exercise using a series of 32 cards, whereby the client is faced with a decision tree, enabling them to define one goal at a time. The exercise was exactly the same as the questionnaire, but focused attention on one item at a time. This was the first mock-up:

Example 10a: Card sort exercise

An explanation of the card sort process

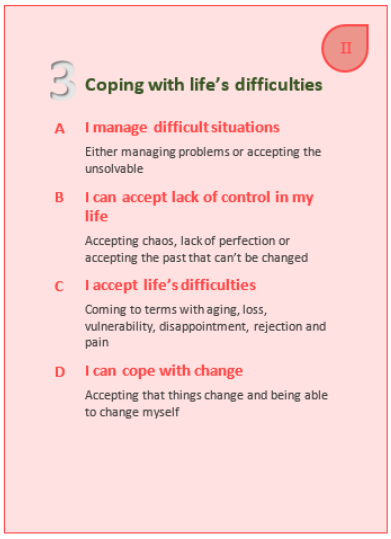
First, the client is asked to pick a topic from the green card which would indicate an area of interest for therapy. For example, he/she may choose "Coping with Life's Difficulties" which is number 3:

Example 10b



Secondly the client is asked to locate the corresponding pink card, in this case pink card number 3. They are asked to choose the quality that they may aspire to, in this case, one of categories A to D. For example he/she may choose "I accept life's difficulties" which is 3c:

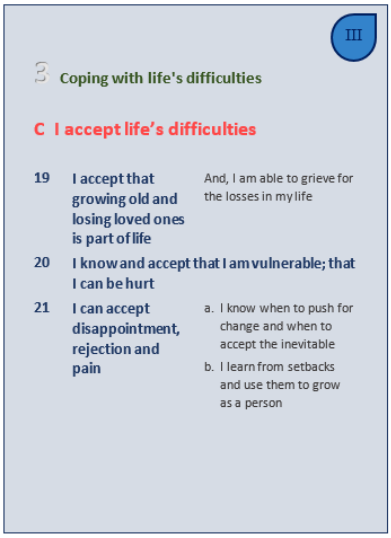
Example 10c



Next they are asked to locate the appropriate blue card, in this case blue card 3c, and to pick an item which they would most like to work towards. For example, one

might pick number 21, point b which is about learning from setbacks. This item then gives the client the basis from which to define their own personal goal for therapy. One number (and letter if there is one) would therefore have been chosen out of a total of 71 choices:

Example 10d



The process of narrowing down a broad set of items seemed to deal with the issue of the questionnaire being overwhelming, allowing the client to focus in on one issue at a time, with the ability to redo the exercise as many times as necessary in order to build up a set of goals. Some form of record was considered necessary for this process of analysis, so a 'learning plan' was designed for completion by the client once goals were chosen. The planning process gave the opportunity to document the client's thinking as would have been done if they had done the questionnaire. There is space to indicate which item was chosen, a goal to work towards, a rating of current performance and space to change goals over time. Some further thought was given here to a rating scale based on more user friendly terms such as "I have a little way to go with this":

Example 11a: Learning plan accompanying card sort exercise

(Front)

Learning Plan

1 = I'm starting from scratch on this
2 = I have quite a long way to go with this
3 = I have a little way to go with this

I	II	III	IV My Specific Goals	V Rating Before Therapy	Changing Goals Over Time
Example 5	B	49a	"I will be happy with my achievements even though I can't compete with my brother" *NB Try to write your goals in terms of what you will be like **after** you have succeeded*	1☐ 2☑ 3☐	"I won't let the thought of failing stop me trying new things"
				1☐ 2☐ 3☐	
				1☐ 2☐ 3☐	
				1☐ 2☐ 3☐	
				1☐ 2☐ 3☐	
				1☐ 2☐ 3☐	

On the back of the form is space to re-rate performance at the end of therapy and to log long term learning. (When folded over, the re-rating section lines up with the original goals):

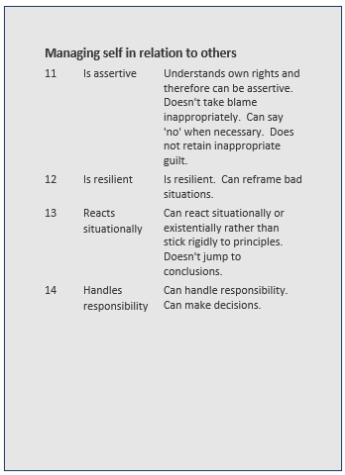
(Back)

1 = I still want to work on this a lot
2 = I still want to work on this quite a bit
3 = I still want to work on this a little
4 = I'm now doing OK with this
5 = This now describes me well

Rating After Therapy	Important Learning Points for the Long term
1☐ 2☐ 3☐ 4☑ 5☐	"I don't need to complete with anyone"
1☐ 2☐ 3☐ 4☐ 5☐	
1☐ 2☐ 3☐ 4☐ 5☐	
1☐ 2☐ 3☐ 4☐ 5☐	
1☐ 2☐ 3☐ 4☐ 5☐	
1☐ 2☐ 3☐ 4☐ 5☐	
1☐ 2☐ 3☐ 4☐ 5☐	
1☐ 2☐ 3☐ 4☐ 5☐	
1☐ 2☐ 3☐ 4☐ 5☐	

On the back of each card are the items in the original un-simplified wording, which allows the therapist to work with the client to complete the learning plan by explaining the context of the item if necessary.

Example 11b: Therapist's notes within card sort exercise



Managing self in relation to others

11	Is assertive	Understands own rights and therefore can be assertive. Doesn't take blame inappropriately. Can say 'no' when necessary. Does not retain inappropriate guilt.
12	Is resilient	Is resilient. Can reframe bad situations.
13	Reacts situationally	Can react situationally or existentially rather than stick rigidly to principles. Doesn't jump to conclusions.
14	Handles responsibility	Can handle responsibility. Can make decisions.

7.3.2 Second Pilot Test and Redesign.

Given that considerable re-working of the design of the instrument had taken place, it was considered that a further brief pilot test of the layout of the card exercise should be undertaken. Again this was a small convenience sample of first 13, and then a further 10 friends, colleagues and relatives known to the researcher, aimed at testing issues such as readability and ease of use.

The first 13 participants were questioned informally and responses noted by hand. The following simple questions were asked: "Were the instructions clear and did the format actually work?" The intent was to test only the clarity of instructions and the format of the cards, since usefulness of the exercise would be tested later.

Initially, respondents pointed out the lack of detail on the first card; the instructions for completion which were considered slightly unclear; and the colour and size of the text was also problematic. The first draft of the associated learning plan needed work on the layout to make it more logical and clear in terms of what was required for its completion. All of these issues were addressed and a new set of cards produced.

Following minor adjustments, a further brief presentation of the cards was completed with a new set of 10 people, all known to the researcher. One suggestion had been to produce the set of cards in a pack of 3 rather than all as one, so both options were offered for testing, one with tabs to help navigate through the blue cards and one set with the colours separated and no tabs. In addition to questions of clarity, respondents were asked which set of cards they preferred. Feedback from both of these initial pilot tests are detailed in file: Supporting Data\Chapter 6 Delphi Study and Chapter 7 Instrument Design\Feedback on Instrument Designs\Analysis.xlsx, (Sheet entitled Initial Design Feedback). Half of the interviews from the second group of people are stored on audio files, all other comments were captured informally.

Example 12: Second set of cards (All in one, or 3 separate packs.)

The analysis of these results suggested further improvements such as removing the roman numerals which were confusing matters. More tabs were suggested to distinguish the pink cards from the blue cards, and shapes to provide a navigation system for anyone suffering from colour blindness. Amongst other minor alterations, it was recommended that the final design excluded some unnecessary numbers and tabs should be added on blank cards rather than attaching them to the first of each set. It was recommended that important numbers were enlarged and symbols moved. The results are shown in Example 13:

Example 13: The final set of cards

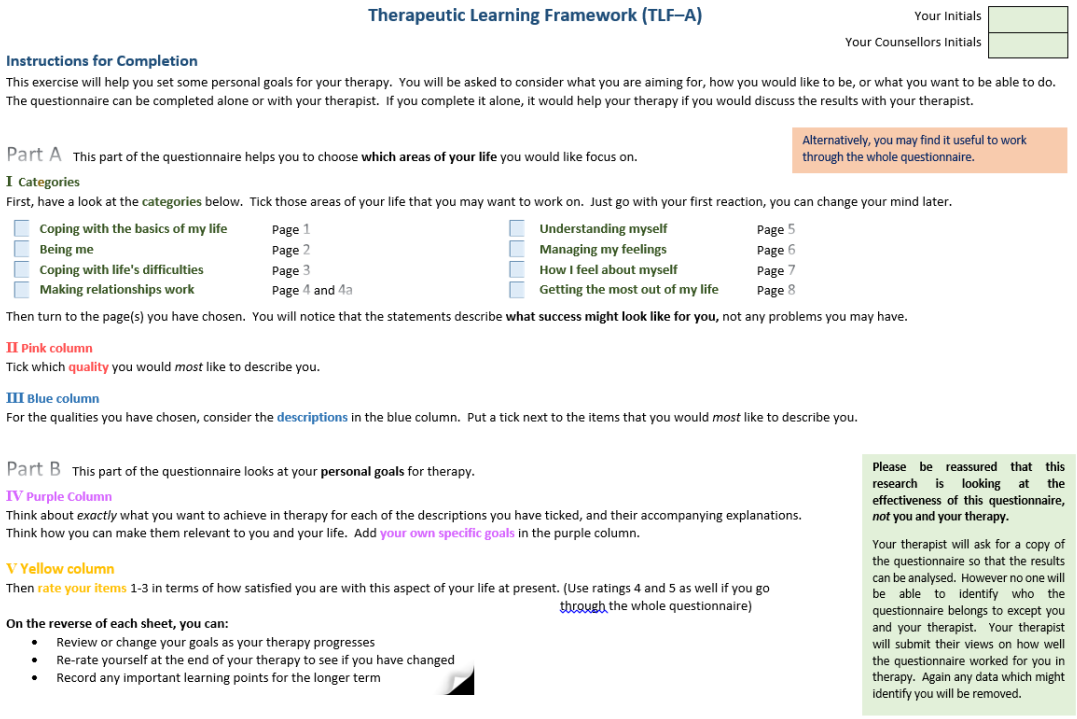
One issue which did come out of the testing of the card sort exercise was that 2 individuals said that they would like to see the items all together so that they could work through them systematically. It was considered therefore that having both the card sort exercise and the full questionnaire available for the client to choose the most appropriate methodology would be worth pilot testing. Some more work was therefore put into the wording of the full questionnaire.

Although the full list of items was considered necessary for holistic thinkers who needed to put specific goals into context, there still seemed to be potential to find the document overwhelming. So, it was decided to develop further the instructions to allow either:

- Completion of only *some* items whilst seeing the context within which they fitted, or
- Completion of the whole document with a view to seeing how different elements linked together

Thus the instructions on the questionnaire were altered to read as follows:

Example 14: Final instructions for the questionnaire



Therapeutic Learning Framework (TLF–A)

Your Initials

Your Counsellors Initials

Instructions for Completion

This exercise will help you set some personal goals for your therapy. You will be asked to consider what you are aiming for, how you would like to be, or what you want to be able to do. The questionnaire can be completed alone or with your therapist. If you complete it alone, it would help your therapy if you would discuss the results with your therapist.

Part A This part of the questionnaire helps you to choose **which areas of your life** you would like focus on.

Alternatively, you may find it useful to work through the whole questionnaire.

I Categories

First, have a look at the categories below. Tick those areas of your life that you may want to work on. Just go with your first reaction, you can change your mind later.

- Coping with the basics of my life — Page 1
- Being me — Page 2
- Coping with life's difficulties — Page 3
- Making relationships work — Page 4 and 4a
- Understanding myself — Page 5
- Managing my feelings — Page 6
- How I feel about myself — Page 7
- Getting the most out of my life — Page 8

Then turn to the page(s) you have chosen. You will notice that the statements describe **what success might look like for you,** not any problems you may have.

II Pink column

Tick which quality you would *most* like to describe you.

III Blue column

For the qualities you have chosen, consider the descriptions in the blue column. Put a tick next to the items that you would *most* like to describe you.

Part B This part of the questionnaire looks at your **personal goals** for therapy.

IV Purple Column

Think about *exactly* what you want to achieve in therapy for each of the descriptions you have ticked, and their accompanying explanations. Think how you can make them relevant to you and your life. Add your own specific goals in the purple column.

V Yellow column

Then rate your items 1-3 in terms of how satisfied you are with this aspect of your life at present. (Use ratings 4 and 5 as well if you go through the whole questionnaire)

On the reverse of each sheet, you can:

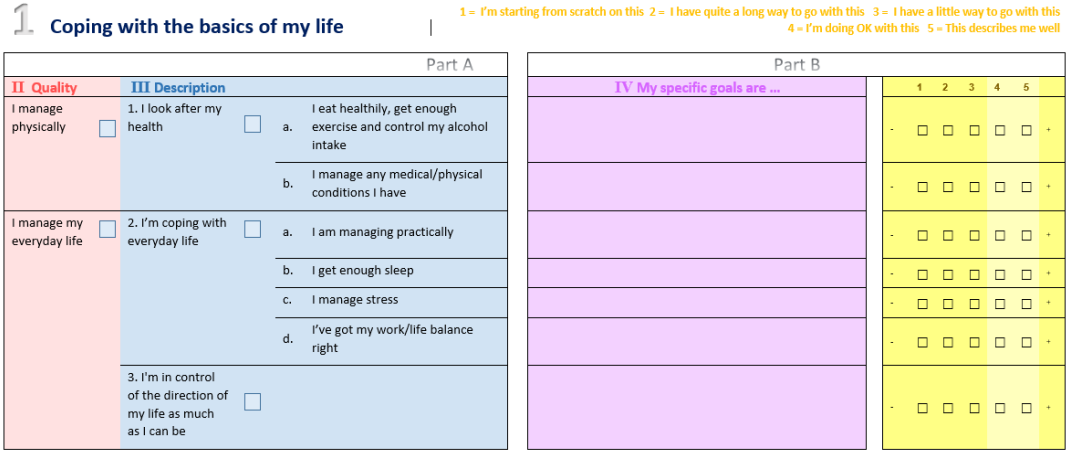
- Review or change your goals as your therapy progresses
- Re-rate yourself at the end of your therapy to see if you have changed
- Record any important learning points for the longer term

Please be reassured that this research is looking at the effectiveness of this questionnaire, *not* you and your therapy.

Your therapist will ask for a copy of the questionnaire so that the results can be analysed. However no one will be able to identify who the questionnaire belongs to except you and your therapist. Your therapist will submit their views on how well the questionnaire worked for you in therapy. Again any data which might identify you will be removed.

The body of the questionnaire was also changed slightly to allow self-rating *after* personal goals had been defined. And finally, the rating scale was changed to that which had been used in the learning plan associated with the card exercise, including measures such as "I'm starting from scratch on this" or "I'm doing OK with this":

Example 15: Final questionnaire design



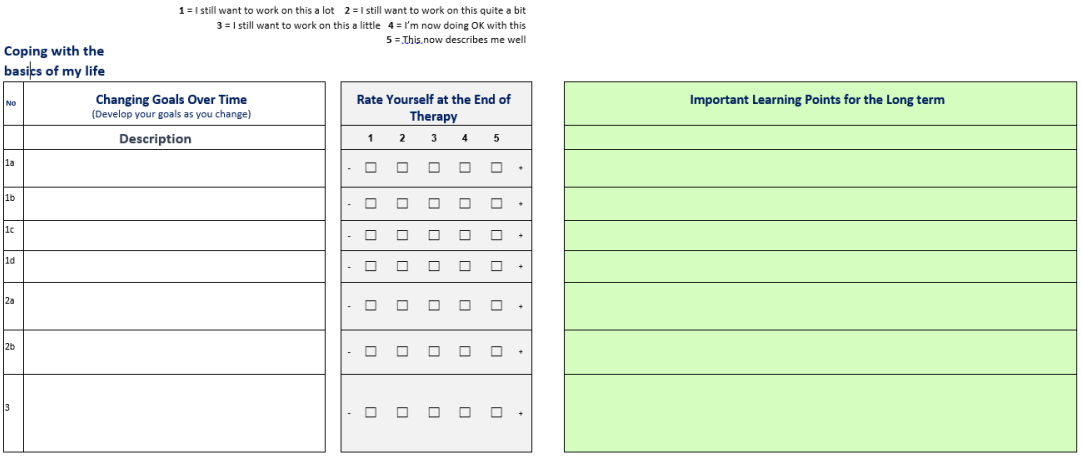
1. Coping with the basics of my life

1 = I'm starting from scratch on this 2 = I have quite a long way to go with this 3 = I have a little way to go with this 4 = I'm doing OK with this 5 = This describes me well

Part A				Part B	
II Quality	III Description			IV My specific goals are ...	1 2 3 4 5
I manage physically ☐	1. I look after my health ☐	a.	I eat healthily, get enough exercise and control my alcohol intake		- ☐ ☐ ☐ ☐ ☐ +
		b.	I manage any medical/physical conditions I have		- ☐ ☐ ☐ ☐ ☐ +
I manage my everyday life ☐	2. I'm coping with everyday life ☐	a.	I am managing practically		- ☐ ☐ ☐ ☐ ☐ +
		b.	I get enough sleep		- ☐ ☐ ☐ ☐ ☐ +
		c.	I manage stress		- ☐ ☐ ☐ ☐ ☐ +
		d.	I've got my work/life balance right		- ☐ ☐ ☐ ☐ ☐ +
	3. I'm in control of the direction of my life as much as I can be ☐				- ☐ ☐ ☐ ☐ ☐ +

Further, the space to self-rate post-therapy and a space to log long term learning points was also added, as on the back of the learning plan:

Example 16: Back of the questionnaire



1 = I still want to work on this a lot 2 = I still want to work on this quite a bit
3 = I still want to work on this a little 4 = I'm now doing OK with this
5 = This now describes me well

Coping with the basics of my life

No	Changing Goals Over Time (Develop your goals as you change)	Rate Yourself at the End of Therapy	Important Learning Points for the Long term
	Description	1 2 3 4 5	
1a		- ☐ ☐ ☐ ☐ ☐ +	
1b		- ☐ ☐ ☐ ☐ ☐ +	
1c		- ☐ ☐ ☐ ☐ ☐ +	
1d		- ☐ ☐ ☐ ☐ ☐ +	
2a		- ☐ ☐ ☐ ☐ ☐ +	
2b		- ☐ ☐ ☐ ☐ ☐ +	
3		- ☐ ☐ ☐ ☐ ☐ +	

(If the page were folded, the post rating lines up with the original goals.)

As had been provided within the card exercise, the original wording of the items was provided in a document for therapists to refer to in the process of working with the client on defining goals if necessary.

Example 17: Therapists notes

Therapists Notes

		Area	Quality	Description	More Details
1	a,b,	**Coping with the Basics of my Life**	Managing physically	Manages physical health	Manages physical health (e.g. diet, exercise, any conditions, e.g. not smoking).
2	a,b, c,d		Managing everyday life	Controls and manages day to day living	Can cope with the basic practicalities of life, (e.g. managing/balancing time, doesn't get overwhelmed, can sleep, focus, concentrate).
3				Self-determines life course	Self-determines direction of life, as far as possible.
4		**Being Me**	Managing self	Engages with self	Responds to own needs/feelings. Communicates with inner self. Engages with self.
5				Owns reactions	Is aware of and accepts own thoughts, feelings and actions
6				Can respond to control self	Can let go of unhelpful thinking, emotions, relationships, the past
7				Is congruent	Is authentic/congruent. Has no need for facades.
8	a,b,			Can be independent	Can be independent (outside of close relationships). Seeks self-evaluation rather than evaluation/approval from others. Has awareness and acceptance that others do not necessarily have the answers.
9				Applies learning	Applies prior learning. (The ability to apply change/learning processes to other life areas or problems in the future.)

7.3.3 Third Pilot Test.

Having ironed out some of the more obvious problems with the layout of the cards and redeveloped the questionnaire based on the responses from the students, a final pilot of both instruments was completed with a group of 21 people. These individuals were a new convenience sample known to the researcher, representing a broad spectrum of ages, occupations and levels of academic achievement. The group were all typical inhabitants of a Derbyshire village, and there was therefore limited variety in their culture or language. The data collection was completed by sitting in a village shop and inviting participation from random members of the village as they came to pick up papers or a pint of milk.

Participants were presented first with the set of cards (and instructions) and later the questionnaire for comparison. Views on their use were sought, asking questions such as “Do the exercises work?”, “Do you understand the instructions?”, “Can you suggest any improvements?”, “Would it help you if you were going for therapy?”, etc. Responses were taped and transcribed, each interview lasting around 10 mins. The results were categorised very simply with little in-depth analysis attempted. It was assumed, for example, that if a participant said that the text was too small, then that could be taken at face value. A literal realist perspective was thus adopted rather than a critical stance for this exercise. 19 of the 21 conversations are stored in audio files, the analysis of which is detailed in file: Supporting Data\Chapter 6 Delphi Study and Chapter 7 Instrument Design\Feedback on Instrument

7.3.4 Final Results and Discussion.

When asked generally about the validity of the instruments, or whether the respondent considered them to represent worthwhile activities, most were very positive. Comments suggested that the questions were informative, pertinent, challenging and interesting. The fact that the cards facilitated a quick answer was appreciated and that it enabled a degree of focus in a potentially confused situation. One comment came from a public sector Director of Education who considered that "…this is a sophisticated tool" and "it's very high quality". Two people, however, commented that not everyone may want to be focused in that way, particularly one client who said that she may just want to talk in a very general sense if she attended therapy.

In terms of the actual instruments, there were positive comments relating particularly to the logical way the process was set out, and the fact that it was an easy process to engage with. With reference to the cards, one commented: "I think it's quite a clever little way of doing it really"; it's "really easy to handle" said another; and "I think it's lovely, it's the sort of thing you can slip into your pocket" was a comment made on a number of occasions. For example, two women pointed out that if it were in their handbag, they could refer to it regularly, such as whilst on a car journey or waiting for an appointment.

In considering the specific process defined by these materials, there were conflicting views. Three negative comments were made such as the questionnaire "…felt like a legal document" and concern was expressed that if a client knew what their problem was they might have difficulty finding it in the pack of cards. Further

both instruments were considered to be rather ‘itemised’, which may have been a comment from someone who thought more holistically. Even so, a similar number of respondents valued the process of channelling their thoughts, saying “it kind of channels my thoughts and streamlines them from being a thousand thoughts all jumping around, to bringing me back down to a narrow channel that would be workable”.

60% of those who expressed a preference would choose to use the cards rather than the questionnaire, commenting that they seem simpler, more focused, and requiring less choices to be made. Eight people considered the questionnaire to be too daunting, or they didn’t like completing forms, or there was too much box ticking. Two people also mentioned the physical properties of having the cards in their hands, one saying “there’s something about being able to have it in your hand like that …that’s a physical thing isn’t it?”

Seven people expressed a preference for the questionnaire, suggesting that: the cards would confuse them; the questionnaire was less complicated; the ‘multiple choice’ box-ticking was helpful; and the fact that “it’s all there” was helpful. The comment “You get a wider view of what it’s all about” seemed to indicate that some people did in fact prefer a more holistic view, as was anticipated at the design stage. Further one participant suggested that “yes, I’d want that open on my desk at home”.

A number of comments were made on how people felt they would approach the process to get the best out of it. One person was used to writing journals and considered that she would integrate her goals into that process. Another said he

would prefer to tick boxes, but not write goals, or at least not at the same time. A couple of others commented about wanting time to consider responses rather than doing it under pressure, although most were content to follow the instructions as indicated. Therein lay an unanticipated problem. It seemed that not everyone was able to follow instructions in the way that the researcher had anticipated. A good proportion of the respondents demonstrated either an inability to follow the instructions, or a concern that others may be unable to do so. "I needed you to explain everything to me first time" said one, and "if you gave this to somebody, I think they'd get confused" said another. Another suggested that "there needs to be a discursive stage before settling on a goal", which seemed to be less a comment about confusing instructions, but more about how to get most value from the exercise. Having considered that the instructions were probably as simple as it was possible to make them, the most obvious conclusion was that, to obtain the most from the exercise, it should not be given to the client pre-therapy, but should be completed after a briefing session with the therapist. Further, one participant's comment: "…if it's going to be used, it has to be used with somebody who knows how to use it", reflects the researcher's view that training in getting the best from the process may be appropriate.

A further unanticipated point of confusion in the exercise was the perspective of the items. Each item is written in a positive way, intended to enable goal setting. Three of the participants, however, were expecting a diagnostic exercise which would help them to identify their problems saying for example "it's written counter-intuitively for me". As such, they were confused when trying to understand the

process. Clearly this perspective would need to be explained in any introduction of the materials.

It had been suggested that having three separate packs of cards may make the process easier to navigate, so that question was asked. Nearly 80% who answered the question preferred 1 pack, suggesting that the cards would be less likely to get muddled. Further a cover card giving brief instructions was considered to be useful.

Six people commented that the print size was too small, but recognised that it might be fine for some people. The participants, however, were mostly not carrying reading glasses with them, so the problem may not necessarily need addressing. Nine people (versus two) said that they used tabs by flipping them over rather than expecting the information to be on the card with the tab on it. Nine people (versus one) also considered that the therapist's notes on the back of the cards did not distract them. Three people felt that the colour coding worked well, whilst two had comments about the black merging into the grey and the red blurring. On a positive note, the one colour blind gentleman who gave feedback said "I think it's fantastic" in response to the symbol system designed to tackle this issue. Finally, 2 respondents also commented that they would like to have the cards as a stand-alone instrument to be used on a self-help basis. This notion provides an avenue for consideration but is beyond the scope of this study.

In summary, comments were made about the questionnaire and the card sort exercise by 24 students and 44 members of the public who were informally questioned. As a result, 45% of the more simply worded items were changed

slightly. Further, the order was changed to reflect Maslow's Hierarchy of Needs, (1943). The instructions and layout of the questionnaire were also developed and finally, the card sort exercise was changed to allow for a more 'user-friendly' instrument. It was considered at the end of this process, that in preparation for stage 3 of the research process, two instruments had been adequately piloted and were ready for formal testing. (The finalised questionnaire and card sort exercise can be found in the following file: Supporting Data\Chapter 6 Delphi Study and Chapter 7 Instrument Design\Final Instruments.) Chapter Eight presents the study that sought to apply the instruments to a clinical setting in order to establish whether the process of setting learning goals would assist the therapeutic process.

Chapter Eight: Study 3: Does Setting Learning Goals Facilitate Positive Outcomes in Therapy?

Testing Two Therapeutic Instruments in a Humanistic Setting

The third study in this series was an initial test of the therapeutic instruments, in preparation for their use within a broader application of learning theory to counselling in Study Four. An 'intervention' was planned using the questionnaire and card sort exercises which would enable therapists to implement a goal setting exercise with their clients and feedback on the success (or otherwise) of the intervention.

8.1 Methodology

The Critical Realist perspective is explained by $D_r \geq D_a \geq D_e$, where D is the domain and r, a, and e are real, actual and empirical respectively (Collier, 1994, p.45). Stages 3 (and 4) of this project seek to test the generative mechanisms considered to underlie specific learning processes in therapy, or what causes $D_r = D_a = D_e$, and this is achieved here in a closed system, through an experiment. Although a closed system can never be fully achieved in this context, Archer and colleagues (2013) suggest that 'transfactual realism' (relating to laws that hold outside of closed systems) should be demonstrated and that experimentation provides a practical, diagnostic, and exploratory process to that end. In essence, in this qualitative experiment (defined by Kleining, 1986), a distinction is made between the event and what causes it. Firstly, conditions necessary for the observable event are created i.e. facilitated goal setting, and secondly, results caused by underlying laws and

mechanisms which are unobservable, (e.g. meanings associated with facilitation processes), are defined.

The theory generation of studies 1 and 2 leads to hypothesis testing here in the form of a quasi-experimental design (Field & Hole, 2003); the hypothesis offered was that goal setting using the prescribed intervention would lead to a successful learning outcome or process of some sort. It is 'quasi' in the sense that it is not possible to isolate cause and effect as conclusively as in a true experimental design. The power of Critical Realism is in its explanatory benefits and not in its power of prediction, which is often the raison d'être for experimentation. Thus the rigours of experimental design are not necessary and the notion of an 'Interpretive Experiment' is more appropriate. Moses and Knutsen (2012) suggest that in this process, "contextual familiarity is allowed to prevail over rigorous application of method" (p.295). In this sense, it is an experimental 'attitude' which prevails. Further explained as 'qualitative experiments', Kleining and Witt (2001) suggest that they are highly significant to psychological research. The standards for evaluating this type of intervention are not empirical veracity; therefore a smaller sample, deriving qualitative data is sufficient. In summary, a qualitative experiment was designed to enable a small group of therapists to test the use of the goal-setting instruments with their own clients. Feedback would then be obtained on how they got on with the process.

The purpose of this stage in the study was to gather data on the following issues:

- Whether humanistic therapists and their clients would be able to gain any benefit from a learning perspective whilst using a goal setting instrument with their clients.
- Whether the instruments facilitated the process of goal setting.
- Whether the items in the 'fully-functioning' learning framework were accessible/appropriate.
- How the process of goal setting worked: Was it joint/collaborative or was the client self-managing?
- How the exercise was best administered, particularly the choice between the (TLF-B) card sort exercise, and the more advanced (TLF-A) questionnaire version.

The sampling strategy used here was in part random, in that a broad range of humanist practitioners with a person-centred foundation were individually invited to participate. Recruits were also engaged on a 'convenience' sampling basis, since the opportunity presented itself to present the materials at a therapist's conference on one specific occasion. The clients that were then recruited via these therapists would therefore be defined by a 'snowball' sampling strategy (Teddlie and Yu, 2007) in that the researcher relied on the therapists to engage them in the study.

8.2 Method

8.2.1. Participants.

In total, 9 therapists agreed to take part, although some expressed reservations about being able to recruit 6 clients due to lack of through-put, holidays, sickness, and so on. (A tenth therapist also provided some feedback although he didn't engage any clients.) Subsequently, 23 clients were included in the study through these therapists, including 1 client who was due to go into therapy and gave feedback directly on her use of the questionnaire. The profile for participants was similar to Study 2 – a semi-random sample of therapists from the BACP website:

Age range	40-65
Sex	5 female, 5 male
Ethnicity	9 white British 1 black British

Therapist	No. of clients
RH	3
MS	9
RS	1
JG	2
SB	1
AP	3
TE	1
CC	1
AF	2
(PL	0)

Identifying data for the clients was retained by either the client or their therapist to maintain confidentiality.

8.2.2 Recruitment.

The participants who had been involved in the Delphi study were approached first in the anticipation that they would continue to be involved. In the event, only 2 participants from this group continued, which was understandable given the time that they had already committed. The researcher then contacted 34 person-centred practitioners (who also described themselves as 'integrative' therapists), advertising on the BACP website, by email. Care was taken to contact only those who had left the 'no canvassing option' unchecked. A group of 12 counsellors working together in a local counselling practice known to the researcher were also approached, this time in person. Once interest was expressed by 10 participants, a follow-up phone call was made to explain the basics of the intervention before materials were sent out. The therapists then recruited their own clients during the course of their usual therapy, or as they started a course of treatment.

8.2.3 Materials.

Initially, the Information Sheet and Consent Forms were either sent by email or explained in person, (see App VI). After the documents had been read by the therapists and agreement to proceed had been obtained, a pack of materials was sent or given to each therapist participant. The pack included 1 pack of cards with 6 Learning Plans, 1 or more questionnaires, 1 therapist Briefing Sheet and Client Information Sheets (plus Consent Form). More copies of the questionnaire were sent to therapists requesting them.

The following questions were included in either the follow-up questionnaire or the telephone interview process, and a summary was sent to the therapists by way of a briefing, in advance:

1. How many of your clients were involved in the process? How many sessions did each client have?
2. How helpful did you find the questionnaire/cards to the therapeutic process? How likely would you be to use the questionnaire/cards with further clients?
3. Were there any significant improvements in your clients' goals?
4. At what stage in your client's therapy did you use the exercises? When do you consider it to be most usefully applied, if at all?
5. Generally, was the idea of *goal setting* helpful to the therapeutic process? Did it fit with your particular style of therapy?
6. Did the questionnaire or the card sort exercise help the goal setting or therapeutic process? If so, how?
7. How did you or your clients decide which exercise to choose – the cards or the questionnaire? Did you choose to present all or just some of the items to the client?
8. Did your clients understand the exercise? Were the instructions clear? Did you have to explain the process?
9. How did the process of goal setting work? Was it joint/collaborative or did the clients work on it unaided?

10. Were the *items* on the cards/in the questionnaire useful/appropriate? Did they make sense to you and your clients? How could they be improved?

11. Why did your clients choose *not* to participate, or alternatively, how did you change the way the materials were used?

All materials are outlined at the following location: Supporting Data\Chapter 8 Intervention\Material Sent Out\Therapists Feedback Form.

8.2.4 Procedure.

In the initial briefing given to the therapists either by phone or in person, they were informed that the instruments could be used at any time in the counselling process and at any time in a session, although it was envisaged that the start of therapy might be appropriate. Also, it was suggested that their clients would have around 6 sessions before re-rating themselves on the Learning Plans. Although there was a clear structure and process documented in the Briefing Sheet itself, it was anticipated that the therapists would find their own way of using the materials and report back on successful implementation strategies that emerged over time.

The therapists were then requested to obtain consent from their own clients. After some initial concerns about paperwork, it was decided that this would be sought largely on a verbal basis, since confidentiality was important in the process of therapy, and the formal process was proving to be off-putting for clients. Finally, it was suggested that informal feedback would be sought from the clients before the therapists gave their feedback at the end of the study.

A questionnaire was sent to each therapist after around 3 months (App. VIII), asking for their feedback on the process of engagement with their client. Not all participants were able to find the time to complete the questionnaire, but were happy to engage in a telephone interview, in which case responses were transcribed. The interviews lasted for around 15 minutes, and proved to be helpful in that a broader range of topics could be covered than was possible in the questionnaire. Further, the interviews gave clarity (and a sense of urgency or efficiency) to the data collection process, whilst enabling the researcher to delve into important issues such as why the therapists didn't feel comfortable with the materials, which had not been anticipated through a question in the questionnaire. (All responses are included in the data analysis file: Supporting Data\Chapter 8 Intervention\Analysis.xls.)

8.2.5 Data Analysis.

The analytical strategy initially followed the guidelines for Thematic Analysis (Braun & Clarke, 2006), with the coding procedure progressing as for the interviews in Study 1. Although it is recommended that no theoretical framework is brought to the data analysis, the researcher's innate theoretical framework naturally provided a foundation. Initially, an analysis of what was 'actually' said was conducted, and then further analysis using a combination of both retroductive and abductive reasoning, ensuring that a purely semantic approach did not dominate and that inferences about causal mechanisms were included. An attempt to understand these structures allowed for more subtle issues to emerge. For example, one participant commented; "I'm person-centred", but then mentioned using 'psychodynamic stuff', being 'Gestalty', using '12 steps stuff', some CBT, "I might ask them to keep a diary", and so on, (TE:20). So, although seemingly contradictory, this therapist

seemed to want to demonstrate his eclecticism and interest in other approaches whilst explaining his commitment to being client-led. Analysis at this level therefore led to new insights. Further, the abductive element of the process sought to highlight data which did not match with the researcher's innate understanding of the subject and thus provide new insights into the topic of goal setting. For example, the use of the instruments as a vehicle to put feelings into words had not been considered previously.

The detailed analysis of the results is contained in file: Supporting Data\Chapter 8 Intervention\Analysis.xls. Firstly the outline semantic coding is presented, then further analysis derived on a case by case basis looks at the feedback holistically. Finally the limited quantitative data is also included.

8.3 Results and Discussion

The results that emerged from the therapist's testing of the instruments with their own clients were particularly interesting, opening a window on therapist beliefs about their role, their purpose, and the subtleties of relationship dynamics. A significant issue for debate amongst person-centred therapists is the degree to which directivity is appropriate in therapy (Kahn, 2002), and since the facilitation of goal setting would involve a degree of directivity by the therapist, this would present an immediate problem for therapists in this exercise who were entirely client-led. Any directive 'tool', such as the instruments designed for this study, would likely get a poor reception from any therapist who regarded the client's process as paramount (Merry, 2000; Wilkins, 2002). Whilst this feedback was expected, what was interesting was the effective use that *was* made of the instruments by person-centred

therapists, (but it was generally those who had embraced the notion of directivity). In summary, a whole range of views on the usefulness of the instruments were elicited from participants, which had less to do with person-centredness than had been expected, but more to do with attitudes to therapist directivity.

The first pieces of feedback sought from the participants provided a useful overview of responses. The questions "how helpful did you find the instruments on a 1 to 10 basis?" and on the same scale, "how likely would you be to use them again?" were asked, eliciting the following actual numerical responses:

1 1 3 4 6 7 7 8 9 9

(A score of 1 indicated a negative response and 10 a positive one. The scores are an average of the 2 questions for each participant. Participants generally rated both questions either high or low, so the average gives a good indication of the spread of responses.) A point of interest is that one of the scores of 9 was given by the therapist with 9 clients, representing a good proportion of the 23 total clients.

The evidential lack of consistency in this range of responses was indicative of the range of views participants expressed relating to their general comfort with directive tools, ranging from "I thought it took it away from their flowing" (TE), to "I think it's really effective… I found it really helpful" (CC). Positive comments demonstrated a comfort with the design of the instruments and with their purpose, such as the benefit of "having a very broad-based set of ideas to stimulate discussion" (AP) or "the items were extremely useful and were useful in different

ways for different clients" (RH). Certain clients seemed to benefit particularly, such as "one client (who) found it really helpful, she's CBT focused so it came naturally" (JG). Some comments suggested that they would be better used only in certain circumstances, for example: "I actually think I could envisage them being more useful where the client is perhaps complaining of a lack of direction" (AP), or if they could complete the process out of the session, that would be helpful (AF). Alternatively, some objected in principle: "I think the whole process is too cumbersome and too much like an alternative to the therapist using the skill of working with the client to identify areas to work on" (PL). In summary, a whole range of views on the instruments were expressed, illustrated neatly in the range of scores presented above.

Although a range of responses to the instruments was expected to a degree, what was *un*expected was the lack of correlation with 'person-centredness'. The most positive responses emerged from therapists who described themselves as 85% and 80% person-centred, whilst the most negative reception came from a therapist who described himself as 60-75% person-centred. Supported by an analysis of the interview dialogues from a 'mechanisms and structures' perspective, what seemed to be the influencing factor on preference for the instruments was a comfort with directivity, rather than not being person-centred. Wachtel (2007), Bohart (2012), and Takens and Lietaer (2004) all support a directive methodology in person-centred therapy, and consistent with these views, any assumption that person-centredness equalled non-directivity was a misunderstanding of the way in which this group of therapists operated in practice.

Those more comfortable with the process said for example, “I try and give people hope which is like a goal in some ways” (CC), and “I’ll pull anything basically, you know various bits and pieces of methodology” (AF). Participants less comfortable with the instruments said for example, “it gave me, if I’m honest, a restricted focus, because then it started leading me to counselling by objectives” (TE) and “I also noticed my discomfort (which surprised me actually), as I moved into a more directive way of working” (AP). Clearly whether the instruments were readily accepted by the therapists’ clients (or not), could be a function of *either* the client’s unique response, *or* the client’s response in the context of the therapeutic encounter. The conclusion that the *attitude* towards directivity was possibly the driver came from specific comments made by the therapists. For example, one therapist commented “I think that not doing it with them or pushing them was me chickening out” (PL) and “I'm the weak point in the process, it could be my lack of structure, that was the barrier here” (AF). It seemed therefore, that the therapists may have affected the client’s views of the instruments based on their own level of comfort with them.

Although it was likely that clients’ views were affected by therapist perceptions, there was a varied client response to the instruments, some seemingly gaining a lot from the experience, others being unwilling to engage at all. Comments such as: “she just really went with it” (CC); “it suited their way of thinking and working” (JG); and “most clients new and old seemed to welcome an opportunity to re-focus” (MS), demonstrated value gained by some. Other comments demonstrated contradictory results such as: “neither of them took to it… I think probably because

I found it cumbersome" (AF) and "when I asked the people who I gave them to, none of them had even tried to" (PL).

As Bandura notes, a significant mechanism of motivation and self-directedness is goal-setting (1999, p.28) and it seemed that clients readily engaged in that process, benefiting from the structure that the instruments brought to their thinking: "The process provided my client greater autonomy and control of areas of their life they wanted to sort" (JG) said one. It helped a client to put her feelings into words (RH) said another. Finally, "it really did focus" (CC), and provided "a framework / structure via which the client could start to think about their goals" (AP) were further comments. The main benefit seemed to be, that clients discovered new areas of focus, as one respondent commented: "it was particularly helpful in that the area she chose to explore was one which neither of us would have anticipated" (RH).

Alternatively, if Rogers' theory of the person - one who moves rationally, exquisitely and subtly towards unconscious goals (Kirschenbaum & Henderson, 1997, p.406) - was the philosophical basis for the therapy for some clients, then this approach was always going to produce cognitive dissonance for their therapist. One therapist said "I felt it would have been inappropriate or even perhaps slightly disrespectful" (AP) to introduce the cards. Another suggested that with one client, "their reaction to the process… was one of mistrust, and the dynamics of our relationship shifted" (JG). Further, the formal nature of the process jarred with one who commented: "Questionnaires frighten the living daylights out of them" (TE). So, forms, goal-setting and directivity emerged as incompatible with an entirely client-led experience and gave some therapists real discomfort.

The more directive therapists were comfortable with the idea of goal setting and therefore discussions with their clients about what they wanted to achieve from therapy came easily. One client "absolutely embraced the process and went running with it, even coming up with additional goals of their own" (JG). Another comment summed up the general picture in terms of client reaction to the instruments: "They all found the idea of participating attractive, and fairly quickly grasped the green - pink - blue framework" (MS). Further, goals adopted had begun to have an impact. One therapist noted that "there have been some results because some of the goals from the first few weeks we've done, she's actually done, already done some of these really specific goals" (CC) and another (JG), documented the positive movements in the ratings given for each of a number of specific goals identified by her client. There seemed therefore, to have been concrete outputs from the process as clients gained a new focus, discovered new avenues of exploration, and engaged in goal directed behaviour (Tolman, 1925).

Sometimes clients just want to feel better, or something different emerges from therapy than was first envisaged, so "how do you put that in a questionnaire?" (TE). This view presented an interesting perspective which was partly anticipated by the introduction of space to add 'changing goals' on the form. It was also noted that sometimes, clients have difficulty in articulating what they want from therapy (McLeod, 2012), and it may be more appropriate that the instruments are used at the end of therapy as a long term planner, or mid-way when a client needs inspiration and is able to operate on a cognitive/rational level.

Most of the therapists who engaged fully in the process of experimenting with the instruments did so on a collaborative basis with their clients, explaining the process and then engaging in a discussion to establish goals (CC; MS; RH; RS). Others just presented the information and allowed the client to use the instruments as they saw fit (AF). Some introduced them very briefly to their clients suggesting they take them home and work through them in more detail (AP). It seemed, however, that the most value was obtained for the clients whose therapist engaged in a prolonged analysis of client goals and application of the resulting information through dialogue.

Mostly the therapists chose which instrument to offer to the client and in one case (RH) the therapist used the cards and then moved onto the questionnaire as the client understood the process better. Most participants engaged in a surprisingly directive process in offering the instruments, but this was understandable given that the therapist had greater knowledge of the instruments initially and was therefore in a better position to match them appropriately to clients.

A number of therapists noted the need for a greater explanation than they had given to their clients (AP; RH), since clients demonstrated some confusion about the process initially. Although the instructions were considered generally clear, it was noted that there were likely points of confusion, (such as the goals being written in a positive way), which needed particular attention.

It was difficult to ascertain whether the clients who did not want to discuss their work on the instruments wanted to keep their thoughts private, or had just not

completed the task. If Vygotsky's 'Zone of Proximal Development' (Vygotskii, et al., 1987) is to be considered relevant, then "there needs to be a discursive stage before settling on a goal" (SB) for the process to be maximised. Further, a complete explanation of how to gain the most from the process would need to be part of that discourse.

Some suggestions were sought as to who the instruments would be best used for, and views ranged from those who are 'calm and focused' (CC), to 'CBT type' clients, or those who "might present with say, a crisis of meaning, midlife crisis, empty nest, recovery following loss or bereavement" (AP), but generally within a more structured or directive approach (AF). No consistent view emerged on this topic, other than suitability for clients who were more goal oriented, or those who would benefit from the encouragement of self-directivity. It would be reasonable to conclude, however, that clients presenting with a specific issue, as mentioned by one participant whose client had been traumatised following a swimming pool accident (AP), may not need to discuss other goals.

The instruments had been introduced to clients at various different points in the process of their therapy which provided some interesting feedback on possibilities that had not been considered prior to the study. 3 therapists introduced their clients to the instruments early in the therapeutic process (RH; JG; RS). Alternatively, clients were introduced mid-way - which for one therapist was after sessions number 112 and 161 (MS). One participant used the questionnaire as a way to end therapy (CC), and to plan a way forward for the client, whilst another said it was "great to refer back to" (RS). Some considered that they shouldn't be used right

at the start of therapy (AF; CC; JG; MS) and another that they should be used when someone is "quite calm and has gone through a lot of talking" (CC). Clearly, a range of possibilities were tested which was helpful, since initially the instructions suggested only using the instruments at the start. Having relaxed this guidance, the therapists considered on the whole that right at the start would probably be the *least* helpful moment to introduce the instruments as relationship building was more important at that point.

Feedback was also sought on the detailed design of the instruments in the anticipation that use in vivo would demonstrate further development needs. Generally, positive comments were made such as: "the instructions are clear" (MS); "really like the colour format – very clear; questions were interesting and pertinent; stand back and the overall picture is informative" (SB); and "the items on the cards/questionnaire are very appropriate" (AP). The layout of the questionnaire was considered helpful in that it allowed clients to see connections between separate elements, since "the whole resulted in more than the sum of the parts" (SB). The items on the instruments were considered to be "remarkably broad based" (AP); helpful in that "I wanted to see if they came up with objectives we hadn't really looked at much – and some did!" (MS); and useful in that they allowed a client to 'normalise' her difficulties and put feelings into words (RH).

On the negative side, some therapists and their clients found the process confusing at first (MS; RH; SB), or longwinded and complex (AF; TE). Further, two therapists commented that their clients were confused about the positive frame in which the outcomes were described, being used to a problem focused perspective

(CC; MS). Another (MS) failed to explain that more than one goal was possible, limiting his client's use of the cards. One client sensibly chose to complete the questionnaire with comments rather than goals, particularly since she had addressed nearly all 71 items individually (SB), and finally, one client ran out of space on the questionnaire since she had gone into great detail specifying her own individualistic goals (CC). In summary, there were some useful points to note in terms of the design, such as enabling clients to just 'comment' rather than setting a goal. It seemed that most problems highlighted, however, were more of a philosophical nature than related to specific design issues.

Finally, some recommendations were made by some therapists to make best use of the instruments. A time-limited setting was suggested by one, where a more specific focus is needed, or even using the cards like 'angel cards' (AP), was suggested. One suggestion which fits well with the learning perspective of this study was to enable the client to use the instruments on a self-managed basis (AF) so that the focusing exercise could be completed at home and the results discussed during therapy.

8.3.1 Quality.

An important aspect of this study was to demonstrate that the research findings were based on a critical investigation of the data (Farquhar, 2012) and, to this end, a separate researcher/therapist was recruited to triangulate the analysis to check for questionable assumptions. The analysis was largely unchallenged at this stage since much of it had been conducted at a semantic level, although comments

such as “I would say I’m person-centred, well I’m eclectic, I’d say I use largely person-centred but I use quite a bit of psychodynamic stuff” needed more analysis. In this case the statement was taken to mean “I'm mostly person-centred, but eclectic”, although no absolute conclusion was possible. It was assumptions such as this which needed validation. The main concern relating to validity of the data was that the participants may have represented an entirely biased sample (Fink, 2003), by only volunteering if they considered the instruments to have merit, skewing the data towards a positive outcome. In practice, a broad range of responses were received, in particular from one participant who would not implement the instruments once he had seen them, due to conflicts with his approach.

Rigour in this study in terms of the comprehensiveness of the data collection (Yardley, 2000) was compromised to a degree by relying on therapists to take on the role of researcher. It had been planned that all participants would follow the experimental structure, particularly in obtaining feedback from their clients after 6 weeks of therapy. In practice, not all therapists were able to follow the prescribed process. For example, one participant retired after introducing the instruments to his clients meaning that feedback from his clients was not possible, although he was able to explain his own perspective. Further, with some therapists, it was not possible to ascertain exactly what feedback had been obtained from which clients, and when it had been obtained. Therefore, what was relied upon instead, was that the therapists had understood the application of the instruments, they had introduced them to a number of their clients and were in a position to feedback their own views on the process, and *may* have also represented their clients’ views.

Thomas suggests that the process of finding principles and theory making "constrains our capacity to examine and to understand the individual, the idiographic" (Thomas, 2011, p.30), and therefore only tentative suggestions are made that the outcomes of this study are generalisable to a larger population. It *may be* that non-directive therapists may generally make good use of the instruments, but what is asserted through this study, is that a small number of therapists *did* find them useful and used them in their own idiosyncratic ways. It is considered that more research on those individual approaches would be necessary to be prescriptive about their use within a wider population.

Yardley (2000) considers transparency and coherence to be a function of the productive value of the narrative. In the sense that the researcher attempts to construct a critical version of reality, it is "the rhetorical power or persuasiveness" of the argument which is in question. This perspective of "clarity and cogency" can only be judged by the reader on the basis that it makes sense to them (p.222). Henwood and Pigeon (1992) also discuss the notion of 'critical' reality, questioning the researcher's representation of the data. Whilst the researcher acknowledges a bias towards positive outcomes based on the investment in developing the instruments, it is suggested that the supporting data file will allow the reader access to that critical reality and the opportunity to validate it. (Detailed analysis of the results is contained in file: Supporting Data\Chapter 8 Intervention\Analysis.xls.)

The same ethical considerations have been applied to this study as to the other studies in terms of obtaining participant consent, maintaining confidentiality, and ensuring, as much as possible, that no harm came to participants. Clearly there was a

potential conflict of interests in asking therapists' existing clients to take part in the exercise, since some may have felt it to be an obligation. Any likelihood that the client might feel obliged, or for the experiment to be inappropriate for the client was a process discussed with, and managed by, therapist and supervisor. In the event, some participants decided not to use the questionnaire with certain clients considering it inappropriate. Further, there was a real possibility that the course of the client's therapy may be detrimentally affected by the experiment. Occasional pieces of feedback suggested that the 'flow' of the therapy was interrupted, in which case, the therapists limited the use of the instruments.

There are also specific ethical issues related to psychological testing which were relevant, based on the British Psychological Society's Code of Practice for Psychological Testing (2010), retrieved from www.bps.org.uk. They suggest that administration of the instrument must be provided by a competent therapist, preferably trained in its application. Appropriate feedback or support should be given, and sensitive data should be handled in confidence and with the appropriate level of security. Whilst all of these issues were addressed even though the instruments were not tests as such, it was considered that going forward, therapists would benefit from better training in order to have implemented the instruments more consistently and effectively.

8.4 Conclusion

It was not surprising that the successful implementation of an instrument which was based on a directive process, in the hands of largely non-directive therapists, was going to generate some concerns. The instruments require a process

which may fit well into the context of a learning approach to therapy, but not necessarily into a standard client-led setting. If the idea of goal-setting using an instrument of this type were to be viable in this setting, much more training, briefing or discussion would be necessary to ensure that it could be used appropriately without disrupting the dynamic of the relationship and the process. What did emerge, was that some person-centred therapists are by nature very comfortable with directivity and are able to integrate such approaches into their existing practise without causing process conflicts. In summary, issues of instrument design were not considered important, but issues relating to the setting in which the instruments were used were. It could be hypothesised therefore, that in the context of a semi-directive approach which aims to facilitate learning, the instruments could be used effectively and congruently.

Chapter Nine: Study 4: Can Person-centred Learning be Facilitated in Counselling?

A Case Study

The fourth study was designed to bring together the initial desk research on learning theory and the results from the first three practical studies in a concluding piece of research: The literature review had already established a broad range of learning theories which may be applicable person-centred therapy, and Study 1 had established that they were not systematically in use in a person-centred setting already. A process for enabling the client to set their own curriculum in the form of personal goals had been enabled through Studies 2 and 3. What was left was the opportunity therefore, to test a selection of these outputs in a clinical setting to address the main question of the thesis – whether person-centred learning facilitation could be integrated into counselling. The most obvious way to put this to the test was in a therapeutic relationship and therefore, through a case study. Further, the researcher was familiar enough with the content of the thesis to make her the most sensible choice for the therapist in this case. So, the aim for the case study was to test the use of a small number of learning theories, based on person-centred principles, with a specific client in therapy. It is worth noting here that there was no intention to engage in Person-centred Therapy with learning processes 'added on', but to trial some 'therapeutic learning processes' which had a person-centred philosophy as a foundation.

9.1 Methodology

Consideration has been given in Chapter Two, Section 2.4 to predicting the type of learning theories which might theoretically merge seamlessly with person-centred therapy in order to produce positive outcomes for the client. Flyvbjerg (2006) suggests that predictive theory cannot exist in social science and that "…to make rule-based knowledge the highest goal of learning is regressive" (p.223). Context-independent theory is not obtainable according to Flyvbjerg, so it is the context-dependent knowledge which can be produced through the study of an individual case that "…is important for the development of a nuanced view of reality" (p.223). Further, Easton (2010) notes that the main benefit to using case studies is the potential to understand an issue comprehensively, in-depth and in a rich, real world context. Processes in addition to outcomes and their underlying associations can be teased out in a real setting, giving access to contextual cues and therefore greater meaning. So, a decision was made to study the real depth, nature and complexity of learning processes and their associated tacit skills through a case study, by describing, exploring and then attempting to explain them. Only some of this was possible whilst studying learning in therapy through desk research alone, and given that Flyvbjerg (2006) concludes by suggesting that case knowledge is fundamental to human learning, it seemed appropriate to use that approach here.

Clearly there are inherent weaknesses in the case study approach, such as a lack of rigour, a lack of objectivity, and a likely bias in the selection of the case leading to an overstatement of outcomes. Further, Bennett (2015) notes "their inappropriateness for judging the relative frequency or representativeness of cases" (p.212). Farquhar (2012) suggests that the issue of rigour at least can be addressed

through a coherent and consistent research design based on a clear philosophical approach and an appropriate research strategy for data collection and analysis. It is therefore these issues that are addressed next.

Case studies are often based simply on observations of a particular phenomenon in a naturalistic setting and Stake, for example, calls for this approach in contrast to a method which seeks to understand complex cases in the light of a preordained theoretical framework (Abma and Stake, 2014). By necessity in this case, the research not only brought a pre-ordained framework to the situation, but manipulated the case process in order to observe the effects of that manipulation on the individual observed. To that extent, it could be regarded as a quasi-experimental case study (Neuman, 2014). Etic issues, in this case those that relate to the learning process, were brought to the study (Abma & Stake, 2014), and observations made largely from the point of view of the observer. In addition, an emic perspective, or that derived from the client's view point, was integrated into the analysis, but given less weighting. Therefore, the case is further conceptualised as contained within a bounded system, here bounded by the theoretical framework, the aims and experience of both client and therapist (Abma & Stake, 2014), and constrained within a specific context. So, the more modern interpretive, constructionist perspective of case study research is less appropriate here than that of Yin which is described as the production of: "(a) an accurate rendition of the facts of the case, (b) some consideration of alternative explanations of these facts, and (c) a conclusion based on the single explanation that appears most congruent with the facts" (Yin, 1981, p61). His emphasis on the production of 'facts' is considered appropriate here in contrast to the analysis and presentation of a constructed view of reality.

Bennett (2015) notes the recent "scientific realist school of thought (which) has emphasized that causal mechanisms, or independent stable factors that link causes to effects under certain conditions, are important to causal explanation" (p.211). He goes on to explain that case study researchers have found benefit in this approach as causal mechanisms are essential to the development of causal theories and causal explanations. Given the Critical Realist underpinning of this study, this case study was therefore well placed to analyse in depth the phenomenon of therapeutic learning and generate theory based on an understanding of real-world, psychological drivers, structures and mechanisms. As a result, learning mechanisms could be derived from an analysis of actual narrative linked to observed outcomes.

Farquhar (2012) notes the limits of utilising pure approaches to reasoning, acknowledging that a combination of approaches is often appropriate. This case study used neither a purely deductive approach - in that an existing, established theory was being tested - nor was it an entirely inductive process whereby a theory was being generated. Instead, as discussed in Chapter Three, a combination of retroductive and abductive reasoning was used. As elements of theory and researcher assumptions were brought to the research, hypotheses were drawn from inferences made about causal mechanisms identified through the analysis. Further, data emerging in addition to that being tested was amalgamated and tentative theories generated. "Building theory from case studies is a research strategy that involves using one or more cases to create theoretical constructs, propositions and/or midrange theory from case-based, empirical evidence" according to Eisenhardt and Graebner (p.25). This is typically based on a variety of data sources, which was not possible here since only one case was used. Ideally therefore, this represents the first

of many cases which, "via recursive cycling among the case data, emerging theory and later extant literature" (Eisenhardt & Graebner, 2007, p.25) would be necessary to develop any robust learning methodology with any potential for generalisation.

According to Siggelkow, a "…valuable use of cases in the context of making a conceptual contribution is to employ them as illustration" (2007, p.21) and it is for this purpose that a decision to summarise the case study was made (see below). As Flyvbjerg (2006) suggests, in the presentation of the case study, the reader is allowed to see the story unfold in its complete and complex diversity, and therefore to make their own interpretations of the data. Rather than summarising a theoretical path, Flyvbjerg prefers to allow the reader to discover their own 'truth'. Therefore it was decided to present (as far as possible given a restricted word count), the client's journey as it unfolded, allowing the reader to judge for themselves what learning processes could have been at work. Although case researchers "tend to be sceptical about erasing phenomenological detail in favour of conceptual closure" (Flyvbjerg, 2006, p.239), it was considered that a degree of 'erasing' would be necessary in order to be able to tease out any learning processes.

A purposive strategy was used in selecting the sample for this case study since, as Patton suggests, the purpose was to understand and illuminate an important case rather than to generalise from a sample to a population (1999). Patton also suggests that a 'highly successful' case can yield more specific results than a 'typical' case, and it was this perspective that the researcher concluded may give it relevance (p.1198). If a client could be found who would be more likely to engage in learning mechanisms and be more able to articulate their own understanding of

them, this may represent an ‘extreme’, or ‘most likely’ case. And further, as Flyvbjerg suggests, “Atypical or extreme cases often reveal more information because they activate more actors and more basic mechanisms in the situation studied” (2006, p.229). The researcher's decision to choose the specific client was therefore based on the premise that a client who was trained in therapy and life coaching, and was acutely aware of and interested in her own processes from an academic and business perspective would potentially yield more data than a ‘typical’ counselling client. It is suggested therefore, that the case may be defined as paradigmatic, or an exemplar of the domain of therapeutic learning, with metaphorical or prototypical value (Flyvbjerg, 2006).

9.2 Method

9.2.1 Participant.

The individual invited to participate in the case study had been for Person-centred Therapy with the researcher 3 years previously and was confirmed not to be in any state of mental health crisis, but engaged in a process of sustained personal development. (Since she had briefly been a client of the researcher’s before, much of the preliminaries whereby client and therapist establish a working relationship had been done. The researcher, however, had no other contact with the client, so the relationship was limited and professional.) The client had previous therapeutic experience in homeopathy and therefore understood what it meant to have a one to one therapeutic relationship. Three years post graduate study on life and business coaching also gave her a good understanding of learning processes related to self-development. The client’s background was considered helpful, although the main reason for the choice of participant was due to a particular ability to be both

internally involved in and externally observing her own personal processes at the same time. Coupled with a good understanding of experiential learning, she was therefore considered ideal in that she could feedback on the success or otherwise of her own learning processes. She is white, British, in her forties and lives in the north of England.

9.2.2 Recruitment.

The client was recruited simply through an email and a telephone conversation in order to explain the aims of the study. She was very keen to participate since, by chance, she regarded herself as being at a cross-roads in her life and was in need of some support.

9.2.3 Materials.

The plan for the therapy before it began consisted of a small selection of learning processes and theories for use by the therapist/researcher which, on the basis of the research outlined in Chapter Two, would most likely produce some benefit for the client. The processes were not shared with the client, but were intended to be:

- A philosophical approach of person-centredness *and* self-directed learning i.e. not ‘teaching’ but ‘facilitated learning’
- Goal setting using the card exercise or the questionnaire
- A focus on the analysis and recap of learning processes
- The explanation of learning models in order to support client progress
- Use of guided enquiry, or directive questioning

- Evaluation of progress: that of client satisfaction, client insight or learning, and (if possible) long term change in the client

At this stage, this seemed to be a sufficient platform from which to initiate the case study, whilst expecting that other learning processes may emerge through the therapy.

9.2.4 Procedure.

Having given her consent to participate (see App. I), some consideration was given to *how much* the client should be briefed on the purpose of the study, since knowing that learning facilitation was intended may well have skewed the responses given in the therapeutic context. Since it was important to capture the client's learning experiences both for research purposes *and* therapeutic purposes, there seemed to be a necessity to explain the philosophy of the approach at the outset. The initial client briefing materials (sent by email), therefore included an explanation of the objectives of the study and the overall therapeutic learning approach (App. IX). A face to face briefing then covered the detailed therapeutic approach and use of the questionnaire and card instruments. 6 x 1 hour therapy sessions were then planned at weekly intervals, with a break of 3 weeks for holidays in the middle. A final review session was also planned in which the client would feedback on her view of the therapy process.

9.2.5 The Case Study Narrative.

The client proceeded to attend 8 x 1 hour sessions with the researcher. Each session was audio taped, transcribed and analysed on an Excel spreadsheet before the next session, allowing for the structure of subsequent sessions to be planned. The

learning processes were implemented where possible; however, it should be noted that whilst the researcher had a good level of background knowledge and some skills which would enable that process to be undertaken, it was in many ways a performance without any rehearsal. Therefore, much of the dialogue would have been different if the researcher had more experience in applying the processes.

Briefing

A pre-briefing exercise was undertaken with the case study client (who is referred to by a pseudonym 'Jane'), to explain the idea of 'learning and therapy' and to introduce her to the idea of the card sort exercise and the questionnaire. Although no therapy was intended for this session, the client summarised that she had a need to establish a way forward at a critical stage in her life, particularly relating to starting up a business on her own. To do this she needed to address issues of insecurity and emotional stability. Jane chose to take the questionnaire home to address it in detail before our first session. She arrived seemingly with a sense of anticipation for her first session a week later, completed questionnaire in hand.

Session 1

The first session began by discussing the goals which had emerged from Jane's consideration of the questionnaire. She had focused on the last section of the questionnaire and seemed content that addressing some higher level objectives holistically would 'fix' some of the more specific underlying issues she had. Her primary goal was best summed up as "standing in my truth, uncompromising of 'this is who I am'" (C14a). What Jane wanted most was a sense of security, which was driven largely because she was just in the process of deciding whether to give up her

job and set up her own business. Being a single mum, understandably, this was presenting her with some significant feelings of insecurity. Having identified this primary goal, supporting objectives were discussed, which centred largely on Jane's ability to remain emotionally stable in challenging situations, namely when others questioned her views or needs (C16).

The researcher's view of the learning process is that establishing exactly what is to be learned is a large part of the problem, since a great deal of effort can be spent on reaching goals which are not actually wanted. As such, nearly the whole of the first 2 sessions and some of session 3 were spent drilling down and down into what the client really wanted. Although the overall goal remained the same, the way in which that goal would be achieved changed many times and insights were gained in the process. A mind map was drawn collaboratively, which at this stage included words such as consistency, self-soothing, understanding process, responsibility, productivity, finances and 'heart' (C28). This diagram summed up the link between the client's need for security, the decision about her potential business launch and an emotional element labelled as 'heart' which permeated everything. Committing goals to paper also forced some clarity and ensured that client and therapist were both working off the same page. On the surface, these issues did not amount to a mental health crisis in any way, but did represent a significant decision point in the client's life.

Matters moved on then to looking at Jane's existing strengths, which had the potential to help her to move forward. Jane felt that her love for, and connection with, other people was a key strength, in addition to the depth of hurt she had felt

and coped with over the years (C34). This motivational process was designed to support and develop Jane's sense of self and to feed into the development of self-efficacy. It was interesting that during this reflection, the client explained her deep desire to be a nun, to reject the world and its responsibilities, and just live a spiritual life. It was a deep need which proved to be significant as the sessions progressed. This spiritual revelation led then into a useful discussion about how Jane would be in her newly envisioned future (C52). As well as feeding goal setting, this also engaged goal-directed behaviour (Bandura, 1999); the more real a goal looks, by describing it in detail, the more the psyche is engaged in achieving it. By the end of this segment, the client had a good description of her future self and her business, albeit more ideal than practical.

The session then moved on to looking at the blocks she was experiencing to progress. It seemed that trying to meet others' expectations was becoming exhausting, and more importantly, affecting the client's belief in herself (C61). Still, with the intention of drilling down to underlying issues, some directive questioning seemed appropriate, based on specific theories such as self-efficacy and assertiveness. It seemed that the issue was not the client's ability to assert herself, nor a lack of belief in herself, but a frustration that people around her did not connect with her way of viewing the world (C81/83).

Having reached the end of the first session, it was then explained to the client that the main therapeutic work would occur outside of therapy as she reflected on and implemented learning and insights. She was encouraged to recap the main learning points and commit to implementing some ideas and moving forward before

the next session. In this case, the client decided to practise staying emotionally centred rather than allowing her 'spectrum' of emotions to run away with her when others challenged her view (C91).

Session 2

So, with more of a focus on learning mechanisms, each subsequent session started with a recap of what the client had implemented between sessions, what had been learned from it, what needed addressing as a result, and what impact there was on long term goals, if any. Jane seemed to have consolidated her goals in her own mind and had put herself into some stressful situations in which she could practise not 'wobbling', with the specific intent to learn what she needed to feel safe (C6). At this point it seemed appropriate to introduce Jane to the idea of identifying her own 'learning gap': the difference between where she was coming from and where she wanted to get to (T11), which would provide further focus for facilitated learning. As the discussion moved on to committing this information to paper again, Jane commented "The thing I want to bring into the world is my business and that is the main thing. And that makes me go 'I could sit here and burst into tears'" (C26), for which insecurity seemed to be the block.

From a Skilled Helper (Egan, 2010) perspective, Jane's goals were clear enough to move forward, but here, the learning was in drilling down even further. So defining 'balance, consistency and security' seemed to be a useful topic. Throughout the sessions it is noted in the analysis, those points when the client seemed to have gained some insight which moved her forward, and one instance occurred here. As Jane talked more about what she meant by balance, she decided

that it would be achieved by *observing* her own processes (C44), and further, that security was related to knowing "this is what I'm supposed to do in the world" (C54) which reflected a more spiritual focus. Finally she identified that her 'sense of self' was fundamental, which she described as "no, this is me, I'm not budging" (C60).

Another important area to discuss in the context of learning is *motivation* to achieve (Miller & Rollnick, 2013), and it was that topic that was addressed next. Jane felt that "I'm dying every day the more I don't do this" (C68), as she considered her business decision. She also explained that her motivation to address her issues of insecurity, inconsistency and so on, were all tied in together with this business idea. At this point she put a figure of 70% on her commitment to move forward (C76). This summative reflection then led to a discussion on the underlying nature of Jane's motivation. What was really driving her was the need to be authentic, to establish a working life that allowed her to truly be herself, although that entailed a significant lack of security which she wanted to control. Jane had taken steps to secure funding to bolster that sense of security, but none had been forthcoming at that point, (C80). Further she had been offered promotion at work which she would have to turn down if she were to go it alone (C90). Lastly, in the discussion on motivation Jane also explained that it was "having that faith, that 'it will happen' (C94). She started to bring in her belief that a higher power would in fact drive the outcome if only she had the courage to trust in that. "I just need to believe that and see that and know that. And I think the more I believe it, the evidence will appear" (C96) she said. Although a passing comment there, she came back to it in depth later.

The final segment of this session was intended to establish for the client that she was in a self-directed learning process and that progress would be managed by her (T97). As such she was asked how she planned on achieving these goals, who would help her, and what role she wanted her therapist to play in it (T99/103), which would form a 'learning plan'. Finally she was asked if she would like to commit to a plan for moving forward before the next session (T109), which resulted in planning largely practical activities related to setting up her business. At this point the enormity of this process for Jane became clear. It really was a leap of faith into the unknown which she was linking to some degree, to the success of the therapeutic process. At least there was now the beginnings of a focus on fundamental learning processes, which if enabled, may help her to move her business idea forward.

Session 3

Session 3 started as usual with a reflection on any learning points that had been gleaned from work done during the week and Jane described learning to stick to her boundaries with other people, enabling a greater sense of security (C2). Since funding had not been forthcoming, Jane was considering staying at work part time. She wasn't too disappointed, however, because she felt that "…something's happening, something's really shifting with me" (C19), and she considered this 'holding time' to be for that purpose.

At this point, there was the opportunity to introduce the idea of 'self-therapy' to Jane, since if she could understand her own learning processes, then she could enable her own learning away from therapy. So, it was explained that a recap of learning processes from the last 2 sessions may enable Jane to plan learning for

herself (T22). The initial discussion was about the intensive amount of 'drilling down' that had been necessary to get to the real core of the issue, which Jane confirmed had been helpful (C23). The dialogue then moved on to developing a plan which detailed how Jane could re-enable those learning experiences (T28). A plan of this nature proved to be difficult to conceptualise, since Jane acknowledged that she found it hard to break learning down into component parts, but rather experienced the world "in a totality" instead (C35). Part of putting a learning plan together is knowing how you learn best, so at least it was concluded that Jane was a fully experiential learner (T40), and would therefore likely benefit from experiential learning situations rather than for example, conceptualising and theorising.

What Jane's learning plan would actually contain still needed addressing (C43), so the session continued with that purpose in mind. She understood the process of analysing her objectives and had determining her own preferred way of learning, but was unclear on what more detail could be added. What followed was an attempt at suggesting the type of content that may go into a learning plan, although something on paper provided by the therapist would have been helpful here - almost a description of possible perspectives from which to address the problem. The client could then mull them over and see which sparked an interest. In this case it could have been Transactional Analysis, self-efficacy, habitual behaviours, mental schemata, and so on. Professionally, the therapist could use their experience to make the choice as to which to bring to the client's attention, but in self-therapy, the individual's decision would need to be facilitated in some way. As I explained this approach, the client picked up on the idea of 'personal power' (C63), so we decided to include that in the 'learning plan' initially, to see if that brought any insights.

The idea of self-efficacy was explained initially (T66), followed by some directive questions based on Transactional Analysis (T68). The idea of problem based learning was also introduced (T70/73), with a view to demonstrating that discussing real live examples often throws a new light on situations. Consideration of motivational drivers also seemed appropriate to bring into the mix (T75), before moving on to questioning Jane on the basis that she may be denying to awareness some relevant material (T85). Clearly the selection of these perspectives was made by the therapist, although ideally the client could be more involved in that decision-making process. One particular insight that emerged from the discussion around these different perspectives was a link between the way Jane experienced her school life and the impact it was having on her ability to focus and produce business material. "It feels really uncomfortable so maybe I need to change some beliefs about that because on some level that's what stops me" (C86). Being forced to sit at a desk and 'produce' had been traumatic for Jane. She needed to be out in nature, freely expressing her creativity.

Given that regular reflection, recap and planning for implementation is part of the learning process, this is what was facilitated at this point (T89/91), before returning to the topics of TA and Motivational Drivers. Jane realised that she was self-sabotaging her business planning and "…kind of chuckling like that naughty child behind the sofa" (C96), from which came the commitment to "…structure every single day … and to have that focus" (C102). At this point the idea of behavioural modelling was introduced which assumes that learning can be derived from seeing another person behave in a way in which you believe may be

advantageous for yourself. The therapist's own rigorously planned schedule which may have been helpful was explained (T103). Jane went on to consider ways in which she would be able to be focused and productive, but it would need to account for her needs for freedom and creativity (C104).

The theory of Andragogy suggests that facilitated adult learning is a two way process and much was learned by the therapist from Jane. In this segment of the session, being a relatively creative thinker, the researcher felt compelled to offer ideas from time to time. On reflection, most were rejected, such as the one about combining desk work with thinking time out in the countryside (T107). Instead, in the 'summary of learning points and commitment to moving forward' section at the end, Jane expressed a wish to explore for herself how she could practically engage in productive business outputs whilst also meeting her needs for space, creativity and contact with people. The reminder for the therapist, however, was (as Jane had decided to do anyway) to enable the client to find their own solutions rather than suggest some.

Session 4

Jane was very positive at the beginning of session 4. "D'you know" she said, "I don't know why I'm surprised by this, but the more I'm engaging in this process …things like this (clicks fingers) are happening and they're falling from the sky" (C4). The learning points from the week's work seemed to be that Jane had learned how to ground herself in a "practical and detailed way" (C2), partly by completely de-cluttering her house it seemed. She was surprised that progress had been in the detail rather than her sense of 'totality' (C6). On the surface this sounded like good

news, but something was concerning. Jane kept describing it as a struggle, as an uncomfortable process, something that wasn't natural for her, and it seemed that unless the reason *why* it was so difficult was uncovered, it would eventually de-rail further progress. On 4 separate occasions in this session Jane was asked if she would like to consider the issue. Each time she said, 'no, I just need to practice' (e.g.T7). Whether this was a valid perspective or not, it was necessary to wait until the end of therapy to find out, since Jane kept batting the question back. What was important, was to learn that once a client has rejected a view, whether it's valid or not, to let it drop.

So, the conversation moved onto reflecting on the week's activities in order to draw any significant learning points from them (T15). It seemed that Jane's sense of security in part lay in her ability to focus and produce, to control her own "airy fairyness" and just get on with it (C16c). As a result of some success in this regard, her commitment to launch her business increased and she turned down an offer of financial support from her family to demonstrate (to herself as much as anyone) that she had the strength to go it alone. "Something's just kind of flicked in me. I've just gone 'No, enough'" (C18), she said.

The therapist then recommended looking at the learning process that had occurred, with a view to being able to enact it again next time (T19b). In the course of that discussion, which revealed that boredom and frustration led Jane to action, she also explained another insight: that "the learning opportunity is - every aspect of me is there and present" (C20b). By this she meant that she realised that she could make a choice as to which emotional state she wanted to engage at any one time.

Then returning to the issue of frustration, she explained a darker, more destructive side to her personality which frightened her (C22a). So, although her emotional states were there and available, there were ones which were destructive and she wasn't entirely sure she had complete control of them (C22b).

As the questionnaire had been developed initially, the resolution of issues like anxiety and depression had been considered, by not actually addressing them directly, but setting positive life goals and focusing on them instead. In that way, if a client was committed to 'developing a sense of self and responsibility for the world', for example, the problem of being anxious about getting ill may naturally dissipate. De Shazer has already explored this perspective (De Shazer & Dolen, 2012), and some anecdotal evidence appeared during this session with Jane. As she found increasing energy to achieve, she noted "Since my Mum left, I've not been able to run. So, there's a block around that. There's things going on there that I've become aware of. So I'm like "No! I'm going to start running'" (C22c). And indeed she had, if only to help release some energy and deal with a destructive frame of mind. The lack of an ability to run seemed to be a longstanding issue which had resolved itself without direct reference to it.

Whilst discussing *how* the client had learned to increase her productivity, further insights emerged. Firstly Jane began to wonder whether 'destructive' was really the right word (C22d), since in fact it seemed to be quite helpful and further that she was beginning to integrate the creative and driven elements of herself (C28b/30). Finally Jane concluded that "I need to learn the balance… I know my process, but I need to learn how to access it consciously. That's it 'consciously'. To

say I consciously choose to move here…" (C40). As the discussion moved on to *how* Jane would do that, the complex interplay between chaos, frustration, boredom, drive, the need for control and minimalism, and the need to create was recognised. In summary, Jane decided "that destructiveness I initially talked about, I've clearly identified it's a central part of creation" (C48), which was a big step forward from it being a source of nervousness and uncomfortableness for her.

At this point there was a concern that the client would prefer to be working on her business plan rather than spending time in therapy, since she seemed to be achieving so much (T49b). Having put this suggestion to her, she explained a definite need to continue. Some more support in managing her emotional states was requested, which was possible from the researcher's perspective. Jane then summarised what she intended to do between sessions, which was largely around practising balancing her emotional states and continuing with the search for funding for her business (C61).

Session 5

Jane seemed to have been very positive when we last met, so it was a surprise to be met by the comments "…huge, huge wobble" (C1a) at the beginning of session 5. As she reflected on her learning during the week, it transpired that Jane had decided to not only completely declutter her house but declutter her memories as well. A big decision to move forward with her life seemed to have been made here. Knowing that the ghosts of a failed marriage would always haunt her and stifle progress, she was determined to deal with them. To that end she had been through 6 large boxes of memories containing items such as her wedding dress, photographs

and memories from her children's early years. She said "It really floored me. It really floored me" (C1b), although she also described feeling more centred as a result (C1c).

Reflecting on her learning points from this exercise, Jane had realised that she had been relying on others for her security for years and denying her own strength (C3a). Further she had realised that since she always had choices, she could create her own security and she didn't have to rely on other people (C3b). Self-reliance seemed to be a big step forward for Jane who had now clarified in her own mind that her sense of security *could* come from herself. As she said, "In summary, my learning from that was, when I truly know my own security, identify it and come from that place, externally, in my external environment, that will come, because I will make that happen" (C5).

With a view to exploring learning from real experiences, the dialogue moved on then to look at how the process of balancing her emotional states had worked (or indeed not worked) during her 'wobble'. What emerged from this discussion was that Jane recognised the depth of feeling which she had not yet dealt with in relation to her past, saying "I couldn't get it out, I still can't get it out. I still can't get that emotion out, I can't access it" (C9). At this point, a person-centred therapist would have stayed with the client to help her through that deep emotional experiencing. In this case, however, the dialogue was kept firmly on the track of process analysis. The intent was to keep the client in an observational place so that she could learn what was needed for her to self-direct that process when she was ready. Therefore the discussion revolved around questions such as whether it would have helped to re-

experience the trauma (T8), how the client had initiated that kind of process in the past (T16), and even how Jane might hypothetically support a friend in the same position (C27). During this conversation Jane decided that the trigger would be something related to her sense of security (C19), and probably re-immersing herself in elements of the experience might initiate it (C27), although that hadn't been entirely successful so far.

As Jane had mentioned the idea of 'immersion' or re-experiencing the situation, the opportunity presented itself to side-step the process for a moment and introduce an important related topic (T28a). Jane was describing very well how she initiated her own learning at the 'concrete experience' point in Kolb's learning cycle. In fact for her, 'concrete' was actually best defined as holistic and experiential, since this 'total experiencing' seemed to initiate the learning process for her. The intention had been to cover this topic at some point in the therapeutic process and it seemed to fit neatly here. So, knowledge of Kolb was then applied to the situation in which Jane found herself to see if it provided any insights (T36). At this point, Jane began to describe her need for a 'total' experience which included both a physical and spiritual dimension since she realised she had been stuck in merely a reflective mode (C37). Maybe that would enable her to access her emotions.

Keeping Jane firmly in control, she was asked whether she would ordinarily benefit from any support in order to engage that experiential process (T46). She reflected briefly on the help that was available from her family if needed, but then identified a significant event two years previously when a friend had prayed for her (C47a). In order to demonstrate that she was in charge of her process, Jane was then

asked if she would like to work on identifying other support mechanisms, or whether she would like to address the issue in therapy. Intuitively, some prayer was also offered (T48). At this point, Jane began to experience her emotions, and after some introspection, said;

> *I'm not quite sure what that emotion is when you said that at the end, because that's where I connect, where I feel safe. So when I come down into the physical of being married, feeling secure, having a home, I go "That's given me no security". Source gives me security* (C49a).

Jane confirmed that she did actually want some prayer, and as that unfolded, her tears really flowed. What was important here, was less that client and therapist had engaged at emotional depth and realised a need in the client, but more that it had been uncovered for the client *how* to do it in the future without a therapist necessarily being involved.

In processing this experience Jane was able to identify her need for connection, not only to her source, but to people as well (C52) concluding "Maybe I just need to journal and chat with Him more and just be like "OK", and be really honest" (C58). Jane also reflected that she had a tendency to intellectualise her processes even in prayer, and lose some of the depth of engagement. Jane had a tendency to absorb herself in analysis *about* what was happening rather than knuckling down and getting on with it, particularly when it came to business planning, and apparently this was also the case in prayer. When asked if she would appreciate feedback, the answer was 'yes', so concurrence with her view about a tendency to over-intellectualise, possibly at the expense of progress, was expressed by the therapist (T59).

The session ended by recapping learning points and committing to some work going forward. Jane decided to apply the notion of 'just do it' rather than 'analyse it' to her everyday activities and to consider further a feeling of struggling with being consigned to manage day to day responsibilities when she much preferred a state of spirituality (or practically being a nun) (C64a/b).

Session 6

Clearly Jane had left session 5 with a belief in the idea of 'connection' and that this was one of the keys to her security. As such, she had decided that her partner Andy (not his real name) should be able to connect with her in a way that enabled that sense of security. Unfortunately she was deeply disappointed since he had clearly not delivered. She therefore arrived asking for 'tools' to enable that connection to be enabled. The learning gap seemed to be that 'others' were not able to see her point of view and therefore questioned her opinions or decisions, thereby setting up a sense of insecurity in herself (C5) – something that needed fixing according to Jane.

A 'Thinking-Feeling-Acting' perspective (Mueller, Dupuy, & Hutchins, 1994) was taken to try to establish what was going on in a typical scenario for her, as emotions cognitions and behaviours all inter-connected (T6). There seemed to be a complex dynamic of Jane needing to feel emotional acceptance, assuming her partner didn't care, telling him how he should communicate with her and generally feeling totally frustrated when he didn't engage. We explored the idea of Jane taking responsibility for her own reactions from a Rational Emotive Behaviour Therapy (REBT) perspective (Ellis, 2013) (C15), a section which was nevertheless concluded

by Jane returning to her original point and commenting that she needed: "The acknowledgement of me saying 'This is who I am, this is what I need. Can we have that conversation? This is how I feel.' When I say that to a man, it's like I'm talking a different language" (C217).

At this point, some directive questioning to address the notion of whether Jane's expectations were realistic seemed potentially helpful (T18). And further, the question of what benefit there was in relying on a specific type of connection with a specific person as a basis for a sense of personal security seemed apt. Meanwhile, Jane continued to question why her girlfriends could understand her perfectly but her partner couldn't. Maybe it's just 'my choice in men' she pondered (C19). So, on the basis of a belief that Jane was being 'overly optimistic' about her partner's capabilities, through a series of directive questions her assumptions about the relationship were uncovered, resulting in this statement; "Do you know, it's really interesting as you said 'expectation', I chuckled inside and I thought 'I've not thought of that'" (C23). As a result, Jane confirmed in her own mind that she definitely had expectations, and that there *must* be a way in which he could meet them - which was not entirely the intended outcome.

Jane went on to define her needs of her significant other, including that it was important that he had an interest in personal development and spirituality (C25a). In the search for some kind of 'tool' which may enable Jane to express her needs in a way in which they might be more likely to be met, we covered some principles of assertiveness (T28), interpersonal skills such as understanding his perspective through questioning (T34), and finally turning to Games People Play for inspiration

(Berne, 2011): "It sounds a little bit to me, like you're going into an 'Adapted Child' position and pushing him into a 'Critical Parent' one", was offered (T36). Much of this session was spent in the presentation of different perspectives from which Jane could view her situation, or take techniques away to implement. At times it seemed that the discussion was caught in the trap of coming up with ideas, only to be told why they wouldn't work. Without that process of challenge and elimination, the researcher is not sure that any conclusion would have been reached at the end of the session. It seemed a frustrating journey, but in the end this is what Jane concluded:

> *What I've brought to you is fundamentally security and in this session I have clearly identified it's because I've not felt secure in my Child place. And I need to look at that and work on that… When I'm in my Adult, I can soothe my own Child. I can do that for myself. Um, but there are some big security issues… and I didn't realise they were coming from my child… the Child insecurity is actually underpinning my Adult insecurity (C68).*

There were clearly some significant insights here, and Jane needed to think through the implications for managing her new life. As she left, it was unclear what decisions she would reach and the direction of her future. An email arrived later that day. Amongst other things it said "Gosh what a day. Amazing light bulb moment this morning. … Also my funding came through. ...God blessed be. Jane".

Review

A separate review session was planned with Jane, since recapping and forward planning are an important part of the learning process. The intent was to allow Jane time to reflect fully on her learning from the sessions with a view to embedding key points in her long term memory. Further, it would give her the opportunity to initiate a new learning plan which would continue her development

after the therapy had finished. Finally, there was a need to evaluate the process from a therapeutic perspective. A review session could be included for any client going through this process, and not just for Jane in the context of this research. (Questions for this review session and the following feedback session are in Appendix X.)

As Jane reflected on her learning from the process, she explained that it had been around her sense of self, her processes and her boundaries (C2/C4), but "it is my security and how to feel safe in the world" (C6). When asked whether she now *felt* safe, or had learned some *methods by which to help her feel* safe on an ongoing basis, she replied "the latter" (C8). There was an important distinction here between solving a problem and learning *how* to solve a problem. Jane explained that she understood more about her issues, and that she needed to work on implementing long term change (C10), which reflected the intention to equip Jane with the tools to move forward and then allow that to happen out of therapy. On reflection, it would have been preferable to have covered Jane's learning points in more detail, but because she had not remembered to bring her questionnaire to the session, that proved difficult.

As the discussion moved on to talking about a learning plan for the future, it was interesting to hear Jane reflecting on her own learning processes and expressing a desire to understand how to apply that knowledge further (C12/28). Then Jane went on to describe "…at the end of our sessions, a huge, huge realisation" (which was around her sense of security) and that she needed to address "…how am I now going to implement that in the world?" (C14). In fact Jane described that she had already done some work on what had happened, why she felt the way she did, and

what support she needed to progress things (C16). One thing she was certain of was that she needed more therapeutic support to address the very specific issue of the difficulty she had with addressing practical matters (C18) and that it would be "something very similar to what we have done" (C24). The acceptance of difficulty with practical matters was particularly interesting because it was the issue which recurred in session 4, but Jane had consistently avoided addressing it. There was a block to addressing the block it seemed. Jane expressed a feeling that she had "…emptied the table, and gone 'OK, I'm now going to build it' (C20), by "moving forward in a totality" (C24), which was a perfect point from which to launch her own self-development.

At this point, Jane was offered a list of the therapeutic processes that she had been guided through to see whether having it clearly identified would assist her in learning planning for herself. For example:

- Identify your main goal and your underlying objectives. Use the questionnaire/cards?
- Keep questioning, what, how, when, etc. until you have uncovered the fundamental issue.
- Consider your motivation to achieve.
- Look at your existing strengths. How can they be made into opportunities?
- What are your blockages to success?
- Consider your own personal way of learning.

(The complete list is in App. XI.)

Although she thought it might be helpful, it would need to be in a different format for her, such as a flow chart (C30). This was another interesting comment, since some thought had already been put into how to present the process in the form of 'programmed learning' including diagrams, graphics, decision trees, etc.

Moving on to an evaluation of the process, Jane was asked to rate the success of the process for her on an increasing scale of 1 to 10, to which she replied "8" (C36). She commented that there had been movement in the scores on her questionnaire, which had been both up and down throughout the process, explaining that movement in any direction was progress in her view (C38). We then moved on to discuss whether the process had been the right *style* of therapy for her. An interesting debate followed in which Jane explained that she felt that the block which stopped her from focusing in on practical activities stopped her from making the best of the process (C46). That perspective makes sense if the process is viewed as a Solution-Focused approach (De Shazer 2012), where practical outcomes are a measure of success. The fact, however, that Jane had learned what she needed to learn in order to make progress was entirely sufficient. The fact that progress would be made at a later date was actually the point.

Finally Jane was asked about real changes that had occurred during therapy and any that she felt would persist long term. Jane felt that there had been movement in her ability to focus on the practical elements of her life (C48), although that still had some way to go (C50). She summarised by saying "I do feel more a sense of self and security in the world and that will improve every single day" (C65), and that "…this is so fundamental to me, this is going to be quite a pivotal point in

my life, most definitely" (C58). This assertion of significant change is something that will be followed up on in around a year's time.

Feedback

Finally Jane was asked to step out of therapeutic mode and consider her journey from a research perspective. She had a range of positive comments to make, some areas of frustration and suggestions for improvement. The areas of frustration from Jane's point of view are considered first.

Jane felt that she was 'a newbie' (C28), when it came to understanding and implementing learning processes, implying a need for greater focus during the sessions on practical application of those theories. She also struggled particularly with having supporting material given to her in lists, on paper. Logical list-making was clearly the way that the researcher processes and presents information, so careful thought needs to be given as to how to present it to someone who comes from the opposite end of the spectrum in the way that they receive and process information. Jane was also concerned about the spiritual element of the process and she commented that leaving out spiritual elements from the questionnaire "is a disservice to somebody's process" (C76), since "when I miss that part of me …it misses a fundamental part of me. I think it's so important" (C48). This issue of spirituality seemed to be a critical issue for Jane, which took time to get to because it was not identified initially. Moving on, Jane put in a request for more directivity in the process, suggesting that a discussion on process half way through the sessions might have been helpful, in which case she would have said "just push me a little bit more" (C74). This was an interesting comment, since it was considered that the

more client-led the process could be, the better; and with a client who wants to develop her sense of self-efficacy, tipping the power balance may not have been helpful to her. Finally, in considering the questionnaire in more detail, Jane gave a score of 7 out of 10 when asked how likely she would be to continue using it (C54/62). Apparently, that score would increase if the questionnaire had been completed in more detail at each session, enabling Jane to refer back to it over time.

Jane had positive comments about the process in which she had engaged and was able to articulate well the reasons for her views. When asked how it compared to other therapies she had knowledge of, she commented that "…it feels very different. So for me, there's dialogue, conversation of every learning part of me and it feels like we identified all of them. And each one's identified, looked at, talked about and then "What are we going to do about it?" Let's move it forward."

We talked in detail about the idea of an overall concept of engaging in an identified learning process and using that as a tool for self-development over time. Jane was clear that it helped her focus in on her issues, to decide on a practical way forward and commit herself to make real changes (C6). She found the process hard to begin with, but considered later, "…it's very much what I was needing, and I didn't realise it at the time" (C8). Further, the discipline of focusing in on learning plans and outcomes "…really helped me to bed that in, to ground that in, to form a new habit of 'this, this is what I'm doing, this is what I've said'" (C66). And Jane considered that this approach or language of learning would be retained by her for future use (C12/14) as she considers new 'learning opportunities' as a matter of course going forward.

Jane was asked whether the whole idea of having goals was helpful and she identified that given her propensity to self-analyse, they were very helpful in 'changing her state' (C68). Further she considered the length of time spent drilling down to establish the root of her issues was well spent since it enabled her to uncover the detail of her fundamental issue (C32). Understandably she considered that should a client present with a clear 'problem', less time would be necessary to establish goals. Jane was also asked whether she would have preferred therapy to focus mainly on the issues she presented with, or whether learning *how* to deal with them was more important to her. Helpfully she suggested a sliding scale whereby the beginnings of therapy would allow the client to experience a degree of 'unburdening', whilst as sessions progressed, the client would begin to feel that the therapy "…gives me the impetus and the empowerment of 'actually, I can do this, I can move my state'" (C16/20).

As previously mentioned, the possibility was there that in focusing on broader life goals in therapy, specific issues may dissipate naturally. Although this perspective was not addressed particularly, Jane noted that the therapy had affected every area of her life 'in totality' (whilst other therapies may have only addressed one issue or level), (C24) and further, that "…when I focus on the forward motion of solution, the problem diminishes" (C22), and "…even if I'm not talking about running, it's going to change everything" (C26). The reader may remember that Jane had been able to run again after being unable to for many years, so a process of incidental change was evidenced here.

Continuing on, Jane was asked how she had considered the role of the therapist, for example, whether as expert, guide, fellow learner and so on. It seemed that the presentation had been as someone who came "from a place of 'I know what I'm doing'", coupled with "you wanting to learn more" (C34), so there seemed to be a sense of expert guidance and co-learner intermingled from Jane's perspective.

Next she was asked about the questionnaire and how helpful it was to the therapeutic process. Jane commented "Initially, I was like 'What! What is this?' By the end I was like 'Oh, it's my best friend'" (C50). On a scale of 1 to 10, "I'd say a ten, I'd say even more", she said, explaining that it became a working document which she referred to every day. She went on to explain that the questionnaire had helped her to focus a fundamental need into practical areas to work on (C30).

Finally Jane was asked whether she considered that her experience may represent a methodology which was worth pursuing as an approach in its own right. She responded "Yes, yes, most definitely, most definitely" (C80). And when asked how she would describe it to a potential client, she said:

> *I would describe it as a talking therapy, with a most definite forward motion of an outcome. And when you have the outcome, you have the skills to say 'I'm going to move this forward' and then you can implement that, so then the problem isn't a problem again. It might bob up again, but you have the tools to go 'Oh, OK, I'm going to go and do this'* (C82).

9.2.6 Data Analysis.

Each therapy session was transcribed and logged into an Excel spreadsheet for analysis. This process was completed as the sessions progressed since the outcome of the analysis provided direction for each of the following sessions. The

analysis was approached from a Critical Realist perspective, analysing the text from the point of view of the empirical, the actual and then underlying mechanisms: Firstly, a total of just under 50,000 words were broken down into 619 segments of related text and then, an assessment of what the client might *actually* be saying produced for each segment. So for example, the statement "I've probably not looked at plan B. I've gone 'I'm not looking at plan B. I'm going for plan A.' The finances will come through and this is where I'm going come hell or high water", was summarised by the researcher as "I don't have a plan B. I'm planning on funding" (session 2, C84). These long statements made by the client necessitated a summary to clarify the flow of the discussion. Summary statements were emailed to the client after each session to be checked for accuracy. The researcher was therefore confident that the interpretation of the events was accurate from the point of view of the client, and that bias had been limited at this stage.

Once the text had been validated by the client, an assessment of what the client was *actually* saying was made. For example, the client commented "So I'm now moving towards 'How does that look?' 'How am I going to bring myself more and more into the world?'" (C44). This was taken to mean "I want to make some significant changes for the future". Next, an assessment of the drivers or *mechanisms* supporting comments was made. In this case, it was considered by the researcher that the client's life stage may be driving her need for change. With a view to ensuring accuracy, the categories of the 'real' and 'underlying mechanisms' were re-analysed and refined at the end of all of the sessions in the light of greater knowledge of the client.

The text was finally collated into 70 segments of discussion topics defined by specific learning processes, largely initiated by the therapist/researcher during therapy. The analysis was approached on the basis of Braun and Clarke's Thematic Analysis (2006), an approach which is particularly suited to the in-depth, Critical Realist perspective needed. A perspective of phronesis, or 'practical wisdom', was also employed on the basis that, as Thomas suggests (2011, p.30), "Teachers are reflective practitioners, developing and using phronesis" or the ability to apply knowledge and experience of a discipline to a new context. Even though the wisdom of knowledge and practice can be brought to the process of analysis, "phronesis thus exists in the person of the researcher and the reader" (Thomas, 2011, p.30), which dictates that the reader will also analyse the text from their own perspective. Further, as Thomas suggests, there is "…a need for provisional, tentative models for interpretation and analysis. These provide for assumptions of variability in the interpretation of exemplary knowledge" (2011, p31). So, Thomas recognises that no interpretation can be definitive, but models are subject to further scrutiny and analysis. The process of detailed analysis which was undertaken in order to categorise each client statement under a different learning process heading is included in data file: Supporting Data\Chapter 9 Case Study\ Case Study Analysis.xlsx. The final process of analysis was also checked for bias by the researcher's supervisors.

9.3 Results

This case study sought to address how to integrate learning processes into a person-centred therapeutic structure. In addition to an understanding of the process, it was also possible that some beneficial outcomes may have accrued. Ideally, in 6

sessions, the client would have explored her issues in enough detail to get to the bottom of them, and set some goals for change. Further it was intended that the client would have developed some ability to manage her own learning and development in relation to those and other identified goals in the future. Finally this ongoing development would be based on the client's own understanding of how she learned, a sense of self efficacy and wanting to continue learning on an ongoing basis.

On reflection, the outcome seemed to have been reasonably successful. The client left having clearly identified issues which needed to be worked on; in her case the inability to stop analysing and actually get something done. She had learned how to plan for learning and change to take place, although she was less confident of her ability to make that work practically. But most of all she had developed a sense of personal power and control over her ongoing development. The idea would be that her development would grow exponentially: If, after each process of change, a client reflects on the learning and plans for new learning based on what new knowledge they have about themselves, change effectively snowballs. So, if that were possible in 6 sessions, the aggregate, and then cumulative therapeutic progress over time could be significant, and all without the ongoing need to pay for therapy.

Through analysis of the transcripts it seemed that 27 generic learning processes had emerged (see Table 3), such as 'establishing existing strengths', and 'engaging goal-directed behaviour', all of which would be appropriate for any client. A further 8 specific theories emerged that were pertinent for this particular client, such as considering 'assertiveness' for example, but would not necessarily be needed

by all clients. Interestingly, although there had been an explicit intention to include certain learning methodologies within the therapeutic encounter from the start, it was in fact in the experience of the therapeutic encounter that they emerged with any kind of clarity and sense of order. The generic learning processes that emerged as codes through the Thematic Analysis were as follows:

Table 3: Generic learning processes

Learning Planning

- Establish Primary Goal; Support Goal Generation with Cards or Questionnaire
- Establish Supporting Objectives
- Ongoing Goal Setting, Clarifying Way Forward
- Establish Existing Strengths
- Identifying the 'Learning Gap'
- Establishing Motivation
- Establish Blocks to Progress
- Understand Own learning Process
- Establish Roles, Establish Self-Directed Learning
- Develop Learning Plan; Produce Contract; Committing Objectives to Paper
- Set Time Frames

Learning Facilitation Techniques

Past

- Enabling Reflection
- Establishing Learning Points; Recapping Learning Points; Enabling the Recap of Learning Points; Recapping Learning from Experience
- Enabling Process Observation
- Clarify the Learning Process (client or therapist); Enabling an Explanation of Learning from Practice

Present

- Enabling Clarity, Summarising
- Quantifying Responses
- Directive Questioning
- Challenging
- Problem-based Learning; Posing Problems
- Support Client's Sense of Self
- Engage Goal Directed Behaviour

Future

- Planning for Learning Transfer; Ensuring Learning is Embedded and will Transfer; Planning to Implement Learning; Enabling Conceptualisation and Experimentation
- Commitment to Move Forward
- Commitment to Active Experimentation

Generic Interventions

- Give Feedback
- Modelling

An intent in the therapeutic process was to not only utilise relevant theories or methodologies, but that the client would understand them and could apply them to other situations. The specific theories used for this client were as follows:

Table 4: Specific Theories

Theory Input
• Assertiveness
• Communication Skills
• Emotional Intelligence
• Learning Styles
• Problems as Opportunities
• Motivational Drivers
• REBT
• Self-Efficacy

Finally, it was considered interesting to note the type of dialogue which was employed by the therapist, particularly in the light of the non-directivity of person-centred therapy. The percentage of different types of questions overall were as follows:

Table 5: Percentage of different types of questions by therapist

Enquiring	
• Directive Questions	**40**
• Clarifying Questions	**22**
• Clarifying Statements	**13**
• Open Questions	**4**
Stating	
• Statements	**20**
• Answers	**1**

9.4 Discussion

9.4.1 Main Principles of Learning which Emerged.

Three key principles emerged from the course of the case study, seemingly providing the foundations to the process as a whole. Firstly, the approaches of 'person-centredness' and self-directed learning were combined, aiming for not teaching but **facilitated learning**. An overriding principle of 'guided enquiry', based on the views of Dewey (1997), was intended to enable the client to gain therapeutic insights and to understand and transfer their learning processes to their own self-therapy (Bohart & Tallman, 1999). Secondly, the therapeutic relationship was intended to be one of **co-enquirers** and co-learners, (Knowles, 1978). There was no expert status for the therapist, the client being as knowledgeable as the therapist. The client brought knowledge of their own needs and processes, the facilitator brought knowledge of learning processes. The exchange of that information through dialogue enabled learning to occur. The facilitator helped to establish the way in

which the client learned, and developed the learning experience or process in line with that understanding, with the very clear intent that the client should leave enabled to re-enact the process for themselves. Finally, it was intended that the possibility for the client to become a long-term **'self-learner'** in relation to therapeutic issues could be explored through the case study. Once learning processes were understood, they could be implemented as a matter of course indefinitely. The client would become an autonomous learner (Knowles, 1978; Betts, 1985), enabled to develop a 'learning self-identity' (Kolb & Kolb, 2009). In summary, the client becomes Rogers' idea of a 'lifelong learner' (Kirschenbaum & Henderson, 1997).

9.4.2 Specific Learning Techniques and Processes.

In the review session, Jane had been introduced to the beginnings of a defined therapeutic learning process in which she had been involved. Ideally, she would then be able to enact it again for herself if issues occurred out of therapy. The learning process is outlined in more detail here:

1. **Set goals**

Goals were established at the start of therapy and revisited throughout. Automatic habits and goal-oriented behaviour were engaged (Aarts and Dijksterhuis, cited in Bargh & Ferguson, 2000, p.933). The ability for the client to programme their own learning was therefore enabled (Skinner, 1954; Cohen, 1962).

2. Establish the learning gap

The client was encouraged to identify their learning 'gap'. That entailed considering prior learning experiences, where they want to be, and what, if any, is the cognitive dissonance (Festinger, 1957). A clear understanding of required change was identified. Existing strengths and blocks to progress were established. Ultimately a learning plan was drawn up which included timescales.

3. Define the client's learning style

The client was encouraged to establish their own way of learning so that they could set up their own learning experiences in the future (Griggs, 1991; Kolb and Kolb, 2000), and integrate that knowledge into the design of their learning plan.

4. Establish their motivation

Motivation for change was established: What was driving the client? Was it typical of Maslow's needs for security for example (1943), or Rogers' idea of self-actualisation (2004) and how was it self-determined (Ryan, et al., 2011)? This was similar to Motivational Interviewing (Miller & Rollnick, 2013), which defined the real need for change. Specific focus on the benefits for change was also made and the process of establishing motivation demonstrated for future use.

5. Use specific learning facilitation techniques

Specific facilitation techniques were used where appropriate; for example, giving feedback (Egan 2014), using behaviour modelling techniques (Bargh and Fergusson, 2000), problem-based learning (Schmidt, Rotgans, & Yew, 2011) and reinforcing or shaping behaviours (Skinner, 1974).

6. Employ predominantly directive questioning

The dialogue was based mostly on questioning which was intended to guide the client to a point of insight; i.e. questions which aimed at the establishment of direction or goals, the analysis of processes, and crystallisation of key information or learning points. This synthesis of the methods of Socrates (Kazantzis, et al., 2014) and Dewey (1997) provided for a valuable dialogue, but one which could be simplified for use by a non-therapist to help the client when they are out of therapy. In the event, the dominant style of questioning in the case study was clearly directive (79% of therapist inputs were of a questioning nature), with typical person-centred reflective statements making up only 20% of the total output. Challenging questions or statements also played a part but require skill to implement without generating defensiveness.

7. Learning outcome and process analysis

Key learning points were regularly recapped for reinforcement and to aid learning transfer. There was a recap of the previous session at the beginning; of the current session at the end; and of the whole process at the end of therapy. Regularly recapping enables learning to be embedded in the long term memory (LeDoux, 1998).

Regular reflection on learning outcomes, but more particularly on learning processes, was enabled. For example, questions such as “How did you make that work for you?” or “Would that approach work in other situations?” and so on, were used. Process observation was facilitated with a view to establishing learning processes and their application in the longer term.

8. Meta-frameworks

Enabling the client to reflect on their own thought processes can be facilitated using a variety of existing therapeutic models and learning frameworks (see Flavell's ideas on Meta-cognition (1979), or Wells' Mindfulness and Metacognitive Therapy (2002)). It is important to note here that the intention was not necessarily to use the methodologies as ends in themselves, but to enable the client to understand and use them in the future. A selection of these theories has already been presented in Chapter Two and some of them proved to be helpful for the case study client. A range of learning theories, although not described explicitly to the client, were considered during the planning of each session:

a. Cognitive analysis

Cognitive processes such as accommodation, assimilation and development of schemata were touched on (Piaget, et al., 1977; Stiles, et al., 1990). The 'integration of selves' (Rogers, 2004), the seeking of Gestalts (Perls, 1992), reframing of 'realities' and use of scripts, (Schank and Ableson, 1977) were also considered. Symbolisation, use of metaphor for understanding and integration of therapies such as psychoanalysis (Freud, 1991) and TA (Berne, 2011) were alluded to. Constructivism (Pascual-Leone & Greenberg, 2001; Polkinghorne, 2010) was used as a structure to enable reflection on learning.

b. Emotional experiencing

Relational depth (Mearns, et al., 2013), emotional experiencing, and understanding through and about emotions were aimed for (Goleman, 2006).

Symbolisation and representation of emotions were also encouraged (Rustin 2003). Person-centred principles were applied to enable emotional engagement and the process of 'becoming' (Rogers, 2004). Knowledge of affective neuroscience supported this process (LeDoux, 1998). An empathic relationship reinforced behaviours and supported growth (Skinner, 1974).

c. Behavioural elements

The development of self-management was encouraged. Behavioural conditioning (Skinner, 1974), roleplay, or skills development was briefly appropriate. Mirroring (Bandler, Grindler, & Andreas, 1982), social learning (Grusec, 1992), and the Zone of Proximal Development (Vygotskii, et al., 1987) were considered. An understanding of the interplay of emotions, behaviours and cognitions was encouraged (LeDoux, 1998) through the principles of Cognitive Based Therapy.

d. Self-efficacy

An understanding of constructivism (Piaget, et al., 1977), personal power, locus of control (Rogers, 2004), and self-efficacy (Bandura, 1999), was useful to support the client's sense of self and their ability to take on responsibility for their own long term development. An understanding of 'What is reality to the client?' was encouraged.

9. Plan for Ongoing learning

The client was encouraged to use current matters as a vehicle to learn how to manage issues in the future. Techniques such as problem-based learning (Bowles,

2012), experiential learning (Kolb & Kolb, 2000), research and experimentation, and so on were facilitated and the processes highlighted. An understanding of the client's own learning processes was regularly reviewed. Support mechanisms were discussed (of which the therapist was one) to enable the client to manage their own longer term needs.

A plan for 'learning transfer' (Marton in Salo, 1993) through 'generalisation' (Olson & Hergenhahn, 2009), and critical reflection (Rogers & Horrocks, 2010) was discussed, and commitment to move forward made at the end of each session and in a review session at the end of therapy.

But surely this is just Solution-focused Therapy?

This initial case study was only able to test a small number of learning concepts and much of the foundation of the process reflected elements of Solution-focused Therapy. A fundamental difference in the approaches was evident, however, since finding solutions was not the main focus of the therapy. Rather understanding the client's own learning processes was the main driver, such that the client would be able to manage her own therapy in the future. Supported by a greater sense of self efficacy, the client developed an understanding and ability to engage in her own long term development and growth. By introducing learning models such as learning planning, and experiential learning, the client was intended to engage a strategy for life long therapeutic learning, without the need for a return to therapy. A shift in focus from outcome to process, therefore gives it a different flavour to Solution-focused Therapy and it is assumed that as experience of more cases allows the processes to be tested further, even more of a learning identity can be created.

A point of reference was taken from an experienced Solution-focused counsellor to gain an expert view. She commented:

> *From the perspective of a qualified counsellor and specialist within 'Solution-focused' Therapy it has been interesting to review your work. Whilst there are several commonalities with Solution Focused Therapy, I consider that the predominance of Learning Theory brings a unique perspective of approach. Acknowledging the core 'person-focused' basis, there is a fair integration of several relevant counselling styles, but also practical key learning skills and analysis tools. The in-depth preparation and identification of client pre-knowledge and awareness, plus analysis and acknowledgement of their dominant learning style, leads to a focused approach on goal diagnosis and to instigating lifetime awareness and self-empowerment tools.*

Although the techniques appear similar, the purpose is quite different and thus the techniques and processes are implemented differently; namely to shed a light on the process rather than to enable outcomes.

9.4.3 Quality.

Flyvbjerg (2006) considers that "the proximity to reality, which the case study entails, and the learning process that it generates for the researcher will often constitute a prerequisite for advanced understanding" (p.236). Considered from a different perspective, there is a perception that case studies tend to confirm ideas pre-formulated by the researcher, and in this case a broad framework of tacit assumptions and beliefs about the possibilities of facilitating learning in a therapeutic setting *were* brought by the researcher, (such as a belief in the value of lifelong learning, and a view that the success of therapy probably lies in learning processes). Whether that is considered helpful to the process, or a source of bias depends on your perspective.

In terms of rigour, Yardley (2000) recommends "prolonged contemplative and empathic exploration of the topic with an attempt to transcend superficial understandings" (p.222) and further, Gibbert and Ruigrok (2010) consider that transparency is the key, achieved by "relaying to the reader the concrete research actions taken, so that he or she may appreciate the logic and purpose of these actions in the context of the specific case study at hand" (p.727). The researcher therefore spent considerable time analysing the case study transcripts, checking back with the case study client to understand thoroughly the meanings and processes emerging from the therapy dialogue, and recording the process in the corresponding data file, (Supporting Data\Chapter 9 Case Study\ Case Study Analysis.xlsx). Trustworthiness of data is also relevant in terms of rigour, and the greatest claim for trustworthiness of the data in this case study lies in the fact that the researcher *was* the therapist and therefore was completely immersed in the data.

The case aimed to explore learning processes in a therapeutic setting, and therefore to some degree, explain how learning came about. Thus, the evaluation squarely confronted the issue of internal validity (Yin, 2013b, p.322). Considerations of rival explanations for effects can also address validity issues and increase confidence in the assumptions made, so Solution-focused Counselling was addressed particularly. The most significant efforts to address issues of validity were made through triangulation of the data, although as Yin notes (2013b), no models to explain 'weak' or 'strong' triangulation in case studies exist. Different types such as 'data source', and 'methods' triangulation exist, but the only real possibility here was

'analyst' triangulation, so both of the researcher's supervisors cross-checked the analysis of the case for bias.

In terms of the reliability of the data, Yardley (2000) points out that the subjectivity inherent in analysing qualitative data makes the subject of inter-rater reliability meaningless. Further, Madill and colleagues (2000) note that the issue of reliability of data within a study based on Critical Realism is a misnomer. "Here, the issue is whether the researcher manages to construct a plausible causal argument that is cogent enough to defend the research conclusions" (Gibbert & Ruigrok, 2010, p. 713). On this point, Siggelkow (2007, p.23) notes that "a common weakness of case-based research papers is… presentation of only those details that relate to the conceptual arguments". So care was taken in the analysis to consider all underlying mechanisms which may have been driving the client's comments, rather than just those which appeared to support a learning outcome. And it is suggested that, as Eisenhardt and Graebner suggest (2007), the data has kept the researcher 'honest' (p.25).

Yardley (2000) considers the benefits of an emphasis on research-in-context, particularly for the health profession. Indeed it was a specific intention of the researcher to embed a proportion of this study in clinical practice to ensure a degree of integrity. Yardley comments on the ability to *create* new solutions through this process rather than explain existing problems. The final case study exemplified this approach particularly, since much of the output was created in the process of engagement rather than bringing a complete theory to the scenario for testing.

Addressing the issue of generalisation, Thomas notes “the absurd position that it is inappropriate to argue, gain insight or learn from particular examples, for fear that this might be thought anecdotal and therefore unscientific” (2011, p.24), and Yin suggests that even case studies can be generalizable to theoretical propositions (2013b). Further, Eisenhardt and Graebner’s view (2007) is that the challenge is to develop theory, not to test it; therefore whether it is generalizable is irrelevant. It was considered that the theory that emerged, if not readily generalisable, would provide the basis for further testing, and that more case studies would consolidate or develop the approach. Further, Flyvbjerg (in Denzin and in Lincoln 2011) discusses the danger of developing a narrative which simplifies data through over-interpretation. He warns against summarising and generalising rich data, recommending to keep it 'open' by telling the story in all its complex diversity and avoiding linking to specialised theories, but rather to broader philosophical positions. The write up therefore cannot be conclusive but descriptive, leaving scope for the reader to reinterpret the learning process (if any) in their own way.

Finally, Yin (2013b) suggests that “instead of pursuing the sample-to-population logic, analytic generalization can serve as an appropriate logic for generalizing the findings from a case study” (p325), which he defines as “the extraction of a more abstract level of ideas from a set of case study findings − ideas that nevertheless can pertain to newer situations“ (p235). He goes on to suggest that this generalization is best accomplished by relating conclusions to the research literature, a process which is addressed in Chapter Ten.

Finlay (2002) explains that reflexivity can take many forms, from examining personal, unconscious reactions, to exploring relationship dynamics, to examining the socially-situated nature of the research (p.224). Personal reflexivity issues have been mentioned elsewhere, but relate to the understanding and experience that the researcher brings about learning and therapy to the case study scenario. Interpersonally (Walsh, 2003), there was a positive and supportive environment created in which the client may have created good outcomes which would not have been there in a different situation; and in terms of methodological reflexivity (Willig, 2013, p.55), it is noted that the empathic nature of the therapy which formed the case study may have had an overly positive impact on outcomes. Malterud (2001), however, suggests establishing strategies for the creation of an acceptable distance from a study in which there is personal involvement, termed 'meta-positions'. In this case, the meta-position adopted by the researcher was intended to be that of 'enquirer into learning processes', rather than a position which set out to prove what the researcher thought might be possible in terms of therapeutic learning. The reality of that outcome is questionable.

9.5 Conclusion

The outcome of this case study was a tentative set of person-centred learning principles which could be applicable to a therapeutic context, but would require further testing to be considered robust. It should also be noted that the principles tested here represent a tiny proportion of possible learning processes available for use in therapy. A complete learning methodology would be much broader in scope, so this study aimed merely to provide a start point for further research. The main learning components emerged as a philosophy of long-term learning, with a 'self-

learner' identity, coupled with a facilitated learning experience, in a climate of co-enquiry. The issues such as goal setting, establishing a learning gap, defining the client's learning style and establishing their motivation provided the backdrop. Using specific learning facilitation techniques with predominantly directive questioning, focusing on learning outcomes, process analysis and meta-frameworks, made up the bulk of the activity. Finally, a plan for ongoing learning and evaluation, and assessment of effectiveness concluded the process. The case study presented here represents merely one example of person-centred learning theory applied to therapy for one particular client. Consideration of the potential to expand this approach is discussed in the following chapter.

Chapter Ten: Overall Discussion

10.1 Overview of the Studies

After being engaged in Person-centred counselling as a counsellee, on one occasion the researcher logged the following reflection in her journal: "What was the point of that? I've just talked myself round in circles for the last hour." It could be assumed that the counsellor was working on the basis that the actualising tendency would operate and that her client would naturally define her own solutions. Change didn't 'just happen' in this case and the researcher was left regarding the experience as unhelpful. It was not surprising that some of the interviewees in Study 1 also had similar concerns, commenting for example: "it's not good enough… just to say that people get better" (K2.1). There is also considerable support in the literature for the perspective that some form of directivity may be necessary (e.g. Kahn, 2012; Hill, 2007; Bohart, 2012).

In addition to an interest in exploring the integration of person-centred learning and counselling, it was this experience of being counselled that encouraged the researcher to consider whether learning theory might make person-centred counselling more efficient, more effective, or more long lasting. Questions of effectiveness and efficiency, however, would need a considerable amount of research to answer. First, the fundamental issue of whether learning theory had any fit with counselling practice at all needed to be addressed. This research project therefore considered these fundamental issues of philosophical fit, theory base, and practical possibilities, as a start point for the longer process necessary to establish whether the

combination might make for a more satisfying counselling experience. On reflection, the researcher was aiming to design the kind of counselling experience that she would have wanted for herself.

The most obvious criticism of a person-centred learning oriented therapy is that person-centred counselling is a process of self-actualisation, and that any direction or learning facilitation by the therapist would run counter to the philosophy of the approach. This view could be easily accepted if Carl Rogers had not been the founder of person-centred learning facilitation as well as Person-centred Therapy (Rogers & Freiberg, 1969). Since the actualisation of his students' potential was enabled by Rogers in his role as tutor, he clearly believed that a person-centred approach to self-development was also possible. It is argued therefore, that since Rogers also regarded therapy as a learning process, then research into how learning facilitation could be applied to person-centred therapy is entirely appropriate.

Granted, many therapeutic approaches have already addressed the subject of learning. For example, Multi-modal Therapy (Lazarus, 2015) is based on elements of learning theory, CBT utilises learning methodologies and Egan's Skilled Helper Model (2014) uses learning processes to enable progress. None, however, are defined entirely by their intent to generate and embed personal learning explicitly. Neither are they defined by a specific intent on the part of the therapist to engage the counsellee in a facilitated process of empowered change which will endure and develop in the absence of therapeutic support post-therapy. If a definition of learning such as the following is adopted;

> *Learning occurs following, or as a result of experience, direct or vicarious; thinking; or insight. It is relatively permanent, usually enhanced by practice, and is purposeful for self-maintenance, survival, or prediction or anticipation of future conditions. Often, there are physiological correlates: Learning either causes or results from changes in the central nervous system* (Gerber, 2001, p.79),

then counselling is a process of engaging the innate resources of the individual to understand their own needs, to engage in a planned strategy to move forward, to understand processes which make sense given a unique perspective, and to ensure the transfer of that understanding to situations outside of therapy on a long term basis. It is this issue of permanence, of being self-maintaining, of generating changes in the brain functioning which would define it as a therapeutic *learning* experience rather than a therapeutic encounter.

What is set out in this thesis are the initial exploratory stages into the possibilities of integrating learning into the therapeutic encounter. Firstly, whether the two subjects could combine philosophically was addressed, and if so, evidence that learning was already a part of the person-centred counselling process was sought. Assuming a philosophical fit, and the approach was not already common practice, the research then proceeded to consider how the process could work practically. The overall aim of the research produced a complex set of questions requiring a number of studies with different methodologies. Given a mixed methods approach, a logical structure of four field studies was designed to enable a conclusion to be drawn as to whether person-centred learning facilitation may be integrated into counselling. In summary, the answer seemed to be ‘probably’.

10.2 Research Process Summary

Bhaskar's paradigm of Critical Realism (2015) provided an appropriate perspective from which to view these questions, allowing for a realist ontology to combine with epistemological relativism. Thus a search for learning principles which may be 'discovered' and regarded as universally applicable, could also be regarded as principles which may emerge and be further described over time. As more research is planned, these learning mechanisms can be re-considered and developed in an on-going process of discovery. For example, on-going counselling cases (not reported here) are now allowing the researcher to re-test learning strategies from which further therapeutic learning principles are emerging.

The project was a search for the 'empirical', the 'actual' and the 'real', or more specifically what could be *observed* in terms of learning, what the learner *actually* experienced and *how* that process occurred. Analysis was conducted with this perspective in mind throughout the studies. So for example, the case study client was *observed* to need experiential engagement in meaningful activities in order to learn about their significance for her future development, which actually ran counter to an expectation that learning would occur for this client through a cognitive process of planning and analysis. In terms of what the client *actually* experienced, it seemed, for example, that whilst the researcher assumed that self-directive forces were at play, in fact there was frustration at not being pushed into learning. Finally, the learning process *occurred* in a much more holistic way than had been anticipated. Thus, three layers of information were obtained, analysed and collated.

The discovery of learning mechanisms was therefore at the heart of the studies. Learning processes emerged particularly in the engagement of therapy, often generating unexpected outcomes. For example, the homework engaged in by the case study client, had it been defined by the researcher may have been in the form of a journal, or a specified practical exercise. The client's personal perspective on the most appropriate learning process for her led her into a wide range of thought processes and activities which probably would have been left unconsidered by a therapist. Subsequently, learning occurred for her through a wide range of processes which included goal setting and planning, reflection and analysis, experiential engagement, spiritual reflection and an ordered conceptualisation of jumbled thoughts. In summary, a much more complex process of learning occurred than was anticipated. Thus, the mechanisms or tendencies which emerged as learning principles encompassed a broad range of learning perspectives, preferences and styles.

Notwithstanding the Critical Realist perspective described above, methodological pragmatism (Morgan, 2014) also provided the drive and impetus behind the study designs. The production of a tangible output in the form of a therapist 'tool' and practical methodology was a significant driver behind the design of the studies. For the researcher, understanding how the two disciplines could be combined would be of little use unless it was going to be put into practice for the benefit of clients.

Given that methodologically, it was an understanding of mechanisms of learning which was to be sought, interviews with therapists, a clinical quasi-experiment and a case study were planned in a mixed methods approach. This integrated approach allowed for both the meaning and quantity elements of these methods to be measured within the same project. Further, a sequential mixed design (Tashakkori & Teddlie, 2010) enabled the studies to build on previous findings rather than contribute separately to one conclusion. For example, the list of outcomes derived in the Delphi study fed into the design of the instruments used in the case study. Axinn and Pearce (2006) also note the ability of MMR to address variance along continua of different dimensions; for example: by combining quantitative data identifying consensus on a list of items, qualitative data which developed the wording of the list, concrete experience in the use of the list in the form of a 'tool', and feedback on the appropriateness of that list therapeutically. Further, *questions* such as "Do person-centred therapists consider learning processes?" were addressed alongside *hypothesis* testing in the quasi-experiment in Study 3, where a learning tool was presented on the assumption that it may accrue therapeutic benefits. Thus questions and hypotheses were integrated into one overall study.

Semi-structured, open-ended interviews in Study 1 were chosen for their flexibility, focusing on a small group of individuals who were regarded as experts in the fields of Person-centred Therapy and learning. They were asked whether they currently consider learning processes in their current practice, since after all, if they *did* systematically, there may have been little point in progressing with the research. This initial qualitative approach allowed for respondents to express concerns as to

the validity of the research, given it seemed on the surface to be internally philosophically contradictory, which then allowed for the topic to be given thorough consideration before progressing with the other studies. Further, the discussions also allowed for new topics, such as self-therapy (KL102) for example, to emerge and feed into later studies, where originally the topic had not been included. In summary, this was the only entirely qualitative piece in the project, which provided a useful foundation to the subsequent studies, since a variety of perspectives and opinions on learning in therapy emerged.

The Responsive Delphi study (Vernon 2009; McKenna 1994) which sought to ratify a list of humanistic learning outcomes proved to be a useful mechanism by which to garner consensus on a large amount of data from a relatively large number of people. In order to simplify the process, a pre-defined list of outcomes was provided for therapists to consider (Hsu & Sandford, 2007; Mullen, 2003; Powell, 2003; Fink, et al., 1984) rather than starting with a blank sheet. Although this list of items was derived from a broad range of available literature on the subject, there is always the question of whether starting with a blank sheet might have generated 'better' results, or alternatively, the question may have proved too overwhelming for some to even consider it. What was particularly useful, however, was the 'virtual discussion' facilitated by this process as each member had the opportunity to evaluate others contributions. Appreciating that this would have been almost impossible to facilitate in a face to face meeting, made the collation of this data all the more satisfying. Despite a lack of consistent guidelines for implementing a successful Delphi (Turoff, 1970), close attention to detail seemed to enable a successful data collection process in this study.

The card sort exercise and questionnaire were tested in Study 3, not with the rigour of a randomised control trial with user manuals, but in a less structured way, through a quasi-experiment (Field & Hole, 2003), which allowed for learning mechanisms to emerge rather than solely be tested. Participants were free to experiment with the materials in whatever way they saw fit, and then feedback on the outcomes of their findings. A free format questionnaire gave scope to collate these qualitative responses, which were analysed and interpreted in the style of an 'Interpretive Experiment' (Moses & Knutsen, 2012). The combination of retroductive and abductive reasoning was a natural fit with this approach allowing for some assumptions about the process of goal setting to be brought to the analysis along with the ability to draw conclusions based on new information. So, for example, from a retroductive perspective, one therapist commented that the discussion about goals had opened up a new avenue of learning for the client which was not "front of mind" (AP11). This comment confirmed a hypothesis that clients could be encouraged to devise new and more personal goals for therapy than were defined in the list of items. Analysing qualitative experimental data from a more abductive perspective, however, provided new insights. Another therapist commented that the client had adopted a greater sense of autonomy and control over her life from engaging with the list of outcomes (JG7). It may be that knowing *what* to aim for was a large part of the learning solution for some clients – a perspective which had not been anticipated.

The final case study was also experimental in design (Neuman, 2014). The etic perspective of the researcher was weighted heavily in the approach, evident in

the specific learning processes chosen for inclusion in the therapy by the researcher, giving a bounded system (Abma & Stake, 2014) within which to experiment. Therefore, only a limited number of learning theories were chosen, applied and tested by the researcher. Causal mechanisms were still the focus for exploration as the case study progressed - as a Critical Realist perspective would suggest. So, for example, although enabling the client to plan activities between sessions was part of the theoretical framework brought to the study, the extent to which she engaged in that process in order to further her own learning was unanticipated, saying "l also looked at the opportunities where I could take it further" (C8). It may be therefore, that the key to successful therapy outcomes may be the engagement of self-defined experiences away from therapy rather than in dialogue for example. This emic perspective emerged in the therapeutic engagement as a causal mechanism not being tested through the initial hypothesis. A complex mixture of results was therefore enabled in the case study design, testing a hypothesis in terms of learning processes, whilst considering the overlapping domains of reality; what could be observed in the engagement, what the researcher/therapist thought was actually occurring and an analysis of how that played out.

10.3 Research Outcomes Summary

10.3.1 A Framework of Therapy Outcomes.

The researcher has some experience of clients in therapy who are 'lost'. They know that they need to change, to move to another life position, or definition of self, or even to solve a problem, but the definition of that change escapes them. Further, the researcher in the role of client needed something specific to aim for in order to engage her motivation to change. Levitt and colleagues (2005), however,

point out that no set of outcomes suitable for a humanistic setting are currently available. It was considered, therefore, that before embarking on the first field study, it was necessary to develop a detailed picture of a 'fully functioning' person in order to enable one of the most fundamental of learning methods, that of goal setting. And given comments indicating that such a description is "a kind of 'holy grail' in the counselling research field", it was concluded that the counselling community might make good use of such a description.

Since Rogers' views on the nature of being fully-functioning (2004) were difficult to crystallise into measurable outcomes, some effort was put into integrating a number of other frameworks, to produce a list of items to be validated by therapists. Further, some of Rogers' points were also presented as processes rather than outcomes, and therefore needed some consideration. In the event, *processes* such as 'I look after myself' were included in the final list of items, in addition to *outcomes* such as 'I know who I am'. Both perspectives were valuable in defining not only a self-actualised state (Maslow, 1943), but a process of 'becoming' (Rogers, 2004). Since the model would be used as a learning tool rather than an outcome measure, a more constructivist perspective was acceptable so that a client could define processes or outcomes in their own terms. In terms of the design of the list of items, Levitt and colleagues (2005) made recommendations such as facilitating open ended responses, which was done in the design of the questionnaire - allowing the client to formulate their own goals. The definition of holistic change, from a humanistic perspective, was achieved by a complete list made available for scrutiny by the client, enabling an understanding of specific issues within their context.

Indeed a number of respondents commented that they appreciated that facet of the design.

10.3.2 Study 1: Views on Learning and Change in Therapeutic Practice.

Study 1 was a pre-study, to establish a foundation of existing knowledge in the field of learning in therapy to support the later experimental stages. Central to this exploration was the question of whether clients 'just' change through the actualisation process, or whether therapists considered they need an active engagement in learning in order for change to happen. Initially, the process of growth and change was considered by the interviewees to be a natural one, unconscious (H63.1), and gained through insight (P4.2), through therapist congruence (H2.1), or as Rogers' suggested, through empathy (1975). Contradictions and confusion then emerged when interviewees were questioned about the role that learning played. Participants commenting variously: that of course people learn (K2.1), but learning and change are not always conscious (P8); that the two are definitely linked (H2), but that change isn't necessarily learning (P12.1); and sometimes change and learning don't happen (K4.2). They considered on the whole, that counselling *was* a learning process but were not clear whether learning caused change, or vice versa, or whether in fact the two issues were separate phenomena. In sum, whilst agreeing that learning and change formed a part of the therapeutic process, there was no clarity on exactly how they occurred.

Although Rogers considered that "there was the possibility of describing the process of therapy in terms of learning theory" (2004, p.127), there was little firm commitment from the interviewees that therapy was a process of *facilitated* learning

either. Bordin notes, "the effort to establish a discontinuity between teaching and psychotherapy seems futile" and "of all theorists, Rogers has, in fact, been most loathe to separate them" (1969, p.44), but there seemed little acknowledgement of this perspective from the participants. In fact, therein lay a problem experienced throughout the studies. Once the study's aims had been introduced to them, some practitioners were adamant that facilitated learning was not appropriate in Person-centred Therapy at all, a view anticipated by one potential interviewee when he said: "I suspect that the approach you have taken would be viewed as particularly problematic by many Person-centred counsellors". Conversely, however, what did emerge from the interviews was that despite acknowledging the non-directive nature of person-centred therapy, all participants explained various directive techniques which they used to enable client progress in therapy.

The issue of the role that goal-setting contributes to clients' progress in person-centred therapy was a second important area of discussion, but was equally inconclusive. Although the establishment of goals by person-centred counsellors was considered largely to be only client driven, interviewees also considered variously; that establishing them provided the therapist with a helicopter view of the process (P36.2), or alternatively, that the therapist could never really know what they were (C14.2), further, they were unique to the client (R48.1), or similar for each client and related to "threat reduction, and integration of symbolisation into the self-concept" (K66.1). Most notable, however, was the view expressed by the majority of interviewees summed up as "of course I've got an agenda!" (H22.4), contradicting later claims of non-directivity.

The third key issue covered in the interviews was that of the *process* of learning, considered largely to be a natural unconscious growth "through osmosis" (P10.1) and that long term change was considered to be the retention of what can't be 'unknown' (H69.2). Although most participants considered that their person-centredness would not allow them to facilitate learning, they did acknowledge using a wide range of processes such as enabling a client to tell their story (H45.2), enabling the challenging of perceptions (K26.1), asking questions (K36.1), offering theories (H41.3) and enabling the seeing of a bigger picture (R16.2). Again, a clear contradiction emerged between the limitations that they acknowledged that the person-centred perspective placed on their directivity, and what they did in practice, often under time pressures (H28.6).

In conclusion, it seemed that these person-centred counsellors were deeply wedded to a philosophical basis for their approach, summed up in their professed strict adherence to the core conditions. As such, to suggest a process of facilitation by the counsellor was always going to raise deep concerns and strong opinions. The researcher had sensed almost an annoyance from some that questions of directivity were even being posed. Once these therapists were questioned more closely, however, about what they actually *did* in practice, a different story emerged, suggesting that not only are they largely directive practitioners, but that they consider long term learning to be an important outcome. Further, this learning is being facilitated in a variety of ways, but without necessarily a defined framework by which to do it.

10.3.3 Study 2: The Production of a Learning Outcomes Framework for Use in Therapy.

In Study 2 it was intended that by combining the previously researched outcome measures (completed through the literature review) with the collective wisdom of a sample of humanistic therapists, a comprehensive learning outcome measure could be created, illustrating the 'fully functioning' individual. This list could then form the basis of a goal setting exercise for use in therapy. It was an exercise which raised pertinent questions such as "Fully functioning in what context?" and "Are these age related?" The reductionist nature of the instrument was rightly questioned on the basis of the holistic nature of person-centred therapy. There was a concern that emergent entities and properties may be ignored in favour of a superficial picture of success. The researcher could suggest, however, that the skill of the therapist enables the process of reconstruction of a holistic picture through the therapeutic dialogue, based on the framework as a start point.

A number of other such concerns needed to be addressed in order to produce an agreed list of learning outcomes. For example, Connolly and Strupp's explanations (1996) of therapeutic outcomes in their cluster analysis included items such as 'better control over temper' or an 'increase in self-understanding'. Thus, outcomes were not absolute, demonstrating that therapeutic success comes in degrees. Goal setting, however, requires an outcome to be defined, to allow measurement. So therefore, a combination of the two perspectives was facilitated. Given an outcome on the questionnaire such as 'I can control myself', the client is then encouraged to set their own goal, which may be 'to stop getting mad at my wife'. The goal is then rated on a relative scale, which may be "I have quite a long

way to go with this", moving towards "I'm doing OK with this". The goal is therefore framed in the context of the client and measured relative to their own conception of progress. Further, during the Delphi study, comments were made by therapists reviewing the item list such as: "It depends on the importance for the client". They also considered that the client's capacity, maturity, context and personality were relevant in deciding on outcomes. These instruments would, in summary, benefit from being a relative rather than absolute measure, and one which could be manipulated based on the perspective of the client. Thus the outcome was developed along the lines of a learning 'tool' rather than an assessment process.

A further point of concern was brought up by both some of the interviewees in the first study and the students who reviewed the initial questionnaire, and that was that each individual is unique, which was contrary to Rogers' view of the fully functioning person. A 'one size fits all' framework may not therefore, be appropriate. Further, one pilot tester from the general public said "I personally would feel more like I would have to stick to what it says". Whilst there is the facility to develop entirely idiosyncratic goals through the use of the questionnaire, it is acknowledged that these are initiated from a defined framework. Given the breadth of humanistic outcomes incorporated into the learning framework design, it is hard to imagine personal goals which are not catered for in some way, but there is the potential for a client to feel led. And vulnerable clients in therapy may be grateful to adopt the perspective of being told what to do - a problematic position for person-centred therapists which would need careful management.

In terms of the physical design of the two instruments, no clear preference for the cards or the questionnaire was expressed during the initial pilot testing, suggesting that discussion with a therapist might be helpful to decide on either option. The response to the card sort exercise whilst being tested by the general public was an interesting one. It had not been anticipated that the pack would be regarded as a' handbag item', or something that could be carried around to be referred to on a regular basis from a self-therapy perspective. It may be, therefore, that further research could test the use of the card sort exercise in that context.

10.3.4 Study 3: Can Goal Setting be Facilitated in Humanistic Therapy Using an 'Instrument'?

Study 3 was designed to test the questionnaire and card sort exercise with therapists and their clients in a clinical setting. 37% of the therapists taking part in the previous Delphi study to define the learning outcomes said they were against the idea of a questionnaire for use in therapy, and the initial recruitment round for therapists to put it into practice in Study 3 had a 3% take up, suggesting that other therapists probably had the same view. It is acknowledged that paperwork is kept to a minimum in PCT since clients often need to just talk without any outcome required (Merry, 2000; Wilkins, 2002), and further, a goal oriented approach does not suit all clients. Also, for some clients it might feel "…like a legal document" and be too prescriptive in nature, as two participants in the pilot tests commented. In a subsequent recruitment round for the third study, however, where the questionnaire and card sort exercise were presented to the therapists for review *before* they were asked to take part, the take up was 83%, with positive comments being made. Further, the feedback on the use of the questionnaire in practice was generally

positive. It may be concluded therefore that although questionnaires may not fit the PC paradigm in theory, when implemented in practice, they are in reality more readily accepted.

On the surface it seemed that predominantly PC Therapists did not readily warm to the idea of an 'instrument' in theory, but they proved to be more amenable in practice. It seemed that regardless of therapeutic approach (within a humanist framework), there was more comfort than expected in the use of the questionnaire and card sort exercise in order to enable client goal setting. Acceptance was dependent, however, on the therapist's views on directivity. Those considering that their approach was quite specifically non-directive (in theory) would therefore not consider using the instruments as a matter of principle. What was interesting, was the lack of correlation between therapists who found the instrument inappropriate and their expressed commitment to person-centredness. Rather, it seemed to be the therapists who regarded themselves as having some directive role, regardless of how person-centred they were (as Kahn (2012) and Hill (2007) recommend), who took to the process most readily.

The use of instruments in therapy, despite having advocates, can be problematic. In addition to being counter-cultural for non-directive therapists, McLeod (2001) questions the validity of using questionnaires within psychotherapy since, in most therapeutic approaches, the conceptualisation of the person implicit in questionnaire design is not compatible with the view of the person held by the therapist. A third reason to question the use of self-assessments is that the way items

are viewed by the client at the beginning of therapy changes over the course of therapy and therefore no objective or generalisable data can be obtained.

There are, however, arguments which support the use of a questionnaire or card sort exercise such as the ones tested in these studies. A meta-analysis by Horvath and colleagues (2011) demonstrates the positive relation between the quality of the therapeutic alliance and diverse outcomes for many different types of psychotherapy. There is also much in recent psychotherapy literature to support collaborative practice in psychotherapy (Anderson & Gerhart, 2012; Paré, & Larner, 2014), and the dialogic nature of the interventions in the studies is intended to contribute to a positive therapeutic alliance. Collaboration is presented as 'knowing-with' the client, of enabling them to socially construct meaning for their life in collaboration with another. As the client works with the therapist to define goals which are transformational and fluid, something more is achieved than may otherwise emerge from self-reflection alone. Gordon and Riess (2005) discuss 'the formulation' (or client assessment) as a collaborative enquiry, which synthesizes "the complex, subtle, and often contradictory aspects of the person's life and experience into a coherent summary" (p.112). They consider that a mutually designed formulation helps to make goals more explicit at the outset and that when the therapist "engages the patient as a partner in creating hypotheses for formulation, both may tap into great resources in the patient for healing, recovery, and collaboration" (p112).

"The fact is that clients' active involvement in the therapeutic process is critical to success" suggest Bohart and Tallman (2010, p.83). They urge that clients

are not seen as inert objects who require techniques to be administered to them, but instead as individuals with the power for self-righting and self-healing. They suggest that "clients often enter therapy with a plan and work to steer sessions in directions that they perceive will be beneficial" (p.89) and it is the intention that the questionnaire would empower the client. They recommend that "The emphasis should be more on helping individual clients use their own resources to change rather than on applying standardized treatment packages" (p.99). A number of the therapist participants in Study 3 recognised this perspective saying for example "I could see clearly where the client wanted to focus the sessions - what to work on with her" (RS). It is suggested therefore, that the potential to enable client engagement through this process is significant, with long term potential for self-healing. The dialogic process also provides valuable information for the therapist. Lambert and colleagues (2001) and Reese and others (2009) have found that feedback about client progress has shown improved client outcomes in comparison to those without feedback. As goals are jointly assessed and rewritten through the course of therapy, feedback on progress is available to the therapist, enabling them to tailor therapeutic practice.

McLeod (2001) questions whether a questionnaire is available that defines personhood from an appropriate perspective. The items are intended to provide that picture for humanist therapists, and further, the idiosyncratic and fluid nature of the goal-setting/measurement process is intended to account for changes in the client's self-perception, and since no absolute measure is intended, the use that is made of the measurement scale is entirely defined by the client. The further development of the questionnaire into a card sort exercise was evolved from Rogers (2003) use of the

Q sort technique who used them with clients to enable them to formulate a picture of the self and then the ideal self. Both instruments attempt to do this in a way that addresses McLeod's concerns.

Some final support for the use of the instruments comes from the literature on client-led activities out of the therapeutic space, and there is the intention that the questionnaire or cards would be referred to at home between sessions. "Using homework as an adjunct to the work that occurs within the counseling session has been shown to be an effective way to promote therapeutic change in a brief period of time" according to Kinnier and Hay (2011). Further, there is a body of research which suggests that written emotional disclosure, usually as homework, is beneficial to therapeutic outcomes (Graf & Geller, 2008). Work at home on client goals and progress towards them is an intended part of the intervention, allowing for progress to be made through self-analysis and the emotional disclosure that facilitates that progress.

There is therefore, much in the literature to support the collaborative use of the questionnaire and card sort interventions with clients. The detailed use of the instruments by clients in study 3, however, was not necessarily recorded by their therapists as part of the research, mainly due to issues of confidentiality. Some dialogic benefits were reported back, for example; the process provided the client with greater autonomy and control of areas of their life they wanted to sort (JG); it enabled the client to control some of the counselling process (RH); and "For a client struggling to put her difficulties into words, it was very helpful" (RH). Despite positive outcomes such as these being noted, little feedback was received on the use

of the rating scales and spaces to log goals as they changed over time. Neither did the case study client report back on their use. It is suggested therefore, that further research is necessary to ascertain the usefulness of the rating scales and the elements of the design of the learning plan intended for completion over time.

Finally, the whole idea of goal-setting, supported for example by Bandura (1999) and Egan (2010), seemed to be regarded as helpful by some clients, but not by others. It may well be simply that some people are naturally goal oriented and others are not. One question worthy of further research therefore, is whether encouraging and enabling those who do not take to the process naturally, to work towards self-defined goals in therapy, may prove beneficial. If as Rogers suggests, the individual moves rationally towards achieving unconscious goals (Kirschenbaum & Henderson, 1997), then bringing them into conscious awareness may enable a more effective or efficient process.

10.3.5 Study 4: Can Person-centred Learning be Facilitated in Counselling?

The final study sought to trial a small number of learning theories with a real client in a clinical setting, although attempting to produce in practice what was planned in theory was challenging. The outcome was a transcript and analysis which attempted to explain the learning processes that had either been facilitated, or had emerged in the engagement between therapist and client. The key learning principles that emerged as being helpful to the therapeutic process during the course of the case study included goal setting, understanding learning processes and self-efficacy.

One of the main hypotheses brought to the case study was that learning and change do not happen efficiently and effectively without a degree of directivity on the part of the therapist. Views which contradict this perspective are numerous in the literature (Merry, 2000; Wilkins, 2002), but whilst the therapist participants in Studies 1 and 3 also disagreed in theory, in practice, they were much more supportive. More recently, this use of directivity - or not, has formed part of the debate on *pluralism* in counselling put forward by Cooper and McLeod (2012). Instead of seeing directivity as a black and white therapeutic preference, they recommend seeking feedback from the client, since different approaches may suit different clients, at different times. Their viewpoint sidesteps the longstanding polarised debates of 'pure' verses 'integrated' approaches and considers the client to be the source of knowledge on what they want from therapy and how that should best be achieved. Knowles Andragogy (1978) also sees learning as a self-directed process, and it was this process of change, driven by the client, which was intended to be at the heart of the case study. However, in order for the therapist to facilitate this process, a degree of directivity was necessary. Cooper and McLeod (2012) refer to this process as meta-therapeutic dialogue, or conversations about the process of therapy. Therefore, in the case study, client insight about process was generated and embedded through metacognition and engagement (Salo, 1993; Flavell, 1979; Glasman, et al., 2004) in order to retain significant learning.

Change, as it is formulated in the consciousness as learned processes, was considered key to the successful outcomes of this perspective on therapy. Further, for the case study client, learning seemed to have provided the potential for long term change: "This is so fundamental to me, this is going to be quite a pivotal point in my

life" (review session, C58), she commented. In addition to Cooper and McLeod (2012), Carey and colleagues (2007) consider that change may be evident in the client's knowledge of process, rather than just as an outcome - for example in the form of insight. Whilst the client seemed to gain insights such as her contact with nature being fundamental to her sense of self (session 3, C104), it was her learning processes which were regularly reviewed and regarded with greater weight in order to enable her 'self-therapist' abilities (e.g. session 4, T19b). Thus, the case study ensured that any change was defined by its learning processes, and therefore the potential to contribute to long term learning was facilitated. Thus learning and change, as Binder and colleagues (2010) suggest, could only be synonymous - a process which was client led as Cooper and McLeod recommend (2012).

An extensive range of learning theories were reviewed before the commencement of the field studies with the intention to identify those which might be applicable to a counselling approach based on person-centred principles. They were categorised into behavioural, cognitive and affective domains, and the most relevant concepts for self-directed learning facilitation identified and incorporated into the case study.

Behavioural learning theory proved to be useful. For example, simple reinforcers were consciously applied throughout the case study (Bandura, 1961; Gerber, 2001) either in the form of direct feedback, or more subtle reinforcing behaviours such as behavioural modelling (Bargh and Fergusson, 2000). Even Dijksterhuis and Van Knippenberg's notion of 'priming' (1998) was implemented by constant questions such as "What did you learn?" and "How will that help you move

things forward?" encouraging the client to look habitually at situations from a learning perspective. A 'sense of purpose' (Tolman, 1925), and further, Aarts and Dijksterhuis's notion (cited in Bargh & Ferguson 2000) that behaviours become automatically linked to goals, led to considerable effort in defining the client's aims in therapy. If these were absolutely clear, then behaviours, in theory, would be 'shaped' with a view to achieving them.

Purposeful goal setting with the client is considered as useful (e.g. Knowles, 1978; Bandura, 1999; Motschnig-Pitrik, 2008; Egan, 2010; Bordin, 1979), and further, Bandura (1999) believed that motivation and self-directedness are driven to a degree by the ability to challenge oneself by setting goals and to evaluate the reaction to one's own behaviour. The expectancy that these goals will be achieved in itself fuels outcomes, as automatic processes or habits are formed. So, within the case study, each client goal was dissected, elaborated upon, illustrated, and its purpose questioned in order to firmly establish a foundation for therapeutic focus, and the client commented on the usefulness of that approach (session 3, C23). More importantly, these goals provided the drive for work completed between sessions, thus beginning a process of habit formation as the goals became embedded in the client's cognitive processing.

The workings of the mind such as through goal setting, provided a more valuable perspective from which to define learning process and outcomes than pure behaviourism, particularly as they related to the case study client's developing sense of self. Specifically, the client's self-concept developed as she assimilated and accommodated new information (Piaget, Gruber, & Voneche 1977). As the sessions

progressed, there was an attempt to move the client towards a new understanding of the nature of 'truth', towards a more constructivist paradigm (e.g. Polkinghorne, 2010), although this was limited in its success due to the therapist's positivist leanings. What was successful, however, was the focus on experiential learning which allowed learning to be constructed from the client's own experiencing (Bruner, 1961).

There were a range of opportunities available to enable affective learning processes during the course of the case study. The complex interplay between feelings, cognitions and actions is often unconscious (LeDoux, 1998) and therefore opportunities to explain the interrelationships were sought; for example, Carey and colleagues (2007) suggest that therapeutic change is best approached by facilitating the client's progress towards an impasse from which they then find solutions for themselves. Thus Gestalt conceptual 'wholes' are addressed by drawing together disparate parts through the problem-solving process. "The clear and sudden understanding of how to solve a problem" (Bowden, et al., 2005, p.3220) then results in insight. Affective learning processes were addressed with the case study client, since a self-directed process, which could be learned and stored for future use, was the aim.

Self-efficacy is a particularly important element of self-directed learning and is demonstrated in a client's belief that they can produce desired effects by their actions (Bandura, 1999). The various influences on self-belief, such as past successes and failures, emotional states and vicarious experiences (Bandura, 1997) were discussed at different points in the therapy. Unconditional positive regard was

also intended to support this process, as did modelling self-belief, giving positive feedback, and generally "…manipulating expectancies and reinforcement so as to bring about new values" (Price & Archbold 1995, p.1265). As therapy had progressed the client seemed to grow in her own sense of self and as a result she considered that although an issue might 'bob up' again, she said "you have the tools to go 'Oh, OK, I'm going to go and do *this*' (feedback session, C82).

Theories of experiential learning suggest that it is the knowledge, skills, attitudes, values, senses, and emotions that can be distilled and consolidated from a client's experience, which can be transferred to other similar situations (Loewenthal, et al., 2005). Derived from this perspective is the experiential learning theory of Kolb & Kolb (2009) from which emerged a cycle of learning based on concrete experience, reflective observation, abstract conceptualization and active experimentation. Kolb's model proved to be very helpful to both therapist and client. As the client seemed to be a highly experiential learner - both concrete and holistic - the progress of therapy could be designed to meet that need. In the longer term, a 'learning self-identity' (Kolb & Kolb, 2009) was aimed for, and was evident in the language that the client used (session 5, C1b).

Directive questioning is a key facilitation technique within Andragogy (Elias, 1979), although one interviewee in the first study regarded questions as inappropriately intrusive and directive in PCT (R64.4). Questions were used by the therapist for 79% of the time in the case study. They were, for example: Socratic in nature (Paraskevas & Wickens, 2003); to enable insight (session 1, T68); to challenge (session 5, T42); or to demonstrate a point (session 6, T34). In fact,

different types of questions (summarised in Table 5, Chapter 9) were used with the specific intent to direct the process towards a defined learning outcome; and although this approach would appear to contradict PC philosophy - as a study demonstrated (Renger 2014) - Person-centred therapists do in fact regularly use questions systematically in the pursuit of therapeutic outcomes.

A focus on motivation was enabled in the case study and contributed to the overall learning outcome for the client. A perspective of self-directed actualisation (Maslow, 1943) was taken, particularly since the client had addressed all of the issues in section 8 of the questionnaire which relate to higher order goals, or self-actualising concepts. Further the spiritual or mystical elements leading to a state of 'peak-experience' or transcendence (Koltko-Rivera, 2006, p.306) were also applicable and discussed. Further, to enable a self-directed approach to learning it was also considered necessary to focus more directly on the issue of motivation rather than leave it to Rogers' actualising tendency (2004). Techniques most associated with Motivational Interviewing were used (Miller & Rollnick, 2013) such as: establishing hindrances to achieving defined goals (e.g. session 5, C45), or dealing with 'stuckness' (session 5, T59), ambivalence, or lack of progress due to difficult choices (session 6, T57). The issue of motivation was addressed largely, however, by a direct conversation about the benefits of change for the client, which proved to be helpful in engaging her in a need to set challenging goals (session 2, C67).

The development of a self-directed therapeutic learner emerged as an important aim of the therapy for the case study client, as Knowles Andragogy (1978)

and Betts and Kercher's Autonomous Learner (Betts, 1985) models would advocate. Practically speaking this was encouraged through behaviour modelling by the therapist in the case study, demonstrating self-acceptance, self-efficacy, belief in the potential for change and knowledge of the need for support mechanisms. Further it was addressed by encouraging the client to set her own criteria for achievement, encouraging her to decide where and how to find the necessary resources to support her progress (e.g. session 2, T103), and enabling her to measure her own success in the review session (Armitage, 2012).

The goal of long term learning is achieved on the basis of successful learning transfer, and close attention was paid to enabling that process for the case study client. The aim was firstly, to use meta-cognitive strategies which would enable learning to be transferred to a *similar situation*. Secondly, the knowledge about this process could then be applied to *similar issues*. Thirdly, learning would be applied to *many contexts*, or in fact to any new learning situation in which the client may see learning potential. Then finally, a *permanent change* in personality would emerge as the client routinely sought new experiential learning situations, before automatically reflecting on and drawing out learning points (Knud, 2009b, p.141).

In addition, other attempts to enable a process of learning transfer were made. The opportunity for generalisation (Rogers & Horrocks, 2010) was initiated (session 3, T70), and critical reflection was encouraged in questions such as "what was it that drove you to …get that power to achieve?" (session 4, T21). An attempt at psycho-education was made with topics such as Transactional Analysis and Communication Skills (Bowles, 2012). Also, problem solving, suggested by Knud (2009b) as an aid

to learning transfer was utilised, for example in session 1 (T41), where a problem was presented for the client to consider. It is acknowledged, however, that as Prochaska and colleagues suggest (cited in Norcross, et al., 2011), learning must be implemented within a number of months (six they suggest) post therapy in order for it to persist. Ideally the learning planning in the final review session assists with this process, although in the case of this client, it was difficult to facilitate that process on paper since she was so averse to written work. Various support mechanisms for the idea of learning transfer were therefore consciously attended to during the course of the case study, often at the expense of a more usual therapeutic intervention, (for example in delaying an experience at emotional depth with the client (session 5, T26)).

Specific strategies were also employed to enable the transfer of learning *processes*, such as conscious attention being paid to situations in which metacognitive questions could be introduced, demonstrated in the question; "So what's the conversation going on in your mind when …?" (session 3, T63). These questions were often based on learning theories which, following an explanation, could then be retained by the client for re-use. Further, meta-cognitive strategies (Cornford, 2002, p.359) such as learning planning were enabled, and a level of engagement activated (Wang and Degol, 2014) to encourage learning to continue. As an interviewee suggested, "unless I understand what I'm doing, I can't replicate it" (K102.2). Each of these approaches would contribute to learning on an ongoing-basis, complimented by self-direction and autonomy.

10.4 Project Limitations

The learning and counselling theories included in the initial literature review were wide-ranging and complex, starting with Tolman's theories on learning from 1925 to Carlson's views on education in 2018. Contributing knowledge came from many parts of the world, for example Singapore (Zepke, 2017), America (Maslow, 1999), Australia (Vygotskii et al., 1987) and European psychology journals. Because of the breadth of material on offer, a systematic review of the literature was not intended. An extensive search, however, of the Sheffield Hallam University set of databases which includes PsycINFO, Scopus, ProQuest, SAGE Journals Online and Web of Science was undertaken using various combinations of search terms; learn/learning; therapy/therapies; psychotherapy/psychotherapies; theory/theories; counseling/counselling and outcome(s). What is presented in the literature review is only a small selection of the resulting topics on learning theory which could be (or already are) applied to therapy, and were considered by the researcher to be most relevant at this stage.

In embarking on the field research, it was not surprising that some 'pure' Person-centred counsellors baulked at the idea of directing learning processes for their clients. The non-directive approach of the 'pure' Person-centred therapist does not easily integrate 'techniques' such as goal-setting, learning planning and the presentation of theories (Levitt, 2005; Merry, 2000; Wilkins, 2002). Thus, the most significant limitation experienced by the researcher was engaging Person-centred counsellors in a directive counselling approach. The intent was not to add to Sanders 'tribes of the Person-centred nation' (2012) with another perspective on Rogers' approach, but to use person-centred learning principles as the foundation to an

approach in its own right. Therefore, those therapists who chose to participate were those who were not wedded to PCT, but willing to consider issues of integration. Indeed some considered that directivity did play a part in PCT (as do for example, Parloff, et al., 1978; Patterson, 1980; Tudor & Worrall, 2006), saying variously "I think everything is directive" (K76.1), or "I don't set out with the intent of directing, however, every time I open my mouth… that impacts on the client at some level" (P34.2). Further, a greater sense of directivity was considered by a number of interviewees in the first study as helpful to shorten therapy timeframes (C6.5; H26.2).

A further significant limitation experienced in the course of this research was obtaining quality, considered and timely data from participants. Regardless of the level of importance attached to it by the researcher, it did not have the same significance to participants. Therefore, not all opinions were given the depth of thought that the researcher hoped for, participants dropped out due to other pressures, and deadlines went unnoticed. As such, all outcomes could be regarded as 'the best that was realistically obtainable' given therapists' busy lives. Numbers of participants were limited due to restrictions on research time and resources - more interviewees, more therapists involved in the Delphi study, and more clients to test the instruments would have been preferable. The third study suffered particularly from participant attrition, meaning that a particular data set (namely that coming direct from clients) was limited. Nevertheless, it is considered that the numbers involved did provide enough data from which to generate tentative conclusions. After all, as Haug suggests: "if a given experience is possible, it is also subject to universalisation" (Willig, 2013, p.17).

It is noted also, that the *application* of the results of the research may have limitations. It might be easy to suggest that a learning approach to therapy may suit all clients in all therapeutic situations, but it is unlikely that such a suggestion would be acceptable. The researcher is engaged currently in a counselling relationship with a client who has suffered the loss of a loved one in traumatic circumstances. This client wishes only to talk about her fiancée and the happiness that he brought her. No goals, learning plan, cognitive restructuring or learning transfer are appropriate, at the moment. She just needs an empathetic ear. So, it is acknowledged that the application of any learning methodology may be suited only to certain clients in certain situations, with a particular type of therapist. In this regard, it is suggested that, a multi-cultural perspective is also needed:

> *Given that most of the work in multicultural psychology is focused on the individual and driven by Western scientific standards and principles (mostly quantitative; emphasis on objectivity), it is clear that multicultural psychology has yet to completely acknowledge how values and potential biases influence its work. Indeed, even the most seemingly "scientific" and "objective" works are undoubtedly still influenced by societal- and individual-level values and biases* (David, et al., 2014).

The view expressed by David and colleagues here is acknowledged in respect of this research project. No data on the ethnicity of most of the participants was sought, but whatever the cultural mix, a degree of bias towards cultural, educational and therapeutic background was inevitable. Indeed the greatest bias has been contributed by the researcher, (a white British, middle aged, female), in designing the materials and studies, and conducting the research.

In developing a list of humanistic learning outcomes - and a therapeutic format in which to use them, there are many issues of diversity to consider: Clients with multiple identities - from bi-racial and multi-racial groups - bring a different world view to the counselling relationship. Indeed, issues of, gender, age, religion, socioeconomic status, sexual orientation, mental ability, physical ability, geographic region, historical experience, and shared experiences (Conner & Walker, 2017) also bring different perspectives. The resulting oppression versus privilege lens (Jun, 2018) through which minority groups view their status makes some of the research outputs inappropriate. For example an item such as 'Understands own rights and therefore can be assertive' is written from a Western perspective which assumes power and autonomy is possible and acceptable. Indeed, the notion of self-actualisation itself focuses on the inner experiencing of the autonomous client rather than any external cultural, ethnic, or communal perspectives. The notion that the client is expected to utilise the learning materials to enable his/her own personal development is a perspective embedded in the Western psyche. Laungani (2004) explains this euro-centric position, and questions how clients from Eastern cultures for example can embrace individualism, when their heritage is "communalism (collectivism), religiosity, determinism, emotionalism and spiritualism", (p205). Even the assumption that the individual is able to set their own goals runs counter to the Eastern perspective which holds the therapist as expert (Winter, et al., 2015).

It is recommended therefore, that in addition to the work already done by seeking ratification of the items from an ethnically and educationally varied number of members of the public, in developing the item list and the therapeutic model further, some consideration is given to the pluralistic perspective of potential clients

(Cooper & McLeod 2012). Having acknowledged the linear, hierarchical, dichotomous thinking style (Jun, 2018) and the Western values, beliefs and biases that have influenced this research, further research with a diverse range of clients will enable a different perspective to be brought. It is hoped that, as David and colleagues suggest (2014), the materials and approach can be embedded in multiple levels of experience and contexts, allowing for lived realities and values that are unheard to be integrated, whilst being open to traditional ways of knowing and healing. Further, assumptions of hierarchy and power can be contested and identity construction can be aligned to different world views.

10.5 Project Development Over Time

The researcher started the research process with a focus on pure Person-centred Therapy and the question of whether it could be made more efficient, or more effective in the longer term - through an application of learning theory. However, as work progressed, it became clear that pure practitioners were not open to any consideration of directivity and were reluctant to take part in the studies. The question therefore broadened out to consider humanistic practitioners who were person-centred, but willing to integrate other methodologies into their practice. Further, the issue of whether therapy could be demonstrably more effective or efficient was considered to be too big a question. Whether person-centred learning in a humanistic context was even *possible* was considered to be a substantial enough topic. Thus, the final focus was on humanistic practitioners' application of facilitated learning to their therapy, rather than making PCT more effective.

10.6 Contribution to Knowledge

It is proposed that the contributions to knowledge of this research are:

1. **A greater understanding of therapists' views on the facilitation of learning and change in Person-centred Therapy.**

It was established through interviews with Person-centred therapists that despite an acknowledgement that therapy is at least in part a learning process, a systematic attempt to facilitate the process is not usually made. A lack of clarity was evident in therapists' understanding of whether clients learn or change. Further, how that process occurred was unclear. Additionally, a dichotomy of being seen to 'do something' towards enabling learning conflicted with a person-centred philosophy of just 'being'.

2. **Two therapeutic instruments (a questionnaire and a card sort exercise) which may be used to enable goal setting, either in or out of therapy.**

The positive reception given to the instruments by both therapists and members of the public would suggest that there may be a place for their use as a therapeutic process tool. Problems in using them effectively would need to be ironed out with clearer instructions and training for therapists.

3. **A framework of humanistic learning outcomes which could be used by therapists with their clients in other ways that have not necessarily been defined by this research.**

The list of 71 items which describe a fully-functioning person may have uses other than that prescribed through the card sort exercise or questionnaire. For example, self-help material could be developed based on the list, or therapists may use the information to assess client progress within any therapeutic methodology.

4. A set of learning principles which may provide the basis for a more systematic application of learning theory to humanistic therapies.

A brief therapeutic intervention with one client has demonstrated the utilisation of a limited number of learning theories as a basis for an approach to therapy. The outcome included the demonstration of a key learning element which was that of an acquired ability to engage in self-therapy, which may enable long term self-development post therapy.

10.7 Potential Applications and Future Research

10.7.1 Implications for Practice.

From this project, the researcher would argue that there seems to be some merit in the use of learning principles in therapy. The theories of Person-centred Therapy and person-centred learning facilitation, coming from the same source, support therapeutic learning outcomes well. Further, in a therapeutic culture of integration, where purist methodologies, whether in research or therapy, are no longer considered able to meet fully the needs of the researcher or client, as Bohart says, openness to new approaches is necessary:

> *If we refuse to allow there to be integrative person-centered practice, restricting person-centered practice to only classical nondirective therapy, we deny clients and the world something very valuable. …persons. We must find a way to integrate the use of techniques together with our belief in these*

> *fundamental attitudes so that clients have the right to get everything they want and need from therapists. This will provide an expansive, inclusive frame which in my opinion is representative of the underlying thrust of person-centered thinking, which has always been towards openness and inclusivity* (Bohart, 2012, p.12).

The use of a learning focused humanistic/person-centred methodology based on principles such as establishing a learning plan, analysing personal learning processes, focusing on meta-cognitive strategies, measuring progress and developing a learning self-identity has been demonstrated through this research. Further development of the approach is planned by the researcher, integrating the many other learning theories which were identified in the process of the literature review. The key aim for this approach would be that in the longer term, the client would learn how to be a self-therapist through a brief set of sessions with the therapist and then potentially return infrequently for help as they learn to manage their own ongoing development. As Burnett and Van Dorssen suggest, "one goal of counselling is the development of skills for lifelong learning by assisting clients to learn how to cope with difficult situations that are encountered throughout the passage of life" (2000, p.24).

10.7.2 Implications for Future Research.

Assuming a learning focused approach were to be tested further, then the following question becomes relevant: "Could this approach be developed into a methodology which makes for a more effective, efficient or long lasting humanistic approach?" A methodology which achieves these aims may be worthy of additional research.

If yet another therapeutic methodology were considered unnecessary, as Tudor & Worrall suggest (2006), a 'meta-theoretical framework' may be helpful in integrating the separate elements of therapy available to the practitioner. Since Burnett & Meacham propose that "a learning dimension may be added to any type of counselling used for any client in any situation" (2002, p.141), a learning meta-theory would be possible. There are a vast number of learning theories which could be combined with those which were reviewed, in order to produce a 'learning meta-framework'. A variety of different therapies could be integrated within a learning structure, which would provide a philosophical and methodological underpinning to enable consistency in approach. For example, Gestalt Therapy, Psychoanalysis and CBT all aim for lasting change which could be readily identified in terms of learning theory. Each addresses meta-cognitive issues such as changes in schemata, which again can be expressed as a theory of learning. The concept of becoming a self-learner is also applicable to each, as the idea of 'self-knowledge' is a common element. Even the notion of facilitated learning is applicable to each approach in the sense that the therapist 'does something' to enable change. Thus the idea of learning could become an 'umbrella' concept, enabling integration of approaches.

The list of items identified through the Delphi study could also benefit from further ratification, for example, areas such as spirituality, sexuality, diversity and physical wellness could be addressed. A larger sample of respondents would be necessary, potentially including a wider range of therapeutic approaches such as psychodynamic, CBT and other humanist approaches such as existential therapy. If the list is to be offered for used by any practitioner then a humanistic bias is not appropriate.

The positive reception that the card sort exercise in particular received from some members of the general public who tested it, suggests that there may be some merit in developing it as a tool for self-therapy. It could be envisaged that a book, or booklet, explaining the use of the cards could provide the information necessary to allow individuals (not necessarily with mental health issues) to redirect the focus of their own lives through this goal setting exercise. The marketing of this toolkit would require further research in order to establish how it might best be presented.

Finally, the key implication for future research is that there is the possibility that a learning based approach to therapy may result in a more effective and efficient way to achieve therapeutic change. Feltham (2010) notes the strong possibility of time wasting and inefficiency where therapeutic change is left to the actualising nature of the client, and there may be advances to be made in this regard. Further, longer term learning retention may lead to less returns to therapy due to relapse, and a greater commitment to therapy goals may also result in less client attrition - hypotheses which could be tested once a more robust therapeutic learning framework were established.

10.7.3 Implications for Training Practitioners.

One important point to emerge in the use of the instruments, was that clients and therapists need to be talked through the use of the instruments in person. No matter how well worded the instructions were, lack of ability, motivation, or time, meant that misunderstandings affected the potential benefits available in the application of the instruments. Therefore, it became increasingly evident that to

engage fully in the process of using the instruments with clients, some training for therapists would be necessary.

The use of the questionnaire or cards by the therapists in Study 3 demonstrated that they could be used in a number of different ways, for example, at different points in the process, at home or in dialogue, with or without instructions and so on. Some approaches seemed to work better than others, for example, using the instruments some way into therapy, in collaboration with the therapist. In addition to discussing these issues, training could also include the subtle differences available to the therapist in using the instruments as an outcome measure or a learning process tool. Other issues, such as avoiding a situation whereby the instruments inappropriately 'steer' clients could be discussed, along with methods to avoid clients feeling like they 'should' be fully functioning in 71 areas, (a reason to use the card sort exercise perhaps). One specific point to be covered would be an explanation of the positive wording of the items, since participants usually expected a questionnaire detailing all of their problems, and as a result were initially confused.

Further, the use of the instruments sits within a broader process of learning facilitation. Therefore, training on the various learning methodologies tested through the case study would also be recommended. It is suggested that, once further research has been conducted on clients in therapy using a learning approach, a workshop would be developed and offered as a CPD programme for therapists. Training would enable them to use the instruments effectively and embed them within a broader learning framework. There may also be the possibility to run a workshop in the style of group therapy which would train individuals to use the

instruments and address their own psychological development without being in a therapeutic relationship.

Conclusion

In the middle of the last century, Bandura (1961) said: "many of the changes that occur in psychotherapy derive from the unwitting application of well-known principles of learning", but "the occurrence of the necessary conditions for learning is more by accident than by intent" (p.155). It is the researcher's view, as a result of this study, that this may well still be the case, and that as Bandura goes on to say: "perhaps, a more deliberate application of our knowledge of the learning process to psychotherapy would yield far more effective results" (p.155).

This series of studies progressed on the basis that, psychotherapy of all varieties is made up of "learning, unlearning, and relearning experiences which can be mediated in many different ways" (Strupp, 1979, p.124), and that as therapists "we mediate and promote a highly complex but extraordinarily important learning experience" (p.127). Others concur with this view, suggesting that "the potential outcome of therapy is a change in perspective; a change premised on learning" (Loewenthal, et al., 2005, p.453). Further, it may well be that "all counselling interventions work because they exist in the context of a learning theory" (Gerber, 2001, p.283). But the most appropriate advocate here is Rogers, who suggested that "in a general way, therapy is a learning process… the client learns new aspects of himself, new ways of relating to others, new ways of behaving," and "therapy has much to… gain from integrating previous knowledge of learning into the known facts about therapy" (2003, p.132). Thus the hypotheses tested and questions posed

during these studies were based on these views: that therapy is a learning process. It is hoped that this perspective may be taken up and developed further as a result of this study.

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APPENDICES

Appendix I Recruitment Email, Information Sheet and Consent Form (Chapter Five, Interviews)

Recruitment Email

Dear
I am currently undertaking a PhD at Sheffield Hallam University, looking at combining learning theory and person-centred theory, to see if it can make therapy more efficient or more effective. I write to ask whether you would kindly consent to take part in this study. Hopefully from taking part, you will gain a new perspective on Person-centred Therapy and I hope ultimately to go on to develop a diagnostic tool which may be useful for your own teaching.

Participation will involve a 45m semi-structured interview in which you would be asked about your views on 'learning in a therapeutic context'. This would be taped, transcribed and analysed along with other person-centred educationalists.

Any information which identifies you will be deleted and a code used in its place, so you can be sure that your views are entirely confidential. All identifying information will be password protected on my PC or physically locked away. Once the thesis has been presented for examination, identifying data will be deleted or destroyed. Ultimately, the anonymised data will be stored at Sheffield Hallam University and the thesis made publicly available. However, you can withdraw from the study, or request for specific parts of your material to be deleted up to 2 weeks after the interview.

If you have any questions, please contact me on:
suerenger@btinternet.com

Alternatively, you may wish to contact my supervisors:

Prof Ann Macaskill:
Phone 0114 225 2497
Email: a.macaskill@shu.ac.uk
Faculty of Development and Society
Sheffield Hallam University
Collegiate Crescent Campus
Sheffield
S10 2BP

Dr Bill Naylor:
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Email: b.naylor@shu.ac.uk
Arundel Building
Sheffield Hallam University
City Campus
122 Charles Street
Sheffield
S1 2NE

Should you feel able to assist me in this process, please sign and retain the attached form. I can take it from you when we meet.

Information Sheet

Invitation
This is an invitation for you to participate in a PhD research project which aims to see whether learning theory and person-centred theory can be usefully combined. In order for you to decide whether to take part, it is important for you to be sure of its purpose and the requirements of you. Please ask if anything is not clear and be sure that committing the time will not cause any difficulties for you.

Why me?
It is understood that you have considerable understanding of person-centred theory and it is your expertise and experience in this area that is particularly of interest. There is no requirement for you to have any background in the field of learning, although I appreciate that you do.

Do I have to get involved?
It is entirely up to you whether to take part or not. Should you wish to do so, the consent form attached needs signing and handing to Sue Renger at the interview. Please keep the information sheet.

What do I have to do?
Once you have agreed to take part, I will arrange to interview you for around 45mins. The discussion will be taped so that I can transcribe it.

Are there any benefits to taking part?
Research participants often gain great benefit from taking part in studies, particularly in this case, to look at person-centred practice from a different perspective. You may find that it provides you with some useful information to include in your therapeutic practice or teaching.

What happens if I am unhappy with the process?
Your right to withdraw from the study stands right up to 2 weeks after the interview, as does your right to ask for material not to be used. Your concerns will be dealt with in the first instance by the researcher and secondly by the supervisors mentioned in the covering letter. The whole process however, is conducted within the BACP Ethical Framework which will ensure that your welfare is placed first.
A summary of the transcript from your interview will be sent to you. Should you wish to withdraw from the study, or ask for material not to be used, please send your comments to Sue Renger using the contact details below. Confirmation of action taken will then be forwarded to you. If you are unhappy with the outcome of this process, contact should be made with either of the supervisors below.

Will my contribution be confidential?
Any identifying information will be coded as soon as possible ensuring that you and your clients cannot be identified in any way. If any information has the potential to reveal your identity or that of your clients, your advice will be sought. The coding data, forms and any other physical material will be stored under lock and key until after the thesis is submitted and then it will be destroyed. All anonymised digital information will be password protected on one PC until submission and then stored securely in the SHU archive.

Further Information

Researcher, Sue Renger:
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Participant Consent Form (Used for all Studies)

Study: "Can learning theory contribute to making Person-centred Therapy a more efficient process?"
Please answer the following questions by ticking the response that applies

	YES	NO
I have read the Information Sheet for this study and have had details of the study explained to me	☐	☐
My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any point.	☐	☐
I understand that I am free to withdraw from the study within the time limits outlined in the Information Sheet, without giving a reason for my withdrawal or to decline to answer any particular questions in the study without any consequences to my future treatment by the researcher.	☐	☐
I agree to provide information to the researchers under the conditions of confidentiality set out in the Information Sheet.	☐	☐
I wish to participate in the study under the conditions set out in the Information Sheet.	☐	☐
I consent to the information collected for the purposes of this research study, once anonymised (so that I cannot be identified), to be used for any other research purposes.	☐	☐

Participants Signature: _____ Date_____

Participants Name (Printed): _____

Contact Details: _____

_____

Researcher's Signature: _____

Researcher's Name (Printed): _____

Researcher's Contact Details:_____

_____

Please keep your copy of the consent form and information sheet together.

Prof Ann Macaskill:
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Faculty of Development and Society
Sheffield Hallam University
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Topic Guide

Main questions

Do clients learn through Person-centred Therapy, or do they 'just' change?
If they do learn, what and how do they learn?

Supplementary questions

Are there any particular theories of learning which you have used in therapy? What was the outcome?
Do you think there is room for the therapist to 'facilitate' learning? If so, how?
What do you consider to be likely humanistic / learning outcomes for your clients?

Appendix II Round 1: Recruitment Email, Information Sheet, Consent Form and Questionnaire, plus Clarification Statements, (Chapter Six, The Delphi Study)

Recruitment Email

Can you help with some PhD research?

Main Question:	"Can learning theory contribute to making person-centred therapy a more efficient process?"
This 'Delphi' study asks:	**What are the learning outcomes of humanistic therapy?**
Do you:	Have experience of counselling within a humanistic framework and a view on what people learn from it?
Will you:	Spare 30 mins on 2 or 3 separate occasions to complete a questionnaire?

Background

I am currently undertaking a PhD at Sheffield Hallam University, looking at combining learning theory and person-centred theory. To do that, I need to know what people learn from therapy. Hopefully if you take part, you will gain a new perspective on the outcomes of person-centred therapy which may be useful for your practice if you are a therapist, or for yourself if you were a client of therapy.

Participation will involve the completion of a questionnaire on 2, possibly 3 separate occasions. The questionnaire lists a number of humanistic/learning outcomes likely from person-centred therapy. You will be asked how much you agree with them on a given scale, and to add any comments you wish. I will then collate the results from all the participants including yourself, combine them, and send out the results for further comments. Once I have some consensus, or stability in the group's opinion, I will conclude the study and send you the final outcome.

If you have any questions about the process, please contact me on:

Information Sheet

Introduction to the Survey

Invitation

This is an invitation for you to participate in a PhD research project which aims to establish your views on client learning outcome in humanistic therapies. In order for you to decide whether to take part, it is important for you to be sure of its purpose and th requirements of you. Please be sure that committing the time will not cause any difficulties for you.

Why me?

It is understood that you have an understanding of, or experience in humanistic therapy and it is your expertise and experience i this area that is particularly of interest.

Do I have to get involved?

It is entirely up to you whether to take part or not.

What is involved?

This is a Delphi study which seeks the anonymous views of a group of participants by questionnaire. This Delphi consultatio exercise will involve two or three 'rounds' of consultation to collate views on likely humanistic/learning outcomes of therapy. will send you a questionnaire which should take no more than around 30mins to complete. Once this information has bee analysed, a second questionnaire will be sent to you based on an analysis of round one. If there appears to be stability i responses, the study will end there. If not, a third questionnaire *may* be sent out based on analysis of data from the previou round. It is possible that each round may occur a number of months apart. In summary, in round one you will be asked for you views on an existing list of therapy outcomes, and any further comments you may have. In round 2, you will be asked to conside the collated views of the participants from round 1. In a *possible* round 3, further views may be sought based on the views fro round 2.

Your email contact details will be deleted at the end of the study and not used for any other purpose than this. Your name will b deleted from the analysis and a code used in its place. In addition, details on your general therapeutic approach may be requeste and results analysed comparatively.

A final report on the Delphi findings will be produced and the report used to inform further practice development. The findin will also be published in relevant academic and practitioner journals. A summary of the findings will be sent to all Delp participants at the end of the project.

Are there any benefits to taking part?

Research participants often gain great benefit from taking part in studies, particularly in this case, to look at the outcomes o person-centred practice from a different perspective. You may find that it provides you with some useful information to use i the context of the therapy process.

What happens if I am unhappy with the process?

Your right to withdraw from the study stands up to 2 weeks after the study finishes, as does your right to ask for material not t be used. In this case, please send your directions to Sue Renger using the contact details below. Any concerns you may have w be dealt with in the first instance by the researcher and secondly by the supervisors below. The whole process however, conducted within the BACP Ethical Framework.

Will my contribution be confidential?

Any identifying information will be coded as soon as possible ensuring that you and anyone you mention cannot be identified i any way. If any information has the potential to reveal anyone's identity, your advice will be sought. The coding data, forms an any other physical material will be stored under lock and key until after the thesis is submitted and then it will be destroyed. A anonymised digital information will be password protected on one PC until submission and then stored securely in the SHU archiv

Delphi Humanistic Therapeutic Outcomes Survey

Consent Form and Questionnaire

By completing and returning the questionnaire attached, you agree that:

- I have read the Background Information Sheet for this study and understand the requirements of me.
- I understand that I am free to withdraw from the study within the time limits outlined in the Background Information Sheet, without giving a reason for my withdrawal or to decline to answer any particular questions in the study without any consequences to my future treatment by the researcher.
- I agree to provide information to the researcher under the conditions of confidentiality set out in the Background Information Sheet.
- I wish to participate in the study under the conditions set out in the Background Information Sheet.
- I consent to the information collected for the purposes of this research study, once anonymised (so that I cannot be identified), to be used for any other research purposes.

Instructions for Completion

"What does a fully functioning person look like?"

For each item on the list below, please **consider whether you regard this outcome as important in the context of humanistic therapy.** First, **indicate your level of agreement.** Then you may wish to make **additional comments** such as "only for more educated clients, or "it is not clear what that this statement really means" for example. The additional pages below provide clarification of each of the statements. Consulting these will add depth to your comments.

If the format of the questionnaire frustrates you, please feel free to complete it in a way which conveys your views on this subject. You may **just want to return some notes** which is fine.

Thanks so much for your help.

	Category	Client States or Traits		Strongly Disagree	Slightly Disagree	Neither	Slightly Agree	Strongly Agree		Any thoughts, comments?
				Please click **one** box for each statement						
1	Understands self	A clear and objective view of self	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Understands different facets of self	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Acknowledges weaknesses, but affirms self	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Understands impact of self on others	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Acknowledges personal needs	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Understands development of self	-	☐	☒	☐	☐	☐	+	Click here to enter text.
2	Trusts self	Has self confidence	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Relies on own counsel	-	☐	☐	☐	☐	☐	+	Click here to enter text.
3	Positive self view	Values self	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Values achievements	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Receives positive feedback	-	☐	☐	☐	☐	☐	+	Click here to enter text.
4	Views on growth	Has a desire for learning	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Has a desire for growth	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Accepts help in the process of growth	-	☐	☐	☐	☐	☐	+	Click here to enter text.
5	Views about Change	Understands the nature of change	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Accepts change	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Integrates new experiences into the self	-	☐	☐	☐	☐	☐	+	Click here to enter text.
6	Accepts lack of control	Accepts lack of control	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Accepts the past	-	☐	☐	☐	☐	☐	+	Click here to enter text.
7	Accepts the negative	Appreciates existential concepts	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Accepts aging and loss	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Accepts own vulnerability	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Accepts pain	-	☐	☐	☐	☐	☐	+	Click here to enter text.
8	The maturing self	Has a firm identity	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Understands complex nature of self	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Is self-directed	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Has personal power	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Is in the process of 'becoming'	-	☐	☐	☐	☐	☐	+	Click here to enter text.
9	A developing world view	Has a broad world view	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Has a positive view of the world	-	☐	☐	☐	☐	☐	+	Click here to enter text.

		Understands their relationship to the world	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Acknowledges spiritual self	-	☐	☐	☐	☐	☐	+	Click here to enter text.
10	Emotional expression	Is emotionally stable	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Awareness of emotion	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Experiences emotional depth	-	☐	☐	☐	☐	☐	+	Click here to enter text.
11	Accessing the inner child	Can be spontaneous	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Can be creative	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Is motivated	-	☐	☐	☐	☐	☐	+	Click here to enter text.
12	Managing practically	Controls and manages day to day living	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Manages physically	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Avoids creating problems	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Controls life course	-	☐	☐	☐	☐	☐	+	Click here to enter text.
13	Managing self	Engages with self	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Owns reactions	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Can react to control self	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Reacts situationally	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Is assertive	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Can be independent	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Is resilient	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Handles responsibility	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Applies self-care	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Applies learning	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Is congruent	-	☐	☐	☐	☐	☐	+	Click here to enter text.
14	Deals with the negative	Can solve problems	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Accepts the unsolvable	-	☐	☐	☐	☐	☐	+	Click here to enter text.
15	Manages own emotions	Expresses emotion	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Manages own cognitions and emotion	-	☐	☐	☐	☐	☐	+	Click here to enter text.
16	Change in relationships	Understands change in relationships	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Does not demand change in relationships	-	☐	☐	☐	☐	☐	+	Click here to enter text.
17	Others viewpoint	Respects difference in others	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Sees others points of view	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Understands own impact on others	-	☐	☐	☐	☐	☐	+	Click here to enter text.
18	Treats others well	Is tolerant	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Is altruistic	- -	☐	☐	☐	☐	☐	+	Click here to enter text.

19	Values relationships	Values giving/receiving care	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Values social contact	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Values intimacy		☐	☐	☐	☐	☐	+	Click here to enter text.
20	Beliefs about others	Trusts others	-	☐	☐	☐	☐	☐	+	Click here to enter text.
21	Managing own needs within relationships	Can be open to others	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Expresses self sexually	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Meets own needs in the context of a relationship	-	☐	☐	☐	☐	☐	+	Click here to enter text.
22	Manages inter-personal issues	Is able to initiate and end relationships	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Communicates effectively with others	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Finds synergy with others	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Is able to commit to relationships	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Gives and receives love	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Supports others	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Can forgive	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Manages relationships	-	☐	☐	☐	☐	☐	+	Click here to enter text.
		Does not need to be responsible for others	-	☐	☐	☐	☐	☐	+	Click here to enter text.

Any missing elements?
Click here to enter text.

Any further comments?
Click here to enter text.

NB Your responses will remain entirely confidential. Contact details below are required merely to send the results to you and ask for further opinions/comments. If you leave an email address, I will send it electronically, or add a postal address for a paper copy.

Name	Click here to enter text.	Years counselling experience	Click here to enter text.
Address (Ignore if you want an online copy)	Click here to enter text.	Main therapeutic approach	Click here to enter text.
Email	Click here to enter text.		

Once complete, please email **by Nov 5th.**

Clarification of Statements

	Category	Client States or Traits	Explanation
1	Understands self	A clear and objective view of self	Able to analyse own thought processes. Is able to be objective about self. Recognises own defences.
		Understands different facets of self	Aware of different 'selves' or layers of personality. Acknowledges types of self or 'community of voices'.
		Acknowledges weaknesses, but affirms self	Can see own problems or deficiencies (e.g., denial, self-doubt, self-fulfilling prophecies, fears, poor coping strategies.) Affirms self in spite of deficiencies.
		Understands impact of self on others	Is aware of own impact on others
		Acknowledges personal needs	Is aware of own needs. Understands own reactions.
		Understands development of self	Understands self in the context of the past, (e.g. neglect, abuse, or style of nurturing).
2	Trusts self	Has self confidence	Is secure and comfortable in self. Has self-esteem. Is confident in self. Is secure in own knowledge.
		Relies on own counsel	Trusts self. Can rely on support from within. Is able to rely on own intuition and experience. Relies on personal wisdom.
3	Positive self view	Values self	Recognises and values personal positive traits. Likes self. Feels it's OK to like self.
		Values achievements	Has a sense of achievement about self, past and present. Has a sense of satisfaction with self and life. Gives self credit for successes.
		Receives positive feedback	Acknowledges positive feedback and experiences respect from others.
4	Views on growth	Has a desire for learning	Has a desire for continuous learning and personal development. Accepts that learning is lifelong.
		Has a desire for growth	Has a desire to grow, achieve, or move forward. Considers options in life. Fear of failure is not an impediment. Has formal or informal aims or goals.
		Accepts help in the process of growth	Accepts that seeking temporary help and support may be necessary at times (e.g., counselling, friends/family, mentoring, teaching, medical help).
5	Views about Change	Understands the nature of change	Accepts that some change may take time and involve hardship. Understands that continued effort is required to maintain change.
		Accepts change	Can accept change, either situational or personal. Understands the inevitability of, or need for change. Knows that change is possible.
		Integrates new experiences into the self	Is open to integrating new experiences into the self-concept without denial or distortion. Rectifies inconsistencies between thoughts and reality. Is not defensive.
6	Accepts lack of control	Accepts lack of control	Accepts chaos or complexity in life. Accepts that perfection is not possible.
		Accepts the past	Doesn't worry about the past, but doesn't deny memories. Accepts that some things are unchangeable.
7	Accepts the negative	Appreciates existential concepts	Accepts existential isolation. Accepts that suffering is inevitable.
		Accepts aging and loss	Accepts loss and understands the process of grieving. Accepts the ageing process.
		Accepts own vulnerability	Accepts and appreciates own vulnerabilities.
		Accepts pain	Can accept disappointment, rejection and setbacks. Can accept pain.
8	The maturing self	Has a firm identity	Has a well-developed and well-founded set of personal values, beliefs, opinions or attitudes.
		Understands complex nature of self	Accepts complex nature of self. Is enlightened. Can see patterns in view of self.
		Is self-directed	Has an internal locus of evaluation. Does not need to meet others expectations. Is not directed by 'oughts' or pleasing others. Is self-directed.

		Has personal power	Possesses personal agency, or empowerment. Awareness and acceptance that decisions/answers to problems come from within the self. Awareness and acceptance of self as responsible for the choices made. Confidence in own decisions.
		Is in the process of 'becoming'	Is 'being' in process. Is maturing, self-actualising or in a process of personal enrichment. Is engaged in the process of pursuit.
9	A developing world view	Has a broad world view	Has a broad view of different perspectives on life. Sees life in perspective, sees a bigger picture.
		Has a positive view of the world	Has a constructive view of the nature of man and the world. Has a sense of hopefulness. Sees the positive rather than the negative - a 'glass half full' person.
		Understands their relationship to the world	Has a sense of oneness with the world. Is in tune with their existence in the world. Understands their place in the world. Has a sense of stewardship for natural resources.
		Acknowledges spiritual self	Appreciates a spiritual or transcendent element of life. Is developing or regaining a sense of spirituality.
10	Emotional expression	Is emotionally stable	Is calm, settled. Has a sense of well-being. Is emotionally stable.
		Awareness of emotion	Is aware of own emotions
		Experiences emotional depth	Experiences deep emotions, e.g. passion. Experiences flow or full engagement.
11	Accessing the inner child	Can be spontaneous	Can be spontaneous. Enjoys taking the initiative. Is able to take risks.
		Can be creative	Expresses self creatively or appreciates creativity
		Is motivated	Is optimistic and positive about the future. Is motivated to live life. Experiences excitement, anticipation, energy. Enjoys new experiences.
12	Managing practically	Controls and manages day to day living	Can cope with the basic practicalities of life, (e.g. managing/balancing time, doesn't get overwhelmed, can sleep, focus, and concentrate).
		Manages physically	Manages physical health (e.g. diet, exercise, any conditions, e.g. not smoking).
		Avoids creating problems	Works to prevent problems rather than reacting to them. Thinks things through before acting.
		Controls life course	Is in control of direction of life
13	Managing self	Engages with self	Responds to own needs/feelings. Communicates with inner self. Engages with self.
		Owns reactions	Takes ownership of own thoughts, feelings and actions
		Can react to control self	Can let go of unhelpful thinking, emotions, relationships, the past
		Reacts situationally	Can react situationally or existentially rather than stick rigidly to principles. Doesn't jump to conclusions.
		Is assertive	Understands own rights and therefore can be assertive. Doesn't take blame inappropriately. Can say 'no' when necessary. Does not retain inappropriate guilt.
		Can be independent	Is independent (outside of close relationships). Seeks self-evaluation rather than evaluation/approval from others. Has awareness and acceptance that others do not have the answers.
		Is resilient	Is resilient. Can reframe bad situations.
		Handles responsibility	Can handle responsibility. Can make decisions.
		Applies self care	Cares for self. Can identify when self-care is necessary.
		Applies learning	Applies prior learning. (The ability to apply change/learning processes to other life areas or problems in the future.)
		Is congruent	Is authentic/congruent. Has no need for facades.
14	Deals with the negative	Can solve problems	Is able to clarify and confront problems or related factors. Can put problems into perspective.
		Accepts the unsolvable	Accepts unsolvable problems. Deals effectively with uncontrollable intrinsic factors (e.g., medical conditions, learning problems).

15	Manages own emotions	Expresses emotion	Expresses emotion appropriately
		Manages own cognitions and emotion	Can manage own cognitions and emotions (e.g. anger, fear, stress, sadness, anxiety). Has ability to accept natural aggressiveness without defensiveness, denial and repression. Is not obsessive. Is mastering symptoms (e.g. fear of flying).
16	Change in relationships	Understands change in relationships	Accepts the need for compromise or that personal change may be necessary for a relationship to work. Accepts that both parties may need to change.
		Does not demand change in relationships	Does not desire others to change. Aware that they cannot make others change.
17	Others viewpoint	Respects difference in others	Accepts that others may be different from self or have different views, with different strengths and weaknesses. Appreciates both equality and diversity in others.
		See others points of view	Awareness of others thoughts, feelings, behaviours, views. Can see through others' eyes.
		Understands own impact on others	Is aware of the impact of self on others. Awareness of how self and other interact and react.
18	Treats others well	Is tolerant	Is tolerant of others. Acknowledges the empowerment or agency of others. Is empathic.
		Is altruistic	Is altruistic. Seeks to avoid harming others. Is interested in others.
19	Values relationships	Values giving/receiving care	Values being needed. Values caring for others, giving, serving.
		Values social contact	Values being part of a community. Values being part of a family. Values friendships.
		Values intimacy	Values a close, intimate, romantic relationship.
20	Beliefs about others	Trusts others	Believes in and values the trustworthiness of others (unless untrustworthiness is proven).
21	Managing own needs within relationships	Can be open to others	Can open up to others, can express needs to others
		Expresses self sexually	Can express self sexually
		Meets own needs in the context of a relationship	Is able to put self first in relationships. Is able to let go of the responsibility for others. Is able to live life for self. Is able to be objective about own needs.
22	Manages interpersonal issues	Is able to initiate and end relationships	Is able to form new relationships. Is able to let go of relationships.
		Communication effectively with others	Is able to communicate effectively with others
		Finds synergy with others	Is able to find synergy or affinity within relationships.
		Is able to commit to relationships	Able to commit to a relationship with loyalty, a sense of responsibility and effort.
		Gives and receives love	Is able to give and receive love
		Supports others	Is responsive to, supportive and encouraging of other individuals. Seeks to mentor others.
		Can forgive	Is able to forgive. Is accepting of parents faults.
		Manages relationships	Is able to control relationships if necessary. Manages relationships with confidence. Can identify and manage dysfunctionality in relationships. Can cope with the behaviour, thoughts or feelings of others. Can manage interpersonal problems such as conflict. Sets boundaries.
		Does not need to be responsible for others	Does not need to rescue others. Does not feel solely responsible for problems and difficulties experienced in relationships.

Wording Changes in Round 1

	Item	Sample comment
5a	Understands the nature of change	"I think clients don't need to understand it theoretically, just recognise and integrate it."
7a	Appreciates existential concepts	"…this understanding will be influenced by client's intellectual competence and emotional maturity."
7d	Accepts pain	"Acceptance can mean ceasing to press for improvement"; "begins to explore its meaning and/or function"; "I see pain as being the motivation for change"
8a	Has a firm identity	"If identity is firm it feels like change/growth opportunities are reduced?"
8b	Understands complex nature of self	"I wouldn`t see this as a pre requisite for successful therapy"
9a	Has a broad world view	"It's for clients to decide importance of this"
9b	Has a positive view of the world	"Ideological"; "Compassion for the negative important"; "Has a *realistic* view of the world"
9d	Acknowledges spiritual self	"a depth of knowledge about what 'feeds' the self in any form"; "I think you can be fully functioning and not spiritual"; "Emotional depth, yes; sense of supernatural, no"
10a	Is emotionally stable	"Too many clients are afraid of their fluctuating emotions. Need to avoid reinforcing that"; "…being fully functioning can be about embracing turbulence"; "What does 'stable' mean?"
11a	Can be spontaneous	"…I don't necessarily see spontaneity as a really important therapy outcome"; "Why inner child?"
11b	Can be creative	"Important to me but not necessarily for client"
12b	Manages physically	"Fully functioning is not the same as perfect specimen."
12c	Avoids creating problems	"Creating problems isn't necessarily bad"; "Sometimes learning can emerge from this"
12d	Controls life course	"Has some power over the decisions and choices however not everything life in life is about choice"
13e	Is assertive	"Contexts may make this impossible"
16b	Does not demand change in relationships	"I would however wish for the client to understand abusive relationships and not to tolerate the unacceptable"
18b	Is altruistic	"Never clear what this means "; "Philosophically impossible concept, so best to avoid the term"
21b	Expresses self sexually	"People have the right to be asexual"

Appendix III Round 2: Questionnaire and Clarification Statements (Chapter Six, The Delphi Study)

Questionnaire

Round 2 Questionnaire

Part A

Most of the items on the list in Round 1 were given a response of 'slightly agree' or 'strongly agree' by most participants. Some items however, had a range of responses. Would you kindly **reconsider** these particular statements in the light of suggested changes by other participants? Alternatively you may just disagree with the item altogether; (other participants' disagreements are in dark red.) Also, some people missed the 'clarification statements' first time round which may help. Numbers indicate total responses from Round 1. Percentages indicate participants making similar comments.

As before, you are considering; "is this outcome important?" in the context of humanistic therapy, (given the change of wording or clarification). Please insert a cross in **one box** each time and add any further comments.

	Category	Client States or Traits	Strongly Disagree	Slightly Disagree	Neither	Slightly Agree	Strongly Agree	Any thoughts, comments?
			Please add an 'x' to one box					
5	**Views about Change**	Understands the ~~nature~~ impact of change		1	13	7	12	It's shouldn't be about 'understanding' change theoretically.
			☐	☐	☐	☐	☐	Comment
7	**Accepts the negative**	Appreciates existential concepts		1	12	9	11	Given that it may be too complex an issue for some clients.
			☐	☐	☐	☐	☐	Comment
		~~Accepts~~ Comes to terms with pain		4	7	11	11	Also, cease to press for improvement; explore its function; use it as motivation for change.
			☐	☐	☐	☐	☐	Comment
8	**The maturing self**	Has a firm identity		7	3	10	13	* NB don't agree or disagree with the statements in red, just assess the item. Identity is not fixed, but changing and growing (18%)
			☐	☐	☐	☐	☐	Comment
		Understands complex nature of self		4	7	9	13	Not necessarily a prerequisite for successful therapy.
			☐	☐	☐	☐	☐	Comment
9	**A developing world view**	Has a broad world view	1	5	4	10	13	Given that it may not be possible for all clients.
			☐	☐	☐	☐	☐	Comment
		Has a positive view of the world	2	5	11	6	9	Too ideological. Compassion for/awareness of the negative may be important (9%). Should be 'appreciation of the world', 'has own view', or 'has realistic view'.
			☐	☐	☐	☐	☐	Comment
		Acknowledges spiritual self	3	1	8	12	9	Whatever 'feeds the self' Not just spiritual, (6%). This element is not necessary, (6%).
			☐	☐	☐	☐	☐	Comment
10	**Emotional expression**	Is emotionally stable		3	7	9	14	Avoid reinforcing fear of fluctuating emotions. May need to embrace turbulence. What does 'stable' mean? (9%)
			☐	☐	☐	☐	☐	Comment

11	**Accessing the inner child**	Can be spontaneous	1	2	7	10	13	Not necessary. Dislike 'inner child'.
			☐	☐	☐	☐	☐	Comment
		Can be creative	1	1	7	12	12	Not necessary for all clients
			☐	☐	☐	☐	☐	Comment

12	**Managing practically**	Manages physically	2	6	7	10	8	Should state 'within physical limits' (18%) (NB See clarification: "Manages physical health eg diet, exercise, any conditions." This isn't about being physically strong/capable.)
			☐	☐	☐	☐	☐	Comment
		Avoids creating problems	4	5	5	9	10	Problems may be good. Add, seeks to learn/benefit from unavoidable problems, 12%
			☐	☐	☐	☐	☐	Comment
		~~Controls~~ Self-determines life course	4	5	5	11	8	Not everything is within an individual's control.
			☐	☐	☐	☐	☐	Comment

13	**Managing self**	Is assertive	1	3	5	11	13	Given that it is context dependent
			☐	☐	☐	☐	☐	Comment

16	**Change in relationships**	Does not demand change in relationships	3	1	7	13	9	Given that change may be necessary in abusive situations (9%)
			☐	☐	☐	☐	☐	Comment

18	**Treats others well**	Is altruistic		1	10	12	10	Unclear term. Philosophically impossible.
			☐	☐	☐	☐	☐	Comment

21	**Managing own needs within relationships**	Expresses self sexually	1	3	7	9	13	Given that it depends on the client. (Individuals have a right to be asexual.)
			☐	☐	☐	☐	☐	Comment

Part B

Some additional issues were raised by more than one or two people. ****This time, please indicate your level of agreement/disagreement with the comments.**

1. Many respondents felt that being 'fully functioning' depended on client variables:

Questions	% of participants responding						
		Please add an 'x' to one box for each statement					
Depends on client issues	55%	☐	☐	☐	☐	☐	For example, the importance to the client, their capacity and maturity Comment

2. Some respondents felt that being 'fully functioning' depended on the context or the relationship within which the client was situated:
:

Questions		Strongly Disagree	Slightly Disagree	Neither	Slightly Agree	Strongly Agree	
Depends on other issues	20%	☐	☐	☐	☐	☐	Such as the context or the clients relationships Comment

3. A number of participants objected to the basic idea of a questionnaire:

Questions		Strongly Disagree	Slightly Disagree	Neither	Slightly Agree	Strongly Agree	
Against the idea of a questionnaire	24%	☐	☐	☐	☐	☐	This was due for example, to it being too reductionist, prescriptive, judgemental or behavioural Comment

4. A few respondents questioned whether some of the outcomes would ever be possible:

Questions		Strongly Disagree	Slightly Disagree	Neither	Slightly Agree	Strongly Agree	
Is some of this really possible?	18%	☐	☐	☐	☐	☐	For example, to understand the self and its relationship to the world; controlling one's life course. Comment

5. Quite a number of people pointed out that the outcomes would be worked towards rather than being an endpoint, an ongoing process that ebbs and flows through life.

Questions		Strongly Disagree	Slightly Disagree	Neither	Slightly Agree	Strongly Agree	
Growth is a process not an endpoint	30%	☐	☐	☐	☐	☐	Comment

6. These elements were considered missing. **Do you agree that they should be added?**

			Strongly Disagree	Slightly Disagree	Neither	Slightly Agree	Strongly Agree	
Missing:	Quality of 'being'	3%	☐	☐	☐	☐	☐	Comment
Missing:	More on self awareness	3%	☐	☐	☐	☐	☐	Comment
Missing:	Sense of humour	3%	☐	☐	☐	☐	☐	Comment

Part C

Finally, these 3 elements had more than 20% of respondents replying 'neither'. It would be helpful for you to re-rate these, or indicate a reason for not expressing a preference.

		Strongly Disagree	Slightly Disagree	Neither	Slightly Agree	Strongly Agree	
Positive self view	Receives positive feedback (Simply a demonstration that the client is growing to be fully functioning)	☐	☐	☐	☐	☐	Comment
Accessing the inner child	Is motivated	☐	☐	☐	☐	☐	Comment
Manages inter-personal issues	Finds ~~synergy~~ connections with others	☐	☐	☐	☐	☐	Comment

Any further comments? Click here to enter text.	Name	

NB As before, your responses will remain entirely confidential.

Clarification Statements

Changes/additions are marked in red. Those in bold with a percentage show where more than one person made a similar comment.

	Category	Client States or Traits	Explanation	Comments from Round 1	Any strong agreement or disagreement?
1	Understands self	A clear and objective view of self	Able to analyse own thought processes. Is able to be objective about self. Recognises own defences.		
		~~Understands~~ Awareness of different facets of self	Aware of different 'selves' or layers of personality. Acknowledges types of self or 'community of voices'.		
		Acknowledges weaknesses, but affirms self	Can see own problems or deficiencies (e.g., denial, self-doubt, self-fulfilling prophecies, fears, poor coping strategies.) Affirms self in spite of deficiencies.		
		Understands impact of self on others	Is aware of own impact on others (but does not take responsibility for others feelings)		
		Acknowledges personal needs	Is aware of own needs. Understands own reactions.		
		Understands development of self	Understands self in the context of the past, (e.g. neglect, abuse, or style of nurturing).		
2	Trusts ~~self~~ themself	Has self confidence	Is secure and comfortable in self. Has self-esteem. Is confident in self. Is secure in own knowledge, (but without arrogance).		
		Relies on own counsel	Trusts self. Can rely on support from within. Is able to rely on own intuition and experience. Relies on personal wisdom. Also able to seek help, (15%). Not to the detriment of others.		
3	Positive self view	Values self	Recognises and values personal positive traits. Likes self. Feels it's OK to like self, (but not egotistically).		
		Values achievements	Has a sense of achievement about self, past and present. Has a sense of satisfaction with self and life. Gives self credit for successes. Sees own worth unconditionally.		
		~~Receives~~ Is able to receive (9%) positive feedback	Acknowledges and makes use of positive feedback. Experiences respect from others.		
4	Views on growth	Has a desire for learning	Has a desire for continuous learning and personal development. Accepts that learning is lifelong.		
		Has a desire for growth	Has a desire to grow, achieve, or move forward. Considers options in life. Fear of failure is not an impediment. Has formal or informal aims or goals. Accepts periods of rest/consolidation.		
		Accepts help in the process of growth	Accepts that seeking temporary help and support may be necessary at times (e.g., counselling, friends/family, mentoring, teaching, medical help).		

5	Views about Change	Understands the ~~nature~~ impact of change	Accepts that some change may take time and involve hardship. Understands that continued effort is required to maintain change.		
		Accepts change	Can accept change, either situational or personal, even when challenging/unwelcome. Understands the inevitability of, or need for change. Knows that change is possible.		
		Integrates new experiences into the self	Is open to integrating new experiences into the self-concept without denial or distortion. Rectifies inconsistencies between thoughts and reality. Is not defensive.		
6	Accepts lack of control	Accepts lack of control	Accepts chaos or complexity in life. Accepts that perfection is not possible. But aware of right to make choices	Too vague	
		Accepts the past	Doesn't worry about the past, but doesn't deny memories. Accepts that some things are unchangeable.	This is in the wrong place	
7	Accepts the negative	Appreciates existential concepts	Accepts existential isolation. Accepts that suffering is inevitable.		
		~~Accepts~~ Comes to terms with aging and loss	Accepts loss and understands the process of grieving. Accepts the ageing process. Can cease to press for improvement	Accepting easily may be a form of denial	
		~~Accepts~~ Comes to terms with own vulnerability	Accepts and appreciates own vulnerabilities.		
		~~Accepts~~ Comes to terms with pain	Can accept disappointment, rejection and setbacks. Can accept psychological and physical pain. Can cease to press for improvement. Explore its function, or use it as motivation for change		
8	The maturing self	Has a firm identity	Has a well developed and well founded set of personal values, beliefs, opinions or attitudes.		
		Understands complex nature of self	Accepts complex nature of self. Is enlightened. Can see patterns in view of self.		
		Is self-directed	Has an internal locus of evaluation. Does not need to meet others expectations. Is not directed by 'oughts' or pleasing others. Is self-directed.		
		Has personal power	Possesses personal agency, or empowerment. Awareness and acceptance that decisions/answers to problems come from within the self. Awareness and acceptance of self as responsible for the choices made. Confidence in own decisions, but is able to use other's power.	Dependent on definition of 'personal power'	
		Is in the process of 'becoming'	Is 'being' in process. Is maturing, self-actualising or in a process of personal enrichment. Is engaged in the process of pursuit.		
9	A developing world view	Has a broad world view	~~Has a broad view of~~ Able to see different perspectives on life. Sees life in perspective, sees a bigger picture.		
		Has a positive view of the world	Has a constructive view of the nature of man and the world. Has a sense of hopefulness. Sees the positive rather		

			than the negative - a 'glass half full' person.		
		Understands their relationship to ~~the~~ their world	Has a sense of oneness with the world. Is in tune with their existence in the world. Understands their place in the world. Has a sense of stewardship for natural resources.	Can *see* they have a relationship to the world would be enough	
		Acknowledges spiritual self	Appreciates a spiritual or transcendent element of life. Is developing or regaining a sense of spirituality.		
10	Emotional expression	Is emotionally stable	Is calm, settled. Has a sense of well-being. Is emotionally stable. Has emotional expression across whole range.		
		Awareness of emotion	Is aware of own emotions		
		Experiences emotional depth	Experiences deep emotions, eg passion. Experiences flow or full engagement.		
11	Accessing the inner child	Can be spontaneous	Can be spontaneous. Enjoys taking the initiative. Is able to take risks. Generates goodwill/humour.		
		Can be creative	Expresses self creatively or appreciates creativity		
		Is motivated	Is optimistic and positive about the future. Is motivated to live life. Experiences excitement, anticipation, energy. Enjoys new experiences.	Don't like 'motivated'.	
12	Managing practically	Controls and manages day to day living	Can cope with the basic practicalities of life, (eg managing/balancing time, doesn't get overwhelmed, can sleep, focus, concentrate).		
		Manages physically	Manages physical health (eg diet, exercise, any conditions, e.g. not smoking).		
		Avoids creating problems	Works to prevent problems rather than reacting to them. Thinks things through before acting.		
		~~Controls~~ Self-determine life course	~~Is in control of~~ Self-determine direction of life.		
13	Managing self	Engages with self	Responds to own needs/feelings. Communicates with inner self. Engages with self.		
		Owns reactions	~~Takes ownership of~~ Is aware of and accepts own thoughts, feelings and actions		
		Can ~~react~~ respond to control self	Can let go of unhelpful thinking, emotions, relationships, the past	Embrace *lack* of control. Have self-compassion where control is not possible.	
		Reacts situationally	Can react situationally or existentially rather than stick rigidly to principles. Doesn't jump to conclusions.		
		Is assertive	Understands own rights and therefore can be assertive. Doesn't take blame inappropriately. Can say 'no' when necessary. Does not retain inappropriate guilt.		

		Can be independent	Is independent (outside of close relationships). Seeks self evaluation rather than evaluation/approval from others. Has awareness and acceptance that others do not have the answers.	But can rely on others (6%)	
		Is resilient	Is resilient. Can reframe bad situations.		
		Handles responsibility	Can handle responsibility. Can make decisions.	This should be about 'self'-responsibility, not responsibility for others (9%).	
		Applies self care	Cares for self. Can identify when self care is necessary.		
		Applies learning	Applies prior learning. (The ability to apply change/learning processes to other life areas or problems in the future.)		
		Is congruent	Is authentic/congruent. Has no need for facades.		
14	Deals with the negative	Can solve problems (or can seek help)	Is able to clarify and confront problems or related factors. Can put problems into perspective.		
		Accepts the unsolvable	Accepts unsolvable problems. Deals effectively with uncontrollable intrinsic factors (e.g., medical conditions, learning problems).		
15	Manages own emotions	Expresses emotion	Expresses emotion appropriately	Any expression of emotion is valid	
		Manages own cognitions and emotion	Can manage own cognitions and emotions (eg anger, fear, stress, sadness, anxiety). Has ability to accept natural aggressiveness without defensiveness, denial and repression. Is not obsessive. Is mastering symptoms (eg fear of flying).		
16	Change in relationships	Understands change in relationships	Accepts the need for compromise or that personal change may be necessary for a relationship to work. Accepts that both parties may need to change.	Relationships involve others; the actions of others might not be understood.	
		Does not demand change in relationships	Does not desire others to change. Aware that they cannot make others change. However, does not tolerate abuse, (9%).		
17	Others viewpoint	Respects difference in others	Accepts that others may be different from self or have different views, with different strengths and weaknesses. Appreciates both equality and diversity in others.	Respect may not always be appropriate.	
		See others points of view	Awareness of others thoughts, feelings, behaviours, views. Can see through others' eyes.		
		Understands own impact on others	Is aware of the impact of self on others. Awareness of how self and other interact and react.	Can never really know this.	
18	Treats others well	Is tolerant	Is tolerant of others. Acknowledges the empowerment or agency of others. Is empathic.		
		Is altruistic	Is altruistic. Seeks to avoid harming others. Is interested in others.		

19	Values relationships	Values giving/receiving care	Values being needed. Values caring for others, giving, serving.		
		Values social contact	Values being part of a community. Values being part of a family. Values friendships.	People have the right to choose isolation.	
		Values intimacy	Values a close, intimate, romantic relationship.		
20	Beliefs about others	Trusts others	Believes in and values the trustworthiness of others (unless untrustworthiness is proven). Is more discerning of others. Based on 'self-trust', (6%)		
21	Managing own needs within relationships	Can be open to others	Can open up to others, can express needs to others	Not necessarily better for the client.	
		Expresses self sexually	Can express self sexually		
		Meets own needs in the context of a relationship	Is able to put self first in relationships. Is able to let go of the responsibility for others. Is able to live life for self. Is able to be objective about own needs. Balanced with the needs of the others.		
22	Manages interpersonal issues	Is able to initiate and end relationships	Is able to form new relationships. Is able to let go of relationships.		
		Communication effectively with others	Is able to communicate effectively with others		
		Finds ~~synergy~~ connection with others	Is able to find synergy or affinity within relationships.		
		Is able to commit to relationships	Able to commit to a relationship with loyalty, a sense of responsibility and effort.		
		Gives and receives love	Is able to give and receive love		
		Supports others	Is responsive to, supportive and encouraging of other individuals. Seeks to mentor others.		
		Can forgive	Is able to forgive. Is accepting of parents faults.		
		Manages relationships	Is able to control relationships if necessary. Manages relationships with confidence. Can identify and manage dysfunctionality in relationships. Can cope with the behaviour, thoughts or feelings of others. Can manage interpersonal problems such as conflict. Sets boundaries.		
		Does not need to be responsible for others	Does not need to rescue others. Does not feel solely responsible for problems and difficulties experienced in relationships.	Does not need to take responsibility for others' ideas.	

Appendix IV Round 3: Email Sent out (Chapter Six, The Delphi Study)

Your results from the last round of the Delphi study are attached, for interest.

The following items were excluded from the final list since they had less than 75% of respondents agreeing (strongly or slightly):

7a	55.6%	Appreciates existential concepts
9b	40.7%	Has a positive view of the world
9d	59.3%	Acknowledges spiritual self
10a	74.1%	Is emotionally stable
11a	66.7%	Can be spontaneous
12c	66.7%	Avoids creating problems
16b	51.9%	Does not demand change in relationships
18b	74.1%	Is altruistic
21b	70.4%	Expresses self sexually

Next Stage

The main study has now been concluded, however, I could really use your help with an 'extra' Delphi stage.

I have attached the list of items worded so that clients can understand them. (I hope that a group of therapists will test this inventory in practice, for which a client version of the document will be needed.) So, would you be able to have look down the blue column and check the wording - with your typical client in mind? It should only take about 15 mins - unless you have lots of suggestions to make. Return by **17th March** would be a good target to aim for if poss. (Your consent to participate will be based on that given in the previous round once you return your response.)

If you need to duck out at this stage I'll understand completely, but do let me know so I don't keep bothering you.

Warmest regards

Appendix V Final Instruments: Questionnaire, Learning plan and Cards (Chapter Six, The Delphi Study)

A complete copy of both of these instruments is included with this thesis, but not bound.

Questionnaire

Page 1 and 2

Therapeutic Learning Framework (TLF–A)

Your Initials

Your Counsellors Initials

Instructions for Completion

This exercise will help you set some personal goals for your therapy. You will be asked to consider what you are aiming for, how you would like to be, or what you want to be able to do. The questionnaire can be completed alone or with your therapist. If you complete it alone, it would help your therapy if you would discuss the results with your therapist.

Part A This part of the questionnaire helps you to choose **which areas of your life** you would like focus on.

Alternatively, you may find it useful to work through the whole questionnaire.

Categories

First, have a look at the categories below. Tick those areas of your life that you may want to work on. Just go with your first reaction, you can change your mind later.

☐ Coping with the basics of my life	Page 1	☐ Understanding myself	Page 5
☐ Being me	Page 2	☐ Managing my feelings	Page 6
☐ Coping with life's difficulties	Page 3	☐ How I feel about myself	Page 7
☐ Making relationships work	Page 4 and 4a	☐ Getting the most out of my life	Page 8

Then turn to the page(s) you have chosen. You will notice that the statements describe **what success might look like for you,** not any problems you may have.

Pink column

Tick which quality you would *most* like to describe you.

Blue column

For the qualities you have chosen, consider the descriptions in the blue column. Put a tick next to the items that you would *most* like to describe you.

Part B This part of the questionnaire looks at your **personal goals** for therapy.

Purple Column

Think about *exactly* what you want to achieve in therapy for each of the descriptions you have ticked, and their accompanying explanations. Think how you can make them relevant to you and your life. Add your own specific goals in the purple column.

Yellow column

Then rate your items 1-3 in terms of how satisfied you are with this aspect of your life at present. (Use ratings 4 and 5 as well if you go through the whole questionnaire)

On the reverse of each sheet, you can:

- Review or change your goals as your therapy progresses
- Re-rate yourself at the end of your therapy to see if you have changed
- Record any important learning points for the longer term

Please be reassured that this research is looking at the effectiveness of this questionnaire, *not* you and your therapy.

Your therapist will ask for a copy of the questionnaire so that the results can be analysed. However no one will be able to identify who the questionnaire belongs to except you and your therapist. Your therapist will submit their views on how well the questionnaire worked for you in therapy. Again any data which might identify you will be removed.

1. Coping with the basics of my life

1 = I'm starting from scratch on this 2 = I have quite a long way to go with this 3 = I have a little way to go with this 4 = I'm doing OK with this 5 = This describes me well

Part A				Part B							
Quality	Description			My specific goals are ...		1	2	3	4	5	
I manage physically ☐	1. I look after my health ☐	a.	I eat healthily, get enough exercise and control my alcohol intake		-	☐	☐	☐	☐	☐	+
		b.	I manage any medical/physical conditions I have		-	☐	☐	☐	☐	☐	+
I manage my everyday life ☐	2. I'm coping with everyday life ☐	a.	I am managing practically		-	☐	☐	☐	☐	☐	+
		b.	I get enough sleep		-	☐	☐	☐	☐	☐	+
		c.	I manage stress		-	☐	☐	☐	☐	☐	+
		d.	I've got my work/life balance right		-	☐	☐	☐	☐	☐	+
	3. I'm in control of the direction of my life as much as I can be ☐				-	☐	☐	☐	☐	☐	+

Learning Plan

Front Page

1 = I still want to work on this a lot
2 = I still want to work on this quite a bit
3 = I still want to work on this a little
4 = I'm now doing OK with this
5 = This now describes me well

Rating After Therapy	Important Learning Points for the Long term
1 2 3 4 ☑ 5	"I don't need to complete with anyone"
1 2 3 4 5	
1 2 3 4 5	
1 2 3 4 5	
1 2 3 4 5	
1 2 3 4 5	
1 2 3 4 5	
1 2 3 4 5	
1 2 3 4 5	

Therapeutic Learning Framework (TLF-B)

Instructions for Completion

This exercise will help you set some personal goals for your therapy. You will be asked to consider **what you are *aiming* for**, how you would like to be, or what you want to be able to do.

This booklet can be completed alone or with your therapist. If you complete it alone, it would help your therapy if you discuss the results with your therapist.

Green Card
First, have a look at the green card at the top of the pack of cards. Pick one of the eight topics that you would most like to focus on with your therapist. (You can choose some more topics later if you wish.) Then write the number at the top of the green column on the Learning Plan inside this booklet.

Pink Cards
Find the pink card with the number you have chosen. You will notice that the statements on the card describe what success might look like for you, not any problems you may have. Pick the quality which you would most like to describe you. Write the letter in the pink column in the learning plan.

Blue Cards
Find the blue card with the number and letter that you have chosen. Again, choose the item that you would most like to describe you. Write the number (and then letter(s) if there are any) in the blue column.

My Specific Goals
Using the topic you have chosen from the blue card and any additional bullet points on the card, develop your own goal for therapy. This may be the same or slightly different to the goal on the card. What is important is that it means something to you.

Rating
It may help you to see your progress if you indicate on the scale where you think you are now in terms of that item. A score of 1 would mean that you want to work hard on that goal and a score of 3 would mean you are nearly there. (Make sure you use the 'before' rating section, not the 'after' one.)

You may now wish to go back and start again with the green card to add more items to your plan.

Monitoring your progress
You can change your goals as your therapy progresses on this document. You can also re-rate yourself at the end of therapy to see how much you have progressed, (on the folded over flap). Finally, you can make a note of important things you have learned and wish to remember in the longer term.

Therapist Initials_____ Date Therapy Started_____
Client Initials _____ Date Plan Started _____
Date Plan Completed_____

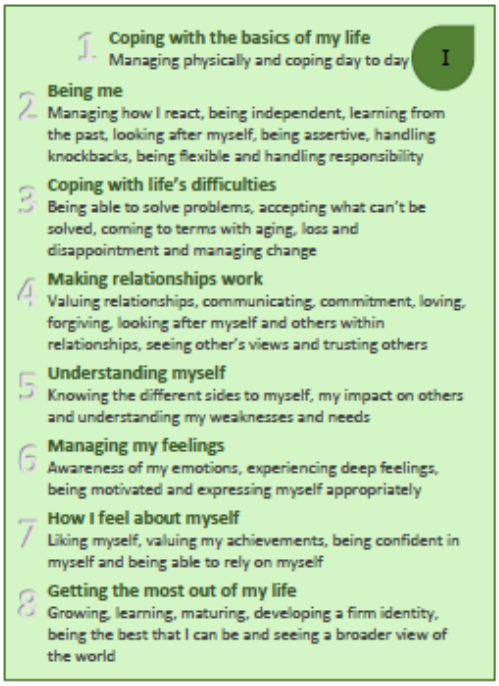
Learning Plan Back Page

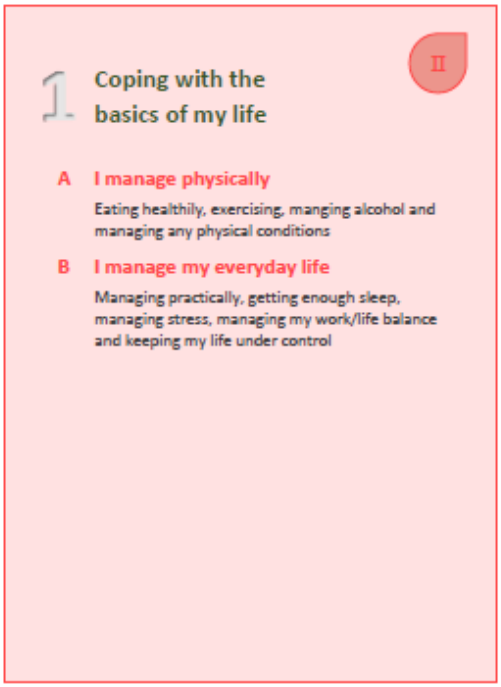
Learning Plan

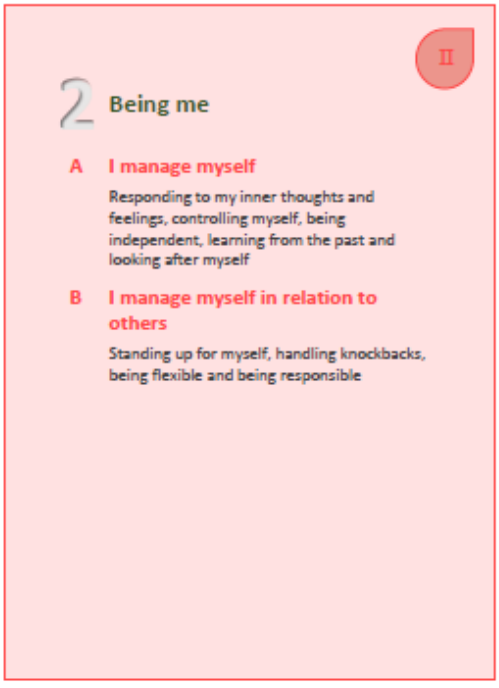
1 = I'm starting from scratch on this
2 = I have quite a long way to go with this
3 = I have a little way to go with this

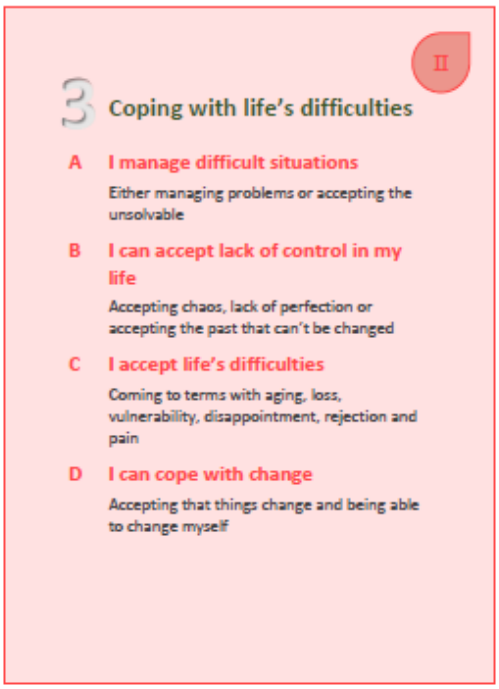
			My Specific Goals	Rating Before Therapy	Changing Goals Over Time
Example 5	B	49a	"I will be happy with my achievements even though I can't compete with my brother" *NB Try to write your goals in terms of what you will be like **after** you have succeeded*	1 2 ☑ 3	"I won't let the thought of failing stop me trying new things"
				1 2 3	
				1 2 3	
				1 2 3	
				1 2 3	
				1 2 3	
				1 2 3	
				1 2 3	
				1 2 3	

First 4 cards









Appendix VI Information and Briefing Sheet for Therapists

(Chapter Seven, Qualitative Experiment)

Information Sheet

Invitation
This is an invitation for you to participate in the third stage of this PhD research project which aims to see whether learning theory and person-centred theory can be usefully combined. In order for you to decide whether to take part, it is important for you to be sure of its purpose and the requirements of you. Please ask if anything is not clear and be sure that commitment will not cause any potential difficulties for you or your clients.

Do I have to get involved?
It is entirely up to you whether to take part or not. Should you wish to do so, the consent form attached needs signing and returning to Sue Renger. Please keep a copy of the Information Sheet.

What do I have to do?
Participation will involve you asking one or more of your clients (ideally 6) if they would wish to participate in the study. If so, you will be provided with a list of desired learning outcomes to discuss with your client. These would be in the form of a questionnaire or 'card sort' exercise. Between you, some general areas of focus, or even specific goals can then be established at the beginning of, or during therapy. This is however, a self-directed process, so you would take on the role of facilitator or helper, not advisor. These areas of focus do not need to be specifically addressed again during the course of therapy, although you or the client may wish to do so, which is fine. After around 6-8 sessions, the areas of focus are reassessed by the client and a measure of progress established. Again this is for the client to do for themselves with support, it is not an external assessment by you.
This process would be followed by a 30-45min interview with you on how it went for this and any other of your clients involved. The interview would be taped, transcribed and returned to you for agreement. The client's questionnaires would also need to be anonymised, copied and made available for analysis. This data would be available to support your interview comments.

Are there any benefits to taking part?
Research participants often gain great benefit from taking part in studies, particularly in this case, to look at therapeutic practice from a different perspective. You may find that it provides you with some useful information to include in your therapeutic practice. It is hoped that your clients may also gain therapeutic benefit from the process.

What happens if I am unhappy with the process?
You or your client are able to withdraw consent at any time before the intervention begins.
Once a client has begun therapy and the intervention has started, they are also able to withdraw from the study and indeed would be encouraged to do so if they felt that the process was not beneficial.
Once clients have engaged in the process and have not asked to be withdrawn, you would be encouraged to see the intervention through to the end, obviously having considered your client's needs.

You may withdraw from the study once any participating clients are happy to conclude or withdraw from the intervention. You may also withdraw from the study for up to 2 weeks after the semi-structured interview has taken place and your transcript has been sent to you for approval.

Both you and your clients have the right to ask for any information you provide to be excluded from analysis and/or publication within the 2 week period outlined above.

Should you wish to withdraw from the study, or ask for material not to be used, please send your comments to Sue Renger using the contact details below. Confirmation of action taken will then be

forwarded to you. If you are unhappy with the outcome of this process, contact should be made with either of the supervisors below. The whole process however, is conducted within the BACP Ethical Framework which will ensure that your welfare and that of your clients are placed first.

Will my contribution be confidential?
Your client's questionnaires should be coded (anonymised) before forwarding to the researcher: They should be encouraged not to write their name, but a set of letters/numbers decided between you, on each form. These codes must be identical to allow for 'before' and 'after' results to be matched up. Any other identifying information, such as your own details, will be coded as soon as possible ensuring that you and your clients cannot be identified in any way. If any information has the potential to reveal your identity or that of your clients, your advice will be sought. The coding data, forms, audio recordings, and any other physical material will be stored under lock and key until after the thesis is submitted and then it will be destroyed. All anonymised digital information will be password protected on one PC until submission and then stored securely in the SHU archive.

Further Information

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Topic Guide for Your Follow-up Interview
I'm trying to get to: "Can a process of facilitated goal setting contribute to the achievement of useful learning outcomes in therapy?" Specifically in this case;

- Did your clients accept therapy as a self-directed learning process in whole or in part?
- Did the exercises support the therapeutic process at all? If so how?
- How did the process of goal setting work? Was it joint/collaborative? Did the client work on it unaided?
- How did you decide which exercise to choose? Did you choose to present all or some of the items to the client for consideration?
- Were there any clear benefits to the client in the use of this approach?

Briefing Sheet

Background and Purpose

Just to put this exercise into context: Study 1 has already established whether a learning perspective can be applied to counselling: Study 2 has identified the ideal learning outcomes for any therapy client, (i.e. what a fully functioning person looks like): Study 3 is designed to test an instrument which enables the client to define their own learning objectives. Specifically, it seeks to establish:

- Whether goal setting in order to support the learning process benefits therapy
- Whether the items in the 'fully-functioning' learning framework are accessible/appropriate
- Whether the instrument design facilitates the process of goal setting, i.e. does it work?

- Further questions to be explored are:
- Whether clients accept therapy as a self-directed learning process in whole or in part
- How the process of goal setting works: Was it joint/collaborative or did the client work on it unaided?
- How the exercise is best administered, particularly the choice between the basic (TLF-B) and advanced (TLF-A) versions

Basic Requirements

You will need to have ideally, 6 clients over the next 2-3 months who will be willing to participate in this exercise. They can be new clients or clients who have been with you for a while. They should be committed to at least 6 further sessions. They do not need to be able to read if you do the exercise with them. Equally, the exercise is also appropriate for the highly educated. It is intended for clients who need to clarify their requirements from therapy, or for those who have reached a point of 'stuckness'. It can even be used towards the end of therapy to establish an ongoing plan for self-help. However, the study would not be appropriate for clients who have a very specific and obvious need such as bereavement counselling for example.

The Research Process

Pre-study

1. You have hopefully already read the information sheet for the study which was sent by email. There is a consent form at the end of that document which needs signing before you begin. I will collect it when I meet you for the interview at the end.
2. Each potential client should be given their Information Sheet and Consent Form (provided). Please explain the details of the study to them if they are not clear. Their Consent Form should be completed by the client and returned to you. I will also collect these Consent Forms when I see you.

The Study

Which one, exercise A or B?

There are 2 versions of the same exercise included: TLF-A is the whole questionnaire - if you have a more educated, holistic thinker, possibly in a more 'coaching-style' relationship, they may prefer this approach. TLF-B is a simplified card-sort version - most clients will use this exercise.

- The questionnaire (TLF-A) has instructions for use on its front page.
- The cards and TLF-B leaflets go together. The client completes the leaflet in conjunction with using the cards. The instructions are on the front of the leaflet.

The best way to understand them is to have a go yourself!

Before

Once explained to your client, the exercises can completed alone or with you - the client chooses. However, you would ordinarily discuss the results as part of the usual therapeutic process. There is then no need to refer back to the document throughout the 6 sessions, but the client may wish to do so. For example, there is space for the client's goals to be updated as therapy progresses.

After

After around 6 sessions the client can re-rate themselves to assess progress. Points to remember can also be added to aid long term learning.

The Post-Study Interviews

Client Interview

Once the client has completed the process, their views on it need to be sought. This can be either an informal interview with you, or they could provide their thoughts on paper. 15-20 mins should be enough to ask them:

1. Did you find the process helpful? If so, how? If not, why?
2. Was the exercise easy to complete? Were the instructions clear? How could they be better?
3. Did the process of goal setting help your therapy? How? Why not?
4. Were the items on the cards/in the questionnaire useful? Did they make sense to you? How could they be changed?
5. Did you work with your therapist or alone to set your goals? How was that helpful?

If you interview your client, some hand-written notes or a recording may be helpful to aid memory recall?

Therapist Interview

Once your clients have all completed the process, I will conduct a 45min interview with you. Ideally I hope to get a summary of the views of your clients as well as your own. Questions will be informal and based around those highlighted at the beginning of this document under the heading of 'Background and Purpose'. The interview will be taped, transcribed, anonymised and analysed.

Analysis

Ultimately, the completed plans are to be retained by the client. However, a copy should be taken. These should be given to me at the final interview for analysis purposes. Any identifying data may be removed beforehand. (I'm happy to do any copying of course.)

Use of the TLF-A (Therapeutic Learning Framework – Advanced)

Client Description

This exercise is suitable for an educated individual or holistic thinker who would be comfortable with a lengthy questionnaire. It is also suitable for anyone who, having done the card exercise, wants to see the whole framework in one document. The client can either pick one or two items from the document to assess. Equally they may wish to work through each item and rate themselves on everything.

Process

Timing

The questionnaire is presented to the client following the briefing and obtaining of consent. This can be before therapy starts, after one or two sessions, or at any time after. The timing is largely decided by the therapist based on their knowledge of the client or in discussion with them.

Completion

The questionnaire can be completed in conjunction with the therapist during the session, or by the client alone in between sessions. The instructions should be self-explanatory, or can be talked through in therapy. The results of the completed questionnaire ideally should be discussed in therapy in order to aid the therapeutic process. The client however, may wish to keep them private.

NB You will note that you only have one copy of the questionnaire. For the sake of this study, and to keep costs down, if the client is likely to only complete 1 or two items in the whole booklet, you may wish to ask them to use a TLF-B leaflet to write on. (If necessary, I can email this to you and it can be simply printed off on paper as many time as you need.) Alternatively I can send you more copies of the questionnaire.

Results

The goals written on the questionnaire can be added to or changed as therapy progresses. After 6 sessions, the client can (on the back of each page) re-rate themselves and add points which they wish to remember to facilitate longer term learning.

Use of the TLF-B (Therapeutic Learning Framework – Basic)

Client Description

The card-sort exercise is designed for a less well educated client who may struggle with a lengthy questionnaire.

Process

Timing

The card-sort exercise is presented to the client following the briefing and obtaining of consent. This can be before therapy starts, after one or two sessions, or at any time after. The timing is largely decided by the therapist based on their knowledge of the client or in discussion with them.

Completion

The exercise can be completed in conjunction with the therapist during the session, or by the client alone in between sessions. The instructions should be self-explanatory, but it is recommended that they are talked through in therapy. The results of the completed questionnaire ideally should be discussed in therapy in order to aid the therapeutic process. The client however, may wish to keep them private.

Results

The goals written on the questionnaire can be added to or changed as therapy progresses. After 6 sessions, the client can (on the back of each page) re-rate themselves and add points which they wish to remember to facilitate longer term learning.

Appendix VII Information Sheet for Clients (Chapter Seven, Qualitative Experiment)

Invitation
This is an invitation for you to participate in this PhD research project which aims to see whether learning theory and counselling theory can be usefully combined. In order for you to decide whether to take part, it is important for you to be sure what is involved. Please ask if anything is not clear and be sure that it is something that you really want to do.

Why me?
You are about to start a course of counselling with a therapist who is interested in this area of research to further their practise. They consider that you may benefit from the approach and have therefore offered you this opportunity to be involved.

Do I have to get involved?
It is entirely up to you whether to take part or not. Your therapy will not be adversely affected in any way if you choose not to participate.

What do I have to do?
Once you have agreed to take part, your therapist will provide you with a questionnaire or 'card sort' exercise to complete and an opportunity to review the exercise later. The exercises should take no more than around 30 mins each to complete. The exercises will enable you to set some goals to work towards in therapy and after around 6 sessions you will be asked to consider whether you have moved towards achieving any of those goals. The information you provide in the exercises will then be analysed by the researcher. However, the emphasis will be on *whether* you have learned rather than, *what* you have learned. Therefore once finished, it should be impossible to identify you from the research report.

Are there any benefits to taking part?
Research participants often gain great benefit from taking part in studies. At worst it may have no effect.

What happens if I am unhappy with the process?
You are able to withdraw consent at any time before the intervention begins. Once you have started the process, you are also able to withdraw from the study, and indeed would be encouraged to do so, if you feel the process is not beneficial. Your therapist will be interviewed to find out how you got on with the questionnaire. Your right to withdraw continues up to 2 weeks after that interview has taken place. You also have the right, within 2 weeks of your therapist's interview, to ask for any information you provide to be excluded from the analysis.

In the case of any problems, your concerns will be dealt with in the first instance by the researcher and secondly by the supervisors mentioned below. The whole process however, is conducted within the BACP Ethical Framework which will ensure that your welfare is placed first.

Will my contribution be confidential?
Any identifying information will be coded as soon as possible ensuring that you cannot be identified in any way. If any information has the potential to reveal your identity your advice will be sought. The coding data, forms and any other physical material will be stored under lock and key until after the thesis is submitted and then it will be destroyed. All anonymised digital information will be password protected on one PC until submission and then stored securely in the SHU archive.

Appendix VIII Therapist and Client Questionnaire (Chapter Seven, Qualitative Experiment)

Research Questionnaire

Background Information

This is the feedback form I promised to send to you for completion during and after your participation in this study. It needs to be completed and returned ideally by **the end of November**.

Thank you

Firstly, thank you so much for your participation in this study so far. Your participation and responses to this feedback form will be of great value to the research process.

Anonymity

Please be assured that your response to this questionnaire will be coded and analysed in such a way that you and your clients cannot be identified.

Research Aims (just for background info)

Broadly speaking, I'm trying to get to: "Can a process of facilitated goal setting contribute to the achievement of useful learning outcomes in therapy?" Most importantly:

- Whether goal setting in order to support the learning process benefits therapy
- Whether the items in the 'fully-functioning' learning framework are accessible/appropriate
- Whether the instrument design facilitates the process of goal setting, i.e. does it work?

- Other questions to be explored if possible are:
- How the process of goal setting works: Was it joint/collaborative or did the client work on it unaided?
- How the exercise is best administered, particularly the choice between the basic (TLF-B) and advanced (TLF-A) versions

Completion of the questionnaire

You might like to add to this document as your clients progress in therapy, or just complete it once they have all finished the process.

Suggested questions to ask your client (before you complete the feedback form)

1. Did you find the process helpful? If so, how? If not, why?
2. Was the exercise easy to complete? Were the instructions clear? How could they be better?
3. How did you choose which exercise to do – the cards or the questionnaire? Did you work with your therapist or alone to set your goals? How was that helpful?
4. Were the items on the cards/in the questionnaire useful? Did they make sense to you? How could they be changed?

What to do next when it is complete

Would you kindly email your questionnaire response to:
Would you also send by mail to;

- Any consent forms for you and your clients
- Copies of your client's completed Learning Plans (if they are happy to disclose them)

NB Do let me know your admin expenses and I'll reimburse them. I can also copy items and return them if necessary.

Please keep the pack of cards to use with other clients if you wish. (All materials are draft versions however, so please don't distribute them further.)

Feedback Form

These questions are **only a guide**. If you wish to feedback your results in another format, for example just written down as your thoughts occur, or in a list on a spreadsheet, that's fine. You may also wish to make points which are not asked for here or you may wish to answer only some of the questions. That's fine too. However, if you could try to cover the following points in some way, that would be very helpful.

Short answers here:

1. How many of your clients were involved in the process? How many sessions did each client have from first seeing the documents to the final use? How much of the process did they each complete?

2. How helpful did you find the questionnaire/cards to the therapeutic process? (Please add an 'x'. Alternatively, add a 'q' for the questionnaire and a 'c' for the cards if you want to give separate answers.)

Unhelpful
Helpful

1	2	3	4	5	6	7	8	9	10

3. How likely would you be to use the questionnaire/cards with further clients? (Instructions as above.)

Unlikely Likely

1	2	3	4	5	6	7	8	9	10

4. Were there any significant improvements in your clients goals (as measured by the ratings before and after on the questionnaire or learning plan), after 6 sessions? NB: I'm just interested in their scores here.

Longer answers here:

5. At what stage in your client's therapy did you use the exercises? When do you consider it to be most usefully applied if at all?

6. Generally, was the idea of *goal setting* helpful to the therapeutic process? Did it fit with your particular style of therapy?

7. Did the *questionnaire or the card sort exercise* specifically help the goal setting or therapeutic process? If so, how?

8. How did you or your clients decide which exercise to choose – the cards or the questionnaire? Did you choose to present all or just some of the items to the client?

9. Did your clients understand the exercise? Were the instructions clear? Did you have to explain the process?

10. How did the process of goal setting work? Was it joint/collaborative or did the clients work on it unaided?

11. Were the *items* on the cards/in the questionnaire useful/appropriate? Did they make sense to you and your clients? How could they be improved?

12. Why did your clients choose *not* to participate, or alternatively, how did you change the way the materials were used?

Appendix IX Information Sheet for Case Study Client (Chapter Eight, Case Study)

Information Sheet
Invitation
This is an invitation for you to participate in this PhD research project which aims to see whether learning theory and counselling theory can be combined beneficially. In order for you to decide whether to take part, it is important for you to be sure what is involved. Please ask if anything is not clear and be sure that it is something that you really want to do.

Why me?
You have demonstrated a previous commitment to personal growth through learning in therapy and it is considered therefore, that you may benefit from this study. You have been offered this opportunity free of charge.

Do I have to get involved?
It is entirely up to you whether to take part or not. Do not hesitate to decline of you are in any doubt.

What do I have to do?
You are asked to attend a minimum of 6 weekly counselling sessions in Litton, lasting for around 50mins each. The counselling will be very similar to your previous experience, but with more of a focus on personal learning. I will provide you with a questionnaire or 'card sort' exercise to complete before you start the sessions and an opportunity to review the exercise at the end. The exercise will enable you to define your personal goals to work towards in therapy. After 6 sessions you will be asked to consider whether you have moved towards achieving any of those goals. The exercises should take no more than around 30 mins each to complete. I will need to use the information you provide in the questionnaires for analysis at the end.

Additionally, I would ask you to partake in a final debriefing session of around an hour, in which I would ask you about your experience of the counselling process. This would be audio-recorded and transcribed. I will forward the transcript to you to check you are happy with the contents. In addition, I will write up your case study using examples from your therapy. However, the emphasis will be on *how* you learn, not *what* you learn. Therefore once finished, it should be impossible to identify you from the text. You will have an opportunity to read the submission to ensure that you cannot be identified in any way.

In order to ensure that my assessment of the counselling process is not biased in any way, it would also be beneficial to tape your counselling sessions and have them reviewed by my supervisors (see below). The recordings would be destroyed once that process has been completed.

Are there any benefits to taking part?
Research participants often gain great benefit from taking part in studies. At worst it may have no effect.

What happens if I am unhappy with the process?
You are able to withdraw consent at any time before the intervention begins. Once you have started the process, you are also able to withdraw from the study and indeed would be encouraged to do so if you feel the process is not beneficial. You also have the right to ask for any information you provide to be excluded from analysis and/or publication within 2 weeks of you seeing a copy of the case study and any other session transcripts.

In the case of any problems, your concerns will be dealt with in the first instance by the researcher and secondly by the supervisors mentioned below. The whole process however, is conducted within the BACP Ethical Framework which will ensure that your welfare is placed first.

Will my contribution be confidential?
Any identifying information will be coded as soon as possible ensuring that you cannot be identified in any way. If any information has the potential to reveal your identity your advice will be sought and changes made. The coding data, forms, audio recording, and any other physical material will be stored under lock and key until after the thesis is submitted and then it will be destroyed. All anonymised digital information will be password protected on one PC until submission and then stored securely in the SHU archive.

Further Information

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Appendix X Client Post-Therapy Review and Feedback Sessions

(Chapter Eight, Case Study)

Post-Therapy Review Session

Purpose
To enable the client to:

- Review what has been learned in the previous 6 sessions – to understand *what* she learned
- The recap on her own learning style/processes – to understand *how* she learned
- To establish how she is going to implement and retain learning/changes in the longer term
- To set new goals for going forward
- To establish a process to achieve new goals

- To consider evaluation of the therapy process:
- Did the client learn what she set out to learn?
- Will she be able to retain/implement that learning?
- Will the learning/changes make any significant difference to her life?
- Was the therapeutic process effective in enabling learning or could it have been done differently/better?

Questions on managing your therapy going forward

1. What are the key learning points from the sessions that you want to take forward?

2. How do you plan to implement that learning going forward?

3. What did you learn about *the way* you learn? Can you apply that to other issues in your life?

4. What new goals would you like to set going forward (refer to questionnaire?)

5. How do you plan on addressing your new goals?

6. This is the structure for self-directed therapeutic learning. Will this be helpful in anyway? (See below)

Evaluation of the Process

1. On a scale of 1-10, how successful was your therapy? Did you learn what you set out to learn? What did the scores on the questionnaire reflect?

2. How well does this style of therapy fit with your preferred way of working? Or would you prefer a different style of therapy?

3. Can you recommend any improvements to the process you have engaged in? Could your therapist have supported you more effectively?

4. Do you think you have made short term changes on issues you identified?

5. Do you think there will be any lasting impact on your life?

Post-Therapy Feedback Session

Specific Case Study Review Questions

On the Process

1. Given your experience of therapy, how did this process compare with other therapeutic approaches?

2. Did the focus on learning methods help, if so how?
    a. Was your therapy affected by the idea that you were focusing on learning- that you were meant to be 'learning' something?
    b. I tried to regularly recap process as well as outcomes, was that any use? For example, was it useful for me to be regularly asking "what was your learning from that?"
    c. Would you normally talk about learning opportunities, or did that come about because of the learning focus of the sessions?

3. Would you prefer to learn *how* to deal with your problem, or just deal with your problem?

4. To what extent do you believe you have learned to manage your own process out of therapy as a result of this approach? Do you feel equipped to manage your own therapy in future?

5. Did you know what you wanted to do before coming to therapy, or did it come from the questionnaire, (particularly the questions in section 8, the more existential ones?)
    a. So security for example, was that pre-decided?
    b. How much of the first 2 sessions in which we talked in detail about your goals was completely clear to you before we talked it through? Was it just a case of you bringing me up to speed, or did it clarify things for you?

6. You talked a lot about 'learning opportunities. Is that natural language for you or did you want to reflect my view of therapy?

7. Do you think we spent to long doing into what your goals actually were at the start? It was 2 whole sessions.

8. How did you view my role – expert, guide, fellow learner?

9. One learning process is role modelling. Were you conscious of that working in any way?

10. What level of significance would you attach to the issues we talked about? For example, we talked for ages about how frustration, destructiveness and productivity are linked. Did we start going round in circles. Should I have guided us out of it?

11. When I asked you half way through if you wanted to stop the sessions you said you reacted strongly. Why was that?

12. Who/where is your source – God, Mother Nature, the elements?

13. Would these items on the questionnaire have helped?
14. Considers the spiritual self:
15. "Seeks to understand the nature of their existence"
16. "Acknowledges transpersonal self; is open to explore or re-explore transcendent self."

On The Questionnaire

1. How helpful did you find the questionnaire to the therapeutic process?

Unhelpful
Helpful

1	2	3	4	5	6	7	8	9	10

2. How likely would you be to continue using the questionnaire post-therapy?

Unlikely Likely

1	2	3	4	5	6	7	8	9	10

3. Why did you choose the questionnaire over the card exercise?

4. Did you understand the questionnaire? Were the instructions clear? Would you have changed the wording of the items?

5. When do you think the questionnaire should be used, e.g. before therapy after a few sessions etc?

6. Generally, was the idea of *goal setting* helpful to the therapeutic process? Did it fit with your needs?

7. Did the questionnaire help the goal setting or therapeutic process? If so, how?

8. Did you find the questionnaire too reductionist for you?

Appendix XI Structure for Self-directed Therapeutic Learning (Chapter Eight, Case Study)

- Identify your main goal and your underlying objectives. Use the questionnaire/cards?
- Keep questioning, what, how, when etc. until you have uncovered the fundamental issue.
- Consider your motivation to achieve.
- Look at your existing strengths. How can they be made into opportunities?
- What are your blockages to success?
- Consider your own personal way of learning.
- 'Identify your learning gap'. Write a learning plan. What, how, when?
- Use Kolb's learning cycle. For you: try something out, reflect on how it worked, crystallise the learning points from it, put them into practice.
- Reflect and recap regularly on what you want to remember.
- Observe your processes and note what helps/hinders.
- Research potential perspectives on the problem – from books, other people, therapy.
- Rate your views, thoughts and emotions – give them a number. Does it change over time?
- Find people who understand you to question and challenge your views.
- Find a good example of your issue in practise. Describe it in detail. What more does it reveal?
- Regularly support and encourage your own sense of self, your own perspective and your own decisions.
- Reconfirm your aims/goals daily. Engage your goal directed behaviour.
- Plan to implement your learning – practise, experiment.
- Commit to implementing a way forward.
- Monitor and measure progress. Reward your successes.