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Schemas, Core Beliefs, Worldviews, and Clinical Practice

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Introduction

As psychologists we are trained to be sensitive to cultural differences. Worldviews and culture are interdependent. They shape our views of everything, including what exists, how we know, how things work, the nature of persons, right and wrong, and the ways we conceptualize human problems, interventions, and treatment goals. Truer or more accurate worldviews can thus benefit clients, while less accurate worldviews may impair treatment or even cause harm.

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ABSTRACT

Clinicians generally seek to do the right thing in their work. In this process, they are inevitably guided daily by their worldviews, which are intertwined with their cultures. Worldviews include beliefs about knowledge claims, the nature of human persons, ethical and moral perspectives, what is healthy and dysfunctional, what makes for optimal human functioning, and specific notions about good and evil (Bufford, 2012). Such belief sets are often referred to as core schemas or cognitive structures.

In America today, three widespread schemas are:

1) Strict empiricism - or science as the preferred way of knowing
2) Materialist reductionism (physicalism) as a view of all that exists
3) Relativism in ethics

Though these are theoretical concepts, they have profound implications and consequences, conscious and unconscious, for clinical work.

Each of these views implicitly rejects holistic and purposeful conceptions of human life. Empiricism, physicalism, and relativism contribute to a partisan, piecemeal, fragmented, disintegrated, and abridged view of the nature of the universe, the course of history, and of human persons.

A more realistic, critically based, evidentially sound view of the nature of reality can make psychotherapy more effective. Holding alternative worldviews could make psychotherapy less effective, useless, or even harmful. We will use clinical examples to illustrate the implications of these notions, and present some ways to sensitively and ethically address them.

GAINING KNOWLEDGE THROUGH BOTH PHILOSOPHY AND SCIENCE

Many personal beliefs and values with important clinical implications naturally follow from the acceptance or rejection of particular views. These include views on whether human beings can know and act upon knowledge apart from science, whether we have merely instrumental or deeply intrinsic value, whether we have libertarian free will or are wholly determined by the laws of physics and chemistry, and whether personal improvement (both moral and non-moral) is possible or rendered incoherent by relativism.

Here we propose first, that knowledge is available in many ways apart from narrow empiricism. Second, we live in a world of immaterial essences joined to physical bodies, not merely material bodies. Third, important core elements of morality and ethics are indeed true for everyone, not merely subject to arbitrary, constructivist, social or individual hermeneutic whims. There is good evidence for these notions and therefore good reason to believe them.

Scientific studies can tell us what is statistically normative, but they cannot tell us what is truly *normal*—or perhaps more aptly what is right and good. Indeed, the very task of defining science (arriving at the answer to the question *what is science?)* is unscientific, for it is an unavoidably philosophical set of questions.

Indeed, to see the absurdity of the converse, try to imagine what it would look like to try to answer the question *what is science* by doing exclusively experimental or empirical activities. Defining science is not an empirical process, but is in the domain of philosophy of science. This brings us to the primacy of philosophy as a second-order discipline, which inevitably manifests judgments prior to all enquiries in other, first-order disciplines, such as the science of psychology.

This is as true in science as in other theoretical enterprises. Before exploration can begin, philosophical questions are either explicitly or implicitly answered, and taken to be the basis upon which all research is conducted. Ethical issues, presuppositions, methodological preferences, and teleology (why is this pursuit being engaged in?) all function as pre-inquiry preliminaries, always and without exception, and we take ourselves to "have knowledge" regarding these things before we test for the null hypothesis.

It has become astonishing in clinical psychology, as in many other disciplines, how the question "what is ultimate?" has been reduced to the pragmatic question, "what works?" It is also disconcerting that many believe the second question can be adequately answered while ignoring the first.

As a practical application, consider how a counselor might respond to a client who claims that part of her problem is "the demons." For a counselor who does not think demons are real, a possible response may be to seek to discredit her belief in demons or to address her delusions. A counselor who considers demons real, however, may want to take or more explorative approach that examines the client's beliefs about demons and her explanation of how they may be a problem . A somewhat different way of approaching this question might be to ask the client: "How do you know that your problem is the demons?" This approach at least allows that the client may know something that the counselor does not know—or at least may not yet know. Even those who believe in the existence of demons may doubt demons account for the client's problems. Similar problems arise when we need to evaluate a claim that "God told me to . . ." Think about the story of the prophet Ezekiel, told to lie on his left side for 390 days (Ez 4).

Similarly, agency matters. The whole counseling process is based on the assumption that what we do as counselors and clients can make a difference. Yet for many, science is undergirded with the implicit belief that material causation is the only form of causation. Under that assumption there is nothing the client can do about his problem—and nothing the counselor can do as well, since the actions of both are determined by their antecedent natural causes. Thus a logical corollary of material causation alone is fatalism and hopelessness.

Though not in a moral sense in most cases, still, our view that some human condition needs to be changed implies a value judgment, a belief about good and evil. A recent client reported that she came to see me because she was angry, sad and tearful, had lost her appetite, and was having difficulty sleeping. Essentially, she implied that this was a bad way for her to be. I agreed. But imagine for a minute that I had not, and said to her, "So how is that a problem?"

Recently another client proposed that her health was failing and her future was likely to become increasingly pain-filled. She indicated that she was considering physician-assisted suicide, legally permissible in Oregon. The unspoken underlying premise for her was that she would be better off dead. However, if Christian views of death are true, she is profoundly wrong. As her therapist, how should I then proceed? The answer hinges on worldview considerations regarding:

- What exists and how we can know it.
- How reality works.
- Good and evil.

Consider the following dialogue:

A CLINICAL DIALOGUE

- Therapist: "Why don't you try the strategies we discussed this next week and see how it goes?"
- Client: "I am a skeptic, doc. I do not like to act unless I *know* that I know all the relevant data. I don't trust anyone or anything unless they can prove it to me."
- Therapist: "So you like evidence for your facts, or you won't proceed?"
- Client: "Yes. And I don't think you have shown me that this will work."
- Therapist: "Can you think of anything that you know, or of any decision you have ever made about which you actually had every conceivable, relevant, or available bit of information, before you proceeded?"
- Client: "Let me see… I guess not, there are a lot of unknowns…"
- Therapist: "So it seems like we can live, think, know, and act in the world without total or 100% proof that it is the best course every time?"
- Client: "I guess that's how I live and make decisions anyway; not based on perfect proof, but on probabilities. I never really thought of it like that."
- Therapist: "And does it seem to you that there is enough evidence, or reason to believe this might work for you?"
- Client: "I guess so."
- Therapist: "Sounds good."

CONCLUSIONS

Worldviews matter. They shape the way we understand ourselves, each other, and the world around us. Counseling or psychotherapy is a thoroughly worldview-embedded enterprise. Our worldviews shape the ways we conceptualize problems, the interventions that we embrace and to which we object, and the goals we desire. For counseling to progress there must be a good enough match between the worldviews of counselor and client so that they can form a relationship or working alliance that share views of the problem interventions, and goals. There must also be an embrace of the notions that such an enterprise is possible, worthwhile, and effective.

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