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ORIGINAL PAPER

Does a Therapist's World View Matter?

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Abstract While past research indicates that mental health professionals are less religious than the public they serve, little is known about the implications of therapists' world views for their practice. In this study, approximately 50 therapists completed surveys that assessed self-identification in relation to spirituality, religion, and/or world view; how relevant they considered their patients' and their own world views; and responses to clinical vignettes involving issues arising in treatment. While a minority considered themselves religious, a majority indicated that they considered themselves moderately or very spiritual. When asked how they would respond to a series of clinical vignettes involving topics such as assisted suicide and encouraging the use of spiritual resources, responses varied significantly by world view. Respondents endorsed several factors limiting the integration of religion/spiritualities/world views into their clinical work. These data raise questions about how to further explore the clinical relevance of the therapist's world view.

Keywords Spiritual · Religious · World view · Psychotherapy

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Introduction

Consistent with contemporary psychiatry's focus on evidence-based interventions, researchers have attempted to quantify and objectify the value of different psychotherapeutic approaches. At the same time, however, psychotherapists themselves remain aware that psychotherapy is an intersubjective process in which two individuals bring their whole selves to the encounter. Since Freud, clinicians have devoted considerable attention to the complexities of transference and countertransference, but relatively little to the clinical relevance of the therapist's personal value system, or world view. How do therapists' personal and professional values shape the goals and actual practice of therapy? How important is congruence between their world views and that of their patients? Beyond acknowledging that value-free psychotherapy is a myth (Bart 1972), how do therapists approach these questions?

Freud (1918) used the term *Weltanschauung* to describe an "an intellectual construction which gives a unified solution of all the problems of our existence in virtue of a comprehensive hypothesis." Polanyi (1958), Vitz (1977), Bergin (1980), and others have pointed out that a person's basic world view (whether labeled religious or scientific) grounds the values which guide his/her behavior. The clinical relevance of patients' values and spiritual commitments is now widely recognized by practitioners of positive psychology, palliative medicine, and culturally competent care (Sulmasy 2007).

In addition to taking patients' cultural and spiritual values into account by providing spiritually sensitive care, a number of mental health professionals have advocated integrating spiritual values and practices into psychotherapy (Sperry and Shafranske 2005). For example, Richards and Bergin (2004) have suggested that because theistic individuals often view the goals and methods of psychotherapy differently from those with a secular perspective, they may benefit from "theistic psychotherapy." Clinicians in various faith traditions have offered more specific forms of spiritually integrated therapy, e.g., "Christian" therapy for Christian clients, or Muslim CBT for Muslims (Hamdan 2008).

Addressing these issues even more broadly, others have pointed out that the existential dimension of patients' struggles creates a role for the therapist to explore and help patients find spiritual answers to questions in domains such as identity, hope, meaning/purpose, and connection (Griffith and Griffith 2002; Peteet 2010). Similarly, patients' moral distress may make it appropriate for clinicians to help them find sources of forgiveness, whether through taking "a fearless moral inventory" in AA or through some other spiritual resource. Palliative Medicine has embraced the goal of relieving the existential and spiritual distress that many individuals experience when facing the end of life. Finally, there is growing acceptance of the view that clinicians work not only to relieve symptoms and eliminate disease, but also to enhance human well-being, a task that can have an important self-transcendent dimension (Cloninger 2004; Vaillant 2008).

A recent meta-analysis identified 46 studies of psychotherapies that incorporate religion and spirituality (involving 3290 subjects) and found that patients in religious/spiritual psychotherapies showed greater improvement than those in alternate secular psychotherapies both on psychological ($d = .26$) and on spiritual ($d = .41$) outcomes, suggesting that these psychotherapies are not only valid treatment options but may actually be more effective for individuals seeking or desiring them (Worthington et al. 2011).

But how do clinicians relate spirituality to their work? In a national survey of 1144 physicians from the USA, Curlin et al. (2005) found that 55 % of those surveyed said that their religious beliefs influenced their practice of medicine. Compared with the general

population, physicians are less likely to say they try to carry their religious beliefs over into all other dealings in life (58 vs. 73 %), twice as likely to consider themselves *spiritual* but not *religious* (20 vs. 9 %), and twice as likely to cope with major problems in life without relying on God (61 vs. 29 %). Curlin et al. (2007) also reported that psychiatrists generally endorse a belief in the positive influences of religion/spirituality on health, but are more likely than other physicians to note that religion/spirituality sometimes causes negative emotions that lead to increased patient suffering (82 vs. 44 %). Compared to other physicians, psychiatrists were more likely to encounter religion/spirituality issues in clinical settings (92 vs. 74 % report their patients sometimes or often mention religion/spirituality issues), and were more open to addressing religion/spirituality issues with patients (93 % say that it is usually or always appropriate to inquire about religion/spirituality, compared to 53 % of other physicians). The authors did not ask about specific interventions, or about how clinicians' own spiritual orientation influenced their approach. Regarding clinicians' spiritual orientation affecting their clinical judgment, in a survey examining the criteria upon which 1000 US primary care physicians base difficult clinical decisions, Lawrence and Curlin (2009) found that doctors with high intrinsic religious motivation were significantly more likely to consider moral guidelines as well as patient wishes than were doctors with low intrinsic motivation who tended to rely almost exclusively on patient wishes without regard to other guidelines. McEvoy et al. (2014) in a survey of 633 clinician educators at Albert Einstein School of Medicine found that spiritual versus religious identity was associated with differences in responses to questions about clinical practice, medical student teaching, and attitudes about the role of religion/spirituality in health care, but details regarding these were not reported.

In a survey of 193 psychiatrist members of the Christian Medical and Dental Society, Galanter and his associates (1991) found that respondents considered psychotropic medication the most effective treatment for acute schizophrenic or manic episodes, but rated the Bible and prayer more highly than medication for suicidal intent, grief reaction, sociopathy, and alcoholism. Whether or not a patient was "committed to Christian beliefs" made a significant difference in whether the respondents would recommend prayer to the patient as treatment. About one-half said they would discourage strongly religious patients from an abortion, homosexual acts, or premarital sex, and about one-third said they would discourage other patients from these activities. In another study, Hofmann and Walach (2011) surveyed 895 German psychotherapists about their religious and spiritual beliefs, practices, and training. Overall, 57 % described themselves as either religious or spiritual, and two-thirds said that religion/spirituality ought to be included as part of their training. Respondents said that, on average, 22 % of their patients bring up religion/spirituality during the course of therapy. Those who predominantly practiced cognitive-behavioral therapy or psychodynamic therapy placed less emphasis on religion/spirituality, compared with those oriented more toward humanistic or integrative therapy.

Little information is available about why some clinicians deal with patients' spirituality more than others. Possible reasons include limited time, expertise, or knowledge of available resources; personal philosophical reservations; and ethical and boundary concerns (Gutheil and Gabbard 1993, 1998). We consider next some ways that a therapist's world view can influence diagnosis, formulation, and treatment, followed by the results of a pilot study we conducted of members of the Massachusetts Psychological Association.

Implications of World View for Diagnosis

Within psychiatry, there is a general understanding that culturally competent care involves eliciting the patient's own explanatory model of his/her symptoms/illness. However, the patient's explanatory model may be very different from that of the clinician. As a result, there may be an unspoken or unconscious tension between the world view of the patient and that of the clinician. There may also be times in which the clinician experiences a conflict between his or her own professional and personal values while treating a patient. For example, a clinician who holds a religious or spiritual world view may appreciate its value, but feel that his or her professional role limits him or her to working with the patient within a generally accepted framework, such as evidence-based practice or a particular modality of psychotherapy. Nevertheless, a clinician's world view could influence diagnosis in at least three ways: by adding to the diagnostic possibilities under consideration, by leading to alternative diagnostic choices, and by reformulating the meaning of a diagnosis.

Consider the example of depression. As Blazer (2011) points out, the struggle with depression reaches to the very core of the spiritual experience in many faith traditions. As a result, a clinician who views faith as of primary importance might be more likely to include in the differential diagnosis of depressed mood "the dark night of the soul," and demoralization. Rather than looking only at DSM-5 diagnostic categories and their traditionally understood risk factors of psychosocial stressors and biological predisposition, he or she would also be looking at the patient's existential state, reflected in his sense of identity, hope, sense of meaning/purpose and connection; Peteet 2010).

Some clinicians who are open to non-naturalistic explanatory models may also be more apt to diagnose conditions not entertained at all by secular counterparts, such as possession rather than a dissociative disorder or schizophrenia. For example, in a controversial article, Irmak (2014) observes the success of a local faith healer in treating patients with schizophrenia and considers whether there is validity to the explanatory model that the hallucinations are actually based on sensory experiences of a demonic world.

Clinicians' world views may also influence how they view generally accepted diagnostic categories. A clinician with a naturalistic world view might be less likely to accept Cloninger's (2011) proposal that a personality disorder can be considered a spiritual deficit. Conversely, a religious therapist might be less likely to view religious beliefs and practices as defensive, or pathological. Differences in diagnosis have obvious implications for formulation and treatment.

Implications of World View for Formulation

In formulating a case, a clinician selects combines relevant conceptual models in order to develop a rationale for the use of particular resources in treatment. The most prevalent of these are biological, psychodynamic, behavioral, social, and existential (Lazare 1973; Peteet 1973). Among the many factors which play a role in this selection are the clinician's training, theoretical orientation and expertise, and the patient's values. The clinician's world view may also play a role. Consider the example of a 40-year-old somewhat perfectionistic woman who has struggled with depression for years and has found benefit both from medication and from experiencing forgiveness through her relationship with God. A clinician with a naturalistic world view might be inclined to focus on her need to optimize her medication regimen, to help her understand the dynamics which lead her to remain

dependent on others including God, and encourage her involvement in a supportive community. A clinician with a spiritual or religious world view might give relatively more attention to how well her spiritual life has been able to address the existential concerns such as guilt, shame, and a low sense of worth to which her personality makes her vulnerable.

Implications of World View for Treatment

Consider briefly some of the avenues by which a clinician's world view might influence treatment: via the therapists' preferred virtues, countertransference and boundary considerations, moral dilemmas, the patient's choice of therapist, and the use of spiritual interventions. Evidence suggests that traditions of belief have a significant impact on the way that clinicians practice. For example, in Curlin et al.'s (2005) survey, 55 % of US physicians surveyed reported that their religious beliefs influence their practice of medicine, and 58 % said that they try to carry their religious beliefs over into all other dealings in life. The virtues of the major traditions overlap, but signature (characteristic or preferred) virtues arguably exist. These include for Jews, communal responsibility and critical thought; for Christians, love and grace; for Muslims, reverence and obedience; for Buddhists, equanimity and compassion; for Hindus, appreciation of Dharma and Karma; and for secularists, respect for scientific evidence and intelligibility. Along with other virtues and influential factors, it seems reasonable to expect that these preferred virtues will shape the way that a therapist understands human flourishing and the ultimate goals of treatment for a given patient (Peteet 2013).

Additionally, several authors have pointed out potential ways that addressing religious or spiritual world views in treatment may affect transference/countertransference dynamics and introduce potential boundary issues. Abernathy and Lancia (1998) describe the various challenges that arise in when clinicians and patients perceive their world views to be overly similar or overly distinct. Interaction between the religious patient's transference and the clinician's countertransference can create unspoken assumptions or collusions of resistance, leading to a treatment impasse. There is also a risk that a clinician and patient who share a faith tradition may erroneously assume that they agree about all spiritual issues, or that a patient uses this perceived similarity in the service of an idealizing transference, feeling that only a therapist who shares his or her faith can truly understand them. Furthermore, patients and clinicians who share a religious world view may be more vulnerable to boundary crossings, for example if the therapist decided to disclose this faith, if he or she shares a relationship with the patient as a member of the same faith community, or if the patient requests a spiritual intervention such as prayer. In discussing boundaries generally, Gutheil and Gabbard (1998) emphasize the importance of boundaries being determined by the context of a therapeutic frame. Yet, currently there are limited guidelines to help clarify the question of what is or is not part of a therapy that aims to address a patient's world view.

Patients and clinicians who share a religious world view may be more vulnerable to boundary crossings, for example if the therapist decided to disclose this faith, if he or she shares a relationship with the patient as a member of the same faith community, if the patient has a need to see the therapist as a "brother" or "sister" in the faith, or if the patient requests a spiritual intervention such as prayer. There is also a risk that a clinician and

patient who share a faith tradition may erroneously assume that they agree about all spiritual issues, and come to misunderstandings because of this.

While most therapists see their role as helping the patient to make his or her own moral decisions, their own values inevitably influence how they help patients think about the moral dimension of choices such as how much to sacrifice for an aging parent, or whether to forgive an abuser. Differences are likely to be greatest in dealing with controversial decisions about abortion, divorce, same sex relationships, or assisted suicide.

Conservative religious individuals who are struggling with the moral dimension of life choices may request to see a therapist of the same faith, or ask the therapist about his or her world view. The therapist's world view is likely to influence the decision whether to work with such a patient, or refer them to a colleague.

Finally, a therapist's world view is likely to influence whether he or she offers spiritual interventions as part of the treatment. Propst et al. (1992) found that religiously oriented CBT for depression was at least as effective when offered by non-religious therapists. Furthermore, most therapists would endorse exploring and fostering the patient's positive secular or religious coping, regardless of their own world views. However, understanding autonomy as optimal functioning rather than freedom from influence (Bishop et al. 2007) highlights the potential role of the therapist's core values in fostering autonomy understood in this sense as flourishing. And as Spero (2010) points out, countertransference and the question of God's reality cannot be eliminated from psychotherapy.

Given the various ways that clinician world view can affect clinical work, we conducted this study to explore how contemporary mental health clinicians (1) describe their world views and (2) report how these world views influence (or fail to influence) their clinical work and personal lives.

Method

Participants included 50 clinicians who were members of the Massachusetts Psychological Association (MPA). Among the 43 respondents (95.3 % psychologists) who completed the full survey, there were 17 males and 26 females, ranging in age from 27 to 71 years ($M = 52.8$, SD 11.8).[1] The respondents had been practicing professionally since graduate school for an average of 19.24 (SD 10.82) years.[2] The large majority (88.4 %) worked in a private practice setting at least part-time. Other practice settings mentioned included hospitals (18.4 %) and agencies/clinics (18.6 %). Most respondents worked with adults (90.7 %) and more than half (53.5 %) worked with children and adolescents.

Materials

The Therapist World View Survey (TWS) is a 27-item questionnaire that combines previously researched survey items and items created for the current study. The survey was administered online to a Listserv of approximately 600 clinicians who are members of the Massachusetts Psychological Association (MPA). Of the ~600 clinicians, 50 clinicians responded via an online invitation. The TWS asked clinicians (1) how they characterized their world views, with special emphasis on religion and spirituality; (2) how they

[1] One respondent declined to disclose age.

[2] One respondent declined to disclose number of years practicing professionally since graduate school.

experienced their world views within both their professional practice and personal lives; and (3) how they would respond to clinical vignettes addressing ethical issues arising in *treatment*.

Vignette 1 asked the respondent to consider a scenario in which he/she was a prescribing clinician in a state where it is legal for physicians to prescribe a lethal dose of medication for a patient who has <6 months to live. In this scenario, a mentally competent cancer patient who is not in physical pain but who wants to control the time of his dying repeatedly asks the respondent to provide him with a prescription. The survey respondent was asked to consider whether or not she/he would provide the patient with the prescription.

Vignette 2 focused on a scenario which consisted of a religious woman coming to a clinician with symptoms of depression and anxiety which she attributes in part to a lack of faith on her part. The vignette asks the respondent to consider how likely the respondent would be to explore the patient's spirituality/religious history, encourage her to engage in spiritual practices like prayer, involvement in faith community or healing ministry, or to pray with her, if she requests it.

Results

Seven respondents answered only the brief introductory section and 43 completed the full (two-part) survey. Fifty-eight percent of the 43 respondents reported being public about their religion/spirituality/world view. When asked about the degree to which religion/spirituality or world view influenced their clinical practice, 19 % said a great deal, 44 % said moderately, 30 % said slightly, and 7 % said not at all. Almost all (95 %) respondents agreed or strongly agreed with the statement "I carry my philosophical/religious/spiritual beliefs over into my other dealings in life."

A large majority of respondents (84 %) considered themselves religious and/or spiritual.[3] While 56 % of respondents reported an affiliation with a traditional religious group (i.e., Buddhist, Catholic, Hindu, Jewish, Muslim, and Protestant),[4] a significant percentage (37 %) reported that they were "spiritual but not religious." Thirty percent of respondents said they were not religious at all, 42 % said they were slightly religious, and more than one-quarter (28 %) said they were moderately or very religious. Only 7 % of respondents said they were not spiritual at all, and almost two-thirds (63 %) said they were moderately or very spiritual.

Vignette 1 In response to vignette 1, 56 % of respondents said they would prescribe the lethal dose. Of the 24 respondents who said they would prescribe the lethal dose, 20 (83 %) indicated that they would prescribe the dose to "enhance autonomy by respecting his choice," 13 (54 %) indicated that they would do so to "relieve suffering," and nine (37 %) selected both of these options. Two respondents provided additional treatment plan details. Seven respondents indicated that they would not prescribe the lethal dose and gave the following reasons: seeing their role as helping patients "find meaning in remaining life" (86 %), "believe taking innocent life is not human prerogative" (43 %), or both (29 %). Nine respondents (21 %) provided alternative answers.[5] Although higher levels of

[3] One respondent did not disclose religiosity and/or spirituality.

[4] Respondents also identified as Atheist, Agnostic, Humanist.

[5] Alternative responses include unsure of what to do, preferring to refer patients to other clinicians, making sure of patients' rationale before deciding.

self-reported religiosity were significantly associated with the decision not to prescribe ($p < .05$), higher levels of self-reported spirituality were not.

Vignette 2 In response to vignette 2, respondents were most likely to explore the patient's spirituality/religious history (never or rarely: 2 %; occasionally: 9 %; frequently or always: 89 %) and least likely to pray with her (never or rarely: 79 %; occasionally: 16 %; frequently or always 5 %). More than half of respondents would encourage the patient to engage in spiritual practices (occasionally: 37 %; frequently or always: 22 %) or to be involved in a faith community or with a healing ministry (occasionally: 40 %; frequently or always: 31 %).

Discussion

In this admittedly small and non-representative sample of psychologists, a majority of respondents reported a traditional religious affiliation. Most psychologists were open to asking patients about their religious/spiritual beliefs and encouraging patients to pray and/or participate in faith communities. While positions on these practices differed modestly according to expressed world views, even individuals who identified as neither religious nor spiritual said they would sometimes recommend religious or spiritual practices.

Although in this way world view did not appear to be related to therapist recommendations for clients to pursue religious or spiritual practices since even among non-religious and/or non-spiritual therapists, a high percentage made such recommendations, and there was some evidence that therapist world view was related to differences in responses to real-world vignettes. Although overall most respondents (56 %) said they would prescribe a lethal dose of medication to a patient who requested it, those who reported higher levels of religiosity were significantly less likely to do so.

The findings of this small, pilot study of clinical psychologists from Massachusetts are congruent with the findings of other recent studies. These studies suggest a sea change in the salience of religion/spirituality in the world views of contemporary psychologists in comparison with similar surveys conducted during previous decades, and in the form reported (from affiliations with traditional religions to orientations that are categorized as "spiritual but not religious"). The patterns also suggest that despite this overall shift among clinicians to world views that are more open to spirituality and religion, a substantial percentage of clinicians do report affiliation with more traditional religious denominations and that such differences in world view may be associated with significant differences in ethical decision making, underscoring the importance of future research on therapists' world views.

Directions for Future Research

The modest findings and the limitations of this pilot study have several implications for future research: First, a more representative sample of clinicians is needed to achieve generalizable findings. Respondents in this study may have been influenced by their interest in the subject. Second, since differences in practice are more likely to be seen across differences in world view, future studies should compare populations of religiously identified therapists with those working in secular institutions. Third, in order to bring out differences in approach which may be influenced by many other factors, clinical vignettes

need to be carefully designed and pilot tested. Responses to our vignette asking whether one would prescribe in a case of assisted suicide are difficult to interpret because psychologists do not in fact prescribe. Fourth, given the requests that many patients make to see a therapist of the same world view, it may be fruitful to study the meaning and the outcome of these requests from the perspective of both the patient and the therapist.

Compliance with Ethical Standards

Conflict of interest Peteet, Rodriguez, Herschkopf, McCarthy, Betts, Romo, and Murphy have no conflicts of interest.

Human Rights All procedures performed in studies involving human participants were in accordance with the ethical standards of the Institutional and/or National Research Committee and with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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