THE ROLE OF VALUES IN PSYCHOTHERAPY PROCESS AND OUTCOME

Lindsey R. Hogan

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APPROVED:

Jennifer L. Callahan, Major Professor
Randall J. Cox, Committee Member
Amy Murrell, Committee Member
Vicki Campbell, Chair of the Department of Psychology
Costas Tsatsoulis, Interim Dean of the Toulouse Graduate School
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Given the importance of client characteristics and preferences, and therapist expertise to evidence-based practice in psychology, the current study sought to contribute to the literature concerning the role of values in psychotherapy. Personal values of clients and trainee therapists in 29 dyads were examined for relationships between client and therapist values and associations with working alliance and outcomes. Although previous literature in this area has suggested that successful therapy is characterized by an increase in similarity of client and therapist values, the current study did not replicate this finding. However, client *perceptions* of therapist values were found to be important to working alliance and outcome. Findings are discussed in terms of suggestions for future research as well as implications for clinical practice, including the importance of discussing expectations and preferences with clients.
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It’s no surprise that, like most large undertakings, dissertations are accomplished with help and support from others. First of these is Dr. Jennifer Callahan, a caring, committed advisor who spent hours reviewing my drafts and humbly sharing her expertise, while also offering encouragement, optimism, and a sense of humor. Thank you times a million.

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I am also grateful to the clients who participated in this project. I further thank my own clients, who gave real meaning to my research interests in improving psychotherapy’s effectiveness.

Finally, I wouldn’t be anywhere without the sustaining love and support of numerous friends, best friend-colleagues, and family. Thank you with all my heart!
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CHAPTER I

INTRODUCTION

Most of the research investigating the role of values in psychotherapy emerged in the 1970s and 1980s and has since lost momentum (Beutler et al., 2004, p. 277). Despite promising findings in the historical literature associated with this area, methodological problems and lack of clarification regarding the exact definition of values thwarted continued research or consistent findings. Despite the paucity of contemporary research, the role of values continues to be recognized as an important component in psychotherapy, particularly with respect to evidence-based practice.

Evidence-based practice in psychology (EBPP) is defined as, “the integration of the best available research with clinical expertise in the context of [client] characteristics, culture, and preferences” (APA, 2006, p. 276). EBPP includes, but distinguishes itself from, empirically supported treatments (ESTs) by starting with the client, asking what research evidence is available to produce the best outcome for a unique individual. Thus, individual client values and preferences are considered a central part of EBPP in balancing the other two “legs” of the EBPP stool (Spring, 2007), and are therefore meant to be incorporated into processes such as treatment planning, treatment outcome tracking, and building of the therapeutic alliance.

Traditionally, therapist values have been discussed in terms of the idea that imposing values and beliefs on clients is unethical, and that psychotherapeutic change should occur outside of the influence of the therapist’s own beliefs and values (Beutler & Bergan, 1991; Weisskopf-Joelson, 1980). However, it seems that therapist values do affect the therapeutic process, even when therapists attempt to stay “value-free.” The
ideal that therapists are to remain neutral in therapy has yielded to research demonstrating relationships between client and therapist values, therapeutic relationship, and outcome (Kelly 1990). Still, these issues are not well-understood, and more research is needed to clarify the role of values in psychotherapy process and outcome so that therapists can appropriately address values in therapy.

**Value Change in Psychotherapy**

Successful therapy is often conceptualized as a persuasive process of change, in which the client’s beliefs, attitudes, or values may shift. However, as Beutler (1979) points out, the notion of persuasion suggests the possibility that the therapist’s own beliefs and values are influential in the change process—a less acknowledged idea, perhaps given its perceived ethical and moral implications. And certainly, we often presume the objects of change in psychotherapy to be inherently pathological or maladaptive, rather than necessarily personal, such as the client’s values (Beutler & Bergan, 1991). However, there is sufficient research to suggest that clients’ values do in fact change to become more in line with those of their therapist, and that this change is related to positive outcome (e.g., Beutler, 1979; Kelly, 1990; Rosenthal, 1955). Kelly (1990) points out that although this trend has been observed, there is lack of clarity regarding its relationship to outcome. Several studies report a significant relationship with improvement only when outcome is rated by the therapist, while others found significant results using measures of symptom reduction or other client ratings of improvement (Kelly 1990). This ambiguity suggests although the trend is observable across different measures of outcome, it is still unclear whether it is a function of therapist bias or other external factors.
The literature is varied with respect to the terms used to describe the phenomenon of clients adopting therapist values over time. Some researchers have used the term *convergence* (Arizmendi et al., 1985; Pepinsky & Karst, 1963), while others have labeled it *assimilation* (Kelly & Strupp, 1992). Convergence typically refers to measuring change by comparing value similarity pre and post treatment but is also used as a term to describe the general phenomenon. While assimilation is also used in a broad context by some researchers, Kelly and Strupp (1992) specifically define assimilation as perceived value change by clients towards those of their therapist, as rated by the clients retrospectively. Although the term convergence would seem to suggest that both clients’ and therapists’ values change, most research assumes that therapists’ values remain constant during therapy (Atkinson et al. 1991; Beutler, 1979). The question of whether therapists’ values change during therapy has therefore not yet been empirically answered.

**Values of Therapists**

Questions have also been raised regarding whether the therapist’s values that are thought to influence clients represent not solely the therapist’s own personal values, but also a set of mental health-related values collectively held by therapists. This is not an unfounded hypothesis, given that research has demonstrated some similarity among therapists with respect to personal characteristics such as political affiliation (McClintock, Spaulting, & Turner, 1965). If the same type of pattern were to exist among therapists’ values for therapy, then the observed trend of clients adopting therapist values may actually represent clients’ movement toward mentally healthy values. Some research supports this possibility—Jensen and Bergin (1988) found that when they
asked therapists about what values they consider to be important for psychotherapy, a consensus emerged on some values (e.g., being a free agent, having a sense of identity and self-worth, and interpersonal communication skills). However, personal beliefs and characteristics of therapists, including gender, marital status, political affiliation, and religious affiliation and commitment were found to influence the values they considered to be important for mental health, suggesting that although it may not be clear whether therapist’s personal values impact the client, they do impact the therapist’s perception of which values are important for mental health and may in turn play a role in the process of change in psychotherapy.

Initial Value Similarity

Another implication of this research is that, theoretically, clients and therapists could potentially have strikingly different value systems at the beginning of therapy. If this is the case, then a question emerges: if values are too dissimilar between a client and a therapist, is the therapeutic relationship negatively affected and therapy subsequently terminated? Several researchers have speculated that initial value similarity and dissimilarity among clients and therapists affect the therapeutic alliance (e.g., Kelly, 1992; Beutler & Bergan, 1991). Kelly (1992) noted that a moderate degree of similarity was positively related to improvement, and hypothesized that “a conspicuous clash hinders the building of alliance” (p. 39). Given that working alliance is a consistent predictor of outcome in psychotherapy (Martin, Garske, & Davis, 2000) investigation of this hypothesis may be especially important to studying the roles of values in psychotherapy process and outcome. There have been few studies attempting to answer these questions, but there is some empirical support for the effect of value
similarity and dissimilarity on working alliance. For instance, Vervaeke, Vertommen, and Storms (1997) found that clients who dropped out of therapy had a higher mean value dissimilarity, and Hersoug, Hoglend, Monsen, and Harik (2001) found that value similarity was related to good working alliance at Sessions 3, 12, and 20.

Although there may be a relationship between value similarity and working alliance, there is also evidence suggesting that perception of value similarity by the client may be a more important factor in building a strong therapeutic relationship. Atkinson et al. (1991) found that clients' perceived value similarity between themselves and their therapists predicted satisfaction with therapy and increased ratings of therapist credibility. Although Vervaeke, Vertommen, and Storms (1997) did not find a relationship between working alliance and similarity in personal characteristics of clients and therapists, clients' average ratings of alliance were higher than therapists'. It was noted that because clients may perceive cues of similarity in values, that this might produce a positive evaluation of the therapeutic relationship, even in the absence of actual similarity. Few studies aside from these have investigated the role of perceived similarity on alliance, and more research is needed to determine the exact relationship between perceived similarity, actual similarity, and alliance and outcome.

Value Similarity and Outcome

Initial value similarity and difference among clients and therapists is most likely related to outcome in a complex way. There is great inconsistency in the literature in this area (Beutler & Bergan, 1991) regarding whether initial dissimilarity or similarity is best for outcome. It may be that similarity on some values, with simultaneous
differences on others may better describe the influence of client and therapist values on improvement (Arizmendi et al., 1985).

Current Study

Given that values are crucial to providing evidence-based practice, there is startling little current research aimed at understanding how values in psychotherapy are related to alliance and outcome. The proposed study seeks to contribute to the literature on values and psychotherapy as it can be understood within an evidence-based practice framework. Existing research has evidenced that the phenomenon of value change in therapy and the degree of discrepancy between client and therapist values have complex, but important, implications for therapeutic alliance and treatment outcomes. This research also challenges the assumption that therapists are effectively refraining from “imposing” values on clients, raising possible ethical concerns and highlighting the need for more research in this area to inform clinicians about the best way to go about addressing values in psychotherapy.
CHAPTER II
REVIEW OF THE LITERATURE

Most of the research investigating the role of values in psychotherapy emerged in the 1970s and 1980s and has since lost momentum (Beutler et al., 2004, p. 277). Despite promising findings and substantial literature in this area, methodological problems and lack of clarification regarding the exact definition of values continue to prevent cumulative research with consistent findings. Although there is a paucity of current research, the role of values continues to be recognized as an important component in psychotherapy, particularly with respect to evidence-based practice.

Evidence-based practice in psychology (EBPP) is defined as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2006, p. 276). This model is often described as a three-legged stool, in which each component is essential for effective clinical practice (Spring, 2007). Best research evidence includes empirical results pertaining to all aspects of practice, addressing a wide range of clinical populations and evaluated based on efficacy and clinical utility. Clinical expertise is necessary to integrate the best research with information about the individual patient, and means maintaining one’s own knowledge of available research and adjusting one’s practice in accordance with patient outcome data.

EBPP encourages the integration of research and practice, including empirically supported treatments (ESTs) and empirically supported principles for assessment and intervention. However, it is especially important to note that EBPP is more comprehensive than ESTs and starts with the patient, asking what research evidence is
available to produce the best outcome for a unique individual. Thus, individual patient values and preferences are considered a central part of EBPP and are meant to be incorporated into treatment planning and building of the therapeutic alliance.

Similarly, an awareness of one’s own values and related biases is important with respect to clinical expertise. Traditionally, therapist values have been discussed in terms of the idea that imposing values and beliefs on clients is unethical, and that psychotherapeutic change should occur outside of the influence of the therapist’s own beliefs and values (Beutler & Bergan, 1991; Weisskopf-Joelson, 1980). However, it seems that therapist values do affect the therapeutic process. Specifically, a change in client values towards those of the therapist has been observed across time, and has been demonstrated to be related to positive outcome. Additional research has indicated that the therapeutic relationship is influenced by the degree of value similarity among clients and therapists, with the possibility that clients’ perception of value similarity or value change also has a significant relationship with outcome. Still, these issues are not well-understood, and more research is needed to clarify the role of values in psychotherapy process and outcome so that therapists can appropriately address values in therapy.

Value Change in Psychotherapy

Successful therapy is often conceptualized as a persuasive process of change, in which the client’s beliefs, attitudes, or values may shift. However, as Beutler (1979) points out, the notion of persuasion suggests the possibility that the therapist’s own beliefs and values are influential in the change process—a less acknowledged idea, perhaps given its ethical and moral implications. And certainly, we presume the objects
of change in psychotherapy to be inherently pathological or maladaptive, rather than necessarily personal, such as the client’s values (Beutler & Bergan, 1991). However, there is sufficient research to suggest that clients’ values do in fact change to become more in line with those of their therapist, and that this change is related to positive outcome (e.g., Beutler, 1979; Kelly, 1990; Rosenthal, 1955).

Some researchers have used the term convergence to refer to the phenomenon of clients adopting therapist values over time (Arizmendi et al., 1985; Pepinsky & Karst, 1963), while others have labeled it assimilation (Kelly & Strupp, 1992). Convergence typically refers to measuring change by comparing value similarity pre and post treatment but is also used as a term to describe the general phenomenon. While assimilation is also used in a broad context by some researchers, Kelly and Strupp (1992) specifically define assimilation as perceived value change by clients towards those of their therapist, as rated by the clients retrospectively. Although the term convergence would seem to suggest that both client and therapist values change, most research assumes that therapist values remain constant during therapy (Atkinson et al., 1991; Beutler, 1979). The question of whether therapist values change during therapy has therefore not yet been empirically answered.

Rosenthal (1955) was one of the first to investigate the role of value change in therapy. He theorized that clients’ positive outcome was related to changes in their moral values toward those of the therapist. He found that the moral values related to sex, aggression, and response to authority in improved psychiatric patients changed in the direction of the therapist’s moral values, while patients who did not improve
evidenced moral value changes in the direction away from the therapist. This research, despite its small sample size, encouraged further investigation of this phenomenon.

Kelly (1990) conducted a critical review of the literature that attempted to provide clarity to the existing research aimed at understanding values and psychotherapy. In an effort to produce findings that were not confounded by construct definition, studies were only included if they utilized constructs directly related to Rokeach’s (1973) definition of a value. Ten studies met the strict inclusion criteria and were critiqued regarding methodological strengths and weaknesses, and four studies with superior psychometric properties were noted. Kelly (1990) concluded that client values do change to become similar to therapist values over time. This process was found to be related to the degree of initial value dissimilarity between client and therapist. With regard to the effect of this phenomenon on outcome, Kelly (1990) found that value convergence is only associated with the therapist’s rating of improvement and not with a client rating or with a measure of symptom reduction. This raises questions of whether the convergence phenomenon may be a function of therapist bias, such that therapists may rate as improved a client who is perceived to hold similar values. With respect to the relationship between initial value similarity of client-therapist dyads and outcome, Kelly (1990) reported studies with conflicting results. Of the four most psychometrically sound studies, two found value similarity to be related to positive outcome, and one study failed to identify a relationship between these variables; furthermore, another study noted that initial similarity of some values and initial dissimilarity of other values was associated with either positive improvement as rated by the therapist or symptom reduction as measured by the SCL-90-R. Kelly (1990) noted that although the remaining six studies were characterized as
psychometrically weaker, their findings generally supported those of the four most psychometrically sound studies included in the review.

In order to further investigate the nature of client’s value changes during therapy, Kelly and Strupp (1992) examined clients’ perception of value change by having them rate perceived value changes retrospectively using the Rokeach Value Survey, at a follow-up assessment after termination. Clients were asked to rate each value according to the change of importance since entering therapy. Outcome was measured from the perspective of the client, therapist, individual clinician, and by the Social Introversion scale of the MMPI, which was found to be elevated pre-treatment (mean $T = 77$).

Although the authors predicted that values related to interpersonal morality would be most likely to change, they instead found that the morality-related values were relatively stable. With regard to overall value change in clients, 64% of perceived changes reported by clients were changes away from the therapists’ values. It is possible, the authors also note, that measuring value change retrospectively produces different results than comparing pre and post measures of values, but this finding is notable in light of several other studies demonstrating a movement of client values or attitudes towards those of the therapist (e.g, Kelly, 1990; Beutler, 1971a, Rosenthal, 1955). With regard to client improvement, assimilation (defined as perceived change in client values towards those of the therapist) was significantly related to therapist assessment of outcome, but not to other methods of outcome assessment.

Another finding by Kelly and Strupp (1992) is particularly notable, regarding the role of religious values. The value of salvation in this study produced a bimodal distribution with respect to perceived change in importance—in general, it was rated as
either very unimportant or very important. Also, salvation was the only value which was rated significantly differently for therapists and clients, but was the only value for which similarity between client and therapist was related to outcome. The authors suggest that perhaps salvation and other religious values may be utilized as matching variables. This is consistent with the resurgence of interest in religious values in therapy around the 1980s and 1990s, possibly attributed to Bergin’s (1980) somewhat controversial article calling for integration of clients’ religious values into therapy. In fact, efforts to consider clients’ religious values and to tailor treatment to religious and spiritual beliefs have shown some effectiveness and have received increasingly greater attention (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; see Hook et al., 2010; and Worthington, Hook, Davis, & McDaniel, 2011 for reviews). The importance of religious values in psychotherapy is further highlighted when one considers that approximately 92% of the population identifies with an organized religion (Kosmin & Lachman, 1993) but that in 1976 an estimated 50% of mental health professionals believed in God (Ragan, Malony, & Beit-Hallahmi, 1976). Although beyond the scope of the proposed investigation, available research suggests that religious values behave differently in psychotherapy in terms of the effects of similarity and dissimilarity on outcome and alliance (Worthington, 1988).

Beutler et al. (1975) investigated the relationship between perceived therapist credibility, attitude change, and psychotherapy outcome. The authors divided 97 psychiatric client-therapist dyads into high, medium, and low similarity with regard to their values, using the Situational Appraisal Inventory, Form J (Pittel & Mendelsohn, 1969). Clients were further divided according to whether they rated their therapist as
high or low perceived credibility on a semantic differential scale. Clients in the low-
similarity group had greater attitude change than clients in the high or medium- similarity
group, but there was no significant relationship found between perceived therapist
credibility and attitude change. However, not surprisingly, clients who perceived their
therapist to be highly credible were more likely to rate themselves as more improved
than clients who perceived their therapist to have low credibility. Interestingly, therapists
who were perceived to have low credibility provided higher improvement ratings as a
function of increased attitude similarity between themselves and their clients. Attitude
change was not significantly related to outcome, but the authors point out the possibility
that attitude similarity could affect the process of attitude change and subsequently
impact psychotherapy improvement.

Landfield and Nawas (1964) hypothesized that improved psychotherapy clients
tend to adopt their therapist ideals, and that a small degree of agreement between
clients and therapists, on factors the client found to be important in understanding
others, would be needed to facilitate improvement. This study built off of a previous
study (Nawas & Landfield, 1963) that also examined client tendency to adopt the frame
of reference of the therapist in terms of personal construct theory, but did not find
significant results evidencing a correlation among improved clients and their adoption of
therapist values. Landfield and Nawas (1964) used three outside raters to divide 36
clients into 2 groups of 18 “most improved” and 18 “least improved” following an
average of 8 sessions. All clients were also asked once per month during treatment to
complete a modified version of the Role Construct Repertory Test (RCRT; Kelly, 1955),
which involved rank ordering construct dimensions in order from most to least important
to understanding people. Clients were also asked to rate themselves as they viewed themselves at that time, to rate their ideal selves, and to rate the therapist as they viewed him or her. Therapists completed the same procedure for clients, but rated their ideal selves only one time during the study. The top five most important and top five least important constructs were identified for each client-therapist dyad. Similarity between client and therapist on which constructs were important to understanding people, defined as agreement on at least one construct from the client’s language dimension, was found to be related to improvement. Results also confirmed the hypothesis that improvement is associated with a movement of the client’s perceived self toward that of the therapist’s ideal.

Some research has aimed at examining whether the convergence phenomenon is observed in group and couples therapy. For example, Beutler (1971a) studied attitude change in ten couples receiving marital therapy from four clinical psychology predoctoral interns, a clinical psychologist, and a social worker. The couples and therapists were administered questionnaires asking them to rank attitudinal statements regarding the following: sex outside of marriage, masturbation, obedience to authority, parent-child relationships, and hostile and aggressive impulses. The questionnaires were first administered to clients after a mean of 3.44 therapy sessions and again after termination or 12 sessions, whichever occurred first. Therapists were administered the questionnaires pre-treatment and were also asked to rate improvement of his or her client on a 7-point Likert scale at the time of the posttest. Beutler (1971a) subtracted average differences between therapist and clients on the pre and posttest questionnaires in order to measure the change in client attitudes over time; similarly, the
same method was used to determine whether each client experienced attitude changes toward or away from his or her spouse. Results demonstrated a significant relationship ($r = .49$, $p < .05$) between clients’ adoption of spouse’s attitudes and therapist rating of improvement. A significant relationship was not found between improvement and client acquisition of therapist attitudes over the course of treatment, but a general trend for clients’ attitudes to move towards therapist attitudes was observed, regardless of degree of improvement. There was no significant difference between attitudinal discrepancy of clients and their spouses before as opposed to after treatment. The author concluded that although clients tended to acquire attitudes of the therapist over time, it was not related to improvement in marital therapy. Instead, successful marital therapy was characterized by spouses who became more attitudinally similar over the course of treatment.
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<td>good N (45 dyads); reliable values instrument; multiple outcome measures</td>
<td>RVS terminal and instrumental values scales; therapist rating of improvement and pre-post SCL-90R</td>
<td>( r = .52 ) (p&lt;.01) between initial dissimilarity and convergence; ( r = .34 ) (p&lt;.05) between rating of improvement and convergence; convergence and similarity not related to improvement as rated by patient or SCL-90R</td>
</tr>
<tr>
<td>Arizmendi, Beutler, Shanofield, Crago, &amp; Hagaman (1985)*</td>
<td>Psychiatric outpatients</td>
<td>good N (45 dyads); reliable values instrument; multiple outcome measures; improved analysis based on multiple regression of specific values on % gain of measures; no values posttest specific outcome</td>
<td>RVS 36 individual values; % gain from therapist rating of improvement; % gain from SCL-90R</td>
<td>( .84 ) (p&lt;.01) mult. R between therapist rating of improvement and initial values similarity; ( .35 ) (p&lt;.05) to ( .61 ) (p&lt;.01) mult. R between improvement on 5 of the SCL-R90 scales and initial values</td>
</tr>
<tr>
<td>Kelly &amp; Strupp (1992)</td>
<td>Adult outpatient</td>
<td>good N (39 dyads); reliable values instrument; multiple outcome measures; value change is measured retrospectively</td>
<td>RVS; client, therapist, observer clinician, Social Introversion scale of MMPI</td>
<td>64% of perceived changes were away from therapist values; value assimilation (convergence) related to therapist outcome rating, ( r = .45 ), (p&lt;.001)</td>
</tr>
<tr>
<td>Beutler et al. (1975)</td>
<td>Psychiatric outpatients</td>
<td>good N (97 dyads); assessed effects of credibility; 2 ratings of outcome; pre and post measures of attitude similarity;</td>
<td>Situational Appraisal Inventory, Form J; patient rating of improvement; therapist rating of improvement</td>
<td>low initial similarity produced greatest attitude change; therapist credibility not related to attitude change; high credibility related to high patient rating of improvement</td>
</tr>
<tr>
<td>Landfield &amp; Nawas (1964)</td>
<td>College student clients</td>
<td>good N (36 dyads); reliable constructs;</td>
<td>Role Construct Repertory Test; outside raters</td>
<td>improvement associated with movement toward therapist ideal; similarity was related to improvement</td>
</tr>
<tr>
<td>Beutler (1971a)</td>
<td>Couples</td>
<td>low N (10 dyads); pre and post measures of attitudes</td>
<td>attitudinal questionnaires; therapist rating of improvement</td>
<td>observed movement toward therapist attitudes but not related to improvement; clients' adoption of spouses' attitudes and therapist rating of outcome positively correlated, ( r = .49 ), p&lt;.05</td>
</tr>
</tbody>
</table>

*Note. *Study reviewed by Kelly (1990)
Individual Value Change

Outside of the psychotherapy literature, little attention has been given the notion that values may have the potential to change over time. In the psychological literature as a whole, values are generally conceptualized as stable entities. This has been a useful idea from a research standpoint, in that it allows values to be conceptualized as individual difference factors or stable client variables that can be used as predictors (Bardi et al., 2009). However, there is some evidence to support naturally occurring longitudinal value change, and understanding this process may significantly contribute to an understanding of value change within a psychotherapy context.

Bardi, Lee, Hofmann-Towfigh, and Soutar (2009) conducted four longitudinal studies that evidenced support for the idea that an individual’s values interact with one another within a quasi-circumplex structure (Schwartz, 1992). This model posits that values are related to each other not necessarily by their label, but by the nature of the underlying motivations behind them. For example, benevolence and achievement are not necessarily opposite values, but benevolence has an underlying motivation of self-transcendence, while achievement’s underlying motivation can be thought of as self-enhancement. An individual who highly values both benevolence and achievement could potentially experience an internal value conflict. Thus, Bardi et al. (2009) posits that when a value changes, its conflicting value will change in the opposite direction, and values with similar underlying motivations will change in the same direction.

Along with internal conflict regarding values an individual already holds, there exist other reasons an individual may experience value change and this line of research also has some implications for understanding how values might operate within a
psychotherapy context. For instance, Rokeach (1968) posited that new information or points of view from significant others can create an internal conflict which leads to value change. If we view the therapist as someone who may challenge an individual's current way of thinking in order to promote change, it seems plausible that therapy may be a catalyst for value change. Moderately positive correlations between value change and age have also been found (Schwartz, 2005b), possibly due to physiological changes or different life situations (such as beginning a new career or retiring). Bardi et al. (2009), however, found that major life events were significant predictors of value change above and beyond age. Given that many people seek therapy in response to life changing-events, we would also expect to see changes in values during therapy. Furthermore, this finding is supportive of previous research indicating that security values increased after the 9/11 terrorist attacks, for instance, but eventually returned to baseline (Verkasaolo, Goodwin, & Bezmenova, 2006). Similarly, it has been shown that at least half of trauma survivors report positive change or growth (Tedeschi & Calhoun, 1995) and that benefit-finding following a trauma produces less depression and more positive affect, despite the negative consequences of the trauma (Helgeson et al., 2006). Indeed, a wealth of research has documented positive change following trauma exposure (e.g., Linley et al., 2003), but is beyond the scope of this review (see Helgeson et al., 2006; and/or Prati & Pietrantoni, 2009 for reviews of post-traumatic growth and related factors). Bardi et al. (2009) points to this phenomenon to highlight a possible limitation in their study; because values were only assessed twice for each group of individuals, it is possible that value change was fleeting and will later revert to baseline. Furthermore, value change found in this study was represented by relatively
small effect sizes, and values were relatively stable with high test-retest reliability. The authors point out, however, that future research should not consider these findings discouraging—although values evidence relative stability, it does not mean that temporary value change, or even small value change, is not meaningful. This is especially relevant with respect to the role of values in psychotherapy process, where small effect sizes are also found. For instance, one must consider that the possible reasons for value change in therapy may be due to significant life events that are clinically relevant. These may also be the times at which an individual is more likely to seek therapy, which may in turn account for some value change not accounted for by psychotherapy alone.

**Are Therapists’ Values Homogenous?**

It has been theorized that the convergence phenomenon is accounted for by homogeneity of therapist values. If this is the case, it becomes possible that instead of moving toward any one therapist’s set of values, client values are simply shifting toward values of therapists in general. Another alternative is that this homogenous set of values represents constructs relevant to mental health in particular, and that therapists endorse a certain set of values.

There is some research supporting these possibilities. Jensen and Bergin (1988) conducted a national survey of mental health professionals to determine which values are considered important to psychotherapy. They created a values questionnaire based on a literature review of values pertinent to mental health practice, which asked therapists to rate their agreement with value statements according to how important to mental health they perceived the values to be on a 7-point Likert scale. Therapists were
also asked to indicate how many clients for whom they felt the value was important in
guiding psychotherapy (all clients, many clients, few clients, or no clients). Results
revealed consensus among therapists in the study about what values are most relevant
to therapy and mental health. Those values included being a free agent, having a sense
of identify and self-worth, interpersonal communication skills, skills in sensitivity and
nurturance, genuineness, honesty, self-control, personal responsibility, commitment in
relationships, having meaningful purposes, deep self-awareness and motivation for
growth, adaptive coping strategies, work fulfillment, and practicing good physical health
habits. However, these findings should be interpreted in light of some important
limitations. First, the researchers point out that the consensus in values among the
therapists may have in part been due to the fact that they chose the values for the
questionnaire based on values and concepts already known to be endorsed by mental
health professionals. They also point out their tendency to use general terms to
describe the values, whereas more specific terms may have resulted in more
discrepancies. Similarly, the researchers chose to exclude controversial values (except
for their interest in the diversity of religion and sex related values) and values which
were not directly related to the psychotherapy situation, such as political views.
However, it should be noted that although political views are not directly related to the
psychotherapy process, it is possible that personal values of therapists are heavily
influenced by political views—especially given that approximately 7 out of 10
psychologists are registered Democrats (McClintock, Spaulting, & Turner, 1965). It
should also be noted that the participants, as well as the researchers, were largely
representative of Western culture.
Although Jensen and Bergin (1988) did not examine the convergence phenomenon, they did find that values endorsed by mental health professionals as pertinent to mental health did appear to be influenced by their personal beliefs. Significant interactions with values endorsed for mental health were found for the personal variables of age, gender, marital status, political outlook, and religious affiliation and commitment. For instance, therapists who were more religious tended to endorse religious values as important to psychotherapy and mental health, and therapists in their first marriages were more likely to endorse marital values. These findings suggest that although it may not be clear whether therapist’s personal values in particular are impacting the client, they do impact the therapist’s perception of which values are important for mental health and may in turn play a role in the process of change in psychotherapy.

The idea that therapist’s personal values may be impacting psychotherapy raises some ethical concerns. However, the authors emphasize that the findings do not seem to threaten values of clients and that most of the agreement among mental health professionals is on values that are directly related to psychological problems or well-being. Most discrepancy was found on specific views regarding sex and religion; these differences are also reflected by more current research in this area (e.g., Ford & Hendrick, 2003).

Welkowitz, Cohen, and Ortmeyer (1967) took a unique approach to exploring the values of therapists, as well as how they compared to the values of clients. The authors wanted to know first, if therapists had similar values, and second, if therapists and their own clients had values that were more similar than values of therapists and clients who
were not working together (termed “not-own” clients, or randomly paired dyads). Instead
of measuring value similarity among therapist dyads pre and post treatment, the
researchers examined the relationship between length of treatment and degree of value
similarity. Clients and doctoral-level therapists at two psychoanalytic training centers in
New York City were administered the Ways to Live scale (WTL; Morris, 1956) and the
Strong Vocational Interest Blank (SVIB; Strong, 1943). All clients had been seen for 1-9
months, with 2 clients having been in therapy for less than 2 months. Additionally, to
test for a relationship between therapist perception of client improvement and value
similarity, therapists rated their clients’ improvement on a 6-point Likert scale 2 weeks
after completion of the values measures. To test the proposition that therapists share a
common set of values, a factor analysis was conducted for each values instrument. Six
factors emerged for each the WTL and the SVIB, and because no significant
concentration of therapists on any of the factors was found, the authors concluded that
therapists in their study do not share a homogenous value system.

Welkowitz, Cohen, and Ortmeyer (1967) then measured differences between
“therapist-own-patient” dyads and the randomly paired dyads. Pairs of therapists and
their own clients were further divided into groups of improved and not-improved based
on the therapist’s ratings, and an ANOVA revealed significant value differences (mean
correlations between therapists and clients) among each of the three groups. Therapists
and their own clients were more similar in values than randomly paired therapists and
clients, and a significant positive relationship was also found between length of time in
therapy and degree of value similarity. Regarding the relationship between value
similarity and therapist rating of outcome, the authors found that clients rated as
improved were more similar to their therapist in values than clients rated as unimproved. It was also concluded that because therapists did not appear to share similar values, that some clients were therefore moving away from the values of therapists who were not their own.

Several considerations are made by the authors in the generalization of these findings. First, they point that although not likely to be the case in this study, it is possible that value similarity effects could be the result of the process of pairing therapists and clients. For instance, if therapists choose their clients, it is possible that they may gravitate towards clients who seem similar to themselves. It is also possible that clients have a tendency to choose or prefer therapists with similar values. On the other hand, the authors note that because value similarity was related to length of time in treatment, it was more likely that the change was related to the therapeutic relationship and not to initial selection process. Another consideration is that the similarity between clients and therapists may be accounted for by a possible\textit{quantitative} difference in values before therapy and not to a\textit{qualitative} difference. Stated another way, perhaps clients who become more similar to therapists in values are simply moving toward greater commitment to or realization of those same values instead of changing the type of values they endorse.

Another implication of this important study is that, theoretically, clients and therapists randomly paired could potentially have strikingly different value systems. If this is the case, then a question emerges: if values are too dissimilar between a client and a therapist, is the therapeutic relationship negatively affected and therapy subsequently terminated?
<table>
<thead>
<tr>
<th>Reference</th>
<th>Population</th>
<th>Psychometric Strength</th>
<th>Primary Measure</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jensen &amp; Bergin (1988)</td>
<td>425 Mental health professionals in the U.S.</td>
<td>measure specific to mental health values; exclusion of controversial values</td>
<td>developed values questionnaire from literature review</td>
<td>therapists agree that certain values are relevant to mental health; therapist values are influenced by personal variables</td>
</tr>
<tr>
<td>Welkowitz, Cohen, &amp; Ortmeyer (1967)*</td>
<td>Psychoanalytic training centers</td>
<td>good N (44 dyads); reliable values instrument; factor analysis of each values instrument</td>
<td>Morris’s Ways to Live scale; Strong Vocational Interest Blank</td>
<td>no significant concentration of therapists on any of 6 emergent factors</td>
</tr>
</tbody>
</table>

*indicates study reviewed by Kelly (1990)
Value Similarity and Dissimilarity

Several researchers have speculated that initial value similarity and dissimilarity among clients and therapists affect the therapeutic alliance (e.g., Kelly, 1992; Beutler & Bergan, 1991). Kelly (1992) noted that a moderate degree of similarity was positively related to improvement, and hypothesized that “a conspicuous clash hinders the building of alliance” (p. 39). Given that working alliance is a consistent predictor of outcome in psychotherapy (Martin, Garske, & Davis, 2000) this area of research may be especially important to studying the roles of values in psychotherapy process and outcome. However, there have been very few studies conducted attempting to answer this question empirically. One of these studies (Beutler, 1971b) was reviewed by Kelly (1990) above, and found that dropout from therapy was not related to whether clients accepted or rejected their therapists’ attitudes.

However, Vervaeke, Vertommen, and Storms (1997) sought to investigate this hypothesis more directly and postulated that a large degree of value dissimilarity (“cumulative incompatibility”) between clients and therapists would negatively affect the beginning phases of the therapy and that initial similarity in values would be a facilitating factor during the initial stages of treatment. Quality of the beginning of therapy was quantified by drop-out, defined as early termination from therapy by a client who expressed a clear initial commitment to treatment. Client and therapist dyads (n = 78) in two outpatient mental health facilities in Belgium took a modified version of the Rokeach Value Survey (RVS, Rokeach, 1973) after the first session. Interested in values insofar as they can be seen as client preferences, each value on the RVS was converted to a 4-point Likert scale and altered to reflect two dimensions of preference: direction
(whether the value was preferred or not preferred) and coerciveness (willpower to achieve the preference). Clients were asked to view the values in the context of the treatment setting and rated both the degree to which they preferred the value (Do you wish to have a treatment in which x value is striven for?) and the degree of coerciveness (Yes, and it must be so; Yes, but it doesn't have to be so; No, but it is allowable; No, and it isn't allowable). Therapists completed a similar measure but were instead asked if they preferred a treatment in which a given value was striven for in treating a particular client. By conceptualizing values as preferences in this way, the authors were able to examine the effects of specific patterns of compatibility. Greatest incompatibility was defined as positive coercive and negative coercive responses of clients and therapists on a particular value and given a weighted value of “2,” noncoercive patterns of incompatibility were assigned a weighted value of “1,” and values which represented neither similarity nor incompatibility were coded “0.” These scores for each value were summed and a cumulative dissimilarity score for each dyad was obtained. A cumulative similarity score was also calculated in the same manner; values for clients and therapists that were rated the same direction and the same degree of coerciveness were rated as “1” and all other entries were coded “0.” The authors found that 75% of therapists rated several values that should not be pursued in therapy: salvation, an exciting life, polite, obedience, and ambitious. Seventy-five percent of clients and therapists agreed that inner harmony, happiness, pleasure, self-report, and family security should be pursued in therapy; all except family security were endorsed by 50% of clients or therapists as coercive. Some client values that were typically endorsed by therapists but not clients were mature love, social recognition, and
independence, while values endorsed typically only by clients were wisdom, a sense of accomplishment, courageous, and self-controlled. The authors point out that in general, therapists tended to endorse fewer coercive preferences than clients, which could reflect therapist tolerance and flexibility, but also had the effect of reducing the number of incompatible combinations between therapists and clients on the values.

Regarding dropout, clients who left therapy early had significantly higher mean value dissimilarity between themselves and their therapists ($t = -2.58$, $p < .01$). Among clients who stayed in therapy and clients who dropped out, no significant differences in value similarity was found. The authors conclude that a cumulative degree of value dissimilarity is associated with dropout, presumably due to the negative impact it has on the therapeutic alliance. They espouse the importance of devoting attention to preferred values of clients, especially when the client’s values are different from one’s own as a therapist. It also is possible that values function in a different way in the beginning of therapy than they do in the later stages.

*Perceived Value Similarity*

Vervaeke, Vertommen, and Storms (1997) also point out that although significant effects were noted by measuring actual value similarity and dissimilarity in this study, that perceived degree of similarity or dissimilarity might be a stronger predictor of dropout and outcome, as suggested by Atkinson et al. (1991). In this latter study, the researchers examined the beliefs clients and therapists have about the causes of the client’s psychological problems. Pretreatment, clients at a university counseling center rank-ordered believed causes of their psychological problems (irrational concerns, job/career/academic difficulty, physical illness, lack of social awareness, biological
imbalances, bad luck). At the same time, therapists rank ordered causes as they believed applied to each individual client. After either three sessions or termination, clients performed a rank ordering again. At this time clients also completed a Counselor Effectiveness Rating Scale (CERS; Atkinson & Wampold, 1982) intended to measure counselor credibility, as well as 3-items measuring their satisfaction with counseling on a 7-point scale. Lastly, clients rated, also on a 7-point scale, the degree to which they believed their counselor’s opinion about the causes of their psychological problems was similar to their own. Results demonstrated that clients’ perceived similarity between themselves and their therapists regarding beliefs about the causes of their problems was found to predict satisfaction with therapy and client-rated counselor credibility, while actual similarity was not significantly related to either of these variables. Evidence was also found in this study for a convergence phenomenon—clients’ beliefs about the causes of their problems became more similar to the therapist’s over time. Before counseling, 54.6% of clients had the same belief about the cause of their problem as their therapist, and after an average of 3 sessions, this number increased to 69.1%. Of the 29% of clients who changed their belief, more than 21% exhibited a change in the direction of the therapist’s beliefs. It is notable that the changes observed in this study occurred after only 3 sessions; presumably, the effects would be more pronounced after more sessions.

Hersoug, Hoglend, Monsen, & Havik (2001) found that value similarity, as measured by the Rokeach Value Survey (RVS; 1973) was related to working alliance as rated by clients on the Working Alliance Inventory (WAI) at the third session and after Sessions 12 and 20. Furthermore, they did not find a relationship between working
alliance and similarity in personal characteristics of clients and therapists, and noted low to moderate correlations between client and therapist ratings of therapeutic alliance. In general, clients’ average ratings of alliance were higher. It was noted that because clients may perceive cues of similarity in values, that this might produce a positive evaluation of working alliance. This is also consistent with the suggestion of Atkinson et al. (1991) that perceptions of similar beliefs are greater predictors of positive improvement in therapy than is actual similarity.

Few studies aside from these have investigated the role of perceived value similarity, and more research is needed to determine the exact relationship between perceived similarity, actual similarity, and alliance and outcome.

Value Similarity and Outcome

Initial value similarity and difference among clients and therapists is most likely related to outcome in a complex way. That is, similarity on some values, with simultaneous differences on others may better describe the influence of client and therapist values on improvement. Arizmendi and colleagues (1985) attempted to elucidate the relationship between pretreatment value similarity and improvement. They surveyed 22 therapists (psychiatric residents, clinical psychology graduate students, social work externs, and a psychiatric nurse) and 45 psychiatric outpatients. Clients completed the SCL-90R (Symptom Checklist Revised; Derogatis et al., 1967) before and after therapy as a measure of client rating of improvement, and the Rokeach Value Survey (RVS; Rokeach, 1968) before therapy. Therapists completed the RVS before therapy and completed a Discharge Summary rating (Beutler & Crago, 1983) after therapy to indicate client improvement. Percent gain scores on each scale of the SCL-
90R and the Discharge Summary measures were calculated. Stepwise multiple regressions revealed that different patterns of initial similarity and differences among values of therapists and patients affected the different outcome measures differently. When therapists rated improvement, clients exhibited the best outcomes when there was a difference between therapists and clients on the values of accomplishment, wisdom, and happiness—values related to “upward mobility,” and similarity on the values of courage, politeness, excitement, and national security—values related to more humanistic concerns. With respect to patient ratings of improvement, a different combination of similarity and dissimilarity among values was found to best predict positive outcome. Although similarity in humanistic concerns was related to patient ratings of outcome, dissimilarity among social attachment and independence-related values produced a stronger correlation.

Hypotheses

Given that values are crucial to providing evidence-based practice, there is startling little current research aimed at understanding how values in psychotherapy are related to alliance and outcome. The proposed study sought to contribute to the literature on values and psychotherapy as it can be understood within an evidence-based practice framework. Existing research has evidenced that the phenomenon of value change in therapy and the degree of discrepancy between client and therapist values have complex, but important implications for therapeutic alliance and treatment outcomes.
Table 3

**Value Similarity and Dissimilarity**

<table>
<thead>
<tr>
<th>Reference</th>
<th>Population</th>
<th>Psychometric Strength</th>
<th>Primary Measure</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vervaeke, Vertommen, &amp; Storms (1997)</td>
<td>Outpatient mental health clinics in Belgium</td>
<td>good N (78 dyads); reliable values measure; distinguished between direction and coerciveness of value preference</td>
<td>Likert-scale version of RVS; dropout defined as early termination by client who had expressed initial commitment to treatment</td>
<td>clients who dropped out had higher mean value dissimilarity ($t = -2.58, p&lt;.05$)</td>
</tr>
<tr>
<td>Atkinson et al., (1991)</td>
<td>University counseling center</td>
<td>multiple regressions</td>
<td>Counselor Effectiveness Rating Scale; 3-item scale measuring satisfaction with counseling; 7-point-scale rating of degree to which clients believed therapists shared their beliefs about causes of psychological problems</td>
<td>perceived similarity predicted satisfaction and credibility</td>
</tr>
<tr>
<td>Hersoug, Hoglend, Monsen, &amp; Harik (2001)</td>
<td>Outpatient psychiatric clinic (non-psychotic)</td>
<td>good N (59 therapists and 270 patients)</td>
<td>RVS; Working Alliance Inventory</td>
<td>value similarity was related to good working alliance at Sessions 3, 12, and 20; clients’ ratings of alliance were higher than therapists’</td>
</tr>
<tr>
<td>Arizmendi, Beutler, Shanfield, Crago, &amp; Hagaman (1985)*</td>
<td>Psychiatric outpatients</td>
<td>good N (45 dyads); reliable values instrument; multiple outcome measures; improved analysis based on multiple regression of specific values on % gain of specific outcome measures; no values posttest</td>
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<td>$.84 (p&lt;.01) mult. R between therapist rating of improvement and initial values similarity; $.35 (p&lt;.05) to $.61 (p&lt;.01) mult. R between improvement on 5 of the SCL-R90 scales and initial values</td>
</tr>
</tbody>
</table>

*indicates study reviewed by Kelly (1990)
This research also challenges the assumption that therapists are effectively refraining from “imposing” values on clients, raising potential ethical concerns and highlighting the need for more research in this area to inform clinicians about the best way to go about addressing values in psychotherapy.

Based on the small body of existing research (Kelly, 1990; Kelly, 1992; Landfield & Nawas, 1964; Rosenthal, 1955) the following hypotheses and research questions were proposed:

1) Dissimilarity/similarity in values will be associated with alliance and outcome.

2) Perceived value similarity/dissimilarity will be a better predictor of working alliance than actual similarity.

3) Is therapists’ perception of client values consistent with clients’ actual values?

4) Is there a significant association between therapists’ and clients’ perception of one another’s value differences/similarities and working alliance?

5) Do client and therapist values converge over the course of psychotherapy? (Although in most of the literature the term ‘convergence’ has been used to convey the idea that client values change in the direction of the therapist’s, the possibility that therapist values may change as well during therapy has not been empirically investigated previously. Thus, the current study used the term convergence to mean the movement of client and/or therapist values towards similarity.)

6) Is convergence, as defined above, significantly associated with positive outcome in the form of lessening symptomatic distress?
CHAPTER III

METHODOLOGY

Participants

Adult, individual therapy clients and doctoral trainee therapists at the University of North Texas Psychology Clinic served as participants. After recruitment, data was obtained from 30 clients and 18 trainee therapists, resulting in 29 client-therapist dyads (one therapist’s client chose not to participate). The distribution of the 29 clients to the 18 individual therapists within the study was as follows: 9 therapists had 1 client, 5 therapists had 2 clients, 2 therapists had 3 clients, and one therapist had 4 clients. Most of the clients (73.3%, \( n = 22 \)) indicated they had attended individual therapy in the past, prior to with their current therapist. Finally, 13.3% \( (n = 4) \) of clients terminated from therapy over the course of the study, including three mutual terminations and one client-initiated termination.

Clients were mostly female (77.4%, \( n = 24 \)) and White (80.6%, \( n = 25 \)), with 3.2% \( (n = 1) \) identifying as Black/African American, 9.7% \( (n = 3) \) as Hispanic/Latino, and 6.5% \( (n = 2) \) as multiracial. Average age of the clients was 32.19. Most clients identified as heterosexual (66.7% \( n = 20 \)) with 16.7% \( (n = 5) \) identifying as bisexual, 13.3% \( (n = 4) \) as “Other,” and 3.3% \( (n = 1) \) as gay or lesbian. Regarding marital status, 46.7% \( (n = 5) \) of clients indicated they were single, 20.0% \( (n = 14) \) in a committed relationship, 16.7% \( (n = 5) \) married/partnered, 13.3% divorced, and 3.3% \( (n = 1) \) living with a committed partner. Most clients reported they had no children or dependents for whom they were the primary caregiver (90% \( n = 27 \)). The majority of the clients indicated they did not ascribe to a particular religion (29%, \( n = 9 \)) or described their religion as “other” (25.8%,
Christian clients consisted of 25.8% (n = 8) of the sample, while 3.2% (n = 1) identified as Buddhist and 3.25% (n = 1) identified themselves as Unitarian Universalist. With respect to political views, 58.6% (n = 17) of the clients noted they were politically liberal, while 13.8% (n = 4) of clients indicated they were independent, 10.3% (n = 3) as moderate, 6.9% (n = 2) conservative, 6.9% as other, and 3.4% libertarian.

Therapists in this study were doctoral trainees completing practicum at the UNT Psychology Clinic. They were also mostly female (72.2%, n = 13) and heterosexual (94.4%, n = 17), with an average age of 23.00 (SD = 1.52). Ethnic distribution of the therapists was 66.7% (n = 12) White, 22.2% (n = 4) Asian (including Middle Eastern) and 11.1% (n = 2) Latino/Hispanic. Therapists indicated they were single (38.9% n = 7), living with a committed partner (27.8%, n = 5), married/partnered (16.7%, n = 3), or in a committed relationship (16.7% n = 3). Most indicated they had no children or dependents (88.9%, n = 16). Religious/spiritual beliefs of the therapists were mostly Christian (55.6%, n = 10), with 11.1% (n = 2) identifying as Agnostic, 11.1 (n = 2) as “Other,” 11.1% (n = 2) identifying as Atheist, 5.6% (n = 1) identifying as Muslim, and 5.6% (n = 1) identifying as Jewish. Politically, the trainees were mostly liberal (61.1% n = 11), with 22.2% (n = 4) indicating they were Moderate, 5.6% (n = 1) Libertarian, and 11.1% (n = 2) Independent.

With respect to training characteristics of the therapists, most of the students were enrolled in a clinical psychology program (50.0%, n = 9), with 33.3% (n = 6) in the clinical health/behavioral medicine program and 16.7% (n = 3) in the counseling psychology program. They were primarily in their third year (61.1%, n = 11) with 22.2% (n = 4) in their second year, 5.6% (n = 1) in their fourth year, and 5.6% (n = 1) in their
first year. Average number of total face-to-face therapy hours with clients was self-reported to be 175.07 ($SD = 159.07$) and ranged from 11 to 800 ($M = 153.52$, $SD = 108.54$ with outlier of 800 removed.) Ten different faculty members were identified as supervisors, and the therapists indicated they were working from a variety of theoretical orientations: psychodynamic (11.1%, $n = 2$), Acceptance and Commitment Therapy (ACT, 16.7%, $n = 3$), Cognitive Behavioral Therapy (CBT, 16.7%, $n = 3$), integration of ACT and psychodynamic therapy (11.1%, $n = 2$), Adlerian (5.6%, $n = 1$), Emotion-focused therapy (EFT, 5.6%, $n = 1$), and Interpersonal (5.6%, $n = 1$). A significant proportion of the trainees indicated they did not work from any particular theoretical orientation (“None,” 27.8%, $n = 5$). The trainees’ tendency to indicate “None” was not correlated with level of experience or number of therapy contact hours.

Measures

*Outcome Questionnaire 45.2 (OQ45.2)*

The OQ45.2 (Lambert et al., 2004) is a 45-item, self-report measure on which clients rate items on a categorical scale ranging from *never* to *almost always*, according to their symptoms over the past week. Three different symptomatic areas are measured on the OQ45.2: subjective distress, interpersonal functioning, and social role performance. Each of these domains generate separate subscores—symptom distress scores 36 and above, interpersonal functioning scores 14 and above, and social scores 12 and above indicate a score in the clinical range for that domain. Each subscore contributes to a total score ranging from 0-180, with a clinical range defined as at or above 63.
The OQ45.2 has been shown to be a sufficiently reliable and valid measure. Test-retest reliability as recorded in the administration and scoring manual is .84, and internal consistency is .93. Concurrent validity with other measures such as the SCL 90 R (Derogatis, 1977) was found to be high. Additionally, the OQ45.2 has been found to possess sufficient sensitivity (Vermeersch, Lambert, & Burlingame, 2000; Vermeersch et al., 2004). The OQ45.2 manual reports a sensitivity of .84 for the clinical cutoff score of 63, meaning that 84% of the non-patient group was distinguished correctly by this cutoff and 16% of the non-patient sample was incorrectly categorized into the patient group. Similarly, the OQ45.2 is shown to distinguish between clinical and non-clinical samples but not between non-patient groups, demonstrating adequate construct validity.

Coefficient alphas for each of the scales in the current sample were .89 for the total score, and .77 to .81 for the symptomatic areas.

*Working Alliance Inventory (WAI)*

The WAI (Horvath & Greenberg, 1986) is one of the most widely-used measures of alliance in psychotherapy. It is a self-report questionnaire that consists of 36 items rated on a 7-point Likert-type scale. There are three 12-item subscales that measure perception of agreement about the goals and tasks in therapy, as well as the development of bond in therapy.

Tracey and Kokotovic (1989) developed a 12-item short form of the WAI (WAI-Short) via confirmatory factor analysis, used in this investigation as part of the routine standard of care in the clinic. The four items from the WAI that loaded highest on each of the subscales were used to create this shortened version, which adequately
measures overall alliance and the three specific components of task, bond, and goal. Thus, the short-form of the WAI is shown to have a similar factor structure to the original version and is useful for efficient assessment of the quality of working alliance. Internal consistencies in the current sample were .89 for the total scores and between .83 and .86 for the subscales.

Life Values Inventory (LVI)

The LVI (Crace & Brown, 1996) was used to assess client and therapist values. The LVI is a free, multiculturally sensitive, self-administered questionnaire that can be completed in under 10 minutes. There are 42 items that examine 14 values, derived using the rational approach to test construction and factor analysis: Achievement, Belonging, Concern for the Environment, Concern for Others, Creativity, Financial Prosperity, Health and Activity, Humility, Independence, Interdependence, Objective Analysis, Privacy, Responsibility, and Spirituality. The individual is asked to identify, on a 5-point Likert-type scale, how often each value currently guides his or her behavior.

The authors of the LVI adopt Rokeach’s (1973) definition of values: “standards that not only guide the behavior of the individuals who hold them, but serve as their basis for judging the behavior of others” (Crace & Brown, 1996). Values are distinguished from interests, preferences, and needs; are considered more stable influences on behavior, and serve as the basis for future goals. Compared to other values inventories, such as the respected Rokeach Value Survey (1973), the LVI is thought to have greater utility because of its consideration of how a person’s values influence behavior, making it particularly suitable for use in a clinical setting. It was also
thought that, theoretically, the values assessed by the LVI may be more applicable to the therapeutic context than those of other values inventories.

Regarding its psychometric properties, the LVI appears to be measuring values that are relatively independent from one another. The measure’s authors report that the highest inter-scale correlation is -.42, and that there are only four correlations greater than .30. Convergent validity of the LVI has been shown to be satisfactory when correlating the LVI scale scores with items from a rating-scale version of the Rokeach Value Survey (RVS), a measure frequently used in values research. Discriminant validity of the LVI with the Crowne-Marlowe Social Desirability Scale indicated that social desirability accounts for a small amount of the variance in LVI scores, with the highest significant correlation (.277) accounting for 7.6% of the variance in the Concern for Others scale.

The LVI scales have good internal and temporal consistency. Coefficient alphas in a sample of adults ranged from .55 (Independence) to .88 (Spirituality), and ten coefficients were higher than .70. In 72 adults, at an interval of 19 days between the initial test and the retest, coefficients for all scales were significant at p < .0001 and ranged from .57 (Concern for Others) to .90 (Spirituality). In the current sample of clients, alphas ranged from .35 to .87 on the scales. Among therapists in this study, alphas ranged from .47 to .92 (please see Table 3 below for coefficient alphas for each value).

*Life Values Inventory—Perceived (LVI-P)*

The LVI-P is a version of the LVI modified for purposes of evaluating client perception of therapist values, and therapist perception of client values. The LVI was
presented to the client with modified instructions: to complete the LVI “as though you are your therapist.” During the first time each client completed this measure, a research assistant ensured that the client understood the instructions and reminded the client that their responses were confidential. The instructions read:

Thank you for participating in this study about values. We would like you to complete the survey again—but this time, please complete the survey as though you are your therapist.

Similar instructions were provided to the therapist (see Appendix E) indicating that the therapist was to complete the measure “as though you are your client.” Coefficient alphas for the Client LVI-P ranged from .44 to .89, and from .41 to .89 for the Therapist LVI-P (see Table 3).

Procedure

All participants were treated in accordance with APA’s Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2010).

Clients

Adult, individual psychotherapy clients participating in the study were recruited via a flier placed in the initial paperwork at the client’s intake appointment, available in the clinic waiting area, and passed out to current clients attending therapy during their check-in and completion of routine paperwork. On the flier, interested clients were asked to provide their name and phone number as permission for the researcher to contact him or her. As an incentive for participation, clients were offered entry into a raffle for a cash prize of $150. When interested clients were assigned to a clinician, per standard clinic procedure, the therapist was notified of his or her client’s interest. A trained research assistant then met with the client following their therapy session, and
obtained informed consent. At that time, the client also completed the demographic survey, the LVI, and the LVIP. All clients were reminded that the therapist would not view their responses on the values measures. As part of the routine standard of care in the clinic, the OQ45.2 was also administered to clients automatically at every session, and the WAI was administered once per month (about every 3 weeks) to all clients. Finally, some demographic information was obtained via the client’s clinic file (in addition to the study demographic survey), including the client’s ethnicity and religious identification.

**Therapists**

Therapists were recruited via email and in person discussions with the researcher. Therapists were told that the study would examine the roles of client and therapist values in therapy, and were provided informed consent forms and information about relevant procedures. To maintain internal validity, therapists were provided minimal information regarding the nature of the measures their participating clients would complete, and did not view their clients’ completed values measures. Additionally, therapists were not provided information about the specific hypotheses of the study. Following informed consent, and at the time their clients completed measures, therapists completed a questionnaire surveying demographic information, as well as the LVI and the LVI-P.
Table 4

Coefficient Alphas for the LVI and LVIP for Clients and Therapists

<table>
<thead>
<tr>
<th>Value</th>
<th>Items</th>
<th>Client LVI</th>
<th>Client LVIP</th>
<th>Therapist LVI</th>
<th>Therapist LVIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement</td>
<td>1, 15, 29</td>
<td>.76</td>
<td>.73</td>
<td>.41</td>
<td>.47</td>
</tr>
<tr>
<td>Belonging</td>
<td>2, 16, 30</td>
<td>.81</td>
<td>.80</td>
<td>.79</td>
<td>.86</td>
</tr>
<tr>
<td>Concern for the Environment</td>
<td>3, 17, 31</td>
<td>.84</td>
<td>.73</td>
<td>.47</td>
<td>.86</td>
</tr>
<tr>
<td>Concern for Others</td>
<td>4, 18, 32</td>
<td>.41</td>
<td>.44</td>
<td>.75</td>
<td>.60</td>
</tr>
<tr>
<td>Creativity</td>
<td>5, 19, 33</td>
<td>.87</td>
<td>.84</td>
<td>.82</td>
<td>.84</td>
</tr>
<tr>
<td>Financial Prosperity</td>
<td>6, 20, 34</td>
<td>.86</td>
<td>.85</td>
<td>.89</td>
<td>.86</td>
</tr>
<tr>
<td>Health and Activity</td>
<td>7, 21, 35</td>
<td>.84</td>
<td>.68</td>
<td>.83</td>
<td>.74</td>
</tr>
<tr>
<td>Humility</td>
<td>8, 22, 36</td>
<td>.82</td>
<td>.77</td>
<td>.86</td>
<td>.92</td>
</tr>
<tr>
<td>Independence</td>
<td>9, 23, 37</td>
<td>.35</td>
<td>.64</td>
<td>.61</td>
<td>.61</td>
</tr>
<tr>
<td>Loyalty to Family or Group</td>
<td>10, 24, 38</td>
<td>.71</td>
<td>.76</td>
<td>.51</td>
<td>.82</td>
</tr>
<tr>
<td>Privacy</td>
<td>11, 25, 39</td>
<td>.86</td>
<td>.71</td>
<td>.65</td>
<td>.84</td>
</tr>
<tr>
<td>Responsibility</td>
<td>12, 26, 40</td>
<td>.65</td>
<td>.64</td>
<td>.58</td>
<td>.83</td>
</tr>
<tr>
<td>Scientific Understanding</td>
<td>13, 27, 41</td>
<td>.80</td>
<td>.80</td>
<td>.56</td>
<td>.89</td>
</tr>
<tr>
<td>Spirituality</td>
<td>14, 28, 42</td>
<td>.80</td>
<td>.89</td>
<td>.88</td>
<td>.75</td>
</tr>
</tbody>
</table>

Table 5

Measures Administered to Clients and Therapists Across the Course of Psychotherapy

<table>
<thead>
<tr>
<th>Time</th>
<th>OQ45.2*</th>
<th>WAI*</th>
<th>LVI</th>
<th>LVI-P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 1</td>
<td>C</td>
<td>C</td>
<td>C, T</td>
<td>C, T</td>
</tr>
<tr>
<td>Every 3rd session</td>
<td>C</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 2</td>
<td>C</td>
<td>C</td>
<td>C, T</td>
<td>C, T</td>
</tr>
<tr>
<td>Every session</td>
<td>C</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Note. *routine standard of care; C = administered to clients; **Early treatment is defined as any point prior to session 5; T = administered to therapists; OQ45.2 = Outcome Questionnaire 45.2; WAI = Working Alliance Inventory; LVI = Life Values Inventory; LVI-P = Life Values Inventory—Perceived.
CHAPTER IV
RESULTS
Demographics Associated with Working Alliance and Outcome

Each of the demographic and other descriptive variables were examined for correlations with the dependent study variables. No differences were found in Total OQ45.2 score or Total Working Alliance Inventory (WAI) score among clients and therapists according to any of the demographic groupings. However, clients who were married were found to have lower scores on the Task scale of the WAI ($r = -3.77, p = .044$), and clients seeing therapists with more contact hours tended to score higher on the Social Role Performance scale of the OQ45.2 ($r = .50, p = .040$), indicating more distress in this area.

Client and Therapist Values

First, a number of relationships were noted between importance ratings for each value and client and therapist demographic variables. In the analyses described below, due to small sample size, some demographic variables were collapsed into three or fewer groups in order to run appropriate post-hoc analyses in determining group differences. The Games-Howell post hoc test was used following the one-way ANOVAs to account for unequal variances. Additionally, Levene’s tests were run for independent samples $t$-tests and interpreted based on the existence of equal variances among the groups.

Client Variables

Client age was found to be negatively correlated with valuing Financial Prosperity ($r = -.45, p = .013$), and positively correlated with Spirituality ($r = .42, p = .021$). Clients
who were men valued Independence significantly more than women ($t[28] = 4.08, p < .001$), while women more strongly valued Loyalty to Family or Group ($t[28] = -2.10, p = .045$) than did men in this sample. Clients identifying as heterosexual tended to more strongly value their Independence than clients who identified as gay, lesbian, bisexual, and who indicated “Other” ($t[28] = 3.96, p < .001$). Having children/dependents or being a primary caregiver was associated with more highly valuing Humility ($t[28] = 12.33, p = .029$) and Spirituality ($t[28] = -2.21, p = .035$). Clients who stated they had liberal political views were less likely to value Humility ($t[27] = -4.43, p < .001$) and Loyalty to Family or Group ($t[27] = -2.50, p = .019$), compared to clients identifying as conservative, libertarian, moderate, independent, or other. Regarding religion, clients who identified with a specific religion (as opposed to indicating they were Atheist, Agnostic, or endorsing “None”) were more likely to value Spirituality ($t[28] = -2.64, p = .015$). Finally, clients who indicated they had had previous therapy were more likely to value Concern for the Environment ($t[28] = -2.33, p = .027$) and Concern for Others ($t[28] = 3.86, p = .027$), but less likely to value Responsibility ($t[28] = 2.11, p = .044$). No differences were found in values among client ethnicity or marital status.

**Therapist Variables**

Therapists who stated they were single more highly valued Independence over those who were in a committed relationship ($F[3, 14] = 3.55, p = .042$). Religious therapists were more likely to value Spirituality than those not identifying with a particular religion ($t[16] = -3.29, p = .005$). No other demographic variables were found to be significantly related to therapist values.
Differences in values were also examined among therapists’ training characteristics. Due to the variety of theoretical orientations present in the study, the theoretical orientation variable was collapsed into three groups to broadly encompass: (1) process-oriented/insight-oriented/experiential therapies (psychodynamic, Acceptance and Commitment Therapy, Interpersonal Therapy, Adlerian therapy, Emotion-focused therapy, integrative psychodynamic/ACT); (2) cognitive behavioral therapy (CBT); and (3) students endorsing that they did not ascribe to any particular theory at this time (“None”). No significant differences were found in values among therapists of different theoretical orientations. However, significant differences were found among experience level of the therapists. Those who had more face-to-face contact hours were less likely to value Financial Prosperity ($r = -.56, p = .015$), and those who had seen clients for more years were more likely to value Creativity ($r = .54, p = .020$) and less likely to value Achievement ($r = .47, p = .049$). No value differences were found among therapists in different PhD programs.

**Comparison of Client and Therapist Values**

Mean comparisons between client and therapist values are displayed in Figure 1. Clients and therapists in this sample are significantly different on several values. Therapists tended to place significantly higher value on Achievement, Health and Activity, and Spirituality, while clients scored higher on Concern for the Environment, Creativity, Humility, Independence, and Privacy. Responsibility was the value both clients and therapists rated as most important. Alternately, clients rated Health and Activity as least important, while therapists’ lowest rated values were tied among Humility, Concern for the Environment, and Creativity.
Therapist Perceptions of Client Values

An exploratory aim of this study was to examine whether therapists are able to accurately perceive the values of their clients, and whether this is associated with outcome or working alliance. To explore this aim, clients’ ratings for each of the 14 values were correlated with therapist’s predictions of how important their client rated the values (on the LVIP). Results showed that therapist’s perceptions positively correlated with client’s actual rating on the values of Concern for the Environment ($r = .61, p < .001$) and Scientific Understanding ($r = .42, p = .038$). No other significant correlations were identified. Next, the total difference between client actual values and therapist perception of client values was calculated by adding the absolute difference between ratings, among client actual values and therapist perceptions, for each value. The total difference score was not correlated with any scales or subscales of the WAI or OQ45.2, suggesting that therapist’s ability to predict client values was not related to outcome or working alliance in this sample. Additionally, regarding client perceptions of therapists’ values, no significant correlations were identified between therapists’ actual values and clients’ perceptions of therapists’ values as rated on the client LVIP.

Therapeutic Relationship and Outcome

Mean scores on the Working Alliance Inventory and OQ45.2 for Time 1 can be seen in Table 6. The mean session number at which the Time 1 data was collected was about session 14, and ranged from session 1 to session 49. No significant relationships were noted between any of the OQ or WAI scores or subscores and session number. No significant relationships among total score or subscale scores were found between working alliance and outcome in this sample.
Values, Outcome, and Working Alliance

First, clients’ and therapists’ actual values were explored for relationships between outcome and working alliance, as measured by the OQ45.2 and the Working Alliance Inventory. No therapist values were found to be associated with working alliance or outcome. However, several client values yielded significant findings. In these analyses, higher OQ scores indicate greater distress, while higher WAI scores indicate stronger alliance. First, valuing Financial Prosperity was associated with higher total OQ scores \( (r = .38, p = .044) \) and remained significant when controlling for client age \( (r = .40, p = .042) \). Financial Prosperity was also associated with the OQ Social subscale, again after controlling for client age \( (r = .41, p = .036) \). OQ Interpersonal subscale scores were negatively associated with client valuing of Privacy \( (r = -.40, p = .033) \). Additionally, a couple variables initially indicated significant relationships, but became nonsignificant after controlling for appropriate demographic variables: (1) valuing Spirituality was associated with the Bond scale of the WAI, but became nonsignificant when controlling for client religion, dependents, and age; and (2) the significant association between valuing Responsibility and the Interpersonal scale on the OQ45.2 became nonsignificant after controlling for previous individual therapy.

To test the hypothesis that dissimilarity in values would be associated with alliance and outcome, the total difference between client and therapist values was correlated with total scores and subscores of the OQ45.2 and WAI. Total difference was calculated by adding the absolute value of the differences between clients and therapists on each of the 14 values. Difference in actual values was not found to be associated with outcome or alliance in this sample.
It was also hypothesized that client perception of therapist values would be a stronger predictor of Working Alliance than the actual values of the therapist. The results indicate evidence in favor of this prediction; above, no actual therapist values were associated with working alliance (or outcome), and here, several client perceptions of therapist values are associated with outcome and alliance. For instance, clients who perceived their therapist as valuing Responsibility indicated stronger therapeutic alliance (Total WAI score, $r = .57$, $p = .005$; Bond, $r = .59$, $p = .003$; Goal, $r = .60$, $p = .002$). Regarding outcome, client perceptions of therapists as more Independent seemed to negatively impact outcome, as indicated by correlations with the Total OQ score ($r = .49$, $p = .018$) and OQ Social scale ($r = .57$, $p = .005$). Correlations with the OQ Social scale remained significant when controlling for the total number of therapist contact hours ($r = .51$, $p = .010$).

Analyses were also conducted regarding the total difference score representing clients’ overall perceived value similarity to their therapist, and alliance and outcome. Clients who perceived the therapist to have more similar values as themselves overall indicated higher scores on the Goal subscale of the Working Alliance at both Time 1 ($r = .44$, $p = .021$) and Time 2 ($r = .70$, $p = .016$). Additionally, at Time 2, clients who perceived therapists to more closely match their own values indicated more distress on the Social Scale of the OQ, even when controlling for number of therapy contact hours ($r = .69$, $p = .018$).

Exploratory Analyses

A small number of clients and their therapists completed all measures a second time ($n = 11$ dyads; 37.9% of the original sample; one client’s therapist did not complete
Time 2 data), at an average of about session number 31, with the Time 2 session numbers ranging from 3 to 58. No significant differences or associations were noted in the analyses on the basis of session number. The additional data was used to explore whether client and therapist values became more similar over time. To accomplish this, the difference between each client and therapist’s rating of each value was calculated, for both Time 1 and Time 2 measurements. Then, the absolute values of each difference were added to create two total difference scores—one representing the client-therapist total value difference in Time 1, and another difference score representing total value difference at Time 2. A paired-samples t-test comparing the total difference scores at Time 1 and Time 2 revealed that clients and therapists in this sample did not become more similar (or more different) in their values over time.

**Outcome and Working Alliance**

Small, but statistically significant improvements in Total WAI were observed from Time 1 ($M = 47.30$, $SD = 9.36$) to Time 2 ($M = 50.50$, $SD = 8.96$), on Total WAI ($t[11] = -2.31$, $p = .04$). Similarly small, but again statistically significant, improvement was also seen on the WAI Goal scale from Time 1 ($M = 14.53$, $SD = 3.62$) to Time 2 ($M = 15.92$, $SD = 3.32$; $t[11] = -2.402$, $p = .035$). Regarding outcome, the criteria for reliable change (Jacobson & Truax, 1992) was not met at Time 2, nor were there statistically significant differences in OQ scores between Time 1 and 2, meaning that no clients in this subsample showed reliable improvement. However, notably, average change scores from Time 1 to Time 2 were all in a positive direction, indicating movement toward less distress as measured by the OQ; additionally, average Total OQ score in Time 2 shifted into the non-clinical range ($M = 61.83$, $SD = 24.72$). OQ Symptomatic distress was also
in the non-clinical range at Time 2 ($M = 35.92$, $SD = 15.81$), as were scores on the Social scale ($M = 11.92$, $SD = 5.56$). The Interpersonal scale showed a score sitting right at the cutoff for clinical distress ($M = 14.00$, $SD = 6.01$). At Time 2, as with Time 1, no relationship was evidenced between working alliance and outcome.

**Summary of Main Findings**

First, it was hypothesized that dissimilarity in values would be associated with poor alliance. In fact, no relationship was found between value differences and outcome/alliance in this sample. It was also hypothesized that perceived similarity or dissimilarity in values would be more strongly associated with working alliance than actual differences or similarities in values, and some evidence was generated to support this. Clients who perceived their therapist as more similar indicated higher Goal scores on the WAI; however, perceived similarity was positively associated with higher distress on the Social Scale of the OQ. Clients who perceived their therapist as valuing Responsibility indicated stronger therapeutic alliance. Regarding outcome, client perceptions of therapists as more Independent negatively impacted outcome, as indicated by correlations with the Total OQ score and OQ Social Role Performance scale. Additionally, three client variables demonstrated relationships with outcome and alliance: 1) valuing Privacy was associated with less interpersonal distress on the OQ45.2; 2) valuing Financial Prosperity was associated with higher distress on the Social Role scale of the OQ45.2; 3) clients who were married had lower scores on the Task subscale of the WAI.

Another aim was to determine if therapists’ perception of client values is consistent with clients’ actual values, and whether this perception is associated with
alliance. Therapists’ perceptions of client values were correlated with clients’ actual values on Concern for the Environment and Scientific Understanding. However, no relationship was found between therapist perceptions and working alliance or outcome.

Exploratory hypotheses predicting value convergence over time were not supported. No convergence, or increased similarity in values, was found between clients and therapists in the study.

Table 6

Mean Scores on OQ45.2 and WAI at Time 1

<table>
<thead>
<tr>
<th>Measure</th>
<th>Clinical Range Cutoff</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>OQ45.2 Total</td>
<td>63 and above</td>
<td>66.77*</td>
<td>20.36</td>
</tr>
<tr>
<td>Symptoms</td>
<td>36 and above</td>
<td>39.8*</td>
<td>13.63</td>
</tr>
<tr>
<td>Social</td>
<td>12 and above</td>
<td>12.03*</td>
<td>5.00</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>14 and above</td>
<td>14.93*</td>
<td>5.02</td>
</tr>
<tr>
<td>Working Alliance Total</td>
<td>-</td>
<td>47.30</td>
<td>9.36</td>
</tr>
<tr>
<td>Goal</td>
<td>-</td>
<td>14.53</td>
<td>3.62</td>
</tr>
<tr>
<td>Task</td>
<td>-</td>
<td>17.3</td>
<td>2.90</td>
</tr>
<tr>
<td>Bond</td>
<td>-</td>
<td>15.47</td>
<td>3.60</td>
</tr>
</tbody>
</table>

N = 30; *clinical range

Table 7

Mean Scores on OQ45.2 and WAI at Time 2

<table>
<thead>
<tr>
<th>Measure</th>
<th>Clinical Range Cutoff</th>
<th>M</th>
<th>SD</th>
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<tbody>
<tr>
<td>OQ45.2 Total</td>
<td>63 and above</td>
<td>61.83</td>
<td>24.72</td>
</tr>
<tr>
<td>Symptoms</td>
<td>36 and above</td>
<td>35.92</td>
<td>15.81</td>
</tr>
<tr>
<td>Social</td>
<td>12 and above</td>
<td>11.92</td>
<td>5.56</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>14 and above</td>
<td>14.00*</td>
<td>6.01</td>
</tr>
<tr>
<td>Working Alliance Total</td>
<td>-</td>
<td>50.50</td>
<td>8.96</td>
</tr>
<tr>
<td>Goal</td>
<td>-</td>
<td>15.92</td>
<td>3.32</td>
</tr>
<tr>
<td>Task</td>
<td>-</td>
<td>17.08</td>
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<tr>
<td>Bond</td>
<td>-</td>
<td>17.08</td>
<td>3.12</td>
</tr>
</tbody>
</table>

N = 12; *clinical range
Figure 1. Mean pairwise comparisons of client and therapist values as rated on the Life Values Inventory (LVI), on each of the 14 values:

**Achievement** (It is important to challenge yourself and work hard to improve), **Belonging** (It is important to be accepted by others and to feel included), **Concern for the Environment** (It is important to protect and preserve the environment), **Concern for Others** (the well-being of others is important), **Creativity** (It is important to have new ideas or to create new things), **Financial Prosperity** (It is important to be successful at making money or buying property), **Health and Activity** (It is important to be healthy and physically active), **Humility** (It is important to be humble and modest about your accomplishments), **Independence** (It is important to make your own decisions and do things your way), **Loyalty to Family or Group** (It is important to follow the traditions and expectations of your family or group), **Privacy** (It is important to have time alone), **Responsibility** (It is important to be dependable and trustworthy), **Scientific Understanding** (It is important to use scientific principles to understand and solve problems), and **Spirituality** (It is important to have spiritual beliefs and to believe that you are part of something greater than yourself). Sparklines represent mean ratings of importance for clients and therapists on each value.
CHAPTER V
DISCUSSION

This research aimed to contribute to the values and psychotherapy literature, examining the role of client and therapist personal values as they relate to evidence-based practice in psychology. Overall, the findings of this study are mixed in terms of consistency with previous psychotherapy literature examining the role of values in therapeutic relationship and outcome (see Table 8), leaving questions for future research. However, the findings also have important implications for clinical practice.

Relationship of Actual Values to Outcome and Alliance

Overall, therapists rated Responsibility as their most important value, and also valued Health and Activity, Achievement, and Spirituality more than clients (though clients also rated Responsibility as most important). Previous literature indicates some evidence that there may be a set of values therapists consider important to mental health; for instance, therapists in Jensen and Bergin’s (1988) study included personal responsibility, good physical health habits, and work fulfillment. Although the present study queried therapists’ personal values, rather than those they considered important to mental health, it is possible there is some overlap between personal values and “mental health” values. This may be especially true for trainee therapists, given that they are likely to be more intensely focused than other established therapists on learning about therapy and mental health, as well as developing their beliefs and identities around their professional activities. This may also help explain the finding that one of therapists’ least important values was Humility. Rather than suggesting that therapists in this study are conceited, it seems more likely that trainee therapists, oriented towards
mental health, may be perceiving humility as measured by the LVI to be associated with lack of self-worth or confidence, or with a lack of genuineness, which Jensen and Bergin (1988) found was considered by therapists to be important to mental health. Examining Humility at the item level on the LVI supports this assertion. For instance, the three items on the Humility scale read, “avoiding credit for my accomplishments,” “downplaying compliments or praise,” and “being quiet about my successes.” Interestingly, clients valued Humility significantly more than therapists did, and it fell among the most important values for clients. It may be again that clients, likely not having been trained extensively in mental health, are able to view the LVI items more closely to the intended construct of Humility.

Jensen and Bergin (1988) also found some evidence that personal characteristics of therapists are associated with values they considered important to mental health, including significant interactions with age, gender, political views, and religious affiliation. In the present study, marital status and religion were also associated with the personal values of Independence (single therapists more than those in committed relationships) and Spirituality, respectively. This suggests the idea that there is some overlap between personal values and values considered important in mental health.

The present study also found relationships between training characteristics and values; therapists who had seen clients for more years were less likely to value Achievement and more likely to value Creativity, and those who had more contact hours were less likely to value Financial Prosperity. As student therapists in this study are progressing through their training, they are possibly less directly goal oriented and more
focused on the process of therapy or perhaps personal fulfillment associated with their work than earlier beginning therapists, who may feel more initial pressure to achieve positive outcomes. Possibly feeling less anxious and more comfortable in a new role, more advanced trainees may be able to utilize more flexibility and creativity in their work.

Many more client demographics were associated with client values than were therapist demographics with therapist values, which may have in part been a function of a larger sample of clients than therapists. Most notable, however, was the finding that clients who had previous therapy, prior to with their current therapist, were more likely to value Concern for the Environment and Concern for Others, and less likely to value Responsibility. Perhaps being in therapy can lead to a greater ability to take the perspective of and have more empathy for others, after having had the experience of another person (the therapist) show empathic, positive regard for oneself. However, another explanation is that clients who choose to continue attending therapy may have different characteristics and values in general than those who do not continue in therapy. More research of a longitudinal nature may be necessary to determine the direction of causality among these variables if this is a consistent finding. The findings also support previous research indicating that responsibility for one’s treatment is associated with more positive outcomes (e.g., Overholser, 2005, Peterson, 1977). In this study, although the construct of Responsibility as measured by the LVI may have been different than a measurement of responsibility for one’s treatment, the lack of reliable improvement on the outcome measure supports the fact that perhaps the clients
in this study have not yet improved, and that the lack of improvement is reflected in clients’ valuing of Responsibility.

Although several significant differences in values were found among clients and therapists in this sample, overall value difference (or similarity) was not found to be associated with therapeutic relationship or outcome. This was true even in the presence of seemingly large differences, such as therapists rating Health and Activity as one of their most important values, while clients rated this value as one of their least important. Furthermore, we did not find in this sample any evidence for convergence, or the shifting of client and/or therapist values towards similarity, unlike some previous findings (e.g., Kelly, 1990; Taber, Leibert, & Agaskar, 2011). This suggests that, in this sample, significant differences in personal values between clients and therapists do not inherently appear to have a positive, or negative, impact on psychotherapy process or outcome.

Alternately, some client values alone did demonstrate some meaningful relationships with outcome and alliance. First, clients who were married tended to have a lower score on the task scale of the WAI. It may be that clients who are married are more focused on maintaining their family relationships or other home-related tasks, and may have less energy and effort to expend on tasks within the therapy process. Clients who valued Financial Prosperity were more likely to have higher distress as measured by total OQ45.2 score and the Social Role scale on the OQ45.2. In interpreting this finding, it may be useful to consider that the training clinic operates on a sliding scale and serves primarily clients of low socio-economic status. It may be that clients under considerable financial stress may feel overworked, an experience also thought to be
captured by the Social Role Performance scale of the OQ45.2. Clients struggling with mental health concerns, who also find that they must work despite these difficulties, may experience more work-related stress. Finally, valuing Privacy was related to less interpersonal distress as measured by the OQ45.2. There are several possible explanations for this finding. First, the Interpersonal Relations score on the OQ measures both distress and conflict in relationships, but may also indicate the absence of relationships. A person who strongly values Privacy may not be engaging in interpersonal relationships enough to experience significant conflict. Alternately, someone within a close relationship may find that their valuing Privacy helps maintain a healthy balance within their interpersonal relationships, as they feel comfortable spending time alone as well as engaging with others.

Perceived Values and Relationship to Outcome and Alliance

Although actual differences in values do not appear to significantly impact outcome or alliance in this sample, significant relationships were observed regarding client perceptions of therapist values. Clients who perceived their therapist to have overall similar values to themselves were likely to have a higher score on the Goal scale of the WAI, but more distress on the Social Role Performance scale of the OQ45.2. This suggests that perhaps when clients feel understood and that they and their therapists are working towards common goals, they also perceive the therapist to share their values. This could also mean that a perception of shared values, but not actual similarity in values, facilitates strong agreement regarding therapeutic goals. Regarding the relationship of perceived value similarity to Social Role Performance distress, it is possible that clients who perceive their therapists as more similar to themselves than
they actually are may show similar patterns in other relationships, where they miss important differences between themselves and others. This could contribute to conflict in relationships.

Clients who perceived therapists to value Responsibility also tended to indicate a stronger alliance. In the context of the finding that clients who have been in therapy previously are less likely to value Responsibility, there are some possible clinical implications associated with these relationships. As stated previously, client sense of responsibility for change in therapy is thought to be associated with good outcomes. It may be important for therapists to both express their sense of responsibility for helping the client, while also cultivating the client’s sense of responsibility in the therapy process as well. Clients who feel supported by an invested therapist and who are also able to own some of aspects of their treatment may be more likely to experience positive changes; this is consistent with previous research discussing the importance of role expectations to developing a strong working alliance (Patterson, Uhlin, & Anderson, 2008) and preventing attrition (Aubuchon-Endsley & Callahan, 2009). The findings here support the practice of addressing expectations at the beginning of therapy.

With respect to client’s perceptions of therapists as valuing Independence, there is some literature to support the findings here that this perception is associated with negative outcomes, within the body of literature examining the importance of client preferences to alliance and outcomes. DeGeorge, Constantino, Greenberg, Swift, and Smith-Hansen (2013) found that, as part of their study examining client preferences for psychotherapist characteristics, that clients rated Autonomy second to last on an adjective checklist of preferred therapist characteristics. The most desired trait was
personal adjustment of the therapist. Clients may desire for their therapist to be responsible and emotionally stable, but not detached or “cold” (Hersoug, Hoglend, Havik, von der Lippe, & Monsen, 2009). DeGeorge and colleagues study findings reiterate the importance of discussing expectations and preferences with clients to facilitate good alliance and outcomes.

Therapists’ ratings of client values were correlated with clients’ actual values on both Scientific Understanding and Concern for the Environment. Notably, Concern for the Environment is a value which clients and therapists rated significantly different in importance. Therapists may be able to detect more drastic client value differences, but have more difficulty perceiving more subtle differences. Additionally, this finding provides more support for the possibility that even in the case of significant actual value differences among clients and therapists, clients and therapists are not becoming more similar in their values over time, as clients who have had previous therapy also were more likely to value Concern for the Environment.

Limitations

Small sample size ($n = 31$ clients, 18 therapists, and 29 dyads) may have been a limitation, particularly when effect sizes were small. Additionally, the sample size limits generalizability to other types of clients and therapists. The therapists and clients in this study represent a small sub-sample of the diverse group of clients in the training clinic, and may have different characteristics than other clients and therapists at the clinic who chose not to participate in the research. As an example, clients in this study may have been more interested in contributing to research and may have been more likely to value Scientific Understanding. They may also have felt a desire to help others,
impacting the degree to which they valued Concern for Others. Several clients in the study commented to the researcher that he or she thought research was interesting and expressed eagerness to learn about the study. Generalizability is also limited more broadly. The study took place in a training clinic, which may have different characteristics and different types of clients and therapists than those in a number of other clinical settings, such as a hospital, private practice, or student counseling center, for instance.

Another limitation involves time of measurement. Much of the previous research involving values and therapeutic alliance measures alliance at the beginning of treatment, within the first 3 sessions. Although measurement at this time was attempted, and no differences were found based on session number, only a few clients in this study completed the measures during the early stages of treatment. It is possible that value similarity plays a larger role at the beginning of treatment, when alliance is developing. In this way, values may be related to preventing or contributing to early dropout, and more research may focus on values during early treatment.

Lack of Relationship between Working Alliance and Outcome

In this sample, no relationship was found between working alliance and outcomes, as measured by OQ scores. Though this is relatively surprising in light of robust findings in the literature regarding the therapeutic relationship as associated with the most variance in outcomes (e.g., Bordin, 1979; Horvath & Greenberg, 1994; Horvath & Symonds, 1991), there are several other factors that may explain this finding in this study. First, clients in this study for whom Time 2 data was gathered did not show reliable improvement on the outcome measure, despite all scores on the OQ except one
(Interpersonal) moving into the non-clinical range at Time 2. However, this does not imply treatment failure. Of the 11 dyads studied at Time 2, only 2 terminated, suggesting that the majority of therapists and clients agreed that more work remained; additionally, it was observed that OQ scores did shift slightly, suggesting possible movement toward reliable change. This is consistent with many of the clients in this training clinic (and within this sample) having had previous therapy, suggesting that this study captured snapshots of longer-term courses of treatment. Furthermore, clients with interpersonal difficulties or personality disorders may benefit from longer-term treatment, which may partially explain the clinical-level score in the area of Interpersonal Relations. If there has not yet been significant improvement, it may be difficult to detect a relationship between good outcome and working alliance; this is supported by previous research positing that alliance measured later in treatment essentially functions as a measure of outcome (Barber, Khalsa, & Sharpless, 2010).

Additionally, the lack of this finding could be understood generally as a result of Type II error and lack of power. The effect sizes found in previous studies for the relationship between alliance and outcome are consistently moderate. Although power in this study was sufficient to detect a moderate effect, the small sample size might have been insufficient if the true effect were in fact small.

Implications and Future Research

The findings in this study reflect the mixed findings in the literature regarding the role of values in psychotherapy. There is much more research needed to elucidate the relationships of client and therapist values, including both actual values and client and
therapist perceptions of values. More recent research is also needed, as the majority of the literature on this topic was conducted prior to the turn of the last century.

As stated previously, many of the problems within the literature (and perhaps the reason for lack of recent research) stem from the different ways of measuring outcome, working alliance, and values. It may be useful to examine the differences in findings among all of these studies meta-analytically.

Operationally defining values appears also to be a particularly challenging task. In particular, some previous research implies that there may be a set of values that are important to mental health. This can raise the questions regarding the possibility that some values are inherently healthy or maladaptive. For instance, if valuing Financial Prosperity is associated with higher distress, does this mean that this is a value therapists should discourage in their clients? Results linking values to distress should not be interpreted as indicators of positive or negative values. There are a number of possible reasons values could be associated with distress (or improvement). Therefore, it is more appropriate to obtain a more in depth understanding clients' values. As an example, although valuing providing for one’s family may be associated with distress, undergoing that distress or learning to tolerate it may be important for the client’s overall well-being. This view is especially reflected by some acceptance-based psychotherapies (e.g., Hayes, Strosahl, & Wilson, 1999), though many types of therapies focus on helping clients more effectively tolerate distress. In this way, it is also important for therapists to be aware of personal biases regarding how their own personal values impact how they view a client’s values. Furthermore, therapies such as acceptance and commitment therapy distinguish between holding a particular value
important, and behaving consistently with that value. Future research may benefit from accounting for this difference; in the current study, the LVI asked about the degree to which a particular value guides behavior.

Kelly (1990) suggests that rather than overall increased similarity in values, that perhaps similarity on some values and dissimilarity on other values is associated with outcome and alliance. This study did not examine whether differences on specific values impacted working alliance or symptoms reduction; future research may examine whether similarity is more beneficial for some values over others. For instance, Kelly and Strupp (1992) note that salvation was the only value rated significantly differently for clients and therapists in their study, and was also significantly associated with outcome.

More research is needed to further elucidate the relationships between values, outcome, and alliance, in terms of the way values change over time, how therapist and client values differ from one another, and the ways these differences impact the process of therapy. Although in the past this body of literature has been dormant and disjointed from current psychotherapy research examining characteristics of evidence-based practice, the findings here demonstrate potential links between values and outcomes. Values are encompassed by client and therapist characteristics within an EBPP model, and findings suggest relationships between values and client preferences, role expectations, and the relationship of these variables to outcome and working alliance. Specifically, clients’ perceptions of therapist values appear to be more important than actual value differences. Future research should focus not only on existing differences
between clients and therapists, but on how clients and therapists perceive one another’s characteristics.
### Table 8

**Comparison of Present Findings to Existing Literature**

<table>
<thead>
<tr>
<th>Reference</th>
<th>Population</th>
<th>N</th>
<th>Primary Features</th>
<th>Results</th>
<th>Replicated in present study?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosenthal (1955)</td>
<td>Adult psychiatric inpatients</td>
<td>9</td>
<td>Rosenthal’s Moral Values Q Sort; patient perception of</td>
<td>$r = .68 \ (p &lt; .02)$ between improvement and value convergence</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farson (1961)</td>
<td>Training clinic</td>
<td>20</td>
<td>Philosophical beliefs; correlation of patient-therapist</td>
<td>Values convergence significant at $p &lt; .05$</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>pre-post Q sorts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cook (1966)*</td>
<td>Training clinic</td>
<td>90</td>
<td>Osgood’s Differential Scale; patient evaluation of outcome</td>
<td>No values convergence or effect on outcome</td>
<td>Yes</td>
</tr>
<tr>
<td>Welkowitz, Cohen, &amp; Ortmeyer (1967)</td>
<td>Psychoanalytic training center</td>
<td>44</td>
<td>Morris’s Ways to Live Scale; therapist rating of improvement</td>
<td>$r = .36 \ (p &lt; .05)$ between improvement and initial value similarity</td>
<td>No</td>
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<td></td>
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<tr>
<td>Beutler (1971)*</td>
<td>Clinic outpatients</td>
<td>10</td>
<td>5 scales based on Rosenthal’s therapeutically relevant values;</td>
<td>1. No correlation between convergence and outcome</td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>therapist rating of improvement</td>
<td></td>
<td>2. Not able to examine</td>
</tr>
<tr>
<td></td>
<td>Trainee clinicians</td>
<td>13</td>
<td>7 scales based on Rosenthal and Rokeach</td>
<td>$r = .76 \ (p &lt; .01)$ between improvement and convergence</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. $r = .52 \ (p &lt; .01)$ between initial dissimilarity and convergence</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. $r = .64 \ (p &lt; .01)$ between initial value dissimilarity and</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>convergence</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>3. convergence and similarity not related to improvement on SCL-90R</td>
<td></td>
</tr>
<tr>
<td>Beutler, Arizmendi, Crago, Shanfield, &amp; Hagaman (1983)*</td>
<td>Psychiatric outpatients</td>
<td>45</td>
<td>RVS; therapist rating of improvement; SCL-90R</td>
<td>1. $r = .35$ to .61 \ ($p &lt; .01$) between SCL-90R and initial value similarity</td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. $r = .84 \ (p &lt; .01)$ between therapist rating of improvement and</td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>initial values similarity</td>
<td>2. Not able to examine</td>
</tr>
<tr>
<td>Arizmendi, Beutler, Shanfield, Crago, &amp; Hagaman (1985)*</td>
<td>Psychiatric outpatients</td>
<td>45</td>
<td>Therapist rating of improvement; SCL-90R</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(table continues).*
Table 8 (continued).

<table>
<thead>
<tr>
<th>Reference</th>
<th>Population</th>
<th>N</th>
<th>Primary Features</th>
<th>Results</th>
<th>Replicated in present study?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kelly &amp; Strupp (1992)</td>
<td>Adult outpatient</td>
<td>39</td>
<td>RVS; client, therapist, and observer rating of improvement; Social Introversion scale of MMPI</td>
<td>1. 64% of perceived value changes were away from therapist values</td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. convergence related to therapist outcome rating ((r = .45, p &lt; .001))</td>
<td>2. Not able to examine</td>
</tr>
<tr>
<td>Beutler et al. (1975)</td>
<td>Psychiatric outpatients</td>
<td>97</td>
<td>Situational Appraisal Inventory Form J; patient and therapist rating of improvement</td>
<td>1. Low initial attitude similarity led to greatest attitude change</td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. therapist credibility not related to attitude change</td>
<td>2. Not examined</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. high credibility related to high patient rating of improvement</td>
<td>3. No; but perception of Responsibility was related to stronger alliance</td>
</tr>
<tr>
<td>Landfield &amp; Nawas (1964)</td>
<td>College student clients</td>
<td>36</td>
<td>Role Construct Repertory Test; outside raters of outcome</td>
<td>1. Improvement associated with movement toward therapist ideal</td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. similarity related to improvement</td>
<td>2. No</td>
</tr>
<tr>
<td>Beutler (1971a)</td>
<td>Couples</td>
<td>10</td>
<td>Attitude questionnaire; therapist rating of improvement</td>
<td>Convergence between spouses positively associated with therapist outcome</td>
<td>Not able to examine</td>
</tr>
</tbody>
</table>

*reviewed by Kelly (1990)
REFERENCES


psychotherapy improvement. *Journal of Social and Clinical Psychology, 1*, 231-245. DOI:10.1521/jscp.1983.1.3.231


