VALUES AND PSYCHOTHERAPY

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(Chapter 4 in *Counseling and Psychotherapy: Theory and Practice*. New York: Harper & Row, 1959. This was perhaps the first book on counseling and psychotherapy that dealt with values.)

Most textbooks in counseling and psychotherapy contain no discussion of the problem of values. The neglect of this area in earlier courses thus means that when the student comes to the practicum, problems arise in his counseling. If he has been exposed to the client-centered philosophy, he is of course usually convinced that he should be nonjudgmental regarding the client's attitudes, beliefs, values, and behavior. Most other approaches to counseling agree upon this. However, this is not sufficient preparation for actually dealing with values in the therapeutic process.

There has been some concern with the place of values in psychotherapy, with psychoanalysts particularly giving this topic considerable attention. The generally accepted point of view has been that the therapist's values should be kept out of the therapeutic relationship. Wilder, commenting upon a paper by Ginsburg, puts it as follows: "It has been taken for granted that the analyst must not try to impose his value systems on the patient," and he adds: "and I still think this to be true" (9). In line with this "hands off" approach, therapists have been exhorted to become aware of their value systems, for the purpose of keeping their own values out of the therapy and to avoid deliberate or unintentional indoctrination of the client.

Perhaps few therapists feel that values should not be *dealt* with in psychotherapy. As Green (10) has pointed out, therapists *must* deal with values, since they are part of the personality of the client, and the source of many of his problems. That some therapists still are uncomfortable in doing so seems to be indicated by Zilboorg's (52) defense of subjectivity, and his statement that while "the psychiatrist is not concerned primarily with moral problems, he does not reject them."

Recently there has been developing the realization that the therapist's own values cannot be kept out of the therapeutic relationship. Before examining this problem and suggesting how it should be handled, perhaps some attempt at defining values is necessary.

DEFINITION OF VALUES

There appears to be no generally accepted, simple definition of values. Williams (quoted by Ginsburg [8]), a sociologist, defines values as "effectively charged conceptual structures registered by the individual which act as directives. They form an important part of the apprehension of self and act as directional factors in the organization of behavior." Kluckhohn

(17, p. 395), an anthropologist, defines a value as "A conception, explicit or implicit, distinctive of an individual or characteristic of a group, of the desirable, which influences the selection from available modes, means, and ends of action." Murphy, Murphy, and Newcomb (26, p. 199), writing from the social psychological point of view, state that a value is simply "the maintenance of a set toward the attainment of a goal," especially when the goal is remote. They tend to relate values to needs, in the sense that objects acquire value as means of satisfying a need. Murphy later (24, p. 270) states that "the central fact about values is that they arise from definite wants," so that a value is "the characteristic of an object which makes it desired or desirable or to be sought after." If object is defined as including other than material or concrete elements, and wants as including psychological and social desires or needs, perhaps this definition can be accepted, at least as partially definitive. Smith (39), a social psychologist, states that "by values I shall mean a person's implicit or explicit standards of choice, insofar as these are invested with obligation or requiredness." Ginsburg (9), a psychiatrist, admitting that values are difficult to define, states that "values are preference statements which are related to generalized notions, principles, or conceptual constructs for which we use the noun *'a value.'"* Values are thus not simply derived from needs, appetites, or interests, which include valuation but are not values, but come into play when a choice must be made which *is not* decided simply on the basis of a need, but is influenced by the ego or ego ideal. In another place (8) he defines a value as "a criterion which helps us to distinguish between alternatives and affords us a base for recognizing ourselves in relation to the rest of the world." Values reflect needs and interests, but are neither of these. Neither are values simply goals, though they may be, but criteria against which goals are chosen.

It appears that a simple, generally acceptable definition of values is difficult if not impossible to formulate, but perhaps we can state some of the characteristics of value which seem to run through the definitions cited above. First of all, values are what might be termed hypothetical constructs. They are not objective they are not objects, or goals, nor are they needs, interests, wants, or desires. But they are tied to both of these. On the one hand they are directed toward objects or goals, in that they constitute criteria or standards for the choice of such objects or goals. On the other hand, they are expressions of wants, interests, desires, and needs; that is, they are preferences. But in addition to being expressions of these characteristics, they are also expressed by them. In a sense, then, values affect our perceptions, and thus our wants and desires. Values then are standards, or criteria, which are nonobjective, in the sense that they represent preferences, which are in part socially or culturally determined.

Secondly, values have a connotation of "right," or "should"—they represent the desirable. As Kluckhohn phrases it, "value implies a code or standard, which has some persistence through time, or put more broadly, which organizes a system of action. Values, conveniently and in accordance with received usage, place things, acts, ways of behaving, goals of action on the approval-disapproval continuum" (17, p. 395). Values are thus related to attitudes and opinions, as well as to interests and preferences.

HOW VALUES AFFECT COUNSELING AND PSYCHOTHERAPY

It was suggested above that values cannot be avoided in counseling and psychotherapy. Many of the client's problems involve values and value conflicts (2, 10). But there are other ways in

which values affect the therapeutic relationship which should be considered in addition to their entering into the content of counseling or psychotherapy.

PHILOSOPHY OF COUNSELING

A philosophy is an integration or system of values, usually resulting in statements of postulates and assumptions, or principles.

It is only natural, and to be expected, that philosophies of counseling and psychotherapy should reflect the philosophies of the societies in which these activities operate. The prevailing philosophy of our society is a democratic one. This is more than a political term, although Meehl and McClosky (21) would make it primarily such. Democratic principles and values have permeated our economic, social, educational, and occupational institutions and relationships. And as Sutich points out, "It is evident that modern therapeutic and analytical principles have their roots in democratic principles. And it is equally evident that most American psychologists are committed to the support of democratic principles throughout the entire range of human behavior" (41). (In Chapter 6 we shall see that this is not universally true.)

What are the democratic principles which are accepted by counselors and psychotherapists? Bixler and Seeman (4), in their discussion of counseling ethics, present the postulates of Hand (12), which succinctly express these principles:

1. The belief that human life, happiness, and well-being are to be valued above all else.

2. The assertion that man is the master of his own destiny, with the right to control it in his own interests in his own way.

3. The determination that the dignity and worth of each person shall be respected at all times and under all conditions.

4. The assumption of the right of individual freedom; the recognition of the right of each person to think his own thoughts and speak his own mind.

The philosophy of the client-centered approach to counseling appears to many counselors to be an expression of this democratic philosophy in the counseling relationship. Rogers (30, p. 5) speaking of the development of client-centered therapy, writes that "some of its roots stretch out into the educational and political philosophy which is at the heart of our American culture." Green (10) feels that client-centered therapy is supported by the "democratic-liberalistic ideology."

The philosophy of client-centered counseling is expressed in the attitudes which the client-centered counselor holds and expresses toward his clients. These basic attitudes may be stated

simply. The client-centered approach to counseling and psychotherapy is based on the following attitudes toward others, whether as clients or persons in other relationships with the counselor:

1. Each person is a person of worth in himself, and is therefore to be respected as such.

2. Each individual has the right to self-direction, to choose or select his own values and goals, to make his own decisions.

These, as simple as they seem, express the philosophy of client-centered counseling. These attitudes would probably be accepted by most counselors today, although the extent to which they are implemented in counseling varies tremendously. The methods of implementing them will be discussed later.

VALUES AND COUNSELING ETHICS

Ethics are in a sense the specifics of a philosophy. It should be apparent from the discussion of the definition of values that values and ethics are related. The ethics of individuals and groups reflect their values. In fact, ethics might be considered as an expression or formalization of a group's values, an attempt to represent or express them in a systematized form. This is no doubt why Sutich (41) became involved in values in his discussion of ethics. Bixler and Seeman (4) state that "ethics are principles of action based on a commonly accepted system of values," thus relating professional ethics to social values. The APA code of ethics states that a cardinal obligation of the psychologist "is to respect the integrity and protect the welfare of the person with whom he is working" (1, p. 49). This is clearly an expression of the value of the individual in our society, as is recognized in Principle 1.13: "The psychologist should express in his professional behavior a firm commitment to those values which lie at the foundation of a democratic society, such as freedom of speech, freedom of research, and respect for the integrity of the individual" (1, p. l0).

The dependence of ethics on society is expressed by Newman (27), who states that codes of ethics "are quite meaningless unless they reflect, on the one hand, a set of social attitudes that are characteristic of the profession, and, on the other hand, attitudes possessed by the society that trusts and respects the profession."

VALUES AND THE GOALS OF COUNSELING AND PSYCHOTHERAPY

Goals reflect values, and therapeutic goals are no exception. The therapist has goals, either specific or general, and these are influenced by his values. "Values determine his concepts of mental health, his goals and aims" (2). Since no complete cure is possible, according to most therapists, what constitutes "tolerable conflict" is a matter of the therapist's values (8). Ginsburg (8) states that "analysts must work with a definition of what constitutes the mental and emotional health they are trying to enable the patient to achieve; that such a definition must reflect the analyst's own values seems self-evident."

Concepts of mental health vary (34). Adjustment has often been conceived as the goal of counseling and psychotherapy. However, there has been increasing dissatisfaction with this concept. The question must be raised, "adjustment to what?" It is evident that adjustment to certain situations is undesirable. Moreover, if everyone were adjusted, change and progress would cease. Lindner (19) has been active in objecting to adjustment as the goal of therapy. Therapeutic progress or even success can be achieved while the client remains unadjusted to his environment, or to some aspects of it. The concept of adjustment is static. It leads to a subjective interpretation, influenced by the bias of the evaluator, or to a mass statistical interpretation, based on a definition of adjustment as nondisturbing behavior. De Grazia's (5, p. 146) illustration of the majority-vote concept of adjustment is pertinent here. He refers to the remark of Nathaniel Lee, the English dramatist, on being confined to Bedlam insane asylum: "The world and I differed as to my being mad, and I was outvoted." Moreover, adjustment to a small or deviant subgroup, *e.g.,* of criminals or addicts, is not evidence of mental health.

Integration is another concept applied to the goals of psychotherapy. This concept stresses the internal state of the client, rather than his adjustment to a particular environment. But, presumably an individual can be integrated as a person while at the same time he is in conflict with his environment; and it has been pointed out that a paranoic may be integrated, yet is not mentally healthy.

Realizing the inadequacy of adjustment and integration, alone or in combination, as criteria of mental health, Jahoda (14, 15) and Smith (38) have added a third, which they call "cognitive adequacy," or the perceptual adequacy for testing thus proposing a triple criterion. Jahoda (14, p. 213), recognizing that "there exists no psychologically meaningful and, from the point of view of research, operationally useful description of what is commonly understood to constitute mental health," examined five criteria: absence of mental disorder or symptoms, normality of behavior, adjustment to the environment, unity of the personality, and the correct perception of reality. The first two were discarded, since symptoms are normal or abnormal depending on the cultural context to define what is normal. Also, recognizing that not every form of adjustment is a positive indication of mental health," and that adjustment may be "passive acceptance of social conditions to the detriment of . . . mental health," she proposes a criterion of active adjustment, or "mastery of the environment, involving a choice of what one adjusts to, and a deliberate modification of environmental conditions" (14, p. 216). Integration, or self-consistency, is not acceptable alone, since it doesn't imply freedom of conflicts with the environment. Correct perception of reality, both of the world and of oneself, while difficult to establish, since the majority judgment is not necessarily correct, is still a useful as a criterion. No one criterion is adequate by itself.

While it is thus difficult to define mental health, counselors and psychotherapists have stated various goals of psychotherapy (16). Adjustment, integration, and an adequate perception of reality usually are included in these goals. One of the most extensive lists of the goals of therapy is that of Maslow (20, ch. 12) in his study of the characteristics of normal, healthy, "self-actualizing people." These characteristics are as follows:

1. More efficient perception of reality and more comfortable relations with it.

2. Acceptance of self and others, and of nature.

3. Spontaneity.

4. Problem-centered rather than ego-centered.

5. Able to be detached from turmoil, to rise above misfortunes.

6. Independence of culture and physical environment

7. Freshness of appreciation.

8. A mystic experience.

9. Gemeinshaftsgefuhl--sympathy and identification with others.

10. Deep interpersonal relations.

11. Democratic character structure.

12. Discrimination between means and ends.

13. Philosophical sense of humor.

14. Creativeness.

15. Resistance to enculturation.

This list includes most of the goals mentioned by other authors (16). No doubt it could be reduced by combination of characteristics. Many of them could be included under the concept of active adjustment or mastery of the environment, others under an accurate perception of reality, and others under integration. These characteristics are similar to the outcomes of client-centered therapy described by Rogers and others. Included is the goal of adequate interpersonal relations stressed by Sullivan, who writes that "One achieves mental health to the extent that one becomes aware of one's interpersonal relations" (40, p. 102). He states that "the processes of psychiatric cure include the maturation of personality, that is, the evolution of capacity for adult interpersonal relations" (40, p. 103). Improvement in mental health includes the development of the ability to relate with persons in terms of their present actual conduct, the acquisition of a realistic role-taking ability. The individual is less prone to project his hostilities, suspicions, and dependencies onto others. While certain attitudes toward others may be irrational, or emotional--of unknown origin--the individual accepts responsibility for them on a mature level.

There has been concern on the part of some regarding such goals as independence, spontaneity, and self-actualization. These goals seem to emphasize the individual to the detriment of society, and to encourage antisocial or asocial behavior. Such fears were felt with regard to sexual expression as a result of psychoanalysis. Mowrer (22, 23) has criticized psychoanalysis for its emphasis on freeing the id from the rule of the superego, and implies that psychotherapy should strengthen the superego. Actually, self-actualization depends on other people. As we shall see later (Chapter 7), the individual is dependent on the esteem and regard of others for his own self-esteem. He is thus dependent on satisfactory interpersonal relations. This means that mature, responsible behavior is essential. In the goals listed above there is this concept of responsibility,

as well as independence. Mowrer (22, 23) has used this concept of responsibility. Shoben (36) has suggested the "development of responsible individuals capable of maintaining and advancing a democratic society" as the goal of student personnel work, involving the "dual commitment to the worth of the individual and the furtherance of democracy."

The goal of psychotherapy might well be thought of as the development of a *responsible independence*. Counseling and psychotherapy thus would attempt to facilitate the development of individual independence in a client who takes responsibility for himself, his behavior, his choices and decisions, and his values and goals. This would be consistent with the democratic concept of the freedom of the individual, and also with the concept of the responsibility which accompanies freedom. Such a goal is clearly an expression of the values of a democratic society.

Responsible independence is perhaps an external definition of mental health. From an internal point of view self-actualization perhaps is an expression of the' same concept. But a more general and universal or inclusive term is self-esteem. Self-esteem seems to be the essential quality of mental health, and its absence the distinguishing characteristic of mental disturbance. It perhaps is the sum or result of the concepts discussed above--active adjustment, integration, cognitive adequacy, responsible independence. Or possibly it can be looked upon as the antecedent or requirement for some of these, and for self-actualization, spontaneity, creativeness, etc. At any rate, self-esteem seems to be the key concept in mental health; it will be referred to frequently in later discussions.[1]

There may seem to be the possibility of a conflict between the attitudes and goals of the counselor and the desires or wishes of the client. The client may not want to take responsibility for himself, to be independent. Clients frequently want immediate practical help on a current pressing problem, rather than to develop the capacity to handle their own problems. They desire relief for their symptoms rather than an understanding of themselves. Should the counselor be committed, as Meehl and McClosky (21) state, "to help the client achieve the client's end," whatever it is? Most counselors would say no. Almost every therapist, not only the client-centered counselor, is prepared "to thwart the momentary motivations of his client, apparently in terms of long-time goals, which are assumed to be mutually acceptable" (21). The counselor's ethics, values, and philosophy determine his goals in counseling, and he should not be required to compromise these. The client who does not wish to work under these conditions is not compelled to do so. He has the freedom to accept or reject any counselor and his services. To the charge

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[1]For a recent detailed consideration of mental health, see Marie Jahoda, *Current concepts of positive mental health.* New York: Basic Books, 1958 (Monogr. Ser. No. 2, Joint Commission on Mental Illness and Health). The striking similarity between the concept developed here and Jahoda's conclusions from a study of the literature is apparent from the following quotation from Jahoda: ".… one value strikes us as being compatible with almost all of the mental health concepts discussed here: an individual should be able to stand on his own two feet without making undue demands or impositions on others" (p. 80).

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that the counselor is putting himself in the position of thinking he knows best what the goals of counseling should be, the answer can only be one of "guilty"—the counselor must be free to choose his own goals for the counseling process. Actually, counselors and therapists have always done so. Psychoanalysts have insisted on the goal of personality reorganization as opposed to symptom relief. And they have sometimes been insistent on rather specific goals. Ginsburg (8) mentions an analyst who was dissatisfied with a patient at the end of analysis because she still attended church. Church attendance was not a value to him—in fact a goal of this particular analysis was the severing of religious ties. Contrasted with this is the goal of Jungian analysts, who often encourage the return of the patient to religion. Although it may smack of "teacher knows best," the client-centered counselor operates on the assumption that the client really needs and wants to develop a state or feeling of self-esteem, responsible independence, etc.; so that in reality the goals of the client, though he may be unaware of them, are the same as those of the counselor. (See Chapter 7 for further consideration of the basic need of individuals.)

THERAPEUTIC METHODS

It should be obvious that if values influence, or even determine, the goals of therapy, they also influence methods and techniques—the implementations of values—and means toward the goals. The APA code of ethics recognizes that "the psychologist's ethical standards and his professional techniques are inseparable" (1, p. 37). Methods and techniques will be dealt with in more detail in another chapter. It is sufficient here to point out their relationship to therapeutic goals. Techniques are not chosen primarily on the pragmatic basis of whether they do or do not provide relief to the client, but in terms of their appropriateness to the ultimate goal of therapy. Respect for or unconditional acceptance of the client is a basis for the development of self-esteem. If this goal includes client responsibility and independence, then it would appear to follow that all techniques should be consistent with this goal. The client learns responsibility by practicing it, and this should begin in psychotherapy, not at its conclusion. The analysts' practice of inducing a dependent transference relationship, which then must be resolved, appears to contradict this principle. Some have felt that this method prolongs therapy unnecessarily. That the transference neurosis is necessary has not been demonstrated; and the fact that profound reorganization of personality has taken place ill therapy without the development and resolution of a transference neurosis would indicate that it is not necessary. (See Chapter 9 for a discussion of transference.)

The counselor's values affect other aspects of the therapeutic relationship also. Ginsburg (8) points out that the role of values in the occupational choice of psychotherapy is a neglected area. He was referring to the monetary values of the practice of psychotherapy. Although the value or goal of earning a good living must not be denied, most people going into counseling or psychotherapy do so out of a desire to help others. This desire represents, in the mentally healthy individual, a value; and it influences the nature of the counseling relationship. Values also enter into the selection of patients or clients, as Ginsburg points out (8).

INFLUENCE OF THE COUNSELOR'S VALUES ON THE CLIENT

We indicated at the beginning of this chapter that the generally accepted point of view has been that the counselor's values should be kept out of the counseling relationship. In addition to Wilder, who was quoted, others have stressed this avoidance of influencing the values of the

client. Deutsch and Murphy stress that "The therapist should by all means avoid impressing his own philosophy on a patient" (6, p. 17). Therapists have been exhorted to become aware of their own value systems, and those of the society and culture in which they work, to better avoid impressing them upon the patient. Most therapists have stressed the importance of allowing the client to develop his own value system (*e.g.,* 47). Some have insisted that the client's value system cannot be influenced b psychotherapy or that only those values which are consistent with his existing value system will be accepted by the client (28).

Is it possible for the therapist to avoid influencing his client? Can he actually prevent such influence? There is growing opinion, and some evidence, that he cannot. Ingham and Love express this conviction:

"The existence of the therapeutic relationship puts the therapist in a position in which he does, without choice, influence values in the mind of the patient. It is almost impossible for a therapist to avoid giving some impression of whether he favors such things as general law and order, personal self-development, and emotional maturity. The development of the relationship partly depends on the expression of such standards, because if the therapist were able to withdraw to such an extent that no evaluative attitudes would be apparent, he would not be able to participate sufficiently. But in an area in which the therapist does avoid revealing his ideas, the patient will project some onto him. So even if he could keep complete silence, he would still represent judgmental attitudes in the mind of the patient. If they have discussed an issue that involves moral values for a period of time, it is evident that the patient will have a concept of what the therapist thinks. His attitudes about right and wrong, or good and bad, are likely to be particularly influential for the patient (13, pp. 75-70)."

Wolberg, commenting on Ginsburg's paper, states that

"No matter how passive the therapist may believe himself to be, and no matter how objective he remains in an attempt to permit the patient to develop his own sense of values, there is an inevitable incorporation within the patient of a new superego patterned after the character of the therapist as he is perceived by the patient. There is almost inevitably an acceptance by the patient of many of the values of the therapist as they are communicated in the interpretation or through direct suggestion, or as they are deduced by the patient from his association with the therapist" (9).

Parloff states that "The disclosure of many of the therapist's values is inevitable . . . such disclosure and communication may occur without the therapist being aware of it" (28). It might be expected that the therapist, by reason of his position and prestige, would become an example to the client, and that the client would tend to imitate him, intentionally or unintentionally, in terms of his perception of the therapist. As Parloff writes, "By virtue of the role of healer and model of mental health that the patient assigns to the therapist, every comment and action of the therapist is given great weight. The patient willingly or unwillingly becomes an avid student of what is pleasing and displeasing to the therapist" (28).

The APA statement quoted earlier continues by saying that "the attitudes, values, and ethical concepts of the psychologist are expressed in his clinical relationships and very directly influence the directions taken by his client" (1, p. 37).

There is some evidence that what these writers claim happens actually does happen. Rosenthal (32) studied 12 patients presenting a wide variety of diagnoses, and ranging in age from 18 to 46, who had from three weeks to one year of psychotherapy. Early in therapy they were given a test of moral values, along with other tests, including the Allport-Vernon-Lindzey Scale of Values. The therapists, who were psychiatric residents, were also given these two tests. The patients repeated the tests at the conclusion of treatment. The moral values test included items concerning sex, aggression, and authority. It was found that, in general, patients' scores on the moral values test changed during therapy' with those patients rated (by independent judges) as improved becoming more like their therapists, while those rated as unimproved tended to become less like their therapists.

In another study, Parloff and his associates (29) had observers list topics discussed during therapy by two schizophrenic patients. Every day, after the therapy hour, the patients and the therapist ranked these topics from most to least important. After therapy had been in progress for nine months, therapist and patients predicted each other's ratings. At the beginning of therapy, the values (as indicated by their ranking of topics) of both patients differed from those of the therapist. As therapy progressed, the patients' values came closer to those of the therapist; although for one patient no closer convergence occurred after the first six weeks of treatment.

There is some clinical evidence that the therapist influences the patient's values without attempting to do so or being aware of it. Parloff refers to the well-known fact that patients conform in their verbalizations to the terminology and theories of the therapist. If therapists value dreams, patients dream; if the therapists value sexual material, patients produce it, etc. "The literature is replete with examples of patients unwittingly adapting their productions and even use of symbols to the particular psychodynamic theories and preferences of their therapist" (28).

One mechanism of such influence is suggested by some interesting experiments of Greenspoon (11) and Verplanck (44, 45). In these studies it was found possible to control the subjects' verbal behavior by means of operant conditioning, without awareness on the part of the subjects. In the case of psychotherapy, it is easy to imagine the effect on the client of such responses of the therapist to the patient's verbalization as a trace of a smile or a pleased look, an incipient nod of the head, or other mannerisms indicating his attitude, favorable or unfavorable, toward the patient's productions-all of which may be unknown to the therapist and the patient. Parloff (28) presents some evidence that the therapist's responses may be classed by observers as "approving" or "disapproving," and that these responses were related to the therapist's ranking of the topics responded to in terms of their importance. This occurred without the therapist being aware of the differential nature of his responses as "approving" or "disapproving." It was also

found that the frequency with which the patient introduced a topic was related to the type of the therapist's response.

INTENTIONAL INFLUENCE OF THE CLIENT'S VALUES

As indicated above, it has been generally agreed that the therapist should not consciously attempt to manipulate the patient's values. Recently, however, there have been what Wilder (in 9) refers to as "rising voices to the effect that the analyst not only does but should transmit his own value system to the patient." He writes: "A patient often says 'Doctor, after all, you seem to have found a measure of peace and stability, why don't you shorten the therapy by simply telling me your philosophy?" Taylor (42), in a letter to the editor, taking issue with the writer of an article making a plea for the abandonment of direction or guidance in counseling, suggests that there are common, general patterns of human conduct which are ethically "good," and that counselors are justified in introducing them in guidance. Weisskopf-Joelson (48) proposes that the inculcation of a philosophy of life be considered as one of the objectives of psychotherapy. Thorne (43) includes reeducation in a philosophy of life as a method of counseling.

Gardner Murphy (25) has recently asked: "Shall personnel and guidance work . . . attempt to impart a philosophy of life?" While admitting that "no one knows enough to construct an adequate philosophy of life," he says that "nevertheless if he who offers guidance is a whole person, with real roots in human culture, he cannot help conveying directly or indirectly to every client what he himself sees and feels, and the perspective in which his own life is lived." He then suggests that "it is not true that the wise man's sharing of a philosophy of life is an arrogant imposition upon a defenseless client." To the argument that all philosophies are subjective, arbitrary, or relative, he points out that nevertheless counselors are influenced by a philosophy in choosing their work. He feels that the young need help and advice from those who have thought things through. But he warns counselors not to "attempt the arrogant and self-defeating task of guiding men and women without a rich, flexible, and ever-growing system of values of your own."

Wrenn (51) writes that the counselor "may or may not . . . assist the client in an understanding of life purposes and meanings, and the alternate ways in which one may relate oneself to the Infinite."

There is some slight evidence, in the studies of Rosenthal and Parloff (32, 28, 29) that those clients who improved, or improved most, tended to approach most closely to their therapists in values. This, if true and borne out by other studies, might appear to be an argument for direct intervention toward influencing the values and philosophies of clients. However, it must be remembered that this result occurred in therapy where apparently no overt or direct attempt was made to influence the client. It might not hold where direct influence was attempted. Indeed, every counselor well knows the resistance that often develops where direct influence is attempted, and the resistance that often follows the attempt to fulfill a direct request of the client for advice or other help.

Granted that the counselor will influence the client, whether he desires or directly attempts to do so, is it therefore justifiable to attempt direct manipulation? Probably not, for a number of reasons.

First of all, while there are no doubt some generally, or even almost universally, accepted principles or ethical rules, these do not constitute a philosophy of life. Each individual's philosophy is different, unique, and something which is probably not adequate for any other individual. One may even question how much agreement there is on ethical principles or rules of behavior. De Grazia cites many illustrations of varying and contradictory or conflicting moral directives given by different therapists (5, pp. 152-155). The only universally proscribed behaviors appear to be the killing of members of one's own group, incest, and possibly betrayal of the group.[2]

Second, it is too much to expect all counselors to have a fully developed, adequate philosophy of life ready to be impressed on the client. All counselors are not, to use Murphy's term, wise men.

Third, the counseling relationship is not the appropriate place for instruction in ethics and a philosophy of life. The home, church, and school are more appropriate sources for such instruction.

Fourth, an individual does not develop a system or code of ethics, or a philosophy of life, from one source, or in a short interval of time. These are the products of a long period of time and many influences.

Fifth, it would appear to be best for each individual to develop his own unique philosophy, and not to be deprived of the experience of doing so. Such a philosophy will probably be more meaningful and effective than one adopted from someone else's no matter how wise a man he be. It cannot be imposed from without, but must be developed from within.

Sixth, we must still accept the right of the client to refuse to accept any system of ethics, or any philosophy of life.

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[2]The existence of infanticide and cannibalism (though the latter usually is not practiced upon members of one's own group), and the intermarriage among royal families, raise a question whether even these are universally prescribed behaviors.

This does not mean that the counselor refuses to discuss ethics, values, or philosophy. It does not mean that he is not concerned about the influence he has on the client in these areas. He recognizes this, and attempts to be a constructive influence, but not by attempting to manipulate the client in the counseling process. He does it by being himself. As Murphy (25) suggests, "A great deal of what you communicate to your client is not what you say but what you are." Further than this, the counselor on some occasions must express his own values. He may do so on the request of the client. But he carefully identifies these expressions as his own, and avoids imposing them on the client, or implying that the client ought to feel the same way.

There may also be times when the counselor, whether by request of the client or not, feels it necessary or desirable to inform the client of the attitudes, standards, or values of society, or the ordinary or generally accepted rules of ethics and morality. In a more or less rational problem-solving type of counseling, for example, where there is lack of information on the part of the client, the counselor may attempt to supply this lack (49).

The counselor should not strive to be an amoral, ethically neutral individual. Such a goal would be impossible of achievement-all of us have values, merely by being living human beings. Nor should the counselor attempt to pretend that he is amoral. It is unlikely that he could successfully give this impression to his clients, but it is also undesirable that the counselor attempt to appear to be other than he actually is. Furthermore, the attempt to appear to be neutral as regards social and ethical standards may lead to the danger of appearing not only to accept the client's unethical or immoral behavior, but of approving or condoning it. Counselors are not indifferent to social and moral standards, and should not attempt to appear to be so. On the other hand, the counselor should not judge or condemn the client because of his behavior or actions. Nor should he exhort or attempt to persuade the client to accept his (the counselor's) or any other specific standards or rules of living.

Biestek (3) presents an excellent discussion of the behavior of the counselor in the area of ethics and standards. He points out that while the counselor may judge the attitudes, standards, or actions of the client in terms of his own or prevailing standards, he does not judge the client himself. He further states that "this judgment is preferably made non-verbally; the client usually is able to make such appraisals of himself in the security of an accepting relationship." He suggests that the counselor cannot be indifferent to social, legal or moral wrong, and must favor the good. "This attitude, even if unexpressed, will be felt intuitively by the client; it serves as a source of strength and support for him. . . . In the non-judgmental attitude the [counselor] does not relinquish his own sense of values, his personal and social ethics. He cannot remain interiorly indifferent to standards contrary to his own if he is to maintain the integrity of his own personality. He must remain true to them. He does not become moralistic, but he has a right to his own sense of social, moral, and spiritual values, personally and professionally" (3).

Ingham and Love give two reasons for avoiding indoctrination of moral standards-. "The first, and most important, is that the therapist might succeed. And no human being is entirely safe in trying to impress his concepts of right and wrong on another, who has a different personality and

background. . . . The second reason is that the therapist might fail. And trying to impress moral values in psychotherapy without success, interferes with the freedom of the participants' communication and the strength of their relationship" (13, p. 77).

The above point of view may appear to be a departure from the client-centered framework. Like many other therapists, the client-centered counselor has professed neutrality, and has felt in many cases that he has achieved it. Actually, he has perhaps been no more successful than have other therapists. De Grazia (5, pp. 152-158) gives examples of the expression of counselor moral attitudes and values from published typescripts of client-centered interviews.

The proposal that the counselor not only should be aware of and has a right to his own moral attitudes and values, but should sometimes express them in the counseling relationship, is consistent with recent developments in client-centered thinking. Stressing that the therapist should be himself in this relationship with the client, Rogers (31) suggests that the therapist should express his own feelings as he experiences them. (See Chapter 9 for further discussion of counselor expression of his own feelings.)

The approach to values in counseling as outlined in this chapter appears to have several advantages. By recognizing that the counselor's moral attitudes and values do enter into counseling, it prevents the counselor from erroneously believing that he is neutral. Freed from this belief, and the feeling that it is necessary or desirable to be neutral, the counselor is better able to recognize and accept his own values. He then can be aware of them in the counseling relationship; and, when he feels that the counseling relationship would be improved or furthered by his expressing his own attitudes and feelings, he can do so. That is, he can freely be himself, without guilt about doing so, or without feeling that he should not have any feelings. Finally, this approach contributes to the openness of the counseling relationship, without violating its client-centeredness. In fact, the relationship is probably more client-centered. That is, where the counselor's attitudes and feelings are unexpressed, even unrecognized by the counselor, they may, and apparently do, have a pressuring influence on the client. Where they are expressed by the counselor and labeled as representing his own values, feelings, attitudes or point of view, or identified as those of others, or society in general, there is less coerciveness about them. While there are some who would sanction the counselor acting as a representative of society in prescribing moral or ethical values or standards (5), the majority of therapies, including client-centered therapy, still insist that the client must freely accept or reject such values, and develop or construct his own ethical system or philosophy of life. Some apparently fear that the client when given such freedom will choose wrongly or adopt an unethical or immoral course of behavior. The client-centered counselor, while not condoning a wrong choice, would respect the client's right to make it. He would feel that the counseling relationship is not the place to teach moral or ethical standards, or a philosophy of life. He is confident, as, apparently some are not, that the client in the therapeutic relationship will be aware of and influenced by social realities. He will leave to the family, the church, and the school, as institutions representing the moral and ethical standards of society, the teaching of such standards.

While the therapist does not teach or impose specific values or a philosophy of life, it should be clear that he does implement in his therapy a philosophy of counseling which in effect is his philosophy of life. His goals, his methods and techniques, and his ethics all express this basic philosophy. No therapist can avoid this. The approach to counseling and psychotherapy outlined in this book is no exception. This approach explicitly accepts and practices a philosophy, or a value system. The essence of this system is the recognition of the value of the individual, his dignity and worth, and his freedom or self-determination in regard to his choices and life goals. In so far as the expression of these values in the therapeutic relationship through the therapist's behavior to the client is an example, the therapist is "teaching," or perhaps imposing his values on the client. The therapist has no choice in this, since all behavior-all goals and methods of therapy are expressions of the therapist's values. The client is, however, free to accept or reject them, to continue therapy or to choose another therapist. The client who continues therapy is accepting the values which the therapist practices, including the goals of his approach to psychotherapy. These are the democratic, humanitarian values inherent in good human relationships, and thus of good mental health.

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