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PHILOSOPHICAL EXPLORATION

What is the Place of Clinicians' Religious or Spiritual Commitments in Psychotherapy? A Virtues-Based Perspective

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Abstract Value neutrality in psychotherapy is widely acknowledged to be a myth, and a majority of US physicians report that their religious faith influences their practice. Most attention to therapists' religious and spiritual commitments has focused on ethical boundaries, transference/countertransference dynamics and questions about how to relate religious and psychological truth. No consensus exists about the legitimate place in psychotherapy of clinicians' differing value commitments. Therapists' virtues are vitally important in psychotherapy, not least in the relational and aspirational process by which the patient identifies with the therapist as they engage together in confronting obstacles which the patient has been unable to surmount alone. Among the individual and cultural factors that shape a therapist's virtues are spiritual traditions, which encourage preferred or characteristic virtues. Arguably, 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. These have differing implications for treatment, as illustrated through the use of a hypothetical case. Attention to differing spiritual and religious virtues in a pluralistic culture offers opportunities for creative dialogue, collaborative teaching and interdisciplinary research.

Keywords Virtue · Psychotherapy · Ethics · Spiritual · Religious

Growing evidence suggests that the religious and spiritual commitments of clinicians influence their work. A 2005 survey of 1,144 US physicians found that 55 % said that their religious beliefs influenced their practice of medicine (Curlin et al. 2005), and a recent unpublished survey of 50 psychologists of the Massachusetts Psychological Association found a similar result.

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With the recognition that value neutrality in psychotherapy is a myth, three major perspectives—ethical, clinical and philosophical—have emerged on how therapists' core values and commitments should (or should not) influence their work.

Guidelines of professional associations such as the American Psychiatric Association encourage psychiatrists to (a) maintain respect for their patients' commitments (values, beliefs and worldviews), (b) warn them against imposing "their own religious/spiritual, antireligious/spiritual, or other values, beliefs and world views on their patients" and (c) recommend that they foster recovery by making treatment decisions with patients in ways that respect and take into meaningful consideration their cultural, religious/spiritual and personal ideals (APA 2006).

Writing from a clinical perspective, authors such as Spero (1995) and Abernathy and Lancia (1998) have explored the complex ways in which a therapist's countertransference can operate in the treatment of religious patients, many of whom may have religious or spiritually based transference reactions to their therapists.

And using a philosophical perspective, a number of authors have called for greater recognition of the values implicit in major psychotherapeutic schools (Holmes and Lindley 1998; Tjeltveit 1999). Bergin (1980) and later Richards and Bergin (2005) have gone further to contrast theistic and secular psychotherapy based on the openness of the therapist to consider God and scripture as normative sources of wisdom. Writing specifically about a single tradition, Johnson (2010) has distinguished five extant models for integrating Christian insights about the human condition into psychotherapy.

Yet consensus is lacking about the appropriate place within psychotherapy of the commitments of a therapist to a particular religious or secular philosophical tradition. A major reason for this may be that the legitimate place of values in psychiatry generally has until recently received little attention. This growing attention has been primarily directed at the role that values as embodied in virtues (or admirable character traits) play in medical ethics (Pellegrino and Thomasma 1993), professionalism (Coulehan 2005), positive psychology (Peterson and Seligman 2004) and psychiatric practice (Radden and Sadler 2010). For example, In *The Virtuous Psychiatrist: Character Ethics in Psychiatric Practice*, Radden and Sadler describe the contributions of a virtue ethics framework to challenges unique to psychiatry such as patient vulnerability, stigma and involuntary treatment. Relatively, little attention has yet been devoted to the function of virtues in psychotherapy, to differences in therapists' preferred virtues or to the role of religious and spiritual communities in shaping and/or supporting these virtues within a pluralistic society.

Virtues in Psychotherapy

As Radden and Sadler point out, in addition to professional virtues (such as integrity, trustworthiness, fidelity and honesty) and medical virtues [such as benevolence, friendliness, respect and justice (Drane 1995), compassion, practical wisdom, fortitude, self-effacement (Pellegrino and Thomasma 1993) and empathy (Larson 2003)], a good therapist needs to both possess and express respect for confidentiality (Dyer 1999), humility (Christianson 1994), warmth and sensitivity (Beauchamp 1999), perseverance (Dickenson and Fulford 2000) and caring (Bloch and Green 2006).

But what exactly is the function of these virtues in psychotherapy? Consider briefly how a therapist's virtues (a) serve to form and maintain the therapeutic alliance, (b) create a secure space for addressing the patient's needs and (c) offer a foundation for identifying and realizing therapeutic goals.

Psychotherapy outcome studies consistently find the quality of the therapeutic relationship more important than therapeutic technique or theoretical orientation (Lambert and Barley 2001; Martin et al. 2000). Factors shown to be important to a therapeutic alliance include the therapist's flexibility, honesty, respect, trustworthiness, confidence, warmth, interest and openness (Ackerman and Hilsenroth 2003).

A critically important goal of the therapeutic alliance is the creation of a safe space in which to explore the patient's concerns (Havens 1989; Weiss 1986; Roth 2000). Helping the patient to feel understood, respected and cared for requires a therapist to put the patient's needs ahead of his own (with self-effacement) and to listen for the deep meaning of the patient's experience (with empathy, openness and wisdom). It also requires the therapist to address patient-specific obstacles, such as pathogenic schemas, beliefs (Weiss 1986) and fears (with hope, patience and flexibility).

Helping a patient to move beyond an understanding of her problems toward recovery entails fostering awareness of potentially achievable, shared goals for improving emotional health (Amering and Schmolke 2009), which may include the enhancement of adaptive personality traits. This is a relational process in which the patient identifies with the therapist as they engage together in confronting obstacles which the patient has been unable to surmount alone (Hamilton 1986; Volkan 1968). Positive therapist qualities such as hopefulness, respect, compassion, fairness and love provide an aspirational basis for a corrective emotional experience (Bridges 2006), which, as Lear (2003) points out, is ironic rather than didactic. It is here that differences in therapists' virtues assume particular importance.

Differing Virtues in a Pluralistic Society

Various traditions in our culture articulate preferred moral ideals to advocate their internalization and support their behavioral expression. Evidence suggests that these traditions have a significant impact on the way that clinicians practice. For example, in Curlin et al. (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 over their religious beliefs over into all other dealings in life.

The virtues of the major traditions overlap, but signature (characteristic or preferred) virtues arguably 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.

Signature Religious Virtues in Psychotherapy

In his classic paper "Hidden conceptual models in clinical psychiatry," Lazare (1973) framed a sample case using medical, behavioral, psychological and social perspectives; a subsequent letter suggested a possible existential frame (Peteet 1973). Lazare's description of the case using a psychological frame offers an opportunity to appreciate the role of differing religious virtues in treatment.

Mrs. J., a 53-year-old widow, had been depressed for a few months after the death of her husband. Although the marriage seemed happy at times, there were many stormy periods during their relation. There had been no visible signs of grief since his death.

Since the funeral, she had been depressed and had lost interest in her surroundings. For no apparent reason, she blamed herself for minor events of the past. Sometimes she criticized herself for traits that characterized her husband more than herself. She had had a similar reaction after the death of her mother 23 years previously, when she and her mother had lived together. From the history, it could be inferred that the relation was characterized by hostile dependency. Six months after the mother's death, the patient married. She seemed intelligent and motivated for treatment and had considered psychotherapy in the past to gain a better understanding of herself.

Jews

Intrinsic to the Jewish faith is a commitment to give back to the community, as expressed in the Prayer of Maimonides: "Thou hast chosen me to watch over the life and health of thy creatures. Enable thy creatures to alleviate their sufferings and to heal their diseases."

Judaism also embodies a long tradition of thinking critically, which implies a practical approach to decision making over reliance on received authority. Scholars (Bakan 1958; Ridgway 2006) have debated the contribution to the development of psychoanalysis made by the Jewishness of Freud, who himself explained it by saying that Jews "lack the mystical element" (Szasz 1978). While psychoanalysis has evolved since Freud, contemporary practitioners who "lack the mystical element" continue to value autonomy and the skeptical, persistent pursuit of insight.

A Jewish therapist might try to help Mrs. J. understand the complexity of her ambivalent relationship with her mother and husband, including how it contributed to choices which may have left her with unconscious regrets and self-recrimination. His aim might be for them to face the truth together so that she could reassess and master her problematic tendency to invest in ultimately unsatisfying relationships.

Christians

Christians believe that the experience of God's unconditional love empowers people to love both others and themselves. Francis of Assisi was repelled by lepers and avoided them as others did until he was moved by the love of Christ to embrace them. Psychologist Marsha Linehan ceased being suicidal after experiencing while praying in a chapel radical acceptance, which she later made a central feature of dialectical behavior therapy (DBT) (Carey 2011). Twelve-step programs invite those who recognize their need to respond to grace by moving through a process of self-assessment and forgiveness to altruism. Love-inspired clinicians will be self-effacing and committed to the underserved (Pellegrino and Thomasma 1996).

A Christian therapist might help Mrs. J. by understanding her well enough for her to feel loved and to find in that experience enough acceptance of herself to go even more deeply into the ways she needed to change. He might also help her to look for sources of love and forgiveness beyond herself and the therapy and with time for ways to love herself and others more effectively.

Muslims

Muslims emphasize submission to the will of Allah in all of life. Among the many virtues based on the Quran are prayerfulness, repentance, honesty, loyalty, sincerity, frugality, prudence, moderation, self-restraint, perseverance, patience, hope, dignity, courage, justice, tolerance, wisdom, good speech, respect, purity, courtesy, kindness, gratitude, generosity and contentment.

The underlying Islamic virtue of reverence implies respect for received wisdom and acceptance of one's limitations. "There is no place for despair because you have confidence in knowing that it's God Himself who is in charge of everything, the All Seeing, All Knowing, and All Fair and Wise God. And for those who fear Allah, He always prepares a way out, and He provides for him from sources he never could imagine. And if anyone puts his trust in Allah, sufficient is Allah for him. For Allah will surely accomplish His purpose: verily, for all things has Allah appointed a due proportion." (Quran, 65: 2–3).

A therapist guided by this ethic would likely encourage Ms. J. to come to terms with the losses of her husband and mother in view of the larger context of her life and to do what she can to live in accordance with her highest values, as the path to fulfillment.

Buddhists

Buddhist virtues of compassion, awareness, harmony and the renunciation of craving as achieved through the practice of mindfulness have increasingly found expression in mainstream psychotherapy (Baer 2006; Segal et al. 2002), as well as in the self-care of clinicians who care for the suffering (Krasner et al. 2009). For example, Buddhist psychology helpfully distinguishes compassion as empathy with a wish to make the sufferer better from its "near enemies" of pity, horrified anxiety and grief (Halifax 2011).

A therapist operating with a Buddhist framework might first join Ms. J. in becoming fully aware of her pain and of its sources in her disappointed wishes for things to be different. By carefully observing these without judgment, he would not only support her calm acceptance of reality, but also offer her a means by which she could become more compassionate toward herself.

Hindus

Two concepts are central to the way that Hindus understand and pursue virtue. Dharma, the divinely established natural order of the universe, underlies a duty to behave in ways that are decent, proper and correct. Karma, the principle of cause and effect, ensures that one's behavior has consequences.

A therapist operating with a framework of Dharma and Karma might explore whether Ms. J's tendency to blame herself after her mother's death reflects a sense of guilt for a failure to live up to her family obligations and whether she is suffering and/or living in fear of its karmic consequences. Rather than helping her find forgiveness, he might focus with her on how to move forward with her life in a more intelligent and dispassionate way.

Secularists

In his book *A Secular Age*, Charles Taylor (2007) documents the way that Western culture as a whole has come to adopt an immanent frame, with its preferred virtues of self-sufficient reason and individual autonomy. While medicine, including psychiatry, has recently shown increasing interest in the clinical relevance of spirituality and religion, secular virtues remain dominant.

A clinician expressing secular virtues might treat Mrs. J. by focusing on evidence for interventions for complicated grief and depression such as cognitive behavior therapy (CBT), which identify the maladaptive aspects of her responses to her loss and support ways she can care better for herself.

Discussion

Several general considerations qualify the suggestion made here that the virtues characteristic of therapists' differing traditions influence the direction of clinical work in recognizable ways. Various factors shape clinicians' personal and professional values, including their own family and childhood experiences, cultural/ethnic background, education, political affiliations or beliefs and, not least, the therapeutic school in which they trained. Implied or implicit values acquired from all of these sources exist in dynamic interplay with those of their spiritual or secular tradition. It is easy to imagine, for example, that a therapist using a psychoanalytic frame might embody virtues characteristic of a Jewish tradition, regardless of his/her personal spiritual convictions.

Several clinical considerations also govern the extent to which virtues fostered by spiritual traditions influence therapy. One is the relationship of the therapist to his or her tradition. An extrinsic or superficial rather than an intrinsic relationship would be expected to have little impact. And a clinician's possession of the virtue of practical wisdom is a prerequisite for fully developing the other virtues. Without it, responsibility and disputation could become rigid and confining, love without boundaries could become masochistic and impractical, and equanimity could become passive, reverence mindless and respect for science reductionistic.

A further consideration is the degree of integration of a patient's spiritual commitments into his or her emotional life. Without knowing what characterizes the patient's best self, or ego ideal, it is difficult for a therapist to know what elements of this ideal self to support, either directly, or through knowing the resources of the patient's tradition. Clinical challenges may also reveal a need for particular virtues. For example, equanimity in the treatment of a trauma survivor may need to be balanced by validation of justified anger and possibly forgiveness. Similarly, reverence for authority may need to be balanced by a way to respect doubt.

Yet a third factor is the match between the therapist's preferred virtues and those of the patient—an issue important to consider with respect to therapeutic fit, informed consent and the feasibility of forging consensus. Problematic patient tendencies embodied in patient schemas benefit from therapist virtues that are potentially corrective—for example, patient impulsivity from therapist patience, patient suspiciousness from therapist transparency, patient insecurity from therapist equanimity and patient pessimism from therapist hopefulness. However, a patient may develop unrealistic expectations of a therapist identified with a particular tradition, making clarification necessary in order to achieve informed consent. For example, a religious patient might expect a therapist with the same

faith to focus directly on her relationship with God, rather than on the unresolved conflicts within herself that make this and other relationships difficult. A non-religious patient on the other hand might feel uncomfortable with a faith-oriented therapist who seems to suggest looking for answers to relational or existential problems outside of the therapy. The potential for a therapist to overvalue, perhaps unconsciously, what has been significant in her own life further highlights the need to clarify early in treatment the nature and goals of the work (Peteet 1994) and to consider whether their core commitments converge enough to make a working agreement possible.

Finally, virtues differ within broad traditions—for example, the emphases and styles of Pentecostals differ from those of the Orthodox within Christianity and those of fundamentalists and liberals within many religious traditions.

Therapists sometimes avoid discussing virtues because morality can connote moralism. Yet we know that while there are ethical risks involved in influencing a patient by suggestion, if only through identification, neutrality with respect to values is both unrealistic and unhelpful (Bishop et al. 2007).

A further reason for the neglect of the virtues in psychotherapy is the connection between virtues and religion, with its frequent connotations of deeply held differences and of conflict with science. Yet a growing body of research points to the importance to human flourishing of positive character traits, including those involving cooperativeness and self-transcendence (Cloninger 2004; Peterson and Seligman 2004) which are upheld by all of the major faith traditions.

Although our culture is pluralistic, religion in the West is largely privatized and compartmentalized. One result of this is that biomedicine is largely dominated by a secular, immanent frame. New physicians receive little if any training regarding the connections between spirituality and health. Nor are they offered many opportunities to reflect on how their own religious or non-religious backgrounds may influence clinical care. Yet as Kinghorn et al. (2007) following MacIntyre (1988) point out, professional virtues need to be sustained by communities committed to transcendent values. Attention to the signature virtues of different traditions can help physicians to articulate their preferred virtues and become more thoughtful about character formation. This could lead to a better understanding of formative spiritual practices (such as Buddhist compassion meditation, the Jesuit examen and Muslim fasting) and of how well they apply outside of the tradition in which they developed (Shuman and Meador 2003). For their part, if religious traditions can articulate and support the expression of their preferred virtues within their own communities, this may provide a safe foundation for dialogue with other faiths that will both enhance medical practice and create opportunities for collaborative teaching and interdisciplinary research—including into how differing virtues function in psychotherapy. For example, future research could explore how the virtues that therapists from a particular tradition believe are most significant influence their work with patients from similar or dissimilar backgrounds and the effect that this has on diagnosis and treatment.

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