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Aaron P. Jackson

Jamie Hansen

Juliann M. Cook-Ly

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Aaron P. Jackson, Jamie Hansen, and Juliann M. Cook-Ly

Brigham Young University

Psychotherapy has historically been viewed as value neutral; however, over the last half-century, developments have led many scholars to conclude that we can no longer dismiss the role of values in therapy. Our position is that therapists and clients will inevitably encounter value conflicts during the course of psychotherapy. This article postulates how such conflicts can be addressed so as to preserve and promote the integrity and well-being of both client and clinician. We review challenges to value neutrality and summarize ethical considerations. We discuss strategies to manage values in psychotherapy and conclude by recommending areas for consideration in professional training.

Psychology has had a longstanding goal of developing an objective, unbiased understanding of human beings. In the same vein, the profession's understanding of psychological dysfunction and treatment has been based on a positivistic philosophy with its accompanying empirical epistemology. Although therapists have their own values and beliefs, they have been expected to suspend those in therapy and adopt a position of neutrality. However, many philosophers (Gadamer, 2004; Tjeltveit, 1999) now doubt the viability of the idea that therapists can somehow suspend their values. These scholars contend that therapist and client values are inescapable in therapy. However, this need not impede therapy. We will suggest that the value conflicts inherent in therapy are important and can be utilized to promote positive change if managed appropriately and ethically.

Ethical guidelines alone do not direct the negotiation of delicate issues often involved in value conflicts. An example of this is the recent lawsuit filed against Eastern Michigan University by a student who was expelled from the school's counseling graduate program for refusing, on religious grounds, to counsel gay and lesbian clients (DeSantis, 2012; see also Mintz et al., 2009). This case highlights the need for strategies to address and manage value differences in therapy.

This paper will provide a working definition for values as well as a historical background of influential psychology theories and how those theories include or disregard the role of values in therapy. Value neutrality is a dominant theme, and we will challenge that notion and emphasize the role of values in psychotherapy along with inherent ethical considerations. We will conclude with recommendations for professional training as a way to manage value conflicts as they arise in therapy.

What We Mean by "Values"

In order to understand the role of values in psychotherapy, we must first understand the definitions of values used by those in the field and the implications these definitions have for therapy. Rokeach (1973) suggests that *values*, as differentiated from *attitudes* and *interests*, are the foundational commitments upon which attitudes and in-

Direct correspondence concerning this article should be addressed to Aaron P. Jackson, Brigham Young University, Provo, UT 84602. Contact aaron_jackson@byu.edu.

terests are based. He defines a value as "an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence" (p. 5). According to Beutler and Bergan (1991), "value connotes both a prescriptive (what is good and should occur) and a proscriptive (what is bad and should not occur) judgment regarding the target of one's attitude" (p. 7). Similarly, Heilman and Witztum (1997) suggest that values be viewed as "judgments (based on behavioral, cognitive, and affective appraisals) as to what is good (what ought to be) and what is bad (what ought to be avoided)" (p. 524). Schwartz (1992) defines values as "1) Concepts or beliefs, which 2) pertain to desirable end-states of behaviors, that 3) transcend specific situations, 4) guide selection or evaluation of behavior" (p. 4). Jensen and Bergin (1988) build on Rokeach's (1973) definition by describing therapist values regarding therapy as a set of "orienting beliefs about what is good and bad for clients and how that good can be achieved" (p. 290). In writing specifically about the role of values in counseling psychology, Mintz et al. (2009) build on Schwartz's (1992) definition by adding that these "orienting beliefs about what is good and desirable . . . guide behavior across professional counseling psychology roles and interactions" (p. 8). Thus values can be understood as core beliefs that provide a moral guide for human action across multiple contexts.

Historical Background

In its early years, psychology attempted to model itself after the natural sciences, which included adopting the physical sciences' methods of inquiry and emphasis on objective, value-free theory, investigation, and practice. Because of its apparent independence from subjective beliefs, scientific knowledge was believed to be trustworthy, while personal values and beliefs were viewed as hazardous to the process of inquiry. This led the field of psychology to view psychotherapy from its inception as a fundamentally technical enterprise in which therapists applied scientific knowledge to client problems. Given this view, the human experiences, values, and commitments of therapists were seen as either irrelevant or potentially harmful. For example, Freud (1912/1964) likened the work of a therapist to that of a "surgeon who puts aside all his feelings" (p. 115) and asserted that a therapist should "be opaque to his patients, and like a mirror, show them nothing but what is shown to him" (p. 118), suggesting that it is not only possible, but also desirable for the therapist's personal attitudes to be kept out of therapy.

Furthermore, Skinner (1971) felt that the behavior modification techniques he advocated were "ethically neutral," saying, "There is nothing in a methodology which determines the values governing it use" (p. 150). For Skinner, values were superfluous to core elements of behaviorism, as the goodness or badness of a behavior was derived not from a moral assessment, but from the contingencies of reinforcement. Thus, the advent of behaviorism reinforced the notion of value-free therapy.

Later humanistic psychologies broke from earlier theories by rejecting the view of the therapist as an objective, neutral scientist, and instead held that the therapeutic relationship with a genuine, involved counselor was essential for therapeutic change. However, this subjective involvement did not extend to the inclusion of therapist beliefs or values in the interactions. Instead, Carl Rogers (1951) held that therapists should "assume . . . the internal frame of reference of the client" and "lay aside all perceptions from the external frame of reference while doing so" (p. 29). In essence, all of the major schools of psychological thought that existed in the middle of the twentieth century advocated either a value-neutral approach to psychotherapy.

The Debate About Value Neutrality

Both theoretical writing and data-based research have called into question the tenability of a value-free strategy for counseling. Some scholars have begun to question the notion of value neutrality and conceptualize therapy as a value-laden enterprise. As Fisher-Smith (1999) states, "Values are the bedrock upon which therapeutic decisions are made" (p. 12). Ethical concerns have also been raised about the influence of values in therapy, and this has led to further discussions on appropriate and ethical value management for therapists (cf. Mintz et al., 2009).

Some have suggested that the impact of counselors' values can still be avoided by having the counselor bracket or suspend his or her values in therapy and by leaving the determination of therapeutic goals to the client. Tjeltveit (2006) finds several problems with this solution. For example, client symptoms may interfere with a client's ability to effectively choose therapeutic goals. In prac-

tice, therapeutic goals are typically determined by the therapist and client in collaboration. However, Tjeltveit notes that even if clients are allowed to independently choose their own therapy goals, such a practice—which he terms *liberal individualism*—is still rooted in a value. By valuing the clients' choosing their own treatment goals, the therapist has imposed a value and a treatment goal. No matter who chooses the goals, the therapist has foundational beliefs about what constitutes positive mental health for clients, which is inherently a value judgment. We must also recognize that *tolerance* and *respect* for client autonomy are both values as well. In essence, values underlie our very definition of healthy, normal, or well-adjusted states of being and are at the core of psychological theories themselves.

Others have suggested that values can be avoided simply by implementing a given scientific method. However, scientific methods and their underlying assumptions are themselves based on certain values and beliefs and preclude other assumptions. The problem is aptly summarized by Slife and Williams (1995).

> Objectivity calls for the scientist to achieve some grounds from which to observe that are independent of, or shielded from, all subjective influences . . .. Because subjective influences—values, emotions—are essential to the very identity of the scientist as a person, and because our history, culture, and so forth are often held implicitly rather than explicitly, it seems unlikely that we would ever achieve this kind of objective ground . . .. . (p. 193)

Over the past several decades, a considerable body of research has provided evidence that client values undergo a shift during the course of therapy to become more like those of the counselor, a phenomenon that has come to be known as *value convergence*. This seems to occur outside the conscious intent or control of the therapist, leading Kelly (1990) to conclude that "therapists do not remain value-free even when they intend to do so" (p. 171). Furthermore, value convergence seems to occur most notably when there is an initial dissimilarity between counselor and client (Kelly, 1990; Beutler, Arizmendi, Crago, Shanfiled, & Hagaman, 1983) and has been consistently linked with ratings of client improvement. However, while an earlier study (Beutler, Pollack, & Jobe, 1978) shows that clients rate their global improvement higher when they adopt their therapists' point of view to a greater degree, a later review article (Kelly, 1990) finds that value convergence is significantly associated with therapists' ratings of improvement but not with clients' ratings or with standardized measures of symptom improvement.

The relationship between initial value similarity and therapeutic outcome also appears to be mixed. The types of values on which the therapists are matched seem to be at least as important as the degree of similarity and dissimilarity within those values. Arizmendi, Beutler, Shanfield, Crago, and Hagaman (1985) find that "a complex pattern of similarities and differences in specific values promote maximal improvement" (p. 16). Kelly and Strupp (1992) find that religiously oriented values appeared to function differently than other values and suggest that religion could be investigated as a trait on which therapists and clients are specifically matched in order to improve outcome. Martinez (1991) finds that both clients and therapists tended to rate client improvement higher when the therapists' religious orientation was more conservative theologically than the clients' and that the clients' ratings of their own improvement in therapy was correlated with initial dissimilarity in religious values. When referring to this change in values, Tjeltveit (1986) prefers the term *value conversion* to value convergence because, as Schwen and Schau (1990) discovered, counselor values tend to remain stable over the course of therapy while client values show significantly less stability. The idea of therapists converting clients, of course, contradicts several values traditionally held by the profession, such as respect for client autonomy, and it raises ethical issues regarding how values should be managed. Given that empirical data consistently demonstrates that value conversion does in fact occur, it would be naïve to ignore or discount the impact of values on the counseling process.

Ethical Considerations

Because of added attention to the issue of values in counseling, value-neutral approaches are increasingly seen as untenable (Bergin, Payne, & Richards, 1996) and perhaps even undesirable. However, this raises ethical questions for many therapists. The influence of therapist values appears to be a threat to psychology's core commitments of client autonomy and respect for differences as articulated in the American Psychological Association (APA) (2002) code of ethics. Five general principles summarize these core values, of which Principles D and

E specifically address therapist "biases" (which necessarily stem from values) as harmful elements of psychotherapy (APA, 2002). APA's admonition "to eliminate the effect . . . of biases" on professional work seems to echo the traditional notion of value neutrality. The possibility that values are affecting psychologists' work seems to challenge the fundamental ethical concerns of protecting client rights and reducing unjust or unfair influence stemming from therapists' beliefs and attitudes.

However, Principle A (Beneficence and Nonmaleficence) asserts that "psychologists strive to benefit those with whom they work" and "seek to safeguard the welfare and rights of those with whom they interact professionally" (APA, 2002). Tjeltveit (2006) argues that any argument of beneficence rests on value judgments about what constitutes a good outcome, as opposed to a bad one, and that psychologists may differ among themselves on what they consider to be a good outcome. Principle A does not clarify whose definition of beneficence takes priority or how therapists should resolve conflicts that arise when the goals of clients conflict with the goals of therapists. Thus, even a principle as fundamental as beneficence is laden with value issues that present ethical concerns.

Other ethical questions arise from the possibility of value conversion in therapy. Tjeltveit (1986) identified the following as possible ethical issues: the reduction of client freedom, failure to provide clients with informed consent, violation of the therapeutic contract, and therapist incompetence in effecting such conversation. Regarding this last issue, Vachon and Agresti (1992) stated, "Because research has provided evidence of the therapists' values affecting their clients' choice of values, it is imperative that psychologists know how to work with both their own values and the values of their clients in order to practice ethically" (p. 510). While ethical discussions are important in raising concerns and shaping professional practices, it is clear that existing ethical guidelines alone do not offer sufficient direction on how best to navigate these delicate issues. A primary concern is how to ethically manage values in counseling to minimize the threat of therapist values on client freedom and autonomy.

Strategies for Managing Values in Therapy

Despite a growing consensus that values are an inescapable part of psychotherapy, there is considerably less agreement about how values should be ethically managed in therapy. We will outline several different strategies, with the understanding that much work remains to be done in addressing this important issue.

Separating Professional Values from Personal Values

While counselors can certainly be expected as human beings to have personal feelings about what constitutes desirable behavior, they can also be expected as psychology professionals to have professional beliefs about what constitutes psychological well-being and what outcomes are desirable for clients who are experiencing emotional distress. The ethical threat personal belief systems pose can be minimized if personal feelings can be distinguished from professional beliefs. This way, therapists may still draw upon values, if only professional ones, to guide therapy. Williams and Levitt (2007) coined the term *value atomization* to describe this strategy (p. 160). They suggest a *morally relativistic stance* (p. ??) in which therapists attempt to situate themselves within their clients' values and guide therapy according to those values. They interviewed 14 therapists and found that they would challenge client values only when they felt that such values would hinder therapeutic progress or when the clients' values differed sharply from their own views of positive mental health. Furthermore, some of the therapists explained that they would directly and explicitly disclose their values to their clients in order to encourage the clients to explore their own values.

Strupp (1980) suggested that practitioners share *essential therapeutic values* (professional values) as opposed to *idiosyncratic values*, which are unique to the individual therapist and can be kept out of the therapeutic encounter. For Strupp, this reduces the issue of indoctrination and other ethical ills associated with value convergence. Strupp held that "to the extent that the therapist's commitment to essential therapeutic values is realized, a number of issues that are frequently discussed in the therapy literature become more or less irrelevant" (p. 400). These issues include gender, sexual values, religious beliefs, and other characteristics. Tjeltveit (1986, 1999) similarly felt that an ethical method for managing values might include a distinction between values directly relevant to the counseling process (such as a belief that depressive symptoms are undesirable and ought to be reduced) and other irrelevant beliefs (including religious and political values).

A value atomization approach assumes that a set of professional values that are fairly consistent across practitioners can guide the process of therapy. Jensen and Bergin (1988) explored this notion and found they could group values into 10 themes: (1) perception and expression of feelings; (2) freedom, autonomy, and responsibility; (3) coping and work satisfaction; (4) self-awareness and growth; (5) interpersonal and family relatedness; (6) physical fitness; (7) mature values; (8) forgiveness; (9) sexual regulation and fulfillment; and (10) religiosity and spirituality. They found a high degree of consensus among the professionals surveyed that the first 7 factors were important for mentally healthy lifestyles, somewhat less consensus about the importance of forgiveness, and even less consensus about the importance of sexual regulation and religiosity. They further found that therapists' personal characteristics and theoretical orientation influenced their views of the 10 values. Their research questions the viability of any consensus around a comprehensive core of therapist values.

Furthermore, some writers have suggested that value atomization is neither tenable nor desirable because values are meaningfully interconnected in complex ways, and therapists cannot be expected to tease apart which values are mental health related and which are not (Fisher-Smith, 1999). It may be that mental health values are interwoven with other values, including those that are more obviously of a moral or ethical nature (Slife et al., 2003, Slife, 2004). Tjeltveit (2006) concedes this point: "It may in some instances be impossible to change health values without also changing moral, religious or political values" (p. 519). If this is the case, the central problem of knowing how and when it is ethically appropriate for the therapist to influence the values of the client remains unresolved. As O'Donahue (1989) opines, "The results of our efforts to understand and help other human beings are a function of our entire web of beliefs" (p. 1468). Thus all of therapists' beliefs, not just professional ones, may be relevant to our work as therapists.

Disclosing Personal Values

A commonly discussed alternative to either neutrality or value atomization is for therapists to be explicit about their values and openly discuss them with clients, whether it be prior to therapy, during therapy, or both (Bergin, 1980, 1985; Giglio, 1993; Slife, 2004). Such self-disclosure can be a way to open a dialogue about differences in values and reduce covert value convergence by making implicit values explicit. However, Lewis (1984) found that subjects in her study had a more negative impression of therapists about whom they had received value information, suggesting that clients may feel more negatively toward counselors whose value positions are disclosed prior to the start of therapy. Given the desire to enhance client autonomy, some therapists may still feel that, despite its potential negatives, self-disclosure remains the most ethical and philosophically consistent choice.

Fisher-Smith (1999) interviewed practicing psychologists about values management in their sessions and found that therapists tend to adopt either a *disclosure mode* (as described above) or a *neutrality mode*, where they attempt to suspend or put aside their own values and beliefs in favor of those of their clients. Regardless of the method of managing values, Fisher-Smith found that all of the therapists interviewed share values of individualism (described as authenticity, agency, and autonomy), and want to promote clients' inner sense of self and their ability to make independent decisions and manage their own lives.

Referring Clients to Therapists with Similar Values

Tjeltveit (1986) proposed that matching clients with counselors prior to therapy, particularly in areas such as religion, would increase the likelihood of positive outcomes. However, Propst (1992) found that religious clients had positive outcomes with non-religious therapists when the therapists had been trained in religious values and religiously oriented therapeutic techniques, which suggests that therapists' ability to respect and understand religious values is the critical variable in outcome rather than personal religious similarity, per se. While matching client and counselor values may appear to have merit, empirical literature does not demonstrate that value similarity between client and counselor improves treatment outcome considerably. In fact, some of the literature seems to suggest that the opposite is true, and that dissimilarity actually predicts greater improvement (Beutler et al., 1983; Kelly, 1990). Also, for many clients, therapist matching may not be an option due to logistical constraints (e.g., size of practice, locale, insurance requirements, etc.).

Adjusting Therapeutic Goals

Situations may arise in which the values of the therapist and the values of the client obviously collide. After all, if all therapist-client pairs shared identical values, then value convergence would not present the ethical dilemma it does, and disclosure of counselor values would be unnecessary. As such, Heilman and Witzum (1997) suggest a *value-sensitive* approach to therapy because significant value conflicts can change the entire course of therapy. The value-sensitive approach aims to protect the larger value-grounded interests of the client, even when doing so conflicts with typically accepted therapy goals or the personal values of the therapist. In other words, the therapists value the client's values more than their own. The result is that, at times, therapists may have to settle for "less than a full resolution of the problem and only deal with some of its limited symptoms" (Heilman & Witzum, 1997, p. 524) in order to preserve clients' value systems. They illustrate this point with examples of therapy with clients from ultraorthodox Jewish backgrounds, for whom pursuing goals that reflect the values of the field, such as open acknowledgment and acceptance of homosexual feelings, would isolate the clients from their social and cultural groundings and may cause greater harm overall than the original problem for which the client sought treatment. The therapist must understand and be sensitive to the cultural values the client brings into therapy and, in some situations, may have to alter the goals of therapy in order to preserve those values.

Seeking Outside Consultation

Williams and Levitt (2007) report that several therapists they studied would seek outside consultation or referral when therapist values and client values were too different. Some therapists felt that a failure to join the clients in examining their lives from the clients' value system reflected an inadequate understanding or ability on their part. In addition, Williams and Levitt observe that the category of values that would be considered sufficiently problematic to initiate a values discussion was very narrow for some practitioners and much broader for others. Accordingly, their recommendation is that therapists make greater use of consultation in order to gain perspective on such differences.

A More Radical Step

Our perspective on addressing the issue of value conflicts is more radical than those we have reviewed. We see a need for a comprehensive overhaul in the way that (a) psychotherapists are trained and (b) psychotherapy is presented to the public.

First, we believe that therapists need to be trained to articulate their values—both therapeutic and personal—and understand the interplay of the two. Williamson (1958), an early counseling psychologist, proposed that all counselors should be experts at understanding how values and morality are inherent in counseling. He stated,

> I have further argued for making explicit our own value orientations as individual counselors, not in order that we may adopt a counselor's orthodox creed, but rather that we may responsibly give societal and moral direction to our individual work. (p. 528)

We concur and suggest that today's pluralistic society makes this awareness and articulation even more important. One way to begin to address this need would be to develop an axiological taxonomy; that is, a system for articulating therapist values. At the very least, therapists need to be trained to articulate their ontological and philosophical assumptions and show how they relate to their theory of change, interventions, and evidence of change. For example, therapists who identify as traditional cognitive-behavioral theorists could articulate their value system as follows:

1. Ontology
   a. the individual mind is the fundamental reality
2. Philosophical Assumptions
   a. Autonomy—the mind has the capacity to change and become more rational and more functional in its evaluations and assessments
   b. Hedonism—happiness, pleasure, and freedom from symptoms are primary motivators
   c. Universalism—there are fundamental laws or rules of functional, effective thinking that apply across situations and time
   d. Stoicism—the ideal attitude is a reasoned restraint in expectations and commitments, along with the capacity to defer gratification

Once psychotherapists have identified a guiding ontological assumption and some fundamental philosophical assumptions, they can more readily articulate how their treatment goals and interventions are based in those as-

sumptions. For example, cognitive-behavioral therapists, making the assumptions listed above, can readily support their use of interventions focused on changing thought patterns to reduce symptoms of anxiety or depression. Alternatively, psychotherapists with a relational ontology and philosophical assumptions of interdependence, altruism, contextualism, and Christian love might focus on the meaning and quality of a client's relationships as gauge of their improvement and quality of life. Clients, once educated about the differences across the various approaches to psychotherapy, could make more informed choices about the psychotherapist values they might want to engage with in therapy.

More Training Considerations

Programs that train new psychologists have particular interest in how therapists handle value differences and the gaps between recommendations and actual practice. One of the most striking consistencies found in the literature on values and psychotherapy is a call for practitioners to more critically examine their own value systems and the way these are communicated in therapy (e.g. Mintz, et al., 2009; Slife, et al., 2003; Tjeltveit, 1986, 2006). Furthermore, therapists are not usually trained in what Tjeltveit (1999) refers to as *ethical acuity*, which is recognizing the value-laden underpinnings of therapy or the way their own values enter into therapy. Also, therapists are not generally trained to help clients clarify their own values, despite the recognition of the role that values play in counseling. Vachon and Agresti (1992) state that it is a skill to understand how the counseling process is value laden, and it is possible to teach people this skill. Training can help practitioners develop the necessary skills in understanding and clarifying values that will allow them to practice ethically and competently.

Issues of value conflicts have been seen as increasingly relevant to training programs due to actual experiences and conflicts between trainees and programs concerning values management. As noted earlier, Eastern Michigan University recently terminated a graduate student from its school psychology program because she refused to counsel LGBT clients. The student subsequently filed a lawsuit, which was dismissed. The ruling specified that instead of exploring options that might allow her to counsel homosexuals about their relationships, the student insisted that she would not engage in gay-affirming counseling, which she viewed as helping a homosexual client engage in an immoral lifestyle (Schmidt, 2010). Subsequent legal action led to a settlement in which the student was paid $75,000 (Kraft, 2012).

In 2004, similar situations occurred which prompted the training director of an APA-accredited counseling psychology doctoral program to initiate a listserv describing the conflicts the program was encountering with students strongly desiring not to work with LGBT clients due to religious beliefs. Other posts followed, with more trainers expressing concern about the consequences of the conflicts between trainees' personal values and professional expectations (cf. Mintz et al., 2009).

The idea that trainees prefer to see clients who are more similar to themselves has received some empirical support (Teasdale & Hill, 2006). Several studies have explored clients' preferences for counselor characteristics, but few have investigated therapists' preferences for client characteristics. Tryon (1986) found that therapists preferred to see clients who were young, attractive, verbal, intelligent, and successful (YAVIS). No studies specifically investigated the preferences of therapists currently in training until Teasdale and Hill (2006) used a paired comparison model to examine preferences for demographic variables as well as "psychological" characteristics. Their findings suggested that students consistently preferred to see clients with similar attitudes and values and that psychological mindedness was the trait most preferred in clients. They speculated that students see clients with similar values as easier to identify and empathize with than those with different values.

When trainees refuse to work with clients with different values, training programs are presented with a problem, because the field places a high value on providing services for underserved or marginalized populations and respecting differences among individuals. Following the 2004 listserv, the training directors who were involved in the discussions reached several conclusions, namely that the general standards and codes of the field, together with a goal to promote social justice, had to outweigh individual trainees' values that allowed intolerant or discriminative attitudes to affect their professional roles. They also agreed that increasingly frequent and complex value conflicts point to a need for greater guidance for trainers on how to manage these difficult situations among their own trainees (Mintz et al., 2009). Mintz et al. (2009) suggested a Counseling Psychology

Model Training Values Statement Addressing Diversity (CPMTVSAD), which would explicate the professional values upon which students' clinical work should be based. While they hold that the field should not influence values that relate exclusively to nonprofessional roles, they argue that the profession can specify expectations for professional roles, even when these expectations are based on values that trainees themselves may not share. To illustrate this point, they cited examples from other fields, such as the debate currently going on about whether pharmacists should be required to dispense birth control pills or other medications to which they are morally opposed.

Mintz et al. (2009) further suggest a value management strategy based on three fundamental skills: (1) understanding the philosophy that undergirds theories and beliefs, (2) deeply examining and reconciling divergent perspectives, and (3) recognizing and attending to transcendent values. Kelly and Strupp (1992) also noted that it might be appropriate for training programs to include a *values sensitization component* as part of training to assist students in increasing both their awareness of their own values and their ability to deal sensitively with the values of clients.

Vachon and Agresti (1992) also presented a proposal for training practitioners to clarify and manage values during psychotherapy by becoming more aware of not only individual and group values, but also the values that underlie therapy interactions and psychological theories themselves. Their recommendations include the ability to translate counseling interactions into their implicit value statements followed by skills in managing these values in ways that benefit the client. They suggest that training programs help students not only to clarify personal values, but also to understand the values underlying theories, techniques, and interventions. They also recommend assisting students in evaluating the value-related issues at work in various particular cases.

Conclusion

In summary, developments over the last half-century have led to a generally accepted position that values cannot be dismissed in psychotherapy. Empirical research has repeatedly confirmed that therapists and clients have encountered and will inevitably continue to encounter conflicts in personal values during the course of therapy. A number of strategies for dealing with value conflicts inherent in counseling have been proposed. These include (a) learning to separate professional values from personal values, (b) clarifying implicit values through therapists' examination of their own value system, (c) disclosing versus remaining neutral regarding therapists' personal values in therapy, (d) referring clients to therapists with similar values, (e) adjusting therapeutic goals, and (f) seeking outside consultation. We propose a somewhat more radical approach that requires psychotherapists to clarify and articulate their values and training programs to teach their students to do so. Furthermore, programs that train new therapists can provide guidance on what is expected in terms of professional values. The proposals discussed will hopefully serve as points of departure in the ongoing and evolving dialogue of professional training values and expectations, with the goal of ultimately preserving the integrity and well-being of both clients and clinicians.

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