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VALUE CONFLICTS IN PSYCHOTHERAPY: PSYCHOLOGY GRADUATES'
PERSPECTIVES

by

Shannon Vincent Wilde

A dissertation submitted to the faculty of

Brigham Young University

In partial fulfillment of the requirements for the degree of

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BRIGHAM YOUNG UNIVERSITY

GRADUATE COMMITTEE APPROVAL

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BRIGHAM YOUNG UNIVERSITY

As chair of the candidate's graduate committee, I have read the dissertation of Shannon Vincent Wilde in its final form and have found that (1) its format, citations, and bibliographical style are consistent and acceptable and fulfill university and department style requirements; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the graduate committee and is ready for submission to the university library.

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ABSTRACT

VALUE CONFLICTS IN PSYCHOTHERAPY: PSYCHOLOGY GRADUATES' PERSPECTIVES

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Doctor of Philosophy

Although psychotherapy has been viewed historically as value-neutral, developments over the last half-century have led to the generally accepted position that values are inescapable in therapy. However, many questions remain as to how values should be managed in psychotherapy in order to protect client autonomy. These issues are of particular concern to training programs, which bear the responsibility of instructing new psychologists in ethical values management and of helping trainees manage personal values when those values are in conflict with those of their clients or with the values of the field in general. One aspect that has not previously been investigated is the perceptions of trainees around value-related issues.

This study used qualitative research methods to investigate the perceptions of recent psychology graduates regarding the role of values, value management strategies, training in value-related areas, and the resolution of value-related dilemmas. Seventeen

recent graduates from Counseling Psychology, Clinical Psychology, or Professional Psychology doctoral programs were interviewed. Their responses led to following nine themes:

1. Psychology graduates disagreed about appropriate roles for therapist values.
2. Value differences between therapist and client were seen as both potentially harmful and potentially helpful.
3. Participants reported using different strategies to manage value differences.
4. Most participants felt it might be acceptable to influence a client to change their values in certain situations.
5. Participants did not report preferences regarding the value similarity of their clients and reported varying reactions to value differences.
6. Participants disagreed on whether trainees should be required to see clients with very different values.
7. Participants generally felt positive about their training experiences, but recommended more practical instruction in values management.
8. Participants' experiences with race and religion suggested unique training concerns.
9. Value-related decisions were seen as contextually grounded and based primarily on perceptions of beneficence.

It is hoped that these findings further the dialogue on appropriate value management strategies in therapy and assist training programs in evaluating the training they provide students in areas of value differences and value conflicts.

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TABLE OF CONTENTS

<i>Introduction</i>	1
Challenges to Value Neutrality	1
Value Management in Theory.....	3
Values Management in Practice	5
Training Issues	7
<i>Review of Literature</i>	9
Historical Background	9
Definitions of Values	11
Challenges to Value Neutrality	13
Theoretical Challenges to Value Neutrality	13
Empirical Challenges to Value Neutrality	16
Ethical Considerations	19
Value Management Strategies.....	23
Separating Professional Values from Personal Values.....	24
Clarifying Implicit Values.....	29
Disclosing Personal Values	30
Referring Clients to Therapists with Similar Values.....	31
Adjusting Therapeutic Goals.....	32
Values Management in Practice	34
Training Considerations.....	40
Statement of the Problem.....	52
Research Questions.....	53
<i>Method</i>	55
Rationale for Qualitative Method.....	55
Participants.....	58
Data Collection.....	60
Data Construction	63
Assumptions of Data Construction.....	63
Steps in Data Construction.....	66
Assumptions of the Researcher	68
<i>Results</i>	70
Theme 1: Roles of Values.....	73
Client Values Essential and Acceptable in Therapy.....	73
Therapist Values Inescapable in Therapy	74
Values inherent in theories and conceptions of psychological health.	74
Values inherent in being human	74

Values inherent in therapy processes	75
Arguments for Minimizing Therapist Values in Session.....	76
Arguments for Including Therapist Values in Session	78
Including values necessary due to inescapability of values	78
Including values less harmful than denying them	79
Including values beneficial to therapy	79
Factors Influencing View of Role of Values.....	81
Experiences with different treatment settings and populations	81
Awareness of Research	83
Theme 2: Consequences of Value Differences in Therapy.....	83
Harmful Consequences of Value Differences	84
Clients do not feel understood, valued, or respected	84
Clients are unable to develop a positive relationship with therapist.....	85
Beneficial Consequences of Value Differences	86
Clients gain new insights and perspectives	86
Clients learn new relationship skills	86
Clients receive feedback on harmful behaviors.....	87
Factors that Determine the Impact of Value Differences	88
Therapists' attitude towards difference	88
Clients' ego strength.	88
Quality and duration of relationship between client and therapist	89
Degree of difference between clients' values and therapists' values	90
Relevance of value conflict to presenting problem	90
Theme 3: Values Management in Session	91
Increasing Awareness of Personal Values	91
Seeking Supervision and Consultation	93
Supervision used to clarify thinking about therapeutic issues.....	94
Supervision used to experience appropriate reactions to value differences.....	95
Supervision used to cope with personal feelings and negative reactions.....	95
Supervision used to guard against client harm and imposition of values.	96
Supervision used to learn new perspectives	96
Exploring or Clarifying Values	97
Value exploration used to maintain therapist neutrality	99
Value exploration used to challenge values without making client defensive	101
Value exploration used to open clients up to alternative positions.....	102
Value exploration used to introduce therapist values	103
Learning About Clients' Value Systems.....	103
Disclosing Therapist Values.....	104
Self-disclosure used to convey understanding.....	105
Self-disclosure used to provide informed consent.....	108
Self-disclosure used to help clients make positive changes	110
Concealing Therapist Values.....	111
Therapist values concealed to avoid imposition of therapist values.....	111
Therapist values concealed to reduce irrelevant information.....	112
Therapist values concealed to reduce client defensiveness.....	113
Therapist values concealed to preserve the therapeutic relationship.....	114

Looking for Common Ground.....	114
Referring Client to another Therapist	115
Theme 4: Appropriateness of Deliberately Influencing Clients' Values.....	117
Views on Acceptability of Influencing Client Values	118
Criteria for Intervention	120
Harm to self or others.....	121
Influence of value on mental health.....	123
Conflict with societal interests or values.....	124
Relevance of value to presenting problem	124
Degree to which client has considered other options.....	124
Values Less Likely to Elicit Intervention.....	125
Values stemming from specific religious or cultural backgrounds.	126
Values stemming from dissimilar religious or cultural traditions	126
Evaluations of Hypothetical Situations of Value Differences.....	127
Hypothetical situations in which clients' values appear harmful	127
Hypothetical situations in which clients' values contradict those of the psychology profession	129
Participants' Strategies for Influencing Client Values	130
Theme 5: Preferences for and Reactions to Value Differences	132
Participants' Preferences for Treating Clients with Similar Values	133
Participants' Preferences for Treating Clients with Different Values	133
Preferences for Treating Clients with both Similar and Different Values	135
Preferences for clients with a mix of value systems	135
Preferences for clients who are similar on at least some value dimensions, but not necessarily all	135
No Preferences for Treating Clients with either Similar or Different Values.....	137
Preferences related to personality similarity, not value similarity.....	137
Similarity or dissimilarity a false dichotomy	138
Personal Reactions to Significant Value Differences	138
Caution and concern about imposing values	139
Curiosity and interest	139
Strongly negative "gut" reactions	140
Surprise.....	140
Situations Eliciting more Strong and Conflicted Reactions.....	142
Value difference occurring in a personally meaningful area.....	142
Personal values in conflict with psychological values.....	144
Clients who are questioning their own values	145
Theme 6: Dilemmas involving Therapists with Preferences to not Treat Clients with Different Values	146
Arguments For Requiring Trainees to Treat Clients with Different Values	148
Educational value of treating dissimilar clients.....	148
Development of multicultural skills.....	149
Personal experiences of professional growth	150
Arguments Against Requiring Trainees to Treat Clients with Different Values	151
Potential for client harm.....	151
Discomfort with forcing trainees into unwanted encounters.....	153

Trainee rights not a significant factor	154
Concerns about Trainees who Refuse to Treat Dissimilar Clients	155
Factors Influencing Participants' Reasoning.....	158
Referring vs. refusing.....	158
Refusing to see individual clients vs. refusing to see groups	159
Refusing out of concern for competence vs. refusing out of bias	159
Arguments For and Against Requiring Licensed Professionals to Treat Clients with Different Values	160
Theme 7: Evaluations of and Recommendations for Training Programs.....	163
Distinctions between Values and Diversity in Evaluations of Training	163
Degree of Satisfaction with Graduate Programs' Training in Value Issues	164
Satisfied with graduate training in values	164
Mostly satisfied with graduate training, but recognize room for improvement ..	165
Not satisfied with graduate training in values	166
Context of Training in Value Issues	167
Coursework.....	167
Clinical settings	168
Strengths and Weaknesses of Graduate Programs.....	169
Developing awareness of personal values a strength.....	169
Teaching practical aspects of managing value differences a weakness.....	169
Incorporating client values into therapy a strength at some programs, weakness at others.....	170
Satisfaction with Internship Programs' Training in Value Issues	171
Recommendations for Training Programs	173
Provide more training in practical aspects of managing value differences.....	173
Encourage supervisors to take a proactive role in providing training on managing value differences	174
Ensure that students provide services to diverse populations	175
Include value-related issues more broadly in course work	176
Include more training in religious diversity	177
Assist students in gaining awareness of personal values	177
Model appropriate respect for others' values by showing respect for students' personal values.....	178
Theme 8: Experiences with Race and Religion.....	179
Participants' Experiences with Race and Racism.....	179
Participants' Experiences with Religious Clients.....	182
Religious Participants' Experiences with Non-religious Clients	185
Religious Participants' Experiences with Training Programs.....	185
Theme 9: Process of Making Value Decisions	190
Value Decisions Depend on a Number of Factors.....	191
Value Decisions Grounded in Perceived Situational Needs	192
Value Decisions Based on Underlying Value of Beneficence	194
Value Decisions not Guided by Firm Rules.....	196
<i>Discussion</i>	199
General Observations about Underlying Values and Value Management	199

Concurrence and Consistencies in Underlying Values	199
Differences and Difficulties in Values Management.....	202
Conflicts between Underlying Values and Value Management.....	203
Specific Observations about Findings	207
Findings about Value Management	207
Interventions often intended to remove therapist values from therapy.....	208
Value management strategies serve multiple functions.....	213
Value management inconsistent with stated positions on other topics.....	215
Value imposition acceptable in situations of harm.....	216
Particular value conflicts managed differently than others.....	218
Therapists hesitant about role of personal values despite seeing beneficial consequences.	220
Reactions to Value Differences	222
Training Issues.....	223
Trainees evaluate training dilemmas differently than programs	223
Training programs lack practical training	227
Reliance on supervision raises concerns	229
Programs may try to alter trainee values.....	230
Trainees perceive conflict between program values and personal values.....	232
Trainees may benefit from specific guidance in working with religious clients.....	235
Recommendations	235
Limitations	236
Directions for Further Research	238
<i>References</i>	240

Introduction

The field of psychology in the United States has long been based on an empirical philosophy or worldview. This philosophy holds that knowledge is derived exclusively through sensory experience with the external world. The methods used in psychology have been largely adapted from the natural sciences, so that the process of psychological inquiry has relied on the careful application of traditional scientific methods involving empirical observation. One of the main purposes of these methods is to eliminate biases which might result from, among other things, the values or beliefs of individual researchers and practitioners. The goal has been to understand human beings in a framework free from human biases that might stem from culture, religion, political ideology or any other non-scientific source of knowledge.

It is not surprising, then, that the understanding of psychological dysfunction and treatment has also taken on a similarly empirical philosophy, and the process of treatment has been seen as a primarily technical one. Therapists providing treatment for psychological distress have been seen as technicians whose personal values are not relevant to the treatment process or outcome. Although therapists would obviously have their own values and beliefs, they were expected to suspend those in therapy and adopt a position of objectivity.

Challenges to Value Neutrality

A sizeable body of scholarly writing has questioned the feasibility of a value-neutral strategy over the last half century. For example, Watson (1958) stated that, "One of the falsehoods with which some therapists console themselves is that their form of treatment is purely technical, so they need take no stand on moral issues" (p. 575). More

recently, O'Donahue (1989) and Slife, Smith and Burchfield (2003), among others, have pointed to the inextricable nature of values in any human endeavor, including therapy and counseling, and have suggested that value free counseling is therefore impossible. Further, they contend that continuing to ignore or deny the impact of values on the counseling process may ultimately be detrimental to the process itself (see also Strupp, 1980).

Several empirical findings have also called into question the value-free nature of counseling and psychotherapy. For one, the values of counselors and clients have been observed to converge over the course of therapy, with the clients' values shifting towards the therapists' more strongly than vice versa (Beutler, 1979). This process tends to occur whether the therapist is aware of it or not (Kelly, 1990). That is, even without a deliberate attempt to "convert" clients, therapists' values tend to be transmitted to their clients and to influence the development of clients' values. Additionally, greater value convergence has been associated with greater therapeutic improvement, especially as determined by therapist ratings of improvement (Kelly, 1990; Kelly and Strupp, 1992). This suggests that therapists rate their clients' improvement in part on the degree to which clients adopt their own value systems. Although the findings on both the degree of value convergence and the impact of value convergence on therapeutic improvement appear to be related to therapist/client value similarity in complex ways, it is clear that therapists' values have a significant impact on both client values and their own perceptions of clients' therapeutic improvement.

As the field has gained greater awareness of the value-laden nature of counseling, attention has naturally turned to the ethical implications inherent when value conflicts arise (Tjeltveit, 1986). The American Psychological Association (APA) has responded by

including statements relative to issues of difference and diversity among clients in its ethical codes and guidelines. These include the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002), which delineates general principles for working with all clients, including those from diverse backgrounds. Other APA publications address issues of values conflict with respect to specific populations which may be seen as different from the majority culture (see, for example, *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients* (APA, 2000) and *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (APA, 1990)). These principles and guidelines all assert the field's overarching value of respect for differences among individuals and urge practitioners to be aware of their individual values and biases and how these may affect their practice. The intent of these publications appears to be focused on reducing the negative effect that personal biases may have on psychologists' work. Implicit in this discussion is that psychologists will have values and biases and that these might come in conflict with the values and biases of clients. Clearly, APA sees these conflicts as potentially harmful; hence the need to clarify professional expectations in order to reduce harm. The field as a whole, then, has indirectly acknowledged the presence of values in therapy and appears to be concerned that value differences could lead to client harm.

Value Management in Theory

As the field has come to recognize the impact of values in psychotherapy, it has also begun to tackle the difficult question about how values in general, and value conflicts in particular, should be managed. One aspect of value related issues that leads to the difficulty in making value management prescriptions is that, while there is general

agreement about desirable therapeutic outcomes in the face of value conflicts, there is less agreement on what in-session activities help therapists to arrive at those outcomes. A focus on outcome rather than process is apparent in many of the ethical guidelines for psychotherapy. For example, APA's ethical guidelines state that psychologists "have respect for the dignity and worth of all people" and "are aware of and respect . . . differences" (APA, 2002, principle E). Further, psychologists are to "take precautions to ensure that their potential biases . . . do not lead to or condone unjust practices" (APA, 2002, Principle D). It is clear that therapists should be respectful and aware of differences, but how a respectful, aware therapist proceeds when confronted with a conflict is less clear. Similarly, the precautions one should take when one has potential biases are defined by the outcome (whatever reduces the potential for unjust practice) rather than the process itself. While many practitioners are clear about desirable outcomes of value conflicts, there is considerably less clarity and agreement about how to reach that outcome. For example, the idea that psychologists should not impose their values on others is a basic tenet of the psychology ethics courses required of all graduate students, but what exactly does it mean to not impose one's values on clients? Should counselors avoid bringing up their own value system when it conflicts with the client's values? Alternatively, should they pretend that they share the client's values in order to reduce harm? Should they simply ignore discussions about values, or refer them to other therapists in order to avoid imposing their own values? Any of those courses of action could be interpreted as respecting individual differences and taking precautions to ensure that biases do not create harm, yet they are very different behaviors that can be presumed to have different outcomes. Part of the discussion on value conflicts, then, should include

not just what psychologists are trying to be or to do, but how they should go about accomplishing those ends.

Many theoretical solutions to the problem of value conflicts in therapy have been suggested. If value neutrality is not possible, one alternative is to isolate particular problematic values which are within the realm of psychologists' expertise and attempt to change those values to healthier alternatives while leaving other less relevant values intact (Strupp, 1980; Tjeltveit, 1986). Other strategies involve matching therapists to clients on the basis of value similarity (Tjeltveit, 1986, Giglio, 1993). Still others have advocated for full disclosure of therapist values, either prior to or during sessions, as a way to protect client autonomy in the face of conflicting values (Slife, 2004, Bergin, 1985, Lewis, 1984). While several solutions have been discussed, there are issues that remain to be investigated, such as whether these strategies are best used together or individually, or whether some might be more appropriate for certain situations or clients than others. Clearly, while these strategies might provide alternatives for practitioners concerned about value conflicts, questions remain about how exactly these strategies should be implemented by practicing therapists in their everyday therapeutic work.

Values Management in Practice

Two studies have investigated how practicing therapists manage values generally in their moment-to-moment therapeutic interactions, and both give further insight on how these therapists handle value conflicts in particular. In one, Fisher-Smith (1999) found that the counselors she interviewed tended to adopt one of two strategies. In the first, which she termed *Neutrality*, counselors attempted to set aside their own values during therapy, in order to avoid having their work influenced by those values. In contrast,

therapists employing the second strategy, which she termed *Disclosure*, articulated their own value systems at the outset of therapy. The therapists' choices of strategy seemed to be influenced by broader professional values and by their awareness of the changing views towards values in psychotherapy outlined earlier, and probably reflected their own beliefs towards both the desirability and inescapability of values in psychotherapy.

Similarly, Williams and Levitt (2007) interviewed eminent therapists and found that they generally wanted to protect client values and attempted to do so both by allowing clients to dictate the course of therapy and by not discussing personal values with clients. However, they also found that these strategies, while frequently used, were also set aside if the therapist felt that client values were harmful, and sometimes when therapists felt that clients might be benefited from exposure to an alternate value system (their own) which they perceived as healthier. Thus, they noted not only differences between therapists with regards to value management, but differences within therapists depending on the needs of the client and the particular value conflicts that arose.

Investigations of how therapists handle the moment-to-moment demands of value management are important in that they articulate the processes that counselors use in handling their own values as part of the larger process of psychotherapy. However, as Williams and Levitt (2007) note, the process of knowing when and how to challenge client values is not one that is widely discussed in the literature. This presents a problem for counselors who desire to respect client values and yet encounter value conflicts in their work, and others who are trying to establish a set of "best practices" principles for dealing with value conflicts.

Training Issues

It is perhaps especially important for those training new psychologists to be able to conceptualize the issues inherent in understanding and resolving values conflicts in therapy. While multicultural education has long been a component of graduate psychology training, the previous belief in value neutrality made discussions about personal values less relevant and therefore a less important part of the training process. Recognizing that values are inescapable elements of the therapy process raises the question of the impact that therapists' values have on the process, and the desirability of therapist transparency with regards to those values, and training programs need to be equipped to deal with these issues with their students. Several training proposals have been suggested (Vachon & Agresti, 1992; Kelly & Strupp, 1992). However, problems with value conflicts still present themselves in training contexts.

Issues related to values value conflicts were brought into focus recently when students at one APA-accredited counseling psychology doctoral program indicated that they "would strongly prefer not to work with gay/lesbian bisexual clients due to strong religious beliefs" (CCPTP listserv, 11/23/2004). The training director of that program then posed the question of how to deal with such students on the Council of Counseling Psychology Training Programs listserv. An extensive dialogue on values and value conflicts in the context of training future psychologists then emerged, culminating in a recommendation for trainers and trainees to become more aware of these issues in order to deal with them more effectively in a training context. Further, training directors in Counseling Psychology training programs felt that those responsible for training future psychologists would benefit from guidance in addressing these conflicts as they arise and

therefore a model training values statement regarding diversity would be helpful in helping the field work through these issues (Mintz et al., in press).

While a model training values statement has been developed and is in press (Mintz, et al., in press), one thing that has not been researched previously is how the students themselves see these issues. Little research, for example, has addressed how students understand the role of their personal values in providing services to clients with different values, or their awareness of value-related issues in the counseling field. It would also be helpful to understand how they actually negotiate situations of value differences in their practice and their reasons for employing those strategies. Finally, assessing the training they have had around these issues and their level of preparation for handling value conflicts would provide guidance to graduate programs in making training decisions in this area

As the values of the students entering into counseling psychology training programs become increasingly diverse, we can expect conflicts between trainees' values and the values of the clients they serve to become increasingly common. This research provides understanding on the perspectives of recent psychology graduates around value conflicts in counseling, which may provide an important tool for graduate and internship programs in developing educational and clinical interventions that will help trainees resolve these issues in helpful ways. With such interventions in place, students will then be better prepared to deliver quality psychological services that ethically address value conflicts both in training contexts and in later professional practice.

Review of Literature

In order to discuss the role of values in psychotherapy, it is helpful to understand how views of the construct have developed and evolved over time and the theoretical and empirical challenges that have formed to traditional value-neutral views of therapy. It is also helpful to understand the ethical issues that present themselves and the solutions proposed to these dilemmas in order to both acknowledge the value-laden nature of therapy and protect client autonomy.

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 their emphasis on objective, value-free theory, investigation, and practice. Scientific methods emphasized the importance of objectivity, which was seen as the route to obtaining information unsullied by personal biases or beliefs. Because of its apparent independence from subjective opinions or beliefs, scientific knowledge was believed to be trustworthy, while personal values and beliefs were viewed as hazardous to the process of inquiry.

The value placed on objectivity and empirical knowledge led the field of psychology to view psychotherapy from its inception as a basically technical enterprise, in which therapists applied scientific knowledge to client problems. Therapists were expected to apply the scientific value of objectivity to therapeutic practices as well, trying to maintain a neutral stance in which personal beliefs or biases were kept out of the picture in order to allow for a correct view of the client and an unbiased application of scientifically-derived principles of treatment. Given this view, the human experiences,

values, and commitments of therapists were seen either as irrelevant or potentially harmful.

In light of the philosophical heritage of psychological understanding, it is perhaps not surprising that early theories advocated an approach to therapy in which therapists' values were deliberately kept out of the therapeutic interactions. For example, Freud (1912/1964) likened the work of a therapist to that of a "surgeon who puts aside all his feelings" (p. 115) suggesting that it is not only possible but desirable for personal feelings to be kept out of therapy. This idea of keeping personal beliefs, values, and feelings out of therapy implied that it then possible for them to have no influence on the course of therapy at all. Freud further held that a therapist should "be opaque to his patients, and like a mirror, show them nothing but that is shown to him" (p.118). This metaphor suggests that analysts' own beliefs or values should be kept completely inaccessible to the patient and underscores the degree to which objectivity was valued in psychoanalytic theories.

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 its use" (p. 150). For Skinner, values themselves, as we commonly understand them, were superfluous to the core elements of behaviorism, as the inherent goodness or badness of a behavior was derived not from a foundational moral assessment but from the contingencies of reinforcement. Those behaviors which were reinforced came to be seen as good, while those that held negative consequences were seen as bad. Accordingly, therapist values would be superfluous to therapy as well. As with psychodynamic theories, the primary job of the therapist was essentially to apply a

particular technology – in this case, behavior modification techniques based on systems of reinforcement – with no value judgments or personal feelings of the therapist necessary for the implementation of such technologies. Thus, the advent of behaviorism reinforced the value-free view of therapy.

Later humanistic psychologies broke from earlier theories by rejecting the view of the therapist as an objective, neutral scientist and instead held that a therapeutic relationship with a genuine, involved counselor was essential for therapeutic change. For example, Rogers (1951) emphasized the importance of an authentic relationship between therapist and client, with the therapist demonstrating empathy, warmth, and positive regard towards the client. Such relationships naturally included subjective involvement in the relationship by the therapist. However, this subjective involvement did not extend to the inclusion of therapist beliefs or values in the interactions. Instead, Rogers 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). This terminology is interesting, bringing to mind Freud’s much earlier suggestion that feelings be “put aside” and again suggesting that personal values or beliefs are things that can (and should) be suspended or temporarily abandoned in favor of the values and beliefs of the client. Thus, all of the major schools of psychological thought extant in the middle of the twentieth century advocated a value-free (or at least value-neutral) approach to psychotherapy.

Definitions of Values

In order to evaluate the role of values in psychotherapy, it is necessary to first have a clearer understanding of the definitions of values used by those in the field and the

implications these definitions have for therapy. One of the most influential definitions of *values* was that suggested by Rokeach (1973), who differentiated values from both *attitudes* and *interests* and suggested that values were the foundational commitments upon which attitudes and interests were based. He defined values 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). Beutler and Bergan (1981) pointed out that “*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. 17). Similarly, Heilman and Witztum (1997) suggested that values can 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). These all include the idea that values specify among alternatives that which is good or preferable and should be and differentiate them from that which is bad, not preferred, and should therefore not occur. Schwartz (1992) emphasized the influence of values on subsequent behavior by defining values as “1) Concepts or beliefs, which 2) pertain to desirable end states or behaviors, that 3) transcend specific situations, 4) guide selection or evaluation of behavior” (p. 4). This definition adds the ideas are that values are applicable across situations and that they make a difference in the choice of behaviors.

The general definitions of values developed in the literature have been influential in defining the values that specifically inform psychotherapy practice, which could be termed professional values. Jensen and Bergin (1988) built 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. (in press) built 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, professional values can be understood as core beliefs that guide professional behavior across multiple contexts.

Challenges to Value Neutrality

Beginning around the 1950’s and on into the 1960’s and 1970’s both research and theoretical writing called into question the tenability of a value-free strategy for counseling. Over that period of time, therapy began to be seen less as value neutral and more as a necessarily value-laden enterprise. Additionally, ethical concerns were raised about the influence of values in therapy that led to further discussion on appropriate and ethical values management.

Theoretical Challenges to Value Neutrality

Given the definitions of values discussed previously, one of the theoretical arguments against value-free or value-neutral counseling becomes clear. It is that values necessarily underlie therapeutic decisions about desirable goals and means to those goals and so therapy must include values of some sort. Any therapy includes some definition by both client and counselor about desirable outcomes (though these may differ, as will be discussed later) which is unavoidably guided by some pre-existing beliefs or assumptions about what constitutes positive mental health. The therapist is then constantly making decisions about helpful or beneficial treatment interventions to employ

to reach those goals. As Fisher-Smith (1999) stated, “Values are the bedrock upon which therapeutic decisions are made” (p. 12).

Some have suggested that counselors’ professional values can still be avoided by leaving the determination of therapeutic goals to the client. Tjeltveit (2006) finds several problems with this solution, including the issue that client symptoms may interfere with a client’s ability to clearly choose therapeutic goals. Because psychological problems often impair both autonomy and judgment, he believes that client choices should only partially dictate ideal outcomes (see also Heilman and Witztum, 1997). Additionally, some clients may select goals which are morally problematic for the therapist or which may run counter to what the therapist sees as a psychologically healthy goal. For example, Strupp (1974) described the classic example of a therapist appropriately refusing to help a client develop greater assertiveness in order to be more successful at luring children into sexual relationships. Less dramatic, but quite likely, are clients who want therapists to help perpetuate an eating disorder or to assist in continuing avoidance behaviors. Tjeltveit (2006) further notes that the idea that clients should choose their own therapy goals is itself rooted in a value, which he terms *liberal individualism*, which clients may not share. He also holds that this belief may rest on an overly simplistic view of the relationship between client and therapist, which suggests that therapists either allow the client alone to choose therapeutic goals, or they impose them on clients. In reality, there are several ethical alternatives to this false dichotomy. All, however, rely on some foundational belief about what constitutes positive mental health for clients and how to achieve it, which is inherently a value judgment.

The fact that values are at the core of therapeutic goals is in fact part of the larger issue that values underlie our very definitions of healthy, normal, or well adjusted states of being (in contrast to abnormal, unhealthy, or pathological states) and thus are at the core of psychological theories themselves. As Fisher-Smith (1999) notes, “Psychotherapy systems make presumptions and evaluations about what psychological health or ideal human behavior is and how best to achieve it. . . . Part of the inescapability of values is their inextricable relation to metaphysical beliefs and philosophies that ground psychological theory and practice” (p.13). The reliance of all theories on an underlying set of beliefs led O’Donahue (1989) to encourage both researchers and practitioners to develop greater skills in evaluating and critiquing the metaphysical issues that underlie their work. He encourages psychologists to view themselves not only as scientist practitioners but also as metaphysicians, given that psychologists’ conceptions of both pathology and treatment rely on undergirding metaphysical issues which are often not evaluated – issues that necessarily include statements of values.

An additional argument for the inescapability of values rests on the logical inconsistencies inherent in the position that values in counseling can be avoided by appealing to philosophies traditionally seen as value-free alternatives. Those who argue against the inclusion of values in counseling typically argue either for a form of objectivity, as embodied in science and scientific methods, or a form of relativism (Richards and Slife, 1999). Relativism holds that there is no grounding for preferring one value above another so we must settle for acceptance and tolerance of all values and allow the clients’ values to dominate. However, scientific methods and their underlying assumptions are themselves based on certain values and beliefs that preclude other

assumptions. It is also important to recognize that tolerance and respect for client autonomy are both values as well. Thus, both objectivity and relativism are grounded in values, though often unexamined, and so are not themselves value-free after all (Richards and Slife, 1999). Appealing to either objectivism or relativism, then, does nothing to eliminate the presence of values in counseling.

Empirical Challenges to Value Neutrality

Empirical work over the last several decades has also worked to debunk the myth of value-free counseling. A considerable body of literature has found evidence that the values of the client 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. Beutler (1979), in reviewing research findings relevant to this phenomenon, concluded that “psychotherapy can be accepted as an attitude persuasion process” (p.438). He notes that psychotherapy is intended by its very nature to produce attitude change in clients, but adds that “it is one thing to consider attitudes and even religious beliefs as changing in psychotherapy but it is quite another to consider the therapy process as one which systematically induces the patient to develop alternative beliefs which approximate *those of their therapist*” (p. 432, italics in the original). Further, Beutler (1979) found that these value changes among clients were not merely a process of maturation or value clarification, but that they were movement towards the specific values of their therapists, with a concomitant change away from the values of other therapists with similar training with whom they did not meet. Perhaps most interesting is that this value convergence seems to occur outside of 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) .

Further research, while consistently confirming a shift in client values over the course of therapy, has shown interesting and sometimes conflicting patterns of value convergence. Value convergence seems to occur most notably when there is an initial dissimilarity between counselor and client. That is, clients whose values differ considerably from their counselor at the onset of therapy show a greater degree of shift towards their counselor’s values than more similar clients (Kelly, 1990, Beutler, Arizmendi, Crago, Shanfield, & Hagaman, 1983). Convergence tended to occur more on some values than on others (Kelly and Strupp, 1992), with personal goals and values related to competence more malleable than those related to morality.

Perhaps one of the most striking findings related to value convergence is that value convergence has been consistently linked with ratings of client improvement, although in complex ways. Initial research showed that a greater value convergence was significantly correlated with greater improvement (Beutler, 1979, Beutler et al 1983), a finding that has been reported in several review articles (Beutler, Crago, & Arizmendi, 1986; Kelly, 1990; Tjeltveit, 1986). However, it should be noted that this may depend in part on how improvement is assessed. While an early study showed that clients rated their global improvement higher when they adopted their therapists point of view to a greater degree, (Beutler, Pollack, & Jobe, 1978), a later review article (Kelly, 1990) found that value convergence was significantly associated with therapists’ ratings of improvement but not with clients’ ratings or with standardized measures of symptom improvement.

Kelly and Strupp (1992) suggested that this pattern may reflect a bias on the part of the therapist rather than genuine improvement.

The relationships between initial value similarity and therapeutic outcome also appear to be mixed. While initial value dissimilarity appears to be correlated with greater improvement in some studies (Beutler et al., 1983), it appears that the types of values on which the therapists and counselors are matched are at least as important as the degree of similarity and dissimilarity. Arizmendi, Beutler, Shanfield, Crago, & Hageman (1985) found that “a complex pattern of similarity and differences in specific values promote maximal improvement” (p.16). Kelly and Strupp’s (1992) research suggested that the configuration of values similarity was not as critical to outcome as the degree of similarity, with clients who were moderately similar to their therapists showing greater improvement than ones who were either more or less similar, suggesting that an intermediate range of agreement on values may promote optimal outcomes.

Kelly and Strupp (1992) found that one religiously oriented value appeared to function differently than the others in that it was the only variable in which similarity was significantly correlated with outcome. They suggested that religion could be investigated as a trait on which therapists and clients are specifically matched in order to improve outcome. Martinez (1991) investigated the function of similarity and dissimilarity in religious values specifically and found that both clients and counselors tended to rate client improvement higher when the therapists’ religious orientation was more conservative theologically than the clients’ and that clients’ ratings of their own improvement in therapy was correlated with initial dissimilarity in religious values. Here, however, the degree of convergence was not related to ratings of improvement.

The process of value convergence may be understood in part by examining value stability among counselors and their clients. Schwen and Schau (1990) found that both counselors and clients represented unique groups with regards to stability of values in that counselors' values showed greater stability over time than normal populations and clients' values showed significantly less stability than norm groups. Not surprisingly, while counselors' values were quite similar when assessed before and after therapy, their clients' values changed significantly. Similarly, while therapists showed significantly greater confidence in their value systems prior to therapy as compared to their clients, clients' confidence levels increased during the course of therapy, narrowing the gap.

The fact that counselor values remain stable over the course of therapy while client values shift points to the concern that Tjeltveit (1986) has raised with the term *value convergence* in that the word convergence indicated a mutual shift towards a middle point. In reality, the value shift occurs more nearly in a unilateral direction, with client values moving towards those of the therapist, whose own values show little change. Accordingly, Tjeltveit prefers the term *value conversion*. The idea of therapists converting clients, of course, flies in the face of several values traditionally held by the profession such as respect for client autonomy and choice and raises ethical issues for the profession on how such values should be managed. However, given the consistent empirical data that such value conversion does in fact occur, it seems naïve to ignore or discount the impact of values on the counseling process.

Ethical Considerations

The end result of the increased attention to the issue of values in counseling through both theoretical work and empirical research is that a value-free or value-neutral

approach to counseling is increasingly seen as untenable (Bergin, Payne, & Richards, 1996) and perhaps even undesirable. As Strupp (1980) wrote, “For one thing, it is impossible for a therapist to interact with another human being for a period of time without the other person becoming aware of the therapists values on a number of subjects, no matter how strenuously the therapist may attempt to present a “neutral” façade. For another, a totally neutral or opaque therapist may be deleterious because what the patient urgently needs is a relationship with a real human being rather than an impersonal analytic technician” (p.396). However, even if value neutrality is seen as undesirable, many psychologists also have ethical concerns with the influence that therapist values have been demonstrated to have on client values.

Writing almost a half century ago, Paul Meehl (1959) suggested that if research showed that all therapists are in fact “crypto-missionaries . . . such a finding would present us with a major professional and ethical problem” (p.257). Several writers have suggested that this is, in fact, the situation that the field of psychology finds itself in (Slife, Smith, & Burchfield, 2003; Tjeltveit, 1986). The conflict seems to stem from the fact that the field of psychology places a high value on safeguarding the freedom and autonomy of clients throughout the therapeutic process and in other psychological endeavors and on providing effective services to both similar and dissimilar clients. The influence of therapist values appears to be a threat to these core commitments of freedom and autonomy.

Values of client autonomy and respect for differences are articulated in the American Psychological Association (APA)’s (2002) code of ethics, which delineates the general values that inform psychologists’ practice and which is intended to provide

direction to psychologists in the ethical practice of their responsibilities. As part of this code, five general principles were developed that summarize the core values that ideally guide practitioners' professional behavior, several of which are relevant to the current discussion. For example, Principles D and E specifically address the role of therapist "biases" (which necessarily stem from values) as harmful elements of psychotherapy. Principle D (Justice) states that "Psychologists ... take precautions to ensure that their potential biases ... do not lead to or condone unjust practices." Similarly, Principle E (Respect for People's Rights and Dignity) advocates awareness of and respect for "cultural, individual, and role differences" and holds that "psychologists try to eliminate the effect on their work of biases based on these factors." Whether the term biases is another word for the values we have been discussing here or whether there are subtle conceptual differences is perhaps open to debate, but clearly biases must stem from personal values regarding what is good and what is bad, and clearly APA is concerned with the threat that counselor biases (and hence values) pose to both justice and respect for differences. Their solution ("to eliminate the effect ...of biases" on professional work) seems to echo the traditional views of value neutrality and it is apparent that APA sees therapist biases as having the potential for causing client harm and therefore as something that deserves ethical consideration. The important point here is that some of the fundamental ethical concerns of the field center around protecting client rights and reducing unjust or unfair influence stemming from therapists beliefs and attitudes—all of which are challenged when therapists are seen as effecting value change during the course of therapy.

Another basic principle which is related to value discussions in therapy is Principle A (Beneficence and Nonmaleficence), which 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.” Although beneficence seems to be an obvious ethical goal for practicing psychologists, Tjeltveit (2006) argues that any understanding of beneficence rests on value judgments about what constitutes a *good* outcome as opposed to a *bad* one and may not be so obvious after all. Psychologists may differ among themselves on what they consider to be a good outcome, and those understandings may also differ from the beliefs of the client, the clients’ family, or other interested parties. Principle A alone does not clarify whose definition of beneficence takes priority or how psychologists should resolve conflicts that arise when the goals of clients conflict with the goals of therapists. Even a principle as fundamental as beneficence, then, is laden with value issues that present ethical concerns.

Tjeltveit (1986) discusses other ethical problems he sees as arising from value conversion. One ethical problem he discusses is the reduction of client freedom, as has been discussed previously, but he also sees the failure to provide clients with complete information about the processes and outcomes of psychotherapy, the violation of the therapeutic contract, and the lack of therapist competence to ethically effect such conversion as additional ethical dilemmas stemming from value conversion. Vachon and Agresti (1992) also underscore the ethical threat arising from value convergence and state “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 to the field in raising concerns and shaping professional practices, it is important to note that ethical guidelines alone do not offer sufficient direction on how best to negotiate ethically delicate issues. Ethical guidelines provide a summary of ideal outcomes but don't necessarily provide insight on how best to arrive at these outcomes. Thus, although it is important to understand the ethical challenges that arise from the influence of therapist values in counseling, the primary concern is knowing how best to manage values in counseling in an ethical manner to minimize the threat of therapist values on client freedom and autonomy.

Value Management Strategies

Despite the growing awareness and general consensus that values are an inescapable part of psychotherapy there is considerably less awareness or consensus on how values should ethically be managed in therapy. Several different strategies have been suggested, although no one method of managing values has come to be generally accepted by the field.

The disagreement among professionals as to appropriate value management strategies is evident in a survey of mental health professionals conducted over twenty years ago (Norcross & Wogan, 1987), in which there was considerable agreement as to the fact that values unavoidably influence therapy but considerable disagreement as to how they should be managed. Eighty-nine percent of respondents agreed that therapist values have a direct effect on therapy and 94% indicated that they believed values are inextricably involved in therapy. Only six percent of psychotherapists felt that therapy could be free of values. However, the professionals showed significant disagreement or indecisiveness on the most effective methods of value management, with participants

almost evenly divided on whether therapist values *should* have a direct influence on therapy (and nearly a quarter of respondents indicating they were undecided on the issue). They also reported mixed agreement on statements that a good therapist must occasionally act as a moralist and that it is best to not deliberately convey therapist values during the counseling session. These therapists also showed a slight trend towards disagreement with the statement that therapists' values should be directly and explicitly expressed to the client. The findings overall are striking for the hesitancy and lack of agreement about values management expressed by the therapists despite the awareness that values do play a role. The authors speculate that these findings might indicate that psychotherapists are ambivalent or have been inadequately trained in value expression or that they may recognize that value management is a complex issue and felt that none of the statements could be universally applied across all situations. Whatever the reason, these findings clearly show that knowing that values enter into the therapeutic process is one thing and knowing what to do with them is quite another.

Separating Professional Values from Personal Values

With the traditional strategy of suspending or "laying aside" personal values being seen as untenable, attention has turned to other ways to ethically manage therapist values during counseling. One possible solution to the ethical concerns of therapist values influencing clients during the course of therapy relies on the distinction between professional values and personal values, with the suggestion that the former could be shared during the course of therapy while the latter are minimized. While counselors can be expected as human beings to have personal feelings about what constitutes good and desirable behavior, they can also be expected as psychology professionals to have certain

beliefs about what constitutes psychological health and well-being and what outcomes are desirable for clients experiencing emotional distress. If these professional beliefs can be distinguished and isolated from personal value systems, a strategy one article termed *value atomization* (Williams & Levitt, 2007), the ethical threat from personal belief systems might be minimized while still allowing the therapist to draw upon professional beliefs to guide therapy. It could be argued that a significant agreement among professionals on these professional values might provide a moral foundation for therapy that nearly all mental health professionals could agree on regardless of their personal values.

This position was articulated by Strupp (1980) who acknowledged that psychotherapy is not a value free- enterprise but felt that it may be possible to limit the values communicated through therapy to those that directly relate to psychological well being. He suggested that there is a set of values which he termed *essential therapeutic values* that are shared by many practitioners. While these are not often directly communicated to the client, the client nevertheless experiences them and internalizes them over the course of therapy. Others of the therapist's values, which Strupp termed *idiosyncratic values* and which are unique to the individual therapist, are deliberately kept out of the therapeutic encounter, reducing 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 less relevant issues include gender, sexual values, religious beliefs, and other characteristics. Essentially, he advocated for the sharing of professional values, while

keeping personal values hidden. The client thus adopts a set of values which lead to greater psychological well-being while leaving values less relevant to therapeutic processes intact.

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 or political values). He held that the former are within the domain of expertise of the therapist and that the therapist therefore has ethical license to influence these beliefs. The latter beliefs, however, should be not be influenced by the therapist as they lie outside the boundaries of the clinician's expertise and the therapist is not a competent authority on them. Again values are divided essentially into personal and professional commitments, with the belief that client autonomy can be preserved if therapists avoid imposing personal beliefs but include professional values in their work.

A value atomization approach to values management assumes that there is a set of professional values that in fact can guide the process of therapy which are fairly consistent across practitioners. A landmark study by Jensen and Bergin (1988) indeed found that mental health professionals in a national survey reported considerable agreement on many values that undergird therapy. They grouped these values into ten themes, which included perception and expression of feelings; freedom, autonomy and responsibility; coping and work satisfaction; self awareness and growth; interpersonal and family relatedness; physical fitness; mature values; forgiveness; sexual regulation and fulfillment; and religiosity and spirituality. They found a high degree of consensus

among the professionals surveyed that the first seven factors were important for mentally healthy lifestyles and important in guiding and evaluating psychotherapy. These values, which they viewed as a mix of psychological concepts and traditional values, could form the basis for a set of essential therapeutic values to guide therapy, as Strupp (1980) suggested.

Jensen and Bergin also found, however, that there was less agreement among professionals as to the value of forgiveness and even less consensus on issues related to sexual regulation and religiosity, two areas they described as reflecting “traditional morality.” They further found that therapist characteristics in some cases influenced their views of the values. For example, the more religious a therapist was, the more likely they were to endorse religiosity as important to mental health. Similarly, psychiatrists and older professionals rated physical fitness as more important than professionals who were younger and those without medical training. Theoretical orientation also affected participants’ rating of the values, suggesting that “one’s personal orientation and life-style influences one’s concept of mentally healthy behavior, as well as the number of clients to whom it is important in treatment” (p. 295).

Therefore, if we only admit into therapy those professional values upon which a large number of professionals agree, we would have to exclude issues related to sexuality and religiosity, issues which may be quite relevant for many clients. Further, the degree of value endorsement by some therapist may relate to their own life style and history, suggesting that an identical value endorsement across therapists may be impossible.

It should be noted that the splitting of values into professional and personal values relies on a particular conception of values that is commonly found in the literature, one

that holds that values are distinct, separable, and independent of another (Levitt, Neimeyer, & Williams, 2005). The instrument most commonly used in the empirical investigation of values, the Rokeach Value Survey (RVS) (Rokeach, 1973), reflects this understanding of values as it measures categories of values independently from others, and so it is not surprising that the majority of empirical values research shares this particular view of values. Given this understanding of values, one value, or a set of related values, could be altered without affecting other values. Clearly, then, this view of values offers an attractive alternative to the problem of value convergence, as it suggests that counselors can assist clients to change particular problematic values (such as perfectionism) without altering other values which are not the focus of therapeutic intervention. Essentially value atomization is an attempt to protect client autonomy by reducing the impact of therapists' irrelevant values on client values.

It is important to recognize that some writers take issue with both the tenability and desirability of a value atomization strategy. For one thing, this strategy still assumes that it is possible to suspend some values and many of the arguments regarding the suspension of values would still hold true. Fisher-Smith (1999) sees this strategy as problematic "because it assumes that the psychotherapist is capable of teasing apart and suspending those values that are not mental health related. The suspending of values is, of course, impossible" (p. 19), and she holds that this applies not just to particular values but to values in general. Further, this strategy assumes that the "teasing apart" of professional and personal values is even possible in the first place. Several writers have suggested that instead of occurring as separate and distinct entities, values are meaningfully interconnected in a complex way, so that values cannot be evaluated or understood except

in the context of the whole value system (Slife, et al., 2003, Slife, 2004). It may be that mental health values are inextricably woven through other values, including those of a moral and ethical nature, so it is not possible to adopt or alter only a single value or an isolated subset of values. If this were the case, then clearly one value cannot be isolated and altered independently of others. Tjeltveit (1986) conceded this point when he wrote that “it may in some instances be impossible to change health values without also changing moral, religious, or political values” (p.519). If that is the case, then the central problem of knowing how and when it is ethically permissible for the therapist to influence the values of her client remains unresolved.

Further, it may be undesirable to attempt to isolate mental health values from other cultural and social values that give human life meaning. In discussing the importance of understanding the metaphysical underpinnings of psychology, O’Donahue (1989) wrote, “... if clinical research and psychotherapy are to be truly meaningful, then they need to be relevant to central beliefs. Psychologists’ research and therapy efforts do not involve merely a circumscribed set of isolated beliefs concerning ‘clinical psychology’. No firm barrier separates our beliefs qua clinical psychologists from all our other beliefs. The results of our efforts to understand and help other human beings are a function of our entire web of beliefs” (p. 1468). Thus, he argues, *all* of our beliefs, not just professional ones, are relevant to our work as psychologists.

Clarifying Implicit Values

With value neutrality not seen as theoretically viable, and some disagreement about the feasibility of value atomization strategies, other suggestions have also been made regarding value management in therapy. One of the most frequent

recommendations in light of the research on values convergence is that therapists should critically examine their own value systems, presumably so that implicit value systems can be evaluated and managed appropriately (Bergin, 1980; Beutler, 1979). As Vachon and Agresti (1992) write, “Now that it is generally recognized that therapists’ values do, in fact, change the values of clients, we may no longer overlook exactly what therapists believe. Nor may we ignore how therapists deal with values in therapy. There is an ethical responsibility to engage in clarifying implicit values in the counseling process” (p.510). However, it is important to note that, while an essential first step towards developing an ethical strategy for value management, clarifying values alone does not inform practitioners on how they should be discussed (or not discussed) with clients, or what kinds of value influences may be ethical and which may not. Although value clarification is an important and frequently recognized part of value management as a whole, it is important to this discussion to realize that clarification alone does not constitute a sufficient strategy for values management in therapeutic interactions.

Disclosing Personal Values

One of the most commonly discussed alternatives to either neutrality or value atomization is for therapists to be explicit about their values and openly discuss them with clients, either prior to therapy or during therapy or both (Bergin, 1980, 1985; Giglio, 1993; Slife, 2004:). This strategy, which could be termed self disclosure, is seen both as a way to open a dialogue about values and value differences and as a means to reduce covert value convergence by making implicit values explicit. Bergin (1985) suggests that such disclosure actually increases client freedom in the session because therapist values are open for discussion and evaluation and implicit values don’t lead to hidden agendas.

In a similar vein, Tjeltveit (1986) suggested that providing the client with informed consent prior to the onset of therapy offers a safeguard against unethical value influences. Lewis (1984) similarly suggests that providing information on counselor values prior to therapy protects clients from covert value influences. Interestingly, however, she also found that subjects in her study had a more negative impression of therapists about whom they had received value information than they did regarding therapists about whom they had received little information, suggesting that clients may feel more negatively towards counselors whose value positions are disclosed prior to the start of therapy. Given the desire to protect client freedom however, some therapists may feel that self disclosure remains the most ethical and theoretically consistent choice.

Referring Clients to Therapists with Similar Values

Another related strategy for avoiding value influence is matching clients with counselors prior to therapy on the basis of value similarity, particularly in areas in which value similarity increases appears to increase the likelihood of positive outcomes. This is suggested by Tjeltveit (1986) as an ethical manner of reducing the threat of values convergence and may be particularly important in the area of religious differences. Several writers have suggested that when religious clients' basic worldviews are incompatible with those of their therapists, as is likely when the client holds a theistic worldview and the counselor does not, a referral to a religious therapist may be appropriate (Bergin, 1980; Bergin, et al., 1996; Giglio, 1993). 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, suggesting that therapists' ability to respect and understand religious values

was the critical variable in outcome rather than personal religious similarity per se. It might be important then, not to match clients and counselors solely on personal variables but also on the basis of the skills and training of the therapist.

While matching client and counselor variables may have merit, it's important to note again that the empirical literature does not demonstrate that value similarity between client and counselor improves treatment outcome considerably. In fact, as was discussed previously, much of the literature seems to suggest that the opposite is true and that dissimilarity, rather than similarity, predicts greater improvement. Further, it is clear that while clients and therapists may be matched on particular values, an exact matching on all values is impossible and it is reasonable to assume that value differences will still exist between clients and counselors. Additionally, for many clients, therapist matching may not be an option due to logistical constraints (size of practice, locale, or insurance requirements, for example). While matching may be a useful tool in some situations, clearly it also cannot be the sole solution for value management.

Adjusting Therapeutic Goals

Inherent in the discussion on values in counseling, of course, is that situations may arise in which the values of the therapist and the values of the client 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. Situations of value conflicts present special challenges in therapy and call for what one study termed a *value-sensitive* approach to therapy (Heilman & Witztum, 1997). These authors hold that significant value conflicts change the entire course of therapy.

Part of the process of therapy assumes that at some point in their encounter, both patient and therapist will share a common perception about what is wrong, what needs to be corrected, and how the latter can help the former in effecting that repair. Furthermore, behind this fundamentally cognitive assumption is yet another supposition: that they both hold a common value orientation about what would in fact be a satisfactory resolution of the distress that brought the patient to the therapist. When, however, the therapeutic encounter takes place between healers and patients who do not share a common culture, either cognitively or affectively, and who also do not share common values, the entire course of the therapy—to say nothing of the character of the encounter—is influenced. (p. 522).

One of the ways in which it is influenced is in the selection of therapeutic goals.

Heilman and Witztum note that, in some situations, “the goals of the therapy as defined by the values and the outlook of the discipline may be counterproductive for the cultural well-being and value orientations of the patient” (pp. 524-525). Further, some clients may be too overwhelmed or be experiencing too much pain to clearly think through the consequences of therapeutic decisions, and so they argue that the value-sensitive therapist must protect the larger value-grounded interests of the client even when doing so conflicts with typical therapy goals. The result, then, may be 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 & Witztum, 1997, p. 524) in order to preserve clients’ value systems. They illustrate this point with examples of therapy clients from ultra-orthodox 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 client from their social and cultural groundings and may cause greater harm overall than the original problem for which the client sought treatment. Thus they hold that in order to ethically manage situations with extreme value conflicts, the therapist has to 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.

Values Management in Practice

While several strategies for value management have been suggested in the literature, few articles discuss how or when these strategies might apply to specific, concrete situations such as counselors are faced with in their work and how (or if) these strategies should be combined to benefit clients. It should be pointed out that one possibility is that there is no single strategy which is helpful for all clients or situations, so that focusing on developing universal principles may be counterproductive. Instead, perhaps therapists should strive, as Walker, Ulissi, and Thurber (1980) wrote, to develop guidelines or principles as aids whose “success ... must inhere in the concept of a ‘responsible professional’ or of an individual ‘acting in good faith’” (p.432). Levitt et al. (2005) suggest that perhaps one reason for the difficulty in developing a values strategy is that psychology’s natural science roots lead it to search for “rule-like solutions” to this dilemma which apply across counseling situations, which are developed outside of the context of actual practice. Counselors’ actual experiences may suggest that universal solutions are impossible, or that the context of negotiating therapeutic interactions in the moment gives rise to different understanding of value management strategies. Consequently, Williams and Levitt (2007) believe, that, alternatively, the field might benefit from developing general principles of value management derived from understanding how these values are handled in actual practice.

In order to understand how therapists manage values in practice, Fisher-Smith (1999) interviewed practicing psychologists about values management in their sessions.

She found that therapists tended to adopt one of two courses of action. In the first, which she termed the *Neutrality* mode, therapists attempted to suspend or put aside their own values and beliefs in favor of those of their clients, a strategy similar to those advocated by the three major schools of psychological thought in the early to middle parts of the twentieth century. The other therapists in her study adopted what she called the *Disclosure* mode, in which therapists' values were clearly and deliberately expressed in order to stimulate a discussion of values.

Interestingly, despite differences in value management, the participants in Fisher-Smith' (1999) study shared many of the same underlying values about psychotherapy. All of the therapists interviewed shared values of individualism (described as authenticity, agency and autonomy), and wanted to promote clients' "inner sense of self and their ability to make independent decisions and manage their own lives" (p. 150). Further, all therapists also were concerned about imposing their own values on the client and the abuse of authority that implies. Those therapists who felt that the expression of their values would threaten client autonomy were most likely to choose the neutrality mode of interaction. They tended to see Individualism values as mutually exclusive with Authority values and chose to abandon a position of authority in order to protect client autonomy and agency.

In contrast, therapists who chose the Disclosure mode of action did not believe that relying on their authority would necessarily threaten client autonomy and agency. Some suggested that the best way to protect client autonomy was to offer full value disclosure at the onset of therapy in order to allow the client to make informed value choices, as was suggested above. They tended to see their own values as foundational to

the process of therapy and were willing to challenge client values that they viewed as harmful or unhealthy. However, they saw this challenge to client values not as an imposition of their own values, but as the offering of a “truth alternative,” which their clients were then free to accept or reject. Predictably, they were more likely than the Neutral therapists to see values as an inescapable part of therapy and less likely than the Neutrality therapists to make a distinction or split between personal and professional values. This suggests that the adoption of either a Neutral or Disclosure strategy was related not only to personal values regarding client autonomy and therapist authority, but also to basic beliefs about the nature of values and the role they play in therapy.

In a somewhat similar vein, Williams and Levitt’s (2007) interviewed eminent psychologists regarding their perceptions of how they managed values during therapy sessions and their findings suggest that the value strategies adopted among this group may be more complex than Fisher-Smith’s dichotomous categorization suggests. They found that the underlying tension for these psychologists was whether to prioritize their own knowledge and values over those of the client, and if so, when and how to do so. The majority of the fourteen therapists interviewed by Williams and Levitt agreed that the presence of values in psychotherapy was unavoidable and that they influenced the course of therapy. Like practitioners in Fisher-Smith’s study, most placed a high value on client autonomy, and Williams and Levitt concluded that they adopted a morally relativistic stance, in which these therapists attempted to situate themselves within their clients’ values and guide therapy according to those values. Many therapists even expressed hesitation about selecting appropriate goals for therapy, seeing themselves as facilitators of the changes that the client wished to make rather than judges of what

changes would be best for the client. In fact, they felt that being neutral and nonjudgmental was a core feature of therapists. As psychodynamic psychologist Adelbert Jenkins said, “[Being nonjudgmental] differentiates him [the therapist] from his [the client’s] Aunt Mame, or his grandmother or someone who knows what he ought to do, and has a value system which they want to impose” (Williams & Levitt, 2007, p. 171). Williams and Levitt concluded that therapists were generally reluctant to encourage clients to change their values because they wanted to be respectful of client values and facilitate their own self-determination.

Williams and Levitt (2007) also note that “there were always limitations, however, to what values and behaviors therapists would accept” (p.171). Although therapists generally deferred to client values, that deference ended when they felt that client values would hinder therapeutic progress, or when those values differed sharply from therapists’ values about positive mental health. In those situations, therapists often initiated a discussion of those values in order to evaluate their efficacy and to encourage them to adopt different, healthier values, as defined by the values of the therapists. Some therapists explained that they would directly and explicitly disclose their own values as part of that value discussion, but that such as disclosure would be done with “directness and humility.” Interestingly, the disclosure of values was not seen as an attempt to protect clients from being influenced by values, as some have suggested, but appears to be done with the specific intent to confront clients about their values and to introduce a dialogue about healthy values that would encourage value exploration.

Another related way in which therapists dealt with client values they saw as problematic was to directly disagree with or challenge clients on those values, a strategy

used most often by cognitive behavioral therapists. By directly confronting clients about goals or behavior they considered problematic, they actively attempted to persuade clients to adopt healthier attitudes. This process of directly challenging values was viewed by therapists as grounded in widely acceptable professional values and therefore did not constitute an abusive imposition of therapist values in their minds.

It is interesting to note that the therapists' views of their own values as described here represent a subtle change from the way therapist values have traditionally been discussed in the literature. Most of the articles discussing therapist values, while recognizing that they are an inescapable part of the therapy process, discuss them as something of a necessary evil, to be aware of and carefully controlled in order to minimize harm. The therapists interviewed in this study, however, clearly saw their own personal value systems not as a liability but as an asset to be used as necessary to promote client welfare. What this shift means to the discussion on therapist values remains to be discussed, but it is an interesting change from most other conceptions of therapist values.

Finally, one option that was alluded to by several therapists was the possibility of seeking outside consultation or referral when therapist values and client values were too different. Several therapists felt that if the gap between therapist and value systems was too wide, it could pose problems for the course of therapy and threaten the success of therapy, and that these incompatibilities might lead to a joint decision to discontinue therapy. Interestingly, some therapists felt that a failure to be able to join the client in examining their lives from the clients' value system reflected an inadequate understanding or ability on their part, although others did not seem to share this position.

Williams and Levitt (2007) concluded that therapists typically attempt to work within client values to direct therapy and make therapeutic decisions, unless they saw those values as problematic or unhealthy. In those cases, most therapists were willing to openly challenge client values in an attempt to help them shift to healthier behavior, attitudes and beliefs, as defined by therapist values. Williams and Levitt observed that the definition of which values and attitudes would be considered sufficiently problematic to initiate a values discussion was very narrow for some practitioners and much broader for others. They further noted that “This decision-making process about when to challenge clients’ constructions of the world is rarely discussed overtly in the psychotherapy literature” (p. 172).

Thus, rather than adopting a purely neutral stance, or an openly disclosing stance, therapists seemed to use both strategies during counseling, deliberately keeping their own values hidden at some junctures of therapy and openly discussing them at others. Therapists generally kept personal values out of the focus of discussions unless a clear conflict arose, at which times counselors generally felt comfortable either challenging client values or discussing their own as a way of opening a value dialogue. It is also worth noting that none of the counselors reported fully disclosing personal values at the onset, instead bringing up personal values only as they arose and seemed directly relevant during the session, and that when personal values were discussed, the intent was not solely to provide informed consent but to persuade clients to adopt healthier values. It is also possible, perhaps even likely given the consistent data on value convergence, that therapists communicated some of their values in other ways that they may not have intended or been aware of and which were thus not recorded in the interviews. Of course,

these would also be expected to impact clients and the therapeutic process and underscore the need for awareness of both underlying values and the way in which these values are communicated to clients.

Training Considerations

Programs which are involved in training new psychologists may have particular interest in understanding how psychologists handle value differences and the gaps between recommendations and actual practice, as they are the ones who will train new generations of psychologists in values management. As discussed previously, Williams and Levitt (2007) identified one gap when they observed that the literature rarely looks at the crucial therapeutic junctures at which clients' problematic values may be challenged and it is likely that training programs rarely examine these either. 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 psychotherapy (for example, Mintz et al., in press; Slife et al., 2003; Tjeltveit, 1986, 2006). This first requires that practitioners acknowledge that therapy is a moral enterprise and develop fundamental skills in understanding the metaphysical components of their work (O'Donahue, 1989). Tjeltveit (1999) frames this challenge as one of developing "ethical acuity," or the ability to see the ethical underpinnings of therapy goals and outcomes and understand these dimensions with clarity and preciseness. However, these skills are often not developed during training or discussed in the literature (O'Donahue, 1989). In addition to this observation that therapists are not usually trained to recognize the value-laden underpinnings of therapy or the ways their own values enter into therapy, Bergin (1985) also pointed out that therapists are not generally trained to

help clients clarify their own values. Despite the recognition of the role that values play in counseling, developing the skills that allow for ethical value management may be somewhat more complicated. As Bergin, Payne, and Richards (1996) suggest, “Value awareness, issues of boundaries, skill and training, autonomy of clients, and respect for individual values tax psychologists’ capacities in conducting this secular and moral encounter ethically and productively” (p. 298).

As Vachon and Agresti write, “It is important to acknowledge that it is a skill to understand how the counseling process is value-laden, and it is possible to teach people this skill” (p. 510). That is, they hold that training can assist practitioners to develop the necessary skills in understanding and clarifying values that will allow them to practice ethically and competently. Not surprisingly, part of the dialogue on the role of values and psychotherapy has included recommendations for training, which of course are particularly relevant for programs which seek to train new psychologists.

Issues of value conflicts have been seen as increasingly relevant to training programs also due to actual experiences and conflicts between trainees and programs concerning values management. In fact, the impetus for the current research was a recent real-life example of the issues relative to value conflicts that was described on a counseling psychology training listserv which prompted considerable discussion among training directors of counseling psychology training programs. The training director of an APA-accredited counseling psychology doctoral program initiated the conversation by describing the conflicts they were encountering at their site in a November 23, 2004 post:

We are having some problems in our program where some of our students would strongly prefer not to work with gay/lesbian/bisexual clients due to strong religious belief. ...I would like to know how you are handling these types of situations in your programs, particularly when students’ personal

values do not match the values of the counseling psychology profession (i.e. ...to serve culturally diverse clients including gay/lesbian/bisexual clients).

Other posts followed, with more trainers expressing concern about the consequences of the conflicts between trainees' personal values and professional expectations, particularly when trainees desired to avoid working with particular clients because of the value conflict. Adding to the difficulty was that the justification given for refusing to work with certain clients was based on religious diversity, which is something psychologists strive to respect. In the words of the original listserv discussion, "The rub seems to come when a religious student states that to make him or her work with GLB clients means to discriminate based on religion, and thus to not respect religious diversity."

It is not known how widespread this situation is, or how common it is for students to request to not work with clients with very different values. However, the idea that trainees prefer to see clients who are more similar to themselves did receive some empirical support in a study by Teasdale and Hill (2006) which found that therapy trainees did express a preference for clients with similar attitudes and values over clients with dissimilar attitudes and values.

Several studies have explored clients' preferences for counselor characteristics, but relatively 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 (commonly referred to by the acronym YAVIS), as compared to clients who exhibited the opposites of those traits. There is also evidence that therapists prefer to work with personal or social concerns rather than vocational issues (Spengler, Blustein, & Strohmer, 1990). Another study (Zivian, Larsen, Know,

Gekoski, & Hatchette, 1992) found that younger clients were preferred to middle aged clients, and middle aged clients were preferred to older ones. However, therapist preferences for clients with similar or dissimilar values had not been evaluated. Further, no studies have specifically investigated the preferences of therapists currently in training.

Teasdale and Hill (2006) investigated therapist preferences for client characteristics, including value similarity, specifically among therapists in training. To further clarify the salience of particular characteristics, they used a paired comparison model examining preferences for various demographic variables (age, gender, race-ethnicity, socioeconomic status, and sexual orientation) as well as “psychological” characteristics of attitudes and values, psychological mindedness, and similarity of problems as compared with the counselor. Their findings suggested that students consistently preferred to see clients with similar attitudes and values, although it was not the most preferred trait (psychological mindedness was the trait most preferred in clients). Similarly, a dissimilar value system was shown to be a non-preferred characteristic – that is, in comparison with other traits, therapists expressed a strong preference not to work with individuals with dissimilar attitudes and values. Again, this preference was second in strength to the preference to not work with non-psychologically minded individuals.

Teasdale and Hill (2006) found that other client traits that were preferred by participants in this study were similar age, rather than older age, and presenting problems that were dissimilar to therapists’ own problems, rather than similar. Trainees in this study did not express a consistent or strong preference with regards to similar or dissimilar gender, race/ethnicity, socioeconomic status, or sexual orientation. This last variable is interesting, particularly in light of the listserv discussion, because it suggests

that respondents viewed the characteristic of sexual orientation as unrelated to the characteristic of similarity of attitudes and values. Clearly, the students described in the original listserv post who expressed a strong preference not to work with gay or lesbian clients on religious grounds saw the clients' sexual orientation as a value position that conflicted with their own. Teasdale and Hill (2006) suggested the possibility that political correctness may have influenced the results in their study, given the emphasis on diversity in many doctoral programs. All of the traits on which trainees expressed a preference (with the exception of age) could be considered psychological variables, while all of the other variables where no preference was clear might be considered demographic variables. Thus, it may be that trainees feel comfortable expressing a preference for particular psychological characteristics in their clients, but do not feel comfortable expressing preferences for demographic traits. An alternate explanation for this distinction is that graduate programs may have adequately prepared counselors for dealing with demographic differences but not for differences in psychological traits such as psychological mindedness and value orientations, and that this lack of preparation makes students uncomfortable in dealing with these differences.

Teasdale and Hill's (2006) research was not able to show why students preferred not to see clients with dissimilar values, although they speculated that students may have seen clients with similar values as easier to identify and empathize with than those with different values. Alternatively, they may have been aware of the concern in the field regarding the imposing of counselor values onto the client and may have been concerned about the possibility of their values influencing treatment with clients with dissimilar values. It also was not possible to assess whether the stated preferences would

affect trainee's choices not to work with particular clients or not. However, several individuals responded to the listserv post quoted above describing similar concerns about trainees preferring not to work with clients with strongly dissimilar values, providing some anecdotal evidence that some trainees are indeed adopting such a preference with regards to these clients.

Having trainees refuse to work with clients with different values presents a problem for training programs because the counseling psychology field places a high value on providing services for underserved or marginalized populations and respecting differences among individuals. Not surprisingly, the initial listserv post prompted an extensive and dynamic discussion among trainers regarding the role of trainee values in therapy and training. Several training directors responded to the initial question, leading to a listserv discussion including over 40 posts and prompting a in a discussion on the topic of value conflicts at a subsequent meeting of training directors at a February 2005 meeting of the Council of Counseling Psychology Training Programs. Along with dealing with the issue of religious students refusing to work with gay/lesbian/bisexual clients, training directors also discussed other potential conflicts that might arise between trainees and the clients they treat.

The training directors reached several conclusions in the February 2005 discussion. First, it was agreed 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. Second, training directors concluded that students are coming to training programs with increasingly diverse backgrounds and values. Third, these increasing differences and

value diversity are raising the issues of value conflicts in training more than has been the case in the past and pushing trainers and programs to evaluate their own values and those of the profession, as well as to develop strategies to deal with value conflicts among trainees and their clients. Finally, these increasingly frequent and complex value conflicts point to a need for greater guidance to trainers on how to manage these difficult situations among their own trainees (Mintz et al., in press).

Mintz and her colleagues (in press) suggested one step towards providing both trainees and trainers the necessary guidance on the issues of values and value conflicts in training would be 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 counseling psychology field cannot and should not influence values that relate exclusively to non-professional 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. As a further example of this point, Mintz et al. (in press) cite the experience of a National Public Radio listener who faced a somewhat similar conflict. In a commentary that aired July 28, 2005 and was, Adam Taylor wrote,

As a vegetarian and a sandwich-maker, if I told my customers that I was morally obligated to not sell them the beef that is written on the menu, I would quickly be out of a job. If someone feels so morally violated by the terms of their job, they should probably find a different line of work. (p. 10)

Similarly, Mintz et al. (in press) argue that one professional competency that should be expected from all psychologists is the ability (and willingness) to counsel individuals whose values differ from those of the clients, and that therefore doing counseling with these individuals during training is a reasonable expectation for training programs to have for their students.

Mintz et al. (in press) further suggest that a statement such as the CPMTVSAD would assist programs in clarifying the value-based expectations that guide professional training. They further suggest a value management strategy, based on three fundamental skills drawn from the philosophy of science literature, which may be helpful in reconciling value conflicts and which they feel should be attended to more explicitly in training contexts. These are (a) understanding the philosophy that undergirds theories and beliefs, (b) deeply examining and reconciling divergent perspectives, and (c) recognizing and attending to transcendent values. Once the underlying beliefs are clarified and understood, they suggest, often the process of wrestling with divergent beliefs generates new alternatives. Focusing on transcendent beliefs can assist in reconciling these different perspectives and providing a value-based approach that is both consistent and allows for diversity. One of the rationales for encouraging the development of these skills, including exploring personal values which may interfere with professional activities is that it changes the focus of value conflicts from a “kind of competition about which value is more legitimate or reasonable” (p. 19) to one of professional competency. This ideally would allow training programs to both respect the values of their trainees and still help them develop the professional competencies necessary to work with clients with dissimilar values in an ethically appropriate manner.

Other training recommendations have grown out of the awareness that values influence both the process and outcome of therapy. After reporting further evidence of value convergence, Kelly and Strupp (1992) note that, given the consistent evidence of the value-laden nature of therapy, it might be appropriate for graduate 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. They note that “effectiveness with some (if not all) patients may improve as values-related issues are processed with greater sensitivity and skill” (p. 39).

Most training programs do attempt to increase trainee’s sensitivity to diverse clients, typically through a course or other instruction on multi-cultural counseling. These courses are intended to alert therapists in training to the differences, including value differences, which may arise from membership in a particular culture, whether that culture is defined by race, ethnicity, gender, religiosity, or other factors. These differences are then seen as primarily responsible for value conflicts among individuals and so the focus has been on understanding these differences in order to minimize these conflicts. For example, although the APA (2002) Ethical Principle E (Respect for People’s Rights and Dignity) states that psychologists respect “individual and role differences,” most of the dialogue about biases and value conflicts focuses on group differences as the origin of these values. For example, Principle E says that “Psychologists are aware of and respect cultural, individual, and role differences” and goes on to clarify that these include “those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and

socioeconomic status.” Implicit in this statement is the idea that difficulties may arise when differences are present and that these differences are likely to arise from membership in a different group, whether racial, religious, age-based, or other groups listed. Certainly, many of these demographic groups impart particular values to those who belong to them (perhaps most clearly seen with religious affiliation or grouping) and so interacting with members of a different group than oneself may involve values that are different than one’s own. Hence, much of the discussion and education on values in counseling has focused on understanding and respecting world views that arise from different backgrounds or group memberships.

Value conflicts that may arise between individuals within a particular group seem to be acknowledged less frequently than those occurring between groups are. For example, among white Christian women (or African American men, or any other group), there may be vastly differing values and beliefs on appropriate gender roles within a family. In this case, a white Christian male counselor may well share the same “age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status” with his client and therefore understand the values imparted by those variables well, yet still have strong value conflicts with a client who sees the issue of gender roles differently. Thus, understanding and respecting group differences alone is not in itself sufficient to address the problem of value conflicts in counseling. While many conflicts in counseling may arise from cultural and group differences, understanding and respecting these differences are crucially important to providing quality counseling, looking at values conflicts only in terms of cultural differences does not provide sufficient breadth to cover the many types of

conflicts that may arise. Therefore, multicultural education alone, while valuable and important, will not provide counselors with the necessary skills for adequately addressing value conflicts.

Vachon and Agresti (1992) presented a proposal for training practitioners to clarify and manage values during psychotherapy by not only becoming more aware of individual and group values, but also the values that underlie therapy interactions and psychological theories themselves. Their recommendations include first the ability to “translate counseling interactions into their implicit value statements” (p.510) followed by skills in managing these values in ways that beneficial to the client. Regarding this first point, they suggest that training programs help students to not only clarify personal values, but also to understand the values underlying theories, techniques, and interventions, a process which they suggest may have been “unconscious, inconsistent, or haphazard up to this point” (p. 511). The second skill they focus on is the development of an ethical framework which allows therapists to evaluate the value-related issues at work in a particular case. Finally they suggest that providing trainees with tools to evaluate and clarify issues related general philosophy-of-life or religious issues will help them understand the value-laden meanings clients bring the therapy and work with them in constructive ways.

It is not known how trainees themselves view these values-related issues. For example, while Teasdale and Hill (2006) found that trainees showed a fairly strong preference not to work with individuals with dissimilar values, their research could not accurately assess the reasons for that preference. It is possible, as they speculated, that trainees were concerned about being able to conduct counseling competently, perhaps

because they felt they lacked skills in working with dissimilar clients. In such a case, a training component such as those outlined above might be helpful in reducing discomfort and allowing them to work productively with dissimilar clients. Similarly, it is possible that the students described in the original listserv post simply felt morally compromised by the requirement to operate within client values they felt were offensive, in which case a value management strategy such as that outlined by Mintz et al. (in press), combined with a statement of professional expectations, might assist them in resolving conflicts. Another possibility is that beginning therapists have less exposure to the professional values that inform the field than do experienced practitioners, so that a statement of these values such as the CPMTVSRD, along with repeated emphasis on these values, might address the issue sufficiently.

Other possibilities for preferring not to see dissimilar clients exist as well. One possibility is that trainees feel that performing therapy with dissimilar clients would be a disservice to clients. Returning to the sandwich maker and pharmacist examples cited earlier, it is likely that neither the roast beef sandwich nor the birth control pills are significantly altered by the values of their dispensers. That is, the product being provided (the pills or the sandwich) is likely to be identical whether the person producing it agrees or disagrees with the moral values of the customer. There is ample evidence, however, that therapy doesn't work that way, that in fact the product being provided (therapy) is very much a product of the values of the one providing it and thus may be substantially different if the therapist agrees or disagrees with the moral values of the client. If students are aware of this dynamic, they may feel that refusing to see certain clients on moral grounds is essentially an extension of the therapist matching or referral strategy discussed

earlier and is intended to protect client autonomy rather than prevent therapist discomfort. If that is the case, then value sensitization would not necessarily be effective in assisting these students to work with dissimilar clients. Clearly, any solution for value-related training concerns should begin with an understanding of the issues that give rise to those concerns in the first place.

Statement of the Problem

Given that both theoretical work and empirical research have demonstrated the value-laden nature of psychotherapy and the ethical concerns that arise from the influence of therapist values in therapy, it is imperative that psychologists understand how to manage those values so that therapy is both ethical and helpful to clients. Several different strategies for managing values in therapy have been suggested, including attempting to remain as neutral as possible, separating personal from professional values, value clarification, disclosure, therapist matching and referral.

One of the necessary prerequisites to a comprehensive value management strategy, however, is training in understanding the value-laden nature of therapy and learning how to manage values during the therapy process. Along with a frequent call for therapists to gain greater awareness of their own values and the impact these have on therapy, several training recommendations have been developed to better prepare students to deal competently with value-related issues.

Discussions related to training are particularly timely as several training directors have expressed concerns over how to respect the values of their students and at the same time train them in performing professional services where they encounter value conflicts. Part of tailoring a solution to these concerns, however, lies in understanding the beliefs or

views that students have regarding values in therapy that might be affecting how they define value expectations for therapy.

Clearly, in order to better assist training programs in developing values training for their students, we need to first understand how trainees view issues related to value conflicts in counseling. Some relevant issues to address include the role that trainees see their own values playing in the therapy process and the level of awareness students have about values-related issues in therapy in general. Along with that, it is helpful to understand how their training programs have prepared them to deal with value issues in counseling, as this has influenced both their awareness of and degree of comfort with situations of value conflicts. It is also interesting to understand whether they feel that either students or professionals (or both) are ethically obligated to provide counseling to individuals with whom they experience value conflicts, and if not, why. This understanding may help training programs arrive at more comprehensive and useful strategies for negotiating these conflicts among their trainees.

Research Questions

Given the current discussions surrounding value conflicts both among training programs and in the literature in general, the current research attempts to answer the following questions:

- What role do psychology graduates think that values should play in the counseling process?
- How do psychology graduates feel about providing therapy to clients whose values are very different from their own? Why?
- How are value differences with clients handled or managed?

- What guiding rules or principles do psychology graduates rely on in evaluating how value differences are managed?
- Do psychology graduates feel that students should be required to provide counseling to clients with very different values? Why or why not?
- What were the educational experiences of psychology graduates regarding values and value conflicts in the counseling/psychotherapy process?

It is hoped that these findings further the dialogue on appropriate value management strategies in therapy and provide additional insight about these issues as psychologists evaluate and create ethical solutions to these dilemmas. It is also hoped that these findings will assist training programs in both assessing and developing appropriate instruction and experiential training for their students in areas of value differences and value conflicts.

Method

The purpose of this study is to investigate psychology trainees' perspectives on value conflicts with clients and how their perspectives influence their therapeutic conceptualizations, theorizing, and behavior. In order to address these questions, this study will use an interview-based qualitative research method. This method utilizes interviews with participants as the data to understand the experiences of participants and the meanings which participants give to those experiences. It is also intended to understand the views, beliefs, and perceptions of participants within the meaningful contexts in which they occur. Kvale (1996) stated that "...interviews are particularly suited for studying people's understanding of the meanings in their lived world, describing their experiences and self-understanding, and clarifying and elaborating their own perspective on their lived world" (p. 105).

Rationale for Qualitative Method

Qualitative research is a method, or a group of related methods, that reject the notion that human experience can be understood from an objective and value-free stance. It makes different assumptions than quantitative research and has different goals. Some of these assumptions are that (a) human reality is socially constructed and context-dependent, rather than occurring as one true objective and measurable reality, and (b) researchers and the phenomena they study are interdependent, rather than independent of each other (McGrath and Johnson, 2003; Ponterotto and Grieger, 1999). The goals of qualitative research are to understand human phenomena and to seek patterns of relationships in particular contexts (McGrath and Johnson, 2003; Ponterotto and Grieger 1999).

One of the goals of qualitative research is to understand the experiences of participants from within the meaningful contexts in which they occur. Interview-based research is useful in being able to clarify and explore these meanings in a way that is not possible in quantitative research. As Kazdin (1998) states, qualitative research also strives to generate knowledge by allowing for understandings of the area of inquiry that may not have previously been accessible to either the participants or the researcher.

Qualitative methods seem to be most appropriate for this study for several reasons. One is that human experience is primarily made meaningful through narrative or linguistic expression (Polkinghorne, 1983) and therefore these forms of expression will most closely approximate the context in which issues of values and value conflicts occur. In discussing the application of qualitative methods to researching values management among psychotherapists, Fisher-Smith (1999) notes that qualitative methods allow “for an exploration of the contradictions and complexities of values management itself.” She adds that “numerical language is not the fundamental language of value expression” (p. 33) and so evaluating therapists’ experiences in psychotherapy through quantitative methods might misrepresent the experience. This is, in part, because the views and beliefs of therapists concerning value management may not be adequately conveyed using quantitative data. The primary language of interview-based qualitative methods is not numerical language, but everyday spoken language, the type that is used to convey meaning in the vast majority of human interaction. This may allow for a more nuanced and richer assessment of participants’ experiences.

Williams and Levitt (2007) point out that while particular quantitative measures may be “helpful in exploring hypotheses about changes in sets of values, they do not

contextualize findings about values within the moment-to-moment interactions of psychotherapy” (p. 161). That is, numerical data is not able to communicate the interplay of therapist values and the process of psychotherapy as it occurs in specific time-limited interactions. Accordingly, empirical literature is inadequate for developing understanding either of how values influence therapy moment to moment or for developing guiding principles for handling these value interactions. Further, Walsh (1995) suggests that value expression is unique to the context and relationship at hand and so empirical measures (which, by their nature, isolate phenomena of interest from their contextual moorings) are incapable of fully capturing the meaning and dimensionality of values in practice. For these reasons, Williams and Levitt (2007), along with others (Walsh, 1995; Slife, 2004) recommend using qualitative methods for the investigation of values and value-related issues.

Another reason for utilizing an interview-based method for collecting data for this study was that an interview format allows for greater exploration and clarification of themes and can clarify definitions for both the researcher and participants. For example, participants varied substantially in their ability to articulate their reasons for choosing the positions and interventions they did. Unlike instrument- or survey-based methods, an interview based method has the advantage of helping participants to clarify their own beliefs or positions and encouraging them to make these explicit in the interview process. Further, some of the terminology used in the discussion on value conflicts has different meaning to different individuals, so that responses on a closed-end instrument or survey may not have the same meaning to the researcher as the participant intended. Interview based research has the advantage of allowing the interviewer and participant to discuss

and clarify meanings so that the participant can accurately convey the meaning he/she gives to the issues.

Participants

Participants in this study were individuals who had either recently graduated or would soon graduate from a doctoral program in clinical, counseling, or professional psychology. At the time of the interview all were within one month of completing an APA-approved predoctoral internship. Twelve had graduated and begun postdoctoral work; five were still completing dissertations and expecting to graduate within four months of the interview but had all other requirements for the Ph.D. completed. Participants had completed an average of 1574 hours of clinical practice prior to beginning the 2000-hour internship, and had had several years of practicum and clerkship placements at various sites. Graduating students were selected for participation in this study because the focus of the study was trainees' attitudes and experiences around value conflicts rather than the attitudes of those already practicing. Further, graduates have completed all the training requirements (including internship) and thus are in a position to reflect on the cumulative products of training around value issues.

Participants were 14 women and three men with a mean age of 30; all but one participant were between 27 and 32 years of age. Of the 17 participants, seven were graduates of counseling psychology programs, seven were graduates of clinical psychology programs, two were receiving the PsyD degree, and one had completed a doctoral degree in a combined clinical/counseling school psychology program. These programs were located throughout the United States, with five in the West, five in the Midwest, five in the East, and two in the South. Internship placements also reflected a

range of settings and locations, with six participants completing internships in university or college counseling centers, five in hospital, inpatient or forensic units, five in community mental health providers, and one in a combined college counseling center/ inpatient program. Of these, six were located in the West, three in the Midwest, five in the East, and two in the South.

Fourteen of the participants identified themselves as European-American, with three individuals identifying with other ethnicities (one East Asian, one Southeast Asian, one multiracial – Native American/ African American/ Caucasian). Additionally, one of the European-American participants identified culturally as an Eastern European American. Eight of the participants said they were religious (three identified themselves as Protestant Christians, two as Evangelical Christians, and one each as Lutheran, Jewish, and LDS); nine said they were not religious. Participants also represented a broad range of theoretical orientations.

Participants were recruited in a number of ways, either via direct email or through emails to their internship sites or graduate programs. Response rates in general were fairly low, probably due in part to the fact that the end of internship is often a busy time for graduates as they prepare to begin their professional careers. Initially fifteen emails were sent out to individuals completing their internships in the state of Utah, because their proximity would allow for in-person interviews. Of these, six individuals participated. Recruiting emails were then sent to approximately thirty internship sites across the country, with three to five interns at each site; six participants were recruited in this manner. Recruiting emails were then sent to 65 counseling psychology doctoral

programs, adding an additional three participants. Finally, two participants were referred by a previous participant.

Kvale (1996) stated that the desirable number of participants to interview in this type of study is the number necessary to answer the desired question, which can be assessed in part by evaluating the degree to which further interviews shed new light on the question. He suggested that “interviews might be conducted until a point of saturation, where further interviews yield little new knowledge” (p. 102), which he stated tends to be at about 15 participants, plus or minus ten. In this study, a point of saturation was established with the fourteenth interview.

Data Collection

Data for this study was collected using an unstructured interview format. Four of the interviews were conducted in person; the remaining 13 were done over the telephone. All of the interviews were conducted by the principal researcher. Prior to the interview, participants were e-mailed a consent form and a list of guiding questions. Just before beginning the interview, participants were briefed to explain the purposes of the study and the format for the interview, obtain informed consent (including consent for audio recording), and answer any questions. A brief demographic questionnaire was completed and definitions of a few key terms were also reviewed for clarification.

The interviews lasted between 22 and 53 minutes, with the majority between 30 and 40 minutes in duration, and were digitally recorded to ensure accuracy in later analysis. An interview guide was used to ensure that the interviews covered the relevant issues and addressed the research questions with sufficient depth. The interview guide included the following questions:

1. What role do you see values playing in the counseling process? Specifically, do you feel that therapists' personal values influence the counseling process? Do you feel that they should influence the therapy process? Why or why not?
2. Do you feel that significant value differences between therapist and client are harmful, helpful, or irrelevant to therapy processes and outcome? Why and how?
3. Do you prefer to see clients with similar values, dissimilar values, or no preference? Why? What are your reactions when you recognize that a client has significantly different values from you?
4. How do you handle value conflicts when providing therapy to a client with very different values? Is the conflict addressed with the client? Why or why not? Do you employ other strategies to deal with the differences? What are those, and why do you use those?
5. Could you give me an example of a situation in which you provided therapy to a client whose values were significantly different from yours? While maintaining confidentiality, can you tell me how you felt about the conflict, how you approached it with the client, and how you felt the conflict and the way it was handled impacted the outcome of the therapy?
6. Do you feel that it is ever appropriate to try to influence a client to alter their values? Would your conclusion be the same if the values in question are based in a cultural, ethnic, or religious background that is different than yours? If they are based in a cultural, ethnic, or religious background that you share, but which you interpret differently? Is it appropriate to intervene if you feel that their values are psychologically unhealthy (for example, perfectionism)? Is it appropriate if those

values conflict with those of the psychology profession, but are not psychologically harmful (for example, values related to social responsibility)?

7. Do you think students should be required to provide counseling to clients with very different values? Why or why not?
8. Do you think licensed professionals should be expected to provide counseling to clients with very different values? Why or why not?
9. Do you feel that your training in your graduate program adequately prepared you to deal with value conflicts in therapy? Was training around value conflicts in your internship helpful? Was training done primarily in coursework or in clinical settings, or both? How do you feel about the training you received on issues of value conflicts, either in your program or internship placements? Do you have any recommendations for training programs in this area?

While an interview guide was used, the interviews were not exclusively conducted in a purely question-and-answer format; rather, the format was more similar to a conversation between the researcher and participant about the topics of this study.

While the researcher generally followed the order of the questions listed in the interview guide, deviations were also made to explore relevant topics as they arose, and not all of the participants were asked all of the questions listed on the guide. In addition to the questions listed on the interview guide, the researcher also asked follow-up questions, specifying questions, interpreting questions and probing questions as appropriate to ensure sufficient depth and specificity, to yield further information, and to ensure that participants' meanings are sufficiently clear for accurate analysis. Structuring questions

were also used to facilitate the flow of the conversation (see Kvale (1996) for a discussion of the different types of questions used in semistructured interview research).

Following the interviews, participants were debriefed to discuss their feelings regarding the research and interview process and to allow for clarification or discussion of any relevant issues not already covered. When the debriefing yielded further understanding about relevant issues, participants' debriefing comments were also added to the data via either audio recording or written notes.

After the interviews were completed, the audio recordings of the interviews were transcribed. Six interviews were transcribed by the principal investigator and the remaining 11 interviews were transcribed by a professional transcriptionist. While transcribing interviews eliminates relevant non-linguistic communication and transforms the contextual and temporal quality of the interview (see Kvale (1996) for a discussion of the challenges inherent in transcription), it also facilitates later analysis and reliability checks. Notes from the researcher were also examined in conjunction with the transcripts to ensure that the meaning apparent in the written form of the interviews approximated the actual experience during the interview as closely as possible. Data construction and interpretation were then based on the combination of transcribed interviews and interview notes.

Data Construction

Assumptions of Data Construction

The current research was based on hermeneutical philosophical assumptions and these assumptions guided both the construction of the data and the process of validating the findings. It may be helpful, then, to explore the assumptions that enter into this

approach in greater depth. As Kvale (1996) notes, “The purpose of hermeneutical interpretation is to obtain a valid and common understanding of the meaning of a text” (p. 46). However, this doesn’t suggest that only one interpretation is valid or correct, or that the interpretation process is a discovery or description of an objective reality. Instead, hermeneutic interpretation is seen as a process of creation characterized by a hermeneutical circle or spiral, where the meaning of the individual components of the text is determined by the global meaning of the whole, which in turn refined and informed by the separate parts. Kvale (1996) lists seven basic canons of hermeneutical interpretation which may be helpful to review here, as they give meaning to the data construction process.

The first canon is that the interpretation of meaning involves a “back and forth process between the parts and the whole” (Kvale, 1996, p. 48). This process, instead of being circular (and leading nowhere), is viewed as spiral, in that the back and forth dialogue opens the possibility for a deepened understanding of the meaning of the text. Second, this interpretive process end when a unified meaning has been developed so that the themes are internally consistent, logical, and coherent. Third, the interpretations of individual parts are validated against the meanings of the whole. Fourth, the interview text is seen as autonomous and “should be understood on the basis of its own frame of reference, by explicating what the text itself states about a theme” (Kvale, 1996, p. 49). This suggests that the interpretations should focus primarily on the autonomous meanings expressed about participants’ lived experiences. A fifth canon suggests that qualitative researchers must have extensive knowledge about the issue under exploration so that subtle meanings and differences are understood. Sixth, hermeneutical interpretation holds

that the researcher cannot remove themselves from the contexts or understandings of their own lived world, suggesting that interpretation is never an objective process. However, investigators can and should be aware of the presuppositions that are brought to the process, not to bracket them and set them aside, but rather to take them into account in the interpretation of the results created during the process. A final canon is that every interpretation involves innovation and creativity, so that the meaning of the text is expanded through new understandings in the interpretive process.

The assumptions of hermeneutic research influence the way that this research is both understood and carried out and the way that the data from the research are formulated and developed into research findings. First, the researcher does not enter the process assuming that objectivity is possible or even desirable. Instead, the research interview and its meanings are seen as a co-creation of both interviewer and interviewee. Further, the researcher must be intimately acquainted with the topic matter at hand – unlike positivistic theories, which suggest that scientific rigor is increased when research designs either eliminate or control for biases due to prior knowledge, hermeneutic interpretations hold that the pre-understandings of the researcher contribute to richer interpretations and meanings. Additionally, during the process of data construction, the researcher uses this background to develop themes from the texts in the ongoing spiral of developing meaning described earlier, rather than relying on numerical counts of particular statements or themes.

Hermeneutic assumptions also have implications for evaluating the validity of the interpretation. First, while the interpretation produced should be valid, internally coherent, and logically consistent, hermeneutic interpretation does not suggest that other valid

interpretations are not possible. Thus, the role of the auditor of research is not to see if the researcher arrived at the “correct” interpretation or meaning, but to verify that the researcher has been honest through the process of interpretation and open to the back-and-forth development of meaning within the text. Further, external auditors or peer reviewers are not seen as being any more likely to arrive at a valid interpretation than those more intimately involved with the subject matter at hand. The interviewees themselves, however, can provide further understandings of their own statements and it is permissible and may be desirable to re-open a dialogue on those points as needed. The current research incorporated these assumptions of hermeneutic research in both the data constructions and validation processes.

Steps in Data Construction

The purpose of the analysis of these transcripts was to both summarize the content of the interviews and to provide a rich, meaningful interpretation of the interviews that adds to the understanding of value issues and conflicts in training. Accordingly, each interview was analyzed first in its entirety and then by individual theme, to develop a rich interpretation of the meanings of the interview. These interpretations were then validated in several ways. This data construction process involved several steps, each of which contributed to both the depth and trustworthiness of the results.

First, the transcripts were examined in their entirety with an attempt to bring as few assumptions or presuppositions to the material as possible. This was an attempt to get an overall picture or feel for the content of the interviews. An unfocused overview also allowed the researcher to develop an understanding of the meanings in the interviews

from the participants' subjective perspectives. Notations were also made as to possible themes developing from the interviews during this overview.

Second, the transcripts were then re-analyzed in depth to make further interpretations of the material. Emerging themes were developed and examined with each successive reading, with the researcher attempting to develop deeper levels of meaning and understanding from the interviews with each reading. As part of this process, the salience and strength of each theme was evaluated throughout the interpretation process. This is where the back-and-forth nature of hermeneutical interpretation was most present, in that the emerging themes gave structure to the transcripts while also being validated against the whole. Themes were also added, modified, and in some cases deleted as this process occurred. Those themes that continued to be supported through successive readings were retained, while those that were not supported during later readings were modified or deleted as necessary.

Third, these themes were then described and summarized in language that most closely approximated the meanings in the transcripts, with the attempt to accurately communicate the findings in succinct and clear statements.

Fourth, selected portions of the transcripts were reviewed by the researcher's dissertation advisor, who served as auditor of the data construction process. The auditor and the researcher reviewed the identified themes against the transcripts to assess the validity and soundness of the data construction process. Because data construction was seen as a necessarily subjective, rather than objective process, it was felt that having an auditor who was familiar with the concepts upon which the study is based would contribute to the soundness of the data construction process.

As a final assurance of validity, participants were contacted via email with the results of the study for their review and feedback. These results included both the identified themes and two to four brief paragraphs of summary statements about the findings relevant to each theme. Participants were encouraged to provide feedback on how well these themes approximated their own view of the interview and responses from participants generally indicated that the findings were consistent with their own interpretations of the topic.

Those themes which were then retained through each of these review processes, and agreed upon by both the researcher and auditor, formed the findings or conclusions of the study.

Assumptions of the Researcher

Because the raw data for this study (the interviews) are a product of the interactions between the participant and the interviewer, and because the views of the interviewer can therefore be expected to influence the finished product to some degree, it may be helpful to evaluate the assumptions that I brought to this project. These are largely based on my own experiences in thinking about values issues and in studying the relevant literature. First, I believe that therapy is not the value neutral experience that it was originally conceived to be, but that values inform all aspects of the therapy experience in one way or another. I also think that as practitioners, we should be able to articulate the values that inform our work and to discuss their impact on the therapy process. While I expected that participants would share a value on client autonomy and freedom, I expected them to be relatively unaware of the value-ladenness of therapy. This was true in some cases and not at all true in others. Although I believe that values are an

integral and unavoidable part of therapy, I also value client freedom and autonomy (as do most psychologists), and feel that clients should be part of the exploration of value differences with the freedom to evaluate and accept or reject alternate values based on their own moral assessments. However, I also believe that clients may benefit from an introduction to alternate value systems which may be healthier or more conducive to their goals, and that practitioners have an obligation to introduce those values which they believe to be beneficial even as they strive to protect client self-determination. In short, I believe that therapist values are relevant to the therapy process and I am interested in understanding how best to include them in ways that both protect clients' rights and allow for a more productive, constructive therapeutic relationship and interventions. These assumptions and beliefs should be taken into account in the evaluation of the process and results of this study.

Results

Interviews were analyzed using the process outlined previously. Nine themes emerged from the data construction process. A brief summary of these themes and the relevant findings will be presented below, followed by a discussion of each theme in greater detail.

The first two themes relate to participants' perceptions about the role of values and value differences in general in therapeutic processes. The first theme specifically addresses the role of values and the finding that although psychology graduates feel that values play a significant role in therapeutic endeavors, they differ considerably on the desirability and perceived extent of that role. The second theme discusses the impact of value differences on therapeutic processes and outcomes. The research suggests that, despite disagreement about the role of values in therapy, most participants feel that significant differences in values between the client and counselor could either be helpful or harmful, depending on the kind of value difference, client characteristics, relevance to the presenting problem, and the way the difference is handled by the therapist.

The next two themes, themes three and four, address how participants handled value differences in therapy. Theme three explores how value differences are managed, including specific strategies that participants used, the factors that influence their use, and the situations in which values management appears to be particularly difficult for participants. It appears that the strategies participants use to manage value differences in therapy vary according to several factors, with most including an awareness of their own values, supervision and consultation, value exploration, or a combination of multiple strategies as part of an ethical values management strategy. Theme four explores whether

it is appropriate for a therapist to deliberately attempt to alter or influence their clients' values when differences arise. In general, it appears that participants differ somewhat on whether it is ethical to influence a client to change their values, with most suggesting that it is acceptable if the value in question leads to harm for the client or others. Other criteria were also mentioned that affect these decisions, including the degree to which the client had thought about the value-based decision.

Themes five and six relate primarily to therapists' personal reactions to value differences, including preferences for value-similar or value-dissimilar clients and to the question of whether therapists should be required to see clients with whom they have a significant value difference. Theme five specifically addresses participants' preferences and reactions, with the finding that most participants generally did not express a preference to see clients with either similar or dissimilar value systems, although when a preference was expressed it was generally for clients with dissimilar values. Further, participants' reactions to seeing clients with different values range from frustration and concern to interest and excitement. Theme six has particular relevance for training programs, as it specifically addresses the dilemma described earlier in which therapists were requesting not to work with specific populations on the basis of significant value differences. The research found that participants were divided on how training dilemmas regarding value conflicts should be addressed, with most recognizing the training value that such experiences hold but expressing concern for the potential for harm to the client. They were similarly divided on whether it was acceptable for licensed professionals to avoid working with value-dissimilar clients, with opinions generally more polarized than when discussing situations of value conflicts in training.

Themes seven and eight are specifically concerned with training considerations, with theme seven discussing participants' perceptions of the adequacy of training they received around value issues and their recommendations for improvement. In general, participants felt positive about the training they received around value-related issues in their graduate programs, but were quite mixed in their reactions to internship training. The most frequent recommendations for training programs were to provide more practical training in negotiating value differences, to encourage supervisors to initiate value discussions with supervisees, and to provide students with a broad range of training experiences. Theme eight discussed particular concerns around race and religious issues, as participants of color reported experiencing racist attitudes from clients and religious clients sometimes appeared to have concerns about therapists with different religious backgrounds. Further, several religious trainees experienced conflict with training programs over value-based issues, suggesting that both race and religion provide unique training concerns for programs.

The final theme differs somewhat from the previous eight themes, in that it examines the process of the value-based reasoning in the previous eight themes, as opposed to the content itself. Throughout the research participants' value decisions seemed to be contextually driven, with beneficence for the client being the highest or overarching value. Many of participants' responses noted that value management is dependent on multiple factors, suggesting that value decisions are made on the basis of contextual requirements rather than according to pre-conceived rules or guidelines. An overarching value of beneficence clearly underlay much of participants' reasoning on

value issues. These underlying assumptions and values will be evident as each of the nine themes is discussed in greater depth.

Theme 1: Roles of Values

Although psychology graduates felt that values play a significant role in therapeutic endeavors, they differed considerably on the desirability and perceived extent of that role. In general, graduates felt that values were inescapable in therapy, although they expressed concern for the consequences of therapist values on client autonomy. Nearly all of the participants interviewed felt that it was impossible for therapy to be truly value-free, but some seemed more comfortable with that position than others. In general, a focus on client values were seen as an acceptable and desirable component of therapy, but the inclusion of therapist values was viewed with more suspicion and participants differed much more sharply on the latter issue.

Client Values Essential and Acceptable in Therapy

All participants felt that client values were a central component of therapy, as articulated by the following statement:

It's almost completely what currency we're working with when we're working with clients. Every assumption they have about who they are, and what they're doing, and what they're feeling, is value-laden. I often think that part of the confusion that comes about for clients is [due to] conflicts in values that they have internally, between this internalized sense of what is supposed to be about this part of themselves versus this other element of themselves that they feel is not in accordance with that.... [Values] are the atoms that make up everything we do.

Further, client values were seen, in the words of one participant, as “all fair game in what they want to bring up; you're free to talk about that.” In other words, participants generally held that client values are an integral component of therapy and felt quite comfortable allowing client values to guide therapeutic interactions.

Therapist Values Inescapable in Therapy

Most of the participants felt that therapist values were an unavoidable part of therapy, and that their influence would be felt into therapy even if the therapist tried to keep them out. Many expressed concerns about the influence of therapist values, but felt that values were pervasive in therapy and thus attempting to minimize them was not a practical strategy. Values were seen as inherent in many aspects of therapy.

Values inherent in theories and conceptions of psychological health. Several suggested that values are inescapable because they are integrated into our very conceptions of what we are doing as psychologists and why.

At some level, I think the whole field of counseling is value-based, even though we try not to be. I think we have ideas about what's healthy and what's not... there's already that bias, so I feel like it's hard to get away from that bias. So I guess I would start from there, just to even acknowledge that there is that bias. Especially learning how to do counseling in this society, in this culture – it already comes with all this baggage.

One participant noted that value orientations are also already built into some of the theories that psychologists use to guide therapy, suggesting that the therapists bring not only personal values but theoretical values into the therapy room. Some of these theoretical values, he noted, leave little room for other points of view:

Sadly, I feel like, especially [with] the cognitive behavioral stuff, there's no space for client's values—it is a technical machine where the values are already built in to the very manualized framework and that's what it is. There's not a lot of space for the therapist's values, either, other than the fact that they're being primary transmitters for this general theoretical framework.

Values inherent in being human. Other participants noted that the inclusion of therapist values is simply an inescapable component of being human. One said, "I think values impact the therapeutic work because we are individuals in this world and it's hard

to come [into therapy] with a blank slate – which is even a value in itself.” One participant reported being asked by a graduate instructor if she felt her Christian beliefs would affect her therapy. She responded that they would, just as other beliefs might, simply because the influence of human values is woven into all our interactions.

Of course [my beliefs] are going to affect [my therapy]. If I’m a Hindu it’s going to affect it, or if I’m a Muslim it’s going to affect it. Even if I were an atheist, it’s going to affect it. We all come with values and to think for a moment that we are value free is pure ignorance and bias. You know, we’re not in a vacuum. Absolutely [values] play into every role because we’re human beings. I as a therapist have values, the client has values – we all have values.

Values inherent in therapy processes. Some participants noted that the influence of therapist values is related to the process of therapy itself. As one noted, “I think in a lot of ways, therapists are sounding boards for their clients and . . . inevitably our values are going to be what gets sounded off. I think in that way, in an implicit sort of manner, it does have an impact on the client.” Another cited research showing that clients over time begin to adopt much of therapists’ own language for looking at their concerns and added,

In part what we’re doing is we’re teaching them a way of understanding their own experience, but what are we teaching them? We’re giving them a new lens, but our lens is shaped in such a way from surrounding society, from a history of a certain profession. . . . So ultimately, as they start describing their experience through a language that we help teach them, we as clinicians are—I don’t want to use the word imposing because it just happens—but we are giving them values around what they’re doing, who they are, their experiences and everything. I think it’s just inevitable that therapists do that.

It’s important to note that for these individuals, the influence of therapist values wasn’t seen as an inherent threat to client autonomy. In fact, they were seen as inescapably guiding the process of therapy, which, to the degree that therapy is helpful, implies that

the inclusion of therapist values may also be beneficial. As an example, one participant suggested that therapist values influence therapy in the following ways:

I think that values are inherent in the counseling process. . . . I think [therapist values] should play an informative role more than any sort of prescriptive role. I would say that they should help a therapist with their conceptualization. I think sometimes they will assist—though usually not in a direct way—with helping a therapist determine interventions.

Arguments for Minimizing Therapist Values in Session

Although participants recognized that therapist values also influenced the process of therapy, many participants expressed reservations about the role that therapist values play in counseling interactions. A significant minority of those interviewed felt that therapist values should be excluded from therapy as much as possible. One graduate stated

I feel that [values] play a bigger role than they should. Generally counselors use their own personal values to guide therapy. I don't feel that therapists' values *should* play a role in therapy – I think it's better for therapists to keep [their values] out of therapy processes altogether.

Similarly, another respondent indicated, “In terms of the decisions [the therapist] makes in treatment, I don't think [therapist values] should play much of a role,” although she went on to acknowledge that values still may play a role, “depending on the individual therapist, how much they let [their values] influence their work.” This statement would suggest that individual therapists can also choose to prevent their values from playing a role. Another participant, while also feeling that personal values should be excluded from therapy, expressed concern that such a strategy might not be feasible. “I think ideally [therapists' values] should play as minimal a role as possible,” she said. “I don't know that that's all that realistic. In my experience, they're going to be there whether you want

them to be or not.” For these individuals, an ethical values management strategy relied on minimizing the role that therapist values played in therapy.

The reasons participants gave for seeing therapist values as an undesirable element in therapy were instructive. As might be expected, nearly all therapists who expressed concern about the role therapist values played in therapy did so out of a desire to respect client values and a belief that client values should take precedence in determining the course of therapy. For example, one participant said,

I think therapy should be all about the client, as much as possible, and respecting their values, instead of imposing your own on them. I don't really think that's the point of therapy. I think you need to be aware of your values and how they interact with the client's but I'd try to leave them out, as much as you can.

Similarly, many expressed concern that a client might feel “judged” by the therapist and might become defensive if conflicting therapist values are evident in therapy. Another participant suggested that therapist values could keep therapists from focusing on client values, saying, “I think, ideally, [therapist values] should play as minimal a role as possible. It's important that we see where the clients are and not always let them know necessarily what our values are.”

Interestingly, about half of the participants used the same word—impose—to describe the perceived threat that therapist values presented to client autonomy, and when it was used it was almost always to describe a harmful or negative interaction (with the exception of one participant who indicated that in cases of child abuse, she “would impose my own values to try to get it to stop”). Clearly, participants felt that “imposing” therapist values on clients was unethical and potentially harmful. None of them clarified what the phrase “imposing values” meant to them, although several participants

contrasted that phrase with respecting or honoring client values (as in “I want to honor their values and not impose [mine] on them”).

Arguments for Including Therapist Values in Session

Most participants recognized that therapist values are inescapable in therapy and felt that their inclusion in therapy should therefore be acknowledged. However, they differed considerably on the perceived desirability of including openly including therapist values in session, with most saying that it was important to recognize their influence only because it was impossible to keep them out. Similarly, many felt that open recognition of the influence of therapist values was at least less harmful than denying that influence, but still did not mention positive consequences of including therapist values. Only a small minority of participants felt that therapist values should be included because they play a positive role.

Including values necessary due to inescapability of values. Interestingly, many of the responses about the role of values in therapy seemed to present the difficulty of removing values from therapy as the rationale for recognizing their inclusion, rather than any positive role values may play. Several responses included phrases about values being “impossible to avoid” or “hard to overcome.” Other therapists, recognizing the inescapability of values in therapy, suggested that “therapists should *work really hard* to make sure they’re not imposing [their values] on the client” (emphasis added). These responses suggest a rather uneasy tension between therapist values and ethical practice in these therapists’ minds—that is, the fact that participants readily acknowledged their presence in therapy was not an indication that they saw therapist values as a positive influence at all. Instead, the implication is that removing therapist values from therapy

would be desirable, but that it would be difficult or impossible to do so and so the next best course is to recognize their influence and attempt to manage them in an ethical manner. For these graduates, therapist values are seen as something of a necessary evil. In the words of one graduate, “Well, it really doesn’t matter if I think [therapist values] should influence therapy, because they’re going to influence it. It’s not a ‘should’ or ‘shouldn’t.’ It would be great if [they] didn’t.”

Including values less harmful than denying them. Several of the participants voiced the opinion that, while values may pose a threat to client freedom, it was more harmful to deny the influence of values in therapy. One participant noted, “I don’t think the therapist can walk into the room and be value-free. I actually think there’s danger in holding that kind of a stance.” This danger was echoed by another graduate who said, “Actually, that person [who attempts to be value-free] is more dangerous than a person who clearly says, ‘Yes, I’ve got values and I’ve got biases.’” Another noted that, “It seems like if you assume that [values] are not part of counseling, you’re probably going to get yourself into trouble.” For these individuals, the threat arising from therapist values was greater when therapists were not aware of their values, although none of them went on to articulate exactly what the threat or danger was, or how it would play out in therapy.

Including values beneficial to therapy. Only a few participants directly stated that they felt therapist values should play a significant role in therapeutic practice because they contributed to therapy in positive ways, and even among those, that role varied. For most of these participants, values were a way of connecting genuinely to other people. One individual traced the development of this belief over time in these words:

Before graduate school, I thought it would be, “No, you keep your values to yourself, it’s not about you....” But then in graduate school later on, there were some really good professors that said, “You know what, you’re human beings too, you have values; you have to be genuine, you have to be kind of dynamic and organic in session, so you can’t just keep that to yourself.”

She went on, however, to add, as others had, that part of the rationale for that belief was the untenability of the alternative, when she said, “Because it’s going to come out anyway, in your personality and things. I think whether or not you want [your values to come out], they will.”

For those who felt that therapist values are a positive contribution to therapy, the reasons given, beyond their inescapability, had to do primarily with authenticity and genuineness. One participant noted that a value-neutral stance could backfire in therapy because it doesn’t reflect the genuine feelings of the therapist. “You have to be genuine with your client about your values because clients will know . . . I think inauthenticity can hurt the therapeutic relationship because [the client] may not trust you.” Not surprisingly, these therapists were more comfortable with self-disclosure in the therapy session than most other participants, as will be seen later.

It’s important to note, also, that even therapists who explicitly bring their own values into therapy reported doing so because they perceived it as helpful to clients, not because they wanted to influence the client to adopt their own position. Even those that bring their values into therapy express hesitancy about doing so and express a desire to respect the beliefs of others. As one said,

I think that they could directly be involved in a helpful way under certain circumstances. And, I think it would really depend on what the therapist’s purpose was. . . . And so it’s really this fine line to say, “Well, how is this [value] kind of serving that person and how much is it their culture and should I respect that? Or, should I let my opinion be known on that?” It’s

a really delicate subject area, I think. I think it can be used and I think it can be—if it needs to be—at times, laid out there that “Well, this is how I believe. It’s a little different [from your beliefs].”

In fact, those who felt that therapist values should be explicitly included were just as likely as others to indicate they it would be inappropriate to impose those values on clients. One participant who felt that therapist values might appropriately be included in therapy explained it in this way:

I would want to help [clients] really mind their own values and maybe my values can be a great mirror point for them to do that. But if I ever thought that someone would say that psychotherapy should be a clinician helping a client come to [the therapist’s] values, I would abandon ship.

Factors Influencing View of Role of Values

While it is clear that participants differed in their views of the role that therapists’ values should play in therapy, the current research did not fully explore the factors that led them to develop these views. It is likely that these views were developed during their training (and one participant cited earlier specifically cited the influence of a professor on her current views that therapist values should be openly acknowledged), but most did not specifically reference their training in discussing their views. Several individuals, however, said that their views on the role of therapist values were defined in part by the treatment setting, or the population they were working with. One individual made reference to published research in discussing his views. Which factors are most influential in helping professionals their view on the role of values remains to be more fully investigated, but it is helpful to explore further the factors that were discussed in understanding how trainees view therapist values in session.

Experiences with different treatment settings and populations. Views of value-related issues in therapy differed somewhat depending on the context in which therapy

was occurring and the types of clients they were seeing. Those individuals who were working in inpatient or forensic units, for example, noted that value neutrality was less practical in those settings. As one participant said, “Working in a forensic setting, it’s seen as okay to change [clients’] values – that’s even the goal in some cases.” Similarly, another participant who worked with in a hospital setting explained why complete value neutrality is impractical in that setting, saying,

I work with very suicidal and homicidal people and they know upfront that one of my values on the treatment team is that I want to make sure they’re safe before they leave. They have to know what that value is and it’s going to have to be there in the relationship.

She felt that in that setting, openly acknowledging her value for client safety was “natural” and inseparable from therapeutic goals. Similarly, participants who worked with severely mentally ill clients expressed concern about attempting to respect clients’ value systems when the value was expressed as part of a delusional belief system. Participants whose primary professional emphasis involved treating children and young adolescents also noted that value issues were somewhat different for those clients, both because of differences in developmental stages related to values and moral development and because of the role of the parent. Several participants noted that parents seemed more concerned about value similarities than their children did and that it was at least as necessary, if not more so, to work within the parents’ value systems as the child’s, since the parents were usually the ones to decide if therapy would continue. Thus, any discussion on the role of values in therapy needs to be sensitive to the differing demands of the settings in which clinicians work. It is important to note, however, that while participants described the roles of values in these settings somewhat differently, they all had also had experiences working with non-institutionalized adults in medium- to long-

term therapy settings, and they described their work in those settings similarly to other participants.

Awareness of Research. It is interesting to note that only one participant referenced research about values in giving a rationale for their position on the role of values in therapy, suggesting that the published literature in this area is not a significant influence in determining participants' views on the role of values. While several individuals felt that values would impact therapy, none mentioned the literature on value convergence or the published theoretical discussion arguing against value neutrality, raising the question of what factors led to the development of these beliefs. Awareness of related research was not an interview question, so it may be that graduates were aware of the literature in this area and that it had informed their answers without being specifically cited. It is also possible that they were generally unaware of the literature but that their responses were guided by personal experiences or opinions expressed in their graduate coursework.

Theme 2: Consequences of Value Differences in Therapy

Participants were asked whether they felt that significant value differences between the therapist and the client were harmful, helpful, or irrelevant. Interestingly, despite the disagreement about the appropriate role for therapist values, most agreed that significant differences in values between the client and counselor could either be helpful or harmful, depending on the kind of value difference, client characteristics, relevance to the presenting problem, and the way the difference is handled by the therapist. Further, most described similar threats and benefits arising from value conflicts. Illustrating these points, one participant said,

It depends on how it's used and how it's discussed. I think there are always differences between how I want to live my life and how clients want to live their lives. And I think it can be harmful if I'm imposing that on clients. But I think when I have been able to have discussions with clients about differences in values, and sort of point out that different people have different expectations for what their lives look like, those have actually been quite productive, because I feel like then clients have been able to get a different perspective on certain situations.

Another added,

I think it depends on the situation and it really depends on the relationship that the therapist and the client have. I think that you can come together with a client who is very different from yourself and you can learn a lot from that client and you can forge a great relationship and even be able to work towards similar goals if you don't share similar values. . . . I think it can be harmful if the therapist is the one allowing his or her values to really dominate the relationship and the course of treatment. It can be harmful if the client isn't feeling heard and they don't feel like their goals are being met because the therapist is the one that's kind of driving the . . . therapy.

Harmful Consequences of Value Differences

Clients do not feel understood, valued, or respected. Value conflicts were seen as harmful when therapists were not respectful of clients' value systems, or when they saw their own value system as superior and attempted to impose that in place of client values. This then may lead to the client feeling misunderstood or marginalized. For example, one participant said, "It could be harmful if the client doesn't feel understood or if they feel like their opinion or whatever isn't valued conceptually. It's harmful if they feel minimized or not respected." A slight majority of the examples of value differences given by the participants, in fact, were ones in which they felt the value difference could be potentially harmful. In most of these cases, the harm seemed to stem primarily from the threat to clients' feelings of value and competence.

Clients are unable to develop a positive relationship with therapist. Some respondents felt that value differences might also be harmful to therapy processes and outcomes via damage to the therapeutic relationship. One felt that, “the whole counseling relationship is based on at least being aware of your values and value differences,” suggesting that a significant value difference might prevent clients from developing a helpful therapeutic relationship with the therapist. There was a slight tendency among participants to feel that value differences posed at least a potential threat to the therapeutic relationship, especially if the difference presents itself early on. One therapist felt that,

I think that [values] also affect how [clients] form a relationship with you and how you form a relationship with them. In my experience, a lot of times clients will look to see if you have similar values as they do. I think sometimes if we do or don't it affects the therapeutic relationship, the ability to build trust, and the ability to feel like you as a therapist relate to them—their experience and what they're going through.

Value differences were also seen as having the potential to lead to the rupture of the relationship. As one graduate noted, “I can conceive of times when the value conflict could be such that it would be implausible for the therapist to be able to maintain a relationship,” leading to referral. Another one noted that the client may also terminate the relationship after picking up on non-verbal cues that communicate that the therapist doesn't like the client, and added, “They might cancel after a session like that, if I give off a vibe where I think they're less-than, or that I don't like them, or that I think they're weird.” It's important to note, however, that other participants did not see value differences as a threat to the therapeutic relationship. In the words of one, “It does affect the relationship but I don't think it's harmful. I have never had a situation where it's

been harmful. I mean, it does affect the relationship, but I don't think in a harming kind of way."

Beneficial Consequences of Value Differences

Clients gain new insights and perspectives. Despite the perceived potential for harm stemming from value differences, participants also saw significant benefits to that might occur when therapists and clients had different values. The benefit most frequently discussed was that clients could see their problem in a new or different way and that the value conflict could become a springboard for a healthy discussion about alternative views. As one graduate said,

One of the main values I think of therapy is to be able to provide a different perspective on someone's life or on a particular circumstance. And so any differences that come into the room pertaining to values would fall in that same category.

One participant described a discussion with a single female client with whom she worked, who was from a traditional religious background and was several years older than the norm for marrying in that culture. The therapist was aware that she and her client differed on values regarding marriage, and described being careful to work within the client's religious values regarding the importance of marriage and family, but also felt that offering another perspective was useful to the client. She said,

I feel like [value differences] can be helpful if there can be a productive dialogue about different perspectives. Like I said with that one woman I worked with—I don't know if I changed her values, but she seemed to take comfort in hearing another perspective, that maybe not everybody thinks that she needs to get married right now.

Clients learn new relationship skills. While the opportunity for new perspectives was the most frequently cited benefit to value differences, another benefit to value differences suggested by some participants is that clients can experience a relationship in

which differences with others are acknowledged in a healthy way, and use that as a model for other relationships. As one participant said, clients' awareness of value differences

can provide useful information for the client about what it's like to have a relationship or connection with someone who is . . . different from him or her. The client is going to have relationships with people who are similar to or different from them in their everyday lives. So how you talk about those things – how you resolve conflict, how you negotiate discrepancies in viewpoints – can be very beneficial, I think.

One therapist echoed this idea, holding that a relationship with one who sees the world very differently opens up possibilities for growth that might not come about without those differences.

I can think of some clinical cases I've had where a fundamental difference in the way we view things, has actually been the grist for the mill for some of the most profound moments of actually meeting each other. Because, to encounter that much difference and still be able to talk meaningfully through the things and to see one another as other and respect that and allow that, in a sense, rupture—to be present without being destructive—is sometimes beautiful.

Clients receive feedback on harmful behaviors. Several participants also gave examples of situations in which clients were involved in behaviors or relationships that they considered harmful. In those situations, therapists appeared to feel that their differences in values regarding these behaviors or relationships were beneficial to the client. One therapist was working with a client whose substance abuse, in her opinion, was quite excessive. When this client asked her therapist what she thought about her substance abuse, the therapist felt that it was beneficial to be honest, to discuss how her values around substance use differed, and to point out the problems she saw. As she noted, "We (therapists) may be the only people in a client's life that are in a position or have the power to share that [feedback] with them." Thus, value differences between client and therapist were seen as positive when they encouraged clients to move in a

healthier direction. Not surprisingly, perhaps, individuals working with severely mentally ill or forensic patients were somewhat more likely to see value differences between themselves and their clients as positive, and more likely to describe situations in which value differences were seen as being beneficial to the client.

Factors that Determine the Impact of Value Differences

One of the most striking consistencies in participants' responses was that many of them answered the question by saying, "It depends" Several factors were described that they felt determined whether a value difference was helpful or harmful. These included how the therapist handled the difference, client characteristics, the strength of the relationship, and the nature of the difference itself.

Therapists' attitude towards difference. The most frequently cited factor affecting the influence of a value difference on therapy outcomes was how the difference was handled by the therapist. As one therapist said, "I think if it's presented well, and in a respectful manner, and it's made into a conversation, then that can look a lot different from forcing it on them." Another one stated,

I think [value differences] can be harmful or helpful depending on how you handle them. I think if you're not aware of them, or if you're imposing them on people, that's probably harmful. But if you have differences and you're able to discuss that and work through it with someone, depending on the client, I think that can be really helpful.

Clients' ego strength. The quote above notes that whether a value difference is helpful or harmful also depends partly on the client. Another respondent elaborated on that by noting that some clients seem more comfortable with having different beliefs than those around them, a trait sometimes described as ego strength.

For some clients who might have a little less ego strength or a little bit more vulnerability, having someone that has a completely different value

system could be incredibly impositional and emotionally violent, if they're not able to, in a sense, maintain their own ground at all and (they) feel like they have to acquiesce. I've seen clients who take anything and everything I say to be the way it is, even if I know at the deepest level that it's just crushing right over their own values, but they can't put it out there because they're not allowed. And, that's still good in that I can hopefully find that and look at that, but it's also dangerous if it remains hidden and not made explicit.

Although he also believes that value differences can be beneficial, this therapist was aware that value differences may be seen as threatening by some clients and reported that he handles these situations differently as a result.

Quality and duration of relationship between client and therapist. Another factor that participants cited as determining whether differences are harmful or helpful was the quality and duration of the relationship with the client. Several participants felt that value differences could be particularly threatening early on in the relationship, before a good working relationship had been established, and that value conflicts might be handled differently depending on both the quality and development of the relationship.

One participant reported judging the quality of the relationship before deciding to challenge a client's racist comments in order to avoid harmful consequences. She later reflected that she could challenge the client's remark in part because "with her I felt like I had enough money in the bank, so to speak, that I could say something without hurting anything, and it didn't." She added, however, that "if I didn't know somebody very well, I think I might let it go early on to see where it might go." Another participant made a similar comment, saying,

There are times when I may not say, "This is the value that I have . . ." but I may present that view as an alternative perspective early on. Later on I might actually say that that is a value that I personally hold. But it might not be that I choose to do that at the beginning of every relationship, especially when I don't have a lot of information about the client.

Degree of difference between clients' values and therapists' values. The impact of the value difference was seen as varying according to the degree of difference between therapist and client and how strongly the value was held by each. For example, one therapist said that she would feel very differently and respond very differently if the client were advocating sexual activities with children as opposed to advocating drug use; although she didn't share either value, she found the first much more offensive than the latter, and felt that the differences would be much more harmful to the therapeutic relationship in the first situation as a result.

Relevance of value conflict to presenting problem. The impact of the value difference, either good or bad, was seen as greater when the difference occurred along a dimension that was relevant to the presenting problem. While most participants disagreed with the idea that a significant value difference could be irrelevant, a few did point out situations in which the value difference seemed to exert little influence on therapy and therefore seemed neither really harmful nor helpful. Several individuals expressed experiences similar to a participant who said, "I don't think that [our value differences] really affected treatment, because they weren't the main focuses of therapy, and it didn't interfere with our treatment goals, the things that I dealt with." This was seen most often when the value difference occurred along a dimension that was not directly related to the clients' presenting problem. As one recent graduate stated, "I think sometimes [a value difference is] not relevant, too, because if the values don't really have anything to do with the presented problem, then it doesn't matter."

Theme 3: Values Management in Session

Participants were asked how they managed value differences in general in therapy and were also asked to give specific examples of situations in which they faced value differences and how these were negotiated with the client. Responses to both of these questions, as well as any examples of clinical practice that were noted in responses to other questions, were evaluated to determine the processes that these graduates go through in dealing with situations of value differences during therapy sessions.

Not surprisingly, perhaps, how participants managed value differences in therapy varied according to several factors. Participants differed significantly among themselves in the responses that were given and it was apparent that individual therapists even handled different situations in a different manner. Thus, the strategies employed varied according to both individual differences and differing contextual demands.

Still, there were several strategies consistently mentioned that were applied across many contexts, including developing value awareness, seeking consultation, and exploring value-related issues with the client as they arose. Other less frequently mentioned interventions included self-disclosure, striving for neutrality, finding common ground with the client, and, as a last resort, referral. Interestingly, the same strategy often seemed to serve several functions. Exploring the functions that each of these serves for the therapist yields important insight on why these strategies are seen as helpful by participants.

Increasing Awareness of Personal Values

A majority of the participants made direct reference to therapists' self-awareness as an essential component of ethically managing value differences, while with many also

including awareness of how those values play out in therapy as a necessary related skill.

For many, this was seen as the most important element, often because it was described as a way to avoid imposing one's own values onto the client in a negative way. For example, one participant said,

I try to be aware. I feel like its probably most damaging if I wasn't aware that there was a value conflict and I was probably pushing a value on somebody else. . . . Being aware of the fact that we might have differing values would allow me to maybe not push [my value] on them, and to manage that aspect a little but more.

Another added,

The therapist [is] always going to have values, so you just have to be aware of them. I think awareness for me is the most important thing. I try really hard not to impose my values on people, and to get a sense of what their values are and try to work within that, as much as I can.

For this individual, awareness was seen as a way of compensating for the pervasive nature of values in psychotherapy and controlling for their potentially negative impact on the client. Because values were seen as influencing the entire therapy process, awareness was seen as also relevant throughout therapy. "The bottom line is that I need to be aware of my values and biases, because there are going to be things that strike me a little differently because of my values" one individual said. "Being aware of that plays a role in every counseling interaction from beginning to end. Being aware of that is the key . . . you have to see if it hinders anything." Another graduate discussed how she actually implemented an awareness strategy in session by saying,

Sometimes I have to check in with myself and make sure I'm not trying to push this person in treatment to be a way that I think they should be, because that's my value. I have to make sure I'm doing in treatment what *their* goals are according to *their* values and not what *my* goals are according to *my* values. I think sometimes I just need to check in with myself and make sure it's not for me—it's more for them.

She went on to describe how this “checking in” process was put into play with several female clients at the state hospital where she worked whose goals did not include education, meaningful careers, or family – all goals that were personally meaningful to the therapist herself. She said,

In working with them . . . a lot of times we were talking about life goals and things they want to do when they leave the hospital. I had to make sure that I was working on the things that they wanted to do because those weren't my goals for them. I had to keep checking in with myself to make sure I was not pushing things that I would want for myself.

Although awareness was usually seen as an on-going process or state of being, several individuals (including this woman) also mentioned that in times of value conflict, they felt an added need to take a moment to evaluate their own feelings and value commitments and how these were influencing the therapy they were providing. Thus awareness was both a desirable state of being that built on past experiences and a specific action to deal with current conflicts.

Seeking Supervision and Consultation

One of the most consistently mentioned strategies for dealing with value conflicts was to seek supervision and consultation. Over half of the participants directly mentioned supervision as a crucial element to managing value differences, with others alluding to the value of supervision in other comments. Overall, regular supervision about value concerns was seen as one of the most helpful ways to deal with value issues that arise in therapy. Most recent graduates seemed to have drawn considerably on supervision and consultation in their training, often mentioning turning to supervisors when discussing real-life value conflicts, suggesting that for the most part they found it quite beneficial. As one participant said, “That’s the great thing about supervision—you

have a helping hand along the way that will be there for you every week to help you out with [difficult situations].”

Participants seemed to differ among themselves in their utilization of supervision, with some more likely to actively seek help with value issues through supervision. One such graduate made this comment:

I really utilize supervision, and I just put it out there for my supervisor, “This is what I’m feeling.” I really process [the value conflict] in supervision and I really try to be aware of what is being triggered in me and where the differences are and why that’s a conflict for me. . . . So the best way [I know how to] handle it is that I just process it to death in supervision and talk about that.

Another stated that

I would probably bring [the value difference] up in supervision – I know I would, because I know that’s how I handle stuff. If I don’t feel very comfortable with something, I bring it up [in supervision] and say “Here’s what I’m thinking, I know what I want to do, I know what I want to say.”

This individual, not surprisingly, consistently made reference to discussions with her supervisor throughout her interview and it was apparent that for her, supervision was an essential tool in dealing with difficult situations in therapy. It is interesting that she also said that in several work environments, she “had to be the one” to bring up value issues in supervision, suggesting that talking about value conflicts with her supervisors was in some ways a personal strategy rather than a general practice for all supervisees.

Supervision used to clarify thinking about therapeutic issues. Participants felt that supervision and/or consultation were helpful in dealing with value issues for many reasons. These included providing clarification, alternate perspectives and modeling of appropriate behavior, along with helping trainees cope with negative feelings and protecting clients from harm. For example, one said that when faced with a value conflict,

“First I would talk with someone else about it. I guess that comes from being a very recent student, but [I would seek] either supervision or consultation just to sort of clarify my thinking on it.” Several students, in fact, alluded to supervisors functioning as sounding boards to help them clarify relevant issues and to generate alternative ways of viewing the situation.

Supervision used to experience appropriate reactions to value differences. A few others mentioned the role of supervisors in modeling appropriate clinical behavior, and said that the experience of discussing a value difference with a supervisor helped them to experience healthy and appropriate responses to such situations. One referred to a supervisor who had provided positive modeling around handling differences by saying that this supervisor “did a [good] job of nuancing [value issues] and I think modeled well how to deal with individual differences in beliefs and values . . . when those situations arose.” This modeling was sometimes done directly through role-playing and at other times was provided indirectly simply by the supervisor’s discussion of value differences with trainees.

Supervision used to cope with personal feelings and negative reactions. A few participants mentioned that supervisors were helpful in assisting them cope with their personal feelings. One said that faced with a value conflict,

I would probably talk about it in supervision, or maybe with a peer I would do that just as a way to check in or maybe ask, “Is this something out of the ordinary that I felt this way?” Just to get it off my chest and deal with it in that manner.

Another described a difficult situation in which she frequently felt angry with a client’s negative attitude of entitlement. She turned to supervision to assist her in managing these feelings and developing more helpful constructions.

I would find myself getting angry and I would go to supervision and say, “I can’t help this person because all they do is complain and their values are very different than mine.” But then, through supervision I would begin to realize that it was almost like a defense mechanism—he could have his values and I could have my values, but the way he processed and the way he expressed himself was more of what was getting in the way.

Supervision used to guard against client harm and imposition of values. Other participants also pointed out that they relied on their supervisors to provide objective feedback to ensure that they were practicing ethically and not exposing the client to harm of any kind. Additionally, supervision was used to guard against unfair imposition of therapist values. For example, one said,

When I became aware that there might be a value conflict, I think I would . . . get some consultation and some supervision about it. If I was going to choose to continue working with this individual, then I would need some sort of a check and balance on my end to make sure that I wasn’t responding to the client in a way that was not meeting the client’s needs. Also, I would need that check and balance to make sure that I wasn’t imposing my values on the client.

In fact, one participant gave a real life example of how a former supervisor had provided that “check and balance” earlier in her career, illustrating how supervision functioned in her professional development.

I had a client that was considering an abortion. At that time, my eyes kind of went up and I had to ask my supervisor how I could help her decide against that. My supervisor told me, “You know, that’s a value difference. If she wants to do that, then that is not against the law. She has every right to have an abortion if she wants to. That’s her choice.” That was how it was in my first semester but now, if I had a client who wanted an abortion, I would just ask them how they arrived at that choice and if they had [moral beliefs] that would make them feel guilty.

Supervision used to learn new perspectives. Supervision was particularly seen as helpful when working with individuals from populations less familiar to the therapist, particularly when the client’s membership in that population led to value differences

between client and counselor. One participant reported that one placement had required consultation or supervision whenever students counseled clients of different backgrounds, which she found helpful. This model provides an example of how training programs could explicitly train students in utilizing supervision to deal with issues of differences.

This participant described some of the benefits she received from this approach:

At the community health center where I worked . . . whenever we had a client come in with a different culture or race we had to discuss the case with an expert They had gone through some sort of training and they usually were of that culture or race, and I think that was a really good thing because you talked to them about the case and you talked to them about your treatment plan, and they were able to really see if there was some obvious cultural bias that you weren't aware of and also say what other issues might be happening with this person. Once I saw a young mixed girl and she was living with her white family and they brought up that maybe she's having some identity issues as she's kind of realizing that she looks different from her mom and those type of things. So I think that was really useful, too, that we had to do that and we kind of got a different perspective. It also made you think about [the differences] when you were making your treatment plan and your diagnosis.

Exploring or Clarifying Values

The most common in-session strategy for managing value differences in therapy was to open a discussion about value issues the client was dealing with, usually without directly referencing the therapists' personal values. This was described in different ways; as "critically dialoging" the value issue, as processing client feelings or questioning, and as discussing alternate points of view. Almost half of participants used the word "explore" or a derivative to describe this process, however, with an overwhelming majority of the remainder describing a similar process to help resolve issues. When discussing their personal strategies for managing value differences, participants described the process of values exploration in the following ways:

- For the most part, unless it comes up naturally in the course of conversation, my values are not explicitly shared with the client. And, so my approach in general is (1) get to know the client's values and (2) get the client to kind of explicate their values for the benefit of myself and for them and (3) help them to critically analyze their values.
- I feel pretty comfortable in exploring with the client where those beliefs come from, if they're comfortable with them, are they common for the group that the client is coming from, whether those beliefs are issues for the client, or whether its more my issue.
- I would provide that sounding board, so to speak, and if it appears to me that they're not coping in a healthy way, then through our discussion and their self-discovery, we would figure out a more healthy way to do that.

Although each of these three therapists uses discussion of values to facilitate client progress, the focus and goals of the process seems to vary slightly for each.

The process of exploring values seemed to be used primarily in two situations. Values exploration, clarification or discussion was mentioned as an intervention almost always when the client herself was unsure of her value system, as might be expected, and seemed to function as a way for the client to help solidify her own value system. It was also used the therapist had concerns about the client's value system, often even when the client didn't see that value as a problem, and was particularly common in situations where the clients' value system contradicted the societal value system. It was clearly used more often in situations involving value difference between client and counselor than in situations of value similarity. At least one therapist directly noted that, although he feels strongly that the questioning process is valuable in helping clients understand their own values, he tends to ask fewer questions when he agrees with the client's value stand than when he disagrees.

When someone is much more in alignment with my values, I won't ask a lot of questions about why they're doing what they're doing. I'll throw out

some interpretations and I'll try to link it up to important dynamics and stuff, but I [won't ask a lot of questions].

Although none of the participants were asked whether they use value exploration just as often when clients presented a value similarity as a value difference, it is instructive to note that there were no examples of situations in which therapists initiated conversations about values when the client felt settled on a value system that the therapist also felt comfortable with. Similarly, participants did not report starting value discussions with clients who were comfortable with their own value and it was a socially acceptable difference, for example, religiosity or sexual orientation, even when they did not share the same value.

Value exploration appeared to serve several function in resolving value conflicts. Many of these revolved around protecting client autonomy but also included reducing defensiveness and challenging harmful values in a non confrontational way.

Value exploration used to maintain therapist neutrality. In many situations, the use of value exploration seemed to function for some as a way to maintain value neutrality. For example, one participant said,

I don't feel like we have the right to impose values. But if they've identified something as a problem for them, then you might want to explore why do you have such a belief, have you considered other beliefs or values. I don't think I would necessarily impose mine but maybe propose some alternatives.

Another female participant said,

Sometimes the young female clients that I see make certain decisions about relationships and education [that I find problematic]. . . . So I constantly feel that I should try to be influential. And I think the way that I express that is to talk to clients about really thoroughly exploring all their choices and making sure they are aware that they have a plethora of options, and then they can decide on that.

Exploration or clarification of values appeared to be particularly useful in situations in which the client was questioning her own value system, in that it appeared to allow the client to explore alternatives without pressure from the therapist. Several therapists mentioned that client questioning was one of the most challenging value situations for them, and exploration allowed them to assist the client in developing a meaningful value system without unfair influence from therapist values. It appeared that the use of value exploration in situations where clients were uncertain of their own values appealed to some clinicians because it encourages the clients' values to take the primary role and allows therapist values to be less prominent. This was of particular interest in cases where participants were concerned about imposing their values on the client. For example, one non-religious individual resolved her dilemma in helping a college-age daughter of conservatively religious parents define her own religious feelings in the following way:

I found that I struggled at times. I wanted to make sure that I was honoring her ... process of coming to her own beliefs and not imposing a more liberal or open belief of my own on her. I tried really hard to, in those discussions, kind of sit back and allow her to say her own beliefs on it, and do more reflection and some of those basic counseling skills.

One individual who reported how he handled a value exploration process with a client who was questioning his sexual orientation expressed doubts about whether such exploration can truly be value neutral. He described his own reservations about considering all sexual orientations equally valid and trying to not allow his own beliefs to unfairly influence the client in the session. However, he noted that

If a client comes in and they're questioning, a therapist who would consider all sexualities to be equal, even though that person would want to remain value-neutral, I think there is a strong possibility that their

acceptance of all sexual lifestyles as valid is going to come into the room. And that poses the very important question for someone who doesn't consider all lifestyles to be equally valid: How important is it to either keep that out of the room or allow it to come into the room?

This participant saw a discussion of value clarification, even when the client himself brings in the conflict, as necessarily laden with both the therapist and client values, suggesting that he felt a strategy of neutral discussion or exploration does not itself guarantee value neutrality or protect against the influence of therapist values in session.

Value exploration used to challenge values without making client defensive.

Value exploration was often used when therapists were concerned about clients' values but did not want to directly challenge them for fear of imposing their own values. One participant described indirectly challenging clients' values by initiating a process of questioning and evaluation:

If it was an adolescent that was coming in who was 15, who wanted to get pregnant now, then I would definitely challenge that. I would do that by saying, "How are things going to work in the long run? What do the other people in your life say about that?"

Another participant suggested that he used value exploration as a way to explore an issue he considered problematic without making the client feel defensive. This particular client had decided to marry an emotionally demeaning boyfriend, despite the objections of family members and friends. The therapist felt that she was not in a place where she could handle an open disclosure of the therapist's concern about her decision, saying that such disclosure would likely make the client feel more defensive. Instead, he said,

I find that I just tend to ask a lot more questions like, 'Okay. It seems like you've really come down to a place of being sure about this. How did this

change from last week?’ And then, if she gives a reason, asking questions about it. I almost harass, but hopefully in a very gentle way where they think I’m curious and inquisitive, but I want them to move from their foreclosed position [to a more open position].

Value exploration used to open clients up to alternative positions. Similarly, other participants expressed using exploration and discussion as a means of moving a client away from what they considered to be unhealthy rigidity on value-related issues. For example, one participant, in discussing the value exploration process, said,

I would approach [strongly held values] in that way. I’d be like, “okay, great,” but I’d still find ways to come at it so that there isn’t that rigidity, so that . . . everything’s considered. When people get past their values, as long as I feel like they’ve considered all the information, then if people want to come down to “Hey, this is what it is,” then [I say], “Great, as long as you know that its part of my job to explore with you some of the other options.” And I think another part of my job is to say, “You don’t have to think like I do, but here’s something else.”

Another participant felt that firm beliefs can reflect a defense against particular issues, which may be helpful to challenge.

If someone comes in and says they’ve figured it out, and they’re situated and they’re set and they’re settled, I would think about that—I won’t challenge that right off the bat, but I definitely wonder, “Okay, maybe that’s where you are right now, but life changes. How do you change with it?” But I’d be curious; I do tend to think that’s a big defense to think that things are as clear as that. I wonder what’s being protected against.

He added that he would feel the same whether the value was similar to his own value system or not, saying that “any position that’s foreclosed on, in my eyes, is unhealthy.”

His therapeutic preference in such situations is to open a discussion to explore the value in question, a discussion in which both he and the client share their own views on the topic and through the back-and-forth exchange come to a new truth previously unavailable to either: “There’s just always this ongoing . . . interpretive thing where we have to always be asking each other, asking the client and having the client ask you,

“What am I bringing into how I’m looking at this?” The end result, he suggested, is that the conversation “allows a new value to form that wasn’t existent beforehand, sort of an emergent property of the two.” This strategy was particularly useful for helping clients question existing value commitments in an open non-confrontational environment, although clearly it necessarily requires that the therapist also be disclosing of personal beliefs and values. For these individuals, value exploration was useful not only in helping clients solidify their personal values, but also in some cases to loosen up value systems that felt overly rigid. In fact, considering alternatives and helping the client to be open to different perspectives seemed to be highly valued therapy goals for many participants.

Value exploration used to introduce therapist values. Sometimes, value exploration was also used as a way for the therapist to communicate some of their own value systems without directly stating those values. Several therapists, when asked if they disclose their personal values, stated that they prefer not to, but that they would present those personal values as an alternative when exploring value issues. For example, one said,

I don’t think I ever said “my values.” Sometimes I would say, “well, I understand that this is the way you view [the issue], but many other people see things *this* way.” [I’d bring up alternatives], but not necessarily make it personal.

Learning About Clients’ Value Systems

Several graduates suggested that one of the most important elements of successfully negotiating value differences for them was to learn about and seek to understand the client’s value system. This was seen as important both because it helped

the therapist to clarify the similarities and differences between them and because it helped the therapist to gain understanding necessary to more effectively work with them.

The following statements illustrate this idea:

- It feels important to me to learn more about and understand my client's values. I have to be really clear in my own mind about how similar or different they are and where they're coming from.
- It seems like it comes down to just not making an assumption that I understand the person without really understanding them, because I've found that that can be pretty problematic at times. So again, regardless of, on paper what a person looks like, when I meet them, it's really important to establish that understanding from their perspective regardless of how close or value similar they may or may not be.
- And I always assume the position of...particularly with cultural and religious issues, I'm there for them to teach me too. I always say that, "You know, I'm a Caucasian female, I need to know from your point of view what this is like."

Although most participants did not elaborate on their reasons for feeling that learning about client values is important, it appeared that this process was intended to both help the therapist to avoid imposing her own values onto the client (particularly in cases of apparent value similarity, as noted above) and to better meet the client's needs by integrating that value system into therapeutic processes. None of the participants, however, cited this as their primary strategy in managing differing value systems however; it was more frequently seen as a necessary pre-requisite to developing an ethical strategy involving other techniques.

Disclosing Therapist Values

A slight majority of respondents said they would occasionally disclose their own personal values in therapy, although they were much more likely to qualify it by saying

they would only employ such a strategy in certain situations than they were with other strategies. Some therapists seemed much more likely to self-disclose than others, with a few viewing disclosure as an integral part of their therapy style and the majority of others suggesting they would use it only in limited situations. Importantly, although value dissimilarity was seen by many participants as potentially damaging to the therapeutic relationship, participants who advocated this strategy instead felt that it was entirely possible to express dissenting views without jeopardizing the alliance. As one said,

I'm not in a position to say that they should change that, but I also don't think that I have to keep hidden that I have a different value about it. I think that I can share that I have a different value about that, but it doesn't mean that I can't have a relationship with that client or can't respect where the client is coming from even if we're different in this way.

Self-disclosure appeared to serve many functions, and different therapists seem to employ it slightly differently than others. Although many participants expressed concern about disclosure of personal values leading to unfair imposition of those values, others suggested that disclosure may actually protect against imposition, as well as convey understanding, trust, and genuineness and help clients move in more healthy directions.

Self-disclosure used to convey understanding. Some therapists said they might be more likely to self-disclose when working with a client with similar values or experiences than while working with ones who held different beliefs. For these individuals, the purpose of self-disclosure was to let the client know that the therapist understood her point of view, or had a similar background that made it unnecessary for the client to explain her feelings further. For example, a religious therapist said,

I really try to be a blank slate in those areas, but at times I do feel like disclosure is important if they're talking about [their religious experiences]. I might disclose, "You know, I've had an experience similar to that, I understand what you're speaking about."

She went on to describe a client who was explaining her excitement at a child's religious participation and paused to ask the therapist directly if she was a person of faith.

At that point, I think I just kind of affirmed, "No, I do understand your faith, I have a faith system myself." So it wasn't an (in an excited voice) "Oh yeah, we're the same denomination!" It was more . . . it just felt genuine to say, "[Yes], I do understand."

These individuals did not describe directly disclosing their value systems in situations where their values did not match the clients', however.

Self-disclosure used to facilitate authenticity and genuineness. Several therapists felt that disclosing personal value systems was a way to be authentic and genuine with the client. For these individuals, value expression was a normal part of establishing an honest, trusting relationship. One individual noted that this might particularly be relevant when the individuals directly asks about the therapist's beliefs or reactions and suggested that if the therapist provides a neutral answer rather than a genuine one, "That client would think, 'This guy isn't even real. Come on!' . . . They might not trust you."

Another described exactly this sort of situation and how she might handle it:

If it's a value like that that I don't agree with, I don't pretend to agree with it. . . . I would still validate them, but I wouldn't agree with them necessarily. It would be inauthentic and I don't think that's a good thing. . . . Clients have [asked me what I think sometimes] actually. You know, like, "Do you think it's bad that I am separated and kissed a guy?" or that kind of thing. . . . Sometimes I'll reflect it back if they're just wanting my approval, but sometimes I'll lay it out on the board [and say] "Yes, I see it a little differently, but that's okay."

She added that her purpose in doing that would be "Being authentic, validation, [and] enhancing the therapeutic relationship," and said also that

I think that it's a really authentic thing to do to not deny your own values. And, of course, the way you do it I think is important. You know, if you do express your own values in therapy I think you also need to make it

really clear that you respect your client's values so it's not like, "Oh, no, I don't believe that." I would never do that.

Another participant made the comment that "I think that what [self-disclosure] means for me, is an honest exchange of reactions. I think that since actions are influenced by values, to not acknowledge that in the process would not allow for genuine exchange." One participant related an experience in which she did share a personal reaction with the client and reflected on her reasons for doing so, which in her case seemed to revolve around maintaining her own personal integrity rather than implementing a therapeutic intervention:

I'm thinking of one client in particular, who was white. We were pretty far along in therapy, so we knew each other pretty well, and she made some statement about [a relative], who was [a person of color], and it was a VERY racist remark, and then kind of looked at me as if I was supposed to feel like "Yeah, I know what you're talking about!" And [I thought], what do I say? How do I be respectful of her and where she's coming from and her experience with that, and still maintain some integrity and honesty of my own, because that's *not* all right with me.

So I think I ended up saying something like, 'Well, hmmm, that hasn't been my experience. Growing up in [an inner city neighborhood] I was around a lot of minority populations and . . . my experience was . . .', and I mentioned a very positive attribute with that cultural group. She kind of got really quiet and we went on and it was fine. It didn't come back up again.

I was actually a little concerned; you know, was that one of those moments where I should have stopped myself because it's not really about me, but I felt like if I didn't say it, it would [bother me]. I'm still a human being, I need to be able to say that in some sense, some way – I'm not just a robot, you can't just say whatever you want, and here's what I feel. So I had to say something to kind of make it better for me in some sense.

In reflecting on that experience later, she commented that, although the client's attitudes about race were not her presenting concern, she still felt like it was appropriate to share her own feelings:

I still do think that I have a responsibility just as a human being, to tell you that that's not all right with me. Just because I'm your therapist doesn't

mean I'm going to sit there and validate every single thing that you say, because that's not going to happen. So it's probably more about me being true to what I [feel]. Because there were other times where I've had clients where I didn't say anything at all. And it kind of bothered me afterwards, like "why didn't you just say something? You have a right to say something."

Self-disclosure used to provide informed consent. A few participants cited disclosure of personal values as a way to protect the client from the influence of therapist values, suggesting that it is a form of informed consent. The following statement illustrates why this might be important:

Ideally I really believe that value differences should be talked about and should be kind of transparent in the therapy relationship, as a form of respect to the client and in part of informed consent for the client to know what your values are, or at least things that might affect the therapeutic relationship or that might affect the client's perception of therapy and you and how you can help them. I really don't think that you have to similar values to help someone, but I think it's good for the client and the therapist to be able to talk about those things.

The idea of providing personal value information to the client as a form of informed consent is especially compelling for those who hold that therapist values impact clients despite our best efforts to do otherwise. Given this assumption, one participant felt that making the underlying value explicit actually helped the client to freely choose his or her own values.

Whether we like it or not, it happens, so I think its important to be aware of what that impact might be and make that explicit where possible with the client, so there's a little bit more objectivity for them, and they can say, "I like that" or not. So you're sort of clarifying what your value might be to them and making it somewhat easier for them to be on board with that or not be on board with that.

This same therapist described a situation in which he explicitly stated his values in order to better protect his client's freedom to choose her own values. The therapist described this particular difference as one that "pulled things" in him, because his client was a

member of a religious group that had split from the therapist's own church over both doctrine and social practices, and so while they shared certain language and background around her problems, he also personally struggled with some of her choices and beliefs. After consulting with supervisors to ascertain whether he would be the best therapist for her, they decided to proceed with therapy but wanted to make the boundaries clear to protect her right to choose her own beliefs.

Part of that process was to clarify with her what my role would be and what I could offer and what I didn't feel comfortable offering, as far as feedback went about some of those things We [talked] about what she wanted out of therapy. In a lot of ways I let her take the lead as far as that goes, but then tried to be a little bit explicit about things that I *wouldn't* try to do, like "I'm not going to try to tell you not to do these things, cause you're an adult and you'll figure that out, whether you want that to continue." Or "If you want to talk about that particular thing I'll let *you* go there and sort of lead the way." So we just made explicit exactly what was going to happen.

I think by making it more explicit, it allowed her, I guess, confidence that it wasn't some sort of "under the radar" push of my values, so she could be aware of where I was coming from and why I was coming from there. And I think it actually worked out really, really well between us. But it was sort of tricky, because I definitely had a value that some of the things that she did, that she didn't think were wrong, I thought were, and maybe not even healthy for her as well. And some of those things, as we talked about it, she decided were unhealthy, and some of them she decided weren't.

In situations where the client was questioning her own values, disclosure of therapist values was seen as a more effective and ethical way of ensuring client autonomy than value neutrality. This view is what led another therapist to describe therapist disclosure not only as a therapist preference, but as a client's right, saying "I guess I think the client has the right to know what the therapist's values are about certain things, especially if they're pertinent to the client's experiences."

Self-disclosure used to help clients make positive changes. Other participants mentioned ways in which the value disclosure might be therapeutic for a client. For example, one noted that “We have a responsibility to educate clients” and that might include pointing out behaviors that we don’t agree with, such as risky sexual behavior, and explaining why we are opposed to them. As an illustration, another therapist related the following experience:

I was working with a client whose substance abuse was, what I thought, quite excessive. I remember the client asking me what I thought about it and I explained that I thought it was excessive and I explained why I thought that and how I thought it was harmful to her. It wasn’t like I kept that from her. I think that the client doesn’t have to be sheltered—and should not be—from getting feedback, especially about behaviors that are damaging to self or others. I think that we have a responsibility, if we see that happening, to not allow the client to continue doing that. The client can choose to do that, but I think that it’s not helpful if we see it as problematic and we allow them to continue to operate with the assumption that we are in agreement with them about that.

Another therapist shared a different experience in which disclosure of personal feelings was helpful for the client, although for different reasons. In this case, the therapist’s personal reaction gave the client encouragement to make positive changes; however, this type of disclosure also carried certain risks.

I just had a client who . . . thankfully she moved out of a horrible home. I was very happy [and] I flat out told her. I said, ‘This is fantastic. This is going to be the beginning of something very new for you.’ And who am I to say that? She’s moving out of her family’s home! I have a lot of values in terms of thinking that it would be better for her to [do that]. But she actually really needed to hear that I thought that that was okay—that she could leave an abusive situation. That was helpful to her. But in certain ways it’s also risky. [What if] a few months down the line she moves back into the home for some reason? You know, then where does she stand in comparison to the way I evaluate her?

Still, the benefits provided by the disclosure of the therapist's feelings, in this case, outweighed the risks, and the therapist viewed the disclosure as a positive influence for his client.

It's clear that for some participants, disclosure became both an "honest exchange of reactions" and a vehicle to help the client move in directions that the therapists perceived to be more healthy and beneficial. Not surprisingly, this strategy was used more frequently when the client's value was seen as harmful to himself or to others. This may explain why some version of disclosure of therapists' personal values was frequently used by therapists working with forensic or severely mentally ill clients (it is also relevant that these therapists generally expressed less concern for imposing their own values on these clients). However, about half of participants who completed their internship in university or community outpatient settings, including the individual quoted above, also utilized disclosure at least some of the time.

Concealing Therapist Values

On the other hand, participants also felt that often the best strategy was to attempt to remain neutral and to *not* reveal information about personal values. This was done, again, for varying reasons in different situations.

Therapist values concealed to avoid imposition of therapist values. The most common, not surprisingly, was to avoid imposing therapist values onto the client and allowing the client sufficient space to explore his or her own values. This motivation was explained by one participant in the following way:

I think the long-term goal of therapy is allowing the therapeutic space to remain a context where the person can continue growing, engaging in self-scrutiny, having the safe attachment with another person wherein that growth can take place. And in certain ways . . . I'd be willing to *not* make

explicit value statements in order to maintain almost a womb-like context wherein someone could feel like they could go either way.

Several appeared to feel that, in cases of value differences, it was important to appear to be neutral in order to avoid imposing a particular path on the client; thus, when a significant difference was apparent, even when it brought a significant personal reaction, they would attempt to conceal that reaction from the client. For example, one said,

If it's [a value] that's totally against mine, then I'm sure I would have a gut reaction internally. But I'm usually the type of person that can stay, on the outside, pretty emotionally calm. I probably would not have a reaction towards them externally.

Another also spoke of her efforts to conceal personal feelings in similar terms, saying, "I'm pretty neutral, generally; I'm pretty good at hiding my emotional reactions, keeping it under control." Clearly, keeping personal values concealed from the client was seen as a positive thing for these therapists. The therapist quoted above went on to say that she kept her feelings hidden largely out of concern for imposing her own values on others; instead, she assisted the clients to explore their own values and beliefs about the issue.

Therapist values concealed to reduce irrelevant information. Although a desire to respect client choice and autonomy was by far the most common reason suggested for keeping personal feelings concealed, other reasons were also suggested. One of the most common reasons for not disclosing a different view was simply that the therapists' view didn't appear to be relevant to the particular context for various reasons. One participant gave the following example of this:

I had a client where we had more of a religious difference. She was having a hard time terminating a relationship she had with her significant other. She was a Wiccan priestess, and I didn't know hardly anything about that but that it was very important to her to be able to use her rituals and to meet with her cousin that she met with every [week]—all of these different things in order to move through this problem. So a lot of [our

work] wasn't even necessarily the sort of things that I would usually recommend [as interventions]. . . . What she wanted to focus on was lighting these candles and calling the four corners of the earth. So I never really had to address that difference because I didn't figure it was going to do any good for our relationship to say, "Well, I don't know [that I agree] about this" because she obviously had some belief in it She knew that there was a difference, but I didn't really go into it. I knew exactly how she wanted to approach it and that was fine with me, so we were going to go ahead and go with that.

The reasons the therapists' views seemed less relevant to the discussion in therapy varied; two of the most common was that the value in question was not related to the presenting problem and that the client was already certain or committed to her value, and so opening a discussion about the value seemed to not make sense in that particular context.

Therapist values concealed to reduce client defensiveness. Some therapists also said that they might not reveal their own feelings about a client's beliefs or behavior out of concern that an overt value difference would arouse the clients' defenses and that progress might be impeded. One explained why she wouldn't reveal to a client that she disagreed with their value system in the following way:

I don't think you want to end up arguing with a client; that usually doesn't turn out well. Because if that happens, they'll get angry, and how are you going to make progress at all? Instead, you kind of go around it and think of possible ways to discuss the issue, instead of saying right out, "well, I disagree."

Similarly, another participant related a clinical experience with a client who had been told by family members and friends that her decision to marry a boyfriend was wrong. Although the therapist, too, had concerns about the consequences of this relationship, said, "I won't question her decision itself because I imagine that's only going to trigger a lot of defenses around her." Instead, he kept his

personal reactions concealed and opened up a discussion to explore the motivations and consequences of the decision.

Therapist values concealed to preserve the therapeutic relationship. A fourth reason given for not disclosing personal reactions was that in some cases, the value difference was seen as harmful to the relationship. For example, a participant who identifies as a lesbian met with a client with strong homophobic beliefs over an extended period of time and found herself unable to discuss the impact his comments were having for her:

He was so prejudiced about gay and lesbian people and he would make terrible remarks about that. It would be really hurtful but I had to be really careful that it didn't get in the way of the work . . . At first it didn't really strike me as anything unusual because he was scared and kind of in an episode. But then, as I got to know him more as a person and he became more dependent on me, it did become hurtful because I couldn't come to self-disclose that. I think it would've hurt the therapeutic alliance. I think that he would've very easily been not able to say those things or not get angry or . . . [not] express himself.

Instead, she managed her feelings through supervision and tried to remind herself that his antagonism was directed at her group rather than herself. While other examples given were somewhat less personally difficult than this one, it is clear that other therapists, as well, evaluated the strength and dynamics of the relationship in deciding whether to self-disclose.

Looking for Common Ground

Although the strategy of looking for common ground with clients was mentioned by relatively few participants, it is interesting that this was included as a primary means of managing value differences for some. These therapists felt that when they only focused on one fact of the client – the conflicting value commitment – they tended to feel more

negatively about the client. When they balanced that with other information and saw the client more three-dimensionally, however, some of the concerns created by the value conflict seemed to fade. The following statement illustrates that dynamic:

I would just try to view that value as *part* of them, that that's not all the person, and there are other good things about them that I'm not bothered by. . . . [I would] try to find the common ground, but not only that, see the big picture and not focus too much on just one aspect.

Another participant suggested that a similar strategy was helpful for her, saying,

I'd like to think ideally, I'd look for other things that balance [the offensive values] out. I mean I've had clients tell me horrific things, about things they've done, and if that's all I know about them, I would probably hate them. But having some of the other information about them makes me think, "Hmm, okay, you know what, I can see where that might be coming from." Not that I agree with it, but it's not random, it's not coming from nowhere.

As an example, the therapist mentioned earlier was aware of similarities with her Wiccan priestess client as well as the religious differences and noted that "the thing that made that easier is that she and I shared a lot of the same morals. She was a good, decent human being who liked to do good for other people, so we didn't have any major conflicts." Thus, focusing on the values they had in common with these clients helped them to build relationships even when other values were significantly different.

Referring Client to another Therapist

Although nearly always mentioned as a last resort, most participants felt that it was acceptable to refer a client to another therapist if a value difference would hinder the therapist's ability to work effectively with a client, and a significant percentage of participants mentioned it as an appropriate part of a general values management strategy. Whether a referral was viewed as positive and helpful was dependent in part on how it

was handled by the therapist. One participant described her concerns about managing referrals by saying,

I really think it comes down to the way you handle it. There has to be a sensitive way of handling it, so it doesn't seem like, this is your fault, or there's something negative. Because I know people who refer all the time. For example, someone comes in and they're borderline, and they might say, "You know that's not my specialty area. I know someone great down the road, and here's their contact information and I can give them a call and let them know you're coming." But if you're going to freak out and be an alarmist, and upset people, [saying] (in a horrified voice) 'No, not you! I don't work with people like you!', then that would not go over [well]. And I have heard horror stories of things like that, from patients who were kicked out of treatment, or referred off in inappropriate ways.

She reported that these clients felt that their previous therapists referred them out of personal dislike and that it was harmful to the clients. She went on to describe how she feels an obligation to the client to act as a "bridge" to the new therapist and will accompany clients to their first appointment with the new therapist if requested.

Another factor that appeared to affect participants' judgment of referral as appropriate or inappropriate was whether the referral was for the client's benefit or the therapist's. One individual who advocated referring a client when all other steps had failed to address the value conflict productively suggested that,

If [the conflict] is affecting the therapeutic alliance so negatively that it can't be repaired . . . then I would say that it's best to refer, because you don't want the clients' chance of improvement to suffer because you can't get over the value difference.

This individual was the only participant who reported actually referring a client because of a significant value difference, although she also mentioned concerns about his style or personality in session. Examining her experience and reasons for doing so gives some insight into how this individual felt about and managed the process.

I had a client last year who . . . had a history of child sexual abuse and brought stuff to therapy that I didn't feel like I could work with. I figured that I would give it a shot, and it was one thing that I just really couldn't get over, not because of him, but the way he approached the subject, being really manipulative, and being in denial, and the way he viewed adult relationships with children, it made me feel really . . . just a really strong reaction. I had one session with him that . . . afterwards I thought I would throw up. And I just said, I can't do this. With him, I consulted with my supervisor quite a bit – we talked a lot about this individual. I couldn't get over the way we viewed people so differently, because it just felt wrong to me.

It was just too much, and . . . I realized that I was just dreading seeing him, that I couldn't stand being in the room with him. And I know that he picked up on that, and our therapeutic alliance just never came to be, and that's generally one of my strong points, but it just didn't happen with this client. I talked to him about what we were working on, and that I felt frustrated and I didn't feel like we were getting anywhere, and that he didn't trust me and I didn't really trust him, and gave him the choice of ending treatment or switching to another therapist. That's a pretty rare instance, to quit working with the client because of the value difference.

She also stated, “I don't think your first action should necessarily be to pawn [the client] off on someone else,” but added that “if you can't work though it and you find yourself hating being in the room with that client, I don't think that's therapeutic for the client. Then it may be best to see if someone else can take that client.”

Theme 4: Appropriateness of Deliberately Influencing Clients' Values

In connection with discussions on how value differences are treated in therapy, participants also responded to several questions about whether it might be appropriate or ethical to deliberately influence a client to change their values. This presented a dilemma for some of the participants, who placed a high value on client autonomy and yet also felt that at times client values could be harmful and that it might be in the client's best interest to change those beliefs. Participants' responses to this conflict ranged from openly stating that it is appropriate to influence a client to alter their values to saying that it would not be acceptable, with most suggesting that client values should be respected but

that intervention may be called for when the value in question leads to harm for the client or others. Other criteria were also mentioned that affect these decisions, including the degree to which the client had thought about the value-based decision and the nature of the larger value system from which the problematic value was derived.

Views on Acceptability of Influencing Client Values

Participants' views of the acceptability of influencing a client to alter personal values shed light both on the conflicts between therapists' values of autonomy and beneficence and the reasoning participants bring to bear in resolving these conflicts. Some participants responded that it is appropriate to attempt to change a client's value system, although most also qualified that statement by stating that they would only do so in certain situations, generally those involving harm to the client. The majority answered the question hesitantly, either saying no and then saying yes, or saying that they wouldn't directly challenge the value but would engage the client in a discussion hoping to open them up to more healthy options, or saying they would only do so under extreme circumstances. Only a few clients answered that they did not feel it appropriate to deliberately try to change a client's values, although those were qualified as well. Some of the responses to this question illustrate the varying views on this issue.

- Yes, and only if you're defining "value system" much broader than like a religious value system. I would say yes because I think a lot of what we deal with in psychology is a person's values interpersonally or inter-psychically. And, so I think you could talk—it's a little bit of a stretch—but you could talk in values language for just about every diagnosis in the DSM, especially for personality disorders.
- Yes, because I'm thinking back to my work with foster parents, when I'm doing training with them. A value that I have, that I think psychology has as well, is to improve interactions between parents and kids, and so definitely . . . I think even in treatment plans I've written "improve communication by doing" this and this. So in that sense, I think it is

appropriate to maybe set the value that they have on their kids and that relationship as a goal.

- Yes, in extreme circumstances. That's come up for me. In my practicum before my internship, I worked with juvenile sex offenders and that was a severe value difference there, too I think it is important to change that value system so that they aren't continuing to reoffend. I think that change isn't necessarily the right word. Maybe a better word is shape.
- It's kind of hard to [change other people's values]. Sometimes I wish that I could, but I do feel like at times it can be appropriate. I think it should be done really thoughtfully, including a lot of thought about what the consequences might be.
- It seems like the [obvious] answer to that would be to say, "No. That's never appropriate." But I don't necessarily think that that's true, actually. When someone's value system is so contrary to what is generally beneficial to society, then it's really hard to not address that and to let that be okay.
- I guess it depends on whether I felt that they were interfering with their functioning; that would be the only reason that I would do it, because I really don't think you should impose your values, especially because you don't know what the effect is going to be on their life . . . is it going to cause problems in their church, or with their family? But if they've identified something as a problem for them, then you might want to explore why do you have such a belief, have you considered other beliefs or values. I don't think I would necessarily impose mine but maybe propose some alternatives.
- It would be hard for me to think of a time where I would really think that that was therapeutic. I guess if there were a situation in which it was harmful to that person, and that was a very clear harm to self. . . . I struggle with that one, because there are times where, I'm pretty liberal, but I still will think, "Oh, that's just not good for them!" but I want to honor their values and not impose on them. So I guess if it's a harm issue, but that's the only time I'd really feel comfortable with that.
- I don't think I could see myself doing that. The closest I think I could ever come to that is asking a client Or explaining to the client where I'm coming from and see if they see any of the same things I'm seeing about their value or just kind of explaining my perspective and how I think it's a value that they're maybe holding on to, how that's impacting their life, and how they feel about it. But certainly nothing, like, covert or disrespectful.

- No, (the therapist should not try to influence the client's values), not unless they were doing something illegal, I don't feel that as a therapist, you should influence them.
- I would say I would never put it in those words, no. I mean, yes—I think I'd want to find, I would want to trust that in their existing values I could find goodness and that in our conversations and in their interaction with my values, in the process we can come to a place of something meaningful taking shape. But I would never want them just to take on, or to move towards, my values.

Criteria for Intervention

Several observations can be made from participants' statements about the appropriateness of influencing client values. Most striking, perhaps, is that participants consistently expressed some informal criteria that would guide them in deciding whether to intervene in a client's value system, often saying something along the lines of, "I wouldn't intervene unless . . ." or "it would only be appropriate if..." and then stating their criteria. In situations that met these criteria, participants then felt it would be acceptable to violate strongly held values of client autonomy in order to benefit the client.

Although a majority of participants had some kind of informal criteria about when they would feel it appropriate to influence client values, it is interesting that few mentioned evaluating those criteria as they described managing a value conflict. If therapists feel that it is appropriate to influence a client to change his or her values in situations of harm, for example, it would make sense that, when faced with a value difference, they might appropriately evaluate the harm that may be caused by the client's value in determining an appropriate course of action. That process was typically not explicitly described, however, and it is not known if participants engaged in that reasoning or evaluation process but did not feel the need to explicitly state it, or if they

generally did not consciously evaluate their own criteria in determining intervention strategies.

The most common reason given for choosing to deliberately influence a client to change personal values was typically related to direct or indirect harm to the client or others. Other criteria were also given, the connection of the value to the presenting problem and awareness of alternatives.

Harm to self or others. The criterion most frequently cited was harm to self and/or others, with the vast majority of participants making direct reference to feeling that it might be ethical to intervene in or influence a client's value system if it was apparent that the value was causing harm, was impairing functioning, or was a "significant detriment" to clients. In contrast, participants felt that it would be *unethical* to intervene or influence a client if the value with which the therapist disagreed was not harming the client. For example, one participant, in evaluating how he handles value differences in his therapy, said, "If its not hurting them or hurting someone else, then I wouldn't probably try to change anything." Another explained her reasoning this way,

In any situation in which people are being harmed . . . [influencing a client to change their values] wouldn't be unethical. But I'm thinking in some of the other ones, where someone isn't necessarily hurt, [it would be]. So if somebody says, "Hey, I hate this group of people" – unless they're saying "hey, I'm going to go do something to harm them," then . . . I probably wouldn't necessarily think "Hey, I'm going to change this."

Another therapist shared the following example with a client:

I also had an example where a woman was extremely religious and I am not. I saw it as a way for hope for her and that's her way of a coping strategy, it wasn't like a delusional sort of thing. I could have viewed it as something that got in the way for her, but it was something of help to her. I guess if I just put it into perspective and understand how their values help them or hurt them, that is the way I've been looking at it . . . I think if it was fanatical, or that I thought it was somehow not keeping her in

reality with what was happening in her life, or if she was depressed and suicidal and if it was not giving her hope, then it would be a whole different situation.

The idea that it is only acceptable to influence clients to change their values when those values are harmful necessarily raises the question of how broadly or narrowly to define harm in evaluating situations of conflict. Sexual abuse was clearly seen as harm and participants felt comfortable intervening. Anorexia was usually seen as harmful and again participants seemed generally comfortable intervening. Other value differences, such as those related to religion, were not seen as harmful to the client, generally, and so participants did not feel it appropriate to influence those clients towards different values. However, several other situations were more ambiguous and it is interesting to see how participants both evaluated and handled these. As an illustration, three participants brought up similar examples in their discussion of value conflicts in which they provided counseling to young women evaluating their education and career decisions. All three placed a high value on education and felt that generally pursuing education would be in these clients' best interest, a value stance that would probably also reflect the general values of the counseling field. All felt it would be appropriate to initiate a discussion on educational values. However, two of the three described trying to remain neutral and non-directive towards their clients despite feeling personally invested in the issue and presenting alternatives without encouraging any particular outcome. The third, on the other hand, felt much more comfortable in directly stating her value for education. In discussing how her personal values play into her work she said,

I think my value for education plays a lot into therapy, especially when I see adolescents who are considering dropping out of school. I value education and I think it opens up a whole world of opportunities, so that is

something I allow to influence my work. It's not something I try to counteract.

Here, she explicitly states that she allows her values to influence her therapy because she sees it as beneficial to the client. Interestingly, she went on to say, "I don't even know if I would really bring [personal values] up. I would bring up what's best for the patient and I think that in general, education is what's best for the patient. I guess that is a value."

Influence of value on mental health. Another criterion that was mentioned, closely related to the first, was whether the value causing concern was related to the client's current distress. When the value was seen as contributing to depression, anxiety, or other mental health issues, therapists tended to see those as more appropriate to influence. Similarly, one participant said that she tries to distinguish between issues of health and issues of values when she is making therapeutic decisions, because she feels it is a professional responsibility to intervene in the first, while feeling a professional responsibility *not* to intervene in the latter.

Early on when I was doing therapy, it was harder for me to differentiate if it was a value difference or a healthy lifestyle difference So I had to ask myself, 'Am I helping them develop a healthy lifestyle or am I pushing my values on them?' I have one client that has sexual relationships indiscriminately and that's not a value that I want to adopt. I don't know if I have an emotional reaction to that; it's more like, how do I help him understand healthy ways of sexual behavior and those types of things.

This individual would not feel comfortable intervening in a value difference but she would in issues of health. The difference, for her, is illustrated in how she described handling this particular client's situation:

I think that people have the right to live the way they want to live. If that means they want to have indiscriminate sex, then, that's their value and that's their business [However], we need to educate the client on healthy ways of doing things, such as contraception.

Conflict with societal interests or values. Other criteria related to the interaction of the value system and the society at large. As might be expected, values which led to illegal or antisocial behavior were seen as more appropriate to change, such as those seen frequently in forensic patients (which likely explains why participants working in forensic settings and with the seriously mentally ill were more likely to feel comfortable deliberately influencing the values of their clients). Several participants mentioned the issues of sexual offenses or child abuse throughout the interview and none mentioned it in a way that suggested such a value should be respected – the implicit assumption was always that it would be appropriate to change the values leading to those behaviors, even when the perpetrators did not share that goal. Thus, values which conflicted with societal interests were almost always seen as appropriate for the therapist to try to alter.

Relevance of value to presenting problem. An additional criterion that participants used in evaluating value differences had to do with the relevance of the value difference to the presenting problem. In general, they seemed more likely to intervene when the value difference in question related to the presenting concern than when it didn't. For example, one said,

In situations like that I'm looking at whether or not that decision (that I disagree with) is based on the problems that they are coming to see me about. If it's not related to the problem at hand then I don't think it's relevant.

However, most therapists would still intervene in a situation which appeared to be harmful, even when the client did not bring it up as the presenting concern.

Degree to which client has considered other options. The final criterion, mentioned by a few participants, appeared to be the degree to which clients had evaluated

other options. In situations where the therapist disagreed with the value stance of the client and it appeared that the client had not considered other alternatives, the therapist was more likely to intervene by encouraging an examination of alternatives. Several therapists appeared to feel that it was not healthy for clients to hold rigid value stances, especially when they had not considered a wide range of alternatives. Accordingly, they felt comfortable initiating a discussion of alternatives, in essence contradicting the client's value stance. Related to this, one participant who worked with adolescents reported evaluating her client's developmental stage to determine whether decisions were well thought out or whether the client might benefit from further examination of the underlying values. However, the therapists who used this criterion in deciding whether to intervene also suggested that once all the alternatives had been considered, they would not try to influence the client to change their value to match the therapist's. As one participant said,

I would probably be more from looking at whether that person is aware that they have choices and is aware of what choices they can make, and if they look at all those, and still make a choice for them that is really against what I personally believe, then I feel like I've done my job in terms of encouraging them to broaden their options. And then they'll do what they like. I guess that would be my main criteria, is if someone is coming in saying, "I have no choice, this is the only thing that I can do," that's usually when I try to use more influence in looking at, "okay that's one choice, what are all your others," and then if that's the one you still choose, then that's okay.

Values Less Likely to Elicit Intervention

Although not mentioned as specific criteria in addressing whether it might be acceptable to influence a client to alter their values, many participants seemed also to consider the source of the value system in evaluating whether they might be likely to intervene in that system. Typically, they were less likely to intervene

when the value stemmed from a specific religious or cultural tradition than when they stemmed from more broadly formed values, particularly when that tradition or background was one which they did not share. This provides conceptual support for a sort of “privileged class” of values, in that therapists may be less likely to intervene with an identical value when that value is tied to one of these specific religious or cultural backgrounds than when it is not. It may be helpful to further explore the beliefs behind the reasoning

Values stemming from specific religious or cultural backgrounds. Although none mentioned it as one of their criteria, it is also interesting to note that it clear that the therapists felt more comfortable in influencing a client’s values if those values were broad-based ones, rather than beliefs tied to particular well-defined value systems, such as those occurring in connection with a religious or cultural background. For example, one therapist quoted above mentioned that improving communication was a value that she felt comfortable imposing on clients, even when they did not share that value, which is an example of a broad-based value derived from the larger culture and psychological fields. In contrast, therapists were generally less willing (with a few exceptions) to intervene in when the client’s values were tied to a larger religious or cultural group. One participant expressed her concern about working within her client’s religious value system in these terms:

Although I feel like I try to be pretty tentative about values that I know to be mine and not theirs, I think there’s a certain sensitivity around that it was interwoven in a religious context, so ... it feels like a bigger deal.

Values stemming from dissimilar religious or cultural traditions. Also, when therapists were asked if they were more or less likely to intervene in a religious or

cultural background they shared with the client as opposed to one they did not, they all indicated that they would be more likely to intervene when their religious or cultural background matched their client's than when they did not. For most, this was an issue of knowing appropriate boundaries and feeling more competent to work within one's own value system than a differing one. For example, one religious participant said,

I think I'm more likely to intervene in a person's values if they have similar values to my own. I think if they are a person who also subscribes to Christianity, I'm able to talk that language and I may challenge a little bit more directly any particular beliefs that I might find to be psychologically unhealthy for them, whereas if someone has a different belief system, I'm not as familiar with it and I think it'd be too presumptive for me to try to intervene in the same way with a value system—religious or cultural—that I'm not as familiar with.

Others' choices to not intervene in value systems they did not share seemed to be related to a desire to communicate to the client the therapists' respect for the unfamiliar value system. Whatever, the reason, it is interesting that therapists consider not only the value itself but the origin and context of the value in evaluating whether to intervene in a problematic value system.

Evaluations of Hypothetical Situations of Value Differences

Some participants were given hypothetical value situations and asked to evaluate whether they would intervene in these situations, always assuming that the client didn't raise the issue as a problem, and if so, how. The way they responded to these situations, particularly their evaluations of whether or not they would consider it ethical to influence the client to change their values, provide concrete illustrations of the more abstract principles discussed earlier in this section.

Hypothetical situations in which clients' values appear harmful. The first type of situation was one in which the value appeared to be harming the client, with an example

of an anorexic client who valued thinness over health, a depressed client whose depression seemed to stem from perfectionistic values, or a client whose drug abuse was interfering with school and relationships. In most cases, not surprisingly, the therapists felt that it would be appropriate to alter those values. One individual, who had initially said that it would not be appropriate to influence clients' values, reconsidered when discussing one of these hypothetical situations, saying, "If it's interfering with their functioning, or negatively affecting their health, that's when you have to pull out the big guns." However, another therapist said that he would not try to change a client's value, even when it appeared to be harmful, and suggested that he would try instead to open a dialogue about the problematic value without either joining in or resisting the value itself. He suggested that he might approach this with the hypothetical anorexic client by saying something along these lines:

The only way that therapy is going to work and I can help you is if I feel like I can join with you and accompany you in it. But I really need to understand why this is your value. So I need to understand why you have to lose this weight. If you can help me get to that place, then maybe we can talk. Then I can figure out if I can really help you; but I still, as of yet, don't really understand why you need to lose another 25 pounds. Can you help me understand?

He then added, "[So I would ask her] to teach me her values. And then, hopefully, that takes us into some of the more emotional stuff behind it or societal stuff And then we get to start working at that level." This, he felt, was a way to begin the work that needs to take place without pushing his own values onto the client. He also added that he prefers that approach "because I find that when you resist someone else's value system it either ends up with you doing violence or the other person not ever feeling truly met."

Hypothetical situations in which clients' values contradict those of the psychology profession. Other hypothetical situations given involved one in which the clients' values contradicted the values of the psychology professions as a whole, but were not necessarily harmful to the clients themselves. Examples of these included a client with racist values, or one who was indifferent to social responsibility, such as a person refusing to help a suicidal friend or a parent not feeling responsible for supporting dependent children. In these situations, therapists tended to be somewhat less likely to intervene than in situations of harm and we are about evenly divided as to how they would handle it, with most expressing a great deal of hesitancy or indecision. Three participants shared their reasoning about this situation in these words:

- That is a grey area. I think I would probably experience negative feelings towards that client, but I think again I would probably talk about alternate view points that most people might have, or why she chose to do that instead of least telling him to call a crisis line or something. But again, it is her choice and it's not necessarily something that's illegal, so.... I don't know what I would do. I don't know how you'd really handle that situation.
- I've had both of those (situations) happen, actually. I think that in both cases – it *may* have been me imposing my values, but in both cases I was able to find a way that what they were doing, not caring for someone else, or being racist, was in contrast with the goals that they were bringing into therapy. So, one happened in a group where this woman was saying very racist things, and she was very isolated from the others and not connected, and so to listen to other people and hear their reactions, she was able to hear that that pushed them away. I don't know what I would do though, if that didn't fit with their goals for therapy, I think I'd be less likely to make an issue out of it, even though it would make me uncomfortable, probably.
- I would start by understanding where their position comes from and what it's rooted in, but I would also find a way to point out that that position could be harmful to the other person and harmful to the client, as well. In both of those cases that you gave me examples of, ultimately, the client is hurt by their particular stance on the matter, too. Sometimes, I think that that can be helpful in creating a little bit of a shift, because then the client realizes that the situation isn't just about the other person, but that is has

an impact on them, as well. That way they can sometimes feel a little more investment in it than they might have before.

Interestingly, the last two responses show that these therapists felt more comfortable in intervening in the situation when they could tie it to client harm or to client goals for therapy – these seemed like appropriate rationales for intervention, while other motivations seemed insufficient.

Participants' Strategies for Influencing Client Values

Although therapists generally wanted to be respectful in how they handled a client's problematic value, they varied considerably in how they might try to approach it. Although participants were not asked specifically how they might go about influencing a client's value system when they felt it was appropriate to do so, several discussed how they might proceed in such situations. First of all, it is apparent that participants were quite aware of and valued client autonomy and several mentioned not wanting to impose their own values on their clients. At the same time, they didn't feel it would be appropriate to either join the client in a problematic value system, either by agreeing in some way or by not raising the issue as a problem. Accordingly, several therapists mentioned that they would initiate a discussion about the problematic value, but that they would try to do so in a way that would preserve client freedom. As one student said, any attempt to influence a client towards healthier values "would be more as a part of a less directive therapy," rather than a direct statement of how the client should change, in order to protect autonomy. Another suggested that she wouldn't look at the situation as trying to change a client, saying "I think that change isn't necessarily the right word. Maybe a better word is shape." Her preferred word choice suggests she views this issue as an attempt to move the client in a healthier direction while preserving client autonomy.

Further, several therapists noted that it is difficult to change the values of others; some even gave this as a reason why they would not try to influence a client except in extreme circumstances. This pragmatic concern was another reason for trying to influence a client through opening up a discussion rather than directly disagreeing. As one said, “I don’t think you can force anything on anybody to change. So I think raising awareness of it would be the first step and then if they wanted to change it, then that’s when we would work on it.” This therapist went on to say that if the client did not want to change, the therapist would then drop the subject, at least until the issue became a problem for the client as well. However, in more harmful situations, some individuals said they would be more focused on influencing the client even if it meant being less respectful of personal values. However, even here, therapists expressed concern about putting too much strain on the relationship through being overly directive. As one said,

What if a sex offender comes in and says, “I like having sex with children”? Obviously that’s not a value that I share and I know I would want to say, that’s wrong, and you can’t do that. . . . First of all, I know that I’m not going to change them if I just attack them anyway. I’ve got to go in some other way, a more subversive way – that’s probably not the best word, but . . . a nicer way, a way that they’ll say, “okay, I never thought of it like that.” Probably because most people are used to other people who *don’t* do that. If I want to get anywhere with them, I’m know that I’m going to have to approach it very differently. So yes, ideally my value would be that I’m going to change something, that I’m going to go in there and fix it, but I’m not going to approach it in a way that they’re not going to respond to it.

Clearly, in this situation, the therapist is less concerned about the client’s freedom to choose personal values than about the need to change behavior, and her concerns about the approach are more a reflection of what will work in the situation to accomplish that goal. This distinction underscores the criteria issue referenced above – in less harmful situations, these student therapists were more likely to exert less directive influence to

help clients change, but under more dangerous situations, therapists felt it ethical to be more forceful.

Theme 5: Preferences for and Reactions to Value Differences

Most participants generally did not express a preference to see clients with either similar or dissimilar value systems, although when a preference was expressed it was generally for clients with dissimilar values. When asked about personal feelings about and reactions to clients with very different values, participants reported reactions ranging from frustration and concern to interest and excitement.

When asked whether they preferred to see clients with similar or dissimilar value systems, the vast majority of participants stated that they did not have a preference, although many in that group then went on to state the advantages of seeing dissimilarly-valued clients and a few indicated that if they did have a preference, it would be for clients with different values. One participant stated that she “secretly” preferred to see clients with similar values, while one indicated that she preferred to see dissimilar clients. A few others felt that their reactions to a client were determined more by the client’s personality than by their value systems, so a discussion of preferences on the basis of value similarity or difference was misleading. The remainder indicated that they either had no preference or that they preferred a mix of similar and dissimilar clients. In order to better understand the preferences expressed by participants, it may be helpful to look at the reasons they gave for those preferences and their perspectives on how the value similarity of the client affects the work that they do in session.

Participants' Preferences for Treating Clients with Similar Values

The reasons that participants cited for their preferences gives some insight into how value differences are perceived by these individuals. The one recent graduate who said that she “secretly prefer[s] to see people that are more similar to myself” added that she felt that way because “it’s easier to connect with them.” It is relevant to note that this individual was finishing her internship with a population whose values were generally quite dissimilar from her, after feeling that she had experienced few value differences in her previous placements, which may have influenced her response. Another participant also said she is more likely to feel connected with like-minded clients, but added, “That’s not always the case. I can work with clients have similar values and not have a strong connection, too.” Thus, some felt it was easier to have a strong relationship with similar clients than with different ones.

Participants' Preferences for Treating Clients with Different Values

In contrast, those who preferred to see clients with contrasting beliefs felt that seeing different clients was interesting or exciting and provided a positive challenge. This is clear in the statement of one therapist who reported that she enjoyed seeing clients from different backgrounds. “I seek out clients with different value systems,” she said, “because I find it interesting and I want to get a pretty wide breadth of experience. So I have chosen to take on some clients here that other clinicians have shied away from.” Others mentioned the personal and professional growth that comes from seeing such individuals.

I know that I’ve really enjoyed the times when I’ve had to think about things differently because someone had a different perspective. But sometimes it’s very uncomfortable. But even in the moment, if it’s

uncomfortable, I think I've benefited from the times where our values are pretty different, so I don't think that I would avoid the situation.

Several of these reasons for preferring clients with different values are evident in the response of a participant who first described some advantages of seeing similar clients, and then mentioned the following advantages of seeing clients with different values:

I think there is something about the challenge that comes with working with someone that does have a different world view than I do that I appreciate. I think it can be very easy to sort of get deluded into thinking that everybody out there is like you, and that's not true. If you have the ability to select clients for your caseload and you're continuously choosing to select clients with whom you have a value similarity and avoid clients with whom you have a value discrepancy, then I think that as a therapist and a person I'm really shortchanging my own growth. I think it can be helpful for clients to work with people whose values differ from their own and I think that can be said for therapists [too].

Others felt like seeing dissimilar clients was more challenging, but also said that they were more careful to avoid imposing their own values as a result, which they saw as a benefit.

I think that when someone comes in with really different values from me, and especially if they're values that really go against what I believe, I think it's a little bit more of a challenge, but I also think because I know that, I make much more of an effort to be aware, and to check out with the client about how we're doing our work, that I'm not bringing my biases in in an unhealthy way.

Some participants cited concerns with seeing similar clients as a rationale for preferring to treat clients with different values. The main disadvantage of seeing similar clients mentioned by participants was that it was too easy to overlook the differences in light of the similarities. For some, this raised concerns about an implicit imposing of values on the client in the areas of difference. Others felt that this might be a concern because of the client's expectations in light of the similarities. One non-affiliated Christian participant gave this rationale for preferring to see clients with different values:

I kind of like to see different value structures than mine because I think it's easy to fall into the trap of the "we're on the same page" mindset. For example, I've had a couple of parents [of underage clients] who've asked me "Are you a Christian?" because they've wanted a therapist who's Christian. I think that gets a little bit awkward because then there's an assumption that your beliefs are going to be exactly what their beliefs are. For me, I haven't really learned to juggle that yet. So it's easier to acknowledge that we're on different pages and to work with that, for me.

Another person mentioned that she wouldn't like to see someone that had exactly the same value system as her simply because nothing new would be brought to the table, adding, "What a boring interchange that would be."

Preferences for Treating Clients with both Similar and Different Values

Most participants did not express a preference for either similar or dissimilar clients. The reasons for this response varied, with some suggesting that they enjoy both similar and dissimilar clients and others suggesting that they preferred clients with similarities in some areas and differences in others. Others suggested that they had no preference because value was less relevant to client preferences than other factors, or that placing clients into either similar or dissimilar categories is inaccurate due to the fact that no client is completely similar or dissimilar. These positions are explored more fully below.

Preferences for clients with a mix of value systems. Several participants said that they preferred to see a mix of clients, with some clients similar to themselves and others dissimilar. Seeing clients across a spectrum of value orientations, they felt, offered more variety and chances for both growth and connection.

Preferences for clients who are similar on at least some value dimensions, but not necessarily all. Another participant expressed his feelings that at least some basic values need to be similar between the client and therapist in order for a connection to occur, and

then considerable value difference on other dimensions can be dealt with in productive ways. He said,

I love learning from clients' different values. I really love when someone comes in and has a very different system and structure so I can learn it, I can join it and I can glean so much from it. And, hopefully, come alongside and help them bolster their own existing value system. However, of course there are [some] value systems—such as if they modeled their lives after “Sex and the City,” and think that that’s what meaningful relationships look like and they value that—that just drive me crazy. You know, it’s very hard to know how to come alongside that with my values being something so different. But if I hear that their values are sort of that “Sex and the City” thing but they have this personality or temperament or deeper dynamic that says to me in a sense, “I want these types of relationships with [others] . . . because I yearn for some deep connection, I yearn for something beyond myself and I’m alone,” then I feel like, “Oh, we have something here to work with.” Because then I almost see that inlet between my values and their values. They don’t have to be the same, but I think I do need points of connection in order to feel like the work’s meaningful.

The idea that participants needed to have at least some minimal connection is somewhat supported by looking at the real-life examples of value differences described by participants. Of the over thirty situations described, six resulted in fairly negative feelings for the therapists, ranging from hurt to anger to disgust. In almost all of these cases, the client held a value that others were unimportant in some way, or that it was okay to hurt others. Given that psychologists as a whole tend to place a high value on helping other people, this is clearly a significant value difference and appears to be a difference that interferes with the progress of therapy. Thus, a shared respect for others may be one of those foundational values that allow for productive interactions even in the face of very different values on other dimensions. A value difference along one of these foundational or fundamental values may impede therapeutic progress more significantly

than other value differences, as was seen with these six cases where therapists felt strongly negative feelings towards their clients.

In contrast, participants mentioned several other value differences that did not threaten therapy. For example, the therapist mentioned earlier whose religious values conflicted with those of her client who was a Wiccan priestess found that because her client “was a good, decent human being who liked to do good for other people,” the value differences weren’t a problem. Thus, it may be that sharing basic values about human interactions is more important for therapists than sharing other values, and facilitates work even on differing value systems.

No Preferences for Treating Clients with either Similar or Different Values

Several participants felt that they could not adequately answer the questions related to personal preferences for client value systems not because they had no personal preferences, but because these preferences were not related solely to issues of values. Others felt that they could not state a preference simply because the vast majority of clients they treat are similar to them in some ways and dissimilar in others, making the issue of similarity a false dichotomy.

Preferences related to personality similarity, not value similarity. Others suggested that their preferences were not related to value similarity, but to similarity on other dimensions, including a similarity or congruence with basic elements of personality.

One gave a personal example of her work with a client she did not care for initially:

In the beginning, I did *not* like working with her at all. It was a couple of months of “just go away”! And then getting to know her more I liked her more, and it wasn’t about the values, because there were a lot of things I did not agree with with her. She had some strong issues about . . . a lot of things, that if I knew just one-on-one, I don’t think I would like her. But there were so many other things about her personality that I got to know.

So I guess it almost didn't matter whether we had the same values or not, because when I get to know your personality, that would make me gel with you anyway.

This participant's experience suggests that value similarity is less crucial to the relationship between therapist and client as therapy progresses, a finding echoed by a few other individuals in the study.

Similarity or dissimilarity a false dichotomy. Several participants also said that the similar/dissimilar values issue was a false dichotomy, as they recognized that they are going to be both similar and dissimilar in at least some way from every client they saw, and that seeing clients only along the similarity/dissimilarity continuum blurred other important facets of the client. One said,

I think everybody sees the world differently than me and everybody else; even if someone matched my cultural and historical background really closely, there would still be so much individual difference between my experience and their experience It would be pretty impossible to say that just about everybody isn't fairly different at some level. Although there might be things where I feel like I can quickly understand what they're talking about because we have some similar background, it seems like taking that for granted would be dangerous because they could be very different still. So regardless of how much overlapping value or background experience there may be, it's still worth exploring or understanding exactly where the client is, their sort of phenomenology. That seems *most* important, as opposed to whether or not I have a comfort level with a particular value system.

Personal Reactions to Significant Value Differences

Participants were also asked about their emotional reactions to value differences in therapy. Reactions ranged from very positive ones to very negative ones and no single reaction was described as applying to all situations of value differences. Reactions varied considerably even among individual therapists, depending on several factors. A discussion of some of the more frequently mentioned reactions follows.

Caution and concern about imposing values. On of the reactions most frequently mentioned by participants upon discovering a significant value difference was caution and concern about managing the difference ethically. One participant said that his reaction “depends on what the values are related to,” then added,

I think in general my reaction, my first reaction is to be inquisitive of and learn about the client’s values. The second is caution—just as far as to what extent I will bring my values into the room because I realize that they would provide a level of influence on the client.

Curiosity and interest. Another frequent reaction mentioned by participants was to be curious and interested in the client’s value system. Some of this curiosity was apparently an attempt to learn about the client’s value system in order to provide more value-consistent services to the client; recall that learning about a client’s value systems was one of the strategies mentioned by participants for dealing with value differences. However, several also mentioned that they enjoy learning about other people and their value systems and so their first reaction upon encountering a significant difference was a positive, interested one. This seemed to occur mostly with client values that were somewhat less personally salient for the therapist, or ones about which therapists had less strong personal opinions. These reactions are seen both in the quote in the previous paragraph where the therapist indicated his first reaction was to be “inquisitive and learn about the client’s values,” and in the one earlier in this section where the therapist stated, “I love learning from clients’ different values. I really love when someone comes in and has a very different system and structure so I can learn it, I can join it and I can glean so much from it.” As is clear from this last statement, value differences can bring positive emotional reactions from therapists who are curious and interested.

Strongly negative “gut” reactions. Other value differences, however, brought negative reactions, which in some cases were quite strong. Clearly, some value differences seemed to have a greater impact on therapists than others. A quarter of participants mentioned having a sudden negative “gut” reaction to recognition of a significantly differing value system, particularly when that difference was personally relevant. In most cases, they then also mentioned their attempts to conceal that reaction, as with the following description:

When I come across a value system that is contradictory to my own, there is that gut reaction It depends on what the value is. Sometimes it’s more curiosity, but other times, I’m sure there is a negative reaction. I don’t think anyone can ever be completely neutral, even if you are trying to appear that way, internally you may not be that way.

Another illustrated the conflict between personal reactions and the desire to remain neutral in session by relating a common experience for her in working with young female clients over decisions not to continue education and career goals, issues that she tends to feel strongly about:

When I have those conversations with someone who is making those kind of choices, part of me is coming out saying, ‘NOOOO! I’m going to ESP “NOOOO!” to you as much as possible!’ [It’s] a good thing that I have a good poker face!

The immediate reactions for these individuals are both a somewhat pained feeling and a concern for remaining neutral, even in the face of strong contradictory feelings.

Surprise. Among other reactions, some mentioned feeling somewhat surprised by value differences, although others mentioned not being surprised because they expect to encounter value differences in their therapeutic work. One therapist who reported feeling surprised on occasion said,

I used to think that it would be impossible almost . . . to be that different from my clients on certain things. But I've had enough experiences with clients where I go "Wow, I can't believe that you think like that!" and then I've had to really, in session, kind of do a double take and say [to myself], "Okay, now keep going, this is all part of it."

Another therapist, in contrast, reported that she didn't expect others to be similar to herself, so that when value differences arose, it *didn't* surprise her.

In general, I don't think that people *will* have the same values as me. I've seen quite a range of individuals, so I've seen quite a range of values as well. . . . So sometimes there's a bit of a negative reaction . . . but at the same time, I'm pretty used to having different clients, so it's not completely unexpected to have value differences.

Varied reactions. Other reactions mentioned by at least two participants were anger, fear, and frustration. These more negative reactions were not universally felt in every situation on value conflict; rather, it appeared that a wide range of reactions were possible even among individual therapists and that these more extreme negative reactions were fairly uncommon for most. The breadth of reactions possible under different conditions are illustrated well by one participant who said,

My reactions vary. At times, I've felt angry and frustrated. At other times I think I may have felt scared. Sometimes I feel curious or excited about the possibility of understanding them a little bit more. In some cases I have framed it negatively but it hasn't always been that way. Sometimes it feels the opposite—like it's stimulating or even neutral, depending on how salient that value is for me. I think that you can have a value difference and have it not be salient to you.

It is important to recognize that the majority of the interviewees felt that their reactions varied depending on the value in question, its salience to them personally, and other factors. This made blanket statements regarding their reactions inaccurate or problematic. One of these factors that influenced personal reactions was the degree of difference between the therapists' values and the clients'. Small differences, noted one

therapist, “just roll right off.” Significant differences, however, were more likely to be met with a stronger reaction and were more likely to elicit negative reactions. Similarly, differences that are not personally salient, either large or small, were often described as being met with interest or curiosity. More personally relevant issues, in contrast, were more likely than less relevant ones to produce a dramatic and sometimes negative “gut” reaction, which then frequently created a concern about concealing that reaction from the client in order to preserve client freedom. Several participants mentioned different types of reactions, depending on the degree of difference and the strength of the therapists’ feelings about the value in question, which often related to its salience for the therapist. Clearly, different situations of value conflicts elicited different reactions in therapists and it is likely that they were handled differently as a result, although the relationship between reactions and values management was not specifically addressed in this study.

Situations Eliciting more Strong and Conflicted Reactions

While participants reported feeling at least somewhat conflicted with a broad range of situations of value differences, three situations seemed to elicit somewhat more strong and conflicted feelings than others. These occurred when counselors identified with clients on a personally meaningful dimension but had value differences in other areas, when personal values conflicted with psychological values, and when clients were unsure of their own values and therapists had a strong value for one of the considered positions.

Value difference occurring in a personally meaningful area. The first occurred in situations in which the value in conflict with the client was one which was very salient or personally meaningful for the client. Salience of the value for

the therapist strongly affected feelings about the value difference, with therapists saying they were more likely to feel conflicted by a value difference when it occurred along a dimension that was personally relevant for them. Several participants mentioned feeling that some differences were more personally compelling to them than others. Some of these “hot buttons” included gender equality, education, racism, and religious differences.

Personally meaningful value differences seemed to evoke particularly strong reactions when the therapist felt some similarity with the client in some areas but had a value difference in others that were important to the therapist. For example, one participant who immigrated to the United States as a child spoke of the difficulty she faced in counseling other clients from her culture when the discussion related to education:

I was working with a lot of teenage girls, especially a lot of teenage girls [from my own culture], who I feel in some ways were looking at me as their therapist, but they were also looking at me as an example—one example—of what women [from my culture] do in this country. And so [I was] trying to be aware of that, and also trying not to impose the path that I have chosen on them. But yet cringing inside when I would hear a fifteen or sixteen year old say “I think I should just get married,” and “who needs an education?”

She also spoke of the struggle between feeling “that I should try to be influential” and not feeling that it was appropriate to directly influence clients. Clearly, these struggles were in part related to her shared cultural background with these clients, and the desire to be influential in positive ways created conflict with her values related to client autonomy and freedom.

Other participants also shared examples in which they felt more personal conflict with a client who shared their religious or cultural background and yet had other values

that conflicted with their own beliefs or life decisions.. For example, one therapist whose parents immigrated to the United States will generally respond to negative comments about immigrants, trying to correct misperceptions in a respectful, constructive way.

When asked how she would handle a situation in which an immigrant client had negative feelings about her immigration status, this therapist responded,

I'm pretty sure that I would bring up my own values there, because again that's one of those hot buttons for me, and I almost feel like I would need to share it because that's how I am. I would probably say more about my personal life more than in [situations where I don't share a similar background]. Because that isn't something that I share, I don't know that value, I don't necessarily share it; this one, I have a stake in, so I would probably say something. It's not just professionally meaningful for me, it's personally meaningful. So I probably would say something – not necessarily to try to change that person, but maybe in a sense I would be if I'm saying, "Hey, here's what I think, or here's what my experience has been."

Some reporting conflict of this kind suggested that they would feel less conflict with a client who is more dissimilar presenting the same value difference.

Personal values in conflict with psychological values. A second situation that seemed to present greater difficulties was when personal values conflicted in important ways with psychological values. Therapists reporting these kinds of struggles often felt pulled between the two value systems, while also trying not to impose either on the client.

As an example, a conservatively religious therapist shared the following experience:

I had a client who was questioning [his sexual orientation] and he had a very strong desire to come to therapy and end up straight. And it just became so much more complicated and complex and difficult for me to figure out how to work with him, what outcome goals to have or not have in my mind because, for non-religious reasons, he wanted a particular outcome that seemed less likely [to happen], seemed to involve denial and to be psychologically unhealthy. But at the same time, [it] fit with some of my [beliefs]—you know, it was a place where my psychological and religious values really conflicted.

Clients who are questioning their own values. These two examples also point to a third type of situation which participants consistently found more difficult to negotiate, those in which the client herself is questioning her value commitments and the value dimension at issue is one about which the therapist has strong feeling. For example, the therapist whose client belonged to a religious group that had split from his own faith felt that the experience “pulled things” for him as he tried to help her decide which of her beliefs were healthy and which were not. Similarly, the non-religious therapist mentioned earlier who was helping the client with very religious parents evaluate her own religious feelings was concerned about not imposing a more liberal belief on the client just because it happened to fit better with the therapist’s feelings and described feeling somewhat more concerned about imposing her own beliefs than she did in other situations. In contrast, the participant with the client who practiced Wicca felt little personal conflict, not because she agreed with the client’s value system more than either of these other participants but because the client was already quite settled about her own beliefs. In fact, several participants indicated that they felt it was harder to negotiate value differences when the client was undecided about a personally relevant value issue than when the client was already firmly decided on a value that conflicted with the therapist’s value. In these situations, the main concern for therapists seemed to be a fear of unfairly influencing the client to move toward their values. It appears that in such situations, the therapists were somewhat more careful not to insert personal values and were more likely to instead opt for strategies involving exploring or clarifying values and evaluating alternatives.

It should also be noted that clients who are questioning do not pose a conflict only for therapists who identify personally with one of the considered options. Any fairly strong opinion in favor of one option over another appears to increase the difficulty if remaining neutral, and thus the level of concern and conflict experienced by counselors. For example, one non-religious participant spoke of how she would handle a client similar to the one described above, who was questioning his sexual identity but wanted to be straight. It is clear that even though she did not feel a personal stake in the issue, it still would present some conflict for her:

The urge would be for me to say, “No, no! It’s okay, and here’s why” . . . in the same way that I would validate a lot of things that clients came with, and they don’t understand why they’re feeling certain things, and validate that. So maybe I might approach it like that where, I would try to find a balance for the client . . . I’d probably say it, but then kind of hold back a little bit, if I found myself thinking it, because it might be too much like an agenda, and that’s not good to do that.

Theme 6: Dilemmas involving Therapists with Preferences to not Treat Clients with

Different Values

Participants were divided on whether both trainees and licensed professionals should be required to treat clients with significantly different values, with most recognizing the training value that such experiences hold for trainees but expressing concern for the potential for harm to the client. Participants were asked whether they believed students should be required to see clients with very different value systems as part of their training. They were also asked if their answers would be the same in situations involving licensed psychologists in order to better understand the reasoning and values behind their answers. These hypothetical situations appeared to create something of an ethical dilemma for many individuals, as they felt that ethical

psychology professionals *should* be able to treat clients that are different than themselves and that seeing diverse clients is a necessary training component. In fact, none of the participants seemed to like the idea that therapists would refuse to see certain clients. At the same time, they didn't want to force either the therapist or an unsuspecting client into a situation in which the value differences could lead to client harm.

A few of the graduates interviewed felt that seeing clients with conflicting values should be required and did not mention client harm. A smaller number said that it was acceptable for therapists to choose not to see particular clients in order to protect the client and did not discuss the benefits or harm to the trainee. The remainder felt that students should be expected and strongly encouraged to treat such individuals due to the educational value of such experiences, but they also felt that trainees should be allowed to refer these clients to other practitioners if they felt that it was in the clients' best interest to do so. Participants in this latter group, however, even differed among themselves in the way that they would view such a referral, with some holding that an inability to treat certain individuals would reflect a professional incompetence and others seeing the situation as more acceptable.

Interestingly, several participants answered one way initially and then later qualified their answers after considering other factors, indicating the complexity of the issue for them. Also, once again, participants' responses did not divide across predictable lines, such as religion, theoretical orientation, or general beliefs concerning the role of therapists' values in the counseling process in a way that might be expected. Religious individuals responded in similar ways to non-religious participants, and those who held that therapist values should be minimized responded similar to those who felt they should

be included and embraced. This pattern could be indicative of similar professional values across all types of participants, or it could be further indication of the complexities of the issues as seen by participants.

Arguments For Requiring Trainees to Treat Clients with Different Values

Educational value of treating dissimilar clients. Participants universally felt that seeing clients with different values was an invaluable training experience and most felt that the ability to effectively treat dissimilar clients was an essential competency that doctoral graduates should have. In fact, those who felt that students should be required to treat clients with dissimilar values often pointed to the educational value of such experiences as rationale for that position. As one respondent said,

I don't think it's fair for students to come in with this clean idea of who they want to see – the kind of people and the kind of problems – and leave it at that. So much growth happens whenever you step outside of that comfort zone and start working with someone who's really different, whether that's a different ethnicity or a different presenting problem or whatever. . . . I think it's really good for students.

Another suggested that working with such differences helps students develop as therapists, as she noted,

Part of being committed to diversity and being sensitive to cultural differences involves exposing oneself to people who are different from you. I think it's how we become better therapists and it's also how we become better people. . . . I think that therapists in training need exposure and should be challenged and pushed a little bit to work with a client who's different.

Several other participants felt that students in training should be exposed to such experiences while they have the benefit of supervision to assist them in developing competency in performing therapy with dissimilar individuals.

As a student it would be more helpful to have the training experience, because how would you be able to even know what you can handle or not?

That would be something that the supervisor can help work through . . . and maybe that will help you in all your work, not just with this one client.

Another benefit of having these experiences in training is that exposure to different situations may provide useful information about a student's interests and capacities, as described by this participant:

I think [seeing clients with different values] is a benefit—I really do. Especially when you're training, that you can get that exposure before you're completed and you're out there on your own, and then you can see the kind of clients you want. But I think the best way to learn is through experience. I think you should at least be exposed to it so you know what your limits are, what you're capable of.

This participant, in fact, was the one described earlier who had found it necessary to refer a client who molested children and as difficult as she found that experience to be, she nevertheless found it helpful for the reasons cited above: "As much as I hated it, now I know my limits; I know that I can't work with that. That's good information to have. So I think it was a good experience."

Development of multicultural skills. While the value of the learning experience was the primary reason given for requiring students to work with clients with dissimilar values, another reason that was given by several participants is that multicultural competence is a fundamental skill for practicing psychologists and that seeing dissimilar clients in training is necessary to develop that skill. As one put it, "There is an ethical obligation for therapists to have enough understanding and awareness of their own values and biases to be able to work with a diverse clientele," and she saw felt that the training period is crucial for developing that understanding and awareness through working with different clients. One graduate who unequivocally stated that students should be required to see clients with dissimilar values reasoned that "It's a matter of diversity. Because I

think values come from a lot of different sources and I think it's unethical to only be able to practice with people who are similar to you in so many different areas." Interestingly, this individual stated that he felt more comfortable with practitioners limiting their practice after graduation on the basis of values, but added, "I think students need to learn it."

Personal experiences of professional growth. Several interviewees, in fact, cited examples in which they had seen clients with different values and had felt that it was a valuable learning experience. In many situations, they worked with populations with whom they had previously felt uncomfortable and came to find that the experience was a positive educational opportunity. Said one:

I think it's a great experience to see a different population. I always thought I could never possibly see sexual offenders in therapy because I thought that is just beyond what I can handle, It's so against my values so I thought I could never see someone in therapy like that. But I've pushed myself to the limit and I decided to do it anyway and I actually really enjoyed the work. I really liked it and I would do it again. . . . I don't think [seeing clients with different values] should be forced on students, but I think that if they have the option and they feel like they can do it, they should take advantage of it. You never know what might come of it.

Another participant described how seeing individuals with whom she had value differences helped her become a better therapist. She had conducted therapy with female survivors of domestic abuse for some time and then began to see the male offenders as well, with whom she had clear and strong differences on values related to gender roles and emotional expression. Despite those differences, she felt that the experience was positive and useful.

I always feel working with batterers helps me become a better advocate for victims, because when I worked primarily with victims, I definitely saw their abusive partners as sort of monsters and inhuman, and it was much easier for me at that point to say this is bad, this is good. When I

started working with abusers and started seeing that these men were similar to my neighbors, and my relatives, and friends—other than the fact that they had been arrested for often beating their partners—it helped me to see their humanity, and it helped me understand better the complex issues that keep women in abusive relationships.

Arguments Against Requiring Trainees to Treat Clients with Different Values

Potential for client harm. Despite the many benefits seen from providing therapy to clients with different values, most students didn't feel that such experiences should necessarily be required, particularly if the therapist is strongly opposed to it. Most students expressed concerns about the potential for client harm that might arise with a student counselor is opposed to treating a particular client but is required to do so by their training program. Several either directly or indirectly referenced APA's ethical principle regarding nonmaleficence, including one participant who said,

I think that our one rule is to do no harm: nonmaleficence and benevolence. Do no harm. I think that if we have a student that hates homosexuals, then I don't want them to work with one because they might do harm to the client.

For another participant, the decision whether or not to work with a particular client was an ethical issue related to understanding therapists' own competencies and boundaries: "I think that we need to know our limits as therapists . . . because the last thing we ever want to do is harm the client." For this reason, she felt that it might be acceptable to refer a client that the therapist "is absolutely not going to be able to connect with," although she also felt that seeing clients with different values was tremendously beneficial.

Another who felt that therapists in training need exposure to different types of clients added,

But I don't want to . . . say that a student should be forced to work with clients who have value discrepancies without having a conversation with them in the first place. There could be danger in requiring that of students,

too because if you don't understand where the value discrepancy comes from and why they're having such a strong reaction, then you may be putting the therapist in a position where they would likely cause harm in working with that person.

Clearly, the main issue for these individuals, and the primary ethical obligation, is to avoid harming the client. In fact, those participants that focused primarily on the experience of the client, rather than on the experience of student therapists, generally were more likely to find it acceptable for student therapists to refuse to work with particular individuals. For example, one participant, when asked if it might be acceptable for student therapists to refuse to see a client on the basis of a value difference, answered,

Yes, as long as it's done in a way that's incredibly respectful and non-shaming and non-violent to the client, absolutely. If someone does not feel like they're in a place in their own journey where they can meaningfully join with another person with a different set of values, then please, may they gently exit. Absolutely.

He stated that this should be done "to protect the client" and added,

Because much like small children, that we don't think they pick up on things, they do. Clients pick up on so much . . . even if the [therapist's] body language tightens up when the client's talking about something that appalls the therapist. These are things that if the therapist doesn't have the ability in their own journey to acknowledge that, name that, put it in the room in a meaningful way, it does get internalized toxically by clients.

For this individual, then, the inherent value-ladenness of therapy implies also the potential for harm to the client when working with someone unable or unwilling to "meaningfully join" with them, suggesting that such encounters might be best avoided for the benefit of the client.

Even among participants who saw significant benefits from students seeing dissimilar clients, protecting the client from harm seemed to take priority over the value of the educational experience for students. That is, the vast majority of participants felt

that seeing clients with dissimilar values was quite beneficial for the student, but also felt that the ethical concerns over harm to the client took precedence, as explained by this participant:

I think that experience is valuable, and I think [students] should be encouraged to work with very different people, but I also think that if someone knows that they will be more harmful than helpful, that that's an opportunity for them to also not be involved. I'd rather protect the client, but I feel like the times that I've worked with people who have had very different values from me, I feel like I've gained something, both as a person and as a counselor.

For this participant, and a majority of the others, the risk of client harm outweighed the benefit to student therapists in these situations and protecting the client became the more pressing ethical imperative.

Discomfort with forcing trainees into unwanted encounters. For many participants, at least some of the danger to clients lay in the idea of students being “required” to see clients with different values, which implied to some that students are forced into situations that they don't want to be in, a situation that seemed unhealthy for both the student therapists and their clients. Others felt uncomfortable with the word “require” because it implies a kind of unethical power that the training program might exert over a therapist. One said, “The word ‘required’ is hard. I think that's maybe what I'm struggling with because there are just so few things in our field that are absolute.” One therapist who felt that students should be pushed to see clients with whom they had significant conflicts added, “But I can't imagine really requiring, or forcing somebody; that doesn't seem like a good idea either.” Another felt that requiring such interactions “sounds like a recipe for disaster” and that it doesn't seem fair or beneficial to either the student therapist or the client.

Most of the participants who felt that students should not be forced to see certain clients still held that seeing differently valued clients was a helpful experience that students should seek if they feel they can do so without harming the client.

I think that it should be really encouraged. I don't know that I would require it because in some cases it could be harmful to clients, if that person is really against it and unwilling.... Now if there's a person who's just a little uneasy but they were fairly open to things, then in those cases I would really encourage it to kind of make them experience different things and gain greater comfort and exposure, but in more severe cases I wouldn't require it.

When the question was rephrased as "Should students be expected or encouraged to see clients with dissimilar values," many of the participants who previously had concerns about the word "require" responded affirmatively. How the differences between requiring, expecting and strongly encouraging students to see dissimilar clients would actually play out in real-life training programs, however, was less clear.

Trainee rights not a significant factor. It is relevant to the discussion, given the original listserv post that generated this debate, that only two respondents made reference to a trainee's rights in evaluating these situations and none mentioned respecting trainees' religious diversity. This suggests that, as a group, participants did not consider a trainee's right to refuse a client to be a significant component in their reasoning on this issue. One of these two respondents stated that, "I think the student should have the right to not see a population if they don't want to, if it violated their own values," but then went on to describe the benefits of seeing differing populations at length. Another stated that, "If some Christians have hatred towards homosexuals, I think they have the right not to see them" (after stating that she absolutely disagreed with the idea that all Christians fall into that category), but as with other participants, her primary reasoning behind that position

was the potential for client harm. Another participant indirectly referenced perceived rights of religious students and suggested that they are *not* sufficient grounds for refusing clients: “You can’t hide behind, ‘My religion says that that’s not okay, therefore....’ One day, you’ve got to figure out where you’re coming from, as a professional and as a person, and you’ve got to work it out.” None of the other respondents referenced individual rights, either directly or indirectly, suggesting that they are not a major factor in evaluating this dilemma for those interviewed. In contrast, all but one participant mentioned the potential for harm to the client in discussing this question. Clearly, the ethical obligation to protect the client was the more pressing concern.

Concerns about Trainees who Refuse to Treat Dissimilar Clients

While allowing that students should not be required to see clients with whom they had strong value conflicts, several participants expressed serious concerns about counselors who would refuse to see certain clients and added that they felt students who refused to see particular clients needed further training to allow them to develop that skill. One student, after suggesting that she wouldn’t require students to see certain clients if they were strongly opposed to it, added that “But then I would suggest a different intervention, like maybe that person shouldn’t graduate. That’s a little strong, but . . . more appropriately, they should get some additional training and try to work through some of that stuff.” This individual described a refusal to work with certain clients as “a *big red flag*” about the competence and ethical skills of the student, a feeling echoed either directly or indirectly by about a third of participants. Others felt less critical towards the hypothetical student, but most still felt that the situation would need to be addressed either by the program or supervisor:

I think there needs to be some flexibility both ways. I think that harm can be done when you say, “So and so *has* to work with this particular client.” But I also think that it should be addressed if the counselor is closed off to certain things, like, “oh, I’m not going to work with this or that,” then there needs to be a conversation about why it’s such an issue for that counselor, and if it’s that strong, then maybe it’s in the client’s best interest not to work with that [student]. That’s a professional development issue.

One respondent said that the decision of how to handle a particular incident would depend in part on continuing patterns in the student’s behavior.

If I were their training supervisor, I would process it; I would want to understand why. I would want them to gain awareness of that blind spot. [If they felt that] they cannot ethically treat the client because of this difference, then I would educate them in the process of referring out. But if I had a certain student who had a pattern of [saying] “Well, I can’t handle this, I can only handle people who are just like me,,” then you’ve got to look at the bigger issue . . .”Why is that a thing that you like you can’t treat?” First and foremost is ethical care for the client, so in that case I would assist them in finding an appropriate referral, but [I’d] look for patterns with that student.

Another felt that exploring the reasons behind a student’s refusal to see a certain client would be important. After commenting on the harm that could arise if students are required to see individuals against their will, she added,

That being said, I think that a lot of times trainees [have reservations about] working with people different from themselves, for reasons that would not be, in my mind, a strong rationale for not seeing that person, like the trainee not feeling as skilled or that they don’t have as much life experience working with someone that different from them. In that case, I think it would be appropriate to push a little bit more.

One participant described a personal experience with a supervisee that had concerns about seeing different clients in which he felt it was appropriate to push her to see those clients despite her discomfort. After expressing his view that it might be acceptable for a therapist to not see a particular client if they are concerned about client harm, he added,

But at the same time, I had one supervisee that only wanted to work with [members of her own minority ethnic group] and she was [a member of this group] and didn't feel comfortable with anybody else at all, and I think that's problematic. There are reasons why she wasn't comfortable with other people and she needed to understand and explore them.

As a supervisor, he felt that the trainee's concerns needed to be addressed in a way that would open her up to seeing a broader range of clients. Interestingly, this situation was the only one reported by a participant in which a student therapist had actually requested not to see certain groups.

One participant made reference to the experience of another student who had reservations about treating particular clients, and the programs' reactions to the student suggest that programs may have serious concerns about trainees who refuse to see students as well. Interestingly, the student in this example appeared to be avoiding these clients to protect them from the potential harm of imposing her own value system, and so was essentially employing a strategy like that recommended by the majority of the participants. Her experience, however, suggested that programs may not see these issues in the same way. The student she referred to was conservatively religious individual who indicated to her program that, while she felt comfortable seeing clients who already identified themselves as gay, Lesbian, or bisexual, she felt less comfortable treating individuals who were questioning their sexual orientation because of her concern for imposing her own beliefs onto them. Specifically, she felt that she might not be the best therapist to help an individual through the "coming out" process and indicated to her program that she felt it would be best to refer in such a situation. The participant noted,

[This student] stated very clearly that she would tell [the client], "I do have a value difference here. I don't want to coach you one way or the other, so I will refer you to someone who can be value-neutral on that or

who is comfortable with that.” Obviously she wasn’t going to do therapy and try to convince them of her own perspective.

Her program, however, felt that such a stance was unethical and unacceptable and suggested that she needed to be able to see clients at any stage of exploration. Even though the motive for referral in this case was to protect the client, her program did not see the preference to refer as an appropriate one, suggesting that some programs may view this issue differently than participants.

Of all the therapeutic experiences described by participants, the two examples above are the only situations in which therapists actually requested not to work with certain clients. One participant, whose experience was discussed earlier, had referred a client (the man who felt that sexual activity with children was acceptable) in part on the basis of the value difference with that client, but she had been willing to see the client, even knowing his history, and had several sessions with him prior to that referral. Participants were not asked directly whether they or a trainee they knew had ever refused to work with individuals or groups on the basis of value differences, but it seems highly likely that they would have brought it up if they had. Thus, based on the experiences of these participants, it appears that this situation is a fairly rare one among psychology graduate students.

Factors Influencing Participants’ Reasoning

Referring vs. refusing. The differences between the three real-life examples mentioned above point to three consistent factors that participants alluded to in making their decisions. The first is that participants generally felt more comfortable with the idea of trainees referring individuals after therapy began, but were notably less comfortable with the idea of trainees ruling out clients before they were even seen. Terminology was

important, too; most participants felt comfortable with a trainee “referring” a client; they were considerably more hostile to the idea of a trainee “refusing” to see an individual. Although, again, none of the students were specifically asked about the difference, their replies strongly suggest that when they viewed the situation as a trainee refusing to see a particular client after recognizing differences, that decision was more likely to be seen as stemming from a concern for client welfare. When they portrayed the dilemma as a trainee refusing to see a client prior to treatment, the motive behind that decision was seen as bias, prejudice, dislike, or hatred.

Refusing to see individual clients vs. refusing to see groups. Participants were also more likely to respond negatively to therapists refusing to treat entire groups rather than refusing to work with individual clients. Although participants’ decision on whether the trainee should be allowed to refuse certain clients did not differ under the two situations, their judgments about whether such a refusal was ethical and acceptable did, with the trainee refusing to see whole groups viewed much more critically than the one refusing to see individuals. Only one respondent directly articulated this difference; she said,

I’ve had clients that I conflict with not so much on values, but more personality, and to me that’s more of an individual case-by-case basis where you say, “I don’t think I’m doing this person justice,” and I’m angry all the time, and that would be bothersome to me *and* the client. But if it’s just a matter of just a blanket group, then maybe you need to work that out a little bit. Again, personality, if it’s an individual thing, [then it might be acceptable]. But [it’s not acceptable] based on just “I don’t want to work with this individual because I don’t like that particular group.

Refusing out of concern for competence vs. refusing out of bias. The second, more fundamental issue that appeared to underlie participant’s reasoning about the particular dilemma; when the issue was one of competence, participants generally viewed a

decision not to treat an individual as acceptable and even beneficial to the client. When the motivation was perceived as bias, however, the same decision was viewed much more critically, although still generally seen as a better alternative for the client than being treated by a therapist that disliked working with them. For many, then, the motive of the therapist was the important factor in deciding whether the decision was appropriate. For example, one participant discussed the hypothetical situation of a therapist expressing a desire not to work with specific populations by saying,

If they know that more harm than good will be done if they work with a specific population, then I think that is a good decision. But if it's out of a prejudice, then, I think that that's not good either.

It should be noted that about a third of participants who discussed motive, either directly or indirectly, presented both competence concerns and bias as possible motives, while the remainder were about evenly split between casting the issue as one of concern for client welfare and assuming that the decision not to treat stemmed from bias.

Arguments For and Against Requiring Licensed Professionals to Treat Clients with Different Values

Participants were also asked whether licensed professionals should be required or expected to treat all clients, or whether it might be acceptable for them to refuse clients with significantly different values. This was primarily done to allow further insight into the reasoning processes underlying participants' decisions regarding these dilemmas. On this issue, again, participants were split, with about half of those who responded feeling that it was acceptable for a licensed professional to refuse certain clients and another half seeing that decision as unprofessional and unethical. Interestingly, responses in general

reflected somewhat more polarized thinking regarding licensed professional as compared to trainees.

Many who felt that students should be required to see clients with different values felt that it was more acceptable for licensed professionals to limit their practice on the basis of value differences because the training component was no longer present.

They more frequently saw these therapists as desiring to protect client interest by referring them to another practitioner. For example, one respondent stated,

I think once you've graduated, you have more say in who you see, because a lot if it is that, at that point, you're no longer just learning; you're expected to know what you're doing. And if you don't feel competent to work with someone, or you don't think you're going to be effective, I think it's actually your responsibility to refer them to someone more appropriate. I think you should be open to work with a wide variety of clients – I think that's to the clinician's benefit as well as the clients' – but I also think you should know your limits.

Among those who felt that licensed professionals should be expected to see all clients regardless of differing values, exceptions were usually still made in situations where clients might be harmed. However, they didn't see this refusal as necessarily morally acceptable, as illustrated by the following statement:

I think that in an ideal world, [clinicians] should see everyone, but again I think that if someone is *that* against seeing a particular group, they're probably doing the client a favor (by refusing to see them). I'd like to see more training happening for people like that so that they could get more comfortable with that sort of thing and not feel like they have to cut off an entire group.

A few others felt strongly that multicultural competence is a fundamental quality that graduating therapists should have and that refusal to see a certain client therefore implies lack of competence as a therapist. For example, when asked if it was acceptable for a licensed professional to not treat certain groups of people, such as clients who

identify as GLBTQ, child molesters, or individuals outside one's racial or ethnic group, one participant responded,

Well, I think that's kind of poor. I think that you should be able to work with all kinds of people and that if you're a therapist – a licensed one, especially – and not open-minded enough to bring in someone that you have a value difference with and try to make it work out, then I think that is unprofessional and it suggests that the therapist has some issues that need to be addressed. That would mean going back and learning the self-discovery and self-awareness process. That needs to take place if you're not willing to see someone [who's] gay or someone that's not white.

Another respondent suggested that if an individual is a “good therapist, then they should be able to handle [a value conflict] and values should not make a difference.” She cited a personal example, saying,

I have a colleague who is very religious and his religion does not believe in homosexuality at all, and he was very good at working with GLBT clients. He took it on knowing his bias, and knowing that his value system was different from theirs, and I think that what he realized is that they were people and that they needed help. That's the thing I can't understand, is how you can put so many restrictions on it if you know that this person is coming to you [for help].

Clearly, for this individual, therapists have an ethical obligation to see individuals regardless of their value systems, and practitioners who allow value differences to interfere with therapy are seen as less adequate than those who don't. This appears to be particularly true when discussing licensed professionals, although similar but more guarded reactions were apparent even when discussing these situations with trainees.

Interestingly, participants appeared to be somewhat more likely to attribute motives of bias or prejudice to licensed professionals than to students. This may be because students are seen as more likely to be concerned about issues of competence or ability to see dissimilarly valued clients; because professionals were assumed to have

those skills, a refusal to see certain clients may have been interpreted as stemming from prejudice instead.

Theme 7: Evaluations of and Recommendations for Training Programs.

Participants were asked an open ended question about whether they felt their training programs and internships had adequately prepared them to deal with issues of value differences in therapy and how. They generally reported positive evaluations about the training they received around value-related issues in their graduate programs, but were quite mixed in their reactions to internship training. They were also asked if they had any specific recommendations for graduate programs or internship sites in this area. While most of the recent graduates felt that their graduate programs had done a good job in educating them on value issues, most also cited recommendations for improvement. The most frequent recommendations were to have more training on the “practical” aspects of values differences and to encourage discussions on value-related issues and exposure to clients with different value systems.

Distinctions between Values and Diversity in Evaluations of Training

Although the question asked specifically addressed issues of values and value differences, it became clear in evaluating the transcribed interviews that some were equating value-related and multicultural or diversity education, while others made a distinction between the two. It was also clear that some were responding to the quantity of training in diversity in evaluating their graduate education, rather than the adequacy of it in preparing them to handle client with different values. The differences between managing values and diversity in general, particularly, seemed to be blurred for many

participants, although it was nicely delineated by one in evaluating how value-related issues were handled in training:

I think [my training program] had a strong emphasis on diversity and therefore the way that they handled it was that you ought to accepting of everything no matter what, which, I think, teaches half of the lesson of values. I think that being able to allow and validate the values of others is important, but they didn't do a good enough job, I don't think, in dealing with the aspects that are inherently value-laden in therapy. You do need to be able to understand how your own values come into play and how to deal with that. And, I don't think there was any explicit training on how to interact your own values—whether they're similar or different—with the values of clients. I think the assumption was, "Diversity is good. Your values don't matter because everybody else's values have equal importance."

Interestingly, this individual felt that focusing on diversity might actually interfere with providing adequate training on handling values in session. If this is true, then, clearly the quantity of training on diversity is a very different matter from the adequacy of training in handling values, a distinction that should be kept in mind in evaluating the findings in this area.

Degree of Satisfaction with Graduate Programs' Training in Value Issues

Satisfied with graduate training in values. A slight majority of participants in the study said that their programs had prepared them well for handling value differences in therapy. The strengths that some of these noted in their programs are illustrated in the following comments:

- I feel like my training at [my school] was, actually, exceptional in that area [of values]. We directly talked about that, I don't even remember in how many classes. We talked about, what happens if your values *do* conflict, whether that's religious, cultural, individual, family values. . . . They spent a lot of time on that.
- I think from the beginning they taught us that the goal is not conversion of someone to your own value system. I think from the beginning they

taught us to allow clients to maintain their own value system and to respect it as a portion of diversity.

Another said, “For me, the things that I felt were most helpful were being able to have an open dialogue about it and process it and talk about potential or hypothetical situations. I think that those trainings have been helpful.”

Mostly satisfied with graduate training, but recognize room for improvement. A little less than half of the participants mentioned that their training in the area of values and value differences had been adequate, but also saw areas where the programs could have provided more helpful instructions. One felt that the value-laden aspects of therapy had been overlooked in favor of multicultural training, saying, “Diversity for the sake of diversity—it was definitely a motto at my program, and so there wasn’t always richness to it.” Another said,

I feel like its been okay, but I feel like it could always be better ... When I think about the value differences I’ve had with clients, they’ve primarily been around cultural issues, and some religious and spiritual issues, and I don’t know that any of the programs I’ve been in really did a good job of that. But I don’t know that they could have either. I mean, I feel like until you’ve had some of those experiences, its hard to wrap your head around what that might feel like and what it might look like.

Unlike the first participant quoted in this paragraph, who felt that a focus on diversity obscured a more full examination of value-related issues, this participant felt that she was not adequately trained in dealing with value differences primarily because such preparation is difficult in the absence of an actual context. Another participant suggested that, while her program helped her to achieve awareness of personal values, it provided less direction on what to do with those values in session, which was a common concern voiced by participants. She said,

I think they did a good job of helping us be aware of our values and aware of how they might get in the way. I think where they sometimes fell short was in what to do with it, sort of the practical aspects of it, like in session, or with the client.

Some participants who felt that their programs were lacking in certain areas remedied those weakness by seeking out additional training. For example, one participant mentioned having worked with a broad range of clients that were racially and religiously diverse. She mentioned that “I think that the reason I had such diverse experiences and was able to work with such different groups was because I sought it.” She added that she sought such experience both out of personal interest and to strengthen her own training. Similarly another participant had felt that working on a research team with individuals working on value-related issues was helpful, saying “I think I just got extra understanding theoretically of things from seeking out some of that research.” Thus, some participants who noted particular deficits in training or who desired extra training in particular areas were able to receive that training by participating in activities outside the required coursework and clinical experiences.

Not satisfied with graduate training in values. Only one participant felt that his graduate training was quite lacking in training around managing value differences, saying that “At [my university], I would say it was pretty basic training and not really an in-depth look at some of the things that we’ve talked about today. In some ways it’s almost like lip service was paid to it.” Differences between therapists and clients were mostly handled in his schools’ multicultural class, which he described as a presentation of “these are the diverse groups, and then the stereotyped generalizations about them that don’t seem that relevant in retrospect.” He noted, however, that his university had been taking steps to address that deficit since that time.

Context of Training in Value Issues

All training programs prepare their students for professional work in psychology through both coursework and clinical experiences with actual clients. Although participants were not specifically asked about the settings in which training in value issues occurred, many volunteered that information in talking about their reactions to their value-related training. Issues of values and value differences came up in both settings, but the degree to which such topics are emphasized appeared to vary according to the program.

Coursework. The frequency with which value issues were brought up in coursework varied considerably for participants. A majority of participants reported that issues of values and/or diversity came up in more than one course, although perhaps not all of them. A few graduates said that value-related issues were only or primarily covered in the required multicultural education course, while slightly more individuals mentioned that issues of diversity and difference came up in every class. Some of the experiences of individuals in this latter group are illustrated below:

- I was lucky because my graduate school, their theme was multicultural training and education. . . . They had a really diverse staff. It comes up in every class, it doesn't matter if its research methods or whatever, there's some element of multicultural in it – what are the multicultural implications of . . . whatever. So we were always talking about that.
- I felt like we had it in classes, we had it in individual supervision, we had it in group supervision, and we had it in our supervision classes when we were taught to supervise. So, when I was supervising masters' students, my supervisor was asking about the differences in our values between me and my supervisee. I just feel like it was all over the place.

Both of the students quoted above, however, also reported feeling the focus on diversity was a little overbearing at times and reflected some mixed feelings about the

intensity of training in this area. One said that although she was grateful for the training and loved her graduate program in general, by the time she got to internship, “I had had so much of it that I was just done!” The other participant echoed similar feelings, saying

We were always talking about [multicultural issues], to the point that I think when I got to internship, it was like, “All right, you know, we get it, we are considering multicultural [factors]”— it was almost to the point where we were like, “Okay, enough of that.”

Interestingly, both participants mentioned these feelings in the context of finding very different attitudes about multicultural training at their internship sites, and missing the emphasis on diversity they had experienced during graduate school. A third student who reported having issues of diversity interwoven in nearly all her coursework also reflected somewhat mixed feelings. She evaluated the abundant multicultural training she had received by saying, “I had diversity crammed down my throat at this school and it was difficult at times to be challenged in that way, but it’s amazing how much it changes you as far as your own open-mindedness and what you thought you were going to be able to tackle.”

Clinical settings. Several also said that, while these issues were discussed in coursework, most of their training in these issues did not come up in courses at all, but rather in clinical settings. For these individuals, then, supervisors became the primary source of training in how to manage values in therapy. This was somewhat of a concern, understandably, for the students who felt that their supervisors were not as concerned about multicultural or value issues as they were. As mentioned previously, several participants commented that the quality of supervision varied considerably, particularly with regards to awareness and management of value-related issues. and a few noted that they perceived that the training received on multicultural issues, both in internship and

training, varied widely among individuals even within the same programs depending on which faculty and staff they had had as advisors or supervisors.

Strengths and Weaknesses of Graduate Programs

Interestingly, many students mentioned the same strengths and weaknesses in their graduate programs, even as their overall evaluations of their satisfaction with the training in value-related issues varied.

Developing awareness of personal values a strength. One strength for many programs seems to be a focus on helping the students gain awareness of and clarify their own values. For example, one said,

From the very beginning in our training program they wanted us to make sure that we began this process with self awareness and self discovery. Even in our first semester there they told us to go buy journals because it's really important to be journaling a lot and figure out what's going on with you and what kind of client will you have the most difficulty working with, which will be the easiest for us to work with and why. So that we know when we come into the session what we're bringing into it that's our own stuff and we can be able to separate that out from what our client is telling us.

Teaching practical aspects of managing value differences a weakness. However, many of those who felt that their graduate programs had done an excellent job with awareness also felt that their programs could have provided more direction on how to actually handle values differences in session. In fact, this was the single most commonly cited weakness of programs. Three participants from different schools shared these feelings:

- I think both [my internship and graduate] programs did phenomenal jobs in terms of being aware of your own values and your own beliefs and any sorts of differences, power differentials, those kinds of things. I think they did a great job on the part of therapist—what are my beliefs and how does that affect therapy. I don't think that either one of my programs did a very good job of [discussing] what beliefs other people [are] bringing in and

what values. What beliefs and values are my patients bringing in and how do we respond to that? It was more being aware of your own beliefs and values and negotiating that.

- We had two classes where we just sat around a room and we tried to have discussions about [our own values]. We had to talk about our own feelings, not about our clients. . . . We had to say “What do *I* believe and what do *I* think. We talked about oppression, how it affects clients and ourselves, how we contribute to oppression. That was hard. . . . It seemed like, in the program, we ended by knowing your part in contributing to some of the difficulties, more on that level, and then [not what to do with them]. That was harder. I think as I went along, I learned for myself what worked.
- I think they did a good job of helping us be aware of our values and aware of how they might get in the way. I think where they sometimes fell short was in what to do with it, sort of the practical aspects of it, like in session, or with the client.

Incorporating client values into therapy a strength at some programs, weakness

at others. One area where training seemed to be somewhat variable was the degree to which students were taught about incorporating clients’ personal values into therapy. All mentioned a value on respecting client beliefs, but few mentioned learning how to incorporate them into therapy. One who did said that,

Part of where I think I received my value to treat the whole person was the emphasis that’s placed there at [my program], treating the family, working with a systems approach, working within their religious framework, cultural framework, all that. So I feel like that training was really good.

One who felt that her program could improve shared the following experience and feelings:

I think that my program did all right with [value-related training] but I think that they could have done more on some things. One thing we had all mentioned is that—I mean, I worked in an area with very religious people—and they never taught us how to integrate the spiritual aspect within therapy. We were in a very conservative Christian environment in that area, where we went to school, and so the fact that we were never taught that I think really showed the bias of the faculty.

I had a client call me and cancel. She said, “I want to cancel because I’m religious and you’re not helping me with that.” I was never

taught, was never encouraged to do that. And I said, “Okay, that’s her choice.” But I thought . . . multiple identities are very important—you know, ethnicity is a part of our identity, age, our sexual orientation, all those things are part of our identity. But faith is also part of our identity. For some people it’s a very strong part of their identity. They don’t leave it at the door and then come into therapy. It’s part of their identity and we need to acknowledge all those aspects of it. When we don’t, I think they stop coming, especially if that’s a strong part of their identity.

People sometimes think, “Well, then they should go to the chaplain.” Well, maybe. Or maybe the psychologists should learn about integration because that’s also actually a big thing in other schools.

She added that her school did have training on religion in her multicultural class, but she felt it had not been sufficiently helpful for her work with religious clients, describing it in the following way,

We did have a topic on religious things, but we had all these people come and talk about their religious beliefs. I felt like it was more like a mish-mash of all these religious beliefs. I thought, “Well thanks, but you didn’t teach me anything about integrating it.” You know, I can read about all sorts of religions, but how do I integrate that and how do I infuse it effectively? That’s the part I’ve been missing because I don’t see it.

She also added that she feels this doesn’t only apply to religious beliefs but to all belief systems – that it would be beneficial to receive training on how to incorporate a wide range of value systems into therapy.

Satisfaction with Internship Programs’ Training in Value Issues

Participants were also asked to evaluate their internship placements on whether those experiences had prepared them well for handling value differences in session. Here, responses were more polarized, with approximately equal numbers saying their internship sites had done well, adequately, and poorly in this area. Far more participants made significantly negative comments about their internship sites than did about their graduate programs. Interestingly, almost all of those who felt very negatively about the value-related training at their internships had internships based in community mental health or

hospital settings, with participants who were working in college or university counseling centers generally reporting more positive experiences with training in this area. The following comments illustrate the concerns of the students who were dissatisfied with their internship training around values and related issues:

- My internship did not really [prepare me to work with value conflicts in therapy], so I'm lucky that I came in kind of already grounded in that area. In some ways, I think my internship has maybe been, I don't want to say contrary to that, because they haven't been, but I've kind of had to come in and step a couple people up because they kind of seemed old-fashioned or something. So there was the potential to move back from where I had progressed.
- No, [value issues were not dealt with in my internship]. I was in a hospital and, not that they're all this way, but the stereotype of being more clinical and not focusing on culture was definitely true there, in my experience. . . . It was a shame too, because that's where you're going to, in many cases, run into more people with different values, just because you're dealing with such a wide range of the population, as opposed to college students who tend to be open-minded and fairly similar. It's unfortunate.

It should be noted that this feeling was not true across the board. Some of the respondents who were most positive about the training they had received in the internships were in locations serving members of the community, rather than college students exclusively. It is also relevant that the concerns appeared to be related to staff and supervisors, and not just to the structure of the program itself – for example, interns at both community and hospital internships, as well as those affiliated with a college or university, mentioned didactic trainings on multicultural issues, but in general those serving an internship at a hospital or community site reported having fewer trainings on these topics and having supervisors who were less interested in multicultural and/or values issues than those in university settings.

Recommendations for Training Programs

Participants were also asked about recommendations for training. Often, their recommendations related to deficits or problems they had noticed at their own programs; sometimes they related to strengths they felt their program had that they hoped other trainees could experience. Other times, they were a reflection on the experiences that they felt would be most valuable for trainees, without any reference to their own experiences. These recommendations are listed below in order of the frequency with which they were mentioned.

Provide more training in practical aspects of managing value differences. First, as mentioned previously, students felt that it would be more helpful to discuss exactly how to negotiate value differences in therapy. Several suggested that their coursework focused more on descriptions of different value systems, rather than providing training on how to work with different value systems. The following comments illustrate this idea:

- I think it would be most important to talk about how you're going to handle value clashes, or how you'll become aware when there's the potential for that, and then how you work that through with a client. . . . I feel like my internship training here . . . [provided more opportunities] to really look at potential value clashes and how I was going to handle those in session. It would have been nice to have had that piece more in a diversity class that I had as opposed to just somewhat general information about particular areas.
- I think it's really important to talk about what kinds of beliefs our patients and clients are bringing in and how to deal with that a little bit more. . . . I guess I mean more hypothetical situations. It could even be done with the beliefs that other people have in the class. How do they interplay together? You know, more practical, I guess. For example "So, hypothetically, this person comes in with this belief and they're saying this; what do you do?" And there's no right or wrong, but just getting the thinking going. Even little things, like it's okay to wait and say, "Let me think about it for a session." Just little things that people don't think to mention to us trainees.

- I think [I would recommend] trying to do more research and also present more information about what to do [with a client during therapy]. . . like I was saying, the practical aspects, what to *do* in the session.

Encourage supervisors to take a proactive role in providing training on managing value differences. The second most common recommendation was for supervisors to take a proactive role in providing training to their supervisees on these issues. This recommendation may be due in part to concerns some participants had with previous supervisors. A little over a quarter of participants mentioning having had fairly negative interactions with supervisors around value issues, or at least perceived supervisors as being less concerned with value issues than themselves. These situations happened slightly more frequently in community settings, but were also reported with college and university staff and faculty. For example, one said “There were exceptions, but I think in general, my peers and I were more aware of and interested in value issues than the supervisors that we were working with.” She felt that some of that was due to the fact that most of them would have completed their training at a time when value issues were not as much in focus as they are today, but noted that it also appeared to be related to priorities. Another said,

I didn't really didn't get much help on [value issues] here. And the supervision really ranged in quality. I had one supervisor who was fantastic, and I could talk to them about value differences, and how to handle them, and I had a few others who were terrible, so that I wouldn't even bother. There was quite a range.

Similarly, a participant who had recently completed her internship at a college counseling center noticed an interesting dichotomy there:

[The internship] presented us with a lot of opportunities to do a lot of [work with diverse clients] but I don't know that the staff wanted to do it amongst themselves so much The psychologists that supervised were

definitely aware of it. But as a whole they didn't necessarily talk about [value] differences amongst themselves, at least that I was aware of.

Whether this reflects a general trend or not is difficult to evaluate; participants were not directly asked about the attitudes of supervisors around this issue, so the comments above were generally made as side notes in response to other issues. While personal differences among supervisors are to be expected, it appears that in some cases training sites were sending their students mixed messages about the importance of value issues in therapy, a conflict that was generally met with frustration or disappointment by trainees.

To make supervision more useful, two participants suggested the following ideas:

- I guess I also think that [value issues have] to be integrated into supervision maybe explicitly. It shouldn't be up to the trainees to always have to bring it up—I think that supervisors need to be cognitive of it as an issue and continually question their students and the clients as well as themselves and their supervisees, you know, the value differences there.
- I think that training programs, in the course of giving supervision in an all these different areas, should be mindful about bringing these things up with trainees, encouraging them to think about them, and eliciting conversations about trainees' values and how they are prepared to deal with clients who come in and are different. I just think it's something that training programs have to be consistently mindful of in all aspects of supervision. I think, for me, it's an area of cultural competency and so it permeates all aspects of training.

Ensure that students provide services to diverse populations. Similarly, several students cited the value of seeing dissimilar clients and said that programs should ensure that their students have access to training experiences with a wide range of individuals. One felt that students should not be able to request certain clients in order to insure diversity, but another suggested that requesting particular types of clients might provide greater diversity. One spoke of ways in which a program might be able to increase the diversity of clients that trainees see:

I would encourage programs to really build relationships with good diverse communities and cultures, religiously, ethnically, socio-economically, in their areas, so that students can get a practicum experience with a variety of different clients and get an opportunity to test out what it feels like to work with people who are very different from you.

Another suggested that supervisors can provide encouragement to students who are hesitant about seeing clients with different values, and spoke of the advantages of doing so:

I think it would be kind of neat if you go to your practicum site and there's an opportunity for a different kind of experience, like a different kind of client coming in or something, and the supervisor encourages you as a student to try it out. . . . [And] I would encourage people that haven't really actually tried to step out of their comfort zone to do it. In my experience, which is still very limited, it gets easier and easier once you do something you're really uncomfortable with. Once you get into the room with someone that's very homicidal or suicidal and you just kind of get to know them and start working with them, it's easier the next time you see one and then pretty soon, you can build connections with them right off the bat. I would just say that it gets easier with time. I think that someone who works exclusively with sex offenders that is not a sex offender themselves is going to find that after a year of working with sex offenders, you don't really think of them necessarily as someone who's so different than you.

Include value-related issues more broadly in course work. Other participants mentioned that coursework could be improved. One improvement would be to broaden the discussion of value-related issues, so that value issues are not discussed exclusively in the requisite diversity or multicultural class. In the words of one participant, “[Programs should] continue to incorporate these discussions into all aspects of the curriculum, as opposed to just having *a* class on diversity or values.” In the same vein, another added,

I feel like that class I had that really focused on diversity, differences, values, [and] how they affect their views, that that was really important. . . . And they often are never discussed until that class, and I wish they were brought up more in other classes.

Another way some suggested that coursework could be improved might be to specifically discuss value related issues, including those occurring within a culture, rather than just cultural differences, as suggested by the following student:

So much about what they talk about is cultural differences and they don't really include value differences in that. . . . I do think that they should train more in the classroom, that it would be more beneficial to students. I think that there is so much emphasis on multicultural issues and I think that they should throw in there more about value differences because you're going to run into a lot of people who have different values than you. . . . Even if I had the same exact cultural background as someone else, it doesn't mean that we'll share the same exact values. I think that they definitely should talk about that more in the classroom.

Include more training in religious diversity. A few religious participants, all religious themselves, suggested that it might be appropriate to include more training on religious diversity, primarily because it is often foundational to many other beliefs and can be an important part of how the client views the world. One suggested that,

Training programs need to do a better job teaching about religious diversity as part of their diversity seminars. I think that is the foundation because then you are truly teaching them to value other people's beliefs when they disagree with you and I think, from that, can hopefully flow a little bit better understanding of different perspectives on topics like sexuality.

Assist students in gaining awareness of personal values. Other participants echoed the emphasis on awareness, suggesting that this is an important skill for trainees to develop in order to work effectively with clients who are different from themselves. Said one:

I think it's really important for training to focus a lot on yourself, for trainees to focus about understanding what their values are, where they come from, how they're different from other people, and what the impact of that might be in counseling.

As has been seen, several participants mentioned that awareness was a central component of their training programs, suggesting that this is a skill that programs value as well.

Model appropriate respect for others' values by showing respect for students' personal values. Finally, a few students had encountered situations in which they felt graduate programs had not been respectful towards the beliefs of their students, even while teaching students to respect clients' values. They felt that programs could better model acceptance of and respect for diverse beliefs. Although not experiencing any problems herself, one graduate, when asked about recommendations for training programs, made the following comments:

I think mainly from what I've heard from other friends who are in different programs is that they feel like programs are almost trying to change their beliefs. They say that the focus is on awareness, but they feel like people are trying to tell them, "If you don't believe this then you're wrong." They feel attacked, so then they just stop talking and they're not open about things My recommendation would be that for the people who are leading these sorts of discussions to realize that if we're supposed to be open to patient values, professors need to be open to student values.

Instead, she felt that, because they were students, "then you have to have the psychology identity and we all have the same beliefs and we all have to have the same [values]." She also added that programs could address that in practical ways as well:

If there are absolute things that [the program is] not open to, then I think that needs to be advertised in training materials, you know, before people are admitted, so they know what they're getting into. So I think being upfront ahead of time and being open to people's beliefs. And helping students find ways to negotiate systems so that if they do have beliefs about things, [the program] can say, "That's okay—but how do we deal with them so that they're not negatively impacting patients or clients?"

Although this individual had not felt that her personal beliefs were not accepted by her program, she did see examples of that in her own program with a supervisee, which is described in greater depth in the next section.

Theme 8: Experiences with Race and Religion

While it certainly comes as no surprise that many value differences stem from issues of race, ethnicity, and religion, participants' experiences in these areas suggest that these are areas which may present unique concerns and that there may be steps training programs can take to better address these issues. Each of the participants in this study was asked to give an example of a situation in which they faced a significant value difference and to describe how they handled it. Several other examples were spontaneously given by the participants, so that over thirty such situations were described altogether. Looking at these situations more closely gives interesting insight into the types of situations in which participants are aware of value conflicts and provides insight on specific steps that training programs might be able to take to better prepare students to handle those differences.

Participants' Experiences with Race and Racism

Interestingly only one of these real-life situations of value differences involved a client whose race was specified as being non-Caucasian (and that lone situation was presented by a therapist of the same ethnic group). It is entirely possible that at least some of the other situations did in fact involve clients of color, but race was not specified as the presenting concern or value difference on any of these. This likely suggests that White therapists did not experience race as a source of value difference.

All of the therapists of color in this sample mentioned experiencing value differences with clients who were White, primarily around their clients' assumptions that these therapists could not help them because they were of a different race. These differences seemed to stem, not from the therapists' attitudes towards White clients (as

they did not report problems with other clients, some of whom presumably were also White), but from the clients' assumptions or negative reactions based on the therapists' race. One therapist was told by a Christian client struggling with religious issues, "You wouldn't understand where I'm coming from because you're Muslim." Although this therapist didn't report feeling that the comment was motivated by racism, it is probable that it was based on her race, since the therapist's religious orientation had not been discussed before and she was, in fact, also Christian. Another participant reported experiencing racism in her work with a client in a rural area who she described as being in late adolescence:

I had a patient who came in and told me he was racist. We didn't really deal with it. So obviously there was a difference in values there. At first he told me his dad was racist and he went off to tell me several racial slurs. Then, probably a few sessions later, he told me he was racist. The comments sort of changed over time to "Well, you're different than the rest of them" and things like that. It wasn't that I really challenged that in the beginning. I set it aside because it felt a little oppositional to me. I told him that if he wanted to talk to me about it then we could, but he was there for a substance use problem so that's where we started. I think a lot of that was that I was in a very racist area, but it's the Midwest area so no one really says anything. It's more like ignorance.

She added that it hadn't bothered her significantly, saying "In the real world, when value things come up I take it very personally. But in therapy, for some reason, I don't. I guess I have a different therapy persona or something."

A third participant also mentioned a situation where a racial difference led to a rupture in the relationship – in this case, the racial biases of a adolescent client's parents led to the early termination of therapy. She reflected on other experiences in her career when she's encountered individuals who were hesitant to work with her because of her race:

I've had some long-term relationships with clients who, much later on, would admit that they weren't sure in the beginning what it [would be] like to work with me, they weren't sure that I would be able to understand. Or some of them because of my name would say, 'I wasn't sure if you could speak English'. And I have appreciated that we had enough of a relationship for those clients to come back and say this is what I initially thought.

In evaluating her training experiences in both her masters and doctoral programs, she noted,

I would say that the worst job that both of the programs I attended did was teaching me how to be a therapist of color working with a majority population client, and sort of when that person and I have a value difference, usually around that I'm not competent because I am a person of color.

It is interesting that, despite having multicultural classes in her programs, one aspect that she felt was lacking was information on dealing with majority population clients who questioned her competency as a therapist from a minority race or ethnic group. It is also relevant that, while neither of the other participants mentioned racial issues in discussing their programs, one did encounter a supervisor in a practicum setting that made racist comments throughout her time there and who did not feel it was appropriate to discuss race as a source of value difference. It should be mentioned that two of these three individuals mentioned that these situations came up mostly in small towns with a largely white population that lacked exposure to minority races and that they felt the racism they experienced was the result of ignorance rather than a clearly formed opinion based on experience. It is possible, therefore, that the experiences of racially diverse therapists in areas with a larger minority population may be different. While the small number of participants in this study who are of a minority race or ethnic group does not allow conclusions to be drawn about whether such experiences are typical of other trainees of

color, it does suggest that unique concerns for these individuals may include managing the racist attitudes of clients and learning how to develop therapeutic relationships with clients who may have concerns about their competence due to racial attitudes.

It is also relevant that a similar experience were reported by the one participant who identified as a member of the GLBTQ population, which was described previously. Although the client was unaware of the difference, in this case, the therapist clearly felt that revealing her sexual orientation would jeopardize her client's ability to progress in therapy because of his strongly negative attitudes around homosexuality. Again, it is not known if other therapists who identify as gay/lesbian experience similar attitudes of hostility regarding their sexual orientation as this one did, but it seems likely that the experience of the participant in this study in not unique. This experience suggests further that therapists from several marginalized populations are likely to experience hostility or discrimination from time to time among their clients, a situation that might appropriately be addressed in training.

Participants' Experiences with Religious Clients

Interestingly, there was some evidence in the study that some religious clients, like the White clients of therapists of color described earlier, may also have concerns about the ability of their non-religious therapists to provide adequate treatment for them. Several therapists described clients either terminating treatment because of religious issues or requesting a transfer to a therapist of their faith, and others related experiences of struggling with religious divides. These therapists did not generally perceive hostile attitudes towards non-religious individuals as the reason for the concern; rather, they perceived that these clients felt that the non-religious therapists would not be able to

understand them and/or respect their beliefs. One participant described her experiences in providing therapy during her internship in an area where the majority of the population was of a particular religious faith:

In terms of religious background, I feel quite different here because I'm not [religious] and most of my clients are. I've never found a problem, but there have been people I've seen at intake or individual, who specifically request a counselor (of their faith), so I transfer them to respect their wishes. But I find that interesting that they feel they can't work with someone who's not (of their faith), because there's so many different religious orientations in this country, and you're never going to be just around one religion . . . It's not something I had experienced before. I don't think anyone ever asked me my religious background was when I was in [the city where I did my graduate training] – I don't think that ever happened.

She felt that her clients were hesitant about working with her because they did not feel she could understand them because she did not share their religious beliefs and added,

I think there are always going to be things that I don't quite understand, that I can ask the client about, but it's like any other difference, any other cultural factor. Personally, I'm always a little surprised they feel that way.

While none of the participants brought up examples where the main value difference related to race, well over half of participants brought up an example where the main value difference was related to religion, with proportions identical for students working in areas with a large number of religious clients and for those in other, less religious areas. About two-thirds of the non-religious participants reported examples of value differences related to religion, compared to half of the religious participants. Clearly, then, participants saw religion as being a major source of value differences with clients. It is also interesting to note, however, that none of the therapists reported not being able to understand the client, or feeling that the value difference led to a negative outcome for the client. Instead, those therapists that mentioned therapy outcomes in these

situations felt that the therapy was productive and helpful to the client, despite the value differences, and felt that they had been able to handle the difference in an ethical manner that did not impose personal values on the client. It is apparent that these individuals felt competent to handle religious differences with clients, in contrast to the apparent perceptions of the religious clients described by the participant above.

Another interesting finding is that almost half of participants, both religious and non-religious, report being asked by religious clients about their religious affiliation. None of them reported a non-religious client asking about their religious background. Most of these therapists who indicated their personal reactions said, although they were willing to share their religious affiliation with those who asked, they generally had mixed feelings about disclosing their religious beliefs. For example, one said,

It's interesting because as soon as a client found out what my religion was, they felt so connected because it was similar to theirs. But at the same time, it may not be the exact type of Christian that you are. I just thought it was interesting that immediately they felt that bond because I said I was a Protestant Christian . . . It [made] them feel more comfortable, but it did bring on new expectations because it was like, "Will you please pray for me?" So it brought on additional expectations.

One explained why she prefers not to share her personal religious commitments with clients in this way,

I also know how suggestible kids can be, and adolescents, the certain developmental stages in college; I've done a lot of work with them. And I don't like to impose my values, and I feel like even a statement where I'm not imposing them but I say, 'my background is...' religiously, that that could, based on their experiences with religion, they could feel judged, they could stereotype.... I just don't think it's a helpful piece for the relationship.

Both religious and non-religious therapists in this study generally reported feeling at least some discomfort about having clients ask about their religious affiliation or beliefs, while

it appears that at least some clients want to know something about their therapists' religious beliefs. It may be helpful, then, for therapists to understand the reasons why these clients are concerned and prepare ways to respond that address those concerns while feeling comfortable for the therapist.

Religious Participants' Experiences with Non-religious Clients

The experiences of religious therapists in this study are also worth noting, as the majority of them reported that they have not felt conflict between their religious commitments and their work as therapists. As one religious participant noted, part of her religious beliefs include the idea of loving and accepting others and she feels that those beliefs fit nicely with the values of the counseling field as a whole, in essence eliminating any conflict she might feel. One person did indicate that he had felt personally conflicted in therapy on previous occasions when client values strongly contradicted his own, but not feeling that the conflict was of sufficient magnitude to jeopardize therapeutic progress or to necessitate referral, but the rest did not report significant conflict with clients due to religious beliefs.

Religious Participants' Experiences with Training Programs

Although religious participants did not report conflict with clients due to religious differences, a significant number of religious participants reported experiencing conflict with their graduate training or internship programs (or at least some of the faculty at those locations) because of their religious beliefs. Most of these were mentioned in response to general questions about training experiences, rather than specific questions about religious conflict. Some of these replies follow.

I [went] to a program where even though the teacher . . . tried to hide her dislike for Christians, I could sense it. One time I was reading my bible

in the lab and I thought she was coming so I shut my bible [quickly] and put it in my drawer—you would've thought it was porn!—because I could sense that she had a clear bias. And it took me until my fourth year to tell her that she had clear biases against it. . . . She made comments throughout, from the first day that I met her, but I don't think she was aware . . . of her anti-Christian biases. She finally acknowledged that she has internalized Christophobia. I mean, she wasn't even aware. But she clearly disliked Christians.

This student also added,

I went to a multicultural seminar and it was interesting—actually, I think the new “homophobia” is “Christophobia,” within counseling circles. It's very interesting. It comes from this stigma that all Christians hate certain groups. It's very silly.

Another said,

[The conflict between my training program and my religious beliefs] was a problem for me for a long time. I think that part of it is that I was in this atmosphere of all these people who were very liberal and sometimes they were disdainful of Christians. Some of them tended to have this generalization that all Christians were very right wing and looking to defeat their rights, and that's really unfortunate because it put me in a spot where I felt caught, because here I am as a Christian and here I am as a psychology student. And how do I do both and be happy?

What helped this student through the conflict was to rely on a supportive group of family members and friends that understood her religious beliefs. As she says,

I kind of met—it wasn't an “underground,” that sounds so CIA-ish— but it was a small network of friends that I met that would say to me, ‘You mentioned something in class one day that makes me wonder if you're Christian.’ So a couple of us would email or call each other every now and then or be able to talk after class about that, and that was really supportive.

Another student reported not experiencing conflicts in graduate school (which was part of a religiously-based institution), but encountering some difficulties upon arriving at internship:

When I first arrived (at my internship), I think [the training director] was scared to death that I was there. The first two or three weeks I was there,

he asked a lot of questions, many of which felt threatening, too direct and I was uncertain how to respond—specifically regarding my religion and then regarding, because of my religion, either my school’s or my own personal stances on sexuality He did ask questions about other religious beliefs, you know—did people at my school have to sign any code of faith that they believed the same things, were there behaviors that we all had to do or had to avoid like drinking and smoking and whatever else. So he did ask questions like that, but I think his primary interest—I think those were just leader questions and [he was] more directly [interested in] what my school’s stance on sexual diversity was and what my own personal beliefs were.

This student also said that a supportive group of three other individuals with similar beliefs helped considerably to deal with the conflict at that site. Interestingly, this intern felt that the training director became less suspicious of religion over time and noted that at a later training meeting on religious diversity,

He . . . became very curious and asked questions directly, not about sexuality now, but just about my religious beliefs in general. And I think it turned out to be a very positive relationship and I think a positive diversity experience.

It is important, however, to recognize that this student also clearly felt that it was necessary to be careful and judicious about revealing personal beliefs during the internship year, out of concern for the possible reactions, as is apparent in the following example:

The assumption was that I believed all sexual lifestyles are equal and valid. And, in fact, it was more than an assumption. When we had training on diversity and sexuality, it was stated overtly —“I am assuming that we all in the room are at this place.” And, the training went from there, based on the fact that we all believe that all sexual lifestyles are equally valid. . . . [My personal feelings are that . . .] I think it’s complex. No, I don’t think that all sexual orientations are equally valid. That’s the short answer. . . . [And had I stated that position in that meeting] I don’t think it would have gone over well. I think that would’ve been really problematic for my overall relationships there. I think officially and as far as training goes, I think I probably would have had much more attention placed on me to make sure that I was not providing therapy that was contrary to the values that they have. And, I think outside of the clinical services I was

providing, I would've been pretty strongly ostracized by staff and interns and everybody—by a number of people on staff. There are a number of people on staff who are religious, and I don't know exactly what their beliefs are, but I know that they would have been more accepting of that position.

Another participant, although she not experience conflict herself, related the following experiences of a student she supervised:

I supervised a Master's student who was a fundamentalist Christian and I felt like there was no tolerance for that. I felt like it could've been handled a little bit differently. And it was one professor in particular, not the whole department. My approach to it was really, you know, she was going to have her beliefs and she can fake it until she gets out of here and then have no skills to deal with it when she's gone, or we can help her find ways to negotiate it. And it's not really modeling what we should be doing with patients either. I think they just over-pathologized her and her beliefs, you know, like something was fundamentally wrong with her and she was attacked a couple of times in class by a professor . . . It just felt a little wrong to me.

One of the disturbing similarities between each of the previous accounts is that the religious student clearly felt that their personal beliefs needed to be concealed or hidden in order to reduce conflict with their training programs. In one case it was as literal as hiding a Bible, but clearly in each of these situations, the religious students felt that it would not be acceptable to be open about personal beliefs. Instead, they felt it necessary to conceal personal beliefs—to “fake it” as the previous quote suggested—in order to preserve relationships with faculty in their training programs.

One individual whose religious beliefs did not match those of the religious program they attended reported similar conflict, suggesting that this type of conflict is not limited to non-religious universities:

In my graduate program . . . I ran into major problems because I did not fit in the orthodox mold. And, by major problems I mean there were a

couple core faculty and some students who were pretty brutal in terms of their proselytizing and in terms of just their desire to make me know how much I don't belong at a place like that . . . I should make it clear that . . . it was very mixed. There were some very painful experiences and some of the most empowering, meaningful experiences I've ever had.

However, the one non-religious participant who attended a religious school did not report conflict despite not sharing the beliefs of the institution. She said, "I kind of worried when I went there, because it is a Christian school, that it might not be as open as it was," but found that value differences were discussed openly and that coursework offered many opportunities to explore differences. She reported that

Before school I wouldn't have felt as confident or comfortable bringing up what a person's spiritual life was and how that affected them clinically and how that affected them as a person. But my program really emphasized a biopsychosexual plus spiritual model and so I really think that integrates the whole person a lot more, so I think we talked about that maybe a lot more at my school than maybe would other schools. And, it was all-encompassing of all religions, not just Christianity.

It should also be noted that several of the religious students in this study reported no or little conflict with their graduate programs (although a majority of those reporting little conflict attended programs where the majority of the faculty and students shared their religious beliefs) and only a small percentage reported significant conflict with an internship site. One religious individual reported, in contrast, positive experiences with supervision at her internship site.

On internship we talked about values explicitly, we had some trainings on that, but my supervisors were both very open to me processing where I may feel a difference. And they knew of course that I was from . . . a religious program and so they would bring that into the picture and say, "okay, given your faith system, is this really bugging you?" So it was directly addressed.

She also felt, however, that coming from an explicitly religious program presented some difficulties when applying for internships, with some training directors and supervisors

making assumptions about her or her training based on the religiously-oriented name of her graduate program alone. She added, laughing, that “I think some of the supervisors [on internship], were just kind of [surprised that I was] a really good therapist . . . and . . . [didn’t] always talk about religion!”

Theme 9: Process of Making Value Decisions

Many of participants’ responses noted that their value management is dependent on multiple factors, suggesting that value decisions are made on the basis of contextual requirements rather than according to pre-conceived rules or guidelines. This theme, unlike the previous ones, reflects the apparent process that participants go through in evaluating value-related decisions in therapy, rather than the content of the responses themselves. Throughout the interviews, participants generally found it difficult to make rule-like statements about values management, often saying that how they would act in a particular situation depended on various factors. Instead, decisions about value management were often tied instead to contextual concerns, particularly perception of client need. Many also remarked that they were they had not thought through why they made the decisions they did regarding value differences until they were specifically asked to for this research, providing support for the premise that individual value decisions were not made on the basis of well-formulated and universally applicable rules developed prior to the interaction, but on the perceived needs of individual clients in the moment. Further, many of the comments tied particular decision to judgments of what might be therapeutic or helpful. In those situations where rule-like statements were made, they were also often tied to beliefs about what might be most beneficial for clients. An overarching value of beneficence underlay much of the reasoning on value issues,

suggesting that this is a fundamental or grounding value for the value decisions described by participants in this study.

Value Decisions Depend on a Number of Factors

One of the most strikingly consistent responses to the interview questions was some variation of “it depends.” The vast majority of participants used a variation of that phrase in response to at least one question, saying that their decision, feelings, or choice in that area would depend on certain factors (and the other participants who did not specifically use the word “depend” made statements indicating that they would behave a certain way in a specified situation under some circumstances but not others, or saying that their decision would be “situational”). The other factors listed varied; many of those have been discussed previously in regards to other themes, such as the nature of the value, the degree of difference, the personal salience of the value, relevance to presenting concerns, the relationship between client and therapist, client characteristics, or the perceived consequences of the value. Regardless of the variables that affect the value-related decision, however, it was clear that very rarely did participants feel that a particular statement applied to all situations. This idea is illustrated in the following responses to various interview questions:

- “I think it depends. It depends on how [the value is] used and how it’s discussed.”
- “I think it depends on the situation and it really depends on the relationship that the therapist and the client have.”
- “I think it all depends on what kind of client you have, what their question is, etc.”

- “I don’t know if I really feel like there’s a good answer to what values the therapist should—what role they should play. I think that it really depends on the situation.”
- “I think that [therapist values] could directly be involved in a helpful way under certain circumstances, I guess. And, I think it would really depend on what the therapist’s purpose was.”
- “I . . . feel fairly comfortable depending on what it is they’re trying to figure out. So there probably would be scenarios that I would want to . . .”
- “You know, it might depend on how I feel about the person as a person . . . and also how long we’ve known each other.”

This answer was given so frequently by some participants that one said, somewhat apologetically “Oh, you’re getting the classic answer again: it depends. But it [really] depends.”

Value Decisions Grounded in Perceived Situational Needs

Value decisions appeared to be grounded in the particular context of the therapy and were clearly situational rather than universal. Unlike rule-like statements which seek to set forth universal guidelines for handling particular situations, the guidelines participants used in making value decisions were consistently seen as grounded in the particular context of therapy, with strategies or views differing according to several situational factors. For example, after explaining how they might view value differences or how they would handle them, participants would then sometimes qualify those statements by adding that that wouldn’t necessarily apply across all contexts. For

example, after stating predicted courses of actions, participants added the following statements:

- “Well, I guess it’s situational but in general I don’t counteract that.”
- “I think, yes, I would intervene, but kind of like in all the other situations I would only sometimes intervene and most times I would do so non-directly.”
- “There would be times and can be times where that might not be helpful to the client, so I wouldn’t say that that’s an all of nothing thing. However, that is my preference to do so.”
- “I wouldn’t want to just do it across the board, but in some cases I think I would.”
- “In a general sense that’s exactly what I would say; I think there are probably exceptions to that.”
- “I think that is true most of the time. I’m not going to say 100% of the time because I think it does depend on the situation.”

In these statements, it’s clear that participants felt that their general response might not be true in particular situations, suggesting that it is largely the situation that determines the best course of action. It may be for this reason that several participants preferred to discuss principles of values in terms of particular situations, or examples. A fairly common response to a question about values management or a value-related dilemma was to give either a real or hypothetical example and then to explain how they would handle that particular example. A few participants asked for examples before answering questions, one saying “I guess I need an example (in order to answer the question)” and then replied by referencing elements of that particular situation.

Interestingly, a few participants made statements suggesting that they would handle a general situation one way, but then talked about handling it differently in more concrete situations, examples that were generated sometimes by the participant and sometimes by the researcher. One participant, who largely answered the questions by references to her own therapy experiences, explained why she found it more constructive to refer to examples by saying, “Examples are helpful because when you ask me questions, I try to think of a context, because values are so, not vague, but you need specific situations.” Clearly, for this individual, value-related discussions need to be tied to particular contexts, because the specifics of those contexts would determine the action taken. This suggests that for these individuals, value decisions are contextually based, rather than made according to a priori rules or guiding principles.

Value Decisions Based on Underlying Value of Beneficence

If we acknowledge that values are grounded in specific contexts, the question still remains as to what factors or values inform those contextually based decisions. In other words, what criteria do participants use in making value-related decisions, and on what deeper values or commitments are they based? The participant quoted above who felt that “you need specific situations’ in talking about values, spontaneously added the following comment about her process of decision making: “I think I figure out where I am in relation to my client and then what interventions do I need to do to make it the best process for them.” In other words her therapeutic decisions are based on what produces the “best process” for the client. Another comment, previously cited, reflected a similar idea as a participant explained why she discusses personal values around education with her clients. She said, “I would bring up what’s best for the patient and I think that in

general, education is what's best for the patient." Here, too, the therapist suggests that therapeutic interventions are made on the basis of "what's best for the patient." Hints of similar reasoning are evident in the following statements made by other participants:

- "As it's therapeutically helpful for the client, [I would make] it explicit what it is that we're potentially in conflict about.
- "Yes, [I would share my values] to a limited extent, if I thought it was going to be therapeutic."
- "I don't think that it's helpful to disclose that."
- "If you still can't work though [the value conflict], I don't think that's therapeutic for the client, and it may be best to see if someone else can take that client."
- "There may come a point where I would decide that it would be therapeutic for the client to know that that was my value...."
- "I might feel pretty strongly that what they're doing might not be as healthy as it could be; hopefully, as we talk . . . they might come to realize that there might be a more healthy way to deal with it."

A large majority of participants, in fact, made direct references to judgments about what is therapeutic, helpful, or healthy for the client and it was clear that these judgments are what guided their decision making process. As one participant stated, "Ultimately, we want them to get better—whatever better means for them."

Participants also made direct reference to the established principles of nonmaleficence and beneficence, saying, for example, "Maybe one governing principle would be "do no harm to the client"— [that] would be the first thing," and "I think that our one rule is to do no harm: nonmaleficence and benevolence." Thus, in both formal, rule-

like statements and in informal judgments of how they might proceed in therapy and why, participants clearly displayed an underlying priority on helping the client and avoiding harm to the client. That this value is foundational to other therapeutic values is suggested by the consistency with which participants said that it was acceptable to influence a client to change their values if the existing value was unhealthy or harmful to the client – in these situations, the value that participants placed on benefiting the client trumped the value that they placed on respecting client beliefs.

Value Decisions not Guided by Firm Rules

It appears that as participants are making therapeutic decisions related to values management in session, they are informed in part by general rules of the profession to do no harm and to benefit the client. Further, as mentioned earlier on, the consistency with which they reported wanting to respect client values and not impose their own suggests that this also may serve as a well-formulated rule to guide therapeutic judgments. Beyond that, however, participants seem generally to apply those rules in more specific ways on a case-by case basis, according to what they feel will be most helpful, beneficial, or therapeutic for the client. While individual differences clearly existed, with some therapists more likely than others to self-disclose, for example, or to seek supervision, it doesn't appear that any one therapist used the same strategy in all situations of value differences, and it doesn't seem that therapists in general made decisions on handling value differences according to firm established personal guidelines. Rather, it appears that they maintained some degree of flexibility, adjusting personal strategies to the needs of particular clients and particular situations as appropriate to most benefit the client.

Although most of the participants had no trouble describing how they might handle specific hypothetical situations (or how they had handled actual experiences in the past), it seemed to be much more difficult to articulate the general rules or beliefs that those actions were based on (aside from the desire to not impose personal values). For example, one participant was explaining why he chose to disclose his personal values to his client and what function that disclosure served in therapy and noted, "It's interesting because I haven't necessarily thought through all the reasons why I was doing it, but it seems like it was in order to" Clearly, he had chosen to self-disclose because he felt it would be helpful, but hadn't articulated before exactly why he thought it might be helpful. He also added later, "So let me clarify, now that I'm actually talking this through out loud," suggesting that although he had thought through some of the issues in general, he hadn't put them into words previously. Another said, "I hadn't thought of it, but I guess I do [handle value differences that way]. That is exactly what I do." Again, with each of these individuals, it was not that they were ignorant of value-related issues; in fact, the examples of value differences they provided showed extensive considerations of the role that values were playing in their therapeutic interactions with these clients and each of them displayed a strong desire to respect and accept the values of their clients. They just didn't appear to have chosen those interventions on the basis of any pre-formulated rules or strategies that were easily articulated. At some level, then, it appears that, for these individuals at least, their values management strategies were spontaneous responses to the perceived needs of individual situations, rather than a response to previously developed principles or rules. While this may be true for many facets of

psychotherapy, this finding underscores the contextual nature of values and the difficulty inherent in making universal statements about values management.

Discussion

In many ways, participants in this study reflected attitudes consistent with previous research. Like the professionals surveyed by Norcross and Wogan (1987) twenty years earlier, the vast majority of respondents felt that values were an inescapable part of psychotherapy. And like those professionals, they differed significantly on the role that they felt values should play in psychotherapy and on how to handle value differences that arose during the process of therapy.

General Observations about Underlying Values and Value Management

Concurrence and Consistencies in Underlying Values

While participants generally agreed on several points related to the role of values in therapy, there did seem to be some consistent individual differences among participants, and these general views about values seem to be related to the way that individuals handled value differences in therapy. Two fundamental beliefs or commitments seem to be apparent from the discussion on the role of values in therapy. First, participants seem to agree, at least in theory, that value-free therapy is not entirely possible. Second, they share a strong concern about imposing their values on others. This leads to an apparent conflict for these individuals: how to include values in therapy without imposing them unfairly onto the client. This tension ran through much of the discussion on value issues and led to some of the individual differences noted.

Interestingly, despite the differences seen between these recent graduates in the way they described handling value differences, several consistencies in underlying values were also noted. Some of these may seem obvious, but they are critical to evaluating how the stage is set for the value dilemmas that follow and to evaluating the training process

which led them to these points. First, participants all shared a concern for the well-being of their clients; the one thread that ran throughout almost all of their reasoning on value issues was the desire to help clients. Usually, this wasn't even explicitly stated, but apparent in comments like, "I just don't think it would be therapeutic to..." or "I felt in that situation it would be most helpful to. . . ." It was clear that participants just assumed that client well-being was the goal. The supreme value for these participants, then, was to act in a way that benefited clients. This in turn led to participants placing a high value on acceptance and respect for clients, with several participants communicating either directly or indirectly that they felt it was important to respect and show acceptance towards their clients. Although it was not openly stated, it was again clear that participants assumed that such respect and acceptance was beneficial for clients. It was this desire to be respecting and accepting that led students to be concerned about imposing their values on their clients. That is, in order to be respectful and accepting of clients and thus beneficial, therapists also felt they should generally show respect and acceptance for client value systems as well. They also shared similar values about the process of the development of client value systems, with freedom and autonomy seen as beneficial for clients and therefore necessary to protect in clients' decision making about values.

It is important to note that although therapists were clear on the fact that their personal values should not be imposed on clients, they were somewhat less clear on what that might mean in practical terms. None were asked to describe exactly what constituted "imposing," or to describe what it might look like in session; none were asked for a definition of "imposing one's values" either, so it difficult to assess exactly what was

meant by that term, but it was clearly considered harmful to clients. It was usually contrasted theoretically, as noted before, to respecting, honoring, or working within client values, as in “I would want to respect my client’s values and not impose my own,” and it was often contrasted behaviorally to open discussion, questioning, or exploring, as in “Instead of imposing my own values, I would want to discuss with them. . . .” It also appeared to be equated with being critical of client values, telling the client they are wrong or telling them what to do. Interestingly, many of the same individuals who expressed concerns about imposing values also felt it would be ethical, under certain situations, to influence a client to change their values, suggesting either that influencing a client for beneficial reasons is not the same as imposing, or that imposing is acceptable if client welfare is at stake. However, for the purposes of this discussion, the relevant issue is that participants universally shared an overriding belief that therapists must benefit clients by respecting and accepting their belief systems and by not imposing their own.

It is interesting, then, to notice the consistencies in what participants *didn't* do. As mentioned, they all shared the value that therapist beliefs should not be imposed on clients, with many expressing it in identical or nearly identical terms, forming what may be the only really well-formed rule or blanket statement in this area. Accordingly, none of the participants mentioned trying to convert clients to their way of thinking, some specifically saying that they would not want to do so even if they could, except in cases of clear harm to clients or society. None of the participants reported being openly critical of clients’ value systems, or telling clients that their values or opinions were wrong. None of the participants reported feeling that clients’ value systems were irrelevant or unimportant. None mentioned feeling that they either wanted to or tried to change values

that they saw as matters of individual choice, rather than issues of harm. More particularly, as we have seen earlier, matters of religion and sexuality seemed to be strictly off-limits for most therapists in training. It is telling, in fact, that the most common reaction mentioned when faced with a value difference was caution or concern, the most immediate emotion being not dislike or disgust or desire to change, but some degree of worry about being able to serve client needs ethically. In terms of the issues that are usually presented as concerns in diversity classes throughout graduate programs, then, it appears that graduates are getting the message.

Differences and Difficulties in Values Management

While respecting client values and autonomy was clearly seen as important, this strategy alone may not be enough to help therapists negotiate the often tricky dilemmas that arise in situations of significant value conflicts. One participant, quoted earlier, described an acceptance of diversity as only “half the lesson on values”. It may be helpful to examine again his statement on the relationship between diversity training and value training to better understand the difference between the two and the difficulties faced by therapists trying to negotiate practical solutions to value differences:

I think they had a strong emphasis on diversity and therefore the way that they handled it was that you ought to accepting of everything no matter what, which teaches half of the lesson of values. I think that being able to allow and validate the values of others is important, but they didn't do a good enough job in dealing with the aspects that are inherently value-laden in therapy. You do need to be able to understand how your own values come into play and how to deal with that. And I don't think there was any explicit training on how to interact your own values—whether they're similar or different—with the values of clients.

In areas of value management, it appears that graduates are a little more divided in both their experiences and beliefs. Although agreeing that therapist values play a role in

therapy, for example, they differed as to what role therapist values should play, with several suggesting that the main goal with regards to values management is to minimize the role of therapist values and others saying that therapist values should be openly included to maximize benefit for the client. What participants do to manage values differs as well; therapists varied considerably in their use of disclosure of personal values, for example, and in the reasons they cited for utilizing it. They disagreed on many dilemmas related to values management – whether it is ethical to influence a client to change their values, for example, and under what circumstances.

Further, there don't appear to be many rule-like statements or guiding principles to assist trainees in negotiating these issues – although trainees are aware that they should not impose their own values, they are left with little guidance as to what actually to do with those values in session. And it is telling that the most frequently cited weakness or deficit in their graduate programs lay in not being taught “the practical aspects” of managing values. Several, in fact, said that diversity training either focused on learning *about* individuals with different values, or on developing awareness of their own values, but not on knowing what to *do* with clients with different values when one becomes aware of the conflict.

Conflicts between Underlying Values and Value Management

Examining both the similarities and differences among participants in values management points to three fundamental contradictions in the way values are discussed and handled, both in graduate training and in the field as a whole. These contradictions appear to run throughout the discussion and reasoning on value issues. First, as noted earlier, nearly all of the participants acknowledged the inescapability of both client and

therapist values as driving forces in therapy. Still, they held that therapists should not impose values and it was clear that the vast majority of the discussion on values management was oriented towards the goal of minimizing the influence of therapist values in therapeutic interactions. Both of these attitudes appear to be central themes of training programs' education on these issues, but they appear to communicate a mixed message. That is, although trainees are made aware that their own values are inescapably intertwined with therapy processes, they are simultaneously encouraged, either directly or indirectly, to remove them from those encounters. It is possible that this simultaneous acknowledgement and denial of the influence of therapist values interferes with the development of "practical" strategies for managing personal values and with knowing how to integrate personal values into therapy in helpful ways. At any rate, it is clear that between the general agreement that therapy is not value neutral and the injunction to not impose one's own values lies a large gap regarding what to actually do with one's values in therapy, and it is within this conceptual gap that therapists must do much of their work. Psychology graduates, and likely psychologists in general, appear to be essentially left on their own to negotiate this conflict.

Similarly, participants were quite familiar with the injunction to avoid imposition of personal values and were equally well versed in the ethical obligation towards beneficence. However, there is little guidance in how therapists should negotiate situations in which these two principles conflict, so participants appeared to craft their own personal solutions that best addressed their perceptions of these ideals. Clearly, a blanket commitment to respect the values of clients does not account for several common scenarios in psychology practice, with which trainees are surely familiar. As an extreme

example of this conflict, psychologists are not only allowed but expected to violate client values when such values lead clients to self harm—the familiar duty to protect. In these cases, client autonomy and freedom to choose may be severely restricted when it is deemed in the best interest of the client. However, other less extreme examples abound of situations in which the values of the client are overridden by those of the field of psychology, all of which are seen in the field as morally acceptable. One such instance is seen in the ban on reparative therapy for homosexual clients and illustrates how, even when clients seek such therapy for value-related reasons, therapists are expected not to endorse that value system and encouraged to offer their own as an alternative. Similarly, therapists are not taught to respect the value system of forensic patients when those value systems lead to criminal behavior. For example, none of the participants appears to feel that it was unethical or immoral to attempt to alter the value system of a child sex offender, even when such a shift was not desired or sought by the offender. Similarly, most participants felt it might be morally acceptable to attempt to influence an anorexic client to adopt healthier values. In all these instances, the values of the therapist are essentially being imposed on the client, yet the imposition is seen as acceptable.

Situations in which counselors are expected or encouraged to impose their own values communicate somewhat mixed messages to trainees about values management. On the one hand, trainees are to respect others' value systems, and on the other hand, they are expected to violate them in situations of harm, although usually the issue of value imposition is not directly or openly stated or addressed. This contradiction would be relatively benign if situations of harm were clear cut, but in fact there are no clear guidelines on what constitutes sufficient harm to justify a therapist-driven intervention in

the problematic value system. Most therapists would agree that extreme situations, such as those described above, merit intervention even against client wishes; most also would agree about a variety of non-problematic values on the opposite end of the harm spectrum that do not require intervention. But there may be a substantial number of situations that fall more in the middle of the range, where therapists may demonstrate less agreement. Again, individual trainees and psychologists are left to navigate these cross-currents of value-related reasoning essentially on their own.

A third contradiction lies in the ways in which therapists' values are portrayed and discussed. Most of the participants, in discussing the role of values, either felt that therapist values should be minimized in session or at least assiduously monitored to avoid unfair imposition. Clearly, therapist values were seen as posing a threat to client autonomy. However, the vast majority also felt that a value difference with the therapist may be helpful for the client and many described various benefits. If therapist values are in fact beneficial, then why would the field so diligently emphasize keeping them out of therapy? It appears that the field also communicates somewhat mixed messages about whether therapist values are beneficial or harmful to clients and thus about whether it may be most helpful to include or exclude them. Again, individual therapists are then left to figure this dilemma out in ways they feel are personally appropriate or helpful.

Additionally, some participants suggested that many of client concerns are value-related and thus an improvement in the presenting problem is not likely without some change in the underlying value system that is contributing to the pathology. If this definition is accepted, then it might seem somewhat strange to suggest that clients should come out of therapy with no change whatsoever in their beliefs about good and

appropriate ways to live their lives. Clearly, a value differential might be helpful in these cases to move clients towards beliefs and values more consistent with positive mental health. However, rarely did participants mention using that differential to benefit clients, except when directly asked if value differences could be helpful. In other words, while therapy at some level was conceived as helping clients to make changes in fundamental beliefs, participants still felt hesitant about explicitly using a difference between the counselor and client to drive those changes. This suggests that, although most stated that there were ways in which therapist values could be helpful, as a whole therapist values were still perceived as more of a threat than a boon in therapy.

It appears that value-related issues in therapy present conceptual contradictions in many ways, and trainees are left with considerable leeway to craft personal solutions as to how to best interpret and enact the sometimes conflicting values of client beneficence and respect for client autonomy. It may be the lack of tightly formulated guidelines in this area that leads to the wide range of individual differences noted in how participants handle value conflict situations, despite sharing considerable similarity in core values. Several of the key elements of these contradictions are seen throughout both the general reasoning about value-related issues and participants' reports of how value differences are managed in session.

Specific Observations about Findings

Findings about Value Management

Given the backdrop of sometimes competing value systems and conceptual complexities, it is instructive to observe how recently graduated therapists go about their work. Participants described several different strategies for managing value differences,

the most common strategies being were awareness, supervision, and exploration or clarification of values. It appears that at least some of the time, these strategies are intended remove the influence of therapist values from therapy, although other functions were served by these interventions as well. Further, several contradictions were noted in the way participants describe handling value systems and their other views in the role of values and the impact of value differences. Further examining how value differences are managed in session, including when therapists impose their own values, bring to light some of these contradictions.

Interventions often intended to remove therapist values from therapy. Many of the strategies used, when examined more closely, had some element of protecting the client from the harmful encroachment of therapist values. The main goal of these strategies seemed to be avoiding the imposition of therapist values. This was particularly true for the strategies of personal awareness and value exploration, but several other strategies were also described as helping therapist to avoid imposing their values.

Awareness is, perhaps, not really a strategy, as it is not so much something that therapists deliberately do in response to a particular situation as it is an activity done in preparation for multiple situations. However, so many participants mentioned it in response to questions of how value differences are managed that it seems appropriate to include it in the discussion. As mentioned earlier, awareness appears to function as a guard against imposing ones values, as seen in the statement of one graduate who said, “I try to be aware. Being aware of the fact that we might have differing values would allow me to not push it on them.” It is likely no coincidence that many of the participants also mentioned that their programs placed significant emphasis on their students developing

self-awareness as part of learning to handle value differences in therapy. Awareness was also mentioned by a few of the participants in evaluating the dilemma of whether counselors should be required to work with individuals with significant value differences; several felt that the hypothetical practitioner in question be allowed to not see the student but receive training to increase self-awareness, suggesting that awareness served almost a remedial function that would help practitioners develop the skills necessary to work with these individuals.

Most participants did not state exactly how they saw self-awareness assisting practitioners to work with clients with different values or to avoid imposing their own values. It appears from their statements that participants felt that awareness of their own biases allowed them to remove them from the therapy session, while values that they were unaware of might not be as effectively eliminated and thus exert their influence covertly. One function that was not explicitly mentioned but which might logically follow, however, is that awareness of biases is a necessary first step towards deliberately eliminating those beliefs. It appears that at least some of the awareness training described in graduate programs may have been in part an attempt to eliminate biases against diverse groups. Thus, trainees may have felt that self-awareness was helpful in eliminating biases which would interfere with the more global values of respect and acceptance. Whether self-awareness is seen as removing biases or simply allowing them to be more carefully guarded against in therapy processes, it still functions as a way to reduce the influence of therapist values in therapy, opening the door for more neutrality on the part of the therapist. The idea that awareness is a fundamental piece of value management

underscores the perception of therapist values as a negative influence or threat to client autonomy or freedom.

Another commonly used strategy was to discuss or explore value-related issues with the client, and interestingly, this was sometimes described as an alternative to imposing values as well. Nearly all participants mentioned some form of discussion, exploring, values clarification, or questioning process, which is probably not surprising since discussion is the medium through which therapy is conducted. What is intriguing is that different participants described this process in slightly different ways, and the different emphases they place on this intervention seem to reflect different motivations for using it. For example, value exploration was described by one therapist as a sharing of personal beliefs back and forth, coming to a new value through the dialogue that was “sort of an emergent property of the two.” Another viewed it as an “honest sharing of personal reactions.” In both of these descriptions, the therapist’s values are clearly interwoven throughout the discussion, although in a way that allows the client to disagree. More commonly, however, the process of values exploration was described as raising and discussing alternatives; as the creation of a space for the client to explore possibilities within their own value system, unencumbered by external pressure; or as a process of clarification in which therapist questions help clients to arrive at their own personal truths, a Socratic kind of coming to knowledge without the intrusion of therapist agendas or beliefs. In these latter descriptions, most often the therapists’ values were not seen as relevant to the process and sometimes were deliberately excluded.

The underlying element in all of the descriptions of value exploration is the absence of external force and the space allowed for personal freedom. Although some

therapists would present their own value systems as part of the discussion, most wouldn't, or would merely present it as an alternative that some people believe, rather than identifying it as a personal belief. For those who made specific reference to keeping their personal values out of the discussion, clearly, the intent behind this withholding was to avoid exerting pressure or influence over the client. This appeared to be another attempt to minimize personal values and maximize client autonomy and perhaps was in some sense a further attempt at neutrality on the part of the therapist. Even with an ostensibly unbiased exploration of values, however, value neutrality is not likely to occur for at least two reasons. First, the very questions that will be raised and the responses to them will stem from the value system of the therapist and will not (and cannot) reflect positions chosen at random from all possible positions on the subject. For example, true neutrality would require that when an adolescent client comes in to discuss educational and vocational options, counselors present not just college or trade school as options, but also dropping out of school altogether, welfare instead of work, and dependence on others instead of self-sufficiency. These latter options, of course, are ones that counselors typically don't present because they fall outside of their value systems. Instead of presenting a truly neutral array of options, the alternatives raised by the therapist tend to be those that are least somewhat consistent with either personal or societal values and thus are not truly neutral after all. Also, one participant noted that he asks fewer questions when a client presents with a value system he agrees with than when one comes up with which he disagrees, so the very decision to open a dialogue about values might itself be value-laden. While many therapists feel these dialogues to explore or clarify values are

useful in helping their clients to understand and develop personally meaningful values, they are still not necessarily neutral with regards to therapist values.

Several strategies other than awareness and exploration also contained elements of protecting clients from the harmful influence of therapist values, at least some of the time. For example, one participant said that she seeks supervision in situations of value differences in order to provide “that check and balance to make sure that I wasn’t imposing my values on the client.” Even self-disclosure, often seen as more threatening to client autonomy than other interventions or strategies, was described by some as a way to make the value difference explicit and thereby protect the client from an “under-the-radar push of my values.” Similarly, referral of a client due to value differences was seen as ethical when it was done to protect the client from the influence of therapist values—the most extreme form of removing therapist values from therapy. Although both supervision and self-disclosure served many other functions, it is interesting that so many of the strategies mentioned in dealing with value differences had some element of trying to eliminate the influence of therapists’ values on the client.

A question that necessarily arises, of course, is how best to accomplish the goal of respecting client values. This question brings up an interesting dichotomy that ran under the surface of several discussions, which is the tension between genuineness and authenticity on the one hand and concealing or hiding personal reactions in order to protect the client on the other hand. Several mentioned deliberately trying to conceal personal reactions – one noting that it was a good thing she had a good poker face. In contrast, others felt that being respectful to the client demanded that they be open and authentic. In both cases, the decisions to conceal or to reveal personal feelings were

intended to improve the therapeutic experience for the client. For example, one participant refrained from making value difference explicit in order to “maintain a womb-like context” of safety for the client; another felt that not acknowledging differences would not allow for the kind of honest exchange necessary for therapeutic progress. However, the junctures at which one course of action might be preferable to the other were not generally addressed.

The finding that many value management strategies are an attempt to protect client autonomy and reduce imposition of therapist values is consistent with Fisher-Smith’s (1999) research. She found that, although practitioners had different methods of dealing with values in therapy, the underlying value for both those who attempted to be neutral and on those who disclosed personal values was on preserving client autonomy and freedom. Like the therapists in her study, the participants in the current study seemed consistently to imply that the goal of value management strategies was to keep therapist values from unfairly influencing clients.

Value management strategies serve multiple functions. Purposes other than maintaining client autonomy were mentioned participants in connections with their value management strategies, and some of the strategies were more inclusive of therapist values. For example, supervision was described by some as being helpful in negotiating the interplay of differing values in session, and the exploring process for others was inherently laden with both client and therapist values in a meaningful interchange. Similarly, the interesting strategy of looking for common ground was inherently based in therapist value systems and was not even something that was made explicit with the client – none of the therapists made mention of bringing this process to the client’s

attention at all. Clearly the goal for that strategy was not to attempt to remove the therapists' values from the session. It would be wrong, then, to assume that all responses to value differences were intended to remove therapist values from therapy.

For at least half of the different strategies mentioned that were used to deal with value differences, several different reasons were given for using them. They seemed to serve different functions, depending on the individual implementing the intervention and the individual situation. No one strategy was seen as applying to all or even most situations of value differences (with the possible exception of awareness, which functions differently than the others). This variability underscores the difficulty of trying to make prescriptive statements about how value differences should be handled. For example, almost all participants who indicated that they would make value differences explicit qualified that by saying they would not do so in all situations and some gave several reasons for that action that might apply differently in different situations. Thus, even providing practitioners with a "tool bag" of interventions or strategies is an incomplete solution to the problem of value differences, because no one solution seems to apply across the board.

Unlike the participants in Fisher-Smith's (1999) study, some of the participants in the current study also mentioned including their personal values in the therapy not solely to protect client autonomy, but also to be genuine and authentic, which was seen as beneficial to the therapeutic relationship. It is interesting that several participants directly referenced the threat to the relationship stemming from value differences in saying how such differences might be harmful, while others directly stated that they made value differences explicit in order to strengthen the relationship.

Value management inconsistent with stated positions on other topics. It is also interesting to note what was not mentioned in the discussion of strategies for addressing value differences. Recall that each participant was asked to describe one or more real-life situations of value conflicts in their everyday work. They were also asked to describe in general terms the strategies used for value management. Their responses on these questions were then compared to their answers on other questions such as the role of values, the consequences of value differences, and the reasoning used in deciding appropriateness of influencing client values. In several areas, their descriptions of values management showed at least some inconsistencies with their stated beliefs in these other areas.

Nearly all therapists said that they felt that a value difference could be both harmful and helpful. In light of this consistent finding, it is interesting that few of the therapists, when asked how value differences were handled, mentioned trying to find ways to bring their own value systems *into* the session to benefit clients. Instead, the focus was largely on trying to keep them *out* of the session. If therapists truly felt that their value systems might be helpful to clients even when they were different, we might expect therapists to respond by saying something along the lines of, "Well, at some point, I would examine my own value system to see if there might be something that would be beneficial for the client to be exposed to and then I look for how I could introduce that in helpful ways." None did. It is likely, given other responses, that that is in fact a process that some go through at least some of the time (such as the examples of therapists working with individuals whose drug use is harming them), but that was never a strategy articulated as a way of managing value differences.

Most of the participants also either directly or indirectly made reference to specific criteria they would use in deciding whether to influence a client to change their value system, with most saying they would try to influence a client to alter their value in situations of harm. However, when asked about strategies for managing value differences, participants did not generally report evaluating whether the clients' value was harmful to them before choosing how to proceed. That fact may lay in the contextual nature of reasoning on value-related issue; that is, the apparent harmfulness or helpfulness of the value is already wrapped up in the value itself, an assumption that participants bring into the very recognition of the value difference, and so it is not explicitly stated. But it does seem interesting that, for example, one respondent said early on in the interview, in the context of a discussion on the role of therapist values in counseling, that "If it's not hurting them or someone else, I don't make too big an issue of it," and then later, when asked how he handles value differences as they arise, makes no mention of evaluating the harmfulness of the value before describing steps taken to protect it. It may be that what sounds like a criteria used in evaluating the need for intervention (the "if . . . then . . ." statement) was in fact more a post-hoc description of why participants engaged in certain actions rather than others, generated for the purpose of the research, than any well-articulated rule that runs through participants' decision making.

Value imposition acceptable in situations of harm. The question about whether it might be appropriate to influence a client to change their values brought intriguing answers, as it asked participants essentially under what circumstances it might be acceptable to violate the strongly-held value of client freedom. Participants frequently had some criteria in mind (often mentioned in passing in response to other questions) for

deciding when it was appropriate to intervene in therapy with the intent to alter a client's value system and these criteria were almost always related to the perception of harm for the client or others. This brings up an interesting dilemma for practitioners, who, as was discussed earlier, place a high value on respecting client autonomy and freedom and yet have a larger value on client beneficence.

In general, as might be expected, the more clear and immediate the danger, the more therapists were willing to sacrifice client self-determination in favor of client well being. Of course, there is precedent for that in the field in extreme cases of danger, such as suicide and homicide, in which client freedom may be all but completely overlooked during the period of crisis. Undoubtedly participants are aware of these situations and the reasoning behind them and these may have informed their own reasoning. However, in situations where danger was less extreme, participants seemed less comfortable in imposing personal values, and in situations that many likely would have found offensive but not harmful (such as racist remarks or a lack of social responsibility) some respondents felt it necessary to tie these to harm in order to feel comfortable about intervening.

The findings from this group of graduating practitioners, in fact, echo many of the findings of the expert practitioners interviewed by Williams and Levitt (2007), who found that these experts were generally willing to intervene in value systems which they felt were deleterious to the client, but that the definition of what constitutes harm was much narrower for some of these experts than for others. They further noted that the evaluating the junctures at which intervention might be appropriate is not overtly discussed in the literature, and the generally hesitant style of responding from the

participants in the current study may have been a reflection of that lack of formal discussion on the topic.

While most therapists felt that it was acceptable to intervene in situations of client harm, the next question, of course, becomes the issue of how narrowly or broadly to define harm and whose values to use in making that definition, as both health and harm are themselves value laden concepts (something, by the way, that was directly addressed by few of the participants citing client harm as their criterion for intervention). The examples given earlier of three female therapists' perspectives on female clients' educational decisions illustrate this point nicely. Does dropping out of high school constitute sufficient harm that a therapist is justified in using more directive methods? One of the three felt it was, stating explicitly that her clinical rule is to do whatever is in the client's best interest and that, because she believes that education is in a client's best interest, she was comfortable with directly stating her value and attempting to influence her client to stay in school. Two others felt it wasn't, taking care to *not* state personal values or beliefs in the discussion. Clearly the decision of what constitutes harm is a personal one and the decision to intervene or not intervene based on the perceived danger to the client is an inherently value-laden one.

Particular value conflicts managed differently than others. Participants indicated less willingness to intervene when the value in question stemmed from membership in a particular religious or cultural group, particularly when it was one that the participant did not share. This suggests that the general rule of intervening to avoid client harm is likely to be stretched a little further when the harm seems to stem from a faith system or cultural background. For example, one therapist described earlier reported feeling

conflicted when counseling a member of a religious group that had split from his own, in part because he felt that in his words, “some of the things that she did, that she didn’t think were wrong, I thought were, and maybe not even healthy for her as well.” While therapists might usually be inclined to intervene with beliefs that were perceived as unhealthy, in this case the beliefs were stemming from religious beliefs that he did not share but felt ethically obligated to protect, creating a moral dilemma as he proceeded to treat her. Here, again, the value on respect and acceptance of client beliefs conflicts with the value on client beneficence; however, because the client beliefs occurred within the context of a faith system, the therapist was willing to allow the client to retain even those beliefs he considered unhealthy.

This brings up the interesting possibility that not all values or value conflicts are handled equally by therapists- that is, therapists may be more willing to intervene with some values than with others. For example, in the real-life examples of value conflicts generated by participants, religion was frequently seen as a source of value difference and in none of the examples did the therapist attempt to change or alter the clients’ religious beliefs; instead, they generally tried to understand the clients’ beliefs and present the therapy in a way that was consistent with those beliefs. With other examples mentioned, such as abuse, different parenting values, and racism, there was often either a direct or indirect assumption that the client would benefit from changing the belief and therapists generally acted differently as a result.

Differences in value management among different situations of conflict were not just related to individual differences between therapists. Several individuals gave multiple examples of value conflicts, including some in which they took a more directive

approach to change a value system and others in which they did not. For example, the participant who conducted therapy with the Wiccan priestess tried to incorporate her client's beliefs into the therapy and did not express disagreement with those beliefs. The same participant, however, also related a situation with a man she worked with that was harming animals and in his case, she openly tried to alter his value around those issues. That may be an extreme contrast, but it does illustrate the possibility that participants feel that certain values are off limits (which, in this study, appeared to include religion and sexuality), while being willing to intervene in other cases of value differences (particularly those which impact society or mental health functioning).

Intervening in some value systems but not others is essentially putting into practice the suggestions of Strupp (1980) and Tjeltveit (1986, 1999) that practitioners may ethically intervene in areas which relate directly to the counseling process but not in areas which lay outside that domain (including religious or political values). Along with bringing up the philosophical arguments against value atomization, however, this dichotomy also brings up the practical dilemma of whether to intervene in situations in which changing mental health values would also impact religious, moral, or political values. Still, it might be interesting to investigate further whether practitioners do in fact treat a certain subset of values differently, and if so, which types of values are seen as protected while others are not and why.

Therapists hesitant about role of personal values despite seeing beneficial consequences. The dilemma of whether to intervene in a client's value system also addresses the core issue of how we view the role of therapist values in counseling. Essentially, it raises the question of whether therapists' primary obligation with regards

to values is to protect the client from the influence of the therapists' values, or whether their job is to use their own values in service of their clients. It also illustrates the dilemma that is created when two of the field's core values—those of respect for client freedom and client beneficence—collide, so that it is not possible to preserve both at the same time. Clearly, for these participants, client beneficence trumps other ethical concerns.

Throughout the interviews, it was clear that at least in some cases, practitioners do see their value systems as better for the clients than the clients' own values. This suggests that part of a therapists' role is to use their own value system (at least those values which reflect the general values of the field) to benefit their clients. It is interesting that nearly all of the participants recognized ways in which their value systems may be helpful, yet much of the discussion of values management centered on removing values from therapy and focused on the threat that therapist values may pose rather than the benefits. It may be that much of these graduates' training with regards to value differences focused on the negative aspects of value differences; this would be consistent with participants' descriptions of training in these areas. It may also be that value differences that were seen as positive were seen as falling under the umbrella of therapeutic responsibilities and so not readily identified by participants as value differences.

In retrospect, it is likely that their responses to that question were shaped in part by the way the question was phrased. Asking whether value differences are helpful or harmful encourages participants to think of ways in which they may be both; a better question might have been to discuss the consequences of value differences in therapy and then look at whether those consequences given reflected a positive or negative outcome.

It is significant, however, that nearly all respondents described, either directly or indirectly, ways in which value differences could be both harmful and beneficial.

Reactions to Value Differences

Overwhelmingly, graduates did not express a preference for seeing clients with either similar or dissimilar values, and when they did, they generally preferred to see dissimilar clients. These findings are opposite those of Teasdale and Hill (2006), who found that therapists in training strongly preferred to see clients with similar attitudes and values and preferred not to see dissimilarly valued clients. Some of the difference may be due to social desirability effects, as graduates might feel that it is less acceptable to prefer clients who are similar to them given the emphasis on diversity in most graduate programs. This is somewhat supported by the way in which participants expressed their feelings – the one who said she preferred similar clients did so somewhat apologetically, saying she “secretly preferred” to see clients who were more similar to her; in contrast, no one said that they “secretly preferred” to see clients who were more different. Further, the mode of data collection differed between the current research and Teasdale and Hill’s study—while the current research was interview based, Teasdale and Hill used paper-and-pencil instrument, which would be less likely to elicit concerns of social desirability.

As several participants mentioned, not all value differences elicit the same reactions. In fact, several participants made reference to the idea that even when some values are different, there are usually others that are similar and vice versa, so that value differences are expected with each client. In looking at participants’ feelings towards their clients with whom they had value differences, it is significant that the only ones that that really bothered them, generally speaking, were those who had significantly different

views about acceptable human interactions and relationships. Thus, not all value differences were seen as equally attractive or equally disturbing. In fact, as one participant noted, even when the apparent value system is offensive (this particular participant made reference to the values underlying a popular cable TV show), looking for points of similarity underlying those values enables sufficient connection to engage the client in meaningful discussion. It is possible, then, that participants' discussions about their reactions to value differences depended in part on the value difference they were thinking of. However, it is significant that in general, participants did not report either disliking or avoiding seeing clients with different values.

Training Issues

Trainees evaluate training dilemmas differently than programs. The issue of therapists avoiding therapy with clients with different values, of course, is at the heart of the value-based dilemma that led to the current research via the Counseling Psychology training directors' listserv discussion reported by Mintz, et al. (in press). In that discussion, training directors reported that some graduate students *did* want to avoid seeing clients with dissimilar values; it is interesting that the responses of the participants in this study generally supported that action but for very different reasons than those given in the original listserv discussion. The general reasoning on this issue by participants in the current research was quite different than that presented by the training director who made the original post. In the original discussion, the argument that students should be allowed to refuse to work with certain clients was based on these students' religious rights, while the argument that they should instead be required to work with these individuals was based on the values of counseling psychology to "to serve

culturally diverse clients including gay/lesbian/bisexual clients.” This implies that when the focus is on benefiting clients, students should be required to treat the client with whom they have a value difference; conversely, when the focus is on benefiting the trainee, they should be allowed to refer that client as an expression of their religious rights.

Participants in the current study did not cast the dilemma in those terms at all. Neither trainee rights nor the values of counseling psychology figured prominently in participants’ reasoning on this issue in the current study, at least not explicitly. Instead, the argument that students should be allowed to refuse to work with certain clients was based almost exclusively on the potential for client harm, and the argument that they should be required to treat these clients based on the value of the educational experience for the student. Put more succinctly, providing treatment to clients with significant value differences is seen as beneficial for the student, but potentially harmful for the client. Thus, as they reasoned, when the focus is on benefiting clients, students should be allowed to refer due to value differences; when the focus is on benefiting trainees instead, they should be required to work with different clients in order to strengthen therapeutic skills. This may be an over-simplification of the positions expressed; for example, it is quite possible that the training director in the original listserv discussion had the training value of seeing diverse clients in mind when he presented the values of the counseling psychology profession as an implied argument against allowing students to refuse clients. However, it is clear that the participants in this study were weighing the value of the educational experience against the potential for client harm in evaluating this dilemma and other considerations were secondary.

It is important to recognize that, although the duty to protect the client outweighed the educational value for many participants, nearly all participants recognized the educational benefit of seeing clients with different values, and many spoke of how such experiences had helped them both personally and professionally. It is also interesting that few of the participants, in discussing their personal experiences, made reference to the potential for client harm – that is, in general, they did not feel that holding a different value system than their own clients was harmful for these clients. It is also important to point out that just because participants tended to prioritize client protection over training considerations did not mean that they were generally supportive of having trainees refuse clients – in fact, many were quite critical of that choice, or expressed concerns about professional competence. They were equally critical of anything that implied force or coercion, as the word “require” did for many, and some felt that having an unwilling therapist provide treatment was not beneficial for either the therapist or the client. Thus, participants felt that, ideally, trainees should be willing to treat clients who are different from them, but that they should also be allowed to refer clients when to do so appeared to be in the client’s best interest.

Two other points are relevant in examining how participants resolved this hypothetical dilemma. One is that those who discussed the perceived motivations generally did not attribute motives of bias to the hypothetical students who expressed a desire not to see clients with different values. In fact, many participants seemed to feel more comfortable casting it as a competence issue, and several made reference to established guidelines which recommend referral when a presenting problem falls outside the boundaries of a therapist’s competence. Others also made reference to the idea that

therapists already refer on the basis of diagnosis, suggesting that referring on the basis of value dissimilarity may be similar. It may be that participants preferred to cast the issue as one of competence because these familiar situations provided a helpful heuristic for solving this problem, or it may be that they had difficulty assigning motives of bias to student therapists because their experience with student therapists (including themselves) provided contradictory evidence for such an attribution. The fact that they were more likely to see licensed practitioners operating out of bias might provide support for the latter.

In the real-life cases of client referral on the basis of value differences, the training programs generally seemed to agree with the views of participants, but not always. For example, based on responses of participants, it seems likely that they would agree with the participant who felt that his supervisee needed to be pushed to work with clients outside of her ethnic group, although she had expressed a preference not to. However, the religious student who felt that it was in the best interest of a client who was coming out to see a different therapist was essentially following a line of reasoning similar to those expressed by participants, but was told by her training program that such an approach was unacceptable. In this situation, it appears that the values of the training program and the values of the graduates in this study differed. It may be that programs place a higher value on the training value of seeing dissimilar clients, or that they are more concerned with encouraging personal values consistent with those of the field, including respect for sexual differences. Whether other programs share the views of this student's program is also not known.

Training programs lack practical training. Training programs play a critical role in helping students understand and work through value differences. The good news for training programs from this research is that most students seemed generally quite pleased with their training and felt that their programs had adequately prepared them to work with clients with different values. Most participants still had some suggestions for improvement, often centering on providing more practical training. However, very few expressed significant dissatisfaction with their training programs. Internships were much more likely to receive negative reviews with regards to value-related training, particularly those in community or hospital settings.

Overall it appears quite clear that graduate programs place a high value on respecting diversity and are teaching their students this value also. It seems curious, then, that a large number of students wanted more training in practical aspects of value management – that is, training aimed at helping students understand how to negotiate differences in session. This suggests that this area may be overlooked in graduate training. That lack may be due to the inherently contextual nature of value-related issues; as one participant noted, “Until you’ve had some of those experiences, its hard to wrap your head around what that might feel like and what it might look like,” making it difficult for programs to train students to handle value differences in the abstract, without the benefit of context to make the issues meaningful.

Another possibility, however, may be the emphasis on diversity itself. Going back to the participant who felt that teaching trainees to accept and validate the values of others was only “half of the lesson of values,” it is clear that, for him, the focus on diversity alone doesn’t teach the other half of the lesson, which is understanding “how to

interact your own values—whether they’re similar or different—with the values of clients.” In fact, in some ways focusing on diversity alone may impede the development of that other half. This participant went on to say that “I think the assumption was, ‘Diversity is good. Your values don’t matter because everybody else’s values have equal importance.’” If programs hold that therapist values “don’t matter” or are an impediment to providing adequate therapy, then it is not surprising that they would not place much emphasis on incorporating those values into therapy.

It is also instructive that when asked whether their training programs had prepared them to work with clients with differing values, a common response was to say something along the lines of “Oh yes, we had lots of training in diversity and multiculturalism.” In essence, a question about the adequacy of training around value-related issues was answered with a response about the quantity of training around multicultural issues. Clearly, several graduates equated quantity of diversity training with preparation for handling value differences. It is possible that their graduate programs shared the same belief. The fact that the most commonly noted deficit of training programs was the lack of practical training suggests that graduates wanted more education on what to *do* with both their values and the values of the client in session as they come up. Instead, they felt that their training focused more heavily on theoretical aspects of values, multiculturalism, and diversity.

If practical training is seen as lacking, it may be helpful to explore exactly how programs are providing training to their students on value-related issues. Although there were no interview questions about how the training provided directly prepared their students for dealing with value-related issues, several participants mentioned training

activities in this area that provide clues as to how training programs are addressing this issue. First, there appeared to be a significant focus in many training programs on helping trainees gain awareness of their own values. Several described having to talk through their own values and beliefs and discuss how those might impact therapy. In fact, the focus on awareness in many programs is likely related to the large number of participants who mentioned awareness as a vital strategy for managing value differences.

Additionally, several students mentioned multicultural classes as being helpful in contributing to this awareness. However, it should be noted that some students felt that their multicultural courses presented information about diverse groups, but not training on how to work with these groups, making the course somewhat less helpful for these students. The most beneficial piece of training in these areas, however, was often seen as the clinical work in which these principles were put into practice, including the supervision around these areas.

Reliance on supervision raises concerns. Supervision was mentioned as a key component of training by many, with several participants identifying it as one of the primary strategies for managing value differences. It might be appropriate, however, to note that many practicing psychologists don't have access to supervision and many may find that avenues for consultation are fewer after graduate school is over. Thus, supervision and consultation may be a less practical strategy for handling value differences among practicing psychologists than among students. None of the participants who mentioned relying on supervision to help them negotiate value differences addressed how they might handle these situations if supervision and consultation become less available as they progress in their careers, but it might be an appropriate point to bring up

with these individuals. Further, the efficacy of supervision in handling these issues seemed to vary. That has to be expected to some degree, of course, since supervisors' backgrounds, training, and personal values will differ, but it might be a concern to some graduate programs to note that some participants felt that they were more interested in understanding value differences than their supervisors. In fact, one of the most frequent recommendations for training programs was for supervisors to bring up value issues more with supervisees, rather than waiting for the trainees to bring them up – essentially, to be proactive in providing training on value issues to their students.

Programs may try to alter trainee values. One recommendation for training programs was for programs to model healthy acceptance of client values by showing respect for trainee values. While this recommendation was not a common one, it does raise the issue of how participants perceive their programs responding to trainees' values. Again, the data in this area are lacking simply because participants were not specifically asked about how training programs viewed therapist values. However, there are some clues that suggest that at least some programs may see at least some of their trainees' values as something of a threat to effective therapy. For example, several participants reported that their programs encouraged awareness of personal values. As has been noted earlier, the chief value of awareness for many participants seemed to be that awareness better enables therapists to suspend their values, or keep them from entering into therapy, suggesting that personal values are seen as somewhat of a threat. Further, at least one participant directly stated, and others indirectly implied, that students have perceived that programs were interested in altering their values as well as raising awareness of them. It is conceptually consistent that if acceptance of other value systems is a goal, it would be

helpful to eliminate values that interfere with acceptance, such as beliefs that other value systems are bad or wrong. After all, being accepting of a particular value is much easier when the value in question is not considered morally wrong. It would follow that training programs may have an interest in expanding the range of values that trainees find morally acceptable in order to increase the capacity for acceptance. This, then, leads to the pertinent question of how training programs manage the personal value systems of their students, while undergoing the process of educating these students in the values of the field.

It could be argued that graduate school is a process of acculturation as well as education, in that trainees acquire the value systems of the psychological fields through continued exposure to those fields. This has some support in the research of Jensen and Bergin (1988), who found considerable value similarity among psychologists, suggesting that, despite dissimilar backgrounds in many ways, psychologists agree on many fundamental beliefs about human nature, health, and pathology. The participants in the current research also show considerable value similarity with regards to fundamental mental health values. For example, participants universally placed a high value on respecting and accepting others, on benefiting clients, and on serving culturally diverse clients. It could be argued that part of the responsibility of graduate programs, in fact, is to help students acquire the professional values of their fields. One primary value of both counseling and clinical psychology, of course, is respect for diversity among our clients and accordingly training programs appropriately place an emphasis on helping students develop values consistent with that goal. In fact, in the discussion that followed the listserv debate on values described by Mintz, et al. (in press), “some argued that the

profession had a mandate to help ensure that the attitudes and practices that serve to devalue and further marginalize oppressed groups are challenged in how we train professionals.” This suggests that training programs have a responsibility to not only raise students’ awareness about value issues but also to “challenge” trainee values that are inconsistent with those of the profession.

Trainees perceive conflict between program values and personal values. One important question for training programs, then, is how to ethically manage situations in which the values of individual trainees conflict with the values of the field, which was the impetus for the listserv discussion that led to this research. In these situations, is it the responsibility of the program to help the student learn to manage those values ethically, or to change those values to fit in line with the profession? While many types of value differences exist, the one that seemed to come up most prominently in the current research was religion and sexuality, particularly homosexuality. While it should be noted that the majority of quotations referenced earlier that alluded to this conflict came from a single interview, the conflict between religious therapists and GLBT clients was also frequently mentioned by others and deserves attention as an test case for a wide range of similar conflicts.

On the one hand, counseling psychology values respect for differences, including sexual differences, and social justice principles suggest that attitudes which devalue particular sexual differences should be challenged. On the other hand, religious beliefs should also be respected, and many religious systems include proscriptions against certain sexual practices, including homosexuality. This then leads to the dilemma faced by the religious student discussed previously, whose instructor assumed “that we all in

the room . . . believe that all sexual lifestyles are equally valid” when in fact the student did not entirely agree. This scenario places students not sharing the particular value of the program in somewhat of a dilemma; do they openly acknowledge their value (which seems particularly appropriate when schools are attempting to increase trainee’s awareness of their own values) or do they conceal them to maintain relationships? It is instructive that, of the four examples cited of religious students who felt some conflict with their non-religious programs over value issues, the overwhelming preference appeared to be to conceal beliefs at least some of the time.

The conflict between trainees’ personal religious beliefs and the values of the field also creates a dilemma for the training program educating the student, and training programs must evaluate whether part of working effectively with different values systems includes changing trainee values that are inconsistent with those value systems. Clearly, it is an ethical responsibility for graduating psychologists to be able to work with diverse clients, including GLBT clients, a conclusion drawn by Mintz, et al. (in press) and supported by the general attitudes of the participants of the study, including religious participants (none of whom, incidentally, said that they were either unwilling or not competent to work with GLBT clients). However, given the inherent value-ladenness of therapy and the frequently cited difficulty of keeping therapists’ values out of the therapy room, is it also an ethical responsibility to have certain personal values on the issue? That is, in the words of the instructor quoted above, is it also ethically imperative for psychologists to have a personal belief that “all sexual lifestyles are equally valid”? If not, exactly how are psychologists without this belief to bring their personal beliefs into the therapy room – or leave them out – in ways that are both ethical and manageable?

Ironically, it is the “practical” aspects of value management that participants cited as most lacking in their programs in general. It may be that, faced with the difficulties of developing good practical solutions in the context-free realm of coursework, some programs are placing more emphasis on shaping values to better fit the profession as a way to address this issue. Further, the finding that many students, when faced with the conflict, appear to conceal their beliefs makes it difficult to wrestle with the dilemma in a productive way. This leads to the concern expressed by one student about the fact that another student and her program seemed to handle the dilemma by avoiding the issue. “She was going to have her beliefs,” said the participant, “and she can fake it until she gets out of here and then have no skills to deal with it when she’s gone, or we can help her find ways to negotiate it.” In the participant’s opinion, the program was focusing more on the former strategy than the latter, which she felt would be more helpful.

Although the dilemma discussed here was between religious students and GLBT clients, both trainees and their programs need skills to address not only this issue but also all types of value conflicts. The conflict that some religious students reported underscores the difficulty of negotiating many of these types of situations. Even when those involved in the conflict were professionals, trained specifically in accepting diverse beliefs, it appears that some students still felt that they had experienced discrimination (ironically, one of the professors that one student felt was most hostile to her religious beliefs was the multicultural class instructor). This may be an illustration, also, of the difficulties inherent when values of client beneficence (in this case, having trainees provide ethical therapy to GLBT clients) clash with values of respecting and accepting other’s values (in this case, the values of religious students regarding sexuality). Perhaps discussing these

conflicting values openly in training settings might help trainees better evaluate such conflicts as they arise for clients.

Trainees may benefit from specific guidance in working with religious clients.

One other aspect of training that it appears could productively receive more focus is helping trainees better understand religious clients' needs. As noted, several participants presented examples of religious difference and without exception those differences were respected and therapists attempted to understand and work within the clients' religious frameworks. It was interesting, however, that so many participants reported having religious clients ask about their personal religious beliefs and that many of them felt uncomfortable with these questions. It may be helpful for students to understand better why these clients are asking about therapists' personal beliefs, what they are concerned about, and how to respond in ways that address the issue comfortably for both the client and the counselor. Training programs might appropriately assist their students to not only understand the perspectives of religious individuals but also to develop responses to their concerns that facilitate trust and understanding. Specifically, because so many participants report being asked by religious clients if they too are religious, it might be helpful for training programs to help students explore the reasons why these questions are asked and prepare answers that address their concerns appropriately and without discomfort.

Recommendations

Overall psychology graduates seemed comfortable in negotiating value-based conflicts and placed considerable value on both helping clients and respecting client's value systems. However, understanding when and how to intervene in value systems in

ways that are helpful for the client was an area where they felt more training might be appropriate. That such understanding is necessary is evidenced both by the generally-held view that therapist values can't be removed from therapy and the belief expressed by some that many of clients' fundamental concerns relate to values. Part of ethically conducting psychologists' work is knowing how to assist clients to examine and develop value systems that are conducive to psychological well being. Therefore, it becomes critical for practitioners to understand value issues and to articulate how and under what circumstances exactly which values may be shaped and which may not. This is where training programs come in, as the major force in shaping new practitioners. Going back to the distinction made at the start of this section, respecting diversity is half of the lesson of values and it appears both from participant comments and from descriptions of practice that psychology graduates understand and share this value. However, they felt significantly less prepared in what that statement described to be the other half of value training – knowing what to do with personal values that are present. While it appears that training programs are doing a good job of helping practitioners keep values out of their therapy, perhaps more training could address how to appropriately bring them in in ways that are helpful to clients, preserving values of client beneficence and respect for client beliefs while also allowing for therapist values to enter into counseling in productive ways.

Limitations

In evaluating the research findings, it is important to first understand certain limitations of the research. First, it is important to keep in mind that all of these individuals were at the end of their graduate training or at the very beginning of their

professional careers and that their responses reflect the cumulative education and experience in value related issues over several years of graduate training. Thus, their responses might not be similar to those of students earlier on in their training and it should not be assumed that these attitudes reflect the attitudes of other students. If we view graduate school partly as a process of acculturation into the value system of the psychological fields, it is apparent that these students would be expected to have greater exposure and thus to have more fully adopted the values and culture of their fields than less experienced students. One interesting area for further research might be to compare first-year students to similar graduates on their attitudes and beliefs regarding value differences in counseling to evaluate exactly how graduate education and acculturation influences these feelings.

Participants in this study may also differ in some regards to professionals as a whole, both with respect to experience in this field and to the importance that professionals as a whole place on multicultural and value issues. If it is the case, as some of the participants' responses suggest, that the value placed on these issues differs somewhat between university settings and community settings, then these participants' recent exposure to the culture of their schools or universities would be expected lead them to reflect counseling beliefs and values more similar to college and university settings than to community settings. Thus, while they may be similar to other early-career psychologists, it would not be reasonable to expect that their responses reflect the views of psychologists as a whole.

Another disclaimer that may be relevant is that value-related issues, particularly multicultural and diversity issues, are issues that can be very emotionally charged and

issues on which graduate programs and society in general are hardly neutral. Tolerance is a value that is strongly held in our society and, arguably, even more strongly held in universities and colleges. Graduates, of course, have been exposed to these values for several years and so are well aware of which attitudes and beliefs would be seen as positive and which would be seen as negative. While it did not seem that any participant was responding in a way that was not genuine, the possibility that responses were shaped by perceptions of social desirability should be kept in mind when evaluating the findings of the current study.

A final point of caution lies in the finding that for many of these individuals, value decisions were highly contextual and how they proceeded with therapy depended not only on general principles but on the perceived needs of the client at the moment. It is possible, then, that when asked to generate more general rules or to articulate guiding principles about values management in counseling, participants were interpreting the idea of values differently or were thinking of different values or different types of situations, which led to their different responses. Thus, it is possible that the widely differing views on many issues are more tied to the difficulty of making general statements in this area and that, faced with real-life situations, these participants may respond more similar than this research suggests.

Directions for Further Research

Most of the topics investigated by this research were covered in less depth in order to evaluate value issue from a broader perspective. It may be helpful, then, to investigate several of these issues in more depth. For example, it would be interesting to

evaluate exactly how value differences are perceived and handled by looking at several real-life examples as they happen, rather than asking participants for only one or two retrospective responses. Further, it might be helpful to understand these issues from the clients' perspectives and investigate how clients feel about value differences, whether they perceive those differences as helpful or harmful, and how they feel about particular interventions used to manage those differences. Because value management strategies seem to rely considerably on contextual demands, it would be helpful to better understand how various factors affect therapists' decision making on these issues. Several participants mentioned the value of examples in discussing value issues – perhaps research that is based in hypothetical situations might yield different information than studies asking for general principles, such as this one.

Several avenues of further research exist with regards to training in these areas. For example, it might be interesting to focus more deeply on trainees' experiences with supervisors around value concerns and to explore how helpful supervision is in resolving those concerns. It would be interesting to investigate the training experiences of religious student in greater depth, to see if the experiences of some of the students in this study are representative of a larger group, and to get the training programs' perspective on these issues. It would also be quite helpful to understand exactly what training programs do to prepare their students in this area and to have students evaluate the efficacy of each of these elements. Finally, it might be helpful to wrestle more deeply with the conceptual conflicts inherent in managing values in therapy, to help students develop understanding and theoretical skills that will assist them in working through future value conflicts that might arise as they provide services to an increasingly diverse clientele.

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